Comprehensive Medication Management Service Model

INSTRUCTIONS FOR USE

This document describes the standardized approach for the provision of comprehensive medication management to patients receiving care from the Pharmacists Clinic, UBC - Faculty of Pharmaceutical Sciences (the Clinic). All clinic pharmacists and learners (students, residents or pharmacists attending for professional development) are expected to follow this standardized approach.

Overview:

All patients receive standardized comprehensive medication management (CMM) to ensure the highest possible level of pharmaceutical care is provided

Objectives of CMM:
1. Optimize drug therapy by identifying and resolving actual or potential drug therapy problems (DTPs)
2. Maximize patient adherence to medications
3. Improve patient understanding and education
4. Improve the quality of life for patients
5. Optimize the quality of care for patients.

CMM is conducted by a pharmacist (or supervised learner) with a patient either in-person, by telephone or by secure telehealth in a manner that respects the patients right to privacy.

By the end of each encounter, each pharmacy practitioner:
1. Prepares a documented record of care provided in Oscar EMR (using the Subjective, Objective, Assessment, Plan format).
2. Provides the patient with an up-to-date best possible medication history (BPMH).
3. Provides the most responsible physician (usually the family physician) and other professionals within the patient's circle of care (where appropriate) with a consultation letter detailing relevant clinical information, recommendations and follow-up plans.

Where **PATIENTS** meet **EXPERT CARE**.

Approach – Introduction

Each encounter starts with a brief introduction/overview/review of service with to patient.
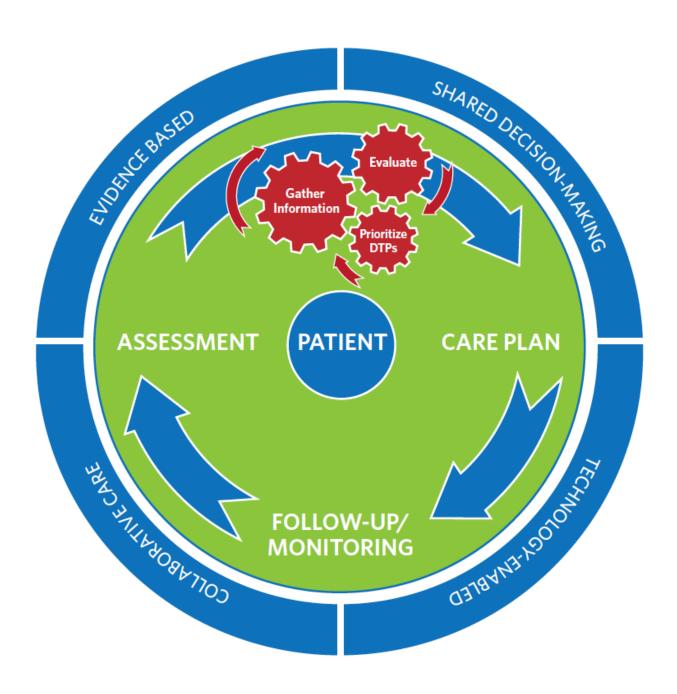
First Encounter

- Welcome and introduction to the Clinic
- Explain the format for the appointment
- Explain affiliation with UBC (when service provided off-site)
- Start a chart for the patient
    - Demographic information (name, address, PHN, date of birth)
    - Health care information (family doctor, usual community pharmacy)
    - Private health insurance (if applicable)
- Obtain patient consent
    - For service (includes accessing medication information on PharmaNet)
    - For learner participation in care (if applicable)
    - For recording of conversations (if applicable)
    - For recording of information in the EMR located at UBC
    - For patient information to go into a data registry for evaluation and research purposes (if applicable – see separate consent forms)

Follow-up Encounter

- Welcome to the Clinic
- Explain the format for the follow-up appointment
- Remind patient of affiliation with UBC (when service provided off-site)
- Review information in chart and update as required
    - Demographic information (name, address, PHN, date of birth)
    - Health care information (family doctor, usual community pharmacy)
    - Private health insurance (if applicable)
- Obtain patient consent (as necessary)
    - For service (includes accessing medication information on PharmaNet)
    - For student participation in care (if applicable)
    - For recording of conversations (if applicable)
    - For recording of information in the EMR located at UBC
    - For patient information to go into a data registry for evaluation and research purposes (if applicable – see separate consent forms)

Approach – Clinical

Although the CMM patient care process is usually presented in diagrams as a linear process, in reality, the discussion, thought processes, decisions, monitoring and communication tend to occur in a less structured, more circular way:

Each patient encounter includes the following components of discussion and documentation:

1. Patient Assessment:

- Subjective and Objective General Findings
    - Chief complaint/reason for referral/appointment
    - Known medical conditions
    - Current medications
        - Medication Reconciliation – using PharmaNet, clinician records, pharmacy records and what the patient is taking at home to reconcile any conflicting information
        - Medication Review – gage patient's understanding about medications and develop an initial draft of a Best Possible Medication History (BPMH)
    - Natural health products and supplements
    - Allergies and adverse reactions
    - Patient barriers
        - Attitudes about medications, self-care, natural health products
        - Financial limitations
        - Language
        - Mobility for in-person visits
        - Perceived understanding of therapy
        - Adherence issues

- Subjective and Objective Findings Specific to each Medical Condition
    - Subjective history of present illness from patient
    - Findings on physical assessment
    - Current monitoring parameters

    This information is documented as Subjective and Objective findings section of the EMR template

- Assessment of Specific Findings for each Medical Condition
    - Identify actual or potential drug therapy problems (DTPs)
    - Prioritize DTPs and patient needs
        - Identify which DTPs will be addressed now and which will be deferred to next encounter

    This information is documented as the Assessment in the EMR teamplate

2. Care Plan:

- P – Care Plans for priority DTPs being addressed today
    - Goals of therapy
        - Specific, Measureable, Action-oriented, Realistic, Time-bound (SMART)
    - Activities/interventions being implemented
    - Summary of what the patient was told, what the patient is responsible for doing and what the pharmacist is responsible for doing.
- Summary of DTPs not addressed today (to be completed at t future date)
- Follow-up Plan
    - Next encounter scheduled to coincide with DTP monitoring timeline
    - BPMH finalized and printed for the patient
    - Consultation note prepared for referring practitioner, family physician and community pharmacist (if applicable)

    This information is documented as the Plan in the EMR template

3. Evaluation of progress and Follow-up (at next encounter):

- S/O - Subjective and Objective General Findings
    - Reason for follow-up
    - New medical conditions
    - Current medications
        - Current BPMH – using PharmaNet, clinician records, pharmacy records and what the patient is taking at home to identify changes to be updated
        - Medication Review – gage patient's understanding about medications and develop an initial draft of a revised Best Possible Medication History (BPMH)
    - Natural health products and supplements
    - Allergies and adverse reactions
    - Patient barriers

- S/O - Subjective and Objective Findings Specific to each Medical Condition
    - Course of present illness as described by patient
    - Findings on physical assessment
    - Current monitoring parameters

    This information is documented as Subjective and Objective findings in the EMR template

- A – Assessment of Specific Findings for each Medical Condition
    - Status of DTPs addressed at the last appointment (resolved, improved, worsened)
    - Review DTPs carried forward from previous appointment and identify new DTPs
        - Prioritize DTPs
        - Identify which DTPs will be addressed now and which will be deferred to next encounter

    This information is documented as the Assessment in the EMR template

- P – Care Plans for priority DTPs being addressed today
  - Goals of therapy (new or revised from previous care plans)
    - Specific, Measureable, Action-oriented, Realistic, Time-bound (SMART)
  - Activities/interventions being implemented
  - Summary of what the patient was told, what the patient is responsible for doing and what the pharmacist is responsible for doing.
- Summary of DTPs not addressed today (to be completed at t future date)
- Follow-up Plan
  - Next encounter scheduled to coincide with monitoring timeline
  - BPMH finalized and printed for the patient
  - Consultation note prepared for referring practitioner, family physician and community pharmacist (if applicable)

This information is documented as the Plan in the EMR template

APPENDIX A - Preparation for the Appointment

The following outlines the responsibilities of the clinic pharmacist, learner (if applicable), and the clinic assistant before the patient appointment. The clinic pharmacist must be well prepared for all patient encounters and complete (or oversee completion of) all of the following activities.

Clinic Pharmacist
Review the reason for the visit and relevant patient information
Conduct any necessary research prior to patient arrival
Prepare any materials or resources that may be necessary
Learner
Review the reason for the visit and relevant patient information
Conduct any necessary research prior to patient arrival
Prepare any materials or resources that may be necessary
Discuss the clinical approach with the pharmacist
Clinic Assistant
Call the patient 1-2 days before their visit to remind them of appointment, confirm reason for appointment, provide details on clinic location/parking and obtain verbal consent (for service, PharmaNet record access, etc., if not already obtained)
Prepare a chart in Oscar and Kroll including information from the patient, referral note and PharmaNet profile
Identify necessary consent(s) and prepare documentation

APPENDIX B - After the Appointment

The following outlines the responsibilities of the clinic pharmacist, learner (if applicable), and the clinic assistant following the patient appointment. The clinic pharmacist is responsible for ensuring all follow-up is completed as required.

Clinic Pharmacist
Complete Documentation – SOAP note, BPMH, consultation note for other health professionals
Conduct any research or follow-up on issues as required
Inform the clinic assistant that documentation is complete
Learner
Complete Documentation – SOAP note, BPMH, consultation note for other health professionals
Conduct any research or follow-up on issues as required
Inform the clinic assistant that documentation is complete
Review the case with the supervising pharmacist
Clinic Assistant
Schedule follow-up appointment for patient
Confirm that documentation is complete
Fax or mail documents to patient or other health professionals
Prepare and submit a claim using the Kroll software

APPENDIX C – Target Time Allocation

The following outlines an estimate of the time required by the clinical team to prepare for, deliver and follow-up after a CMM service appointment. The time range will vary depending on patient complexity, the experience of the pharmacist and which team members are involved.

Before the appointment	
Pharmacist	15 minutes
Learner	15 minutes
Clinic Assistant	10 minutes
During the Appointment	
Pharmacist	30-45 minutes
Learner	45-60 minutes
After the Appointment	
Pharmacist	15 minutes
Learner	30-60 minutes
Clinic Assistant	10 minutes