

# Do Our Pharmacy Standards Promote Integrated Care?

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Health care should be clinically effective, cost-effective and safe. Worldwide, reforms are in progress to cope with the rising costs of health care resulting from demographic changes and medical advances. Two approaches are commonly adopted to address these challenges: utilizing the skills of the wider health care workforce and transferring the balance of care from secondary to primary care settings. At the same time, it is accepted that patients should be partners in decision-making about their care, which leads to patient empowerment and better health outcomes. These service reforms have been challenged because of concerns over safety, and continuity of care may have suffered. Patients complain of having to repeatedly tell an increasing number of different professionals the same details of their medical (and social) situations.

A relatively recent concept designed to address some of these concerns is integrated care, defined by the World Health Organization as “a concept bringing together inputs, delivery, management and organisations of service related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.”<sup>1</sup> Integrated care is not a single entity but a multidimensional philosophy of care, including vertical integration across settings and horizontal integration within teams.

Those with the most complex health care needs are most likely to benefit from integrated care. Data from the United Kingdom show that 4 out of 5 people 75 years of age or older take a prescription medicine, and 36% are taking 4 or more.<sup>2</sup> Adverse events associated with medicines are increasingly common because of drug interactions from polypharmacy regimens, unnoticed contraindications to prescribed medicines due to comorbidities, and the physiological changes associated with aging. All health care professionals need to be aware of the changing balance of risks and benefits of medicine use in patients with complex needs, and pharmacists, as experts in medicines, are best placed to advise on safe and effective medicine management.

Pharmacists know how integral their profession is to ensuring safe, clinically effective, and cost-effective medicine use.



However, despite pharmacy’s inalienable right to be represented in the core health care team, delivering integrated care, most of the initiatives related to integrated care centre on physicians’ roles and practices; involvement of members of the wider health care team is commonly limited to nursing.

To make the case to our colleagues who are not pharmacists, consider the following 3 examples. A recent large study conducted in Scotland showed that ward pharmacists identified and resolved prescribing errors in the drug charts of 36% of patients.<sup>3</sup> On average, 7.5% of the prescriptions written by doctors contained an error.<sup>3</sup> Integrating pharmacists earlier into the prescribing process and enabling them to apply their traditional skills of prescription checking at an earlier stage would pre-empt such errors and avoid the risk of them being undetected because of a lack of pharmacy resources to cover all wards. Yet a common way to reduce health care costs is by freezing vacant positions, and so pharmacy teams are depleted at the very time pharmacists are needed most.

The second example builds on the first. Most errors occur either at admission or upon discharge. Although medicine reconciliation is recognized widely as one way of reducing errors in practice, many challenges remain. Patients, especially those with unscheduled admissions, may not always be able to clearly communicate their current medications. In addition, access to “emergency care records” (a password-protected electronic dataset with core medical information on every patient in Scotland, accessible by authorized doctors and pharmacists

providing unscheduled care) is not always possible, and pharmacists are not always present at the point of admission.

Pilot studies in Scotland have demonstrated the benefit of electronically sharing, between community and hospital pharmacists, information about a patient's medications at both admission and discharge. Patients have been willing to consent to this use of their data, and pharmacists believe medication safety incidents have been averted. This is an excellent example of integration of care across settings with the patient at its heart.

The third example is relevant to both service redesign and extended roles. Pharmacist prescribing has now been introduced in Canada and the United Kingdom and is especially well established in Scotland. In some hospitals, the majority of pharmacists are prescribing, often in clinical areas where specialist understanding of medications is required (e.g., oncology and cystic fibrosis). Anecdotal and research evidence suggests that prescribing by pharmacists is well regarded and effective. In a study of general practice-based pharmacist prescribing for patients with chronic pain, pain outcomes were significantly better in the group with pharmacist prescribing than in the usual care group.<sup>4</sup> However, despite these endorsements, financial constraints are limiting wider implementation. Instead, prescribing is delegated to specialist nurses, who have less formal training in therapeutics.

Much of what pharmacists do is governed by professional standards, and to conclude this article, we reflect on how such standards promote integrated care.

The Canadian standards for professional hospital pharmacy practice<sup>5</sup> contain many relevant statements to support integrated care, including 2.4 ("Responsible for continuous pharmaceutical care and seamless care of patients"), 2.8 ("Collaborates with patients to assess needs, establish mutual goals and develop and implement a care plan"), 2.9 ("Collaborates with other health care providers"), and 4.1 ("Develops and sustains collaborative partnerships with patients, patient groups, other healthcare professionals . . .").

The UK standards<sup>6</sup> reflect similar aspirations. One of their 10 listed dimensions of care is "integrated transfer of care". Given that pharmacists already have an appropriate framework in place, what more should be done to ensure that this framework is translated into a practice model that allows pharmacists to play their part in delivering integrated care? Four approaches are suggested.

First, there is a need to create and disseminate a greater body of research evidence. A single study will not change practice. Studies such as those summarized above should trigger further work extending the evidence to different geographic and clinical contexts. Second, further and meaningful joint undergraduate and postgraduate training is needed, to increase mutual interprofessional understanding and respect. Third, in

jurisdictions where pharmacists do not have access to patients' complete medical records, such access should be established, to enable pharmacists to provide the best pharmaceutical care, informed by previous medical history and management. Finally, all pharmacists must lobby policy-makers to ensure that the skills of the profession are fully recognized and integrated into health care planning. Hospital pharmacists should certainly rejoice in the undoubted progress of the past decade, but much remains to be done.

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