PHARMACY ASSOCIATION OF NOVA SCOTIA

Managing Chronic Disease - Pharmacist Certificate Program(s)

As the prevalence of chronic disease continues to rise, opportunities for pharmacists to be compensated for their interventions in the area of chronic disease, from both the private and public sector continue to become available across the country.

Pharmacists are uniquely positioned to provide services that support positive patient outcomes in chronic disease, due to their knowledge, skills and accessibility. Pharmacist consultations that include medication management services along with coaching and support for lifestyle modifications have resulted in significant benefit to their patients.

This program has been developed to support pharmacists in the provision of chronic disease management services. The program will cover cardiovascular disease, diabetes, asthma/COPD and smoking cessation. Each of these sections will include a refresher on the disease states, along with updates with respect to current practice guidelines, and practical applications for patients.

As a pre-requisite to any of the disease based courses, pharmacists will be required to complete a module on Behavioural Change Counselling, to support their role in motivational coaching and lifestyle modifications. A module on the Care Plan Process will also be required. It will provide guidance and support with respect to the process flow, documentation and follow-up in the provision of these services.

Overview of PANS Managing Chronic Disease Certificate Program

The following courses must be completed:

- Behavioural Change Counselling
- The Care Plan Process
- Diabetes Modules
- Asthma and COPD Modules
- Cardiovascular Disease Modules
- Smoking Cessation Modules

Behavioural Change Counselling

Pre-requisite Courses

- None

Learning Objectives

After completion of this module, the learner will be able to:

- Establish a change-based relationship by promoting collaboration and empowerment while avoiding teaching and telling
- Conduct a readiness assessment and promote readiness when it is low
- Support the patient in evidence based behaviour modification interventions
- Identify psychosocial factors that are associated with success and maintenance of success

Outline (1.5 hours)

Change-based relationships

- Motivational communication
- Patient Centered Listening

Understanding behavior

- Defining the behavior to be changed
- Determining readiness to change
- Enhancing readiness when it is lacking

Behaviour Modification

- Behavior modification when readiness is there
- Applications to lifestyle modifications such as diet and exercise

Psychosocial implications

- Acknowledging the psychosocial implications
- Working with psychosocial implications

The Care Plan Process

Pre-requisite Courses

- Behavioural Change Counselling

Learning Objectives

After completion of this module, the learner will be able to:

- Implement the patient care process and how to establish a successful care plan
    - Gather information and complete a patient assessment
    - Discuss health goals and formulate a plan to reach these goals with the patient
    - Collaborate with other health care professionals to help formulate the best care plan for the patient
    - Formulate and implement a care plan with the patient
    - Provide ongoing follow-up and support the patient in meeting established goals
- Incorporate care planning into practice
- Understand the necessary documentation associated with the care plan and meeting provincial standards of practice

Outline (1.5 hours)

- The patient care process and where care plans fit in
- Identifying and consenting patients (will be general – study info will be provided at live session)
- Preparation needed prior to patient interview
    - Collaboration
    - Best Medication History
    - Patient adherence and med profile -perform a quick assessment
    - Organizing paperwork and tools
    - Organize information for the patient
    - Review therapeutics if needed
- Conducting a patient interview
    - Collecting relevant information
    - Formulating health goals with patient
    - Assessing readiness
    - Assessing drug therapy
- Establishing goals and next steps with the patient
- Collaborating and ongoing communication with the physician
- Following up with patients, reviewing progress and planning next steps
- Documentation
- Examples with cases

Asthma and Chronic Obstructive Pulmonary Disease (COPD) Modules

Pre-requisite Courses

- Behavioural Change Counselling
- The Care Plan Process

Learning Objectives

- Provide evidence based patient education regarding the management of Asthma and COPD including, pharmacological and non-pharmacological management of COPD.
- Counsel patients regarding the appropriate use of inhalation devices.
- Utilize Asthma and COPD assessment tools to communicate with, and assess the patient. Collaborate with the patient's health care providers where appropriate.
- Create Asthma and COPD Action Plans, and establish health goals to monitor as part of an overall patient care plan.
- Identify resources to provide ongoing support to disease management for COPD.

Outline (4.5 hours)

Module 1: Asthma

- Pathophysiology and Epidemiology of Asthma
- Guidelines for the Management of Asthma
- Treatment Options for Asthma
- Asthma Action Plans
- Immunization Recommendations for Patients with Asthma
- Tools and Resources for Asthma Management
- Case Study

Module 2: COPD

- Meet Our Patients
- COPD – Pathophysiology, Epidemiology and Impact on Canadians
- Diagnosis and Assessment of COPD
- Treatment Options for COPD
- Action Plans for COPD
- Management of Stable COPD and Acute Exacerbations of COPD
- Comparison of Inhalation Devices
- Tools and Resources for COPD Management

Diabetes Modules

Pre-requisite Courses

- Behavioural Change Counselling
- The Care Plan Process

Learning Objectives

After completing this module, the learner will be able to:

- Provide education to patients regarding diabetes including medication therapy and lifestyle modifications.
- Implement recommendations from the 2013 Canadian Diabetes Guidelines
- Individualize treatment plans and targets to their patients

Outline (6 hours)

Module 1: Overview
- Overview
- Pathophysiology
- Differentiate between types of diabetes
- Diagnostic criteria
- Targets
- Laboratory recommendations

Module 2: Complications of Diabetes
- Short term complications
- Long term complications
- Sick day management
- Special circumstances: pre-procedure and surgery

Module 3: Non-pharmacological management
- Lifestyle Modifications
- Exercise recommendations
- Basic nutrition counselling

Module 4: Pharmacotherapy
- Oral medication therapy
- Non-insulin injection therapy
- Insulin therapy
- Continuous subcutaneous insulin infusion therapy
- Individualizing therapy

Module 5: Monitoring
- Self-monitoring of blood glucose
- Reviewing blood glucose results
- Pattern management

Module 6: Patient Centered Care

- Example initial and follow up appointment flow
- Documentation
- Case Study

Cardiovascular Health Modules

Pre-requisite Courses

- Behavioural Change Counselling
- The Care Plan Process

Learning Objectives

After Completion of the module the learner will be able to:

- Complete a cardiovascular risk assessment using the Framingham Risk Calculator
- Optimize medication regimens with patients and implement strategies to improve adherence
- Create an individualized treatment plan for patients with ischemic heart disease, dyslipidemia and hypertension based on current guidelines
- Identify key principles of lifestyle modification and create a simple plan for patients to follow

Outline (2 hours)

Module 1: Ischemic Heart Disease

- Introduction
- Pathophysiology
- Prevalence
- Cardiovascular Risk Assessments and Screening
- Targets
- Medications and Pharmacoeconomics
- Prevention and Lifestyle Modifications
- Case Study

Module 2: Hypertension

- Introduction
- Pathophysiology
- Prevalence
- Cardiovascular Risk Assessments and Screening
- Targets
- Medications and Pharmacoeconomics
- Prevention and Lifestyle Modifications
- Case Study

Smoking Cessation Program

Content adapted, with permission, from the Canadian Pharmacists Association's 2016/2017 Quit Smoking and Inhaling Tobacco CE program

Learning Objectives

Module 1
After completing this module, participants will be able to:

- Discuss the risks of tobacco use and the benefit of quitting
- Assess the client's readiness to quit
- Utilize a 5 A's approach: Ask, Advise, Assess, Assist, Arrange
- Describe the professional and financial rewards for providing "above-and-beyond" care for clients quitting smoking

Module 2
After completing this module, participants will be able to:

- Discuss the reasons people smoke, including physical and behavioural dependence
- Stimulate and support a client's desire to deal with their addiction to nicotine, including withdrawal symptoms
- Recognize the utility of supportive measures in the smoker wishing to quit

Module 3
After completing this module, participants will be able to:

- Outline available smoking cessation aids and the characteristics that may make an aid more appropriate than others in certain clinical situations
- Discuss the use of aids in terms of its indication, precautions, and counselling issues
- Discuss alternate cessation methods
- Discuss useful behaviour tips

Module 4
After completing this module, participants will be able to:

- Communicate effectively with your client
- Provide effective face-to-face counselling and telephone or in-person follow-up
- Refer clients to appropriate outside resources

Outline (4.5 hours)

Module 1: Starting Intervention: Why They Should Quit and How You Should Help Them
Module 2: Addiction and Its Implications

Module 3: Pharmacotherapy and Behavior
Module 4: Counselling Process and Putting It All Together

GreenShield Cardiovascular Health Coaching Program

This online module, provides operational support and guidance for pharmacists and is required for those that wish to provide the Greenshield Cardiovascular Health Coaching service to their eligible patients. For further information about this program, visit https://www.providerconnect.ca/HealthCoaching/ProgramInformation.aspx.