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A New Pharmaceutical Care Concept: More Capable, Motivated, and Timely

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When the concept of "pharmaceutical care" (PC) born at the beginning of the 1990s, very few authors could envision its contributions throughout of these decades, not only for patients but also for our profession.[1]

However, it could not be otherwise, as the context has radically changed worldwide in every possible way. Nowadays, a much more complex and specialized pharmacological arsenal is available, together with new health care and a regulatory framework.

For many years, different authors have agreed that the traditional concept of PC has already reached its limit, being necessary to transform it, not to change it.[1] For that, it is essential to reconsider a definition of our activity much more in line with the times and needs of patients today. The importance of our participation in the improvements in therapeutic results is evident, as there are many challenges to face. First, complex treatments in delicate pathologies that require active and trained patients for their self-care out of their usual environment. Second, the loss of effectiveness due to poor adherence or persistence. Third, iatrogenic damage caused by avoidable interactions in reviewable polypharmacy regimes. Fourth, the incorporation of new concepts such as aging or de-prescription. And last, but not least, the high economic impact of some drugs that require optimization of the results to the maximum.

Recently, the logical dynamism and the progression of our profession have led to the adaptation of some health care environments according to their possibilities. Furthermore, current regulations have generated a critical variability that, at least, should be considered as a weakness in our professional model, and does not guarantee our contribution to obtain the best results in the health of our patients.

Due to all of this, Blackburn et al[2] suggested the importance of modifying the current definition of PC and its associated care processes, in order to ensure the targeting of the pharmaceutical activities on high-priority patients on a consistent basis. However, despite this need of transformation, the strategy to follow to face this challenge and give the correct answers has not been contemplated in depth from a global to a national perspective.

As a response to the need of transforming the assistance in extreme care and professional situations, the MAPEX project "Strategic map for outpatient care" emerged in 2014 in Spain, aiming to be "the bridge uniting patients and their results in health, together with the healthcare system as efficiently as possible." Up to date, more than 200 hospitals and hospital pharmacists throughout the country have already collaborated, together with other health professionals from other clinical specialists.[3,4]

The requirement of a radius of action including the micro (local environments), meso (political bodies or decisions at the legal level), and macro-level (identifying and acting health trends that will influence our activity in the coming years) became evident from the very beginning. Moreover, the instruments, processes, and results that we are looking for in this new health care model have, inevitably, placed the patient as the center of our activity. Thus, the orientation to the individual and population needs, efficiency, technical quality, involvement and co-responsibility, accessibility, and professional integration should be the key elements of this new model, based on the elements described by the Spanish initials "CMO."

The definition and approach of PC should contemplate nowadays the three main needs identified in the patients that we currently manage.

The model of care followed so far relied excessively on the medication, obviating the uniqueness of each patient. For that, this conception focused implicitly our activity on the search of individual intervention. The different needs of the patients cannot be ignored (which is the first pillar of our new model), regardless of the similarity of their prescribed medication. In fact, the effects of the factors in their needs are not only related to prescribed pharmacotherapy, as some factors such as educational, cognitive-functional, demographic, or use of health resources, among others, should be taken into account when focusing on providing more value to those patients in more need. Therefore, there is a need to stratify or segment our population in order to be able to organize and prioritize resources. In this sense, we move from a medicine-centered model to a patient-centered model. It is what we have defined as "capacity." Following

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this approach, some stratification models are already published and available.[4,5]

Taking another differential leap, it has been years since the clinical practice model of the American Society of Health-System Pharmacists advocated the use of pharmacotherapeutic complexity criteria to select those suitable patients in order to be performed the most intensive PC.[6] This helps in the evolution from the more traditional approach of polypharmacy to a more qualitative and discriminating one. Surprisingly, this last approach is scarcely known by the rest of the multidisciplinary team yet.[7]

Other differentiating aspect respect the traditional is that this new model is no longer transversally focused, but longitudinally in time. The idea of focusing on medication as the pivotal axis of our actions should be dismissed, together with management of drug-related problems as our main contribution to the health care team. Instead, it would be interesting to move forward to a work focused on the patients and their pharmacotherapy objectives.

There is no doubt that being able to use a more specific and unambiguous terminology known by all professionals would accelerate the entry point automatically to understand, coordinate, and integrate information more easily in the health care teams.

From this perspective, the clinical interview, usually used in more traditional models, must give a way to motivational interviewing. Thus, we can act not only on those priority target-patients but also on all targeted, maintaining the internal strengths that they demonstrate having and that will last over time.

Therefore, a relationship with patients based on pharmacotherapy objectives is established and, to do so, the motivational interview should be used as a key work tool. Thus, our activity must move forward on our skills and competencies to ensure that patients are able to achieve the short and medium-long-term aims of their prescribed medications.[8,9]

Moreover, even such a traditional activity must also be reconsidered to address new concepts and definitions, such as primary and secondary adherence. And, going much further, being conscious of the level of activation of patients in relation to their pharmacotherapy.[9]

The last big step is to understand that PC is not only done face-to-face, but mostly when patients are outside the health areas, in their daily life. We should delete the idea of PC being carried out in the presence of the patient, as we can carry out our activity not only in the hospital but from the hospital as well, and not in an "episodic" way but "continuous," according to the needs of the patient. The possibility of making decisions in "real time" or "useful time" will undoubtedly allow us to be much more efficient than previously imagined.

Probably, the scope of action with a greater projection for the next few years is the development of projects that improve the so-called "opportunity" concept, being close to our patients when they need us. For this, it is essential to use already-proven resources that enable empowerment and improve self-care of patients, particularly those in the baseline stratification models, including information and communication technologies and tools.[10]

With the approach and development of these three pillars, we have reached a new definition of PC, being understood as

> the professional activity by which the pharmacist links with the patient and the rest of the healthcare professionals in order to attend them according to their needs, proposing strategies to align and achieve short and long-term objectives in relation to the pharmacotherapy, and using the TICs and the TACs to carry out a continuous interaction with them.

We understand that this new way of working is perfectly applicable to any environment in any country in the world, and that this method will respond to some of the most important future challenges, such as shared decision-making.[11-14]

Like all disruptive innovations, we understand that it will not be easy to expand. Strategically, it is essential to begin by teaching, at all levels, but especially from the students of faculties and the degree, and training specialists. The taxonomy of the interventions carried out would undoubtedly be one of the first concepts to be taught, being a fundamental element for interpreting and expressing in a univocal way the interventions made to each type of patient.[15]

To demonstrate the commitment and self-demand in terms of quality in Spain, the MAPEX project will shortly launch a pioneer worldwide-quality standard, which will certify the activity of pharmacy services and pharmacists following this new way of working with patients.

Without a doubt, faced with the new professional challenges that we will have to face, this new way of working with patients will give us the possibility of being capable of giving the optimal response, allowing our patients (and us) to be more motivated and more efficient when intervening. It's our moment, let's not waste the opportunity!

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References

1. Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. *Am J Hosp Pharm*. 1990;47(3):533-543. http://www.ncbi.nlm.nih.gov/pubmed/2316538. Accessed April 16, 2019.

2. Blackburn DF, Yakiwchuk EM, Jorgenson DJ, Mansell KD. Proposing a redefinition of pharmaceutical care. *Ann Pharmacother*. 2012;46(3):447-449. doi:10.1345/aph.1Q585.
3. Morillo Verdugo R, Sáez de la Fuente J, Calleja Hernandez MÁ. [MAPEX: look deeper, looking away]. *Farm Hosp*. 2015;39(4):189-191. doi:10.7399/fh.2015.39.4.9407.
4. Spanish strategic map for outpatient care of the Spanish Society of Hospital Pharmacist. Date unknown. https://www.sefh.es/mapex/index.php. Accessed July 19, 2019.
5. Morillo-Verdugo R, Martínez-Sesmero JM, Lázaro-López A, Sánchez-Rubio J, Navarro-Aznárez H, DeMiguel-Cascón M. Development of a risk stratification model for pharmaceutical care in HIV patients. *Farm Hosp*. 2017;41(3):346-356. doi:10.7399/fh.2017.41.3.10655.
6. The consensus of the Pharmacy Practice Model Summit. *Am J Heal Pharm*. 2011;68(12):1148-1152. doi:10.2146/ajhp110060.
7. Wimmer BC, Bell JS, Fastbom J, Wiese MD, Johnell K. Medication regimen complexity and polypharmacy as factors associated with all-cause mortality in older people: a population-based cohort study. *Ann Pharmacother*. 2016;50(2):89-95. doi:10.1177/1060028015621071.
8. Miller W, Rolnick S. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York, 2002.
9. Morillo-Verdugo R, Robustillo-Cortés MA, Manzano García M, Almeida-González CV. Influence of pharmacist intervention, based on CMO model, to improve activation in HIV patients. *Rev Esp Quimioter*. 2019;32(1):40-49. http://www.ncbi.nlm.nih.gov/pubmed/30569694. Accessed April 16, 2019.
10. Alexander E, Butler CD, Darr A, et al. ASHP statement on telepharmacy. *Am J Health Syst Pharm*. 2017;74(9):e236-e241. doi:10.2146/ajhp170039.
11. *Pharmacy Professionals Use Shared Decision Making Approaches to Help Patients Better Understand Their Medicines*. Date unknown. http://personcentredcare.health.org.uk/sites/default/files/resources/pharmacy_case_study.pdf. Accessed July 19, 2019.
12. Margusino-Framiñán L, Cid-Silva P, Martínez-Roca C, et al. Implementation of specialized pharmaceutical care hospital outpatient clinics in a hospital pharmacy department. *Farm Hosp*. 2017;41(6):660-666. doi:10.7399/fh.10771.
13. Morillo-Verdugo R, Robustillo-Cortés M, de LA, Martín-Conde MT, et al. Effect of a structured pharmaceutical care intervention versus usual care on cardiovascular risk in HIV patients on antiretroviral therapy: INFAMERICA study. *Ann Pharmacother*. 2018;52(11):1098-1108. doi:10.1177/1060028018778045.
14. Cantillana-Suárez M, de G, Manzano-García M, Robustillo-Cortés M, de LA, Morillo-Verdugo R. Evaluation of HIV+ patients experience with pharmaceutical care based on AMO-methodology. *Farm Hosp*. 2018;42(5):200-203. doi:10.7399/fh.10947.
15. Morillo Verdugo R, Villarreal Arevalo AL, Alvarez De Sotomayor M, Robustillo Cortes M, de LA. Development of a taxonomy for pharmaceutical interventions in HIV+ patients based on the CMO model. *Farm Hosp*. 2016;40(6):544-568. doi:10.7399/fh.2016.40.6.10567.