Appendix 5.3

Pharmacist Letter of Understanding

I agree to have my pharmacy participate in the Cardiovascular Health Awareness Program (CHAP). I have read the Community Pharmacist Information Sheet and have had all my questions about CHAP answered. I understand that participation in CHAP involves the following (please check each box to indicate you have read and understood these responsibilities):

- ❑ X blood pressure risk awareness sessions will be held in my pharmacy per month, over a period of X months.
- ❑ I, or a designated pharmacy staff member, will be contacted by a member of the CHAP Team, regarding the organization and operation of these sessions.
- ❑ This pharmacy can discontinue CHAP Sessions with two weeks written notice to the Local Lead Organization.
- ❑ The CHAP Team can discontinue CHAP Sessions at this pharmacy with two weeks written notice to the pharmacist/pharmacy owner.

For a small portion of session participants with hyper- or hypotension, or other pressing health concerns, who are my **regular** clients, I (or the clinical pharmacist on duty) will provide usual clinical practice that includes:

- ❑ Clients meeting predefined criteria will be referred to me by the volunteer peer health educators running the session (see **CHAP Session Blood Pressure Recommendation Protocol** attached.)
- ❑ If I am currently providing the MedsCheck service to my clients, CHAP participants taking three or more prescription medications can be referred to me by the volunteer peer health educators to receive this service.
- ❑ I will also provide CHAP specific assessment for simple drug-related problems (e.g., compliance issues, drug-induced hyper- or hypotension, and drug interactions) using the blood pressure readings and cardiovascular risk profile information provided, as well as a medication and ompliance history that I will complete with the client. Assessment for more complex drug-related problems is not a requirement for participation in CHAP.
- ❑ I will provide education, monitoring and follow-up, as necessary, for clients with drug-related problems.
- ❑ I will use my professional judgment to determine if it is necessary to communicate with the client's physician (For example, by phone or by faxing him/her the completed **CHAP Pharmacist Assessment Form**, with the participant's permission).

For a small proportion of participants who are **not my regular clients**, but who experience a high blood pressure reading (≥180/120) at the session, or who experience a low reading (<90/60) and are feeling unwell, the following services will be provided:

- ❑ A volunteer peer health educator will notify me (or the clinical pharmacist on duty) and the on-call community health nurse of the participant's condition and the community health nurse will telephone the participant's family physician that day to ensure the patient is followed-up. The participant's CHAP Risk Profile Recording Form will also be faxed to his/her family physician's office that day.

If a participant experiences an abnormally high blood pressure reading (≥210/120) at the session, the following services will be provided:

- ❑ A volunteer peer health educator will notify me (or the clinical pharmacist on duty) and the on-call community health nurse of the participant's

condition and the community health nurse will telephone the participant's family physician IMMEDIATELY for an urgent appointment. If the family physician is not available, the nurse will send the participant to the Emergency Department of the nearest hospital. The participant's CHAP Risk Profile Recording Form will also be faxed to his/her family physician's office that day.

In all instances where I (or the clinical pharmacist on duty) have been consulted:

- ❑ I (or the clinical pharmacist on duty) will document my activities for **each** participant (both regular and non-regular clients), on the **CHAP Pharmacist Assessment Form**.
- ❑ If I chose to keep and maintain information on CHAP participants (for example, blood pressure readings, CVD and stroke risk profiles, **CHAP Pharmacist Assessment Forms**), I (or the clinical pharmacist on duty) will maintain files that are confidential, kept in a secure area, and only accessible by me, my clinical pharmacists, and CHAP research staff in a manner consistent with applicable privacy legislation.

Name of Responsible Pharmacist (Owner / Manager) (Please Print)

_____ _____

Signature of Pharmacist Date

_____ _____

For more information about CHAP, call:
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www.chapprogram.ca