Pharmacy Name
Street Address

Doctor Name
Street Address

Dear Dr.

Your patient Health Card No. , has elected to participate in the Green Shield Canada (GSC) **Pharmacist Health Coaching – Cardiovascular Program**, a health management program supported by GSC and available to all patients under 65 years of age diagnosed with both hypertension and elevated cholesterol who have extended health care coverage with GSC.

Under the banner Change4Life®, GSC is focused on developing benefits plans that will support Canadians to better manage their health. For further information on GSC's Change4Life initiatives, please refer to our website – greenshield.ca.

The **Pharmacist Health Coaching – Cardiovascular Program** aims to empower patients to take ownership of their overall cardiovascular health and engages community pharmacists to coach them in doing so by:

- ✓ providing guidance and support to achieve target blood pressure and cholesterol levels
- ✓ implementing strategies that help improve adherence to drug therapies
- ✓ offering support to adopt healthy lifestyle behaviours that positively impact overall health

The program is based on a successful pilot project* sponsored by GSC in partnership with the Ontario Pharmacists Association which provided clear evidence that a significant number of patients who received pharmacists' counselling services had lower blood pressure, lower body mass indexes, improved medication adherence, and reduced drug costs.

The program consists of an initial evaluation and three follow-up consultations within a period of one year during which the pharmacist will:

- ✓ assess medication adherence**, blood pressure and cholesterol control, presence of modifiable risk factors, and cardiovascular risk
- ✓ provide patient education on healthy behaviours and lifestyle changes
- ✓ establish patient-driven goals

The purpose of this letter is to communicate to you findings and goals established during the initial visit and provide you with an update of the patient's progress during follow-up evaluations. We value our professional relationship and trust that you will find the information useful and relevant. Should you have any questions, please feel free to contact us at the number below.

Sincerely,

**Impact of Community Pharmacist Interventions in Hypertension Management on Patient Outcomes: A Randomized Controlled Trial. Available at https://www.opatoday.com/Media/Default/Advocacy/Final%20Report%20(Final).pdf*

***Self-reported medication adherence was assessed using the Morisky Medication Adherence Scale-MMAS-4. Morisky DE, Green LW, Levine DM. Concurrent and Predictive Validity of a Self-Reported Measure of Medication Adherence and Long-Term Predictive Validity of Blood Pressure Control. Med Care 1986; 24:67-74.*

PHARMACIST HEALTH COACHING – CARDIOVASCULAR PROGRAM

PHYSICIAN COMMUNICATION

DATE AND VISIT

Date of Evaluation: / / ☐ Initial Visit ☐ 1st Follow-up ☐ 2nd Follow-up ☐ 3rd Follow-up

PATIENT INFORMATION

Last Name		First Name
Gender	Date of Birth / /	Health Card #
Home Phone ( )		Cell Phone ( )
Address		Unit #
City	Province	Postal Code

MEDICATION HISTORY & ADHERENCE ASSESSMENT

Please refer to enclosed Medication Assessment document.

BLOOD PRESSURE ASSESSMENT

Office BP Target:

☐ ≤ 120 SBP mmHg (HIGH RISK)
☐ < 130/80 mmHg (DM)
☐ < 140/90 mmHg (ALL OTHERS/CKD)

Average HOME ☐ Not available

____ / ____ mmHg

PHARMACY BP ____ / ____ mmHg

CHOLESTEROL ASSESSMENT

LDL Target:

☐ < 2.0 mmol/L
☐ Other _____ mmol/L

Lipid Measurement	☐ Not available
Total cholesterol	_____ mmol/L
Low-density lipoprotein	_____ mmol/L
High-density lipoprotein	_____ mmol/L
Non-HDL	_____ mmol/L
Triglycerides	_____ mmol/L

10-YEAR CARDIOVASCULAR RISK

Framingham Risk Category:

☐ Low risk (<10%) ☐ Intermediate risk (10-19%) ☐ High risk (≥20%) ☐ Unable to calculate

LIFESTYLE ASSESSMENT

PHARMACIST HEALTH COACHING – CARDIOVASCULAR PROGRAM

PHYSICIAN COMMUNICATION

PATIENT GOALS & ACTION PLAN

PHARMACIST RECOMMENDATIONS	FOR PHYSICIAN REVIEW
Issue Identified	**Physician Comments**
Recommendation ☐ For information only ☐ Action required ➔	**Make change as recommended** ☐ Yes ☐ No
Issue Identified	**Physician Comments**
Recommendation ☐ For information only ☐ Action required ➔	**Make change as recommended** ☐ Yes ☐ No
Issue Identified	**Physician Comments**
Recommendation ☐ For information only ☐ Action required ➔	**Make change as recommended** ☐ Yes ☐ No
Pharmacist Name: _____ Lic. #: _____ _____ Pharmacist Signature Date: / /	_____ Physician Signature Lic. #: _____ Date: / /