

ustekinumab prescriptions that required validation from the inspection service.

Main outcome measures: gender, age, dose, time in treatment, previous use of a biological anti-TNF, changes in frequency of administration, induction posology at the beginning.

Statistics: Descriptive analysis of qualitative and quantitative data, unpaired t-test with SPSS 17.0.

**Results** The review consisted of 57 patients (56.1% men) with a mean age of 52 (SD 12.9) for men and 43 years old (SD 19.2) for women ( $P = 0.05$ ). In 9 patients (one woman) the dose used was 90 mg. In 35 cases (61.4%) the patients received a previous treatment with biological anti-TNF and in 12 patients the treatment started every 12 weeks directly (without induction). The physicians changed the frequency in 10 patients (17.5%): 5 with doses every 16–20 weeks and 5 with interruptions with a mean of 7.6 months.

Currently 11 patients have stopped the treatment and the average time of treatment is 19.3 months (SD 9.9).

**Conclusions** Ustekinumab was the first-line biological treatment in 38.6% of patients.

A significant number of patients used 90 mg, and it could be interesting to evaluate whether a 45 mg dose would be sufficiently effective to reduce the cost.

No conflict of interest.

#### OHP-084 WHAT CONCEPTS ARE USED TO DESCRIBE THE COOPERATION MECHANISMS BETWEEN THE HOSPITAL SECTOR AND PRIMARY CARE? ANALYSIS OF TERMINOLOGY

doi:10.1136/ejhp-2013-000276.457

<sup>1</sup>S Vogler, <sup>1</sup>N Zimmermann, <sup>1</sup>C Habl, <sup>1</sup>C Leopold, <sup>1</sup>K Habimana, <sup>2</sup>A Mantel-Teeuwisse, <sup>3</sup>E Dolinar. <sup>1</sup>Gesundheit Österreich GmbH/Austrian Health Institute, Health Economics, Vienna, Austria; <sup>2</sup>Utrecht University, WHO Collaborating Centre for Pharmacoepidemiology and Pharmaceutical Policy Analysis, Utrecht, The Netherlands; <sup>3</sup>Retired, Chief Hospital Pharmacist, Vienna, Austria

**Background** Cooperation between the hospital sector and primary care is addressed under different names which hampers sharing and identifying existing practises and policies in this field.

**Purpose** To get a better understanding of the concept of medicines management at the interface of the hospital and primary care sectors (hereafter called interface management).

**Materials and Methods** Narrative literature review searching Medline, EMBASE, Google Scholar, Web of Science (ISI), supplemented by hand searching (snowballing) to detect grey literature and contacts with policy makers, researchers and hospital pharmacists to identify further references. Search terms included interface (management), seamless care, continuous care, transitional care, transition in combination with medication, medicines, drugs and pharmaceuticals. Interventions that did not address medicines were excluded; the search period was 1990 to September 2012.

**Results** In English-language literature, the most commonly applied terms are seamless care, integrated care, comprehensive care, trans-mural care, transitional care and continuity of care for which, in most cases, generally accepted and repeatedly quoted definitions exist. A more recent terminology is 'interface management'. In many cases, specific projects such as hospital discharge programmes are described without any explicit reference to overall concepts such as interface management or seamless care. Tools such as medicines reconciliation and/or patient counselling can be used to improve medicines management at the interface but they are not necessarily used as specific interface management measures.

**Conclusions** Even in the English-language literature, the mechanisms of cooperation between the hospital sector and the primary

care are referred to under different names. It is recommended to include specific interface management measures as search terms in a literature review on interface management since overall concepts such as seamless care and interface management are likely to yield few results. Terminology work to increase clarity in this field is needed.

No conflict of interest.

## Clinical pharmacy and clinical trials (including case series)

### CPC-001 A CLINICAL PHARMACIST FOR OUTPATIENT CONSULTATIONS IN A HEART FAILURE CLINIC

doi:10.1136/ejhp-2013-000276.458

<sup>1</sup>O Jullien, <sup>2</sup>P Sterckx, <sup>2</sup>S Huez, <sup>2</sup>JL Vachier, <sup>1</sup>S Lorent. <sup>1</sup>Erasme Hospital, Pharmacy, Brussels, Belgium; <sup>2</sup>Erasme Hospital, Cardiology, Brussels, Belgium

**Background** Heart Failure (HF) is a severe chronic condition requiring polymedication, which is associated with a risk of non-adherence to chronic Heart Failure (CHF) treatment.

We recently demonstrated that a clinical pharmacist (CP) can be successfully integrated into a cardiology department to improve HF patient care by supervising the treatment. In addition, in 2009 we developed a dedicated CP outpatient consultation integrated in the Heart Failure Clinic (HFC) at our institution.

**Purpose** To provide a description of the role of the CP in an outpatient HFC.

**Materials and Methods** 325 patients with HF are monitored at our HFC. All patients are seen by the CP during a dedicated consultation, which includes the following: 1) preparation of the patient's file; 2) the complete history of medical treatment is checked; 3) the record of drugs is updated; 4) vital signs and electrocardiography are performed by the HF nurse. The patient is then seen by the cardiologist who updates the treatment plan. The patient is then seen by the CP who draws up and issues a plan to put the new treatment into practice, which includes scheduling phone contact for drug uptitration. Finally, the CP and the HF nurse ensure that the plan is followed by weekly scheduled phone consultations.

**Results** Each HF patient is seen at the outpatient clinic for approximately 45 minutes. On a yearly basis, the CP establishes 584 pharmaceutical plans and performs 197 phone consultations for follow up, resulting in 97 changed treatments.

**Conclusions** The integration of a CP into the HFC is important to improve management of HF through dedicated outpatient consultations, implementation of treatment plans and checking the patient's adherence.

No conflict of interest.

### CPC-002 A MULTICENTRE RETROSPECTIVE STUDY TO EVALUATE THE ECONOMIC IMPACT OF THE PRESCRIBING MODELS FOR TRASTUZUMAB IN THE PIEMONTE REGION

doi:10.1136/ejhp-2013-000276.459

<sup>1</sup>DA Barilà, <sup>1</sup>A Bianco, <sup>2</sup>S Bustreo, <sup>2</sup>M Donadio, <sup>3</sup>S Rosso, <sup>1</sup>F Cattell. <sup>1</sup>A.O Città della Salute e della Scienza di Torino, S.C Pharmacy, Turin, Italy; <sup>2</sup>A.O Città della Salute e della Scienza di Torino, Medical Oncology Senological Breast Unit, Turin, Italy; <sup>3</sup>A.O Città della Salute e della Scienza di Torino, CPO Piedmont, Turin, Italy

**Background** In recent years, there has been a rapid and constant increase in the costs of cancer treatment but, with limited health care resources, it is essential to consider the economic implications of different health interventions.