

# Pharmacist and Nurse Practitioner Collaboration in Nurse-managed Health Clinic

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## ABSTRACT

Medication therapy problems, such as incorrect dosing, adverse drug reactions, and decreased adherence, result in harm to patients and increases in costs. In the literature, there are many examples of pharmacist-physician partnerships aimed to optimize patients' medication use. As more nurse-managed health clinics continue to open, it is important for the nurse practitioner to consider partnership opportunities. In this report we describe an interprofessional "teamlet" consisting of a pharmacist and nurse practitioner as a model of collaborative care.

**Keywords:** collaborative care, interprofessional team, medication management, nurse-managed health clinic, pharmacist

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## BACKGROUND

For many patients, optimal medication use is an essential component of receiving the best care possible. The Institute of Medicine asserts that "Pharmaceuticals are the most common medical intervention, and their potential for both help and harm is enormous. Ensuring that the American people get the most benefit from advances in pharmacology is a critical component of improving the national health care system."<sup>1(p13)</sup> However, it can be difficult to ensure that patients are receiving an optimized medication regimen. Patients commonly struggle with medications for various reasons. For example, some patients may not take medications as directed due to lack of education about the medication or disease it is treating, others may have difficulty affording or obtaining their medication, and still others may experience side effects that limit their ability to take the prescribed medication. These types of medication problems, among many others, impact the Triple Aim<sup>2</sup>—a concept that originated with the Institute for Healthcare Improvement with a goal to decrease overall health care costs, improve the patient's experience, and optimize health care for the

population—by harming the patient and increasing their costs of care. To illustrate this point, drug-related morbidity and mortality accounts for annual costs of > \$200 billion in the United States—which is a greater cost than that spent on all medications annually.<sup>3</sup>

Our primary care clinic is a nurse practitioner-managed health clinic. Three nurse practitioners (NPs) provide about 1.5 full-time equivalents of care and 1 clinical pharmacist provides 0.4 full-time equivalent of care. We have taken a proactive approach to optimizing medication management through a partnership of NPs and clinical pharmacists. In our clinic, patients are seen in a variety of ways: through individual appointments with the NP; individual appointments with the clinical pharmacist; or through a co-visit with both the NP and pharmacist. For any patient with complex medication needs (these needs could be recognized by any member of our clinic, including the scheduler, medical assistant, or any provider), we attempt to perform a co-visit when the patient establishes care with our clinic. A patient visit through this partnership is illustrated in the case described.

## CASE REPORT

A 30-year-old woman, “Sue,” with a history of asthma, seasonal allergies, and depression with psychotic features, presented to the clinic with a chief complaint of diarrhea after recent antibiotic use for treatment of a sinus infection. The NP and pharmacist were the providers of Sue’s primary care and conducted a co-visit with Sue. An outside psychiatrist managed her mental health needs. At this visit, the chief complaint was addressed by stopping the antibiotic as sufficient treatment length was achieved.

After the patient’s chief complaint was resolved, the pharmacist led the assessment of all the patient’s current medications. Each medication was evaluated for indication, effectiveness, safety, and convenience. Through this interview, the pharmacist and NP learned of several problems and worked with the patient on resolution:

- *Asthma.* When the pharmacist asked Sue about inhaler use, it became evident that there were gaps in understanding of her inhalers and she was using her controller inhaler as a rescue inhaler. As a result, Sue reported frequent nighttime awakenings and coughing with exertion. The NP identified that Sue’s asthma was severe, persistent, and poorly controlled, and may have been contributing to her frequent sinus infections. The patient was instructed on the appropriate use of inhalers and an asthma action plan was developed. The pharmacist categorized the medication therapy problem as an inappropriate adherence.
- *Allergies.* The pharmacist asked Sue about her use of a steroid nasal spray and learned that the patient thought therapy was discontinued as she no longer had refills. With this, the patient reported frequent episodes of congestion and nasal discharge, which likely exacerbated her allergies, leading to frequent sinus infections. Refills of the nasal steroid spray were provided. The pharmacist categorized the medication therapy problem as non-adherence with need for education.
- *Depression.* When asked about medication changes, the pharmacist identified that Sue was experiencing dry mouth, which was likely

associated with a recent dose increase in aripiprazole as prescribed by her psychiatrist to improve depressive symptoms. Sue stated she did not mention dry mouth to her psychiatrist out of concern that her discomfort would not be concerning to her psychiatrist. The patient was referred to dentistry due to oral health concerns from persistent dry mouth. The pharmacist categorized the medication therapy problem as adverse drug reaction.

At follow-up, 1 week later, Sue reported appropriate adherence to both her nasal spray and inhalers and noted that her residual allergy symptoms had resolved. Some nasal drainage continued but no other side effects were mentioned. Sue was pleased with this control and noted that, with resolution of these symptoms, she could now exercise, and was no longer having nighttime awakenings. She had not yet presented for follow-up with dentistry or discussed dry mouth with her psychiatrist.

## THE PHARMACIST’S ROLE

The pharmacist’s role in primary care is expanding. In our clinic, comprehensive medication management (CMM) is practiced by the pharmacist. CMM by a pharmacist is considered a standard of practice by pharmacy organizations and is funded through certain government payers and private payers.<sup>4</sup> CMM has several key components including: assessing each medication a patient is taking for indication, effectiveness, safety, and convenience; creating a care plan in coordination with the patient and the patient’s providers; and conducting follow-up visits with the patient to ensure that medication-therapy problems are resolved.<sup>3</sup>

CMM is a service that is distinct from, and complementary to, that of a primary care provider. CMM can help unveil medication adherence problems, medication interactions, and in general can increase patient satisfaction, as the practice helps to tailor a patient’s medication regimen to their individual goals and needs.

In Sue’s case, when the pharmacist reviewed each medication, several issues were uncovered that may not have been identified or likely would not have been discovered as quickly in a routine primary care

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