The Consultant Pharmacist and the Physician in the Nursing Home: Roles, Relationships, and a Recipe for Success

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Nursing homes must provide sophisticated medical and personal care to a broad spectrum of residents and patients. Medications are an increasingly important part of that care. The risks and benefits of medications are widely published, but not necessarily recognized in the care of individual patients. Decisions about medications must be made in the proper context of the patient. Medications are often indicated for various illnesses, symptoms, and risk factors, but clinically significant adverse consequences of medications are common and typically mimic common syndromes. Timely recognition and management of adverse consequences requires vigilance and a high index of suspicion. Many factors influence medication prescribing and use in the nursing home. Newly updated OBRA surveyor guidance emphasizes the importance of following the full care process in implementing, dosing, monitoring, and adjusting medications. Physicians and consultant pharmacists have prominent, complementary roles in addressing medications in the nursing home. The purpose of this article is to clarify these roles, identify their basis (primarily, the care process), and discuss how physicians and consultant pharmacists can collaborate effectively to optimize medication use and minimize preventable adverse consequences. (J Am Med Dir Assoc 2007; 8:55–64)

Keywords: Medications; nursing home; medical directors; consultant pharmacists

Both physicians and consultant pharmacists have a long-standing role in nursing home care. The physician role was emphasized in 1974, when medical directors were required in all skilled nursing facilities. It was intensified in 1987, when the OBRA ‘87 regulations required all nursing facilities to have a medical director and reinforced that each resident should have an attending physician who visits the resident at specified intervals.

In 1974, Medicare Conditions of Participation first mandated a quarterly drug regimen review (DRR) by a consultant pharmacist in nursing facilities, which was later increased to monthly. Subsequently, the State Operations Manual (SOM) has expanded its guidance to surveyors regarding the required elements of a DRR, to help them determine if an effective DRR was occurring.

In theory, the DRR (now referred to as the Medication Regimen Review, or MRR) promotes joint consultant pharmacist and attending physician efforts to resolve medication-related problems. To some extent, this has happened. However, the overall performance of both consultant pharmacists and physicians has been inconsistent and the relationship has sometimes been collaborative and constructive, and sometimes antagonistic and unproductive.

DESIRABLE INTERDISCIPLINARY APPROACH

The interdisciplinary team includes a variety of health care professionals; however, this article will focus on the roles and interactions of the physician and the consultant pharmacist in the long-term care setting. For various reasons, an interdisciplinary approach to geriatric care is desirable.1 Interdisciplinary teams have been shown to have the potential to help prevent adverse drug reactions; however, it is insufficient to simply advocate for the “interdisciplinary team” without clarifying roles and responsibilities. Key elements for an effective interdisciplinary approach include (1) a shared purpose and goal, (2) clear roles and responsibilities, (3) appropriate contributions from team members, (4) cooperation and coordination of activities, and (5) growth of mutual trust through an ongoing relationship.1

THE CURRENT ENVIRONMENT

In the current health care environment, many factors, as discussed herein, influence the use of medications and the roles of physicians and consultant pharmacists.

More Medications and More Opportunities for Both Benefits and Problems

In the past 30 years, the number of available medications has grown tremendously. At the same time, the development of formularies and, recently, the advent of Medicare Part D
Nursing homes care for both long-term residents and postacute patients. The long-term residents generally are older and have multiple physical illnesses and functional and psychological impairments. Compared to the past, fewer admissions come from the community while more come directly from the acute hospital. Typically, short-stay patients are younger, have a relatively short length of stay (several weeks to several months), and are likely to be discharged elsewhere.

The care focus in nursing homes has shifted over several decades. Traditionally, nursing homes mostly addressed the consequences of illness and injury; for example, impaired mobility, self-care deficit, and incontinence. Currently, more individuals need and receive treatment for the causes of disability and dysfunction, as well. Expectations are higher for the effective management and prevention of medical illnesses and complications, as well as geriatric syndromes and symptoms such as falls, distressed behavior, sleep disturbances, and anorexia or weight loss. There are more interventions to prevent illness (eg, influenza vaccination), prevent complications from an illness (eg, strict management of diabetes to try to prevent progressive renal failure), or reduce the risk of complications from existing disabilities (eg, minimize fall risk in someone with impaired gait and balance due to an old stroke). Although nonpharmacological interventions are often feasible and effective to complement or replace medications, they are probably underused.

More nursing facilities have the opportunity to treat acute illnesses without hospitalization. There are programs specifically designed to avoid hospitalizing nursing home residents. Postacute settings such as the skilled nursing facility are admitting hospital discharges with more complex conditions and unresolved or undiagnosed symptoms. Hospitals nationwide are continually pressured to discharge patients sooner, often before acute illnesses are fully resolved and before important comorbidities are fully identified or managed.

Typically, nursing home residents take several medications simultaneously. Thus, the nursing facility increasingly has the burden to deal aggressively with medication risks and complications, with relatively little guidance or support from other segments of the health care system. In addition, the nursing facility bears the consequences of negative outcomes related to medications such as delirium, recurrent falls, anorexia leading to weight loss, or excessive sedation causing immobility that leads to skin breakdown. Medication-related symptoms are difficult to distinguish from symptoms related to patient comorbidities, making diagnosis and treatment complex and challenging.

Multiple Prescribers

More practitioners are likely to be involved in the care of a given individual, including attending physicians, midlevel practitioners, hospital physicians, multiple consultants, hospice providers, and so on. Practitioners confront the conflicting pressures to manage diseases and symptoms for meaningful results while not causing additional harm. Providers and practitioners often struggle to identify the proper balance between treating aggressively and watchful waiting. For many, the safe approach seems to be: when in doubt, initiate or continue treatment.

In addition, during hospitalization, many individuals receive medications to treat their acute illness; for prophylaxis (eg, for gastrointestinal bleeding); or to treat complications (such as atrial fibrillation) or symptoms such as confusion, agitation, and vomiting. While some of these medications are necessary and are targeted to identifiable illnesses, others may be added without adequate attention to the differential diagnosis of symptoms, relative risks and benefits, critical drug interactions, or serious adverse consequences. Acute care practitioners may discharge patients without recognizing or documenting active adverse consequences, or before adverse consequences become evident. The postacute provider may not be aware that a patient’s medications should be monitored, may be causing adverse consequences, or should subsequently be adjusted (eg, acute doses of amiodarone or opioid analgesics) or stopped (eg, prophylactic proton pump inhibitors or psychopharmacologic medications that were initiated to address acute problems). Conversely, a nursing home resident may also have a beneficial medication discontinued during hospitalization. For example, because of impending surgery or a miscommunication about the purpose of the medication (such as an acetylcholinesterase inhibitor), a useful chronic medication may not be listed as a discharge order and therefore not be reordered upon admission elsewhere. Medication reconciliation at the time of hospital discharge and facility admission is critical.

There is often considerable pressure to institute or continue medications. Both physicians and staff may consider giving a medication order to be the quickest way to handle a reported symptom or problem such as insomnia or agitated behavior. Both facility staff and family members can influence the physician to order treatments, or influence the nurses to persuade a physician to order medications. However, staff and family members are often less aware of the risks to the patient of inadequate assessment or analysis of the meaning and causes of symptoms.
Continuing Recognition of Medication-related Concerns

For more than 40 years, both professional and lay publications have identified concerns about medications and their potential complications such as anticholinergic toxicity. Drug safety has become a major initiative in various campaigns and programs to improve the quality of health care. For example, the Institute for Healthcare Improvement has included prevention of adverse drug events (ADEs) in its “100,000 Lives” campaign.

Studies have repeatedly shown that nursing home residents receive many medications in the nursing home and hospital that have been identified as high risk or inappropriate for this unique population; they experience many adverse consequences related to medications and to the withdrawal of medications, and those adverse consequence are often not recognized or managed appropriately. Studies have identified the increased risk of medication-related adverse consequences in individuals with certain risk factors including the number of medications and multiple comorbidities. Adverse consequences can occur even when the treatments are potentially beneficial. For example, the broad campaign to treat pain vigorously has led to substantial issues with the proper usage and monitoring for adverse consequences of analgesics, as well as problems of storage, reconciliation, and diversion of opioids.

Many community-dwelling elderly are also exposed to problematic medications. When they are admitted to a nursing facility, these individuals may already be receiving problematic medications or inappropriate doses and they may be experiencing a significant adverse consequence as a result of those medications. Adverse medication consequences can be a primary reason for functional or cognitive decline that results in the need for institutional placement.

Regulations and Surveyor Guidance Regarding Medications and Pharmacy Services

The OBRA ’87 regulations include several requirements regarding medications generally and the use of specific medication classes such as antipsychotics. After several revisions through the years, substantial changes in OBRA surveyor guidance were finalized in 2006 related to unnecessary drugs (F329), pharmacy services (F425), and medication regimen review (F428). These changes will impact the roles of and relationships among, the consultant pharmacist, the attending physician, and the medical director.

F329 (Unnecessary Drugs) guidance is substantially altered to better promote appropriate drug and dosage selection and to require monitoring for therapeutic efficacy and adverse consequences for all medications that are given to nursing facility residents. It emphasizes the care process as the basis for decisions to initiate medications, select specific medications and doses, evaluate potential risks and benefits, and monitor the benefits and risks relative to individualized therapeutic goals.

This move to recognize the potential problems associated with more than just psychopharmacologic medications will likely require increased collaboration among the consultant pharmacist, attending physicians, and medical director. While the physician ultimately determines the need and desired therapeutic goals for a chosen medication, the consultant pharmacist can provide useful information about the expected timeline for efficacy, adjusted dosing based on pharmacokinetics and the resident’s other medical conditions, and expected side effects, and can help identify options for monitoring the efficacy of the medication (eg, the goal for an antihypertensive medication might be to reduce blood pressure below a set target number [eg, 130/80], whereas the goal for a cholinesterase inhibitor might be to reduce the frequency of behavioral outbursts or to slow the decline in activities of daily living [ADL] function, depending on the individual). The consultant pharmacist can help monitor for progress toward therapeutic goals during the monthly MRR and inform the physician about any obstacles or successes in obtaining them. These activities can augment the physician’s clinical observations of the resident and facilitate prompt identification of adverse consequences or treatment failures.

The revised surveyor guidance also clarifies expectations for recognizing, evaluating, and addressing adverse consequences of medications. This is especially important for adverse consequences that might otherwise result in the use of additional medications or health care services. The physician should evaluate new symptoms or a worsening of the resident’s condition, paying attention to current medication therapy, especially any medications that have been added or changed within the past 30 days, as a potential cause of the change in condition. The consultant pharmacist can help ensure that the nursing staff are aware of potential adverse consequences, are monitoring for them, and promptly notify the consultant pharmacist and physician when evidence of adverse consequences is identified.

F425 (Pharmacy Services) and F428 (Medication Regimen Review) guidance revisions recognize that most of the guidelines for the clinical aspects of the MRR were moved to F329. The revised F425 now emphasizes collaboration between the consultant pharmacist and the facility leadership (including the medical director) and staff to develop and implement pharmaceutical services procedures and to help the facility identify, evaluate, and address/resolve pharmaceutical concerns and issues that affect resident care, medical care, or quality of life. F428 continues to require the consultant pharmacist to perform an MRR monthly or more often if the resident’s condition warrants, and to communicate any identified irregularities to the attending physician and the director of nursing. But it expands the definition of MRR to require a more thorough evaluation of a resident’s medication regimen, with the goals of promoting positive outcomes; preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities; and minimizing associated adverse consequences.

Developments (Particularly Medicare Part D) Affecting the Cost and Availability of Medications

Medicare Part D, designed primarily as a community-based program, is likely to have ongoing effects on Medicare bene-
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nursing facilities include the following:

- Multiple Prescription Drug Plans (PDPs) with different formularies, rules, and requirements
- Reconciling diverse medication regimens with formularies (eg, therapeutic substitution)
- Reconciling changes in medication regimens with patient choice/change of drug plans
- Maneuvering through various formulary restrictions and exceptions
- Reconciling cost and clinical considerations such as efficacy, safety, and adverse consequences
- Providing documentation that can meet requirements both for clinical and reimbursement purposes, without having duplicative approaches.

Ideally, physicians would know the resident’s Part D plan and formulary options before ordering any medications. But for various reasons, Part D plan information and formulary coverage is often unavailable. Typically, the dispensing pharmacist is the first to identify that an ordered medication is not covered by the resident’s Part D plan or is subject to prior authorization or other restrictions. When this occurs, the dispensing pharmacist notifies the physician regarding options for medicating the resident (eg, change to a covered alternative, complete necessary paperwork for prior authorization, or file a coverage exception request).

Over time, the consultant pharmacist can monitor for formulary compliance during the monthly MRR, especially for medications having therapy limitations or those requiring special monitoring or diagnostic testing. When contacting the physician, the consultant pharmacist should distinguish Part D formulary issues from clinical concerns. While most Part D formulary issues can be addressed without affecting the resident negatively, some recommended formulary-focused changes may be clinically inappropriate. The consultant pharmacist should remind the physician of the option to file a prior authorization or coverage exception request to obtain medically necessary medications for his patient, or to consider whether the patient truly needs the medication in question.

PRINCIPLES PERTINENT TO BOTH PHYSICIANS AND CONSULTANT PHARMACISTS

Basis for the Care Process

The body’s organ systems function as an integrated system. Anyone’s current health status, including signs and symptoms, results from many factors, including congenital disorders, chronic conditions, lifestyle (diet, exercise, smoking, substance abuse, and so forth), current medications, and acute illness and injury. Medications both affect and are affected by a person’s overall condition and current homeostatic balances.

A primary goal of medicine and geriatrics is to not do harm while trying to do good. This goal is particularly difficult to achieve when treating the frail, nursing home elderly who have decreased function and organ reserve because of illness and aging. When homeostasis is already impaired by age, illness, or adverse consequences of medications, additional medications or medical illnesses may cause substantial if not life-threatening disruption.

Relevance of the Care Process

The care process, which has a critical biological basis, is a common interest of both consultant pharmacists and physicians. Key elements of the care process include recognition and identification of a problem/risk, assessment (collecting information), diagnosis/cause identification, management/treatment, monitoring, and revising interventions as warranted.

The effective management of those with chronic illnesses and disabilities requires attention to both causes and consequences, and their links, in order to decide whether to treat causes, consequences, both, or neither. Adherence to the full-care delivery process helps to optimize outcomes, while skipping key steps can reduce that likelihood. For example, additional medications may be introduced unnecessarily to address symptoms caused by the adverse consequence of existing ones.

The Idea of Medications in Context

As identified in the Interpretive Guidelines for F329, medications may serve several purposes, including curing an acute illness, diagnosing a disease or condition, arresting or slowing a disease process, reducing or eliminating symptoms, or preventing a disease or symptom. Thus, it is important for both the consultant pharmacist and the attending physician to understand why a medication was prescribed or is being contemplated.

A drug regimen consists of a number of individual medications that act and often interact. No matter what the indications or risks for a specific medication, its effects and consequences are necessarily experienced by the whole patient, and affected by comorbid conditions and other medications.

Based on these principles, the realities of “disease management” invariably differ in those with multiple comorbidities compared with otherwise relatively healthy individuals with isolated acute or chronic illnesses. For the former group, medications given to address a specific diagnosis or symptom often affect each other; for example, cholinesterase inhibitors given to individuals with dementia along with anticholinergic medications to treat gastrointestinal symptoms or urinary incontinence, or metoclopramide given to individuals who are also getting antiparkinson medications. Relevant factors in addition to specific symptoms or organ impairments include a patient’s prognosis, goals, wishes, overall function, and desired quality of life.
KEY PRINCIPLES OF EFFECTIVE CONSULTANT PHARMACIST–PHYSICIAN INTERACTION AND COMMUNICATION

Relevant Roles and Responsibilities Regarding Medication Treatment

The common ground of the consultant pharmacist and the physician is the patient and the care process. As Table 1 indicates, both disciplines have complementary roles in optimizing treatment with medications and trying to avoid preventable medication-related complications. Recommendations and decisions about medications (for example, whether to initiate or stop a medication, change a dose, or add or substitute another medication) require a patient-oriented review with a focus on medications, which is different from just reviewing medications and diagnoses.

The guidance for F329 notes, “The attending physician plays a key leadership role in medication management by developing, monitoring, and modifying the medication regimen in conjunction with residents and/or representative(s) and other professionals and direct care staff (the interdisciplinary team).” The guidance also notes that, “Members of the interdisciplinary team participate in the care process as they identify, assess, address, monitor, and communicate the resident’s needs and changes in condition.”

The consultant pharmacist identifies, assesses, monitors (including recommending laboratory testing and reviewing test results), and communicates information about aspects of the medication regimen, and must review all medications and advise the physician and others about their appropriateness, safety, and consistency with recommendations for use. The physician must interpret the significance of signs and symptoms, identify their most likely causes, and evaluate whether medications make sense in light of the whole picture.

Optimizing Consultant Pharmacist-Physician Interactions

Examples of potential barriers to effective consultant pharmacist-physician interactions include the following:

- Limited direct interaction between the consultant pharmacist and physician, which may also limit opportunities to establish a collegial relationship
- Limitations in conveying consultant pharmacist recommendations, which are mostly written rather than discussed directly with the physician
- Incomplete documentation or data available in the clinical record, which may lead the consultant pharmacist or physician to an inaccurate conclusion, recommendation, or response
- Delays in receiving and responding to the consultant pharmacist’s recommendation, which may affect the relevance of any comments or responses
- Inadequate understanding or acknowledgment by the physician of the requirement for, and responsibilities of, the consultant pharmacist.

Overcoming these barriers can promote optimal patient care. The medical director, consultant pharmacist, and other facility leadership can develop a policy on the basic approaches to the MRR. This policy would describe explicitly the process for the consultant pharmacist and physicians to communicate (in writing, through verbal communication, or both) and the timing and form of such communication (eg, a potentially harmful situation requires prompt verbal notification of the physician, whereas a request for a routine dose reduction could be written for review at the next required physician visit). The acceptable time frame for physician response to the recommendation, the expected documentation to be included on the recommendation and the physician response, and where the completed document should be retained (eg, in the resident’s chart or in a separate file) should all be specified.

The typical written consultant pharmacist recommendation presents a particular communication challenge. Because it is often faxed to the physician’s office for review, and the physician rarely has access to the resident’s chart at his or her office, the recommendation should contain enough supporting information to facilitate a decision, for example, a detailed analysis of the situation prompting the recommendation (including relevant clinical history); pertinent vital signs, lab work, and patient characteristics; input from other disciplines involved in the care; the consultant pharmacist’s evaluation of the situation; and options for addressing the situation. Well-constructed recommendations can generally be approved and implemented quickly because the physician has all of the information needed to make a well-informed decision. Recommendations should focus primarily on benefits and risks to the patient, and secondarily on cost effectiveness and regulatory compliance.

When vital facts and data are missing from the clinical record, the consultant pharmacist may reach an irrelevant conclusion. The physician’s response should include information that he or she believes discounts the validity of the consultant pharmacist’s recommendation, and document any additional relevant information in the resident’s chart, as needed. Conversely, the consultant pharmacist should recognize that there are often several valid options for managing a situation, and should invite sharing of additional information and/or consideration of diverse treatment opinions.

When the interaction between the consultant pharmacist and physician breaks down, the medical director is a key mediator. Common communications failures include the physician’s failure to respond, or inappropriate or excessively delayed response to a consultant pharmacist’s communication. Although the consultant pharmacist would typically notify the director of nursing and facility administration in these situations, recent revisions to the Medical Director (F501) surveyor guidance expect the medical director to intervene with physicians who fail to comply with facility policy, including responses to consultant pharmacist’s recommendations. Depending on the urgency of the recommendation to prevent patient harm, the medical director’s help may be needed immediately. Less urgent issues can be addressed during the quality assurance committee meeting or routine medical director visit.

Some physicians and pharmacists have established formal
Table 1. Complementary Physician–Consultant Pharmacist Roles Related to Key Steps in the Care Process

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<th>Key Steps</th>
<th>Key Questions</th>
<th>Physician Roles</th>
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<td>General Roles in the Care Process</td>
<td>How can physicians and consultant pharmacists address medications in the proper patient context?</td>
<td>Base decisions about prescribing medications on (1) the context of the whole patient, including prognosis, wishes, ability to cooperate with treatment, potential benefits and risks posed by treatment, relevant clinical literature, etc, and (2) pertinent medical and pharmacologic principles, including characteristics and relative benefits, risks, and burdens of medications.</td>
<td>Base recommendations to physicians about medications on a review of relevant factors about the patient. Provide input on the appropriateness, safety, characteristics, benefits, risks, and cost-effectiveness of prescribed medications, and recommend alternative treatment when appropriate.</td>
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<td>Evaluate the pertinence of recommendations from other disciplines (for example, whether they are based on a cogent analysis of all pertinent information) and seek additional information (patient evaluation, diagnostic testing, etc) as needed to clarify those recommendations.</td>
<td>Clarify for the physician the basis of any recommendations and identify key information that might not have been available or still needs to be obtained; eg, to justify an indication for a medication or warrant a particular medication or a selected dose or dosage form.</td>
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<td>Seek and use all appropriate information needed to make or verify diagnoses.</td>
<td>Give pertinent information that can help the physician identify the significance of symptoms and verify diagnoses on which prescribing decisions are based.</td>
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<td>Reconsider diagnoses and related treatments if they cannot be supported by existing or additional information.</td>
<td>In making recommendations about medications, consider pertinent factors, including life expectancy, comorbidities, patient goals, advance directives, and the objectives for a specific treatment.</td>
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<td>Clearly document and communicate the diagnosis and goal of treatment in the clinical record.</td>
<td>Help identify situations where the staff are misinterpreting regulations or the physician may be getting pressured by staff, patients, or families to order medications despite unclear indications or inadequate problem definition or cause identification.</td>
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<td>Be alert to recommendations for medications from other disciplines (nurses, dietitians, etc) that may be based on misinterpretations of regulatory requirements or that are not based on an adequate care process.</td>
<td>Help identify situations where multiple practitioners have prescribed or recommended problematic or incompatible medications.</td>
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<td>Coordinate and oversee orders given or recommended by other physicians and consultants, to ensure that these are compatible, pertinent to the patient, and do not unduly elevate overall risk.</td>
<td>In collaboration with other staff, provide the physician with information (observations, historical data, etc) that would help to (1) define and clarify the patient’s physical, functional, and psychosocial status, symptoms, needs, abilities, deficits, risks, comorbid conditions, prognosis, etc, and (2) determine the significance of symptoms, findings, or risks.</td>
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<td>Recognition</td>
<td>What are the individual’s symptoms, needs, abilities, deficits, risks, comorbid conditions, prognosis, etc?</td>
<td>Perform targeted or comprehensive history and physical exam, depending on the situation. Define the problem correctly and in sufficient detail to permit subsequent clinical decision making. As indicated, order and interpret additional consultations and tests that clarify the nature, significance, and causes of symptoms and risks. Receive relevant information (observations and data) from others about the patient’s physical, functional, and psychosocial status, symptoms, needs, abilities, deficits, risks, comorbid condition, prognosis, etc.</td>
<td>Verify the meaning of symptoms, findings, or risks, eg, decide whether behavior, swallowing, etc, is just a variant of normal, a temporary issue, or representative of a meaningful problem.</td>
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<td>Diagnosis/Cause Identification</td>
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<td>Clarify symptoms and identify causes</td>
<td>What factors are causing or affecting signs, symptoms, and risks?</td>
<td>Identify the need for any additional evaluation, including the relevance of proposed evaluations to overall condition, prognosis, wishes, risks, etc. Evaluate the patient and the information provided to identify factors (acute or chronic medical conditions, medications, etc) that are most likely causing or contributing to symptoms or risks. Be alert to the potential for many medications in diverse categories to cause adverse consequences, either individually or in combination.</td>
<td>Identify and report existing medications that may be causing symptoms (and new or worsening medical conditions) and that may have the potential to increase risks, cause adverse consequences, affect diagnostic test results. Identify and report relevant information that can help the physician identify causes of symptoms or abnormalities. Identify interventions or tests that might help identify whether medications or medication-related adverse consequences are a contributing factor.</td>
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| Treatment | When should a symptom, condition, or risk factor be addressed with a medical intervention, and when should that medical intervention include medications? | Collaborate with those of other disciplines to identify situations where alternatives to medications may be appropriate and help staff select relevant alternatives. Determine whether the patient could benefit from a medical intervention, based on relevant considerations (e.g., prognosis, wishes, ability to cooperate with treatment, potential benefits and risks posed by treatment, relevant clinical literature, etc.). Based on weighing relevant information, determine whether a medication is appropriate. | Provide information (e.g., about the patient, from relevant clinical literature) that can help the physician determine whether a medical intervention (including possibly medications) is relevant to a patient’s problems, risks, and situation. Help identify situations where a medication may not be the primary or necessary intervention for a symptom or condition or where evidence is lacking that appropriate nonpharmacologic alternatives have been considered or tried. Help identify situations where treatable conditions may benefit from pertinent pharmacologic interventions that may not yet have been identified or tried. |

<p>| Make initial medication selections | When a medication is indicated, which medication, dose, and duration are appropriate? | Prescribe medication in doses and for a duration that are pertinent to a patient’s overall situation (including the patient’s existing medication regimen, risk factors, comorbidities, potential medication benefits and adverse consequences; physical, functional, and psychosocial status; symptoms, needs, abilities, deficits, risks, wishes, prognosis, etc) and that take into account potential benefits and risks of proposed medications. Strive to minimize situations where a patient receives high-risk medications and dosages without clear clinical justification, consideration of safer alternatives, or intensified monitoring. | Make any recommendations about medications and doses in the context of the whole patient picture (including the patient’s existing medication regimen, risk factors, comorbidities, potential medication benefits and adverse consequences; physical, functional, and psychosocial status; symptoms, needs, abilities, deficits, risks, wishes, prognosis, etc) as well as potential benefits and risks of proposed medications for a specific patient. Identify and report medications that do not meet criteria for appropriate indications, dose, or duration or that have a high risk of adverse consequences. |
| Table 1. Continued |
|-------------------|-----------------|------------------------------------------------|------------------------------------------------|
| <strong>Key Steps</strong>      | <strong>Key Questions</strong> | <strong>Physician Roles</strong>                            | <strong>Consultant Pharmacist Roles</strong>                |
| Authorize medications appropriately | How should orders be written to ensure that they are appropriate, timely, safe, and compliant with pertinent legal and regulatory requirements? | Write or give orders that are appropriate, timely, safe, and compliant with pertinent legal and regulatory requirements. | Advise the staff, physicians, medical director, and others about the attributes and components of appropriate and safe order writing. |
| Authorize medications appropriately | How will the prescribed medication be evaluated for safety and efficacy? | Identify the goals of therapy and parameters for monitoring the medication’s efficacy and safety. | Collaborate with, or advise, the staff and physician to identify the goals of therapy and parameters for monitoring efficacy and safety. |
| Authorize medications appropriately | How will the prescribed medication be evaluated for safety and efficacy? | Ensure that any as-needed (PRN) orders contain key information including the indication(s), specific circumstance(s) for use, and the desired frequency of administration. | Identify and report orders that do not meet the criteria for safety, timeliness, etc. |
| Authorize medications appropriately | How will the prescribed medication be evaluated for safety and efficacy? | Identify and report PRN medications that lack key information, such as the indication(s), specific circumstance(s) for use, and the desired frequency of administration. | Identify and report PRN medications that lack key information, such as the indication(s), specific circumstance(s) for use, and the desired frequency of administration. |
| <strong>Monitoring</strong> | What is to be assessed in order to determine the effectiveness of medications and identify related adverse consequences? | Review the patient’s progress, discuss with other staff, and re-examine the patient, as indicated, to ascertain current status. | Collaborate with, or advise, the physician and staff to identify the benefits and adverse consequences of medications. |
| Assess the patient’s progress, including the impact (both positive and negative) of any interventions | What is to be assessed in order to determine the effectiveness of medications and identify related adverse consequences? | Establish or confirm goals for treatment and monitoring parameters, including for specific medications or combinations. | Collaborate with, or advise, the physician and staff to identify pertinent treatment goals. |
| Decide whether to modify the existing medication regimen | Which of a patient’s existing medications should be continued and which should be modified or discontinued? | Evaluate benefits and possible adverse consequences of the existing medication regimen. | Collaborate with, or advise, the staff and practitioner to identify monitoring parameters for various medications and conditions. |
| Decide whether to modify the existing medication regimen | Which of a patient’s existing medications should be continued and which should be modified or discontinued? | Recognize that stabilization or absence of symptoms may mean that the underlying cause has stabilized or resolved, making it reasonable to see whether the patient can remain stable or improve with a lesser dose or without the medication. | Help identify situations where stabilization or absence of symptoms may make it reasonable to consider tapering a medication dosage to see whether the patient can remain stable or improved with a lesser dose or without the medication. |
| Decide whether to modify the existing medication regimen | Which of a patient’s existing medications should be continued and which should be modified or discontinued? | Decide to maintain, modify, or stop medications and doses based on the whole patient picture, including the patient’s existing medication regimen, risk factors, comorbidities, identified medication benefits and adverse consequences; physical, functional, and psychosocial status; symptoms, needs, abilities, deficits, risks, wishes, prognosis, etc. | Provide the physician with relevant information (data, observations, etc) that supports any recommendations about whether to maintain, modify, or stop medications and doses in the context of the whole patient picture, including the patient’s existing medication regimen, risk factors, comorbidities, potential medication benefits and adverse consequences; physical, functional, and psychosocial status; symptoms, needs, abilities, deficits, risks, wishes, prognosis, etc. |</p>
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<td>Is the patient experiencing any adverse consequences and what is their significance?</td>
<td>Be alert to the possibility of adverse consequences in any patient with new-onset significant symptoms, condition change, functional decline, failure to improve as anticipated, or otherwise unexplained findings</td>
<td>Respond promptly and act appropriately after identifying, or when informed of, suspected adverse consequences related to one or more current medications</td>
<td>Encourage the physicians and other staff—and help educate and train them—to seek, identify, and report adverse consequences related to medications</td>
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<td>Determine the clinical significant of any adverse consequences, including their impact on the patient’s medical and psychological condition, function, and quality of life</td>
<td>Collaborate with the medical director and other staff to establish and implement a process to report and respond in a timely fashion to medication-related adverse consequences, including what responses and actions to expect of physicians and what to do if those responses don’t happen</td>
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<td>Respond appropriately to a medication regimen review, especially when it concerns patient safety, indications, and risks</td>
<td>Provide clinically pertinent responses, explanations and related documentation, especially when not accepting recommendations</td>
<td>If someone has a new or worsening condition or symptom, or one that does not improve as anticipated, help the staff and physician review medications in the current regimen that could be causing that problem or exacerbating a condition</td>
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<td>Help identify situations where adverse drug reactions are not being recognized or adequately conveyed to physicians by other staff, or are not being responded to appropriately by physicians</td>
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<td>In performing medication regimen reviews, include adequacy of indications, issues of dosage and duration, safety (including adverse consequences), and risks</td>
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<td>In any recommendation, emphasize the clinical rationale; if the attending physician fails to respond appropriately, the medical director and consultant pharmacist may offer clinical and regulatory guidance to support the request</td>
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collaborative practice arrangements (where authorized by state law or regulation). Following appropriate state and regulatory requirements, the physician may authorize the pharmacist to modify a resident’s medication therapy for clinical and/or reimbursement reasons. Generally, when a collaborative practice is established, the physician is notified of changes, either as they occur or periodically, depending on the situation.

**SUMMARY: AN UPDATED PERSPECTIVE**

This article has explored the basis for, and attempted to clarify, the relative roles and responsibilities of attending physicians, medical directors, and consultant pharmacists in long-term care, to help optimize their performance and interactions and thereby improve patient care.

The physician and consultant pharmacist have complementary roles with a common basis and objectives. The physician seeks, analyzes, and acts appropriately on medically relevant information in order to diagnose and establish a prognosis, and to prescribe and monitor medications and other treatments appropriately. The consultant pharmacist recognizes, evaluates, and reports information related to medications, including their potential benefits, documented efficacy, and suspected adverse consequences for individual patients. Through effective collaboration, the physician and consultant pharmacist can improve therapeutic outcomes, reduce medication-related problems, and enhance facility regulatory compliance.

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**REFERENCES**