PATIENT VIGNETTES

Refer to PharmD: What We May Finally Achieve

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Editor's note: In response to JLGH*'s call for narrative submissions, these vignettes were offered as reminders that each patient is an individual with unique needs. Chelsea Cunningham authored the warfarin vignettes, and Michelle Link Patterson wrote those about diabetes and other topics. All names are changed in accordance with HIPAA policy. The journal's editors invite you to submit your stories as well.*

FINALLY … SOMEONE WHO REALLY LISTENS TO ME

Sharon has been on warfarin for years for antiphospholipid syndrome and a history of stroke. Like many health care organizations, LG Health uses an algorithm to guide dose adjustments when an international normalized ration (INR) is out of goal range. For most patients, this algorithm works splendidly. For some, however, we must still work off-protocol.

Of the hundreds of patients I've managed, Sharon is the most sensitive to dose adjustments: a 2% change in weekly dose is enough to change her INR by over a point. Prior to switching to a pharmacist-driven anticoagulation service, Sharon would often express her concern to the medical staff about an advised "per protocol" dose change. Knowing how she had responded to dose changes in the past, she would occasionally disregard our instructions and make adjustments on her own. When calculating the risks, she said she sometimes needed to make this choice to keep herself safe.

When I initially addressed her INR under my care, she carefully expressed concern about my "per protocol" dose change. Through shared clinical decision-making, we collaborated and agreed on a plan. From that point forward, I asked for her thoughts and whether she was comfortable with the plan. On more than one occasion, she has thanked me for being a partner in her health by developing a plan *with* her instead of dictating instructions. Although her INRs are still labile and occasionally defy prediction, we are always in agreement on the plan; to her that makes *all* the difference.

FINALLY … WE AGREED ON A PLAN

Thomas was referred to the pharmacy clinic last summer with an A1C of 8.8%. During the initial outreach, he declined to schedule a visit and noted that he was "figuring things out on my own." Within six months, the patient's primary care physician placed a second pharmacy clinic referral. I reached out to the patient; he noted he was prescribed sitagliptin but did not want to start it until his pharmacy appointment.

A month later, he presented to the pharmacy clinic with his wife. At that time, we completed a diabetes disease state review, as well as an overview of potential therapeutic lifestyle modifications and medications. The patient noted that he preferred to consider herbal supplements over more commonly prescribed medications. I was honest with him — we discussed the supplements he wanted to take and the data to support or refute their use. He appreciated that I kept an open mind. By the end of the visit, we had agreed that he would start taking liraglutide instead of sitagliptin.

A month later, I called the patient for our scheduled telephone visit, and he reported that he did not start liraglutide due to "thousands of lawsuits against it" that he had seen online. He found two supplements he wanted to try instead. His A1C remained high at 9.2%, and we discussed both the gravity of his situation and his motivations for healthy living — including his young children. In collaboration with his physician, we checked an insulin level, c-peptide, and fasting glucose; these showed severe insulin resistance.

After I reviewed these results with him, he decided to begin taking a GLP1 medication but preferred a tablet instead of an injection. We were able to get a prior authorization approved for oral semaglutide, and this time the patient started using the medication, electing to hold off on starting any additional supplements given the paucity of evidence for those products.

A few days later, Thomas left me a voicemail thanking me for supporting him through his decision-making process, one that we as health care providers may take for granted. I see patients every day who are taking three, four, or even five medications for one disease state. Thomas's case is a reminder that the emotional burden of taking even one additional medication should be carefully considered.

FINALLY … A DIFFERENT ANTICOAGULANT

Alice struggled for years with labile INRs due to difficulty understanding the impact of eating foods high in vitamin K, as well as challenges overcoming transportation barriers to get to the lab for her INRs. She also took primidone, so apixaban and rivaroxaban were not options due to a drug interaction.

She and her daughter met with the patient's neurologist and discussed an alternate therapy, yet she was hesitant to change since she had been taking primidone "for years." When I saw they were considering this change, I discussed with the patient and her daughter that if she switched from primidone, she would be able to switch from warfarin as well. They were elated by this news, and it was the deciding factor for the patient to stop primidone.

Soon after, Alice started apixaban. She shared that her favorite part of this change was that she can now eat all the green vegetables and liver that she wants without worrying about having a blood clot! This patient is a reminder that we should periodically reassess current therapies and that we can leverage patient preferences to direct patients toward the ideal treatment choice.

FINALLY … WE MADE SENSE OF A CRAZY MED LIST

Betty was referred to the pharmacy clinic for diabetes management with a note from her doctor: "I am worried she is not taking her aspirin and clopidogrel." When I scheduled our first appointment, I asked the patient to bring all her medication bottles so we could review them together. She presented with a list of 24 medications and over 30 bottles that needed to be reconciled.

After our visit, I recommended stopping five of her medications and removed four others she was not taking. We consulted with our cardiology pharmacy colleagues and were able to change her metoprolol to the extended-release formulation to reduce pill burden.

Betty was overdue in seeing her oncologist, so we were able to connect her back with her doctor at that office. That visit resulted in cessation of yet another medication. Overall, the patient went from a list with 24 medications to 12, and she is now working with the Ambulatory Collaborative Care Team to get set up with simplified pill packets, which we hope will improve her adherence.

FINALLY … A PROACTIVE APPROACH

Claire recently moved to this area and established care with one of our primary care providers, who transferred anticoagulation management to our warfarin clinic. Although she had been on warfarin for many years, it is helpful to review patient expectations and assess one's knowledge base, especially during an initial visit.

During our appointment, I talked about vitamin K foods and requested she inform me of any changes in her dietary habits, as these can affect warfarin needs. I also requested that she tell me about any medicine changes as they occur rather than at her next scheduled visit.

When we have reviewed her care, she has reflected that her prior provider had simply adjusted her warfarin dose when her INR was out of range. She is pleased we are now taking a proactive approach to *prevent* an out-of-range INR rather than simply reacting to it.

FINALLY AT GOAL … BUT LACKING CONTENTMENT

In medicine, we set goals for and with our patients, and continue to follow-up with them until we achieve them. However, our goals may not be the same as the patient's goals, and it can be difficult to reconcile opposing priorities. Luke was referred to me just over a year ago with uncontrolled diabetes (A1C 9.6%), uncontrolled hypertension (187/87 mmHg), and an elevated LDL-C (76 mg/dL).

Since his referral, we have started insulin and made changes to blood pressure medications; his A1C is now 6.7%, his BP is 135/57, and his LDL-C is 63 mg/dL. Despite what I perceived as great success in achieving the patient's health goals, however, he has expressed discontentment at the burden and copays that come with taking so many medications every month. I shared that I wholeheartedly understand his frustrations.

We discussed several times why each medication is medically necessary and why he should continue to take them. Although he had been taking 10 daily medications when he was first referred to me, and he was now on only eight a day, the burden of daily insulin injections has led to frustration and dissatisfaction. Despite not being able to safely discontinue many of these medications, Luke has continued to follow-up regularly with me and work on lifestyle modifications.

I share his hope that we will be able to reduce his medication burden further. To work toward that goal, we will need to maintain open and honest lines of dialogue to ensure there is a bridge, and not a barrier in our way.

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