NEWS

From the Desk of the ACCP President

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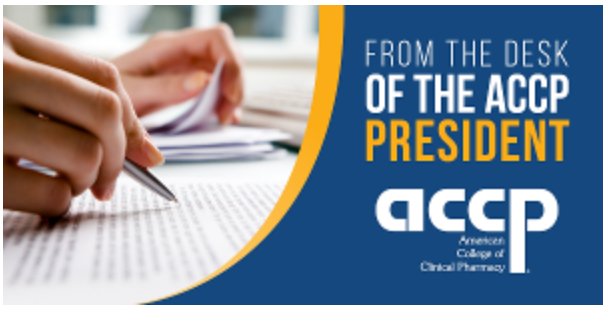

Patients Need More Than One Pharmacist

Achieving medication optimization is a team effort. The patient care team is often thought of as the patient and a mix of health professionals, including a clinical pharmacist. Clinical pharmacists typically practice in an inpatient acute care setting or an ambulatory clinic. However, patient care is not routinely transitioned from the clinical pharmacist to pharmacists practicing in the community, who are often called on to extend this care. Indeed, patients generally have more and better access to community pharmacists than to acute care clinical pharmacists. Thus, to ensure medication optimization across the care continuum, community pharmacists should be part of the patient care team. Provision of comprehensive medication management (CMM) involves patient assessment, patient education, provider education/consultation, and complex disease state management and monitoring, as well as many steps in between. But to truly achieve medication optimization beyond CMM alone, clinical pharmacists must develop coordinated and connected models of care that include community pharmacists.

How can a partnership be formed between practice-based pharmacists in a team-based environment and pharmacists in a community pharmacy setting? To address this, ACCP, the National Community Pharmacists Association Innovation Center, and the Community Pharmacy Enhanced Services Network collaborated to engage teams of clinic- and community-based pharmacists working cooperatively. To share the knowledge gained from these teams, this collaboration developed consensus guiding statements on how community- and clinic-based pharmacists can partner to achieve medication optimization (in press, to be published in the August issue of *JACCP*). These statements identify mutual trust and a commitment to individual patient goals as essential components of effective pharmacist teams. In addition, pharmacist teams establish early on how patient-specific information should be communicated. Moreover, the interventions of clinic- and community-based pharmacists must be complementary and well coordinated.

To better understand the time such partnerships require of community pharmacists, a recent *JACCP* article (https://doi.org/10.1002/jac5.1139) reviewed community pharmacists' notes during a transitions of care interventional study whose primary objective was to advance communication between institution-based pharmacists and community pharmacists to improve patient care. After hospital discharge, community pharmacists were involved in an average of three visits per patient within 90 days post-discharge, spending a mean of 9 minutes with patients during each visit.

The paper also notes that care transitions carry a high risk of medication misadventures such as errors, adverse effects, and nonadherence, probably because patients often have more complex medication regimens on discharge than on admission. But this isn't the only instance where patients can benefit from a team of pharmacists who communicate and coordinate efforts to achieve medication optimization. The challenge is for clinic-based pharmacists to build collaborative bridges with their pharmacist colleagues in community pharmacy settings – it's time to embrace the tenet that medication optimization requires more than one pharmacist on the team.