An Interprofessional Care Approach at a Supported Living Center

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Commentary

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Editor’s Note: This is the transcript of an interview between James Kundart, HIP Editor-in-Chief, and Abimbola Farinde. Minor edits have been made in the transcription for clarity and to remove filler words. The audio recording of this interview is available on the article metadata page: http://dx.doi.org/10.7772/2159-1253.10

James Kundart: We are on the air with Dr. Farinde from the Lufkin State Supported Living Center.

I wanted to ask some questions on care and interprofessional practice. I’m James Kundart the editor of the journal and we want to see if we can explore certain issues that involve multiple health care professions taking care of individuals who are in an institutional care setting for mental health or intellectual disabilities.

I understand that in the past you have worked with individuals who are affected by various mental health issues. Can you tell us a little more about that and what you do?

Abimbola Farinde: At this particular institution, it is geared towards providing health care services. We have services such as medical, adjunctive therapies for those with mental impairments and developmental delays. The population can consist of individuals as young as 8 years old to 80 plus. The population is a wide array of individuals that are treated at this facility. This facility is recognized as an intermediate care facility by the state which means that every so often surveyors come to assess compliance with programs and ensure that individuals are receiving appropriate care (e.g. medical, rehabilitation services).

Kundart: You were describing that both pediatrics and geriatrics are at the facility with children as young as eight and adults older than 80 years. Can you describe in more detail for those of various health professions, the profile of the children, older adults, and those in between.

Farinde: In terms of the make-up of the population, it runs the gamut in terms of age range. Individuals typically have a diagnosis of severe or profound mental retardation. That’s the large majority of diagnoses that are observed at the facility. There is also the presence of a co-occurring Axis I diagnosis whether it may be schizophrenia (the most prevalent) at the facility. As well as seeing autistic disorder diagnosis. With the older population we have comorbid medical conditions (e.g. diabetes, hypertension, elevated cholesterol), generally what is seen with the other population. For the most part, the individuals reside in different homes and are separated by males and females and they also try to separate them based on age range. The facility attempts to keep similar age groups together within the same living area.

Kundart: These residents of the facility, it sounds like some of them have things that were there since birth in the case of intellectual disabilities, autism, or genetic predisposition to mental illness, but came on in teen-
age years or young adulthood. Are they receiving all of their healthcare at the facility, and if so how does that work? Whether it may be nurses or primary care physicians or pharmacists like yourself? How does that work for providing interprofessional healthcare?

Farinde: Well, in terms of the make-up of the team, there is the primary provider. At this facility there are five physicians assigned to 300 plus patients so it is a lot of work for these physicians. These physicians typically see these individuals on a regular basis. There are also attending nurses around the clock. They also have psychologists assigned to each individual, and they are the eyes and ears for the physicians because they monitor the residents' behaviors. In terms of making changes in their treatment plan, the majority of the information comes from the psychologists, and this information helps the physicians to determine if any changes need to be made to medication regimen or therapies. The physicians rely on the psychologists a great deal within this facility. In terms of how the patients are seen, the physicians visit the homes where there are set stations to see the residents for evaluation of their current condition.

Kundart: If I heard you correctly, 300 plus residents split among five physicians. There is a resident for every day of the year but more than one physician there. They are seeing residents more than once a year and it is not like a typical situation where you go for your annual check-up if you are healthy. There is nursing around the clock at the facility. A lot of psychological care because of the nature of the patient population, and a lot of pharmaceutical care. Speaking of the interface between psychology and pharmacy, I know like in states, like the one I am in, Oregon, the psychologists are not able to prescribe oral medications, but they do so through nurse practitioners. How does it work in Texas for that particular problem?

Farinde: Well, within this particular facility and in Texas, there is not a program that allows psychologists to have prescriptive authority, but in Texas nurse practitioners do have prescriptive authority. Within the facility, physicians and physician assistants have prescriptive authority. The physician assistants come in place of the physicians to assess these individuals. In terms of the interaction between psychologists and pharmacists, psychologists typically come to the pharmacists whenever they are preparing information to present at the interdisciplinary team meetings about the residents' current medication and what could potentially be causing behavioral issues. For example, if a resident is initially started on topiramate, and the psychologists notice an increase in behaviors, and the psychologist may consult with the psychologist to help to determine if the medication might be a potential contributor to the behaviors. This information is presented to the physician during the team meeting, and a discussion generally occurs to determine if the initiation of topiramate may be the contributing factor for the change in behavior. A large majority of the meetings are focused on monitoring the behaviors of the residents, whether they are sleeping or eating well, or engaging in disruptive behaviors that would warrant the initiation of pharmacological and nonpharmacological interventions. The interaction between the various disciplines at this facility is continuous and it is something that I have seen that have the ability to bring about positive patient care outcomes, and providing good patient care.

Kundart: I know that the drug topiramate(Topamax) has been implicated in optometry of unusual presentation of angle closure glaucoma. It is a strong medication and like all strong medications it can definitely have strong side effects if not prescribed judiciously. That is a good example that you bring up there. How much overlap is there between mental impairments and autism? Is there an overlap between the various conditions where residents who have comorbid or co-occurring conditions?

Farinde: In this particular population, there definitely is a great overlap, especially with the adult population we definitely see a lot of medical conditions with diabetes, hypertension, cholesterol issues, but this may also be related to the fact that they are placed on mood stabilizers, antipsychotic medications, anxiolytics, so these medications can potentially be contributing factors. The individuals that we do have extensive comorbid conditions which is why it is so important that we have the primary care physicians also working alongside the psychiatrists at the facility. In terms of treating both the medical and psychiatric conditions, it is important for both sides to collaborate when it comes to treatment. For example, if a patient is placed on a beta blocker (propranolol). This medication can be used for aggression in certain patients, and of course it is used for blood pressure. In terms of proper management, the medical staff has to communicate with psychiatry or
mental health staff about what the medication is being used for, and both sides can closely monitor for any adverse effects that may result from the resident being on this medication. This practice allows for collaborations to occur among the disciplines especially with medications that have multiple indications.

**Kundart:** Well understood, and I know that we used topical beta blocker for glaucoma, and they are drugs of abuse occasionally among graduate students who are looking to decrease tremors due to nervousness and have practical exams to complete. That is of course the non-residential population.

There are teams consisting of psychiatry, professional psychology, nursing, and of course pharmacy and others. When this team meets irregularly or weekly, can you tell us how that works?

**Farinde:** These meetings are typically set up by the psychology department and based on whether they identify any behavioral issues or anything related to person's treatment at the facility. This is of course a requirement for the residents at the facility. Each month the residents have to be assessed completely in terms of their medical condition, where they currently stand, and if any changes need to be made to their treatment plan. During these meetings, the primary care physician is the lead, we have the psychiatrist as well and then nursing staff and pharmacists. As a pharmacist on the team, my responsibility is to bring the most updated list of the residents' medication profile and assess for any potential drug-drug interactions, drug-food interactions, or drug-lab interactions and make recommendations for any types of changes that might benefit the patient. After looking at their lab work and their current condition, recommendations are made to the primary care physician, and also psychiatrist, and these recommendations may or may not be accepted for implementation. Everyone has a voice at these meetings which is one of the reasons why I believe it is a good approach to providing patient care because it is not just one discipline but every single discipline that is involved in the care of the residents should be involved in their treatment and present at the meetings.

**Kundart:** So all 300 residents need to have their records gone over every month. That is quite a handful.

**Farinde:** It can be challenging but one thing that I have learned is that to actually go to the homes and see the residents and become better at placing the names to the faces. At the facility, the residents also have direct care staff that are monitoring them 24 hours a day along with having the attending nurses. I get the opportunity to go to the homes and see the residents whenever an issue is brought to my attention. If a psychologist or a nurse voices their concern about a medication becoming a potential cause of a side effect, when presented with this issue, I make it a point to go to the homes and observe for myself what they are reporting in the patient. Based of the observation I am able to make a recommendation at the follow-up meeting to address the issue.

**Kundart:** While respecting patient privacy, are there specific medication interactions you can think of that you commonly run into with this residential population?

**Farinde:** I think it is more with food or drink interactions. For example they might be given caffeine or citrus and with one example, Buspar, and if a patient is given a citrus fruit (e.g grapefruit) this can increase the level of Buspar to cause adverse or toxic side effects. This is an interactions that most clinicians may not be aware of and it is something that I make it a point to write down whenever I perform a medication review or evaluation. In terms of drug-drug interactions, the most commonly identified would be among the antipsychotic medications. It may be the fact that a resident is placed on two or more antipsychotic medications or an antipsychotic medication with a mood stabilizer that has the potential to cause significant movement disorders if they are not routinely monitored. That is where the monitoring of movement problems comes into play and why monitoring is required quarterly and sometimes monthly in
certain instances based on the medication. Monitoring is a big issue at the facility, and I always make it a point to identify the potential for increased drug levels with the combination of some of the psychotropic medications which a large majority of our residents are on. Also try to continuously identify for drug-food interactions that may also occur with the particular medication that the residents might be placed on.

Kundart: I think you indicated why we will always need pharmacists because these things are hard for the average individual to keep track of so that is why we pay you the big bucks. I know the older patients who are residents who might be on blood thinners and would have a contraindication for foods that are high in vitamin K, like the green leafy vegetables, and that is sad in a way because those are healthy food for us in general but it would be more sad if the blood thinner does not do its job for them to have a fatal clot of some sort.

Farinde: The message I try to communicate to patients or anyone who starts on the blood thinner is that the person does not have to completely wipe out the foods that contain vitamin K, but making sure that consumption is in moderation, whether the person is residential or non-residential, it is the same message which is to be consistent with consumption and in moderation. This message is also provided to physicians whenever blood thinners are started on the residents.

Kundart: That is good. Whether it is said wrong or patients hear it wrong it is good to know that they are not prevented from eating spinach again.

Farinde: Some individuals believe that once they are started on a blood thinner they are limited from any greens.

Kundart: Some of the greens are highest in lutein, carotenoids, and xanthines that are very important in the prevention of macular degeneration in older populations.

Farinde: The psychotropic polypharmacy committee in which I had to serve as head of along with the chief of psychiatry because it was such a big issue with the over-prescribing of these medications so it was necessary for routine monitoring to occur. The fact that we had surveyors coming in to determine whether or not we were doing this correctly kept us up to date and make sure we were compliant. Making sure that indications were being provided for each psychotropic medication that was initiated.

Kundart: Psychotropic polypharmacy is not an area I knew existed but it makes sense in light of what you have been sharing, particularly for this residential population. In general you probably have some differences in your residents for whom healthcare has to be provided more or less objectively because the resident might not be in a position to communicate verbally or such. There are others, depending on their state of mental health could include some level of subjective input, is that true? Or was the case of the residents at this facility done more objectively in every case?

Farinde: The large majority of patient care was done objectively. Since most of the individuals were nonverbal, most of the information that was used to determine what direction to take with treatment came from information that was provided by the direct care staff. They were told to monitor the frequency of sleeping patterns, eating behaviors, bowel movements, urinary output so everything was being monitored and this information was being presented at each meeting in order to determine what needed to be done with that individual. That was the primary approach that was taken at the facility. The psychologists were also monitoring the number of behavioral disturbances by the direct care staff, and they also visited the homes to get a firsthand account of eating, sleep patterns to report to the primary physicians and psychiatrists. Everything was done objectively for the most part.

Kundart: That is challenging. Those who are in pediatric care, particularly with younger children, know how objective an exam or healthcare has to be, but this is a whole other challenge to provide objective care to these individuals of various ages all along the lifespan.

Farinde: It takes a very skilled and trained individual to do this type of work. The physicians are able to take all of the data that is presented to them and rely heavily on information from direct care staff to guide them in terms of what needs to be done with a patient. They are relying on other staff members to assist with providing appropriate healthcare to the residents. Everything could not be done by the physician alone because the physician required the assistance of other disciplines in order to ensure that healthcare needs were being met.
for the residents.

Kundart: Many of these individuals are residents because their needs are beyond what family members or caregivers might be able to provide even if they have family nearby. I imagine others had family come and visit and perhaps give some historical perspective on changes over time. Did family members sometimes provide input for care of these residents?

Farinde: Family members do routinely come and visit these residents and sometimes do sometimes take the residents offsite. During the monthly meetings, the family members can come in and can provide input to the team. They provide information about what they have observed so far with the resident being at the facility and if they have seen dramatic improvements or minimal improvement with their [...] They have an input and have a part in the treatment of their family member. Whenever the family members do come they can participate in the team meeting and provide recommendations in terms of what they think is the next step to take with regard to making sure that the treatment that is being provided is the best.

Kundart: It sounds like working at this facility is a demanding but rewarding job to have to participate in. If, however, we can give you the power to change things in the future, how might you see the interprofessional progress occur moving forward for the next generation of residents at a facility like this, or how would you redesign things if you could make any changes?

Farinde: One thing I would change with regards to the interprofessional progress would be to have more clinical pharmacists on the team. I was actually the first at this facility. The concept of having a clinical pharmacist as a member of the interdisciplinary team was a novel approach to patient care at the facility, or new approach, but sheds light that there are benefits to having a clinical pharmacist on the team, and they were able to see the result of that through my involvement with the rounds and the team meetings whenever an issue was brought up with regards to a resident's medication profile. Also to have a larger number of physicians; the ratio of residents to physicians would be something I would like to see change in the future. I commend the physicians for being dedicated and knowing each medication profile and medical conditions of each resident. They developed this bond with these residents and have known them for so long but it would be beneficial to have more physicians come on board to help assist with the workload.

Kundart: Well whether it comes to making the valuable contribution of clinical pharmacist or increasing the ratio of residents to physician, I imagine that it all comes down to the funding in the end. That is something that is always in short supply and perhaps now more than ever. Is there anything else you would like to share about working at the residential care facility and the role of the clinical pharmacist in terms of taking care and working as part of this clearly interprofessional team?

Farinde: As an individual who has been able to gain valuable experience in this setting, I feel that taking this approach with regards to providing patient care is the future direction of healthcare. Within our society there is a greater movement towards this approach and we have observed the benefits that can come from having multiple disciplines collaborate and make sure that all of the issues that are affecting a patient are being adequately addressed. By having multiple disciplines being involved, there is a decreased likelihood that the ball will be dropped when it comes to providing patient care. The goal of the facility is to try to make individuals independent as they can be and not have them reside at the facility for the rest of their lives if this is not necessary. This is where the skills development and therapy can move residents towards this goal. The interprofessional approach to providing health care is one that I would recommend to any facility.

Kundart: I want to thank you very much, Dr. Farinde, for this interview.

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