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Nurse Practitioner and Pharmacist Interactions

Implications for Effectiveness of Interdisciplinary Health Care Teams

Many providers have had the experience of being interrupted during a patient visit by a call from a pharmacy requesting clarification or additional information prior to processing a prescription. Often the request is not directly related to the prescription itself, such as requests for your Drug Enforcement Administration (DEA) number, National Provider Identification (NPI) number, or name of your supervising physician. This is irksome for providers when a DEA number is requested even when a controlled substance was not prescribed or when the pharmacy asks for a physician name when there are no physicians in the practice. Nurse practitioners (NPs), like other licensed providers, all go through various credentialing processes on a regular basis, which require the provider to produce copies of license numbers, NPI, DEA, evidence of current cardiopulmonary resuscitation (CPR) training, etc. This type of data is maintained in many duplicated databases and even available on the internet such as the Board of Nursing or the National Provider Identifier website. Perhaps because of this type of repetitive requests, we may not be particularly receptive when asked for this information by yet another health care provider.

In order to improve interdisciplinary communication and collaboration, we need to start by trying to understand why other health care providers such as the pharmacist or pharmacist assistant make these types of requests. Why might a pharmacy ask for a DEA number for non-scheduled medications? Why do pharmacies ask for NPI numbers when processing prescriptions for patients not on Medicaid or Medicare? What if you don't have one or both of these numbers? Can a legitimate prescription written by a licensed provider not be processed by the pharmacy if the provider does not have a DEA or NPI number?

Improved interdisciplinary and interprofessional health care team relationships have been targeted as one method for patients to receive more consistent and safe care. A true

interdisciplinary approach to health care requires basic communication, competence, respect for the work of others and willingness to help one another[1]. One of the obstacles to this team approach occurs when there is a lack of understanding of each disciplines point of view as we independently provide services for the patient.

As nurses we are well aware of the high intensity and workload volumes that we deal with, however, we may not be as familiar with the conditions many pharmacists work under. The scope of the particular problem being discussed in this article needs to be viewed in the light of the 846 million prescriptions that NPs and Physician's Assistants (PAs) write each year, in addition to the millions of prescriptions being written by physicians each year[2]. On top of that the number of prescriptions written continues to increase, along with the number of patients on multiple medications, leading to even more possible drug-drug interactions and side effects. Most pharmacies employ an average of 1.2 pharmacists for every hour the store is open and each pharmacist fills an average of 14.1 prescriptions per hour. The effect of increased pharmacist workload on outcomes was demonstrated in a 2007 study, which documented a 3 percent increase in pharmacy errors related to drug-drug interactions for each additional prescription filled per hour[3].

Similar to other health care professionals, pharmacists operate under numerous guidelines and regulations. Pharmacy service standards are developed by the National Council for Prescription Drug Programs (NCPDP), an accredited not-for-profit organization[4]. In 1996 the adoption of the Health Insurance Portability and Accountability Act (HIPAA) required health care providers to use a standard unique identifier for transactions. The NPI was established as that standard unique identifier[5]. The goal was to simplify the claims submission process while accurately collecting health care provider data, facilitate electronic submission, and to evaluate the efficiency and effectiveness of the general health care system. Providers must apply to the National Plan and Provider Enumeration System (NPPES) in order to be assigned an NPI number. The NPPES collects identifying information on the health care providers and then

assigns each a unique ten digit NPI. The NPI was intended to become the national standard for identifying providers for various payment systems, forms and reports. Implementation of the NPI requirement began May 23, 2007 with small health plans implementation on May 23, 2008. The NPI is now the required identifier for the federal (Medicare and the Medicaid) system. All third party payers (commercial insurers, Blue Cross/Blue Shield, and self-insurers) now also require the NPI as the provider identifier <u>but may continue to have other requirements, such as the DEA number.</u>

So how does this affect the way pharmacies process a prescription for payment and reimbursement? When the patient presents a prescription to the pharmacy, the information is entered into a computer system, where the mandated electronic fields are displayed, completed, and then transmitted for payment approval. The process may be interrupted if all of the information is not available. The pharmacy benefit manager responds to the electronic request by approving or rejecting the claim. However, if the pharmacy does not have all of the information required by their particular form, which may include NPI number but may also include a space for the DEA number, name of a physician, or other numbers, the claim cannot be transmitted or will be rejected if transmitted. This does not mean the prescription is not valid, or that you do not have the right to write the prescription within your legal scope of practice. It simply means that the pharmacy must be able produce all of the information that may be required by various insurance plans before the claims manager will agree to allow the pharmacy to process the prescription.

Of note, this has nothing to do with the type of payment system used or the type of medication ordered. This can also occur in some states if your State Medicaid Provider number is not updated on an annual basis, even if you have a current NPI and DEA number.

The pharmacy needs to ensure that they will be reimbursed for the medication, so having complete and accurate information prior to processing the patient's prescription is important. On the first visit from a new patient, or when a patient brings in a prescription from a

new provider, the pharmacy will gather the information needed not only for the current prescription, but any future prescriptions that may come from this provider. The information goes into an electronic form that collects data for the pharmacy's provider database. The forms are usually set to collect as much information as possible, because various insurance companies require different numbers and information.

In the event that information about the provider is missing, the pharmacist can try the following: query to find the missing information, as most of this information is available on the internet, or call the provider's office to inquire about the missing information. Unlike your social security number or your taxpayer identification number, the NPI must be disclosed to the general public under the Freedom of Information Act (FOIA). A searchable database for NPI numbers can be obtained at https://nppes.cms.hhs.gov/NPPES/Welcome.do Also, most state licensure boards have searchable websites where provider license numbers can be obtained.

However, using the internet to obtain missing information is not as easy as it may seem at first glance. For example, using the online NPI database requires an internet connection, and while most pharmacies have the ability to connect to the internet, the pharmacist still may not be able to connect to the NPI database. Similar to many hospitals, many large pharmacy chains block users from all but specifically pre-approved web sites. Even if the pharmacist does have access to the NPI database, it requires that the pharmacist be able to read your name and spell it correctly to enter it into the database. Readability can be difficult if your information is not pre-printed onto your prescription forms. Also, while the provider name is searchable, a search of a provider name will produce all providers nationwide with the same name. Selecting the appropriate provider NPI requires the pharmacist to know the practice the provider is associated with or where their last practice was (in the case of a newly relocated provider who has not updated their NPI information). As providers we are responsible for logging on to the NPI website and updating our practice information whenever it changes. If our practice location information is out of date on the website it can be difficult for the pharmacist to locate the correct

NPI number. For providers who work in multiple locations, or who have common names, it also makes it very difficult for the pharmacist to select the correct NPI from the online database. As demonstrated, it may be better and more reliable for the pharmacy to contact the provider's office for the missing information.

Having professionally printed prescription forms with your license number and NPI number on the form improves communications and speeds up the claims process for your patients. Having a space for your DEA number is also a good idea. But you should not have the DEA number pre-printed on prescription forms, this type of information should be entered by the provider only when a prescription for a controlled substance is written. In some states it is illegal to have the DEA number pre-printed on a prescription form.

It is agreed that the pharmacy claims form systems must be updated to meet current prescribing laws and require a provider name rather than a physician name. However, the individual pharmacist in a chain pharmacy probably has little to no control over these forms. Under the current system, the pharmacist may have to leave a blank space in the form if the form says physician name rather than provider name. This means that insurance company reports, both internal and those mailed out to patients, may list all medications that have been prescribed to the patient, along with the date that the medication was prescribed. However, the report will only list who actually prescribed the medication if the prescriber was a physician. In many of these system's reporting mechanisms, when an NP writes a prescription a dash is entered in the place of the NP name, since the original data collection form completed by the pharmacy had asked for physician name. The dash mark or blank space in the report indicates that the prescription was written by a non-physician, and subsequently makes it difficult or impossible for the insurance company or the patient to track which provider actually prescribed the medication in question.

In the end, rejected claims or prescriptions not processed for any reason are a barrier to the delivery of quality health care. The outcome of a rejected claim is disruption in care - the

prescription is not processed in a timely fashion, or the patient must pay the full cost of the prescription, or the patient gives up and goes home without the prescription. Working with local pharmacies to make sure your information is readily available and readable will avoid many phone calls from the pharmacy.

The issue as described above is just one of a number of ways that NPs and pharmacists can work together to improve patient outcomes. It is very important that we work together to recognize and respond correctly to misunderstandings to both improve patient care and pave the way for future collaborative work. For example, as providers we may think that pharmacists know all about the regulations concerning prescription privileges of various providers. However, in reality pharmacists may not be fully aware of the regulations concerning NP/PA prescriptive privileges. While the information is probably available on the internet somewhere, searching for it is very time consuming in an already busy day, and the pharmacist may not have access to websites that contain the information. Other means of obtaining this information may be equally problematic. New pharmacists may expect experienced pharmacists to know all of the regulations, but if the experienced pharmacist is not up to date this merely compounds the problem by spreading more misinformation bolstered by authority.

This is a common problem, a survey study of pharmacists in Colorado found that fewer than half of the pharmacists knew the requirements for an Advanced Practice Registered Nurse's (APRN) prescriptive authority[7]. Of the pharmacists who responded, 24% stated that they used the collaborating physician name to label prescriptions written by a nurse practitioner. An additional 35% said if the NP had a DEA then they could label with the NP name, but otherwise they could not. Over 50% said they could not track prescriptions written by nurse practitioners because their computer systems "do not accommodate any names except physician names."

Other comments written by the pharmacists in this survey that were incorrect concerning nurse practitioner practice in Colorado at the time of the study included (p. 39):

“NPs do not qualify as primary care providers, therefore label with the physician’s name”

“Medicaid requires a physician’s name and number”

“NP must have a DEA number to prescribe”

“NP can only prescribe certain drugs and the MD must come up with the list”

“NP must have a special license to prescribe”

“NP have limited formularies”

“NP cannot delegate, they must call in their own scripts”

“We cannot differentiate between providers: there is no practitioner directory for NPs”

Most pharmacists in this study also were concerned that NP prescribing increased the workload of pharmacists, as they had to do the following: Look up the name of the collaborative physician, check the NP’s credentials, fill out additional forms because the NP does not have a DEA, and increased workload by answering NP questions or checking inaccurate dosage or directions.

Some of the pharmacists in this study recognized that they might need to learn more about prescribing abilities of nurse practitioners. Pharmacist comments indicated: “both the board of pharmacy and the medical board have been very vague on the laws. I would like more information sent to us” (p. 38). This last comment brings up a concern; the pharmacists were looking to their own board of pharmacy or the medical board to give them information concerning the regulations of another profession. This is a problem because the board of nursing is the one who makes regulations concerning the practice of nursing, and it is the nursing statues that contain all of the provisions and regulations concerning scope of practice for nurse practitioners, including regulations concerning our prescriptive abilities within a given state. As might be expected, this confusion voiced by the pharmacists in the survey highlights the difficulties they face trying to keep up with regulations concerning multiple providers. This becomes even more difficult if you practice near a state line and have more than one set of state regulations involved.

Recommendations to Improve Collaboration

The new Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (2011), states that “Nurses and physicians—not to mention pharmacists and social workers—typically are not educated together, yet they are increasingly required to cooperate and collaborate more closely in the delivery of care” (p. 31). The IOM has given the charge that all health professionals be educated to deliver patient-centered care as members of an interdisciplinary team. To demonstrate this interdisciplinary approach, The *Future of Nursing* report was not written by nurses alone, but was written by an interdisciplinary group of nurses, nurse educators, physicians, physician educators, business people, CEO’s, consultants and others who are heavily invested in improving the US health care system. The IOM report made striking and effective calls for change within nursing and the health care system, including recommendations not only for more effective interdisciplinary work, but for removal of scope of practice barriers. “Advanced practice registered nurses should be able to practice to the full extent of their education and training” (p. 9). The report also makes specific recommendations to remove barriers to nurse practitioner practice[8].

To help meet the need for a more effective collaborative working team, the team members from different professions, such as physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, respiratory therapists, and other health care providers, should be accepted as coming from disciplines with different (but often equivalent) educational paths. These different experiences give each member specialized knowledge, skills and methods. Each member should be valued for their different skills, opinions and philosophical viewpoints concerning the best way to care for the patient.

Pharmacists are an excellent example of a highly educated group of professionals whose talents may be underutilized, possibly due to misunderstanding and even mistrust between the providers and the pharmacists. This is unfortunate because the pharmacist is a professional whose contribution to the interdisciplinary team could be invaluable. Integrating the

bodies of expertise, coordinating, collaborating and communicating with one another would result in optimized care for shared patients. NPs and PAs learning more about the responsibilities and functions of pharmacists, and pharmacists learning about NP/PAs would enhance this collaborative relationship.

Once becoming more aware of each other's role, it will be easier to coordinate care and assist in changing perceptions. As NPs and PAs we should be aware of the difficulties pharmacists have in understanding and implementing all the prescribing rules and regulations for every discipline. One pharmacist in the Blair and Leners study commented "it would be helpful if all prescribers, including NP's would notify all pharmacies in the area when they start practice and sent their license and DEA numbers. A personal visit to the pharmacies near their office would be great" (p. 38). While this might not be practical if there are a large number of pharmacies in the area, a visit to even a few of the major pharmacies to introduce ourselves would probably go a long way in paving the road for future successful collaborations. Another idea would be to send information cards with all of our basic information and license numbers along with a picture to all local pharmacies. This could help smooth the transition into a new work setting and, depending on where you work, you may be able to get the clinic to do this for you. After all, most hospitals widely advertize information about new physician providers, using newsletters, websites, bulk mailings and even billboards. However, they seldom make the same effort to introduce new nurse practitioners or physician assistants to the community.

In addition to providing a clear advantage for our patients, working in a respectful collaborative environment can only strengthen the political advocacy position of all professions involved. At least one article in a pharmacy journal has taken note of nurse practitioner's success in obtaining additional privileges, and suggests that pharmacists could learn something from the nurse practitioners[9]. Just think what might be accomplished if NP's, PA's, pharmacists, physical therapists and other allied health professionals all worked together to support each other's advocacy agendas! But as noted at the start of this article, it all begins with basic

communication, competence, respect for the work of others and willingness to help one another.

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