REFLECTION

Why Warfarin Should Be Managed in Primary Care

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ABSTRACT

For 5 years, our family medicine clinic's physician-pharmacy team managed anticoagulation onsite. Now, against our recommendations and desires as a clinic, anticoagulation at our site is no longer managed by our local interdisciplinary team. Instead, it is being managed by our system's centralized anticoagulation team. Although some may point out that anticoagulation management is one small element of our practice, we believe eliminating this could open the door to other changes to our scope of practice. Anticoagulation belongs in primary care where comprehensive care, ongoing relationships between patients and care teams, and flexible office visit agendas optimize this service.

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Management of anticoagulation belongs in primary care. Family medicine physicians and pharmacists provide comprehensive, whole-person care. Family physicians are dedicated to the whole person and serve as guides to define evidence-based, patient-centered goals.[1] Pharmacists complement this care by optimizing medicines to achieve these goals.[2] Care within this scope aligns with the needs of warfarin. Its complex nature needs a patient, thorough, and dedicated review during each international normalized ratio (INR) check to ensure continued alignment with fluxing patient health status and related goals. Family medicine physicians and pharmacists are natural allies in problem solving and facilitating warfarin management in primary care.[3,4]

We learned this firsthand in 2016 when our family medicine clinic added a pharmacist. As we standardized INR monitoring and warfarin management, we learned to work as a physician-pharmacist team. For the first time, we had the capacity to build and maintain a process involving standardization of documentation and implementing a dosing and monitoring protocol. This work produced smoother transitions between office visits and care team members and evidence-based treatment decisions. In addition, a process was developed for office visits where patients were presenting solely for a laboratory draw. In this scenario, if an INR was drawn and the patient was not seeing the physician, the pharmacist would manage the result and relay the plan to the primary physician. This ensured the plan was developed in real time, based on a comprehensive history, rather than a stand-alone INR value in the physician's in-basket, one lacking the necessary history to make an assessment and requiring further follow-up with the patient. This also allowed for collaboration asynchronously to ensure cohesiveness with previously established goals of care.

In 2021, our health system informed us that anticoagulation would no longer be managed by our local interdisciplinary team, but instead by our system's centralized anticoagulation team. Anticoagulation has an impact on a patient's entire medication regimen and treatment plan that reaches beyond complex drug interactions. Managing warfarin anticoagulation is a complicated series of decisions, requiring an overall plan to ensure cohesiveness. Anticoagulation and warfarin management require comprehensive care, an ongoing relationship between the patient and care team, and flexibility in the office visit agenda.

We have learned that relationships are the foundation of team-based, interdisciplinary, integrated care[7] and are essential for the sometimes mundane yet critical management of warfarin. Without relationships, the repetitive history gathering required to assess warfarin therapy may not be given the attention it deserves. Without relationships, it may be more difficult to create a "judgment-free" zone when assessing food and beverage indiscretions or medication adherence. Frequent

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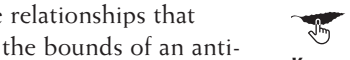
INR visits familiarize family medicine teams with their patients leading to benefits far beyond anticoagulation. The transition of these visits to siloed, specialty care teams risks increased cost of care,[5] increased likelihood of hospitalization,[6] increased burden to patients coordinating their own care,[8] and the loss of these irreplaceable relationships that serve the patient and care team outside the bounds of an anticoagulation visit.

It is family medicine's ability to have flexible office visit agendas that have allowed these visits for "INR checks" to achieve more than what was expected at the surface. These visits served as an opportunity for patients to share other concerns or for the physician-pharmacist team to check in on other elements of a patient's care. For example, when a 97-year-old patient came in for an INR check and reported new hypoglycemia with mealtime insulin, we were able to both adjust warfarin and insulin dosing. In a 37-year-old patient with uncontrolled hypertension and elevated cardiac risk, we not only addressed anticoagulation but also adjusted his antihypertensives and introduced the role of a statin in primary prevention. Our actions went well beyond just assessing their warfarin regimens to enhancing their overall medical care. Together as a physician-pharmacist team, we passed the baton back and forth in the marathon that is primary care.

To compare the quality of the anticoagulation care provided, it is common to look at "time in therapeutic range." With this as our litmus test, the literature tells us that care is superior when provided in anticoagulation clinics compared with "usual care,"[9] however this is a limited perspective to take. Not only are these comparisons lacking patient-oriented outcomes, they also are not an accurate comparison to the current state of affairs in family medicine. Our care model is built upon the foundation of proficient, integrated, team-based care.[10]

We are greatly saddened by the loss of anticoagulation management as a part of our scope of work in primary care. We miss seeing our patients and it feels absurd to tell them anticoagulation care is no longer in our purview. Why fracture our patients' care when our current, local standardized process for INR monitoring and warfarin management is allowing us to tackle multiple needs simultaneously, ie, anticoagulation care, preventive and health maintenance, and management of comorbid conditions. Maintaining a broad scope of practice benefits physicians as much as patients as it has been shown to decrease the risk of provider burnout[11] and improve the likelihood of achieving Maintenance of Certification.[12]

If the health care system can justify this change to our clinic practice despite adequate support systems in place[13] like interdisciplinary, physician-pharmacist teams,[3] how far-reaching is it to remove insulin management, or the care of pregnant patients? We need to hold true to what defines family medicine, anticoagulation being one of many examples: comprehensive care, relationship-driven health care team members, and care for the whole person.



Key words: anticoagulation; family practice; patient-centered care; patient care team; integrated health care delivery

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