Moving beyond Filling Prescriptions at a Moment in Time, to **Caring for Patients** over Time

Change Package

November 2019

Community Pharmacy Foundation

www.flipthepharmacy.com

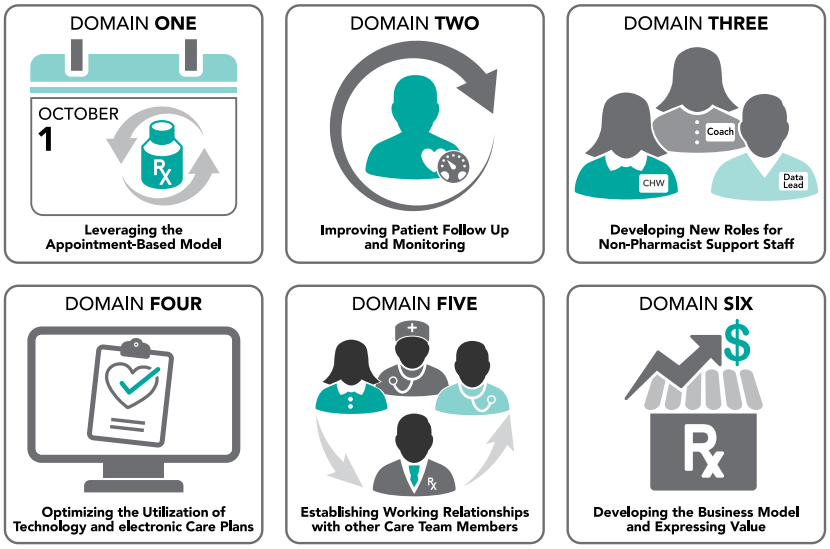
CPESN

Welcome to the **Flip the Pharmacy** Change Package

Pharmacy practice transformation requires big changes. This **Change Package** is your guide for practice transformation. This **Change Package** is designed to offer you a stepwise approach to help you transform 3 key areas of your pharmacy:

1. Your Workflow
2. Your Patient Care Processes
3. How you lead your Business

The **Change Package** will provide you focused practice transformation activities to develop each of the 6 Domains.



Each month, the **Change Package** will prescribe specific steps to help your team implement workflow innovations designed to assist your pharmacy with implementing patient care precesses.

Here's how to make it work:

- **Each month:**
  - Review and lead team through the **Change Package**
  - Keep your entire team engaged in the Domain focus of the month
  - Complete your **Change Package** monthly requirements, if you are part of the flip the pharmacy cohort
- **As needed:**
  - Check in with your coach for near-real time feedback, if you are part of the flip the pharmacy cohort

DOMAIN **TWO**

Improving Patient Follow Up and Monitoring

Domain 2: ***Improving Patient Follow Up and Monitoring*** – Community-Based Pharmacies have great opportunity to lead the health care system in effective patient follow up and monitoring utilizing system-leading number of patient touch points.

Domain 2: *Improving Patient Follow up and Monitoring* Progression 1: *Hypertension Focus*

This **Change Package** will help your pharmacy develop a patient care record that is longitudinal; building on the interventions made each month to optimize medication therapy and achieve therapeutic outcomes.

Monthly Focus:

- Complete and document patient follow up on eCare plans submitted during the prior month, which were related to medication synchronization to support care
- Prepare your pharmacy team to monitor patients

Flip the Pharmacy Monthly Required Goals:

- ☐ Document 25 eCare plans with a focus on patients with hypertension
- ☐ Identify a non-pharmacist staff member to complete the American Heart Association Training
- ☐ Review the persona and document the sample case as an eCare plan

INVOLVE YOUR TEAM! Share the monthly focus and goals with your team.

- **Team Huddles:** Join the team together for a short 5 minute team huddle to share information.
- **Newsletter:** Share details and post for all to see.
- **Designate a champion:** This person will lead the change and handle team questions.

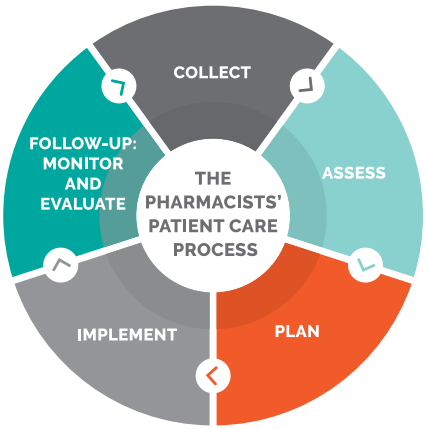
Ask your coach if you need more details!

Workflow Innovation:
Identify Patients with Hypertension, Asking about Goals and Monitoring

Monthly Focus: Hypertension Patients

Each workflow innovation will enhance your pharmacy's workflow to support integration of The Pharmacist's Patient Care Process into your pharmacy's operations.

This month, we'll focus on documenting eCare plans for patients with **hypertension**.



Goal: **Document 25 eCare plans with a focus on patients with hypertension**

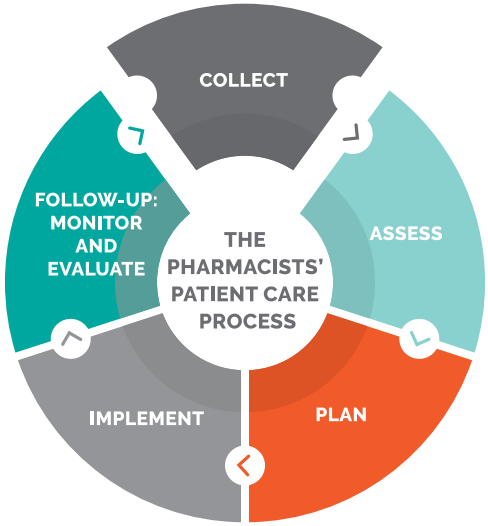
STEP ONE: Find your patients!

ACTION ➔ Use the following methods to identify patients with hypertension (for eCare plan documentation)

1. Review your Medication Synchronization eCare plans from last month. Identify any patients who are taking anti-hypertensive medications.
    a. Gather the Patient Encounter documentation forms completed last month.
    b. Review each patient's medication profile to identify any patients taking an anti-hypertensive medication
2. Run a report of one anti-hypertensive medication (ex: ACE inhibitor).
    a. Review the report and identify patients who have filled a prescription for this medication at your pharmacy over the last 30-60 days
3. If your eCare plan documentation system allows, run a report of patients who have been diagnosed with hypertension.
    a. Review this list and select patients for follow up.

STEP TWO: Collect information!

As part of The Pharmacist's Patient Care Process, collection of subjective and objective information about the patient is the first step. This ensures all relevant medical/medication history and clinical status of the patient is shared with the pharmacy team.



Subjective information
is information that comes from the patient

Objective information
is information that is measured

ACTION → Conduct a patient interview using the Hypertension Follow Up Guide

1. **Review your list of patients with hypertension** and determine how you will follow up with the patient.
   - **For patients enrolled in medication synchronization that have an eCare plan from last month:**
     - Implement the guide during the during the pre-appointment phone call
     - Use the guide to counsel at the medication pickup
   - **For patients identified by a report:**
     - Assign a staff member (Pharmacist or Pharmacy Technician, if trained) to call each patient on the list and ask the questions on the Hypertension Follow Up Guide. This should ideally be done during the pre-appointment phone call for medication synchronization.
     - If the patient is not yet enrolled, this is a good time to enroll them into your medication synchronization.

   TIP → **Add the Hypertension Follow Up Guide to your medication synchronization processs**

2. Use the **Hypertension Follow Up Guide** to start your Conversation.
   - Depending on your workflow and staff training – this form may be completed by a Pharmacist or a Pharmacy Technician.

3. Document information in the patient's **eCare plan** to collect information for follow up.

Hypertension Follow Up Guide

Patient Name:_____ DOB: _____Today's Date: _____

At each medication pick up, assess:

1. In the past 14 days, how many days have you missed at least one dose of any medication?

2. Are you having any issues with your medications?

3. What target goal blood pressure did your doctor tell you?

4. How often are you monitoring your BP? Do you write your measurements down?

5. How often do you consume foods high in sodium, sugar, animal fat, sugary drinks, and alcohol?

6. How often per week do you exercise or engage in a physical activity?

Check in on the following at the initial assessment and also, every 3 months:

1. How often do you smoke or use tobacco/are you exposed to any secondhand smoke?

2. Do you have a family history of high blood pressure?

Training on Blood Pressure Measurement

Directions: Identify a non-pharmacist staff member to complete the **American Heart Association** Training, *The Importance of Measuring Blood Pressure Accurately*. At least one staff member must complete the training. **The non-pharmacist personnel completing the training should be someone who will, in the future, be measuring blood pressure.** Next month's domain will focus on blood pressure measurement by staff members.

Once the training is complete, the person who completes the training should submit the attestation form to document completion. **This course is provided free, online and is about 15 minutes long.** The course is not accredited for Pharmacy Technicians or Pharmacists so no CPE will be awarded.

STEP ONE: Assign the training

- Non Pharmacist: Select at least one non-Pharmacist staff member to complete the training. This should be someone who will likely take blood pressure measurements in the future.
- A Pharmacist may also want to complete the course so they can answer staff questions. Pharmacists are encouraged to complete the training annually to stay up-to-date on measuring blood pressure.

STEP TWO: Take the course

ACCESS COURSE HERE

STEP THREE: Document completion of the training

DOCUMENT TRAINING HERE

CASE INSTRUCTIONS: Let's Practice!

Patient Case Materials

Step 1: Review the Persona for French Fry (next page)

- The persona is intended to help give pharmacies a picture of a real patient who may be visiting your pharmacy. You will see French Fry in future cases as we will build upon this case.
- Please note that the medication related problem, intervention, and goal sections have different color text. This particular information is reflective in the patient case. The intent is for you to realize the patient care aspects that you are performing can be correlated into the eCare Plan *(see Sample Care Plan Case)*.

Step 2: Complete the Sample Care Plan

- The case includes the pertinent information that will be included in the care plan documentation within your respective platform.
- The boxed text at the top of the case that review French Fry is information pulled from the persona that helps us to note the important information for the care plan.
- **Please document the sample patient case before moving on to documenting real patients.**
- Please document this sample case exactly as it states within your respective technology partner for eCare Plan documentation.
  - Items to document exactly as stated in the sample care plan: Patient Demographics, Allergies, Active Medication List, Medication Related Problems and Interventions, and Goals
  - Item to document that can vary if easier than creating a new prescriber: Prescriber Information
- Medication Related Problems (MRPs) and Interventions Details:
  - SNOMED CT codes allow CPESN USA to receive the data from your technology partner in a standardized way. If you have problems finding the text as described in the next sentence, you may use the SNOMED CT code to search within the MRPs or Interventions section of the technology platform. Text for MRP will be listed as "**Deficient knowledge of disease process**" and the text for intervention will be listed as "**Recommendation to monitor physiologic parameters**."
- Goals Details:
  - Free-text that you type in to the care plan that is individualized for each patient. The intent of the goal is to help achieve the intervention that is being set.

Step 3: Print and Implement Use of the Patient Encounter Form

- Print out multiple copies and cut out and distribute to your pharmacy staff members involved in the appointment-based model workflow.

Step 4: Document 25 eCare Plans for Patient Encounters Related to Hypertension

- Once you have the sample case completed and submitted to CPESN® USA, proceed with documenting within your appointment-based model workflow.
- The Patient Encounter Documentation form is to help you document your patient encounters on paper initially and then implementing within workflow.

PERSONA #1.2

French Fry

Improve patient follow-up and monitoring

DATE OF BIRTH: January 13, 1979
RACE: White
GENDER: Male
OCCUPATION: College Professor
ADDRESS: 241 Cheeseburger Hwy, Pickle Junction, OH 00000
PROBLEM LIST: Hypertension. Overweight (calculated BMI = 29.6)

HISTORY OF PRESENT ILLNESS

FF was diagnosed approximately one year ago with essential hypertension following complaints of headaches that persisted for several days. Hypertension is uncontrolled. In October, FF was enrolled into medication synchronization.

PAST MEDICAL HISTORY

Right ankle–torn ligaments–multiple episodes, Left knee–torn meniscus X 3, hypokalemic

ACTIVE MEDICATIONS

Lisinopril/HCTZ 20/12.5–2 tablets every morning, Amlodipine 5 mg every morning, Potassium Chloride 20 mEQ–2 tablets every morning.
Prescriber: Coach Well, MD

FILL HISTORY

Previously nonadherent. All medications were synchronized and filled on the same day for a 30 day supply with a start day of 10/15/19.

ALLERGIES

- Penicillin

SOCIAL HISTORY

FF works as a college professor. He has never smoked and, on average, has 2 alcoholic drinks/week. He doesn't exercise and admits little physical activity.

VITAL SIGNS AND LABS

- **Vital signs:** Not measured
- **Renal:** Blood work was completed, but not requested so unaware of lab results
- **Basic metabolic panel:** completed (pharmacist unaware of results)

MEDICATION RELATED PROBLEM(S)

FF is adherent to his medications now.
FF states that he does not know what his blood pressure goal is, and FF has not been monitoring his blood pressure at home because he does not have a device.

INTERVENTION(S) AND EDUCATION (RECOMMENDATIONS)

FF is continuing to get his medications filled on the same day each month, so enrolling into the pharmacy's medication synchronization program has been a success.
After further discussion and education, FF likes the idea of self-monitoring his blood pressure at home. FF states he wants to purchase a blood pressure monitoring device and wants it delivered with his medications. The pharmacist asked if he would be willing to come into the pharmacy to get his blood pressure checked, but he says he doesn't have time this month.

GOAL

Improved adherence: FF has continued to set his reminder on his cell phone.
Monitor blood pressure at least on 3 different occasions per week and record on provided paper. Overall goal is for readings to be <130/<90 mmHg.

MONITORING PLAN AND FOLLOW-UP

Monitor blood pressure at least on 3 different occasions per week and record on provided paper. Overall goal is for readings to be <130/<90 mmHg.

Patient Encounter Documentation Form How-To Guide

MEDICATION RELATED PROBLEM (MRP): Check the problem that you identify for a patient and put the date that this problem was identified

To the right of each row, common interventions are listed for the MRP

Patient Encounter Documentation Form	
Patient Name:	**Medication:**
DOB:	**Rx #:**
Medication Related Problem Date Identified:_____	**Intervention** Date Resolved:_____
☐ Noncompliance with medication regimen	☐ Medication synchronization or synchronization of repeat medication
☐ Deficient knowledge of disease process	☐ Recommendation to monitor physiologic parameters
Goal: Monitor BP at least 3 different times/week and record on provided paper. Overall goal is for readings to be <130/<90 mmHg.	

GOAL: Free text format that is a goal the patient wants to focus on achieving. Could be different for each patient

INTERVENTION: Select a resolution (AKA intervention) to the MRP that you identified

Put the date the MRP was resolved. This may or may not be the same date as the MRP was identified

You may select one or more of these interventions for the MRP

There may be other interventions that are applicable to the MRP, but were not listed for simplicity purposes

There could be instances that you have an intervention but not necessarily a MRP

For your reference:

Medication Related Problem	SNOMED CT Code
Noncompliance with medication regimen	129834002
Deficient knowledge of disease process	129864005
Intervention	**SNOMED CT Code**
Medication synchronization (may be found as synchronization of repeat medication)	415693003
Recommendation to monitor physiologic parameters	432371000124100

HOW TO DOCUMENT CARE PLANS USING THE ENCOUNTER FORM FOR THIS MONTH'S FOCUS:

1. Document the follow up from last month by selecting *deficient knowledge of disease process* (as the MRP) and select *recommendation to monitor physiologic parameters* as the intervention.
2. Document the patient is noncompliant and enrolled into medication synchronization, as this may be the first care plan for the patient.
3. If this is the patient's first care plan for medication sync, follow steps 1 and 2 to document as appropriate.

After you have documented the MRP, intervention, and goal on paper, document within your technology partner for the eCare Plan.

Sample Care Plan Case

You follow up with French Fry 5 days prior to his next medication start date. FF confirms that he only has 5 pills left in each of his 3 medication bottles. Therefore, you conclude that FF is adherent to his medications. FF confirms that he has successfully been utilizing the alarm on his cell phone, which reminds him to take his medications every morning.

FF denies any side effects (e.g., dizziness, orthostatic HTN, lightheadedness, etc.) related to his blood pressure (BP) medications.

FF states that he does not know what his BP goal is, and FF has not been monitoring his BP at home because he does not have a device. After further discussion and education, FF likes the idea of self-monitoring his BP at home. FF states he wants to purchase a BP monitoring device and wants it delivered with his medications.

The pharmacist asked if he would be willing to come into the pharmacy to get his BP checked, but he states he doesn't have time this month. FF states that he will come into the pharmacy next month to get his BP measured when he picks up his December medication fills, and he will bring in his BP log from November.

Goal for November: FF to monitor BP at least 3 different times/week and record on provided paper. Overall goal is for readings to be <130/<90 mmHg

Patient Demographics:

Patient First Name: French **Patient Last Name:** Fry **Patient DOB:** 1/13/79

Address: 241 Cheeseburger Hwy **City:** Pickle Junction **State:** OH **Zip:** 00000 **Phone:** 919-555-5555

Allergies: Penicillin

Prescriber Information:

Name: Coach Wellness, MD **Address:** 222 Healthy Shores Ln, Pickle Junction, OH 00000

Phone: 999-999-9999 **NPI Number:** 1234567890

Active Medication List:

Medication Name	Directions	Prescriber
Lisinopril/HCTZ 20/12.5 mg	2 tablets every morning	Coach Wellness, MD
Amlodipine 5 mg	1 tablet every morning	Coach Wellness, MD
Potassium Chloride 20 mEQ	2 tablets every morning	Coach Wellness, MD

Medication Related Problems (MRPs) and Interventions:

- **MRP (10/15/19):** Noncompliance with medication regimen (SNOMED CT: 129834002) – **(status: COMPLETE)**
  - **MRP Note:** Patient is about 15 days late filling lisinopril/hctz 20/12.5 mg. Amlodipine and potassium are filled on different days. FF doesn't seem to be consistent with timing and frequency of refills.
- **Intervention (10/15/19):** Medication synchronization/synchronization of repeat medication (SNOMED CT: 415693003) – **(status: COMPLETE)**
  - **Intervention Note:** FF is being enrolled into our sync program and we will be aligning his medication fills on the same day each month with follow-up calls at least 5 days prior to next refills.
- **MRP (11/11/19):** Deficient knowledge of disease process (SNOMED CT: 129864005)
  - **MRP Note:** FF states that he does not know what his blood pressure (BP) goal is, and FF has not been monitoring his BP at home because he does not have a device.
- **Intervention (11/11/19):** Recommendation to monitor physiologic parameters (SNOMED CT: 432371000124100)
  - **Intervention Note:** After further discussion and education, FF likes the idea of self-monitoring his BP at home. FF states he wants to purchase a BP monitoring device and wants it delivered with his medications. The pharmacist asked if he would be willing to come into the pharmacy to get his BP checked, but he says he doesn't have time this month. FF states that he will come into the pharmacy next month to get his BP measured when he picks up his December medication fills, and he will bring in his BP log from November.

Goals (Free-Text):

1. **Goal Note (10/16/19):** Set a reminder alarm on cell phone to take medications every day – **(status: COMPLETE)**
2. **Goal Note (11/11/19):** Monitor BP at least 3 different times/week and record on provided paper. Overall goal is for readings to be <130/<90 mmHg

Patient Encounter Documentation Form

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