Diabetes & Social Determinants of Health Month 3

Flip the Pharmacy: Champion Checklist

- ☐ **Understand the importance of leveraging the appointment-based model**
- ☐ **Consider what additional resources you need to help your pharmacy team feel more comfortable providing diabetes care**
  - APhA's The Pharmacist & Patient-Centered Diabetes Care Training Program – Click **HERE**
  - American Diabetes Association Standards of Medical Care in Diabetes – 2021 Living Standards – Click **HERE**
  - Diabetes Review: Medication Selection Related to Comorbidities
    - Click **HERE** to watch the presentation from Angelina Tucker, CPESN Texas Managing Network Facilitator, for a refresher on Medication Selection Related to Comorbidities and **HERE** to view the slides
- ☐ **Workflow Innovations:**
  - Discuss comorbidities and related goals with your patients with diabetes

    GOAL→ Collect blood pressure readings from 10 patients with diabetes
  - Offer point of care testing/monitoring in the pharmacy when appropriate
- ☐ **MILESTONE CHANGE:** The eCare Plan submission requirement of 10 eCare Plans per quarter has been moved to start in Q3 (July 2021 – September 2021).

During this progression, we have discussed various ways to identify our patients with diabetes, enrolled them in med sync when possible, started discussing their blood glucose goals, and documented at least 5 A1c measurements. This month we are going to focus on monitoring and medication optimization as it relates to comorbid conditions. Some of this monitoring can be done in the pharmacy with point of care testing. We will also discuss how to start offering point of care testing or improve your current services.

Workflow Innovation:

Discuss Comorbidities and Related Goals With Your Patients With Diabetes

We know our patients with diabetes are complex and more often than not have additional comorbid conditions. Diabetes in particular increases the risk of cardiovascular disease. We can assist our patients by educating them about possible comorbidities and ensuring that their medications are optimized to reduce their possible risk.

Proactive Approach to monitoring patients with diabetes and cardiovascular disease

- **CONTINUE:** Use the appointment-based model and med sync process to regularly monitor your patients with diabetes.
  - Last month we talked about medication care gaps: ACEi/ARBs and statins.
- **START THIS MONTH:** Create a process to monitor your patients with diabetes and cardiovascular disease.
  - To ensure these medications are optimized, we should be reviewing relevant monitoring parameters—at a minimum, **blood pressure readings** and **lipid panel**.
    - **3 ways to gather this information:**
      1. Perform/monitor in the pharmacy
      2. Request from the patient
      3. Request from their prescriber

Ideas for requesting labs from the patient:

- **Start by asking the patient to provide relevant information if it is available.**
  - If you haven't regularly requested labs from your patients in the past, you may want to start with some "know your numbers" education and a handout as a conversation starter.
    - ADA's *"Diabetes and Heart Disease"* Handout – Click **HERE**
    - Click **HERE** for other patient handouts available from the ADA Patient Education Library (sign up for a free account)
  - If the patient does not know their most recent labs, they can use the handout as a reminder to look if they have the information at home or ask at their next physician appointment.

Mention this handout to the patient and that you will be providing it to them when they pick up their medications. Print the handouts and place with the monthly med sync prescriptions.

  - This type of conversation starter will help to make patients and staff more comfortable in discussing labs. Patients will get used to you asking about labs routinely going forward.

Empower your support staff to assist by providing the educational handout to patients and starting the conversation.

Create a "know your numbers" campaign in the pharmacy. You can promote throughout the pharmacy and on your social media.

- **Once you and your staff feel more comfortable asking for this type of information, consider adding questions to med sync calls asking patients for recent blood pressure readings and their most recent lipid panel.**
  - For example, if you are using the **Med Sync Monthly Check-in Guide** provided in the Month 1 change package or a similar tool, add a few questions related to monitoring parameters:
    - *"How is this medication working for you?"*
    - *"Have you had any labs drawn in the past month?"*
    - *"Do you monitor your blood pressure at home?"*
    - *"What was your most recent blood pressure reading?"*
  - If the patient has had labs but doesn't know the results or is a poor historian, request them from their physician during the med sync process.
    - Click **HERE** for a template fax you can use

- **Depending on what is easiest for your workflow, you could also use the Patient Encounter Documentation Form for eCare Planning as a flag to remind staff to discuss with the patient when they are in the pharmacy to pick up their prescriptions** (See ***Appendix A***).

- **Document labs along with the date of the test so that you can follow up at the appropriate time (e.g. 12 months from last lipid panel)**
  - **Workflow ideas:**
    - Some technology vendors allow you to create a task and associate a follow up alert. Consider using this type of tool for regular follow up (e.g. set a follow up alert for 12 months since last lipid panel).
    - If your care plan vendor has a singular place all lab values are documented, review this monthly as part of your med sync process and assess if you need to request labs from the patient/their provider this month.
    - Add or use an existing template for diabetes care plans that has a section to remind you to review appropriate labs.

Having the patient's labs can help provide a more meaningful discussion with the patient while assisting with monitoring their prescription therapy for effectiveness and following up.

Reactive Approach to monitoring patients with diabetes and cardiovascular disease

- **Flag prescriptions when you are filling a blood pressure medication or a statin for a patient with diabetes.**

Use the Patient Encounter Documentation Form for eCare Planning (See *Appendix A*) and/or the ADA's "*Diabetes and Heart Disease*" Handout as a flag to talk to patients about their labs.

- **Workflow ideas:**
  - Some pharmacy management systems allow you to add a trigger if a prescription meets certain criteria (e.g. alert when filling a statin for a patient with medical condition of diabetes). Use these triggers to remind staff to flag the prescription for counseling.
  - Educate staff to put a bag tag or another method to flag the prescription for counseling whenever they are filling a statin or ACEi/ARB.

    NOTE: *We should be monitoring any patient on a statin or blood pressure medication. This method will be effective for capturing all those patients but might be overwhelming when you start.*
  - If you are using any of the reactive methods, discuss med sync with these patients while counseling so you can continue to build your appointment-based model and more easily monitor these complex patients.

GOAL: Document at least 10 blood pressure readings this month.

- Determine with your coach what is an appropriate goal for your team.
  - Maybe you've been collecting blood pressures routinely since the Hypertension Progression and should focus on lipids this month.
  - Or this might be a good way to re-engage staff or get started with blood pressure monitoring.
- Consider taking blood pressures in the pharmacy and documenting. More information available below for staff training.

Patient Encounter Documentation Form for eCare Planning

Patient Encounter Documentation Form for eCare Planning	
Patient Name:_____ **DOB:**_____	
Encounter Reason	Date Identified:_____
☐ Medication synchronization	☐ Diabetes Medication Review
☐ Assessment of risk of type 2 diabetes mellitus	☐ Initial diabetic assessment
☐ Follow-up diabetic assessment	
Medication-Related Problems	Date Identified:_____
☐ Deficient knowledge of disease process	
☐ Noncompliance with medication regimen	
☐ Medication not effective	
Interventions	Date Resolved:_____
☐ Hemoglobin A1c measurement	
☐ Blood glucose monitoring	
☐ Med Sync or synchronization of repeat medication	
☐ Recommendation to monitor physiologic parameters	
Notes:	Results Date:_____
A1c:_____	Blood Glucose:_____
BP:_____	TC/HDL/LDL/TG:_____
Circle one for the lab value:	
Patient-reported	Prescriber-reported Pharmacy-reported

Click **HERE** to print the above form and utilize it as your documentation source. (See ***Appendix A***.)

This documentation form provides a few examples of relevant SNOMED CT codes. For a more comprehensive list, Click **HERE** or view ***Appendix B***.

Revisiting the Diabetes Checklist for Patient Encounters

- **This month we have added new sections to the Diabetes Checklist for Additional Monitoring.**
  - **NOTE:** *The Diabetes Checklist is meant to be a comprehensive resource.*
    - Some of the Checklist applies to workflow innovations related to medication optimization (e.g. checking to see if A1c, BP, lipids are at goal) and should be part of routine patient care.
    - However, some of the additional resources/talking points on the Checklist go above and beyond routine medication optimization services and may be more relevant as references for payer opportunities, DSME, etc.
- **The Checklist is a great tool to use for your work up of the patient. Click HERE for a printable version.**
- **With your coach, determine where your pharmacy is at and how this tool might be helpful for you and your staff.**
  - Consider using the first month as "fact finding" discussion with the patient.
  - Use the "Know your numbers" conversation starter.
- **Continue assessing each month and make recommendations when appropriate.**

Diabetes Checklist for Patient Encounters

☐ **Adherence Assessment**

- Date discussed with patient:_____
- Workflow preparation ideas:
  - Run report for "Adherence Report Card" if possible
  - Manually assess adherence based off of refill dates
- Talking point suggestions to help support the eCare plan:
  - How are you taking your medications?
  - How many doses have you missed in the last week?
  - What are your biggest challenges with your medications?

☐ **Glycemic Target Assessment**

- Date discussed with patient:_____
- Workflow preparation ideas:
  - Request A1C or Blood Glucose results from provider/patient or obtain at pharmacy.
- A1C/Blood Glucose:_____, Date obtained:_____
  - ○ Patient-reported ○ Provider-reported ○ Pharmacy-reported
  - Meeting goal? Twice a year (Date of next A1C:_____)
  - Not at goal? At least quarterly (Date of next A1C:_____)
- Talking point suggestions:
  - How often do you monitor your blood glucose?
  - What was your most recent blood glucose reading?
  - What (and when) was your most recent A1C?

☐ **Medication Care Gaps***

- Date discussed with patient/provider:_____
- Workflow preparation ideas:
  - Review medication profile during med sync process
  - Provide recommendation to provider when appropriate
- ACEi/ARB: Indicated? yes/no Currently taking? yes/no
- Statins: Indicated? yes/no Currently taking? yes/no
- Aspirin: Indicated? yes/no Currently taking? yes/no

*For more detailed information about medication care gaps, click **HERE** to download **Goals and Standards of Care for Patients with Diabetes**.

☐ **Preventative Care**

- Dilated eye exam: Annual (Date of next exam:_____)
- Complete foot exam: Annual (Date of next exam:_____)
- Dental exam: Every 6 months (Date of next exam:_____)

☐ **Immunizations**

- Workflow preparation ideas:
  - Check immunization registry prior to discussing with patient
  - If a vaccine is needed, consider having the prescription already run so cost is available for the patient.

NOTE: *You must be really careful with this and pharmacy audits. If the immunization prescription is not input on the same date as it was administered, it is recommended you re-process the prescription for the day the immunization is provided to the patient.*

Immunization Schedule			
Vaccine	Recommendation	Date(s) Received	Is vaccine needed?
Flu	*Annually*		
Tdap	*Every 10 years*		
PPSV23 – 19-64 years	*One dose*		
PPSV23 – *≥ 65 years*	*One dose; if PCV13 given, then give PPSV23 ≥ 1 year after and ≥ 5 years after any PPSV23 at < 65 years*		
PCV13 – 19-64 years	None		
PCV13 – ≥ 65 years, without immunocompromising condition, cochlear implant, or CSF leak – shared decision-making discussion with physician	One dose		
Hepatitis B series	*If not completed previously*		
Herpes zoster	*2 dose series recommended at 50+*		
COVID-19	*1-2 doses (depending on vaccine)*		

☐ **Additional Monitoring:**

- Workflow preparation ideas:
  - Review patient profile for relevant labs during the med sync process.
    - If needed, request from the patient during the med sync call.
    - Other options for obtaining labs:
      - Have the patient bring their lab documentation to the pharmacy utilizing the appointment-based model.
      - Request the information from the physician.
      - Offer POCT in the pharmacy to obtain labs if the patient has not had relevant labs recently.
- **Lipid profile**
  - Annually and as needed after initiation/dose change of medications that affect values
  - TC:_____, LDL:_____, HDL:_____, TG:_____, Date obtained:_____
    - ○ Patient-reported ○ Provider-reported ○ Pharmacy-reported
- **Liver function tests**
  - Annually and as needed after initiation/dose change of medications that affect values
  - AST:_____, ALT:_____, Date obtained:_____
    - ○ Patient-reported ○ Provider-reported ○ Pharmacy-reported
- **Serum potassium levels** (patients on ACEs, ARBs, or diuretics)
  - Annually and more frequently in CKD or change in medications that affect kidney function or serum potassium
  - Potassium:_____, Date obtained:_____
    - ○ Patient-reported ○ Provider-reported ○ Pharmacy-reported
- **Chronic Kidney Disease** (urinary albumin, estimated glomerular filtration rate, serum creatinine)
  - Annually
  - Urinary Albumin:_____, eGFR:_____, sCr:_____, Date obtained:_____
    - ○ Patient-reported ○ Provider-reported

Other Considerations from the ADA Guidelines Related to Comorbidities That Could Be Addressed by the Pharmacy:

- **Decreased cognitive function/dementia**
  - Simplification of regimen
    - Combination medications
    - Once daily dosing
    - Med sync
    - Adherence packaging
  - Minimize hypoglycemia risk
    - Avoid and/or discontinue high risk medications when possible
- **Metformin use—periodic vitamin B-12 levels** (especially those with anemia or peripheral neuropathy)
  - Fill history (timeline of metformin use)
  - Supplementation
  - Recommendation for follow up with physician

Workflow Innovation:

Offer Point of Care Testing/Monitoring in the Pharmacy When Appropriate

What if the patient hasn't had labs recently? This is an opportunity to offer in-pharmacy monitoring services.

- The easiest way to get started with in-pharmacy services is to offer blood pressure monitoring because most of us already have a cuff and offer the service, even if not regularly. Use this opportunity to start routinely offering blood pressure checks to your patients.
- Consider how this will impact your workflow. Who normally takes the blood pressures? Is it the pharmacist? If so, have you thought of involving your support staff? This would free up pharmacist time and allow for this valuable service to be offered more routinely.
  - These workflow considerations and involvement of support staff apply to all of the following point of care tests.

ACTION ITEM→ If not previously completed during the Hypertension Progression, identify a non-pharmacist staff member to complete the American Heart Association Training, Measuring Blood Pressure Accurately. This course is provided free, online. NOTE: The course is not accredited for Pharmacy Technicians or Pharmacists so no CPE will be awarded.

- For more workflow ideas about blood pressure monitoring, revisit the Hypertension Progression.

SME TIP **We found that once we started routinely asking for blood pressure readings and monitoring in the pharmacy, patients were coming in just to review their readings or have their blood pressure checked. Consider making a blood pressure log available to patients so they can easily provide readings.**

- Click **HERE** for a template blood pressure log you can share with patients

- Other point of care tests like blood glucose, A1c, lipids, and liver enzymes can be offered in the pharmacy as well. However, you must have a CLIA Waiver to provide them. For more information on how to obtain a CLIA Waiver, refer to the CLIA Waiver Instructions provided as part of the COVID-19 Best Practices – Click **HERE**.
- Blood glucose monitoring is an inexpensive way to get started with point of care testing, although it would typically be used for screening purposes.
- Some of the most relevant labs you can provide in the pharmacy related to diabetes and cardiovascular disease medication optimization are A1c, lipids, and liver enzymes (statin use).
- **Steps to get started:**
  1. Purchase a point of care testing device that can perform your desired tests
     - Check out this **CHART** to view options on A1C devices/cost
  2. Train your staff to use the device (don't forget support staff)
  3. Determine how you will bill for the service
     - Here are some possible revenue opportunities:
       - Cash service
       - Medical billing
         - Some payer opportunities (e.g. states with provider status are piloting or reimburse for pharmacist POCT)
       - CPESN payer programs that may be available to you locally
  4. Market your point of care testing services

     

     With many high deductible plans, patients are willing to pay for cash services. Be sure to market your services and consider targeted information to local employers/ employees with high deductible plans.

  5. Document any pharmacy-obtained labs in a care plan and share with the patient's physician.
     - In future months we will discuss making clinical recommendations to the physician if the patient is not at goal. If you are comfortable, you can get started making recommendations right away.

Appendices

Patient Encounter Documentation Form for eCare Planning

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☐ Deficient knowledge of disease process

☐ Noncompliance with medication regimen

☐ Medication not effective

Interventions Date Resolved:_____________

☐ Hemoglobin A1c measurement

☐ Blood glucose monitoring

☐ Med Sync or synchronization of repeat medication

☐ Recommendation to monitor physiologic parameters

Notes: Results Date:_____________

A1c:_____________ Blood Glucose:____________________

BP:_____________ TC/HDL/LDL/TG:____________________

Circle one for the lab value:

Patient-reported Prescriber-reported Pharmacy-reported

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Patient-reported Prescriber-reported Pharmacy-reported

eCare Plan Documentation Guide for Commonly Used Medication Related Problems and Interventions: SNOMED CT Descriptions

Medication Related **Problem**	Medication Related **Intervention**
Noncompliance with medication regimen (finding) Detailed Reasons for Noncompliance: Uses less medication than prescribed Patient unable to obtain medication Patient refuses to take medication Patient misunderstood treatment instructions Patient does not understand why taking all medication	Medication change to generic Medication therapy changed Medication dosage form changed Medication education Synchronization of repeat medication Assessment of barriers to adherence Monitoring adherence to medication regimen Assessment of adherence to medication regimen Medication regimen compliance education Renewal of prescription Drug therapy discontinued Discussed with doctor Discussed with patient
Patient forgets to take medication	Synchronization of repeat medication Education about medication regimen adherence
Cost effective medication alternatives available	Medication change to generic Medication therapy changed Drug therapy discontinued Recommendation to discontinue medication
Adverse medication interaction with medication	Medication therapy changed Medication dose changed Drug therapy discontinued Recommendation to change medication Medication interaction education Discussed with doctor Discussed with patient
Medication Overuse	Medication Education Discussed with doctor
Patient unable to obtain medication [e.g., prior auth needed or patient needs refills]	Insurance authorization Discussed with doctor
Drug allergy	Discussed with doctor Discussed with patient Recommendation to change medication
Medication therapy unnecessary	Drug therapy discontinued Recommendation to discontinue medication Recommendation to change medication Discussed with doctor Discussed with patient
Additional medication therapy required	Over-the-counter medication started Prescription medication started (situation) Recommendation to start prescription medication

Medication Related **Problem**	Medication Related **Intervention**
New medication needed for condition	Discussed with patient
	Discussed with doctor
Medication not effective	Medication therapy changed
	Drug therapy discontinued
	Medication dose increased
	Medication dosage form changed
	Recommendation to discontinue medication
	Discussed with doctor
Medication dosage too low	Medication therapy changed
	Medication course duration changed
	Medication dose changed
	Medication dose increased
	Medication dosing interval changed
	Medication education
	Prescribed medication education
	Discussed with doctor
Medication dosage too high	Medication course duration changed
	Medication dose changed
	Medication dosing interval changed
	Drug therapy discontinued
	Recommendation to discontinue medication
	Discussed with doctor
Not up to date with immunizations (finding) - Problem observation	Administration of substance to produce immunity, either active or passive
	Influenza vaccination
	Pneumococcal vaccination
	Vaccine refused by parent
	Vaccine refused by patient
	Immunization status screening
	Immunization education
	Medication Related Intervention
	Medication Reconciliation
	Medication Monitoring
	Comprehensive medication therapy review
	Risk evaluation and mitigation strategy consultation
	Discussed with carer