Diabetes & Social Determinants of Health Month 4

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**
  - *If additional resources are needed, select appropriate resources and set a timeline with expectations of when the materials should be reviewed.*
  - **NEW: Population Health and Social Determinants of Health in Diabetes Management** – Click **HERE**
    - Check out this review of social determinants of health and the pharmacist's role with continuing education available from Power-Pak C.E.
  - 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**
- ☐ **Workflow Innovations:**
  - **Assess patient adherence and identify any potential barriers.**
  - **Communicate what you have learned about your patients with their prescribers.**
  - **Review ways social determinants of health can be addressed during workflow processes.**
- ☐ **MILESTONE REMINDER: The eCare Plan submission requirement of 10 eCare Plans per quarter starts this month!**

Now that you feel comfortable discussing blood glucose goals with your patients and have started requesting A1c measurements from the patient, their prescriber, or are obtaining in the pharmacy—focus on your patients that are not at goal. Assess their adherence and identify any potential barriers. Review their medications to determine if any medication-related problems exist. Communicate any relevant information to their prescriber such as adherence summaries, care plans, potential medication-related problems, and pharmacy-obtained labs. This Change Package will also discuss ways that we can address social determinants of health in the pharmacy.

Workflow Innovation:

Assess Patient Adherence and Identify Any Potential Barriers.

We should regularly be assessing adherence to ensure medication regimens are optimized. **It is important to assess adherence before making any clinical recommendations about adjusting or adding medication.**

Proactive Approach to Addressing Adherence:

- **Med Sync Patients**
  - Assess whether or not they are at goal (collected A1c/blood glucose readings)
    - **If not at goal, why?** Before addressing medication changes such as increased dose or additional therapy, **always assess adherence.**
      - Even though a patient is on med sync, we know that they may not take their medications as prescribed. You can start assessing adherence by checking their Proportion of Days Covered (PDC) score in the pharmacy management system prior to making their med sync call.
    - Utilize your pharmacy's med sync process or the **Med Sync Monthly Check-in Guide** (Click **HERE**) or **Diabetes Checklist for Patient Encounters** (Click **HERE**)
      - Ask questions like:
        - How many tablets remain in each bottle?
        - How many doses of [medication name] have you missed each week?
        - What is causing you to miss your medications?

          __ Cannot afford them

          __ Concern about side effect(s)

          __ Doesn't help me feel better

          __ Makes me feel worse

          __ Don't believe the medication works

          __ Forget to take it

          __ Lost the prescription

          __ Out of refills

          __ Other:_____

- **Patients not on Med Sync**
  - Assess fill history/check PDC score
    - Consider creating a **Patient Adherence Summary** to share with prescribers to assist in addressing adherence (See ***Appendix A***)
  - Utilize available tools within your pharmacy management system
    - Some systems allow you to create an "Adherence Report Card"

Reactive Approach to Addressing Adherence:

- **Insurance identified patients that are non-adherent**
  - Medication therapy management (MTM) vendors
  - EQuIPP
  - CPESN payer programs

Identify barriers that are impacting patient non-adherence and help find a solution that is right for the patient.

Cause for Non-Adherence	Solution
Do not know why I need to take the medication	Disease-state medication counseling using motivational interviewing approach
Forget to order refills	Use electronic refill reminders
Forget to take each day	Dose reminders, or if multiple meds, compliance packaging
Inconvenience of multiple medications and multiple trips to pharmacy	Medication synchronization
Intolerable side effects	Therapeutic interchange/prescriber collaboration
Cost	Therapeutic interchange, formulary review, patient assistance programs

**Review the upcoming workflow innovations to help with prescriber collaboration.*

ACTION ITEM→ Document non-adherence and the steps you took to help resolve in an eCare Plan for at least **10 patients** this month.

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 B***.)

Communicate What You Have Learned About Your Patients With Their Prescribers.

Communicating with Prescribers

Communication with prescribers is key to transforming your pharmacy practice to moving beyond filling prescriptions at a moment in time to caring for patients over time. Below is a simplistic overview of a **3 step process** to developing a collaborative working relationship.

STEP ONE: Complete an introductory conversation with prescribers

STEP TWO: Start sharing interventions and monitoring with prescribers

STEP THREE: Visit the prescriber

STEP ONE: Complete an Introductory Conversation with Prescribers

NOTE: *If you have previously completed prescriber outreach, consider re-engaging or reaching out to additional prescribers in your area.*

- Select one prescriber to have an initial conversation.

  KEY - Focus on shared patients with diabetes
- How to select a provider?
  - Run report of patients on diabetes medications by prescriber
  - Select one you know well/comfortable with and have shared patients
  - Call and explain the "new" role of your pharmacy and discuss shared patients
  - Be sure to quantify the number of patients you share with the prescriber or practice
  - Ask what you can do to better assist the prescriber in managing patients
  - Discuss communications you may have previously sent regarding care gaps
    - Is that the best way to communicate going forward? Ask how the prescriber would like this information communicated and begin to establish your collaborative relationship.
      - Call
      - Fax
      - HIPAA compliant messaging
      - EHR access if possible

STEP TWO: Start Communicating with Prescribers

- Begin faxing or calling prescribers on mutual patients as part of your **care coordination** efforts. Share pharmacy-obtained labs, adherence summary reports, medication lists and/or intervention notes related to identified drug therapy problems.
  - Here are some template faxes you can use:
    - Pharmacy-obtained labs - Click **HERE**
    - Adherence summary report - Click **HERE**
    - Care gaps - Click **HERE**
    - Clinical intervention template - Click **HERE**

NOTE: *The prescriber may be overwhelmed by the amount of communication we could send (e.g. regular adherence summaries on all patients). Consider focusing on communications regarding non-adherent patients and/or those not at goal. Be concise and share meaningful information. If you identify a problem, always have a recommendation for a solution and what actions you are taking to ensure that patients' medications are optimized.*

What Is **Care Coordination**?

Care coordination is defined by the National Institutes of Health as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Why Is **Care Coordination** Important?

We are part of the healthcare team and have a professional responsibility to ensure that our patients' medications are optimized. This requires working collaboratively with providers, sharing our "workups" of mutual patients, identifying and resolving medication-related problems, and making appropriate clinical interventions.

It is important to document our care coordination efforts for workflow efficiency, to show our value, and for your legal record of care. Document your communication with prescribers in a care coordination note as part of your eCare Plan.

What Is a **Care Coordination Note**?

The intent of a care coordination note is to document the status of coordination with providers NOT meant to go to providers. The status may include what, when, and whom.

> **Example Care Coordination Note:** 7/9/21: DKA diagnosed with DM last month. Faxed statin use in diabetes recommendation to Dr. Wellness.
>
> *Example corresponding SNOMED CT CODE: Coordination of care plan (procedure) 711069006*

STEP THREE: Visit the Prescriber

- Scheduling prescriber visits is not required but you may want to consider creating a list of local prescribers to visit for a meeting.
- Visiting local prescribers will help to further develop the relationship with prescribers and their staff.
- Sometimes it may be challenging to visit prescribers, but that doesn't mean you cannot build rapport or trust. This can be developed by providing clinical recommendations that are evidence-based and/or guideline directed. That is why it is important to be familiar with the guidelines and appropriate therapies. Prescribers will see your competence through your workups and interventions.
- For more information about conducting prescriber visits (including talking points, what kind of data to share, and how to create an infographic to share with the prescriber) refer to the **Hypertension Progression Month 6 Change Package** (Click **HERE**) and/or the **Pharmacist-Prescriber CollaborationToolkit** (Click **HERE**) created by the University of Pittsburgh School of Pharmacy.

Review Ways Social Determinants of Health Can Be Addressed During Workflow Processes.

Check out this review of social determinants of health and the pharmacist's role with continuing education available from Power-Pak C.E.

Population Health and Social Determinants of Health in Diabetes Management - Click **HERE**

What Are **Social Determinants of Health**?

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Healthy People 2030, US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved June 15, 2021, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

General ideas of how you can and are addressing SDoH in a community pharmacy:

- Health care access and quality
  - Enhanced pharmacy services
    - Medication reconciliation during transitions of care
    - Comprehensive medication reviews
    - Immunization screening and/or administration
    - Medication synchronization
    - Personal medication records
  - Pharmacy delivery services
- Social and community context
  - You are likely the most accessible health care provider in the community
    - Ready access to unscheduled face-to-face meetings with a pharmacist
- Education access and quality
  - Access to diabetes prevention programs and diabetes self management education through the pharmacy
- Neighborhood and physical environment
  - Pharmacy access in the community
  - Pharmacy delivery services
- Economic stability
  - Assessing insurance status
  - Assisting with manufacturer programs and/or directing to patient assistance programs

Ideas on addressing SDoH related to diabetes during workflow:

- Assessing adherence barriers potentially related to SDoH
  - Enroll in med sync and/or offer delivery if limited access to pharmacy services/transportation issues (health care access and quality)
  - Provide appropriate learning level education about purpose of medications if patient is unsure of why they take it (education access and quality)
    - Click **HERE** for examples of patient health literacy measures including a Single Question Health Literacy Screening Tool

      "How confident are you filling out medical forms by yourself?"

      1-Extremely **2**-Quite a bit **3**-Somewhat **4**-A little **5**-Not at all

    - Scores 3 or greater indicate inadequate health literacy
  - Suggest a medication alarm and/or electronic refill reminders if the patient has access to the technology (education access and quality)
  - If the patient is overwhelmed by the number of medications and/or number of doses per day, work with their prescriber to simplify their medication regimen (education access and quality)
  - Assessing insurance status (economic stability)
    - If insured:
      - Assess for any cost prohibitive medications or testing supplies
        - Formulary assessment
          - Switch to a medication in a lower tier
        - Prior authorization processes within the pharmacy/communication with the patient
        - Available manufacturer programs for medications if not government sponsored insurance
        - Alternative more affordable cash pay testing supplies
    - If uninsured:
      - Selection of affordable generic medications when possible
      - Connect to patient assistance programs for brand name medications
      - Local resources
        - Free clinics/charitable pharmacies
        - Department of Social Services/Jobs and Family Services to obtain assistance if applicable

You are most likely already addressing some of these in the pharmacy. Document in an eCare Plan to show your value!

The upcoming Change Package will address how you can formally assess SDoH in the pharmacy.

Appendices

PATIENT ADHERENCE SUMMARY

Date_____

Patient Name _____ Prescriber_____

DOB_____ Fax_____

Current Complete Medication List (including OTC, herbals, supplements)

Medication Name/Strength	Directions	Indication	PDC %**

***Proportion of Days Covered (PDC) measures the percentage of days covered by a prescription medication within the calendar year. PDC < 80% for a given medication is classified as "non-adherent."*

Adherence Summary of Non-Adherent Medications Listed Above (over the last 6 months)

Medication	Date(s) Filled	Quantity	Day Supply

Pharmacist Adherence Assessment and Patient-Reported Comments:

Pharmacist Name _____ Pharmacist Signature _____
(please print)

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☐ Deficient knowledge of disease process

☐ Noncompliance with medication regimen

☐ Medication not effective

Interventions Date Resolved:______________

☐ Hemoglobin A1c measurement

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☐ Recommendation to monitor physiologic parameters

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