Diabetes & Social Determinants of Health Month 5

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**
  - **NEW: Community Health Workers in Community-Based Pharmacy Care Delivery** – Click **HERE**
    - This CE (3 hours of self-paced modules) will help you and your staff gain an understanding of how CHWs can be a health resource to individuals in their communities in addition to assisting them with their medication needs.
    - Click **HERE** to review the **CHW Toolkit**
- ☐ **Workflow Innovations:**
  - **Make clinical interventions concerning medication-related problems and communicate your recommendations with prescribers.**
  - **Make a plan at your pharmacy for addressing and documenting Social Determinants of Health.**
  - **Build a community resource guide for your team to be able to refer patients to local resources.**
- ☐ **GOAL:** Follow up with your 5 (or more) patients from Month 1 and document their most recent Hemoglobin A1C in an eCare Plan this month. (Note: Some may not be due for a recheck until next month.)
- ☐ **MILESTONE REMINDER: Submit 10 eCare Plans per quarter (started July 2021).**

Last month we began outreach to prescribers and shared relevant information related to our mutual patients with diabetes who are not at goal. This month we will focus on making clinical interventions and communicating recommendations with prescribers. We will also discuss assessing social determinants of health (SDoH) and developing a community resource referral guide.

Workflow Innovation:

Make Clinical Interventions Concerning Medication-Related Problems and Communicate Your Recommendations With Prescribers.

During the course of this progression, we have assessed patients' glycemic status, adherence, and medication regimen. Along the way, you have been identifying medication-related problems (MRPs). This month we are going to focus on making clinical interventions concerning those MRPs and communicating your recommendations to the prescriber. You likely have already started to do this in your pharmacy so we will focus on workflow best practices and how to improve or create processes.

STEP ONE: Identify a Medication-Related Problem

- Identified during the med sync process
- Identified by insurance (e.g. MTM vendor, EQuIPP, CPESN payer program)
- Identified during pharmacy monitoring, consultation, or point of care testing

Example MRP SNOMED CT Codes:

- Noncompliance with medication regimen
- Additional medication therapy required
- Medication dosage too high/low
- Adverse medication interaction with medication
- Cost effective medication alternatives available
- Patient unable to obtain medication
- Medication therapy unnecessary
- Not up to date with immunizations

STEP TWO: Determine Your Clinical Intervention

Intervention	SNOMED CT Code Examples
Medication synchronization	▪ Synchronization of repeat medication
Adherence packaging	▪ Promotion of adherence to medication using pill dose dispenser ▪ Synchronization of repeat medication
Dosage adjustments	▪ Recommendation to change medication dose ▪ Recommendation to decrease medication dose ▪ Recommendation to increase medication dose ▪ Medication dose increased ▪ Medication dose decreased
Change therapy	▪ Recommendation to change medication ▪ Medication changed ▪ Medication change to generic ▪ Medication changed to therapeutic equivalent
Additional therapy needed	▪ Recommendation to start prescription medication ▪ Prescription medication started
Medication simplification	▪ Recommendation to discontinue medication ▪ Drug therapy discontinued ▪ Medication Reconciliation
Administer or recommend immunization	▪ Administration of substance to produce immunity, either active or passive ▪ Administration of vaccine product containing only Influenza virus antigen ▪ Administration of vaccine product containing only Streptococcus pneumoniae antigen

STEP THREE: Communicate Your Recommendations with the Prescriber

- Here are some clinical interventions we've already discussed and the template prescriber communications:
  - Pharmacy-obtained labs - Click **HERE**
  - Adherence summary report - Click **HERE**
  - Care gaps - Click **HERE**
  - Clinical intervention template - Click **HERE**
  - Adherence packaging - Click **HERE**

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.

STEP FOUR: Document in an eCare Plan

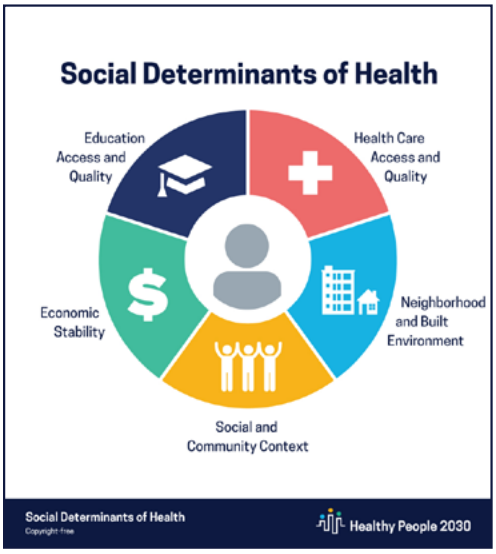
- Use care plans to document the steps you have taken to 1) identify MRPs and 2) any steps taken to resolve the MRP, *including care coordination notes related to prescriber communications*.

SME TIP **eCare plans can be a great tool to enhance communication between pharmacy team members so that everyone knows what steps have been taken to address MRPs and where you are at in the process of resolving the MRP. Some care plan vendors allow you to create "actions" associated with the care plan so that the team can see what patients might have "pending" issues. For example, a care coordination eCare plan is documented when we call a prescriber to request a change in therapy. This is left pending until we hear back from the prescriber. It is an easy way for the pharmacy team to know what is going on with a particular patient without having to have the "doctor call" stack of papers in front of them.**

ACTION ITEM → With your coach, determine which type of MRP the pharmacy team should focus on this month. For example, you might want to continue focusing on non-adherence. Consider addressing medication regimen simplification for non-adherent patients and communicate any recommended changes to the prescriber.

Make a Plan at Your Pharmacy for Addressing and Documenting Social Determinants of Health

Last month we defined Social Determinants of Health (SDoH) and discussed ways you may already be addressing them in the pharmacy. This month we are going to make a plan for addressing and documenting SDoH by understanding your population, reviewing available screening tools, and creating a community resource guide for your team.



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

Understand your Patient Population

You may already have a pretty good grasp on your patient population but here are some tools to help you better understand the population you serve and their unique needs.

- Community Demographics
  - Look at your county statistics for health behaviors and social and economic factors – Click **HERE**
  - Census data – Click **HERE**
  - City data – Click **HERE**

Even though we are not specifically going to focus on diabetes during this SDoH change package, you can utilize the American Diabetes Association provided **Population Served and DSMES Service Assessment** to help assess your resources and identify if any gaps exist as they relate to patient education. (This tool is meant for the DSME program but may be a helpful exercise to evaluate your current available resources.) Click **HERE** to access tool.

This would be a great exercise for an APPE student to provide an outside perspective on your population and resource availability. For example, do you need insulin pen training devices, low literacy education material, etc.? The student could also reasonably obtain many resources for the pharmacy.

Determine How the Pharmacy Can Focus on SDoH Based on the Resources at the Pharmacy.

Identify the staff member(s) who may take this on (examples: technician or delivery driver)

- Staff roles
  - Determine who should be "in charge" of the SDoH program at your pharmacy. Any staff member can make a screening questionnaire available or identify a patient to screen, but you should have an "SDoH Champion" who can make sure needs are addressed and follow up is completed when necessary.

The SDoH champion should be a technician, clerk, or delivery driver who may naturally already take on this role because of their social nature. They are someone who easily elicits information from patients and will make the referral process feel natural.

Formal SDoH screening may not be sustainable in community pharmacies without an active payer program/reimbursement model. However, we recommend you become familiar with resources and tools available in order to apply this at your pharmacy to address and document SDoH organically identified by the pharmacy team.

As discussed in last month's change package, your pharmacy most likely already offers various levels of enhanced services that to help meet SDoH needs.

SDoH Services in Community Pharmacy

SDoH Parameter	Enhanced Services
Environment	Hand Delivery Face-to-Face Access
Economic Stability	Cost Effectiveness Evaluation Discount Prescription Coupons
Education	Health Literacy
Social/Community	Social Support
Health & Healthcare	Care Management Program Adherence Program

There Are Many Screening Tools Available to Assess SDoH. We Have Included Several for Your Reference.

- Screening tools for SDoH
  - Currently, there is not a standardized tool that is specific to the community pharmacy setting. One non-standardized tool that is reviewed in the NCPA and CPESN USA Community Health Workers in Community-Based Pharmacy Care Delivery Modules is available on page 9 of the toolkit associated with the CE – Click **HERE**.
  - Standardized tools that are available for SDoH
    - PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences – Click **HERE**
    - The Accountable Health Communities Health-Related Social Needs Screening Tool – Click **HERE**
    - CLEAR Toolkit – Click **HERE**

The FtP Pharmacy Champion or identified SDoH Champion should review training that is available for SDoH to become more familiar with the concept and to understand the resources your pharmacy may offer depending on staff availability.

CPESN USA and NCPA worked together to come up with ***Community Health Workers in Community-Based Pharmacy Care Delivery***
Click **HERE** to access this CE (3 hours of self-paced modules). These modules are intended to help community-based pharmacists and staff members gain an understanding of how Community Health Workers (CHWs) can be a health resource to individuals in their communities in addition to assisting them with their medication needs.

- Click **HERE** to review the CHW Toolkit that accompanies the modules.

Even though this training is intended for potential Community Health Workers, it provides great SDoH-related resources to glean information and apply to your pharmacy.

As of July 2021, at least 2 programs that are focused on SDoH have completed the CPESN USA / NCPA CHW training.

Click **HERE** to view slides from the NCPA Annual Meeting in 2020 about CPESN Pharmacies who are providing SDoH services.

Develop a Community Resource Guide For Your Team to Be Able to Refer Patients to Local Resources.

To effectively address SDoH after identified, knowing where to refer patients when they have a need is important.

Consider starting out with utilizing **www.findhelp.org** powered by Aunt Bertha to connect a patient with a resource when an issue is identified or to begin developing your community resource guide.

Knowing your local resources to help connect patients with is valuable and builds loyalty. By developing a community resource guide, you will more easily know where to refer patients when a need is discovered, even if you are not actively screening patients.

ACTION ITEM→ Know the resources in your community. Use the following starter guide to help your pharmacy create a site-specific guide.

- Click **HERE** to view examples of resources by category on page 14 ofthe CHW Toolkit.
  - Click **HERE** to edit and make your own resource guide for your pharmacy (see *Appendix A*).

    **Remember that many insurers have specific resources available. Consider including referrals to their care management team (especially for Medicaid beneficiaries).*

Recommendations on completing your community resource guide:

- Find 2 to 3 key resources for each category (e.g., Social Isolation, Food Insecurity) in your geographical area.
- Call the organization and establish contact with them about their services and the appropriate contact person.
- Be sure to ask the organization what the most appropriate procedure and person would be for patient referrals.
- Document the preferred mode of contact (e.g. email, phone call) for each organization along with who and when you spoke with them.

SME TIP **Utilize your SDoH champion or a student to create the community resource guide.**

NOTE: *Be sure to review your local regulations regarding your duty to report. During the SDoH screening process, you may be required to report various findings to local agencies. For example, in Ohio, pharmacists are mandatory reporters of suspected elder abuse.*

Implement SDoH Screening at the Pharmacy.

- How to use a screening tool
  - Ask the questions during your appointment-based model (e.g., med sync interactions).
  - Give to patients while they are waiting on prescriptions or immunization observation.

    SME TIP **Make a QR code for the screening questionnaire available to patients in your waiting area.**
  - Attach to your online immunization questionnaire.

Examples of workflows that pharmacies have been involved in:

	TECHNICIAN	DELIVERY DRIVER
IDENTIFY	Patient cannot afford copays for all medicines ready, leaves some behind to "pickup later"	Patient complains they have no car to go to doctor appointments, thankful pharmacy delivers
SCREEN	Engages patient in conversation regarding medication costs, financial security	Engages patient in conversation regarding transportation concerns
REFER	Refers to pharmacist for insurance discussion and/or social worker for financial assistance	Refers patient to social worker and/or insurance company to explore transportation services

- Taking action when a need is identified

  As we previously discussed, you are likely already addressing SDoH in the pharmacy by delivering to patients when you identify a transportation issue or suggesting a lower cost alternative for a medication when you know the patient cannot afford what the physician prescribed. Using the screening tools, you might be taking action on needs that are not traditionally addressed at the pharmacy (i.e. housing, food insecurity, etc.). That is where your SDoH Champion and community resource guide come in.

  - The SDoH champion should use the community resource guide to identify where to refer the patient.
  - Any identified needs and referrals should be documented in an eCare plan.
  - The SDoH Champion should follow up to ensure that the need was met or if additional action is required.
    - Click **HERE** for an example of an internal worksheet for documentation

Ensure it is the SDoH Champion who is following up with the patient and not a student or other staff member who the patient does not have an established relationship with so that the patient will be more receptive, and they can close the loop on the issue.

SDoH Tracking Chart

Patient Name	Resource Identified & Contact Person	Date Contacted	Date Followed Up (1-2 weeks) and with whom (Patient or Resource)	Status/Progress of Intervention

Even if you are not providing patients with SDoH questionnaires, you can still refer them to local resources and document your work!

Example SNOMED Codes for eCare plan documentation:

SDoH Category	SNOMED CT Description / Code
Food Insecurity	Food Insecurity (733423003)
Loneliness	Feeling Lonely (267076002)
Social Isolation	Social exclusion (105412007)
Support	Receives no social support (445071000124105) Lacks emotional support (422786001)
Housing Adequacy	Unsatisfactory living conditions (308899009)
Financial Stress	Financial problem (160932005)
Perceived Stress	Stress-related problem (162218007)
Mindfulness	Difficulty coping (18232000)
Medication Adherence	Noncompliance for Medication Regimen (129834002)
Health Literacy	Deficient knowledge (54777007)

Appendices

Agency	Information
	Address:
	Phone Number:
	Website/Phone Resources:
	Services Provided:
	Address:
	Phone Number:
	Website/Phone Resources:
	Services Provided:
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