Diabetes & Social Determinants of Health Month 1
NEW PROGRESSION

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**
- ☐ **Workflow Innovations:**
  - Get to know your patients with diabetes and enroll them in Med Sync!
  - Assess your clinical documentation process.
  - Review the goals and standards of care for your patients with diabetes.
- ☐ **GOAL: Document the Hemoglobin A1C of 5 patients in an eCare Plan this month.** (We will collect A1Cs from these same patients in Month 6.)
- ☐ **MILESTONE CHANGE:** The eCare Plan submission requirement of 10 eCare Plans per quarter has been moved to start in Q3 (July 2021 – September 2021).

A New Progression!

This month we begin our Diabetes & Social Determinants of Health Progression. We have been experiencing practice transformation at a rapid speed over the past year, particularly with COVID-19 testing and vaccinations. Although we are leaving the Immunization Progression, we recognize that many pharmacies are giving vaccinations (likely more than they have ever given before). We know that it takes a tremendous amount of time and effort to vaccinate your communities, but also feel it is pertinent to provide you with this next progression as many of you have payer programs or opportunities focused on diabetes and/or social determinants of health.

The first few months, we will focus on diabetes. You will find references to social determinants of health (such as the "Comprehensive Medical Evaluation and Assessment of Comorbidities" Table on the last page of the change package), but it will not be the main focus of the change package until later in the progression.

We are excited to get started with this new progression and hope that it coincides with life returning to a more normal state thanks to all the hard work you've been doing!

NOTE: The American Diabetes Association Standards of Medical Care 2021 Guidelines were used as the reference for all clinical recommendations referred to in the Change Package. Goals and therapy for your patients should be assessed and individualized by the care team in a patient-centered approach.

Workflow Innovations

Get to Know Your Patients With Diabetes and Enroll Them in Med Sync!

It is important to get to know your patients with diabetes so that you can focus on optimizing their care. Your pharmacy team can make a huge impact on the quality of life of your patients with diabetes through optimized medication regimens and assistance with lifestyle changes. You can also make a big difference to payers and the cost of diabetes to the health care system. Patients with diabetes are often complex patients with comorbid conditions. Remember that just as we are approaching practice transformation in incremental changes, so too will you need to approach your patients with diabetes in a step-by-step fashion to avoid overwhelming your staff and your patients.

Proactive Approach to Finding your Patients with Diabetes

Individuals with diabetes are probably the most important group to enroll in medication synchronization. Leveraging the appointment-based model will allow your team to routinely assess, act/refer, and follow up with these complex patients.

How to enroll patients with diabetes in Med Sync:

- Run a report to find your patients with diabetes. Flag their profiles to ask about Med Sync enrollment during their next fill.

SME TIP **If you want to find your patients with diabetes, run a report of patients that have had prescriptions filled within the last 6 months and filter to only include patients that have filled a metformin and/or insulin product.**

- Some pharmacy management systems allow you to create triggers to alert you when filling certain medications. For example, when a metformin or insulin prescription is filled, your system would alert you to check Med Sync status. Flag these patients with diabetes using your determined workflow process (bag tag, point of sale alert, etc.) and discuss with them at pick up.

  NOTE: *This may become tedious/create alert fatigue over time, so consider a 1 to 2 month push for existing patients.*

- Ask your support staff to be on the lookout for any patients with diabetes medications during the normal filling process and screen for Med Sync status.

Reactive Approach to Finding your Patients with Diabetes

You can also find your patients with diabetes that may have been identified by their insurance through various platforms. This is a great way to start small and focus on patients that need your more immediate attention. Enroll these patients in Med Sync and begin to address issues that have been identified by their insurance such as gaps in care.

Where to find patients that have already been identified by their insurance:

- Medication therapy management (MTM) vendors
- EQuIPP

What is EQuIPP?

Electronic Quality Improvement Platform for Plans & Pharmacies (EQuIPP) is a performance information management platform that makes unbiased, benchmarked performance data available to both health plans and community pharmacy organizations. Click **HERE**

Access your "Pharmacy Dashboard" to see your Performance Scores. Key metrics to review related to your patients with diabetes are:

- Proportion of Days Covered: Diabetes Rate or "Diabetes PDC"
- Statin Use in Persons with Diabetes or "Statin Use in Diabetes"

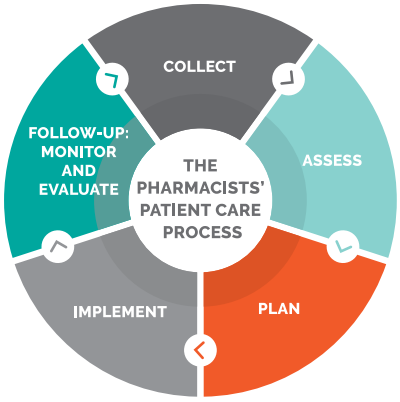
Compare your Performance Score with your Goal. For those metrics where your Performance Score does not exceed your Goal, you should be able to review a list of your "Outliers." The "Outliers" are the patients you should be targeting for Med Sync. For example, the "Diabetes PDC" Outliers are not meeting the PDC goal and need assistance with adherence. Improving the PDC will help to improve your Performance Score and reduce DIR fees. Although there may not be a specific payer program related to these patients, it will help to improve the bottom line and your pharmacy's sustainability.

Assess Your Clinical Documentation Process

As you begin this progression, start by assessing your clinical documentation process. Documentation should encompass the steps of The Pharmacists' Patient Care Process. Review *Appendix A* for more detailed information about The Pharmacists' Patient Care Process.

As you are assessing your site's documentation process, here are some questions to consider:

- What is your pharmacy's process for documentation of patient care?
- Is the documented information easily accessible?
- Is your team routinely reviewing patient records?
- Is your team adding new information after each patient encounter?
- Does your whole team participate in the documentation of care?



Click **HERE** to read more from Randy McDonough, Director of Practice Transformation, about how Towncrest Pharmacy handles clinical documentation.

ACTION ITEMS:

GOAL: Document the Hemoglobin A1C of 5 patients in an eCare Plan this month.

(We will collect A1Cs from these same patients in Month 6.)

- Select 5 of the patients you have identified to enroll in Med Sync and collect their A1Cs. This can be patient or provider reported. If you have the capability, you could also use a point of care test to assess their A1C.

SME TIP **Ask patients for their most recent A1C during your Med Sync workflow process. This could be done during their Med Sync call or when they come in to pick up their medication.**

- Utilize the **Patient Encounter Documentation Form** as provided provided on the next page to develop an eCare plan specific to a patient. This information will help you to follow the patient from month to month.
  - Create an eCare plan focused on patients who are enrolled in Med Sync and have diabetes.
    - If you want to take this a step further and focus on building out your Med Sync process, review *Appendix B* for a Med Sync Monthly Check-in Guide. This can be used as a guide to standardize your pharmacy team's documentation and make your Med Sync process more efficient.

Patient Encounter Documentation Form for eCare Planning

Below are ideas for eCare plan documentation for this month. All eCare plans need an Encounter Reason with a Medication Related Problem and/or Intervention. Document whatever is most appropriate for the patient. You can choose from the provided list of possible scenarios on the Patient Documentation Form. Each of the items are related to a SNOMED CT code that you are able to find within your documentation platform for the eCare plan.

For example, this month you want to record 5 A1C measurements. You may choose an "Encounter Reason" of "Initial Diabetic Assessment" for these patients and then select an "Intervention" of "Hemoglobin A1c Measurement" to record this information.

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	
Interventions	Date Resolved:_____
☐ Hemoglobin A1c measurement	
☐ Blood glucose monitoring	
☐ Med Sync or synchronization of repeat medication	
Notes:	
A1c:_____	Results Date:_____
Blood Glucose:_____	Results Date:_____
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 C*.)

Review the Goals and Standards of Care for Your Patients With Diabetes

Diabetes Glycemic Recommendations	
A1C	<7%
Preprandial BG	80-130 mg/dL
Peak postprandial BG (1-2 hrs postprandial)	<180 mg/dL

We are providing the information below as a reference point only for Month 1. However, in future months we are going to focus on these standards of care for your patients with diabetes as well as workflow ideas for incorporating opportunities related to the standards from different platforms. If your pharmacy is prepared to focus on these aspects prior to being reviewed in future change packages, please do so.

Cardiovascular Disease Goals	
BP (HTN at higher CV risk and safely achievable)	< 130/80
BP (HTN at lower CV risk)	< 140/90
ACE/ARB first-line therapy for diabetes + CAD	
Statin (moderate-intensity) as primary prevention in ages 40-75 yrs without CVD or Statin as primary prevention in ages 20-39 yrs if additional CV risk factors	
Statin for all patients with CVD if not otherwise contraindicated	
Aspirin therapy (75-162mg/day) as primary prevention for those at increased risk of CVD after assessing benefit vs. bleeding risk and secondary prevention in those with CVD	

Immunizations	
Hepatitis B (< 60 yrs, ≥ 60 yrs discuss with doctor)	2 or 3 dose series
Influenza	Annual
Pneumonia (PPSV23)	
19-64 years	One dose
≥ 65 years	One dose; if PCV13 given, then give PPSV23 ≥ 1 year after and ≥ 5 years after any PPSV23 at < 65 years
Pneumonia (PCV13)	
19-64 years	None
≥ 65 years, without immunocompromising condition, cochlear implant, or CSF leak - shared decision-making discussion with physician	One dose

Review of Diabetes Diagnosis Criteria

Diagnosis of Diabetes Criteria	
Fasting BG	≥ 126 mg/dL
A1C	≥ 6.5%
Random BG (with symptoms of hyperglycemia)	≥ 200 mg/dL
2 hour OGTT	≥ 200 mg/dL

Comprehensive evaluation and assessments that could be completed by the pharmacy:

BEHAVIORAL FACTORS	▪ Eating patterns and weight history
	▪ Assess familiarity with carbohydrate counting (e.g., type 1 diabetes, type 2 diabetes treated with MDI)
	▪ Physical activity and sleep behaviors
	▪ Tobacco, alcohol, and substance use
MEDICATIONS AND VACCINATIONS	▪ Current medication regimen
	▪ Medication-taking behavior
	▪ Medication intolerance or side effects
	▪ Complementary and alternative medicine use
	▪ Vaccination history and needs
TECHNOLOGY USE	▪ Assess use of health apps, online education, patient portals, etc.
	▪ Glucose monitoring (meter/CGM): results and data use
	▪ Review insulin pump settings and use
SOCIAL LIFE ASSESSMENT	**Social network**
	▪ Identify existing social supports
	▪ Identify surrogate decision maker, advanced care plan
	▪ Identify social determinants of health (e.g., food security, housing stability & homelessness, transportation access, financial security, community safety)

Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Medical Care in Diabetes - 2021. Diabetes Care 2021;44(Suppl. 1):S40-S52

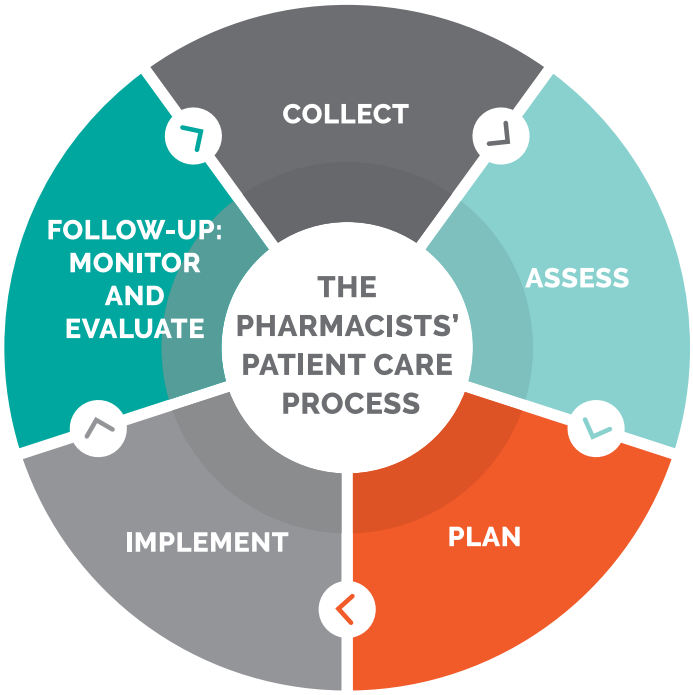
Appendices

The Pharmacists' Patient Care Process

The Pharmacists' Patient Care Process was released by the Joint Commission of Pharmacy Practitioners in 2014. It offers a comprehensive approach to pharmacist provided, patient-centered care that is delivered in collaboration with other members of the health care team.

This Process Involves the Following Steps:

1. Collecting information about the patient
2. Assessing that information
3. Developing a patient-centered care plan
4. Implementing that plan
5. Following up to monitor and evaluate effectiveness



Using principles of evidence-based practice, pharmacists:

COLLECT
The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/ medication history and clinical status of the patient.

ASSESS
The pharmacist assesses the information collected and analyzes the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care.

PLAN
The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver that is evidence-based and cost-effective.

IMPLEMENT
The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.

FOLLOW-UP: MONITOR AND EVALUATE
The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.

*https://jcpp.net/patient-care-process/

Med Sync Monthly Check-in Guide

Med Sync Monthly Check-in Guide		
Before calling the patient, review the most recent care plan. In particular, note medication therapy problems that are not yet resolved or interventions that have been planned but not completed, as you will want to follow up on those. Also, review the open patient-centered goals, as you should be asking the patient for an update on their goals at least monthly.		
N/A	N/A	What new medicines, either prescription or over the counter, have you started taking in the past month?
Yes	No	Have you been to the doctor in the past month? If yes, what doctors did you see? Were any changes made to your medicines? If no, when is your next doctor's appointment? Is it a regular check-up, or have you made the appointment because you are feeling ill?
Yes	No	Have you been to the hospital or emergency department in the past month? If so, why? How are you feeling now? Were any changes made to your medicines? If it was your asthma that caused you to go to the hospital, do you know what happened that made your asthma symptoms get worse? Have you already made those changes to your medicine? Do you have a follow up appointment scheduled with your primary care doctor?
Yes	No	Has the doctor prescribed any medicines that you have not filled? Can you tell me a little bit about why you decided not to fill this medicine?
Yes	No	Did the doctor stop any of your medicines or change the directions or the dose? If yes, ask patient for details about medication changes.
Yes	No	Have you stopped or changed any medicines on your own? If yes, is your doctor aware that you stopped this medicine?
Yes	No	Do you get any prescriptions from other pharmacies? If so, which ones?
N/A	N/A	For medicines that you take only when you need them, such as your _____ *[pharmacy staff to give example from the patient's med list - inhalers/creams/etc]*, how much is left? How often have you used it recently? (Compare to most recent fill date.) Do you need more?
Yes	No	Are you going to be able to pay copays for all of your medicines this month?

N/A	N/A	For patients receiving packaging: What day/pack are you currently on? (Consider having delivery driver confirm amount remaining.) For patients with bottles: How many tablets remain in each bottle? (Consider having delivery driver confirm amount remaining.)
N/A	N/A	Review the patient's list of medications, noting the NAME, STRENGTH, and DIRECTIONS for each. Ensure that the patient is taking the medications as they are written and according to the directions we have on file. Note any differences. If the patient appears to be non-adherent, ask the following: 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: ***If a patient refuses any CHRONIC medications, the pharmacist should be notified and given any explanation the patient offers for not taking the medication.*** Be sure to ask about PRN medications each month. If a patient does not want a PRN medication, this is not considered an adherence concern. ***If any problems, changes, non-compliance, etc are found, the pharmacist should be notified. Consider notifying other care team members as well.***

Red = Recommended for pharmacist review

Please note that the thresholds/responses that are listed as needing pharmacist review are general guidance. Your pharmacy should review the responses in red and change them, if necessary, to align with the comfort level of your pharmacist staff before using the form.

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☐ Follow-up diabetic assessment

Medication-Related Problems Date Identified:____________

☐ Deficient knowledge of disease process

☐ Noncompliance with medication regimen

Interventions Date Resolved:____________

☐ Hemoglobin A1c measurement

☐ Blood glucose monitoring

☐ Med Sync or synchronization of repeat medication

Notes:

A1c:____________ Results Date:______________

Blood Glucose:____________ Results Date:______________

Circle one for the lab value:

Patient-reported Prescriber-reported Pharmacy-reported

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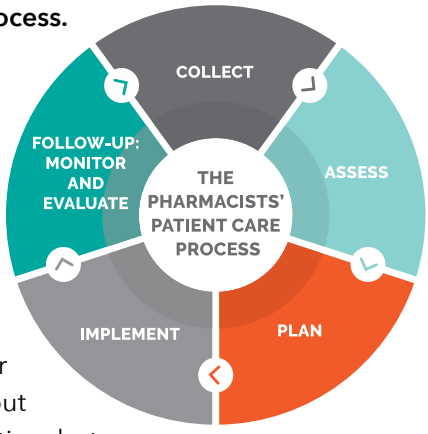
Clinical Documentation and The Patient Record

A Note from Randy McDonough, Director of Practice Transformation

We have coined the phrase ***"make every encounter count"*** as pharmacists need to be intentional and deliberate with each patient encounter as it relates to data collection, identifying and resolving medication-related problems (MRPs), interventions made, communication with the care team, and ***documentation***. As we transition back to our progressions (e.g. Diabetes and Social Determinants of Health) format, we need to be intentional on how we optimize each encounter with the patient. Documentation is a crucial part of caring for our patients.

Documentation should encompass the steps of The Pharmacists' Patient Care Process.



Reasons we document patient care activities:

1. Legal record of care that supports your work/activities
2. Proof for auditing purposes for payer programs

The first reason we document patient care is the most important. Clinical documentation is your ongoing record of care for patients—in essence "your work-up" of patients. As part of your "work-up", data collection is key in that it provides you with the information needed to appropriately clinically evaluate your patients. Data collection is on an ongoing process that can happen in workflow—but it needs to be in a format or platform that allows you to not only add new information, but also access

1. previous interventions that pharmacists have made (MRPs identified and resolved),
2. actions that need to be completed (follow up and monitoring), and
3. other supplemental information that completes the patient record (labs, vitals, discharge summaries, physician/stakeholder progress notes, etc.).

At Towncrest Pharmacy, we ask our patients with diabetes about their blood sugars, hypoglycemic events, appropriateness of therapy (e.g. statins, ACEI/ARBs), A1Cs, and other diabetes related information. Given that diabetes is associated with an increased risk of cardiovascular events ensuring assessing your patients' cardiovascular status also becomes important (BPs, lipid panels, etc.). It is important that you start to create your "record" of the patient – a record that is ***easily accessible*** during your "encounter" with the patient and that you ***review it*** and ***add to it with each encounter***. As part of your pharmacist responsibilities, the record should also include your professional assessment to determine if the patient has a medication-related problem and what interventions/recommendations you made (including your clinical note to the prescriber). All this information is housed in the clinical record—the record you should be accessing and reviewing whenever you encounter the patient.

By doing this consistently and repeatedly, you will find as I have, that patients do have medication-related problems that require your attention and expertise. By developing your process (including e-care plan submission), you'll find it becomes a routine aspect of your day-to-day activities.