Diabetes & Social Determinants of Health Month 2

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: Addressing Gaps in Care
    - Click **HERE** to watch this 10 minute presentation from Angelina Tucker, CPESN Texas Managing Network Facilitator, for a refresher on Gaps in Care and **HERE** to view the slides
  - Review of motivational interviewing techniques
    - For a brief review of Motivational Interviewing and utilizing this technique to help improve adherence, click **HERE** to view a presentation provided by Randy McDonough
    - Comprehensive Motivational Interviewing Training (Developed by Bruce Berger and Bill Villaume – includes 8 hours of CE) – Click **HERE**
- [ ] **Workflow Innovations:**
  - Discuss blood glucose and A1C goals with your patients with diabetes.
    - **Reminder: GOAL: Document the Hemoglobin A1C of 5 patients in an eCare Plan this month if you haven't yet or set a higher goal for your team.** (Aim to collect A1C's from these same patients in Month 6.)
  - Identify and address gaps in care for you patients with diabetes.
- [ ] **MILESTONE CHANGE:** The eCare Plan submission requirement of 10 eCare Plans per quarter has been moved to start in Q3 (July 2021 – September 2021).

Workflow Innovations

Discuss Blood Glucose and A1C Goals with Your Patients with Diabetes.

Ideas for getting started

1. **Start the conversation.**

It is important to start and continue dialogue with your patients about their diabetes. A great conversation starter is asking about their blood glucose readings. Ask targeted questions like:

- When was the last time you had your labs drawn?
- What (and when) was your most recent A1C?
- How often do you monitor your blood glucose?
- What was your most recent blood glucose reading?

➔ **NOTE:** *Try to target patients you feel are not at goal or could most benefit from pharmacy services like med sync.*

2. **Assess whether or not the patient is at goal.**
Reference the table in Appendix A for a refresher on glycemic targets for patients with diabetes. If the patient is not sure of their A1C or does not remember when they last had labs drawn, consider requesting from their physician. Click **HERE** for a template fax you can use at your pharmacy.

3. **How can you help?**
Review motivational interviewing techniques so that you can best assist the patient in making positive changes toward their health goals. Click **HERE** to check out a brief MI review from Randy McDonough or click **HERE** to sign up for comMIt for health care professionals (8 hours of CE).

Through this dialogue you may be able to identify potential medication-related problems and barriers related to social determinants of health.

4. **Come up with a plan.**
Pick one or two things for you and your patient to focus on this month.
   - Discuss enrolling them in med sync to help with adherence along with any other medication use supports that may be appropriate such as adherence packaging.
   - Refer to the next workflow innovation for ideas on how to address gaps in care.

   NOTE: *Remember that patients with diabetes are complex and change is difficult—just like transforming your pharmacy is not easy. Consider using the same stepwise approach with your patients with diabetes. Focus on incremental changes to assist them in meeting their goals.*

5. **Document your care plan.**
Document the information you learned from the patient and your plan of action in an eCare plan so that you can provide follow up and monitoring each month.

6. **Continue the conversation!**
Each interaction with the patient is an opportunity to assist them in reaching their goals. Remember, perceptions are the patients' reality and how they form their expectations. If the patients' expectations are not met, they may become frustrated. Help to change expectations of your pharmacy so that over time you have raised the bar on patient expectations, which will lead to loyalty as they recognize your practice as "different."

Ideas for pharmacy staff to change patients expectations

- Collect clinical information
- Counsel and educate about medications
- Follow up with patients
- Collaborate with other health care professionals to ensure medication optimization

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

(Aim to collect A1C's from these same patients in Month 6.)

Types of patients to focus on during this month for A1C collection:

1. Patients who may benefit the most from pharmacy staff follow-up
2. Patients who you know may have been or are recently non-adherent
3. Patients recently diagnosed with diabetes

If you haven't done so yet, be sure to **document the Hemoglobin A1C of 5 patients in an eCare Plan this month** or if you are ready, set a higher goal for your team!

Identify and Address Gaps in Care for Your Patients with Diabetes.

Diabetes Review
For a quick review of goals and standards of care, check out Appendix A for the tables shared in the Month 1 Change Package. You can also click **HERE** to watch a brief 10 minute presentation, "Diabetes Review: Addressing Gaps in Care," from Angelina Tucker, CPESN Texas Managing Network Facilitator and **HERE** to view the slides.

Two Approaches to Focusing on Patients with Diabetes

Choose what is best for your Workflow *(It may be a combination of them or just one approach to start)*:

1. **Proactive –** Utilize the Med Sync Process during the Appointment-Based Model
2. **Reactive –** Reacting to CPESN payer programs, MTM Platform targeted interventions, or EQuIPP outliers (similar to what many community pharmacies are used to doing)

Proactive Approach to Identifying Gaps in Care Utilizing the Diabetes Checklist during the Appointment-Based Model (i.e., Med Sync)

Last month we focused on finding your patients with diabetes and enrolling them in med sync. This month we will focus on identifying gaps in care during the med sync process. Click **HERE** for a printable version of the Diabetes Checklist for Patient Encounter reviewed below.

Diabetes Checklist for Patient Encounters

This information is intended to provide clinical considerations while combining ideas for workflow and eCare plan documentation.

eCare Plan Documentation Tips

In case you are unsure or struggling with eCare plan documentation, review the sample/test case from the previous progression and submit a test eCare Plan if you haven't already. Each one gets easier! If you know how to submit a care plan – no need to re-watch the videos!

- Click **HERE** to view the test eCare plan.
- View the Technology Solution Partners specific videos within the FtP Workflows email.

How to Use the Diabetes Checklist and Document eCare Plans:

- See below for a "cheat sheet" on how to document each of the Diabetes Checklist Scenarios within the eCare plan.
  - Additional SNOMED CT codes may be used but this provides examples that can be used as a starting point.

Diabetes Checklist Scenario	Encounter Reason/ Medication Related Problem (MRP) SNOMED CT Code Description	Intervention SNOMED CT Code Description
Adherence Assessment	Assessment of compliance with medication regimen (encounter reason)	Medication synchronization/ synchronization of repeat medication
Glycemic Target Assessment	Blood glucose monitoring (encounter reason)	Diabetic education
Medication Care Gaps	Additional medication required (MRP)	☐ Recommendation to start prescription medication ☐ Prescription medication started
Preventative Care	Assessment of health and social care needs (encounter reason)	Diabetic education
Immunizations	Not up to date with immunizations (MRP)	☐ Administration of substance to produce immunity, either active or passive ☐ Immunization status screening

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, refer to Appendix A.

☐ **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*		
≥ 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		
≥ 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)*		

Consider focusing on one or two things this month. Looking for statins and ACEi/ARBs is a great place to start when reviewing medication profiles. Click HERE for an editable example of a prescriber communication tool you can customize for your pharmacy and use to recommend needed statin therapy.

Reactive Approach to Identifying Gaps in Care

Last month we looked at a reactive approach to finding your patients with diabetes since various platforms may have already identified your patients with poor adherence or gaps in care. This is a great way to start small and focus on patients that need your more immediate attention.

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

- Medication therapy management (MTM) vendors
- EQuIPP

Workflow Tips:

- **MTM**
  - Integrate MTM TIPs into your workflow process so care gaps are addressed during the sync process and a pharmacy staff member is following up with the patient and prescriber.
    - 2 workflow ideas depending on your preference/pharmacy capabilities:
      1. Review MTM vendor platforms for TIPs on a monthly basis. Support staff can print a report of available TIPs and flag those patients with a note on their profile to review (ideally) during the sync process or during their next fill if they are not on med sync. (Offer your med sync program to these patients when possible.)
      2. Some pharmacy management systems integrate TIPs from MTM vendors into their system. Patients are already flagged as having a TIP that can be addressed during med sync.

We use bright colored chip clips to notify pharmacy staff that a patient has a TIP or CMR available. The pharmacy technician identifies that the patient has a TIP during med sync or the filling process and puts a clip on the patient's basket. The pharmacist addresses the TIP if possible during the verification process. When appropriate, the clip is moved to the patient's completed hanging bag if it can be addressed at pick up. Integrating MTM into workflow makes it easier for staff to manage and feels more natural when discussing with patients.

- **EQuIPP**
  - Similarly, integrate reviewing EQuIPP "outliers" during your workflow process. Support staff can run reports on a monthly basis and flag the outliers so they can be addressed during the med sync process.

If you have identified a particular Part D program that is negatively impacting STAR ratings/DIR fees, consider running a report of all patients enrolled in that plan and flagging them for med sync. By asking those patients to be in your med sync program, you will be able to keep a closer eye on them as it relates to gaps in care and adherence. Try to address the EQuIPP outliers as soon as possible.

Appendix

Goals and Standards of Care for Patients with Diabetes

Diabetes Glycemic Recommendations	
A1C	<7%
Preprandial BG	80-130 mg/dL
Peak postprandial BG (1-2 hrs postprandial)	<180 mg/dL
Time in range (continuous glucose monitoring)	>70%

Cardiovascular Disease Goals	
BP (HTN at higher CV risk and safely achievable)	< 130/80
BP (HTN at lower CV risk)	< 140/90
ACEi/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	
SGLT-2 Inhibitors for Type 2 diabetes and atherosclerotic CVD, multiple atherosclerotic CVD risk factors, or diabetic kidney disease to reduce risk of CV events and/or HF hospitalization	
SGLT-2 Inhibitors for Type 2 diabetes and HF to reduce risk of worsening HF and death	
GLP-1 receptor agonists for Type 2 diabetes and atherosclerotic CVD, multiple atherosclerotic CVD risk factors, or CKD and increased risk for CV events to reduce risk of CV events and renal end point	
Beta Blockers in patients with prior MI x 3 years after the event or in patients with HF unless otherwise contraindicated	

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