ZUFALL HEALTH CENTER

Engaging Patients with Diabetes in Self-Management A Clinical Pharmacy Services Approach

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Learning Objectives

- List three components for CPS
- Describe how to integrate CPS into the primary care team
- Explain how CPS aligns with PCMH and Meaningful Use

Zufall Health Center – A Federally Qualified Health Center serving Morris, Warren, Sussex, Hunterdon and Somerset Counties

- Established in 1990 in church basement in Dover by Dr. Zufall and volunteer physicians
- FQHC since 2004; providing entire range of primary medical, dental and enabling services
- Have 6 sites including a mobile medical van
- Serving uninsured, underinsured, homeless, residents of public housing, farm workers
- Open 7 days a week, extended hours
- NCQA PCMH Level 3
- Bilingual staff and on call services

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Patient Services

- Pediatrics
- Adult Medicine
- Women's Health
- Ryan White Part A, C & F
- Dental
- Podiatry
- Behavioral Health
- Neurology
- Clinical Pharmacy Services
- Outreach and Health Fairs
- 340B Pharmacy
- Reach Out and Read
- Patient Navigation
- Case Management
- Health Literacy Program
- ACA Enrollment
- School-based dental program

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Facts and Statistics 2013

- Served over 21,000 patients with approximately 62,000 visits
- 65% of adults either overweight or obese
- 13% have diabetes, 16% have hypertension
- 85% of patients are taking more than one medication on a regular basis
- Many patients taking duplicate medications/not taking medications as directed

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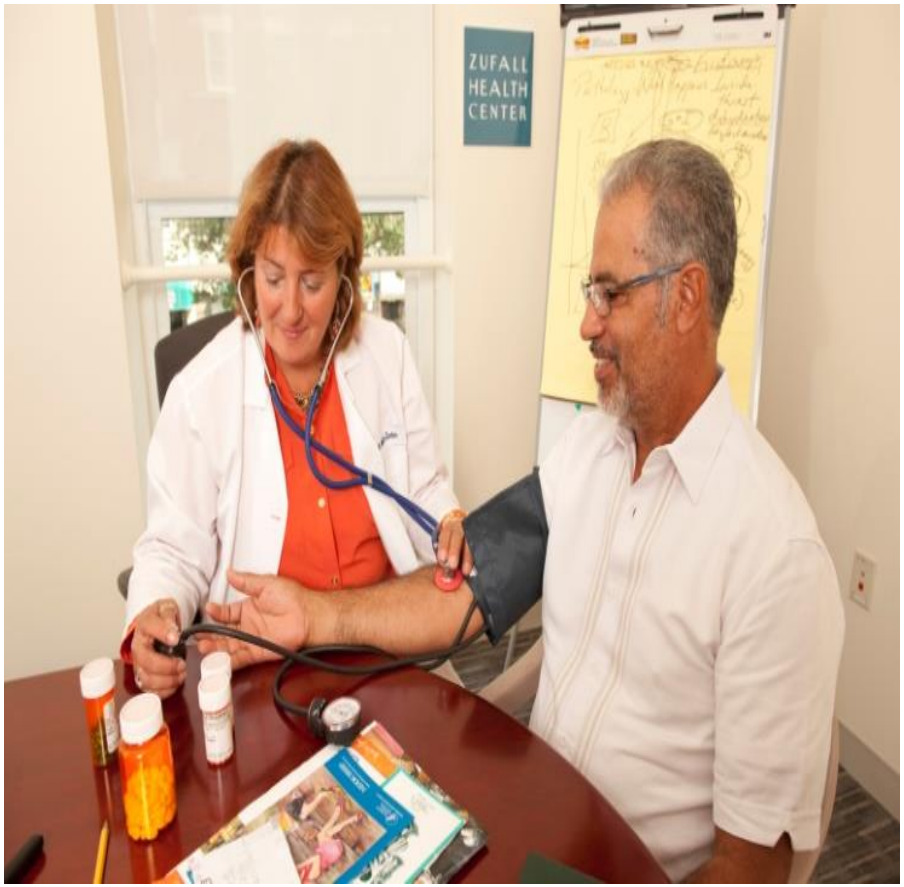
Patient Safety and Pharmacy Services Collaborative (PSPC)

- Joined in 2008, now in our 5th year
- Providing Clinical Pharmacy Services to patients with chronic diseases
- Pharmacist is integrated in primary care/team work/coordinated care
- Have seen over 3,000 patients, the majority with diabetes out of control
- Seeing consistent improvements in all health and safety measures



CLINICAL PHARMACY SERVICES: Elements/Components

- Patient Centered
- Comprehensive
- Conducted Regularly
- Team Collaboration
- Prevention
- Care Transitions

Project IMPACT-Diabetes

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Clinical Pharmacy Services = Improved Outcomes

- **Prospective Chart Review**
  - THE BIG PICTURE – CLUES TO PATIENT BEHAVIOR
- **Retrospective Chart Review**
  - Drug Utilization/Medical, Social, Family History/Self-Efficacy/Adherence
- **Medication Therapy Management**
  - Review of all medications, patient education, action plan, identification of medication related problems
- **Disease State Management**
  - Consultations, adjustments, referrals, screenings, counseling and self management education
- **Medication Access**
  - uninsured, not covered-i.e.: Donut Hole in Medicare

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Clinical Pharmacy Services = Improved Outcomes

- **Preventive Care-** immunizations, foot exams
- **Drug Information** – patient, team
- **Medication Reconciliation** – Brown Bag
- **Patient Counseling**- DSMT, MTM
- **Provider Education** – buy-in

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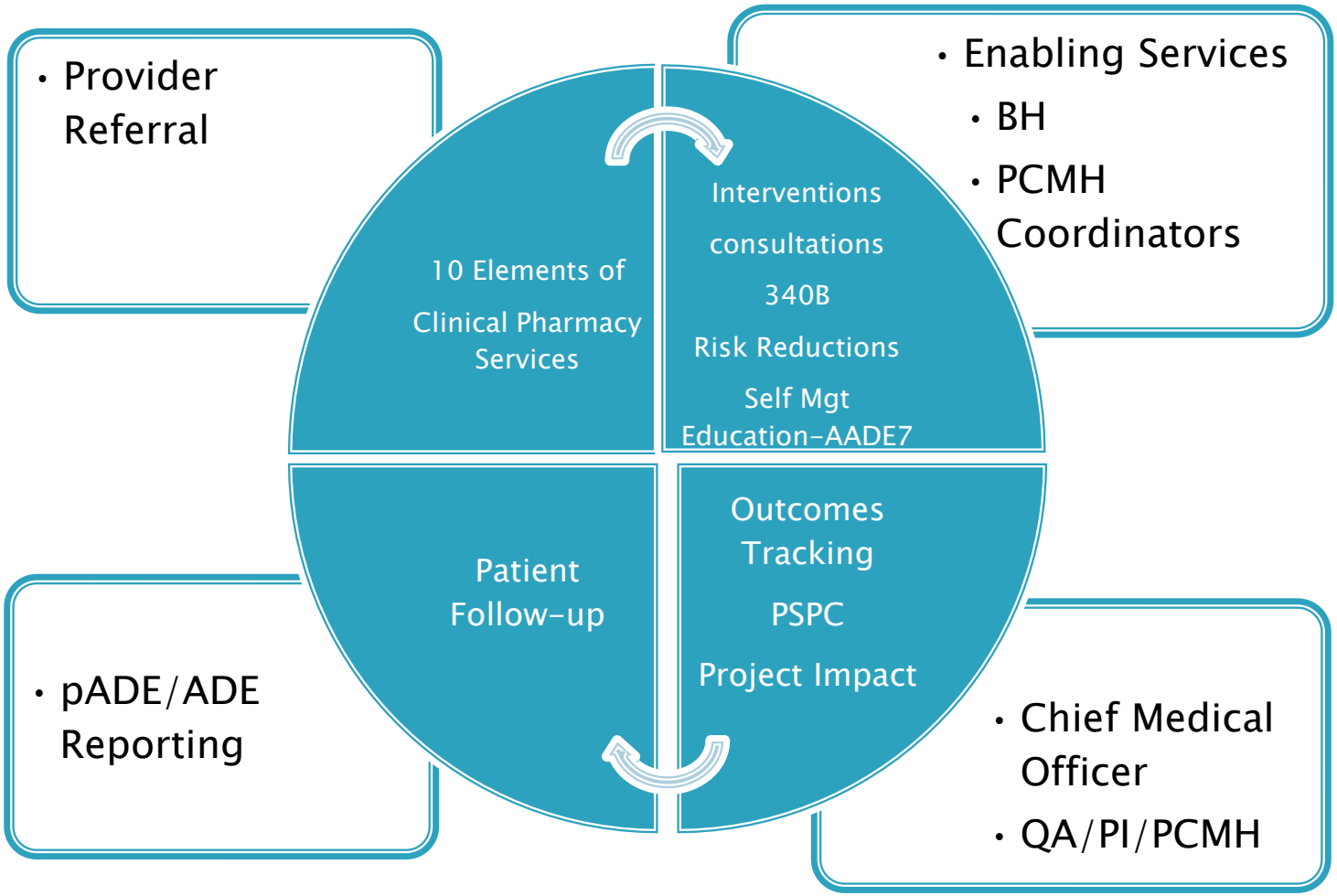
Which is not a component of CPS?

- Medication Therapy Management
- Patient Counseling- self management
- Medication Access
- Walking the dog ✔

What Services can CPS deliver that improves patient outcomes?

- Medication Therapy Management, Self Management Education, Medication Access ✔
- Count Pills
- Draw necessary lab orders
- Diagnose

Coordination of Care – our Delivery Model



Delivery Model PCMH Alignment

- Coordination of Care- Interdisciplinary Team
  - Engagement of team members
  - Enhanced communications
- Population Management
  - Identification of high risk population
  - Tracking- patient follow-up
  - Community Resources
- Medication Therapy Management
  - Identification of Medication Related Problems
  - Meaningful Use
- Continuous Quality Improvement
  - Patient Satisfaction
  - Development of Patient Education Tools

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What service in CPS aligns with CMS Meaningful Use?

- Medication Therapy Management-medication reconciliation ✓
- Provider Consultation
- Prospective Chart Review
- Medication Access

What worked?

- Trusting patient- pharmacist relationship
- Patient centered
- Face to Face encounters-30 minutes to an hour
- Frequent follow-up as needed
- Targeted interventions
  - Disease-specific
  - Culturally competent
  - Health literacy conscious
  - Barriers identified
  - Evidence Based
- Collaboration with clinical team for coordination of care

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Which CPS Component is not aligned with PCMH?

- Medication Therapy Management
- Coordination of Care
- Population Management
- Getting together with friends ✔

TOOLS– Adherence Sheet

Name:	Date: ___/___/____							
								
Medications - Medicinas	**What is it for? - Para Que Es?**	Before Breakfast - Antes del Desayuno	After Breakfast - Despues del Desayuno	Before Lunch - Antes del Almuerzo	After Lunch - Despues del Almuerzo	Before Dinner - Antes De La Comida	After Dinner - Despues De La Comida	Bedtime - Al Acostarse

- Teach Back
- Personal Medication Record
- Medication Action Plan
- Health Literacy/Literacy
- Self Management Tool

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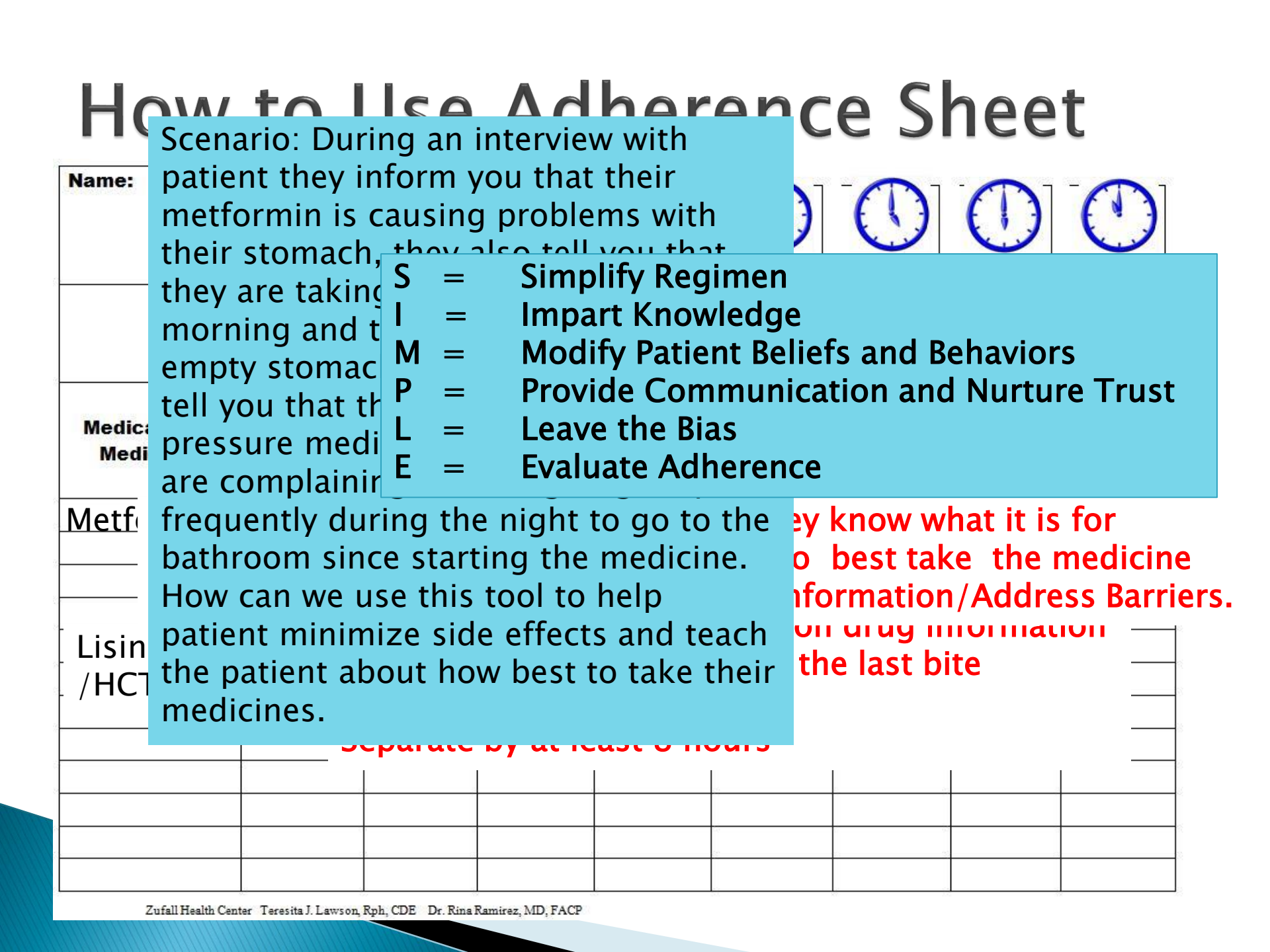
How to Use Adherence Sheet

Scenario: During an interview with patient they inform you that their metformin is causing problems with their stomach, they also tell you that they are taking morning and t empty stomac tell you that th pressure medi are complainir frequently during the night to go to the bathroom since starting the medicine. How can we use this tool to help patient minimize side effects and teach the patient about how best to take their medicines.

S	=	Simplify Regimen
I	=	Impart Knowledge
M	=	Modify Patient Beliefs and Behaviors
P	=	Provide Communication and Nurture Trust
L	=	Leave the Bias
E	=	Evaluate Adherence



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Adherence Tool- interactive

- Patient Knowledge, Comprehension and Self Efficacy Assessment
- Improves Adherence- " The SIMPLE Method"
  - **S=** **Simplify Regimen**
  - **I=** **Impart Knowledge**
  - **M=** **Modify Patient Beliefs and Behaviors**
  - **P=** **Provide Communication and Trust**
  - **L=** **Leave the Bias**
  - **E =** **Evaluate Adherence**
- Addresses Barriers- forgetfulness, side effects
- Engages patient in the process
- Helps identify Solutions
- Literacy- Universal Symbols, Clocks
- Reduces Side Effects- Enhances Acceptance
- Medication Reconciliation- Meaningful Use/PCMH
- Self-Management Take Home Tool for Patient/Medication Action Plan

TOOLS- Patient Education

- Counseling Tool- Simple/Health Literacy/Literacy
- Improves Adherence
- Educates Patient on Refills
- Helps patient navigate the system
- Patient feels less intimidated and more in control
- Integrates patient as integral to process
- Improves Communications- All Parties
- Engages Community 340B Partners

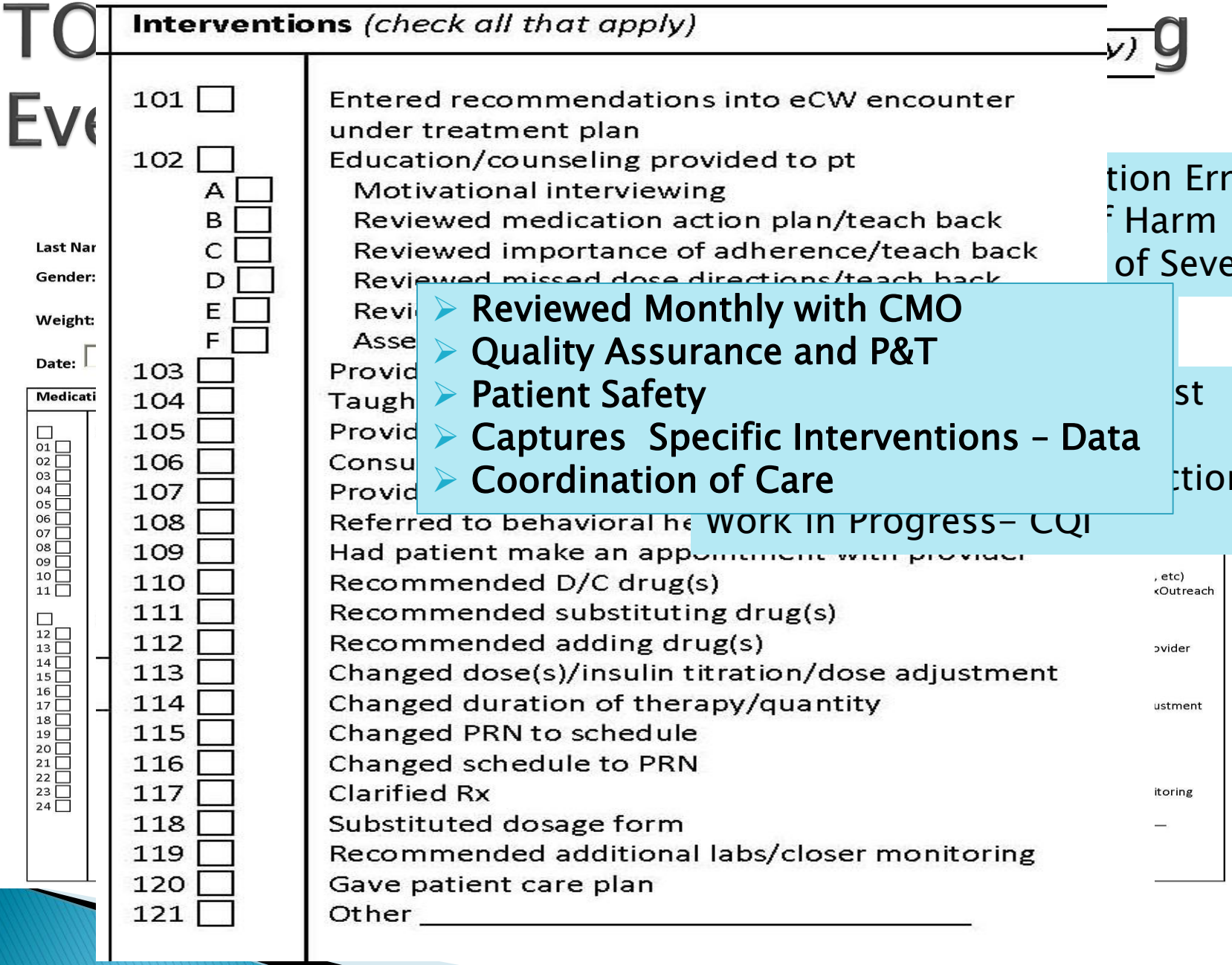
TOOLS- Medication Non-Adherence Risk Assessment

- **Preventive Medicine: EMBEDDED IN EMR**

  Clinical Pharmacy: Drug Adherence: Risk Assessment

  - I am convinced of the importance of my medicine 0-10 10,
  - I worry that my medicine will do more harm than good to me 0-10 0,
  - How committed are you to starting the medicine and staying on the medicine? 0-10 10,
  - Do you sometimes forget to take your medicine? Not at all, Several Days, More than half the days, All the time

- **Conducted for all Patients**
- **Helps Identify Barriers- Cognitive Issues, Health Beliefs, Self Efficacy**
- **Helps Identify potential for Non-Adherence**
- **Embedded in CPS Encounter**

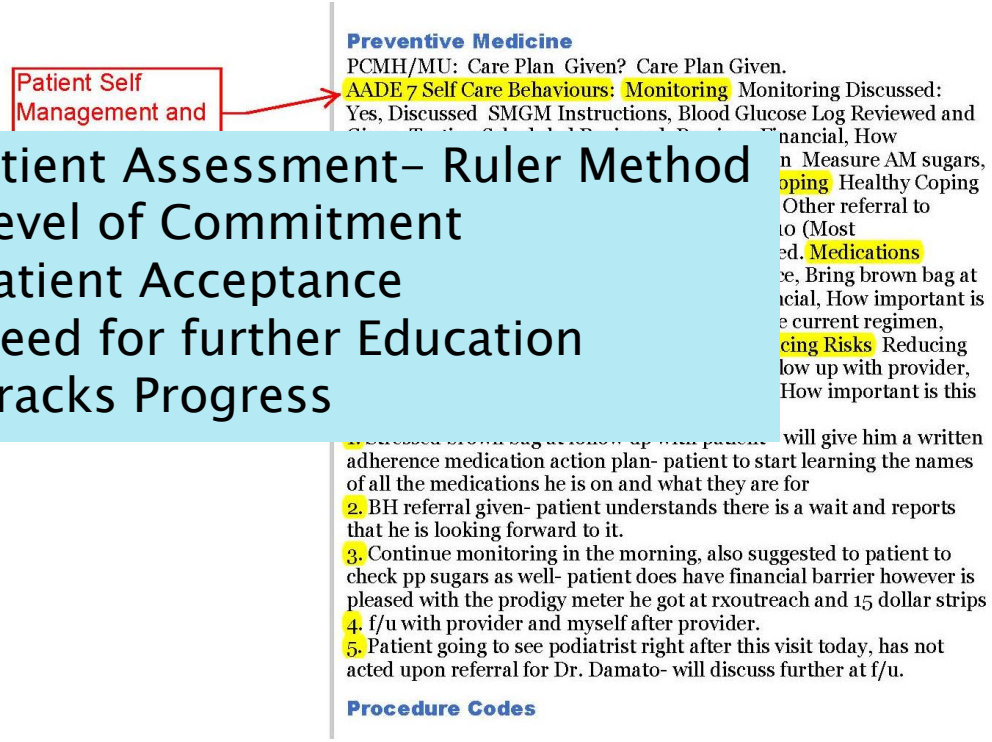

Interventions (check all that apply)
101 Entered recommendations into eCW encounter under treatment plan
102 Education/counseling provided to pt
A Motivational interviewing
B Reviewed medication action plan/teach back
C Reviewed importance of adherence/teach back
D
E
F
103
104
105
106
107
108
109
110 Recommended D/C drug(s)
111 Recommended substituting drug(s)
112 Recommended adding drug(s)
113 Changed dose(s)/insulin titration/dose adjustment
114 Changed duration of therapy/quantity
115 Changed PRN to schedule
116 Changed schedule to PRN
117 Clarified Rx
118 Substituted dosage form
119 Recommended additional labs/closer monitoring
120 Gave patient care plan
121 Other
Reviewed Monthly with CMO
Quality Assurance and P&T
Patient Safety
Captures Specific Interventions – Data
Coordination of Care
Work In Progress- CQI
tion Errors
Harm
of Severity
Last Nar
Gender:
Weight:
Date:
Medicati

TOOLS- Self Management Education Curriculum

- AADE 7 Self Care Behaviors- EMBEDDED IN EMR
  - Healthy Eating
  - Being Active
  - Medications
  - Monitoring
  - Reducing Risks
  - Problem Solving
  - Healthy Coping

Patient Self Management and

Patient Assessment- Ruler Method
- Level of Commitment
- Patient Acceptance
- Need for further Education
- Tracks Progress



Preventive Medicine

PCMH/MU: Care Plan Given? Care Plan Given.

AADE 7 Self Care Behaviours: Monitoring Monitoring Discussed: Yes, Discussed SMGM Instructions, Blood Glucose Log Reviewed and

nancial, How

n Measure AM sugars,

oping Healthy Coping

Other referral to

10 (Most

ed. Medications

e, Bring brown bag at

ncial, How important is

e current regimen,

cing Risks Reducing

low up with provider,

How important is this

will give him a written adherence medication action plan- patient to start learning the names of all the medications he is on and what they are for

2. BH referral given- patient understands there is a wait and reports that he is looking forward to it.

3. Continue monitoring in the morning, also suggested to patient to check pp sugars as well- patient does have financial barrier however is pleased with the prodigy meter he got at rxoutreach and 15 dollar strips

4. f/u with provider and myself after provider.

5. Patient going to see podiatrist right after this visit today, has not acted upon referral for Dr. Damato- will discuss further at f/u.

Procedure Codes

Practical Implications

- Health Center leadership commitment and support
- Provider buy-in
- Pharmacist committed to patient population
- Advanced Practice Pharmacist – CDE, PGYs
- **Access to electronic medical records crucial to success**
- Cost – Pharmacist salary, space, support staff, equipment, EMR license
- Sustainability-APhA Foundation Project Impact Diabetes

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What element is crucial to assure that the pharmacist optimally benefits the patient and the team?

- Home visits
- Telecommunications/video conferencing
- Access to Electronic Medical Records ✔
- Grand Rounds

Project IMPACT – Diabetes APhA Foundation

- One of 25 organizations selected due to our success with the PSPC
- Used our established process of integrated care
- Included diabetes education and self-management curriculum
- Collected health measures and reported data on a monthly basis

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Zufall Project IMPACT-Diabetes

- Enrolled and followed 84 patients for one year
  - Average of 4 visits per patient
  - More >50% received action plans
- Results
  - HbA1c levels significantly reduced by 0.9% (p=.0002).
  - Improvements were seen in cholesterol and blood pressure (p=0.164, p=0.444)
  - 65.2% had eye exams, 84.2% had foot exams, and 70% received their flu vaccine
  - 28.6% of patients that smoked cigarettes quit smoking

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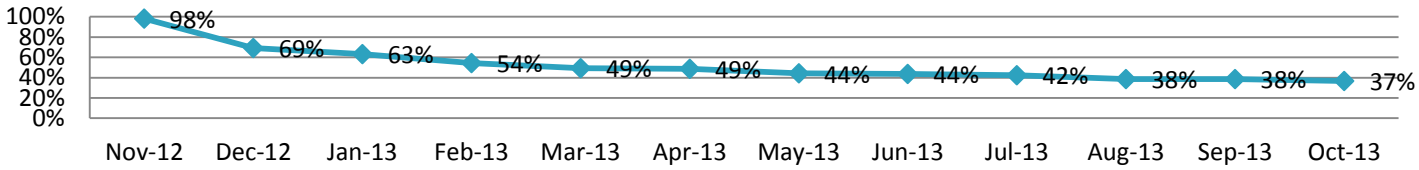
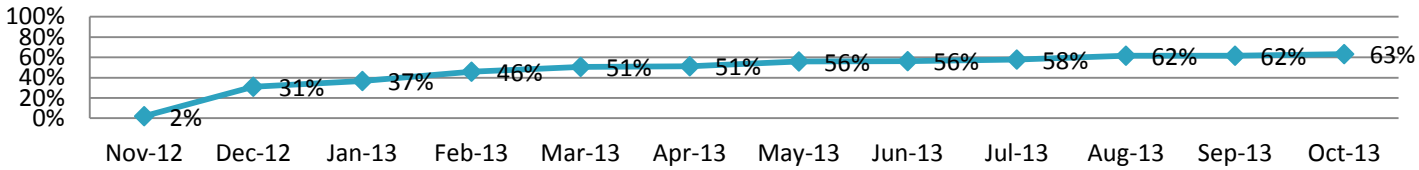
PSPC Outcomes –Diabetes

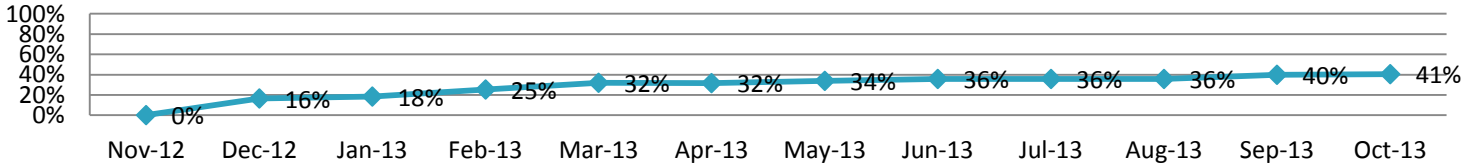
Percentage of patients in the PoF whose most recent hemoglobin A1c level is greater than 9% **37%**



Percentage Change/ Percentage Improvement (Percentage of patients with HbA1c <9%) **63%**

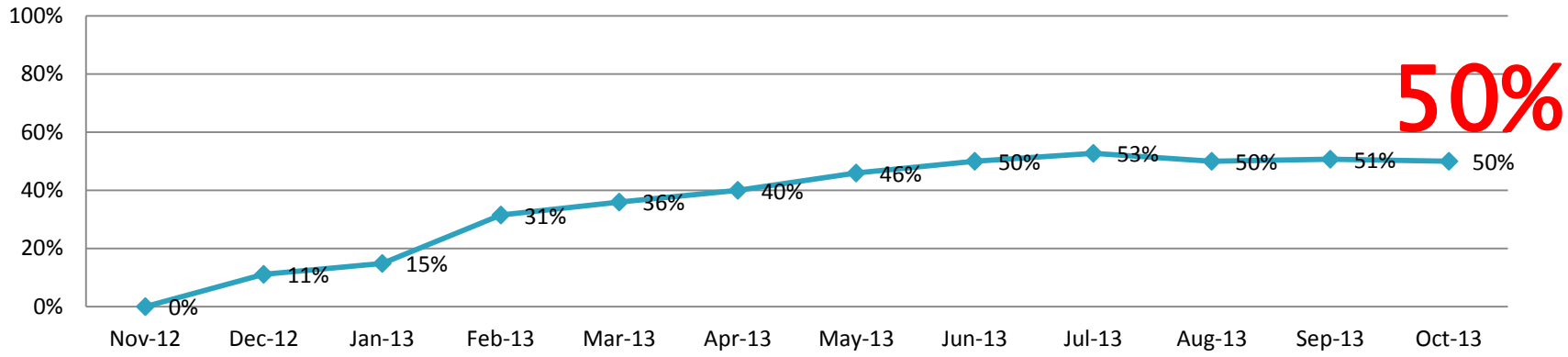


Percentage of patients in the PoF whose most recent hemoglobin A1c level is less than 8 % **41%**



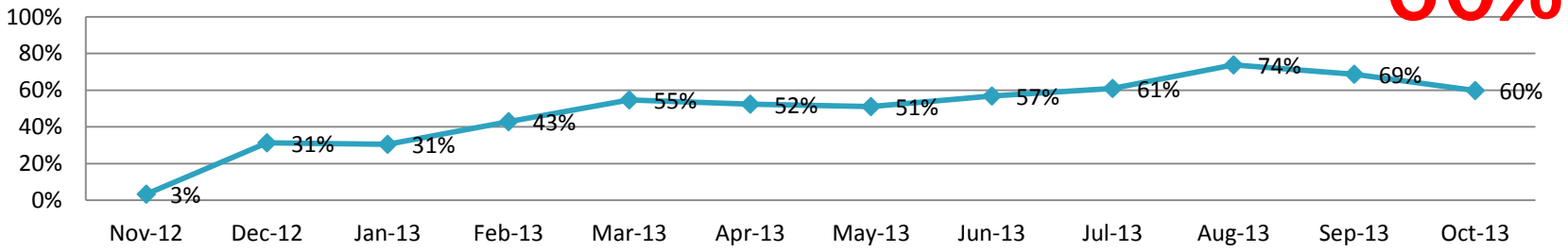
PSPC Outcomes – Cholesterol and Hypertension

Percentage of patients in the PoF whose LDL is at goal



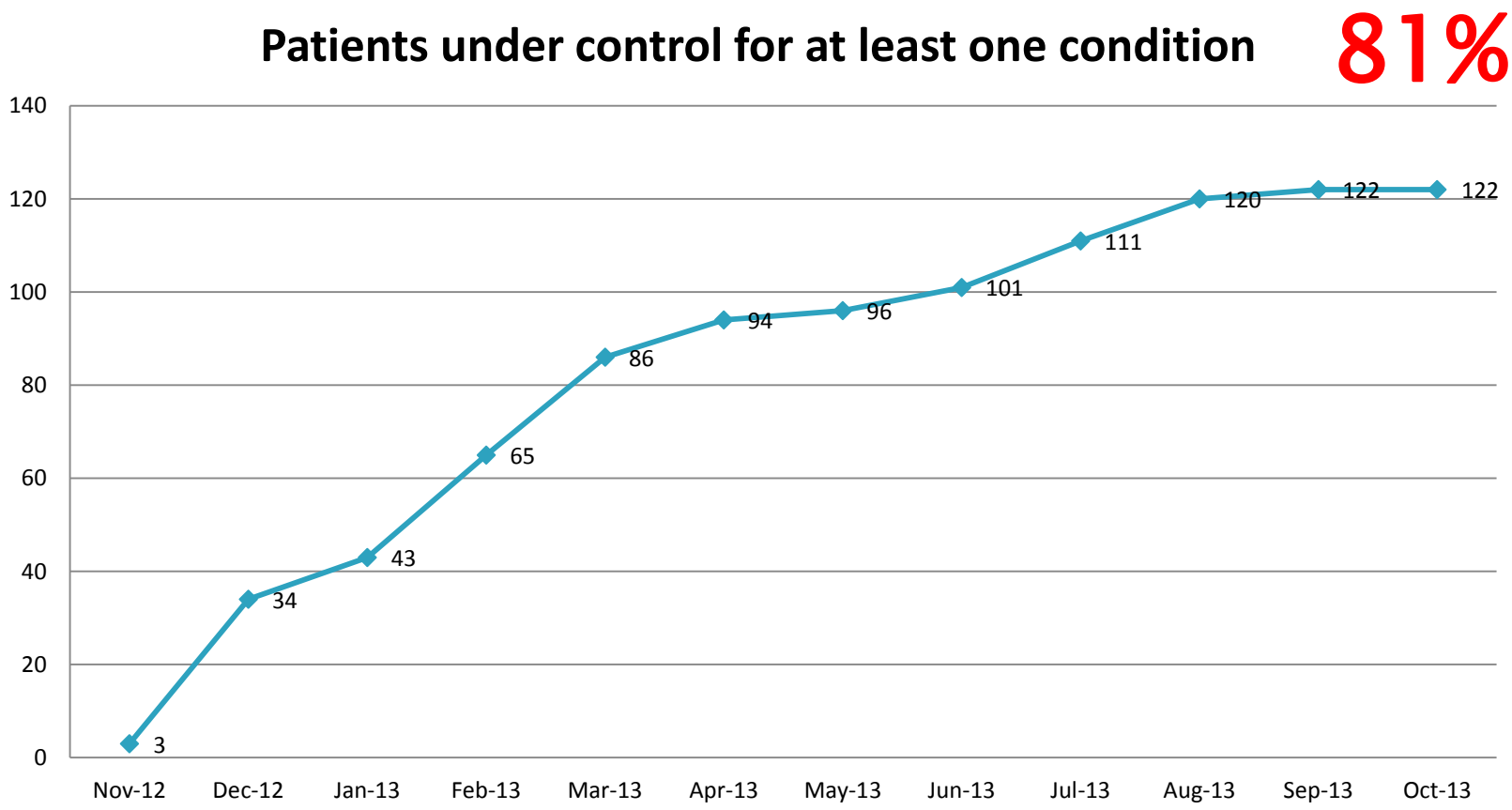
50%

Percentage of patients in the PoF whose most recent blood pressure is under 140/90



60%

PSPC Outcomes on All Conditions Followed



A pharmacist in the care team results in:

- Improves medication adherence
- Enhances patient safety
- Improves access to medications
- Enhanced self-management by the patient to accept drug and lifestyle changes regimen
- Increased efficiencies in the health care delivery model
- Improved screening and prevention services
- Added value to care- improved outcomes
- Decreased ED visits and hospitalizations

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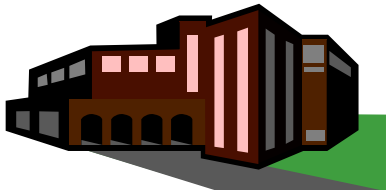
Value of CPS Integration in Primary Care

Reality	Savings
IMS Study -Medication misuse->$200B=8% costs	$200B= cost to insure 24 million uninsured Americans
CDC- non-adherence costs $2K/pt/physician/yr in extra visits	$35.7M (Zufall 85% of 21K patients) x1500 Health Centers=$53.6B
CDC- improved self management cost to savings ratio1:10	Cost to Savings Zufall est.$250,000/yr=$2.5M x 1500 Health Centers=$3.75B
2025- costs projected to double	Double all numbers by 2025

Next Steps to Include CPS in the Care Team

- Become a Teaching Site for Pharmacists



- Advanced Practice Students

- Introduce Annual Well Visits
- Increase Access to Care – Provider Status for Pharmacists

Questions?

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  - Rina Ramirez – rramirez@zufallhealth.org

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