

MTM STUDENT PHARMACY PROJECT

May 19, 2022

NDPhA NORTH DAKOTA
PHARMACISTS
ASSOCIATION

NDSU SCHOOL OF
PHARMACY

NORTH
Dakota | Health
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Agenda

- Pharmacy Project Overview
- Overview of Prediabetes, Diabetes and Hypertension
- Pharmacy Manual
- Virtual binder
- Patient Engagement/Data Tracking
- Questions

Housekeeping

- Please mute your phones/computers when not speaking
- This training is being recorded – and will be available for you to access after the training.
- When asking a question, please turn on your camera, if possible.



INTRODUCTIONS

NDSU School of Pharmacy: Dr. Elizabeth Skoy, Dr. Natasha Petry

North Dakota Pharmacists Association: Dr. Jesse Rue

North Dakota Dept of Health: Brianna Monahan and Tiffany Knauf



PHARMACY PROJECT OVERVIEW

Elizabeth Skoy, PharmD

1815 Student Scholarship Program

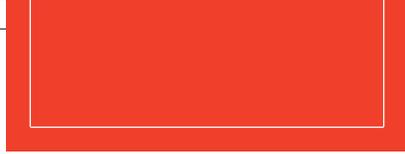
- Supported through a grant with the ND Department of Health (DP18-1815).
 - The purpose of this grant is to implement and evaluate evidence-based strategies to prevent and control diabetes and heart disease especially for underserved populations in North Dakota, through work with Health Systems, Pharmacies and community partners.
- Objective
 - To fulfill the mission of North Dakota State University as a land grant institution and serve the citizens of North Dakota by assisting pharmacists to expand the provision of community pharmacist delivered clinical services.
- Introduction of scholarship program to students (September)
- Scholarship applications
 - Matched 41 rotations
- Disbursement upon successful completion of all requirements
 - Successfully complete the rotation
 - Fulfill 1815 scholarship obligations (reports/surveys)

What will your rotation look like?

- Goal: Through collaboration between the North Dakota Department of Health (NDDoH), NDSU School of Pharmacy and community pharmacies, the goal is to improve policies and processes that help people control high blood pressure and cholesterol, and prevent or manage diabetes.
- Key objectives:
 - Through weekly patient encounters, we hope you will complete the following targets:
 - 5 hypertension/blood pressure interventions
 - 1 SMBP loaner cuff consultation and 2 SMBP trainings
 - 5 prediabetes screenings – with 1 referral to the National Diabetes Prevention Program (NDPP)
 - 2 diabetes interventions
 - 5 immunization reviews and delivery
 - 5 patient/provider follow-ups
 - 4 MTM workups (2 for each hypertension and diabetes)
 - These will be tracked weekly, and entered into an online survey platform. We'll go into depth on this later.



OVERVIEW OF PREDIABETES, DIABETES AND HYPERTENSION



PREDIABETES

Prediabetes

A condition marked by blood sugar above the normal range, but not so high as to be diagnosed as diabetes

Diagnosis criteria:

- Hemoglobin A1c 5.7% - 6.4%
- Fasting blood glucose 100 - 125 mg/dL
- 2-hour oral glucose 140 - 199 mg/dL

Prevalence:

- 88 million American adults (1 in 3) are estimated to have prediabetes
- >80% of patients with prediabetes have never been diagnosed and are unaware of their risk
- In ND, ~7.4% of adults have been diagnosed with prediabetes

Risk factors:

- Overweight and Obesity
 - Abdominal adiposity
- Being 45 years or older
- Family history of type 2 diabetes
- Hypertension (HTN)
- Being physically active less than 3 times a week
- History of gestational diabetes
- American Indians (AI) and Asian Americans are at increased risk for type 2 diabetes

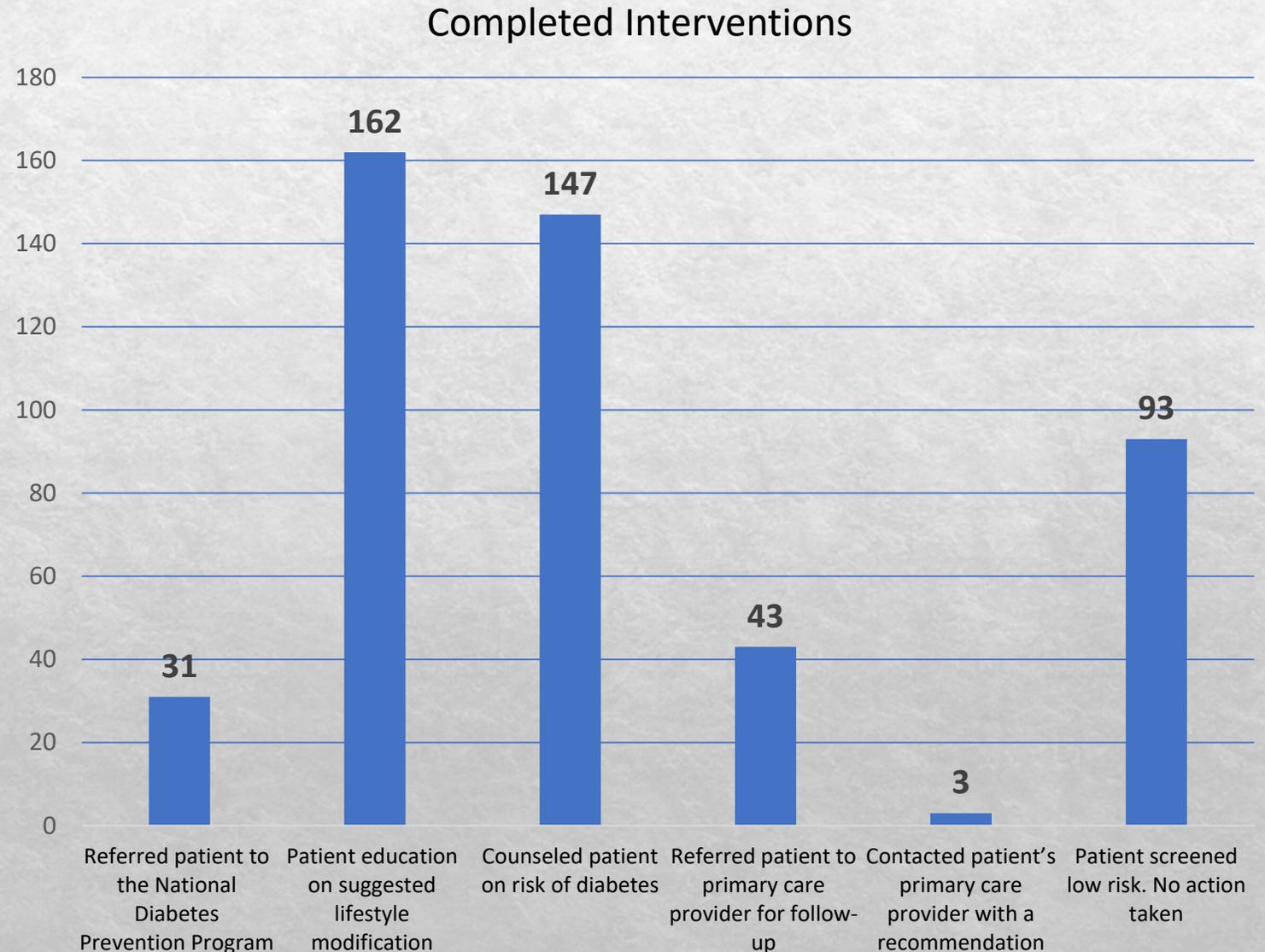
Prediabetes Case

- LW presents to the pharmacy to purchase some pseudoephedrine for allergies. Student offers prediabetes screening log. LW's prediabetes risk test score was a 6.
- Student counseled patient on risk of diabetes, provided patient education on suggested lifestyle modification, referred patient to primary care provider for follow up and referred patient to the National Diabetes Prevention Program.
- If point of care testing is available, could consider offering test for BG/A1c
- Student logged information in Prediabetes Screening Log

Prediabetes Student Data

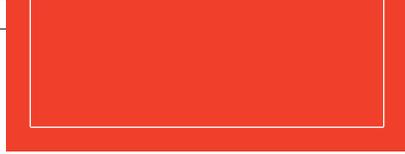
2021-2022

- # of Patients Screened: 255
 - # High Risk: 136
 - 53% of those screened
- How long did this intervention take?
 - Less than 3 minutes – (n=20)
 - 3 to 5 minutes – (n=42)
 - More than 5 minutes – (n=8)



Success Stories from Students

- I looked through the patient's labs and did not find an A1c value. I contacted the PCP and recommended ordering an A1c lab at the patient's next visit.
- I checked the blood glucose and it was 99. We had a long conversation about diet and exercise changes to his daily health plans.
- Patient does not have Medicare drug coverage. To save money, he states he doesn't take meds on one day each week. This doesn't line up with fill history (90DS every 150 days), however I didn't seem to change his mind. Trying to figure out other cost-effective options for him. Hopefully discussion about prediabetes risk and potential cost of diabetic medications will sway him to be more adherent with current medications.



DIABETES

Diabetes

Diagnosis criteria:

- HbA1c >6.4%
- Fasting blood glucose >126 mg/dL
- 2-hour oral glucose 140-199 mg/dL
- Random blood glucose level of > 200 mg/dL plus presence of symptoms

Prevalence:

- 34 million Americans have diabetes (about 1 in 10)
- Approximately 90-95% of cases are type 2 diabetes

Diabetes Control

- Well-controlled is typically HbA1c <7%
 - Avg BG 154 mg/dL (8.6 mmol/L)
- Target range may be more (A1c >6.5%) or less stringent (A1c <8%) depending on patient's:
 - Potential risk of hypoglycemia
 - Disease duration
 - Life expectancy
 - Comorbidities
 - Vascular complications
 - Preferences
 - Resources/support systems
- Health system quality metrics = HbA1c <9% (212 mg/dL)

Effective diabetes management requires:

- Routine care
- Multidisciplinary team approach
- Appropriate therapeutic interventions
- Medication adherence
- Self-monitoring
- Patient education
- Support system
- Appropriate lifestyle choices

Diabetes Case

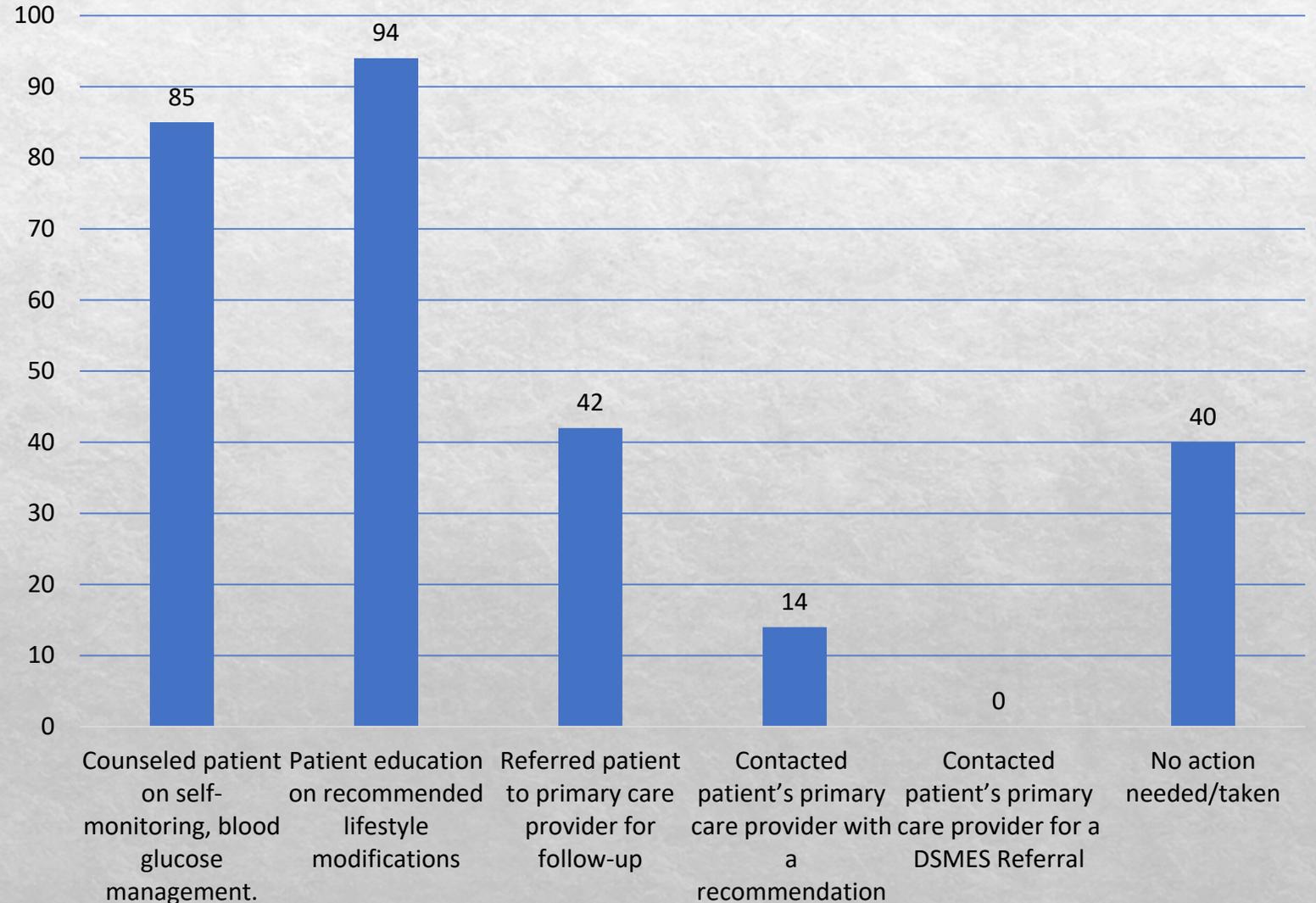
- CM is 57 years old and a well-known patient of the pharmacy. CM currently takes insulin glargine 18 units subcutaneously at bedtime. CM comes into the pharmacy today and when asked reports blood sugars are “fine.” After further prompting, CM reports a recent blood glucose of 258 fasting this morning (source: SMBG).
- Student counseled CM on SMBG management, provided patient education on recommended lifestyle modifications, and contact patient’s primary care provider with a recommendation to increase insulin glargine by 4 units.
- Next steps: provide follow up information to patient and student to log information in the Diabetes Assessment Log

Diabetes Student Data

2021-2022

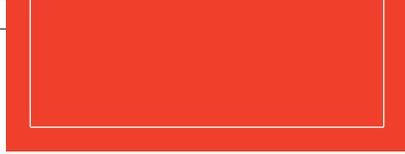
Completed Interventions

- # of Patients w/ Intervention: 159
 - Of the 154 pts that provided recent blood glucose or A1cs,
 - 49 were elevated (A1c > 7)
 - Source of A1cs
 - Patient Self-Report (n=52)
 - Patient medical record (n=90)
 - Unable to obtain (n=9)
- Estimated date of most recent A1c?
 - Less than 3 months (n=109)
 - 3-6 months (n=34)
 - 6-12 months (n=11)
 - More than 12 months (n=2)
- How long did this intervention take?
 - Less than 5 minutes – (n=24)
 - 5 to 10 minutes – (n=34)
 - More than 10 minutes – (n=10)



Success Stories from Students

- Patient was not administering insulin properly, he was not inserting the needle straight in and straight out and was instead bending the needle. I instructed him how to properly administer insulin.
- Patient was wondering if insulin pens or vials would be cheaper for her. I looked into it and found that the vials were cheaper. She prefers the pens as they are easier to draw up/measure for use with her insulin pump.
- I met with this patient for a diabetes initial visit. We reviewed his diabetic medications which were all going great for him and even helped his A1c drop from 11 to 8.4 since July. I explained to the patient about being on a statin and how it will help lower his cholesterol and triglycerides which he was struggling with dropping. I also spoke about the risk reduction for heart attack and stroke. He was onboard for adding a statin, so I followed up with his provider for this addition.
- Due to the patient's insurance, the patient's long-acting insulin was recently switched to a different long-acting insulin. The directions for the patient's old insulin had the patient injecting 10 units in the morning and in the evening, but the new directions had the patient injecting 10 units in the morning and 20 units in the evening. The patient experienced low blood sugars in the 50's and 60's and started taking her insulin as 10 units in the morning and evening. This resolved the low blood sugar issues and the patient's blood sugar reading were well controlled with her A1C being 6.2 as measured by lab prior to her visit with me. The pharmacist was able to adjust the patient's insulin dosing through a collaborative practice agreement and decreased the patient's insulin dose to how she is taking it. The provider was notified of this adjustment.



HYPERTENSION

Hypertension

Diagnosis criteria:*

- Two or more elevated readings at 2 separate appointments/locations.

<u>Category</u>	<u>Systolic</u>		<u>Diastolic</u>
Normal	Less than 120	AND	Less than 80
Elevated	120-129	AND	Less than 80
Hypertension (1)	130-139	OR	80-89
Hypertension (2)	140 or higher	OR	90 or higher
Hypertension Crisis	Higher than 180	AND/OR	Higher than 120

*Substantially higher prevalence of HBP under the new guideline (46% vs. 32% of adults)

Prevalence:

- 32.1% prevalence among US adults
 - 40.5% among adults 45-64
 - 65.9% among adults 65+
- 29.6% of ND adults reported ever being told by a doctor, nurse or other health professional that they have high blood pressure. (2017 ND BRFSS)

Hypertension

- **Control criteria:**

- The Systolic target <130 mm Hg and a Diastolic target of <80 mm Hg.

- **Control rates:**

- 22.7% of ND adults have UNCONTROLLED hypertension
- Across the US only about half of people with hypertension have it under control (61% with old guidelines, and 47% with new guidelines)

- **Why Hypertension Matters?**

- **First heart attack:** About 7 of every 10 people having their first heart attack have high blood pressure.
- **Heart failure:** About 7 of every 10 people with chronic heart failure have high blood pressure.
- **First stroke:** About 8 of every 10 people having their first stroke have high blood pressure.

Competencies for Accurate BP



Hypertension/Blood Pressure Case

- KJ presents to the pharmacy and student offers to take blood pressure. BP measured at 150/99 mmHg. KJ has history of hypertension and reports decent adherence to medication but is known to miss a dose or two a week (which is backed up when fill history is reviewed)
- Student counseled KJ on medication adherence and referred to PCP for follow-up. Student counseled KJ on at home BP monitoring and recommended follow-up screening at the pharmacy.
- Information entered into BP Log

Loaner cuff program

- 5 cellular loaner cuffs per pharmacy are available.
- We are utilizing the BodyTrace cellular cuff and the Diasyst platform to monitor.
- The cuffs are cellular and the interface is simple—no wifi, no bluetooth, just hit the Start button
- To begin, you will have access to add new patients to Diasyst. It's very easy, takes only a few minutes (truly).
- You can then access all of your patient data through Diasyst on the cloud at provider.diasyst.com
- To recycle a cuff, follow cleaning directions and send a support note with the patient MRN number to Diasyst to assign to a new patient when needed.
- **CONTACT: Jesse Rue (jrue@aboutthepatient.net) with ANY CHALLENGES.**
- There is an additional short training available to you on this platform.

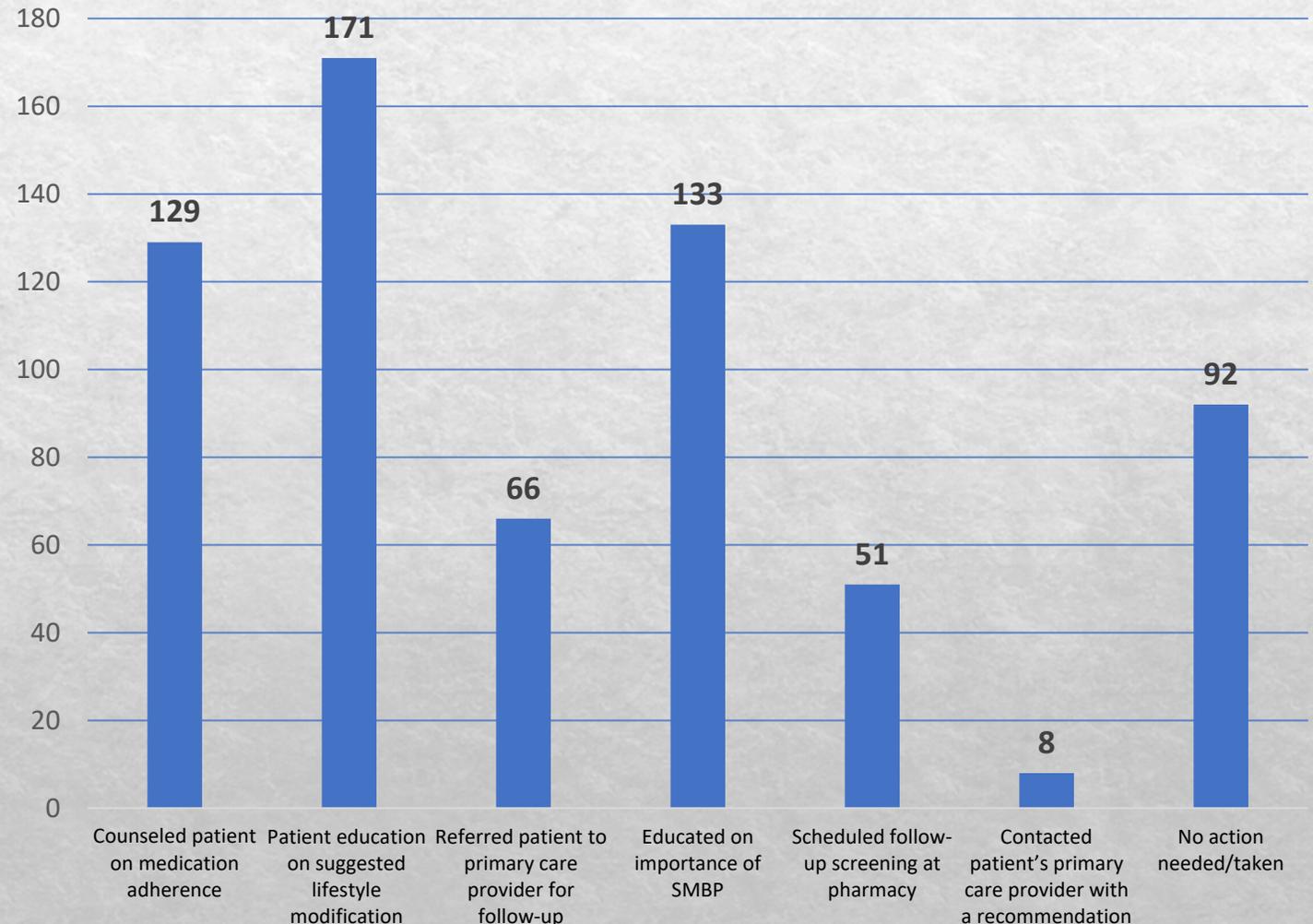


SMBP Case

- AB brought in SMBP readings from home. The last 3 BP readings were in the 140's for systolic and in the 80's for diastolic. Patient was on low dose of hypertension medication.
- Student contacted AB's PCP with recommendation for dose increase, educated patient on lifestyle modifications, demonstrated how to check for cuff accuracy, and logged information in SMBP Training Log.

Hypertension/High Blood Pressure Student Data 2021-2022

- # of Patients Screened: 316
 - Systolic BP: 273 had an elevated reading (greater than 120)
 - 86.4% were elevated
 - Diastolic BP: 164 had an elevated reading (greater than 80)
 - 51.9% were elevated
- Was the BP rechecked if elevated?
 - Yes, still elevated (n=93)
 - Yes, no longer elevated (n=22)
 - No, not rechecked (n=75)
 - Not elevated BP (n=114)
- How long did this intervention take?
 - Less than 3 minutes – (n=7)
 - 3 to 5 minutes – (n=58)
 - More than 5 minutes – (n=16)



Success Stories from Students

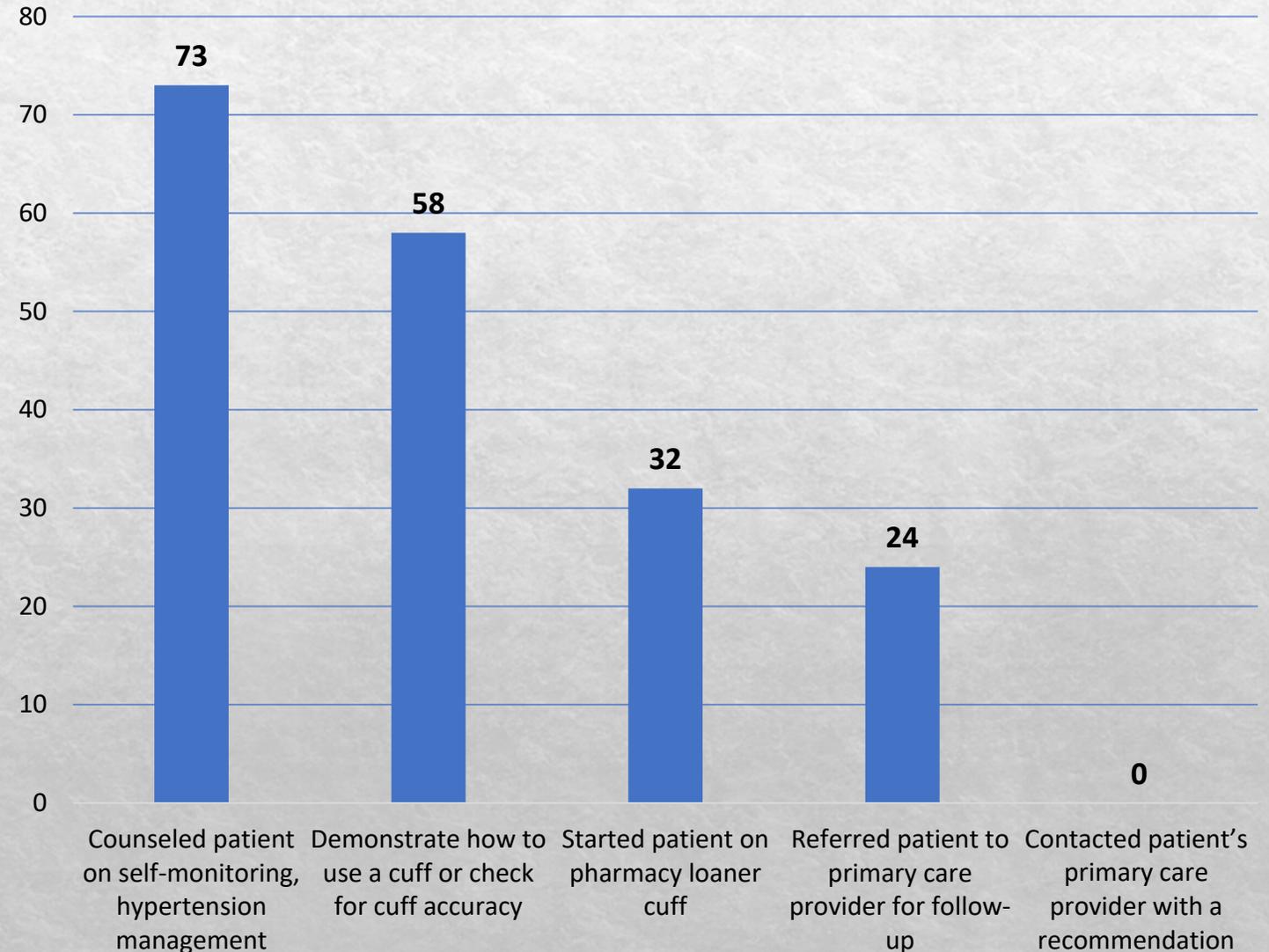
- Patient presented for MTM blood pressure of 150/88 upon repeat blood pressure after waiting 5 minutes and having patient try to relax blood pressure was 145/84. I reviewed patient's labs and current hypertension therapy and sent a recommendation to their PCP 1 to start spironolactone 25mg PO daily in this patient.
- Patient was extremely hypertensive; I took her blood pressure 2 different times, and she was feeling very anxious. Had her husband with her and I discussed going to the hospital that day and she said she had anxiety meds she wanted to take first and then if it did not help, she would go in. She was not a current patient of Gateways so I was unable to find her providers information at that time to discuss it with him.
- Contacted patient's provider regarding a contraindicated blood pressure medication the patient was prescribed and his current CHF diagnosis. His blood pressure was uncontrolled, and it could have been worsening his CHF so there was no reason for him to continue it at the time.
- Patient stopped taking one of her blood pressure medications due to feeling dizzy and not well after taking it. PCP had quadrupled the dose of the medication at the last visit (patient went from losartan 25 mg once daily to 50 mg BID). Pharmacy recommended that PCP reduce patient's dose to 50 mg once daily. Once patient is adherent to that dose, if blood pressure is still elevated, suggest further adjustments of blood pressure medications.

Self-Measured Blood Pressure Student Data

2021-2022

Completed Interventions

- # of Patients Screened: 76
 - Systolic BP: 75 had an elevated reading over 120
 - 98.7% were elevated
 - Diastolic BP: 60 had an elevated reading over 80
 - 78.9% were elevated
- Was the BP rechecked if elevated?
 - Yes, still elevated (n=42)
 - Yes, no longer elevated (n=2)
 - No, not rechecked (n=25)
 - Not elevated BP (n=7)
- Patient with Current HTN Dx?
 - 56 of the patients had a current Dx (73.7%)
- How long did this intervention take?
 - Less than 5 minutes – (n=10)
 - 5 to 10 minutes – (n=33)
 - More than 10 minutes – (n=5)



Success Stories from Students

- Patient's blood pressure was uncontrolled while consistently taking his medications (per patient). The patient was very frustrated because he mentioned he had spoken to his provider before about his consistently high blood pressure readings but said that the provider never changed his medications.
- Patient needed help choosing a BP monitor/cuff. Made recommendation and sold monitor to her.
- I contacted patient's primary care provider for a dose increase because his last 3 blood pressure readings have been in the 140's for SBP and in the 80's for DBP. And patient was not in the therapeutic dose range of his medication



IMMUNIZATIONS

Immunizations

- While immunizations are not the primary focus for the 1815 Enhanced MTM Rotation
 - Immunizations are important for individuals with chronic disease
- Lots of resources in your Virtual Binder
- You will be tracking these on your Student Weekly Task Log.



MEDICATION THERAPY MANAGEMENT (MTM) AND FOLLOW-UPS

HEALTH INFORMATION FORM
North Dakota State University School of Pharmacy

PATIENT INFORMATION

First three letters of first name:	Age:	Gender: M / F
Telephone:	Height:	Weight:
Primary care physician:	Date of last visit:	

SOCIAL DRUG USE

Tobacco Use:	Never	Type of tobacco:	Quit date:	If currently smoking, packs per day:	If currently smoking, tried to quit _____ times
Caffeine Use:	Never	Type of caffeine:	Cups/cans per day:		
Alcohol Use:	Never	Occasionally	Number of drinks/week	Do you ever drink more than three drinks per day? Yes/No	

ALLERGY INFORMATION

Allergies:	Cause:	Please Describe Reaction or Side Effect
	Medicine/Food/Preservative	(rash, nausea, constipation, drowsiness, dizziness, etc.)

MEDICATION INFORMATION

Please list ALL prescription and non-prescription medications, vitamins, and herbs

Medication	Strength	Directions	What you use it for

PERSONAL MEDICAL HISTORY

Please indicate if you have ever experienced any of the following conditions listed.

Anxiety	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Cancer	Yes	No
Bleeding disorder	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Epilepsy (seizures)	Yes	No
Glaucoma	Yes	No	Hay fever (allergies)	Yes	No
Heart attack (myocardial infarction)	Yes	No	Heart failure	Yes	No
High blood pressure (hypertension)	Yes	No	High cholesterol (Hyperlipidemia)	Yes	No
Insomnia	Yes	No	Kidney disease	Yes	No
Lung disorder (COPD/emphysema)	Yes	No	Migraine headaches	Yes	No
Osteoporosis	Yes	No	Stroke	Yes	No
Thyroid disorders	Yes	No	Ulcers or heartburn /GERD	Yes	No
Attention deficit disorder/ADHD	Yes	No	Chronic pain	Yes	No
Other:			Other:		

Do you currently exercise?	Never	Regularly	Times per week:	Average number of minutes per workout:
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Immunization History: Screened by pharmacy

Review of Systems

Please circle if you are CURRENTLY experiencing any of the following.

General	Weight gain/loss	Headache	Head, Ear, Eye	Changes in vision	Changes in hearing
Cardiovascular	Fatigue	Dizziness	Respiratory	Sore mouth	Bloody nose
	Chest pain	Palpitations		Shortness of breath	Cough
Digestive	Dizzy when rising	Bleeding	Mood	Wheezing	Sputum
	Heartburn	Nausea/vomiting		Chest Tightness	
Extremities	Abdominal pain	Diarhea	Muscles/Bones	Changes in sleep pattern	Suicidal thoughts
	Constipation			Difficulty focusing	Anxiety
Neuro	Excessive bruising	Numbness/tingling	Genitourinary	Back pain	Joint pain
	Rash	Foot sores		Muscle weakness	Muscle pain
	Memory loss	Fainting		Muscle cramps	
	Migraine headaches			Blood in urine	Impotence
				Incontinence	Burning

To be Completed at the Pharmacy

Immunizations needed per screening:		Blood Pressure	
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Health Information Form

Drug Therapy Problem Identification

Drug Therapy Problem

Dosage Too Low

- Wrong dose
- Frequency inappropriate
- Drug interaction
- Duration inappropriate
- Incorrect administration

Dosage Too High

- Wrong dose
- Frequency inappropriate
- Duration inappropriate
- Drug interaction
- Incorrect administration

Ineffective Medication

- More effective drug available
- Condition refractory to drug
- Dosage form inappropriate
- Not effective for condition
- Contraindication present

Needs Additional Drug Therapy

- Untreated condition
- Preventative/prophylactic
- Immunizations
- Synergistic/additive effect

Unnecessary Drug Therapy

- No medical indication
- Duplicate therapy
- Nondrug therapy indicated
- Addictive/recreational
- Treating avoidable ADR

Experiencing Adverse Drug Reaction

- Undesirable effect
- Unsafe drug for patient
- Drug interaction
- Dose administered/changed too rapidly
- Allergic reaction
- Contraindications present
- Incorrect administration

Adherence

- Directions not understood
- Patient prefers not to take
- Patient forgets to take
- Cannot swallow/administer
- Drug product not available
- Inappropriate administration technique

Cost Containment

- Patient cannot afford
- Generic alternative available
- Pill splitting indicated
- More cost effective medication available

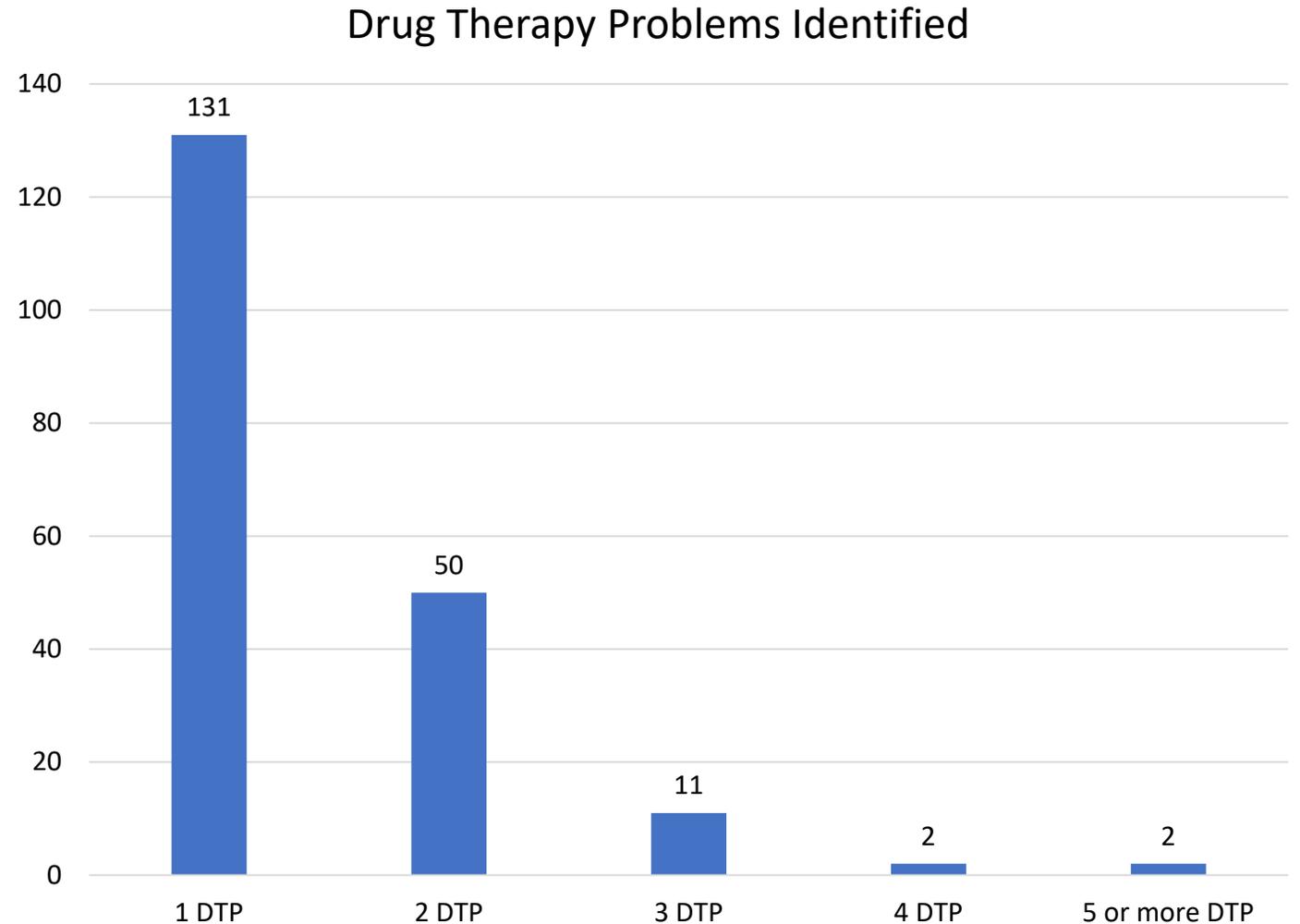
Summary:

Provider contacted YES / NO

MTM – Student Interventions

2021-2022

- ◆ 214 MTMs conducted
 - ◆ Provided thru 3rd Party:
 - ◆ Medicaid (n=8)
 - ◆ Payable Platform (n=147)
 - ◆ Not paid (n=48)
 - ◆ Chronic Disease Addressed:
 - ◆ Hypertension (n=151)
 - ◆ Diabetes (n=104)
 - ◆ High Cholesterol (n=71)
 - ◆ How long did this intervention take? *
 - ◆ Less than 15 minutes – (n=68)
 - ◆ 15 to 30 minutes – (n=103)
 - ◆ 30 to 45 minutes – (n=39)
 - ◆ 45 to 60 minutes – (n=2)
 - ◆ More than 60 minutes – (n=2)



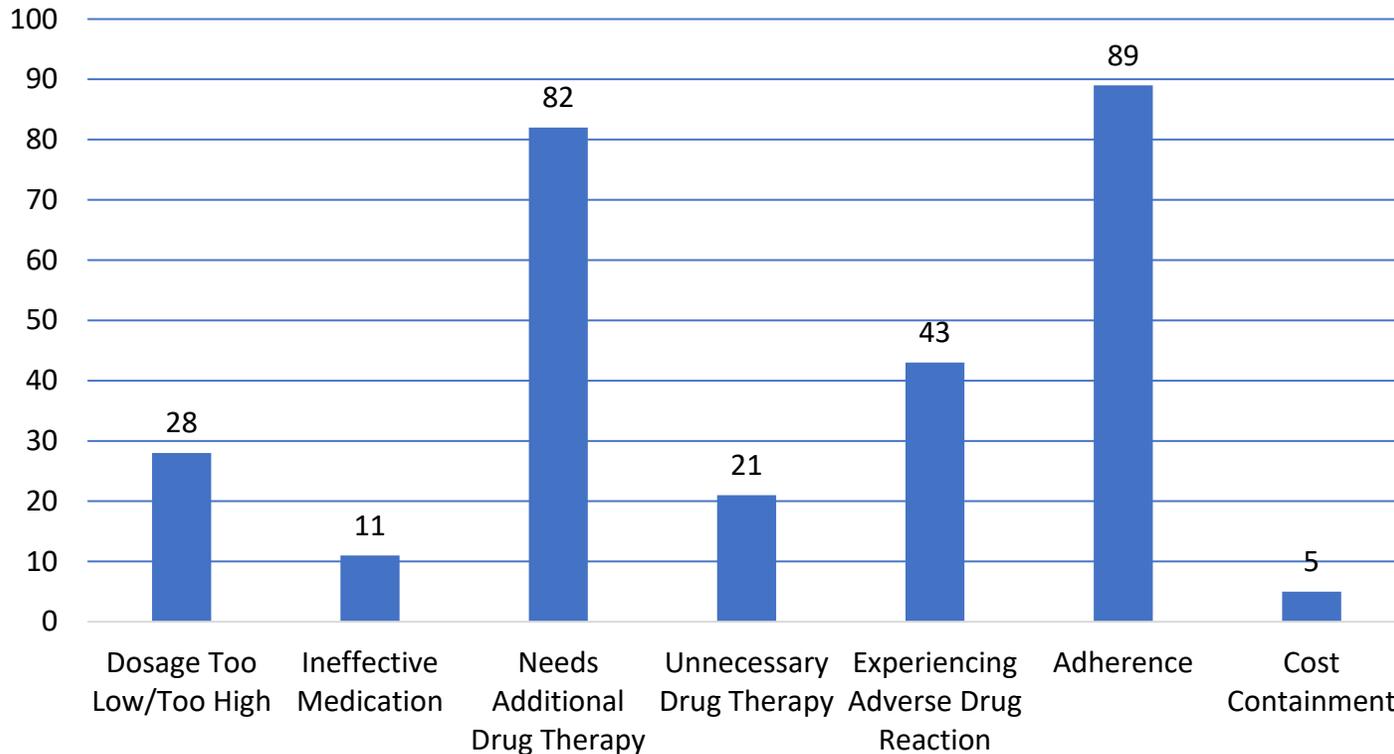
MTM – Student Interventions

2021-2022

◆ Drug Therapy Problems

◆ A total of 282 were identified

Drug Therapy Problems Identified



- ◆ Dosage Too Low/Too High (n=28)
 - ◆ Wrong dose (n=13)
- ◆ Ineffective Medication (n=11)
 - ◆ More effective drug available (n=4)
- ◆ Needs Additional Drug Therapy (n=82)
 - ◆ Untreated condition (n=16)
 - ◆ Preventative/prophylactic (n=14)
 - ◆ Immunizations (n=42)
- ◆ Unnecessary Drug Therapy (n=21)
 - ◆ No medical indication (n=3)
 - ◆ Duplicate therapy (n=10)
- ◆ Experiencing Adverse Drug Reaction (n=43)
 - ◆ Undesirable effect (n=24)
- ◆ Adherence (n=89)
 - ◆ Directions not understood (n=10)
 - ◆ Inappropriate administration technique (n=6)
 - ◆ Patient prefers not to take (n=9)
 - ◆ Patient forgets to take (n=53)
- ◆ Cost Containment (n=5)

Patient/Provider Follow-Ups

- Patient Follow-Up
- Provider Follow-Up
- Multiple "widgets" per patient, if applicable.
- Medication effectiveness/appropriateness
- Adherence
- Clinical endpoints and outcomes of care
- Achievement of goals

Patient/Provider Follow-Ups Target: 5+/week

Date	Chronic Disease(s) addressed:	Who was followed up with?	Action taken (see codes below and list all that apply)	Relevant notes:
	HTN DM Chol.	Patient Provider		
	HTN DM Chol.	Patient Provider		
	HTN DM Chol.	Patient Provider		
	HTN DM Chol.	Patient Provider		
	HTN DM Chol.	Patient Provider		
	HTN DM Chol.	Patient Provider		

1. Patient had visit with provider.
2. Patient had chronic disease (lab/BP) rechecked with provider.
3. Medication was adjusted by provider, counseled patient on new medication.
4. Patient/provider did not discuss.
5. Patient reported following lifestyle modification recommendations.
6. Patient reported increased medication adherence.
7. Need to follow-up with patient/provider again.
8. Patient has appointment scheduled.
9. Patient reported adverse health event.
10. Other: _____



ADDITIONAL TRAININGS

Blood Pressure Protocol Training

- Created in conjunction with the ND Million Hearts Program, and in collaboration with the ND Department of Health.
- Over 2,700 medical and allied health professionals have attended.
- Evaluations indicate that over 92% of attendees were taking blood in accurately and WILL make a change to their process.
- Training Objectives:
 - Identify prevalence of Hypertension in ND
 - Explain why accuracy in measurement of blood pressure is critical
 - Identify lifestyle recommendations to lower blood pressure
 - Recommend tools for education, workflows & review approved community-based protocol
 - Demonstrate proper sizing of BP cuffs and demonstrate proper technique for taking blood pressure in an ambulatory setting
 - Discuss alternate blood pressure measurement sites
- **Will be available for you to watch virtually on our 1815 MTM Student Rotation Website!**

Motivational Interviewing Training

Skills Taught:

- Asking open-ended questions
- Reflective listening
- Showing empathy
- Building trust
- Establishing and maintaining a non-judgmental tone

Chronic Disease Issues:

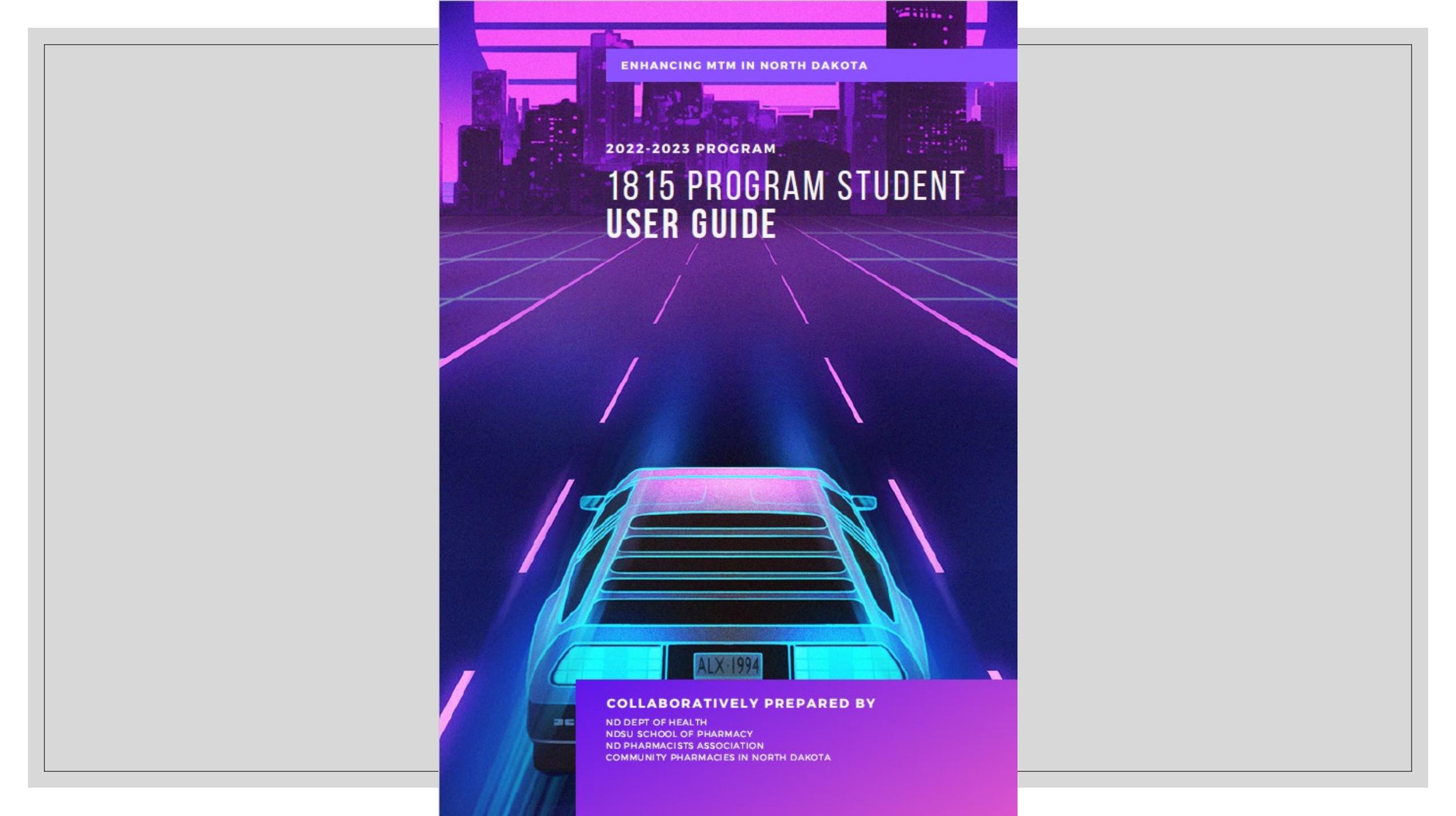
- Medication Adherence
- Nutrition & Physical Activity
- Obesity
- Diabetes Management
- Cardiovascular Disease
- Smoking Cessation

Chronic Disease Conversation Skills prepares health professionals to use motivational interviewing (MI) techniques to guide patients toward healthy changes. This learning experience provides practice with four virtual patients, building learners' skills and confidence having real-world, complex conversations.





PHARMACY MANUAL



ENHANCING MTM IN NORTH DAKOTA

2022-2023 PROGRAM

1815 PROGRAM STUDENT USER GUIDE

COLLABORATIVELY PREPARED BY

ND DEPT OF HEALTH
NDSU SCHOOL OF PHARMACY
ND PHARMACISTS ASSOCIATION
COMMUNITY PHARMACIES IN NORTH DAKOTA

Weekly Targets

The infographic is a blue-to-teal gradient rectangle containing seven white circles with black outlines, each containing a number. To the right of each circle is a bold title and a description of the target. The targets are: 4 MTM Workups, 5 Blood Pressure Assessment, 5 Prediabetes Screen + Refer, 2 Self-Measured BP Loaner+Education, 5 Immunizations, 2 Diabetes Assessment, and 5 Patient/Provider Follow-ups.

4	MTM WORKUPS 2-HYPERTENSION PTS PER WEEK 2-DIABETES PTS PER WEEK	5	BLOOD PRESSURE ASSESSMENT TAKE 5 BLOOD PRESSURES EACH WEEK
5	PREDIABETES SCREEN + REFER SCREEN 5 PER WEEK REFER 1 PER WEEK (NDC3)	2	SELF-MEASURED BP LOANER+EDUCATION 1 OF EACH PER WEEK
5	IMMUNIZATIONS SCREEN AND OFFER TO DELIVER 5 PTS VACCINES BEYOND FLU EACH WEEK	2	DIABETES ASSESSMENT REVIEW MOST RECENT A1C 2 PER WEEK
5	PATIENT/PROVIDER FOLLOW-UPS ...THOSE REFERRALS OR RECOMMENDATIONS YOU MADE? REFERRING ISNT ENOUGH, FOLLOW-UP TO MAKE SURE IT ACTUALLY HAPPENED! 5 FOLLOW UPS PER WEEK, CAN BE ON MTM OR NEED FOR LABS, ETC.		

DO MORE. WITH ONE PATIENT

LET'S GET EFFICIENT. LET'S GET CRAFTY. LET'S GET RELENTLESS.

HOW CAN I DO THIS? HOW CAN I HIT THESE NUMBERS
EACH WEEK?

THERE WERE INDEED CHALLENGES

WE SURE AREN'T PERFECT. HELP MAKE US MORE PERFECT.

WHAT DIDN'T WORK SO GREAT IN THE FIRST YEAR DID
GET BETTER IN THE SECOND.

It's not all rainbow skies and gumdrop smiles here in the pharmacy. We do have areas of improvement from the pilot and we think you can do it.

FOLLOW UP AND EVALUATION

WE'RE HERE TO SUPPORT YOUR WORK. AND COLLECT YOUR DATA.

WE WANT TO KNOW ABOUT THE IMPACT YOU'RE MAKING

At the end of each week we need you to complete the data spreadsheet and rotation survey. We're asking nicely but it's required. You signed a paper promising to do it, and we believed you.

At the end of the rotation please complete final data spreadsheet, and rotation survey. Again, asking nicely (but it's required).

BLOOD PRESSURE ASSESSMENT

TAKE SOME BP. NOT GOOD? RECHECK! HELP THEM!

TRY LOOKING THROUGH THE PICK-UP BINS TO SEE WHO IS ON HTN MEDS. TARGET THEM WITH A NOTE TO DO A BP AT PICKUP.

MANY STUDENTS SUCCEED AT ASKING PATIENTS TO DO A BP DURING COUNSELING SESSIONS. TECHS MAY HELP WITH RECRUITING AS WELL.

SCREEN 5 EACH WEEK

IF BP IS ELEVATED, RECHECK IT. MAKE A PLAN FOR FOLLOWUP AND THEN FOLLOW UP! USE THE BLOOD PRESSURE SCREENING ALGORITHM TOOL TO HELP.

WE KNOW YOU KNOW HOW TO TAKE A BP. **WE BELIEVE THERE IS GREAT EDUCATIONAL VALUE IN CONVINCING PEOPLE TO LET YOU CARE FOR THEM** AND IN ACTUALLY FINDING A WAY TO DO SOMETHING WITH THE DATA...ACTIVATING THE PATIENT TO TAKE ACTION HAS ENORMOUS VALUE!

SMBP TRAINING + LOANER

SMBP IS THE GOLD STANDARD AND GIVES CREDIBILITY



HEY, A LOT OF PEOPLE DON'T WANT TO SPEND THE COIN TO BUY A BLOOD PRESSURE CUFF. WE GET IT.

THAT'S WHY WE ARE INSTALLING BP CUFF LOANER PROGRAMS FOR SMBP (SELF-MONITORED BLOOD PRESSURE).

EACH WEEK, RECRUIT A PATIENT TO JOIN THE LOANER PROGRAM.

THIS IS A GREAT AREA FOR FOLLOW-UP. YOU WILL BE ABLE TO VIEW PATIENT BP READINGS IN REAL TIME THROUGH THE CLOUD, WHICH GIVES YOU HARD DATA TO HAVE BETTER CHATS WITH THEIR MEDICAL STAFF.

PATIENTS WILL HAVE THE CUFFS FOR 2-3 WEEKS. DEFINITELY BE SURE TO FOLLOW UP WITH PATIENTS AT LEAST WEEKLY ABOUT THEIR READINGS AND TO REMIND THEM TO KEEP TESTING. ALSO FOLLOW UP TO ENSURE THE CUFFS ARE RETURNED. **WE HAVE A [SHORT VIDEO](#) ONLINE TO HELP.**

**TRAIN 1
LOAN 1**

PREDIABETES SCREEN + REFER

SCREENING IS GOOD. BUT IT CAN BE BETTER.

PERFORM PREDIABETES SCREENING AT MED PICKUP OR MEDICATION COUNSELING SESSION. WORKS PRETTY WELL.

REFER AGREEABLE PATIENTS TO NATIONAL DIABETES PREVENTION PROGRAM (NDPP) THROUGH NDC3.ORG

SCREEN 5 REFER 1

...ACTUALLY REFER, THOUGH...TALK PAST THE SALE AND SEND IN THEIR INFO TO THE COORDINATOR VIA NDC3.ORG UNLESS THEY REALLY REFUSE.

WE THINK THAT'S WHERE THE EDUCATIONAL VALUE FOR YOU REALLY IS...ANYONE CAN ADMINISTER THE SCREENING, BUT ACTUALLY ACTIVATING THE PATIENT TO GET INTO THE PROGRAM? DIFFICULT. GET GOOD AT IT AND IT WILL BENEFIT YOUR ENTIRE CAREER.

AS NOT EVERY PATIENT WILL COMPLETE SCREENING, WE SUGGEST IDENTIFYING AT LEAST 5 MEN AND 5 WOMEN \geq 50 YEARS OLD TAKING HTN MEDS WEEKLY IN AN ATTEMPT TO SCREEN AT LEAST 5 TOTAL PER WEEK.

DIABETES ASSESSMENT

GET THOSE A1C'S UP TO DATE



CHECK FOR RECENT A1C

EACH WEEK, TARGET TWO DIABETES PATIENTS FOR AN A1C REVIEW

YOU CAN REVIEW THE PATIENT A1C ON NDHIN

IF IT'S NOT UP TO DATE, YOUR PHARMACY IS SUPPLIED WITH POC A1C TESTS THROUGH THIS PROGRAM SO YOU CAN CHECK ON THE SPOT

THIS ALLOWS YOU TO CLOSE A VERY COMMON GAP IN DIABETES CARE, GIVES YOU OPPORTUNITY TO FOLLOW UP WITH PATIENT AND PROVIDER, AND PERHAPS EVEN GETS YOU TO PERFORM A POC TEST IN THE PHARM.

IMMUNIZATION SCREENING

SCREEN. STICK. REPEAT.



USE THE NORTH DAKOTA IMMUNIZATION INFORMATION SYSTEM (NDIIS) TO SCREEN 5 PATIENTS PER WEEK FOR IMMUNIZATION NEEDS.

SCREEN AND ADMINISTER

FOR ANY GAPS IDENTIFIED, RECRUIT PATIENTS FOR A VACCINE VISIT AND ADMINISTER THE NEEDED VACCINE(S).

FLU VACCINE AND COVID NEEDS DON'T COUNT. THEY'RE JUST TOO EASY TO GET. WE NEED TO LOOK AT SOME CHRONIC DISEASE NEEDS.

PATIENT/PROVIDER FOLLOW-UP

CLOSE THE LOOP. ADVOCATE FOR YOUR PATIENTS.

FOLLOW-UP WITH GUSTO

EACH WEEK, LOOK FOR 5 RECOMMENDATIONS/REFERRALS/PATIENTS WHO JUST NEED MONITORING OF THEIR CARE. FOLLOW UP WITH THE PATIENT AND/OR PROVIDER AS APPROPRIATE.

WE NEED YOU TO MOVE US PAST MAKING A RECOMMENDATION ALONE AND MOVING ON. WE NEED YOU TO ADVOCATE FOR YOUR PATIENTS BY ENSURING THAT IF THEY NEEDED AN APPOINTMENT OR SOME LAB WORK OR A MED CHANGE THAT IT GOT ADDRESSED. SOMETIMES A PATIENT PHYSICIAN ULTIMATELY DISAGREES WITH YOUR RECOMMENDATION AND DECLINES IT--THAT'S OK, WE JUST HAVE TO MAKE SURE WE GET PAST THE POINT WHERE PATIENTS SAY 'I'LL THINK ABOUT IT' AS THEY LEAVE THE PHARMACY.

REMEMBER, THERE WERE HUNDREDS OF DRUG THERAPY PROBLEMS IDENTIFIED BY STUDENTS LAST YEAR. IDENTIFYING PROBLEMS ISN'T GOING TO BE ENOUGH FOR PHARMACY IN THE FUTURE, **YOU'RE GOING TO INCREASINGLY BE RESPONSIBLE FOR RESULTS.** STAND UP FOR THOSE PATIENTS, LET A LITTLE BIT OF BULLDOG OUT AND KEEP FOLLOWING UP.

CLOSE THE LOOP!

MTM EXPANSION

MAKE MTM MATTER A BIT MORE.



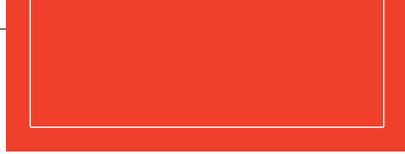
THE GOAL IS TO **COMPLETE 2 HTN REVIEWS AND 2 DIABETES REVIEWS EACH WEEK.**

IF THERE ARE PAID CMR OPPORTUNITIES ON DM OR HTN PATIENTS AT THE PHARMACY, GREAT!

TWO DM MTM
TWO HTN MTM

IF NOT, THEN RECRUIT PATIENTS FOR A HIGH QUALITY CMR TO GET THEM CLOSER TO GUIDELINE CARE.

MANY STUDENTS HAD SUCCESS IN DOING THE WORKUPS FIRST AND THEN ATTACHING THEM TO THE BAG FOR A DISCUSSION. THE SKY IS THE LIMIT, TEST YOURSELF TO FIND INNOVATIVE METHODS TO CONNECT.



VIRTUAL BINDER OF RESOURCES

Binder Overview

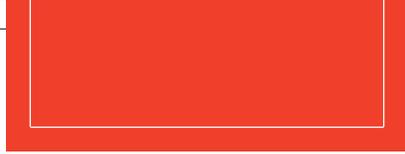
- Program Contact Information
- Enhancing MTM: Pilot Program User Guide
- Pharmacy Rotation: Forms, Documents and Data Collection
 - Paper forms for Qualtrics Patient Care
 - Health History/MTM form
 - DTP identification form
- Pharmacists Patient Care Process
- Immunization Resources
- Hypertension and Self-Measured Blood Pressure Resources
- Prediabetes Resources
- Diabetes Resources
- Lifestyle Modification Resources
- Motivational Interviewing Resources
- Copy of Student MOU

Virtual Binder

1815 MTM Pharmacy Student/Preceptor Training

May 19, 2022

[Virtual Binder](#)



QUESTIONS?

MTM STUDENT PHARMACY PROJECT

Patient Engagement

NDPhA NORTH DAKOTA
PHARMACISTS
ASSOCIATION

NDSU SCHOOL OF
PHARMACY

NORTH
Dakota | Health
Be Legendary.™

How to Engage

- Think about how to take this to the next level.
- There are no perfect patients.
 - What are you able to help them with?
- How do you use what you know about patients to engage with them?
 - What is their motivation?
 - Do you need to help them identify their motivation?
 - Communication
 - Patient friendly language
 - Health Literacy
 - Cultural considerations/preferences
 - Build Rapport
 - Meaningful and achievable goals for patient

"A strong clinician-patient relationship is the cornerstone to any successful patient engagement and therapeutic paradigm, including participation in the decision-making process and patient adherence to treatment recommendations."
(Figge, 2016)



The Importance of Patient Follow-Up Care

- Timely follow-up with patients is vital for ensuring they're **moving forward** with the prescribed treatment plan, such as undergoing testing and taking their medications. In addition to increasing the likelihood of a **positive outcome**, a medical follow-up is critical for **minimizing safety and liability concerns**.
 - By [Gallagher Healthcare](#)



Patient interaction

- Follow-up
 - Not just “screening to screen”
- Responsibility as a health professional
- Have those difficult conversations
 - The more you practice, the easier it becomes
- Lessons Learned
- Gaps



Reporting Requirements

- [Pre-Rotation Survey](#)
- Patient care tracking
 - [Student Weekly Task Log](#)  
 - [MTM Health Information Form](#)  
 - [Drug Therapy Problem Worksheet](#)  
- [Post Rotation Survey](#)
- Others
 - Ratings of preceptor
 - Reflection
 - Preceptor rating of students

Outcomes

- Weekly data tracking reports
- No patient identifiers reported to us

Determined by the Institutional Review Board (IRB) at NDSU as quality control.

HEALTH INFORMATION FORM
North Dakota State University School of Pharmacy

PATIENT INFORMATION					
First three letters of first name:			Age:	Gender: M / F	
Telephone:			Height:	Weight:	
Primary care physician:			Date of last visit:		
SOCIAL DRUG USE					
Tobacco Use:	Never	Type of tobacco:	Quit date:	If currently smoking, packs per day:	If currently smoking, tried to quit _____ times
Caffeine Use:	Never	Type of caffeine:		Cups/cans per day:	
Alcohol Use:	Never	Occasionally	Number of drinks/week		Do you ever drink more than three drinks per day? Yes / No
ALLERGY INFORMATION					
Allergies:	Cause:		Please Describe Reaction or Side Effect		
	Medicine/Food/Preservative		(rash, nausea, constipation, drowsiness, dizziness, etc.)		
MEDICATION INFORMATION					
Please list ALL prescription and non-prescription medications, vitamins, and herbs					
Medication	Strength	Directions		What you use it for	

Surveys for Performance Tracking

[MTM Student Data Tracking](#)

Blood Pressure Assessment Log, Target: 5+/week Week 2

Date	Initial Blood Pressure in mmHg	If BP is over 140/90, was the BP retaken? <small>Yes still elevated, Yes no longer elevated, No, not rechecked</small>	Action taken (see codes below and list all that apply)	Relevant notes
2/14	131/84		2	
2/15	122/68		7	
2/16	124/70		7	on BP weeks
2/16	131/80		2	

1. Counseled patient on medication adherence
 2. Patient education on suggested lifestyle modification
 3. Referred patient to primary care provider for follow-up
 4. Counseled patient on at-home BP monitoring
 5. Scheduled follow-up screening at the pharmacy at a later date
 6. Contacted patient's primary care provider with recommendation(s)
 7. No action needed/taken.
 8. Other: please describe

(one of each)

Surveys for Performance Tracking

Prediabetes Screening Log, Target: 5+/week including 1 NDPP referral

Date	Prediabetes risk test score	Action taken (see codes below and list all numbers that apply)	Relevant notes
11/16	7	4, 3	
11/17	5	1, 2	
11/17	7	3, 2	Pt was aware of risks, Plans to inc physical activity
11/18	8	2, 3, 4	
11/19	3	2, 3	

Surveys for Performance Tracking

Medication Therapy Management (Comprehensive Medication Review)

Target: 2+ /week for each hypertension and diabetes

Date	Chronic Disease(s) addressed:	Was the MTM done thru...? Medicaid, Payable Platform, Not paid.	Complete Drug Therapy Problem worksheet. Relevant notes:
3/22	HTN DM Chol.	Payable Platform	no drug therapy problems. Patient adherent
3/22	HTN DM Chol.	Payable Platform	don decrease on Brilinta, notified patient of new Rx for next fill.
3/22	HTN DM Chol.	Payable Platform	CMR, patient on acyclovir treatment for cold sores, she stated one tube lasts 1-2 years. I told her to monitor the expiration date.
3/23	HTN DM Chol. Asthma	Medicaid	Non-adherent to asthma medication. Patient forgets to take so we discussed strategies to help him remember.

Questions?

- Scholarship money awarded
- Scholarship banquet (attendance)
- How often will we be checking in on them? 1-2 times per rotation.
 - Who will monitor Qualtrics? Tiffany Knauf and Dr. Skoy
- Who do they contact with issues?
 - Preceptor (day to day questions, patient specific questions)
 - NDSU (start here if preceptor can't answer and/or issue with preceptor)
 - NDPhA (manual or process questions for implementation)
 - NDDoH (survey functionality issues)



QUESTIONS?



Thank
you!