MTM STUDENT PHARMACY PROJECT

May 18, 2020

NDPhA NORTH DAKOTA PHARMACISTS ASSOCIATION

NDSU SCHOOL OF PHARMACY

NORTH Dakota | Health

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Agenda

10:00a - 11:30a – Introduction and Overview

- Introductions
- Overview of 1815 project
- Pharmacy Project Overview
- Overview of Hypertension, Diabetes and Prediabetes
- Pharmacy Manual
- Southpointe testimonial
- Virtual binder
- Questions

11:30a – 12:00p - Breakouts for Students and Preceptors

12:00p – 1:00p – Data Collection, Recap and Questions

- Data Entry/Tracking – Patient Privacy
- Student/Preceptor surveys
- Questions

Disclosures

None of today's presenters have disclosures or conflicts of interest.

Objectives

- Describe North Dakota State University School of Pharmacy involvement in the 1815 grant.
- Discuss how students and preceptors can collaborate to advance the practice of pharmacy in North Dakota.
- Describe what is required of students and pharmacists who participate in the 1815 project.

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.
  - You can also chat in questions, using the chat function on the bottom of your screen.

INTRODUCTIONS

NDSU School of Pharmacy: Dr. Elizabeth Skoy, Dr. Natasha Petry
North Dakota Pharmacists Assocation: Dr. Jesse Rue
North Dakota Dept of Health: Brianna Monahan and Tiffany Knauf

CDC DP18-1815

- Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke Grant - CDC-RFA-DP18-1815 (DP1815)
- 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.
- This will happen through collaboration between the North Dakota Department of Health (NDDoH) and:
  - health systems
  - pharmacies (including NDSU School of Pharmacy and NDPhA)
  - community entities

  to improve policies and processes that help people control high blood pressure and cholesterol, and prevent or manage diabetes.
- Two Categories: 1) Category A – Diabetes; 2) Category B - Hypertension

Roles in Pharmacy Efforts

ND Pharmacists Assocation

- Oversee statewide pharmacy assessment
- Technical assistance to pharmacies and students on MTM efforts
- Statewide training and strategic planning.

NDDoH

- Technical assistance to pharmacy partners
- Oversee pharmacy contracts

NDSU School of Pharmacy

- Support the student scholarship process, and support students.
- Provide additional educational opportunities to students and staff.

Community Pharmacy

- Work to enhance or expand MTM services, with grant assistance.

Other partners

- Thrifty White Pharmacies, Altru Health System, and Trinity Health.

Performance Measures Snapshot – Category A

	STRATEGIES	Short Term PMs	Intermediate PMs	Long Term PMs
DIABETES MANAGEMENT	Increase access to and participation in DSMES programs	# & proportion of new recognized/accredited DSMES programs	**# *PWD* with at least 1 encounter at ADA-recognized/AADE accredited DSMES program**	**Proportion of *PWD* with an A1C > 9**
	Engaging pharmacists in MTM or DSMES	# pharmacy locations/pharmacists using patient care processes that promote MTM or DSMES for *PWD*		
DIABETES PREVENTION	Identify and refer to National DPP	# patients served in healthcare organizations with systems to identify *PWpreD* & refer to National DPP	**# participants enrolled in CDC-recognized lifestyle change programs**	**# *PWpreD* participating in CDC recognized lifestyle change programs who achieved 5-7% weight loss**
	Obtain National DPP coverage as health benefit	# employees; Medicaid beneficiaries; state/public employees; employees of private sector who have National DPP as covered benefit		
	Increase enrollment in National DPP			

Performance Measures Snapshot – Category B

CVD CLINICAL MEASURES	Use EHRs and Health Information Technology to improve HTN outcomes	# & % of patients within health care systems with systems to report standardized clinical quality measures for management & treatment of patients with high BP (e.g. NQF18)	**#/% of providers with protocol for identifying patients with undiagnosed HTN** **% patients with high BP in adherence to medication regimens** **% patients at high risk of cardiovascular events who were prescribed or on statin therapy** **#/% patients with high BP that have self-management plan**	% adults with known high BP who have achieved BP control % patients with total cholesterol at goal (LDL & HDL)
	Use evidence-based quality measurement to eliminate healthcare disparities	# & % of clinics or providers that use standardized quality measures to track differences in BP control & cholesterol management in priority populations compared to overall populations		
CVD - TEAM BASED CARE	Engage non-physician team members in HTN and cholesterol management	# & % of patients in health care systems that have policies or systems to encourage a multi-disciplinary team approach to BP control & cholesterol management		
	Adopt MTM between pharmacists & physicians	# & % of pharmacists engaged in MTM to promote medication self-management & lifestyle modification for high BP & high blood cholesterol		
CVD – COMMUNITY / CLINICAL LINKS	Facilitate self-measured blood pressure monitoring (SMBP) with clinical support	# & % of patients within health care systems with policies or systems to encourage SMBP tied to clinical support		

PHARMACY PROJECT OVERVIEW

Elizabeth Skoy, PharmD

1815 Student Scholarship Program

- 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 (October)
- Scholarship applications
  - 2 rounds
  - Matched 20 of the 35 offered
- Disbursement upon successful completion of all requirements
  - Successfully complete the rotation
  - Fulfill 1815 scholarship obligations (reports/surveys)

OVERVIEW OF PREDIABETES, DIABETES AND HYPERTENSION

Prediabetes

Diagnosis criteria:

- HbA1c 5.7% to 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) have prediabetes
- >80% of patients with prediabetes have never been diagnosed
- Partnering health systems data, indicates that only 6.8% (n=20,546/301,525) has been diagnosed in ND with prediabetes

Risk factors:

- Being overweight
- Being 45 years or older
- Having a parent, brother, or sister with Type 2 Diabetes
- Being physically active less than 3 times a week
- Ever having gestational diabetes (diabetes during pregnancy) or giving birth to a baby who weighed more than 9 pounds

Prediabetes Case

- CW is a 54-year old American Indian high school science teacher who comes to your pharmacy every month to fill hypertension and dyslipidemia medications. PMH includes hypertension, dyslipidemia, obesity, and osteoarthritis. He is noticeably overweight. In a previous trip to the pharmacy he asked a question about diabetes saying his brother had just been diagnosed.

- Question 1: Is he at risk for developing diabetes?
- Question 2: As a community pharmacist, what role can you play related to prediabetes?

Prediabetes: Role of Pharmacy

Current role:

- National Diabetes Prevention Program
- Employee-based prevention programs
- Counsel on lifestyle modifications
- Educate on prediabetes
- Screening
  - Point of Care testing
  - Risk assessment form

Potential/Future/Possible Role:

- Increase awareness of prediabetes and the National DPP
- Reimbursement for related services
- Inclusion of students, residents, technicians
- DPP Lifestyle Change Program enrollment as a recognized site
- Expansion of number of pharmacies/pharmacists performing items in "Current role" list

Diabetes

Diagnosis criteria:

- HbA1c >6.4%
- Fasting blood glucose >126 mg/dL
- 2-hour oral glucose 140-199 mg/dL

Prevalence:

- 34 million Americans have diabetes (about 1 in 10)
- Approximately 90-95% of them have Type 2 Diabetes
- The rate of Diabetes in ND increased from 8.2% in 2011 to 9.4% in 2018

Control Rate/Quality Measures:

- Quality: HbA1c <9% (some PC require <8%)
- Control: HbA1c <7%

Risk factors for health complications:

- Overweight and Obesity
- Tobacco use
- Physical inactivity

Implications for patients:

- Decreased quality of life
- 2.3x higher healthcare expenditure, average $16,750 per year
- Increased risk for heart disease, stroke, kidney disease, and 60% higher risk of early death

Diabetes Case

- JM is a 63-year old female with a PMH of diabetes, hypertension, dyslipidemia, and hypothyroidism. She refills her prescriptions every 3 months for 90-day supplies but is often seen in the front part of the pharmacy purchasing greeting cards and doing other shopping.

Question: As a community pharmacist, what role can you play to assist JM in her care related to diabetes?

Diabetes: Role of Pharmacy

Current role:

- Deliver diabetes self-management training (DSMT)
- Disease State Management through Collaborative Practice Agreements
- Monitoring
- Identify/resolve nonadherence
- Counsel on lifestyle modifications
- Counsel on medications
- Counsel on disease process
- Action plans for hypoglycemia
- Providing/Recommending Immunizations
- Perform Diabetic Foot Exams
- Transitions of Care

Potential/Future/Possible Role:

- Reimbursement for services
- Expansion of number of pharmacies/pharmacists performing items in "Current role" list
- Utilize: Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists

Hypertension

Diagnosis criteria:*

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

Category	Systolic		Diastolic
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.

SMBP and Patient Monitoring

Common symptoms for Hypertension? None!

Symptoms that MAY be seen with Hypertension?

- Headaches
- Shortness of breath, especially with exertion
- Symptoms related to complications:
  - Chest discomfort, Stroke, Kidney failure

We need you!

- There is sufficient evidence of the effectiveness for SMBP to improve BP when used alone (training provided for proper use and communication)
- There is strong evidence for the effectiveness of SMBP to improve BP when combined with additional support (i.e., patient counseling, education, or web-based support)

Why Self-Measured Blood Pressure (SMBP)?

- Use self-measured blood pressure monitoring (SMBP) to diagnose and reassess HBP
- SMBP refers to the regular measurement of BP by the patient outside of the clinic setting.
- SMBP can be used to confirm the diagnosis of HBP based on elevated office readings and for titration of BP-lowering medication.
  - Provides multiple BPs over a longer period of time (more representative of patient's true BP)
- SMBP can help differentiate between sustained, white coat, and masked hypertension.

Accuracy in Blood Pressure

Accuracy in Blood Pressure

Observer Factors	Patient Factors	System Factors
Wrong cuff size	Full bladder	Location of monitor/device
Cuff placed over clothing	Stimulants	Noise
Improper positioning	Recent exercise	Work Flows
No rest	Recent meal	
Terminal digit preference	Talking, texting, reading	
Talking to patient		
Too rapid cuff deflation		

Hypertension Case

- SA is a 41-year-old male with newly diagnosed hypertension. He has filled occasional pain and antibiotic prescriptions at your pharmacy before and presents with a new prescription for lisinopril.

Question: As a community pharmacist, what role can you play to assist SA in his care related to hypertension?

Hypertension: Role of Pharmacy

Current role:

- Monitoring
- Disease State Management through Collaborative Practice Agreements
  - Medication titration
- Counsel on lifestyle modifications
- Counsel on medications
- Counsel on disease process
- Transitions of Care
- Identify/resolve nonadherence

- Potential/Future/Possible Role:
  - Reimbursement for services
  - Expansion of number of pharmacies/pharmacists performing items in "Current role" list

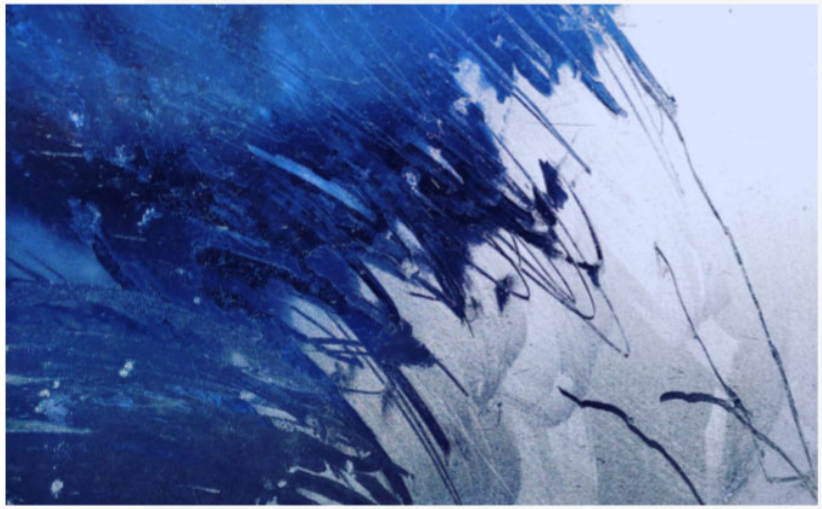
(Wagner et al, 2020)

PHARMACY MANUAL

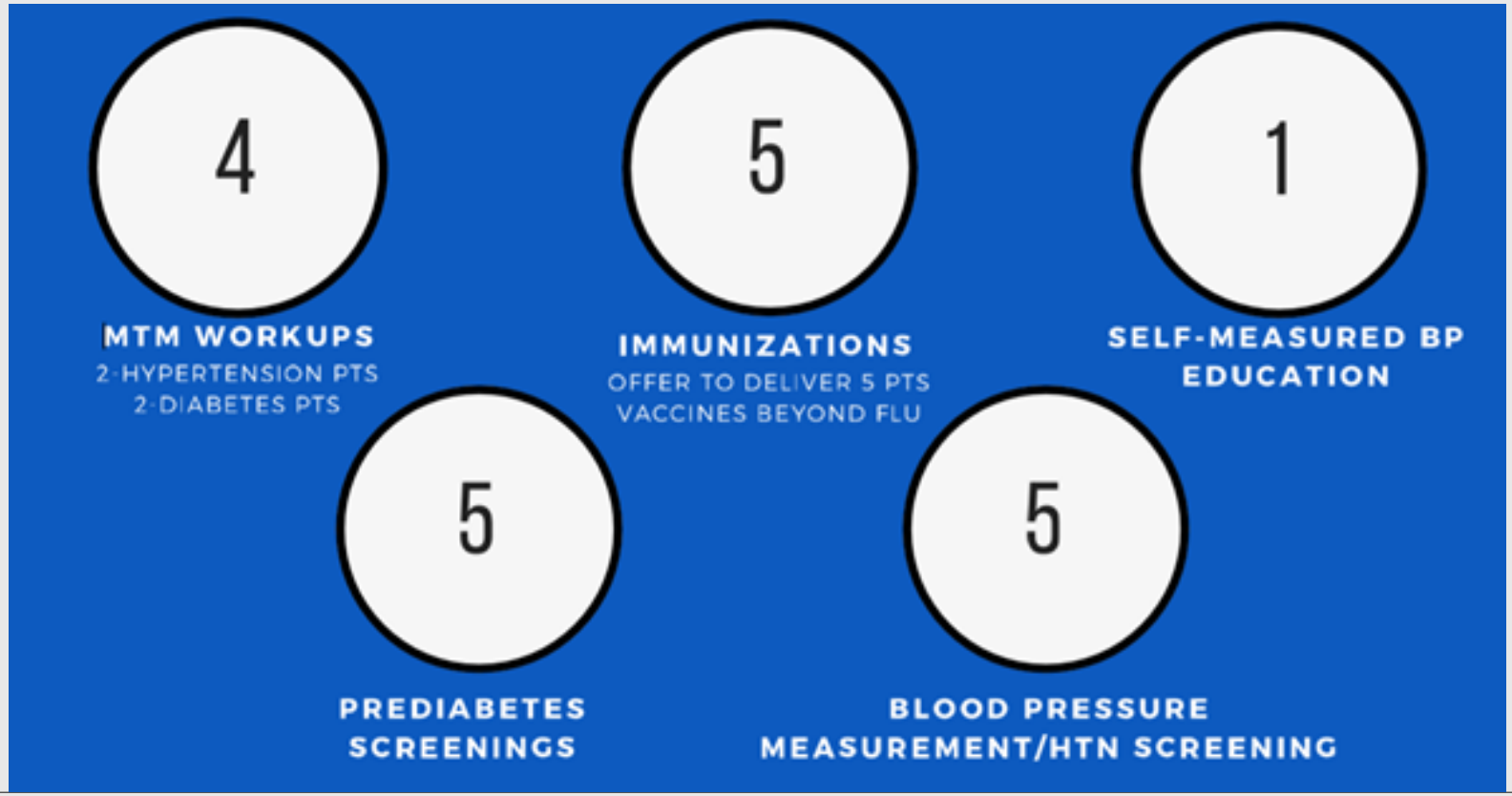
ENHANCING MTM IN NORTH DAKOTA

PILOT PROGRAM

SOUTHPOINTE PHARMACY
USER GUIDE



Weekly Targets



PREDIABETES AND THE NATIONAL DIABETES PREVENTION PROGRAM

SCREENING AND REFERRAL PROCEDURE

ONE IN FOUR ADULTS IN NORTH DAKOTA HAS PREDIABETES

PREDIABETES IS MARKED BY ELEVATED BLOOD GLUCOSE LEVELS THAT DO NOT REACH THE LEVEL OF DIABETES DIAGNOSIS.

PREDIABETES IS DEFINED AS EXHIBITING AT LEAST ONE OF THE FOLLOWING:

- A1C OF 5.7-6.4%
- FASTING PLASMA GLUCOSE OF 100-125MG/DL
- PLASMA GLUCOSE 2 HOURS AFTER 75GM GLUCOSE LOAD OF 140-199MG/DL

IDENTIFY 10 SCREEN 5

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

WHILE WE ENCOURAGE YOU TO SCREEN ALL PATIENT FOR PREDIABETES, THIS AGE RANGE IS AT HIGHEST RISK.

METHOD 1

1. GENERATE TARGETED PATIENT LIST

2. WHEN AVAILABLE, THIS LIST IS REVIEWED AGAINST HEIGHT AND WEIGHT DATA IN NDHIN TO FURTHER IMPROVE ACCURACY.

3. ENGAGE WITH TARGETED PATIENTS VIA PHONE CALL, REFILL SYNC VISIT, OR REFILL VISIT TO RECRUIT PATIENTS FOR REFERRAL TO NATIONAL DPP.

4.USE THE PREDIABETES RISK TEST
HTTP://WWW.DIABETESND.ORG/IMAGE/CACHE/PREDIABETESTEST_CDC.PDF

5. REFER AGREEABLE PATIENTS TO NATIONAL DIABETES PREVENTION PROGRAM.

METHOD 2

1. PERFORM PREDIABETES SCREENING AT MED PICKUP OR MEDICATION COUNSELING SESSION.

2. USE THE PRE-DIABETES RISK TEST
HTTP://WWW.DIABETESND.ORG/IMAGE/CACHE/PREDIABETESTEST_CDC.PDF

3. REFER AGREEABLE PATIENTS TO NATIONAL DPP PROGRAM.

HYPERTENSION **MANAGEMENT**

SCREEN, REFER, EDUCATE ON SMBP

ONE IN THREE ADULTS IN NORTH DAKOTA HAS HYPERTENSION

INTERESTINGLY, DIFFERENT ORGANIZATIONS ENDORSE DIFFERENT BLOOD PRESSURE LEVELS FOR DIAGNOSIS AND MANAGEMENT OF HYPERTENSION.

- FOR THE PURPOSES OF THIS PROJECT, **CONSIDER ANY PATIENT EXCEEDING 130/80MMHG AS BEING IN NEED OF REFERRAL BASED ON 2017 ACC/AHA GUIDELINES.**

SCREEN AND EDUCATE	**SCREEN OR MONITOR AT LEAST 5 PATIENTS PER WEEK.** TO DO THIS, PERFORM BLOOD PRESSURE CHECK IN THE PHARMACY USING THE COMMUNITY SCREENING ALGORITHM FOR PROPER PATIENT POSITIONING ON AT LEAST 5 PATIENTS. THESE MAY BE SCREENINGS FOR PATIENTS UNDIAGNOSED FOR HYPERTENSION OR THEY CAN BE CURRENT HYPERTENSION PATIENTS TO MONITOR THEIR CONDITION. **EDUCATE AT LEAST ONE PATIENT PER WEEK ON SELF-MEASURED BLOOD PRESSURE.**

METHOD 1

1. REPORT IS RUN TO CREATE TARGETED PATIENT LIST BASED UPON CRITERIA CHOSEN BY PRECEPTOR

2. STUDENT RECRUITS PATIENTS FOR SCREENING AT REFILL PICKUP, MED SYNC REFILL APPOINTMENT OR OTHER TIME AND REFERS ANY PATIENT >130/80 MMHG TO APPROPRIATE RESOURCE SUCH AS CLINIC UTILIZING THE COMMUNITY SCREENING ALGORITHM

3. STUDENT PROVIDES SMBP EDUCATION

METHOD 2

1. STUDENTS PERFORM MEDICATION COUNSELING AT PICKUP AND RECRUIT PATIENTS FOR AD HOC BLOOD PRESSURE SCREENING

2. STUDENT REFERS ANY PATIENT >130/80 MMHG TO APPROPRIATE RESOURCE SUCH AS CLINIC UTILIZING THE COMMUNITY SCREENING ALGORITHM

3. STUDENT PROVIDES SMBP EDUCATION AND COMPLETES DOCUMENTATION

IMMUNIZATION **DELIVERY**

SCREEN, ADMINISTER, GROW THE PROGRAM

NORTH DAKOTA HAS A PRESSING PUBLIC HEALTH NEED TO INCREASE IMMUNIZATION RATES

WHILE PROGRESS HAS BEEN MADE IN DELIVERING INFLUENZA VACCINES AT COMMUNITY PHARMACIES, GREAT OPPORTUNITY EXISTS TO EXPAND DELIVERY OF OTHER VACCINES.

- **FOCUS ON EXPANDING DELIVERY OF SHINGRIX, PPSV23, TDAP, AND TD VACCINES OR OTHERS AS DIRECTED BY PRECEPTOR. IF PHARMACY DOES NOT OFFER EXPANDED LIST OF VACCINES, DISCUSS WITH PRECEPTOR HOW TO EVALUATE THE OPPORTUNITY AT THE PHARMACY AND IF EXPANSION MAKES SENSE THERE.**

SCREEN AND DELIVER

UTILIZE THE NORTH DAKOTA IMMUNIZATION INFORMATION SYSTEM (KNOWN AS NDIIS OR THOR) TO SCREEN PATIENTS UTILIZING THE FORECASTER TOOL.

THIS IS AVAILABLE THROUGH NDHIN, THE STATE MEDICAL RECORD AVAILABLE AT THE PHARMACY.

METHOD

1. SCREEN PATIENTS AND DELIVER IMMUNIZATIONS AT MED PICKUP OR MED SYNC OR RUN REPORT TO IDENTIFY TARGETED PATIENTS TO ENGAGE.

2. USE THE IMMUNIZATION INFORMATION AND PREDICTOR WITHIN NDHIN WHEN PREPARING FOR PATIENTS TO APPROACH. ALTERNATIVELY, THE CDC RECOMMENDED IMMUNIZATION SCHEDULE DOCUMENT IS USEFUL: HTTPS://WWW.CDC.GOV/VACCINES/SCHEDULES/DOWNLOADS/ADULT/ADULT-COMBINED-SCHEDULE.PDF

3. FOCUS ON INFLUENZA, SHINGRIX, PNEUMOCOCCAL 13, PNEUMOCOCCAL 23, TDAP, TD. CONTRAINDICATIONS AND SPECIAL SITUATIONS MUST BE DEFINED AND CONSIDERED.

4. SCREENING QUESTIONNAIRE, VAR, PROVIDER NOTIFICATION FORM CAN BE FOUND AT HTTPS://WWW.NDSU.EDU/CENTERS/IMMUNIZE/TOOLKIT/

5. BILLING AND DOCUMENTATION COMPLETED PROPERLY PER PRECEPTOR

6. SCHEDULE ANY FOLLOW-UP APPROPRIATELY (SUCH AS SECOND-DOSE ZOSTER)

MTM EXPANSION

SCREENING AND REFERRAL PROCEDURE

PATIENTS BENEFIT WHEN PHARMACISTS USE THEIR CLINICAL KNOWLEDGE TO ENSURE OPTIMAL MEDICATION THERAPY

CLINICAL PHARMACY PRACTICE CAN OCCUR IN ANY SETTING AND THERE IS A GREAT NEED TO EXPAND MTM SERVICES IN COMMUNITY PHARMACIES, PARTICULARLY IN HYPERTENSION AND DIABETES CARE.

UTILIZE THE PROTOCOLS AT END OF THIS GUIDE AS A FRAMEWORK (OR OTHER PROTOCOLS AS DIRECTED BY YOUR PRECEPTOR).

- **WE NEED YOU TO TAKE THE INITIATIVE TO PERFORM HIGH QUALITY PATIENT REVIEWS AND DISCUSS THE PLAN WITH A PRECEPTOR TO IMPACT PATIENT CARE.**

FINANCES MATTER

DISCUSS WITH YOUR PRECEPTOR IF REIMBURSEMENT IS AVAILABLE FOR YOUR REVIEWS.

HOWEVER, TARGET PATIENTS AND COMPLETE REVIEWS EVEN IF THERE ISN'T REIMBURSEMENT ATTACHED SO THAT YOU OFFER ENHANCED CARE TO PATIENTS.

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

METHOD 1	1. UTILIZE PATIENT TARGETED LIST TO SELECT PATIENTS FOR REVIEW 2. DISCUSS CASE AND PLAN WITH PRECEPTOR, UTILIZING RESOURCES SUCH AS: • DISEASE STATE PROTOCOLS • NDHIN 3. SCHEDULE AND PERFORM SERVICES PER REQUIREMENTS 4. MAY BE ABLE TO ATTACH DOCUMENTATION TO REFILL SYNC VISIT OR AD HOC REFILL 5. RELAY INFORMATION TO OTHER HEALTH PROVIDERS AS APPROPRIATE 6. SCHEDULE FOLLOW-UP AS APPROPRIATE
METHOD 2	1. REVIEW PRE-POPULATED APPLICATIONS (EX: OUTCOMES, DOCSTATION) FOR OPPORTUNITIES 2. DISCUSS CASE AND PLAN WITH PRECEPTOR, UTILIZING RESOURCES SUCH AS: • DISEASE STATE PROTOCOLS • NDHIN 3. SCHEDULE AND PERFORM SERVICES PER REQUIREMENTS 4. ENSURE DOCUMENTATION AND BILLING COMPLETED APPROPRIATELY PER PRECEPTOR 5. RELAY INFORMATION TO OTHER HEALTH PROVIDERS AS APPROPRIATE 6. SCHEDULE FOLLOW-UP AS APPROPRIATE

The following is a suggested systematic approach to follow within the pharmacy. There is understanding that every pharmacy may vary slightly, so it is important to coordinate with your preceptor to finalize how to implement the program.

1. **Run reports to create targeted patient list (described later)**

2. **Develop strategy with preceptor for engaging with patients effectively. Pick 2 or 3 of the options below:**

- Review med sync pickups for the week and select/schedule those patients
- Place notes with medications awaiting pickup asking staff to contact you directly for consultation when patient arrives
- Directly call patients to discuss plan or schedule visits as appropriate
- Recruit candidates ad hoc when patient arrives at pharmacy or during counseling
- Review pharmacy's clinical platforms in use (examples may include Outcomes, DocStation, etc) for potential candidates in need of further intervention

DISCUSS THIS WITH PRECEPTOR TO CREATE SUCCESSFUL STRATEGY

Prediabetes Screening Patient Report:

- Run report to identify patients at highest risk: ≥50 years old AND taking HTN meds; other criteria can be selected from the prediabetes risk test

HTN/Diabetes Patient Report for MTM

- Run report to identify patients on HTN and/or diabetes medications to target for MTM reviews

Immunization screenings:

- Utilize the North Dakota Immunization Information System (known as NDIIS or THOR) to screen patients utilizing the Forecaster tool. This is available through NDHIN, the state medical record available at the pharmacy.

Blood pressure screenings:

- Prioritize patients with hypertension having medication changes in the past six months. Screening is also desired to find undiagnosed hypertension. Discuss with preceptor to create successful strategy.

COMMUNITY **RESOURCES**

HERE'S A CONTACT LIST OF COMMUNITY RESOURCES YOU WILL USE TO GET PATIENTS THE HELP THEY NEED.

ASK YOUR PRECEPTOR HOW BEST TO CONTACT YOUR PATIENT'S PROVIDER.

RESOURCE	CONTACT INFO
DIABETES PREVENTION PROGRAM	CONTACT NIKKI JOHNSON 701.231.5165
SANFORD SOUTHPOINTE CLINIC	701.234.2000
FARGO CASS PUBLIC HEALTH **1240 25TH ST S, FARGO**	701.241.1360

SOUTHPOINTE TESTIMONIAL

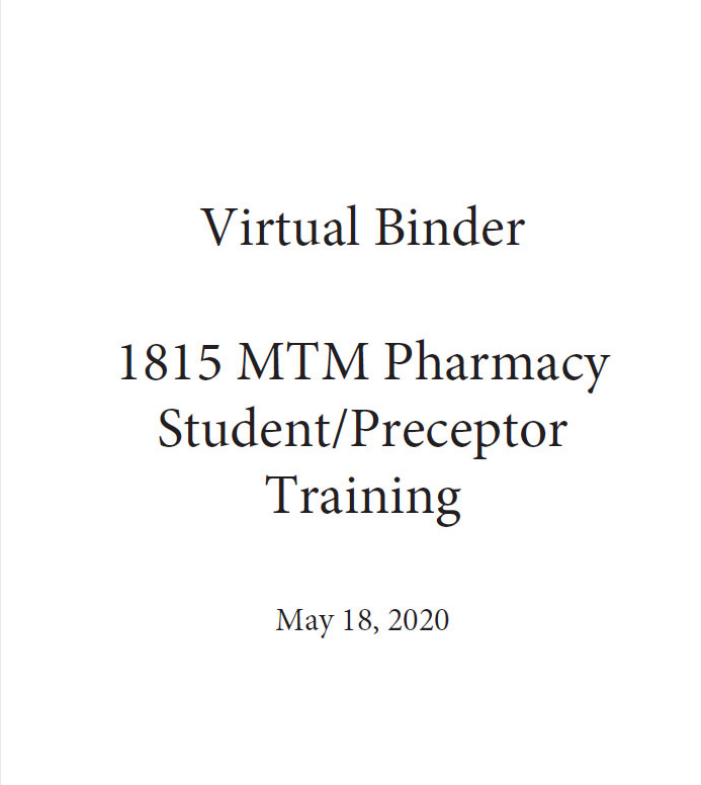
Jeff Jacobson, PharmD

Southpointe's experiences in the pilot

VIRTUAL BINDER OF RESOURCES

Binder Overview

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



Virtual Binder

QUESTIONS?