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Promoting Patient Self-Management for Culturally Diverse Populations

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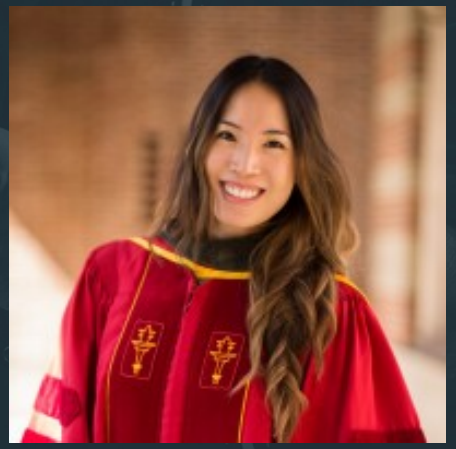
Director of Population Health
USC School of Pharmacy



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USC School of Pharmacy

Learning Objectives

1

Provide culturally sensitive care to diverse patient populations

2

Recognize and overcome personal cultural biases

3

Incorporate proven techniques for patient engagement

"It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has”

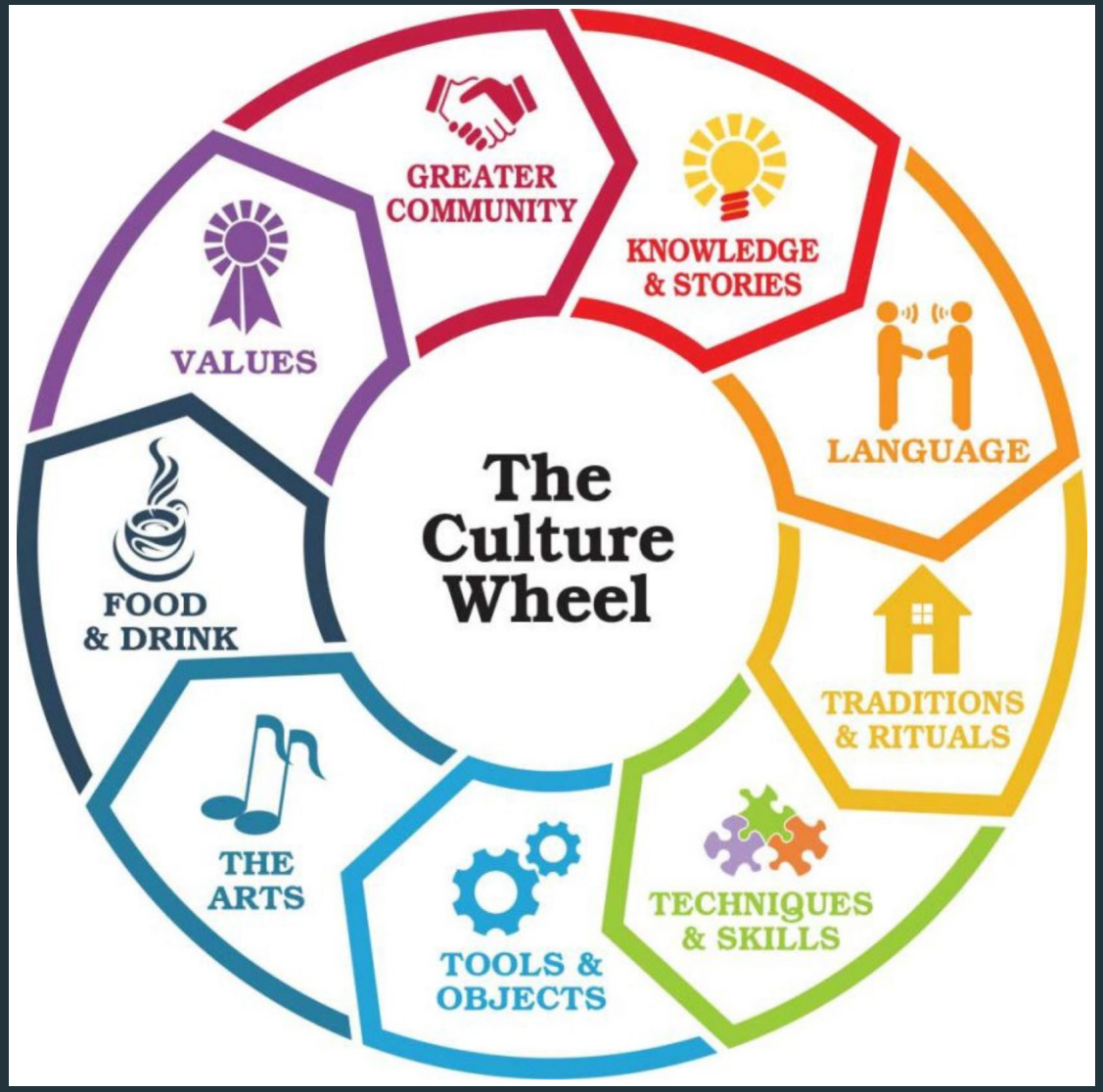
Pre/Post Assessment Question 1

What is cultural sensitivity/competence?

a) Refers to respecting people with any cultural background, and creating and fostering an atmosphere of non-discrimination in society
b) Being open to the idea of changing cultural attitudes
c) The traditions, beliefs, customs, history, folklore, and institutions of a group of people
d) Knowing about some cultural characteristics, history, values, beliefs, and behaviors of another ethnic or cultural group.

Definitions

- **"Culture"** is defined as the shared traditions, beliefs, customs, history, folklore, and institutions of a group of people
  - Challenge: Patients may not realize they have customs that jeopardize their wellness
  - Influences patients' responses to illness and treatment
- **"Cultural Knowledge"** means that you know about some cultural characteristics, history, values, beliefs, and behaviors of another ethnic or cultural group



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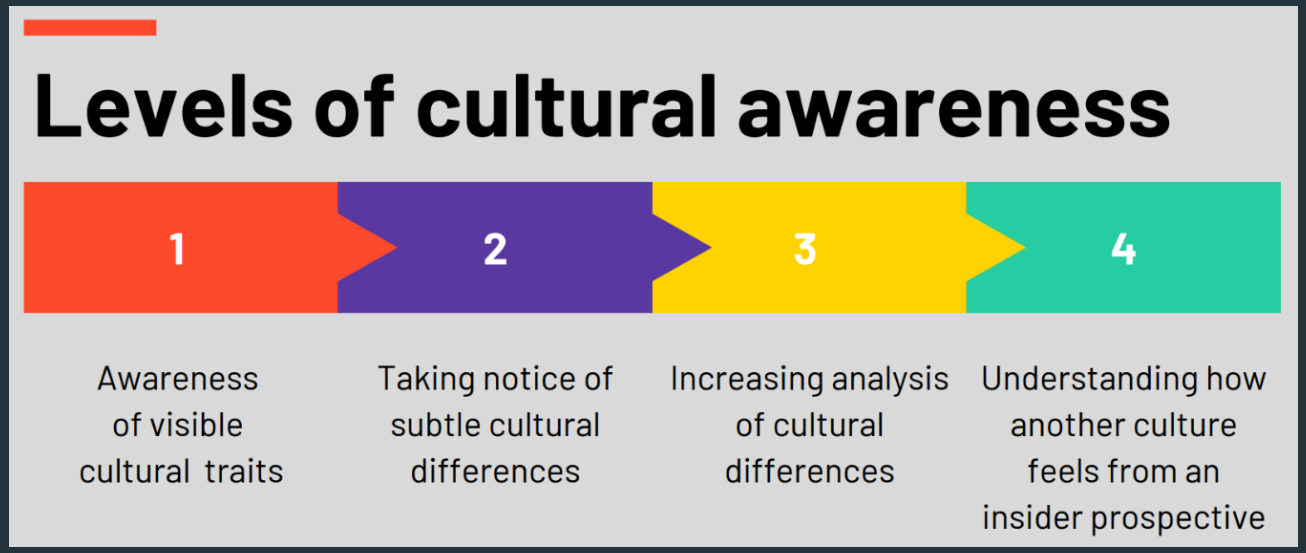
https://medium.com/@beautehealthy/what-is-culture-types-of-culture-elements-of-culture-characteristics-of-culture-7b4d65caddc7

Definitions

- **“Cultural Awareness”** is the next stage of understanding other groups -- being open to the idea of changing cultural attitudes
- **“Cultural Sensitivity” / “Cultural Competence”** brings together the previous stages and adds operational effectiveness. Refers to respecting people with any cultural background (i.e. knowing that differences exist between cultures, but not assigning values to the differences), and creating and fostering an atmosphere of non-discrimination in society



Cultural Awareness Checklist

1. Establish clear communication

- Make sure you know your patient's preferred method of communicating and arrange professional interpretation if necessary.

2. Be aware of non-verbal cues without jumping to conclusions

- Non-verbal communication conveys a lot of critical information—but it may differ dramatically across cultures. Don't make any assumptions without knowing the person's customs.

3. Ask openly about potentially relevant traditions and customs

- This includes exploring potential spiritual/religious practices, dietary considerations, and cultural norms that may be particularly important to the patient's clinical situation.

4. Use normalizing statements

- A respectful way to ask about sensitive issues like cultural or religious customs is to first explain that they are very common. (e.g. "A lot of my patients have customs or practices that are important for me to know about so I can make sure to give you the best possible care.")

5. Examine your own biases

- We all have unconscious biases and prejudices that impact our relationships with patients. Identifying and understanding these biases helps to control them, and is essential to achieving cultural awareness.

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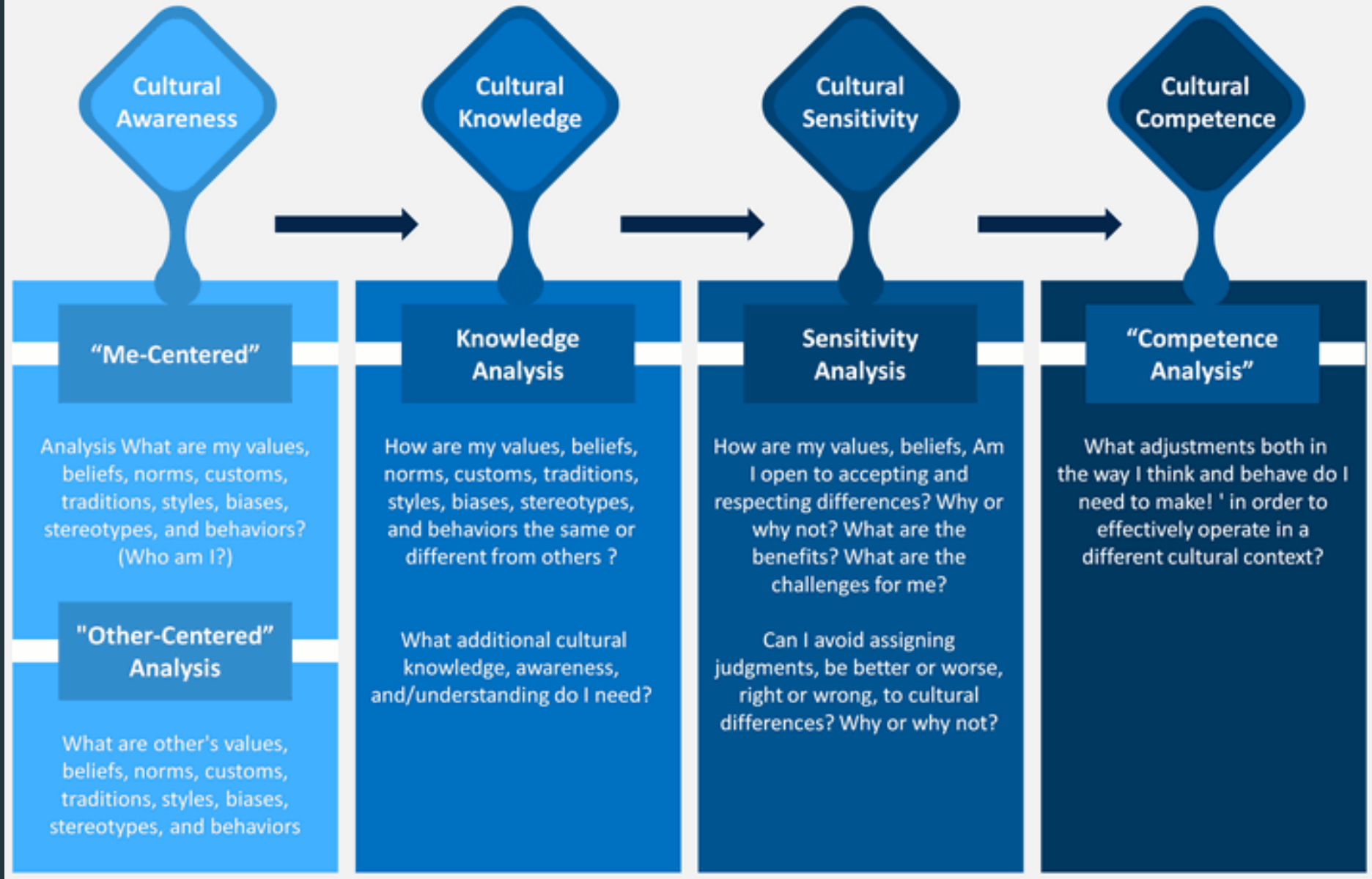
https://www.qualityinteractions.com/hubfs/cultural%20awareness%20checklist.png?hsCtaTracking=b9427f6d-b3d9-4b3e-91ac-b4ff47193c71%7C990318ea-5b0a-49a8-8256-173e32174c14

CULTURAL COMPETENCE

Cultural Competence Model



5 Essential Principles of Cultural Competence

1. **Valuing Diversity:** accepting and respecting differences between and within cultures
2. **Conducting cultural self-assessment:** assessment of your own culture and those you are caring for so that you adjust to other cultures
3. **Understanding the dynamics of difference**
4. **Institutionalizing cultural knowledge:** train yourselves and staff about various cultures you work with and be able to effectively utilize knowledge gained (i.e. being culturally competent)
5. **Adapting to diversity:** recognize, respect, and value all cultures and integrate those values into the patient care you provide

https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culturally-competent-organizations/main#:~:text=%22Cultural%20awareness%22%20is%20the%20next,worse%2C%20right%20or%20wrong).

Pre/Post Assessment Question 2

Which of the following statements is true?

a) African Americans and other ethnic minorities report less partnership with physicians, less participation in medical decisions, and lower levels of satisfaction with care.
b) Compared to other minority groups, Asian Americans are least likely to feel that their doctor understood their background and values and are most likely to report that their doctor looked down on them.
c) African Americans, Latinos, and Asian Americans, are more likely than Whites to report that they believe they would have received better care if they had been of a different race or ethnicity
d) All of the above

Why is Cultural Competence Important?

- Positive health consequences
- High quality care
- Patient satisfaction

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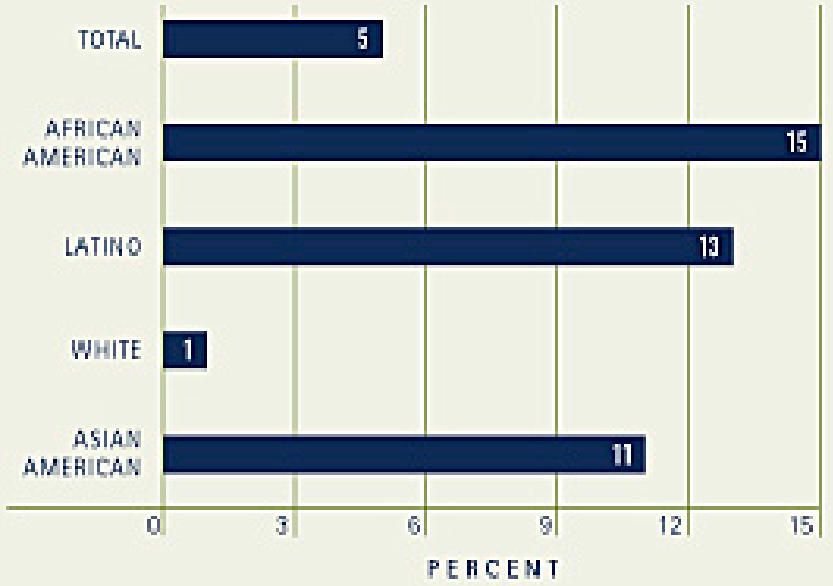
Racial and Ethnic Minorities are Less Satisfied with the Health Care They Receive

FIGURE 4

Proportion of people who believe they would receive better health care if they were of a different race and/or ethnicity, total and by race/ethnicity

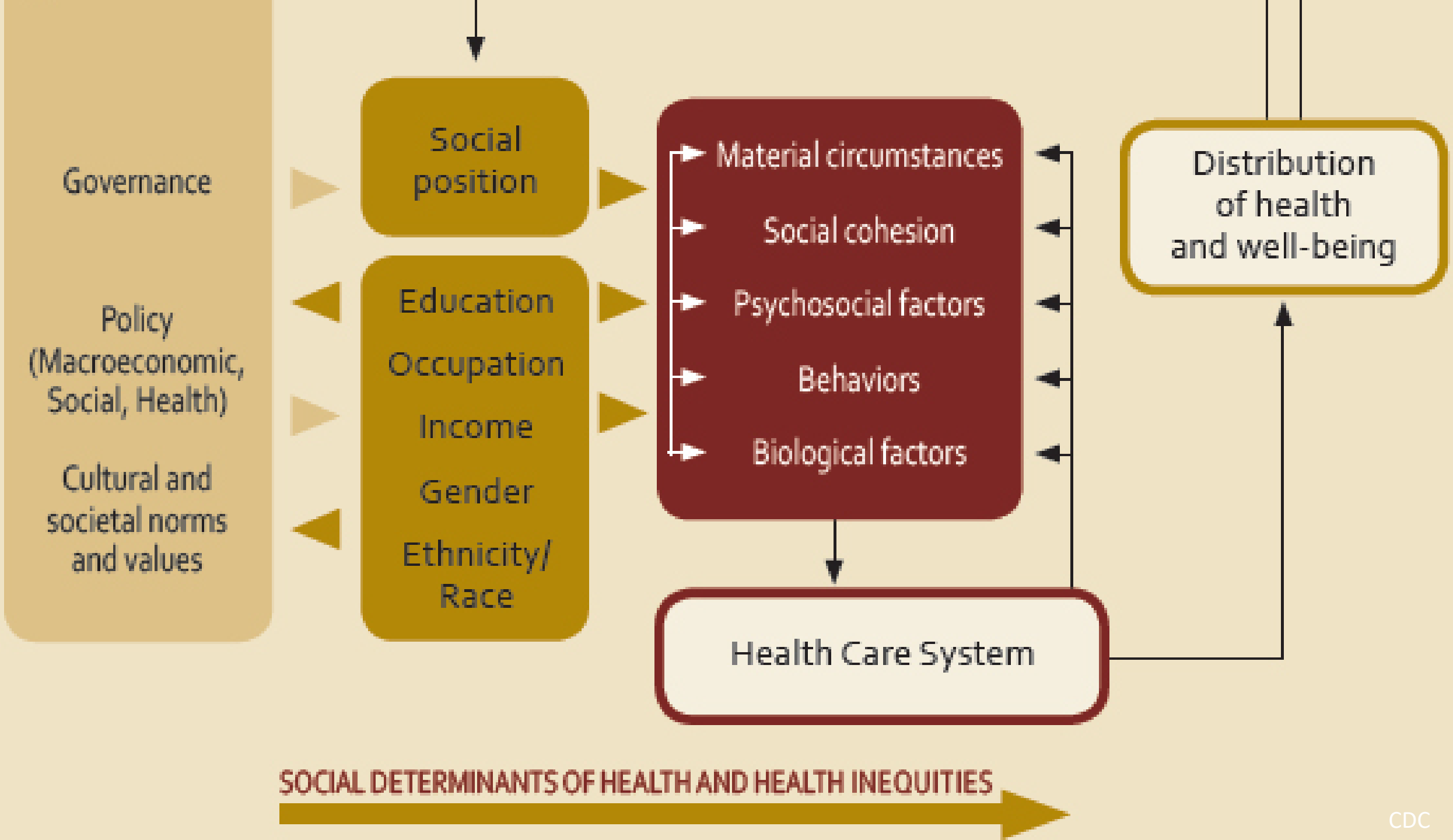


SOURCE: Collins, K.S., Hughes, D.L., Doty, M.M., Ives, B.L., Edwards, J.N. & Tenney, K. 2002. *Diverse communities, common concerns: Assessing health care quality for minority Americans.* New York: The Commonwealth Fund.

African Americans, Latinos, and Asian Americans, are more likely than Whites to report that they believe they would have received better care if they had been of a different race or ethnicity (see Figure 4).[Collins]

How do you practice Cultural Competence?

- https://www.youtube.com/watch?v=E6u-T_P8VDg (3:52 min)


Governance
Policy (Macroeconomic, Social, Health)
Cultural and societal norms and values
Social position
Education
Occupation
Income
Gender
Ethnicity/ Race
Material circumstances
Social cohesion
Psychosocial factors
Behaviors
Biological factors
Health Care System
Distribution of health and well-being
SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUITIES

CDC

How does implicit bias affect health care?

- Influence diagnosis and treatment decisions and levels of care
- Unequal quality of treatment
- Poor clinician-patient interaction
- Inability to engage and educate patients

”Create social and physical environments that promote good health for all”

Healthy People 2020

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Sociocultural Competency in Clinical Pharmacy Patient Visits

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- Various factors shape individual values, beliefs and behaviors about health and well-being
  - Language & communication preferences
  - Literacy level
  - Race
  - Religion
  - Ethnicity / Nationality
  - Gender
  - Socioeconomic status
  - Physical ability
  - Mental ability
  - Sexual orientation
  - Occupation

Tips to Improve Sociocultural Awareness and Mitigate Biases

- Ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system
- Understanding of these factors will impact aspects of clinical pharmacy visits such as
  - Family & caregivers engagement
  - Nutrition / diet concerns
  - Exercise recommendations
  - Medication recommendations
- Cultural competency training

Pre/Post Assessment Question 3

Juan is a 34-year old male Latino patient with uncontrolled diabetes. He only speaks Spanish. Juan believes insulin makes you blind and causes kidney damage. He works 12-16 hour shifts as a construction worker 6-7 days a week. His lunch consists of fast food and a soda daily or left over dinner from the day before (i.e. burritos, tacos, rice & beans). Which of the following is a way to apply cultural competency to your initial CMM visit with Juan?

a) Tell Juan that his ideas about insulin are complete nonsense and ridiculous.
b) Leverage your Hispanic pharmacy technician to work with you in conducting aspects of the patient assessment, medication therapy evaluation, plan and follow up. This would include translating and coming up with a plan that is well suited to Juan's Latino cultural needs.
c) Ask Juan to monitor his blood glucose 3-4 times daily.
d) Schedule an in person follow up appointment in one week.

Leveraging pharmacy technicians & interns

- Based on culture, can better tailor:

1. Patient Assessment
2. Evaluation of Medication Therapy
3. Development & Initiation of Plan
4. Follow-up & Medication Monitoring

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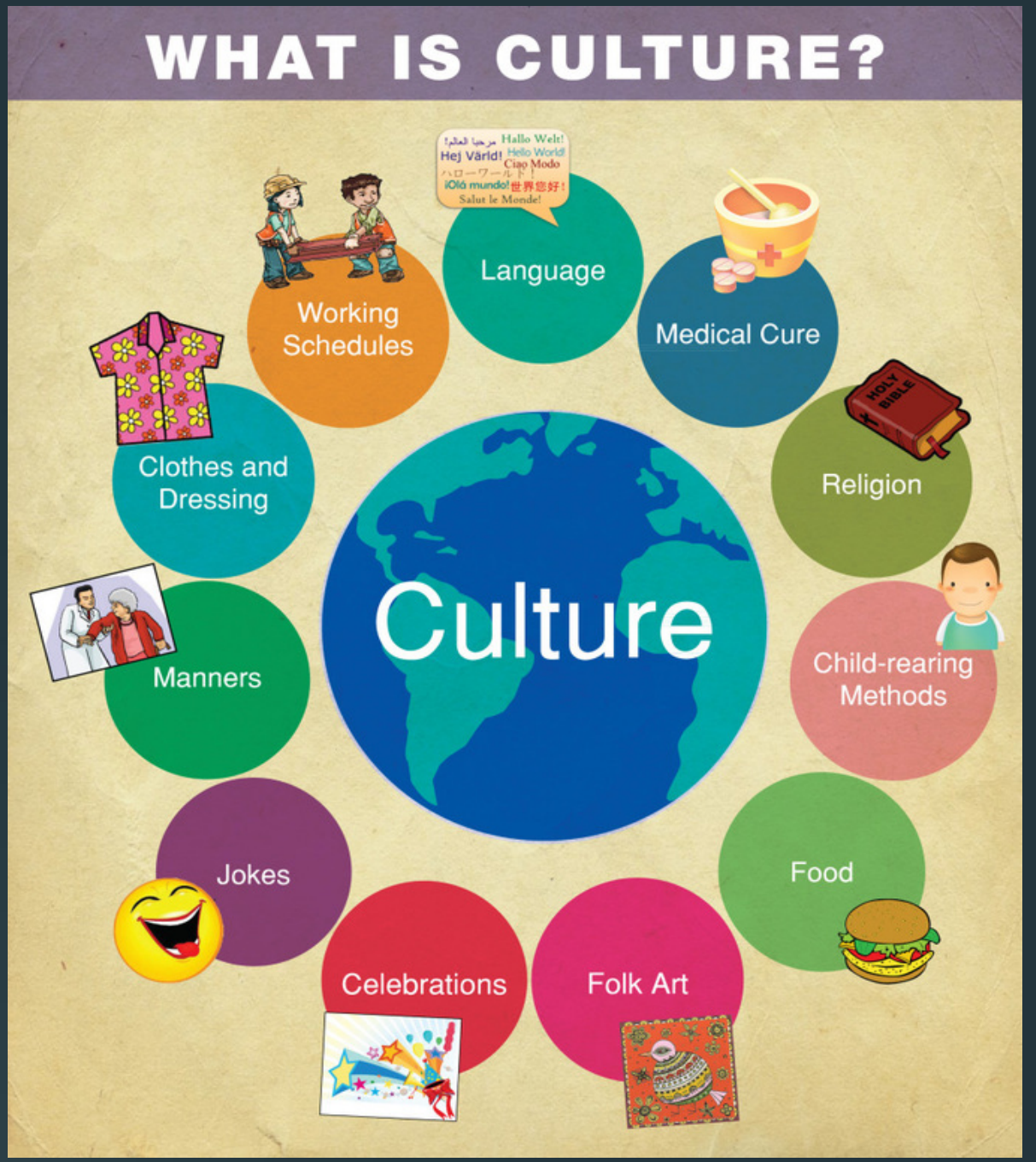


https://culturesandsocietiesblock1.weebly.com/cultures-and-societies-content.html

Pre/Post Assessment Question 4

Shared decision making is a tool to:

a) Engage with patients
b) Present options to patients
c) Establish partnerships
d) All of the above

Shared Decision Making process

ESTABLISH A PARTNERSHIP

EXCHANGE INFORMATION

WEIGH THE OPTIONS

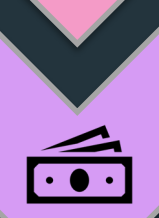
MAKE A DECISION

The Importance of Patient Engagement

- Shared power and responsibility ⟶ *Patient Empowerment*
- Enhanced patient-provider communication (services = needs)

- Patients are better able to make informed decisions (*Patient Activation*)
- Improved quality and more-efficient health care

- Improved population health and outcomes
- Increased patient safety and wellness



- Control (or reduction) of health care costs

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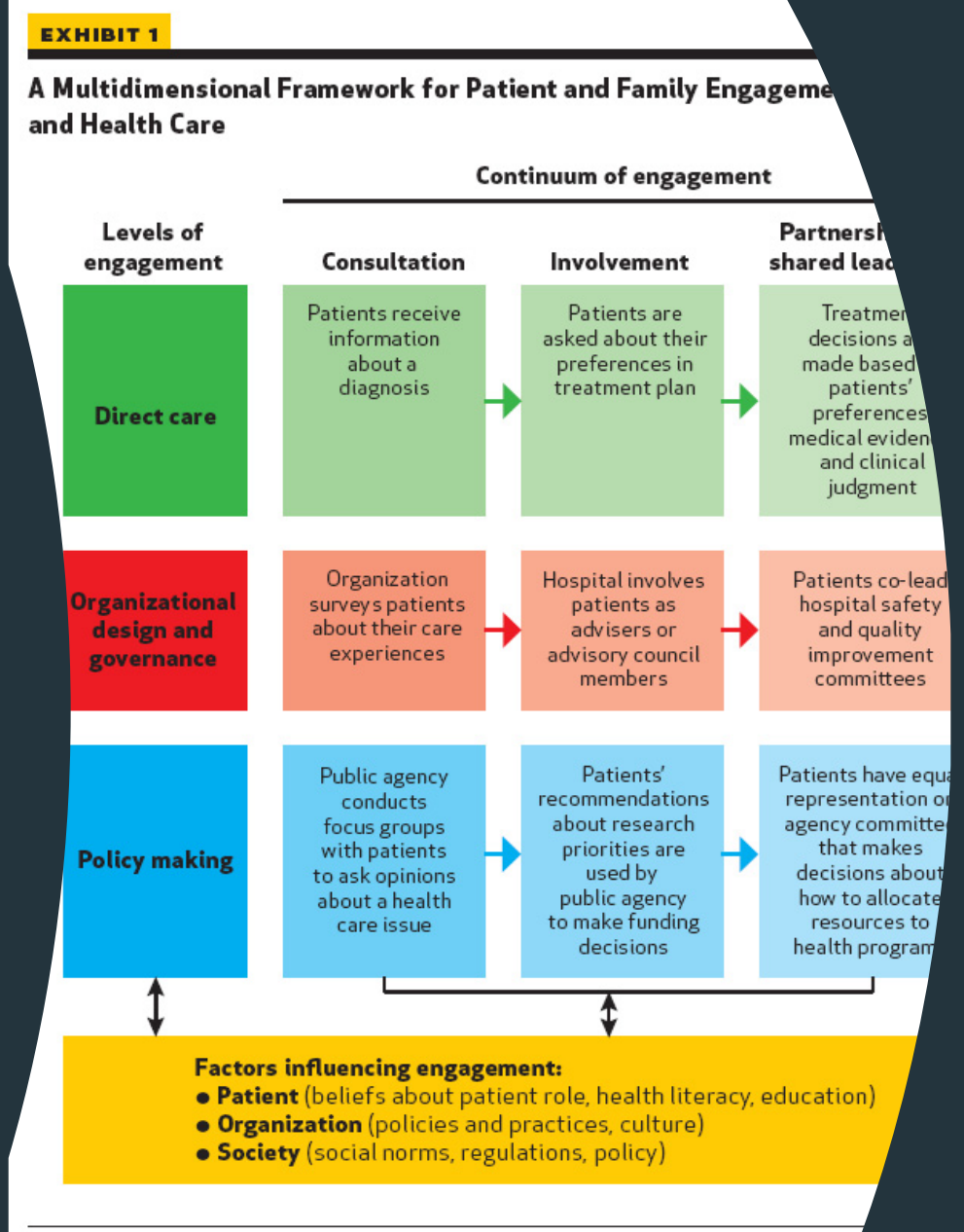
Carman KL, Dardess P, Maurer M, et al. *Health Aff (Millwood).* 2013;32(2):223-231.

Multidimensional Framework for Patient (and Family Engagement in Health and Health Care)



- Activities range along a continuum

  Consultation ⟶ Partnership ⟶ Shared Leadership
- Occurs at different levels
  - Individual health behavior or direct care interactions
  - Organizational design and governance
  - Policy making
- **Multiple factors affect patients' willingness and ability to engage**

Figure from Carman KL, Dardess P, Maurer M, et al. *Health Aff (Millwood* 2013;32(2):223-231.

Multidimensional Framework for Patient (and Family) Engagement in Health and Health Care

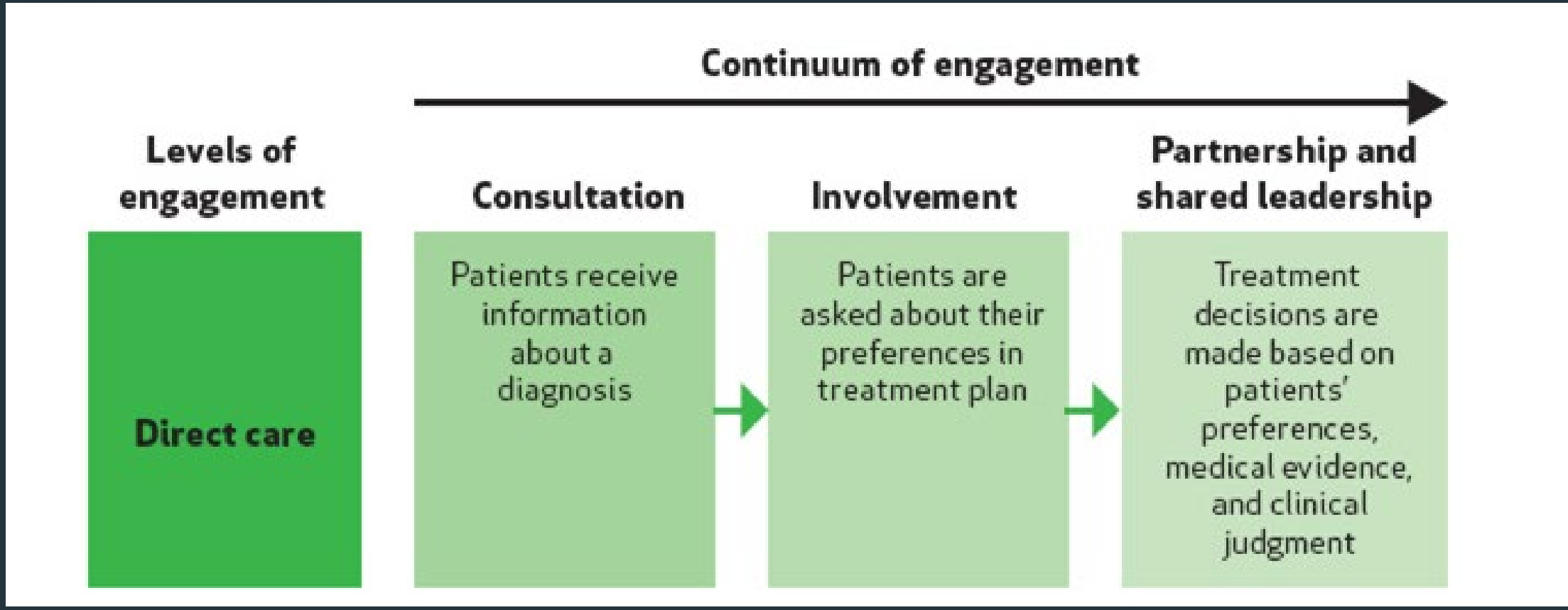


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Figure from Carman KL, Dardess P, Maurer M, et al. *Health Aff (Millwood)*. 2013;32(2):223-231.

Multidimensional Framework for Patient (and Family) Engagement in Health and Health Care

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Figure from Carman KL, Dardess P, Maurer M, et al. *Health Aff (Millwood)*. 2013;32(2):223-231.

Pre/Post Assessment Question 5

Optimal patient-centered care incorporates various concepts and factors. Which of the following statement(s) are true. *Select all that apply:*

a) Patient engagement promotes patient activation which may lead to positive patient behavior, care experience, and health outcomes

b) Experts recommend providers to challenge their patients and encourage them to take larger steps in bettering their health regardless of the patients' level of activation

c) Shared-decision making is most effective when the patient works directly with their primary care provider for diagnostic evaluation of their disease state(s) as this is most crucial for patient engagement and activation

d) Inclusion of patients in the care decision-making process helps them to better understand their role in the care process, share their values and preferences, and build their skills and confidence to manage their own health

Patient Activation

- Patient understanding of their role in the care process ⟶ **Knowledge, skills, and confidence to manage their own health and wellness**
- Emphasizes **patients' willingness and ability** to take independent actions
- **One aspect of an individual's capacity to engage in their care** *("patient engagement")*
- Emphasizes need for a systematic approach in **encouraging patients to play a more active role** in their own health

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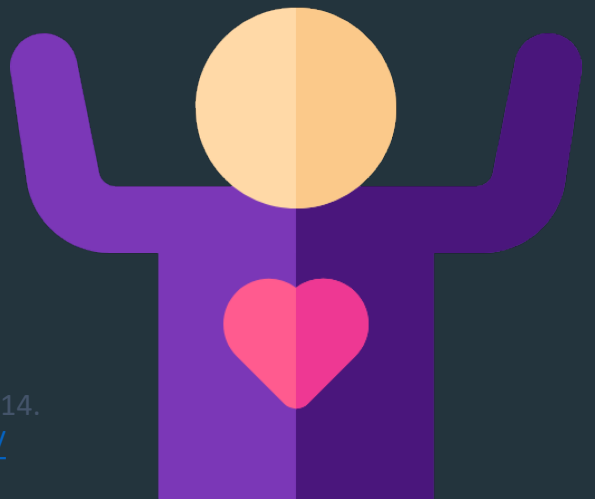
Hibbard JH, Mahoney E. *Patient Educ Couns*. 2010;78(3):377–381.
Hibbard JH, Greene J. *Health Aff (Millwood)*. 2013;32(2):207–214.
Illustration by Freepik Company S.L. https://www.flaticon.com/

Benefits of Patient Activation

- Growing evidence that patients who are **more activated** (vs. less activated):
  - Engage in significantly more **preventative** (regular check-up, screenings, immunization) and **healthy behavior** (diet/exercise)
  - More likely to **avoid health-damaging behavior** (smoking/illicit drugs)
  - ≥ 2x likely to **prepare questions** for providers, **know treatment guidelines** for their medical conditions, **seek out health information** and quality healthcare providers
  - **Adhere to treatment and self-monitoring** at home for chronic illnesses



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Hibbard JH, Greene J. *Health Aff (Millwood)*. 2013;32(2):207–214.
Illustration by Freepik Company S.L. https://www.flaticon.com/

Higher Activation Correlated with Better Self-Management

- **[Rask et al., 2009]** Cohort study of adult participants (n = 287; mean age 51.5 ± 10.9 yrs), inner-city public hospital clinic, living with diabetes, 90.2% AA, 58.9% female, 71.9% uninsured
- **62.2%** with high activation PAM scores
- **More likely to perform feet checks, receive eye examinations, and exercise regularly**
- **[Salyers et al., 2009]** Cross-sectional, mixed-methods, descriptive study of adult participants (n = 40; mean age 43.5 ± 15.2 yrs), community mental health center, living with serious mental illnesses, 78% Caucasian, 53% female
  - Patient activation **positively** related to **self-management of mental illness**
  - **Negatively** related to **substance misuse**

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Rask KJ, et al. *Diabetes Educ.* 2009;35(4):622-630.
Salyers MP, et al. *Psychiatr Serv*. 2009;60(11):1535-1539.

Activation May Lead to Better Outcomes & Care Experience

- Several studies reported patients with **higher activation scores** **more likely to have normal levels of BMI, A1c%, BP, and lipid panel** (vs. patients with lower scores)
- Alexander *et al.* cross-sectional study of adult participants with **higher activation scores** reported **higher-quality interpersonal exchanges with physicians, greater fairness, and more out-of-office contact with physicians**
- Improved health outcomes and care experience ⟶ A process that involves multiple stakeholders, including patients

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Hibbard JH, Greene J. *Health Aff (Millwood)*. 2013;32(2):207–214.
Alexander JA, Hearld LR, Mittler JN, Harvey J. *Health Serv Res*. 2012;47(3 Pt 1):1201–1223.

Higher Activation May Lower Health Care Costs

- Greene *et al*. – Cross-sectional study of 25,047 adult patients in a large health care delivery system in Minnesota:
  - For **every additional 10-points on a PAM score**, the predicted **probability of having an ED visit was 1% point lower**
- Hibbard *et al*. – Cross-sectional study of 33,163 adult patients in the same large health care delivery system in Minnesota:
  - Patients with lowest PAM score had 8% higher predicted average billed care costs in 2010 and 21% higher in the first-half of 2011
  - **Overall, less activated patients having significantly higher costs** vs. more activated patients

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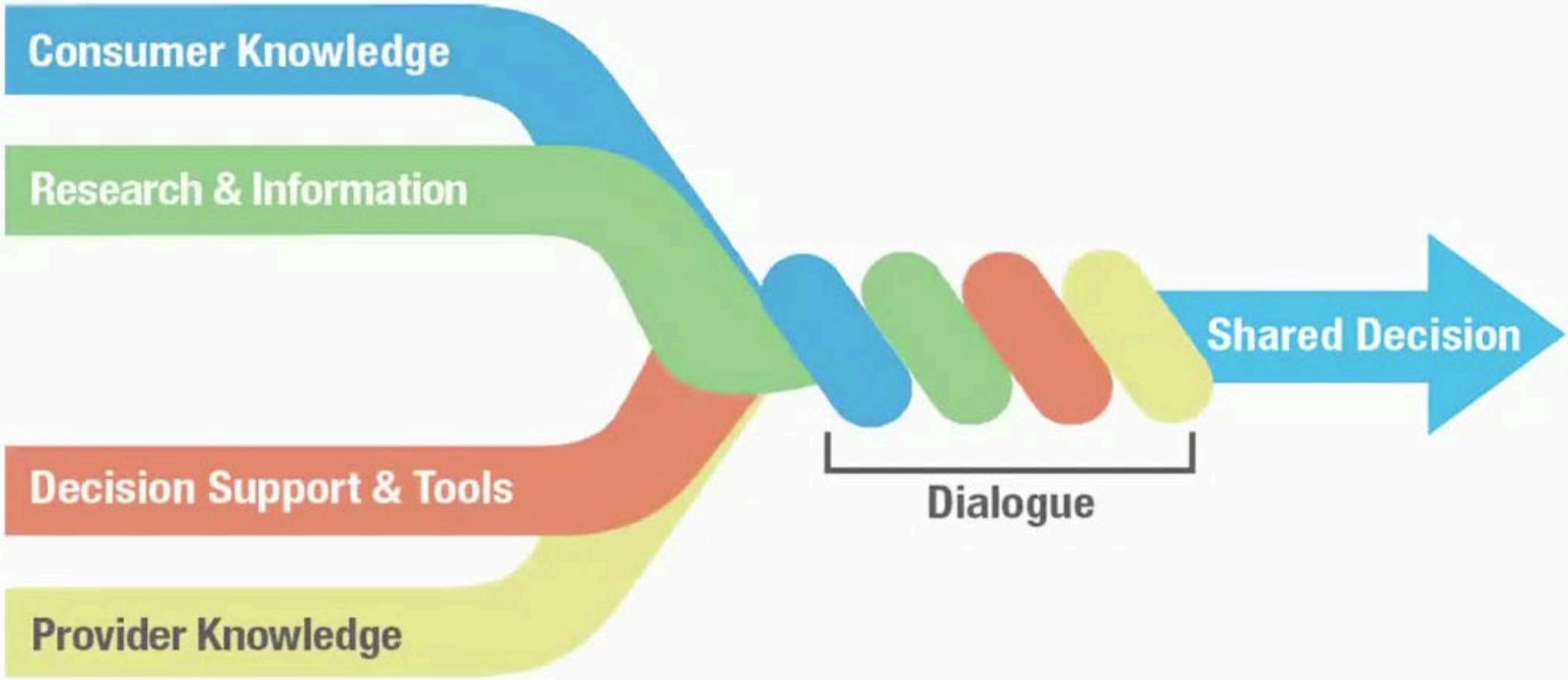
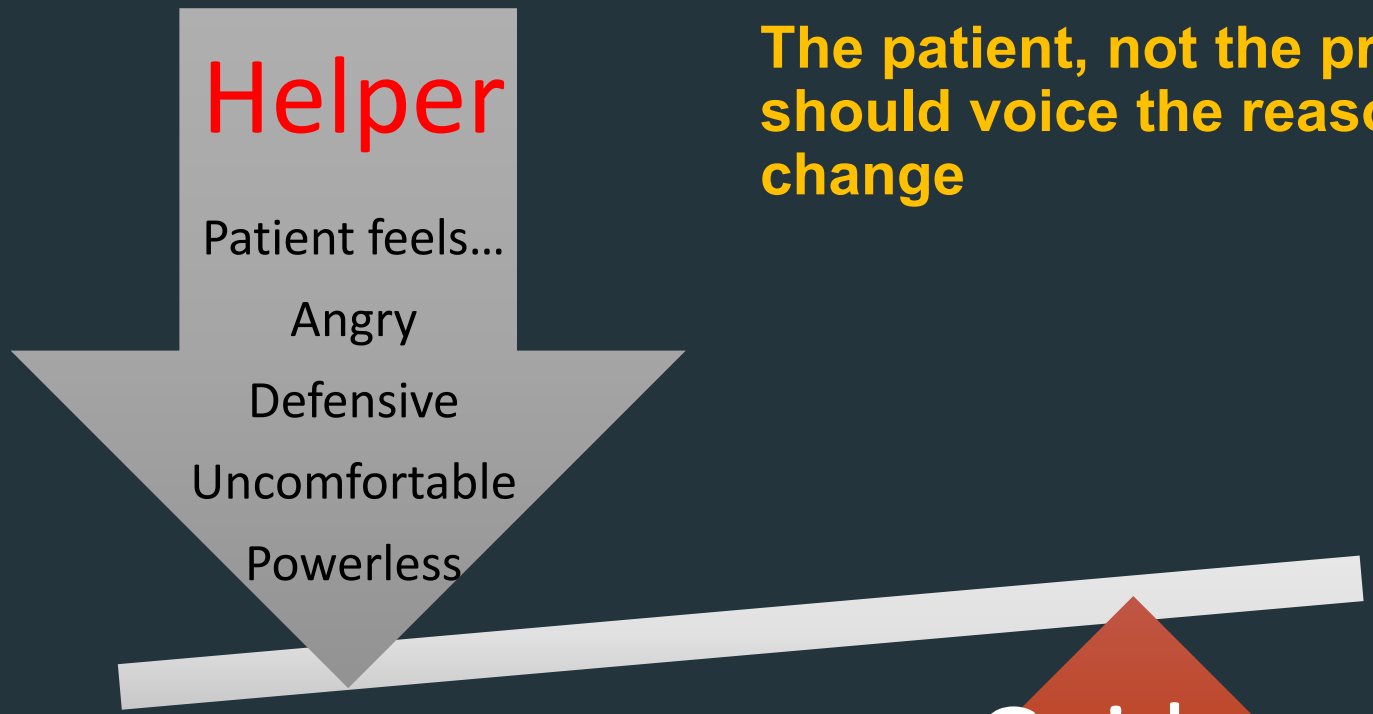
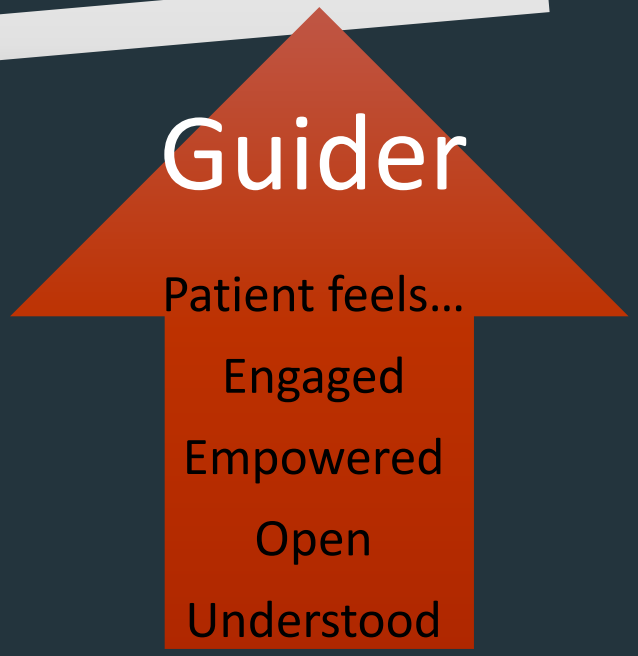
Greene J, Hibbard JH. *J Gen Intern Med.* 2012;27(5):520-526.
Hibbard JH, Greene J. *Health Aff (Millwood)*. 2013;32(2):207–214.
Hibbard JH, Greene J, Overton V. *Health Aff (Millwood)*. 2013;32(2):216–222.
Illustration by Freepik Company S.L. https://www.flaticon.com/

Shared Decision Making





The patient, not the practitioner, should voice the reasons for change



The practitioner should use high-quality listening

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Miller WR, Rollnick S. Motivational Interviewing: helping people change. 3rd ed. New York, NY: Guilford Press. 2013.

References

- Betancourt, J. R., Green, A. R., & Carrillo, J. E. 2002. Cultural competence in health care: Emerging frameworks and practical approaches. New York: The Commonwealth Fund.
- Brownlee, T., & Lee, K. (2020). Section 7. Building Culturally Competent Organizations. Retrieved August 03, 2020, from https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culturally-competent-organizations/main
- Collins, K.S., Hughes, D. L., Doty, M. M., Ives, B. L. Edwards, J. N., & Tenney, K. 2002. Diverse communities, common concerns: Assessing health care quality for minority Americans. New York: The Commonwealth Fund.
- Cooper, L. A., Roter, D. L. 2003. Patient-provider communication: The effect of race and ethnicity on process and outcomes of healthcare. In B. D. Smedley, A. Y. Stith & A. R. Nelson (Eds.) Unequal treatment: Confronting racial and ethnic disparities in health care (pp. 552-593). Washington, DC: The National Academies Press.
- Green, A., Dr. (2019, February 14). Cultural Awareness in Healthcare: A Checklist. Retrieved August 03, 2020, from https://www.qualityinteractions.com/blog/cultural-awareness-in-healthcare-checklist
- Saha, S., Arbelaez, J. J., Cooper, L. A. 2003. Patient-physician relationships and racial disparities in the quality of health care. American Journal of Public Health, 93, 1713-1719.
- Wilson, J.F. 2003. The crucial link between literacy and health. Annals of Internal Medicine, 139, 875-878.

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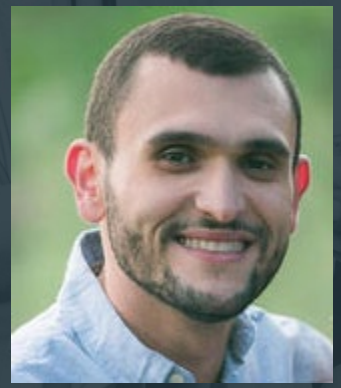
CMM Webinar Series:
Keys to Providing Effective Follow-up Care



Nader Tossoun, PharmD, APh, BCPS, CDCES
Clinical Pharmacist
Knollwood Pharmacy
Northeast Valley Health Center

Objectives

1. Select an appropriate frequency of follow-up based on individual patient / clinical needs
2. Leverage other individuals or strategies to provide effective follow-up care and monitoring
3. Establish a system for patients to contact pharmacist providers regarding home self-management / monitoring results

Pre/Post-Test

1. Which of these is true when scheduling a follow-up appointment for a patient who is on insulin?
   a) A 2-7 day follow-up is appropriate if the patient is reporting nocturnal hypoglycemia
   b) As the patient's A1c improves, 3-6 months follow-ups are recommended
   c) When the patient is at goal, the clinical pharmacy technician should check-up on the patient at least quarterly to assure patient maintains health goals.
   d) Only A and C
   e) All the above

2. Family members are untrustworthy resources to help with a patient's self-management goals and these duties should only be delegated to licensed healthcare professionals.
   a) True
   b) False

3. Which of these statements is true?
   a) Pharmacists should empower patients to solve their own problems when they have questions about their insulin doses and rely on figuring out the answers to their questions themselves.
   b) Pharmacists should encourage patients to call them whenever they think they are having adverse reactions from their medications
   c) Pharmacists should refrain from having their patients follow-up with other care coordinators or health educators and persuade the patient to only follow-up with themselves in order to consolidate and simplify care.
   d) It is better to wait until a patient is able to make an in-person visit than opt for telephone appointments because they are more effective

Patient Case

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Patient Case

- March 26, 2020; 10:45 AM (Virtual Visit d/t stay-at-home orders)
- MG is a 54 y.o. F patient with a PMH sig for DM type 2 (diagnosed 2014) and mixed hyperlipidemia; referred to clinical pharmacy for DM management
- Uninsured (on 340B program)
- Social History: works part-time at school and takes care of her grandchildren; lives with husband and adult daughter; no smoking hx; no alcohol hx
- Has a few readings from glucometer:
  - AM: 249, 222, 264, 245, 251, 280
  - PM: 414
- Current Medications:
  - Metformin 1000mg BID (started 11/2014)
  - Glimepride 4mg BID (started 7/2016)
  - Pioglitazone 30mg daily (5/2018)
  - Atorvastatin 20mg daily

Results are viewed by lab short description.

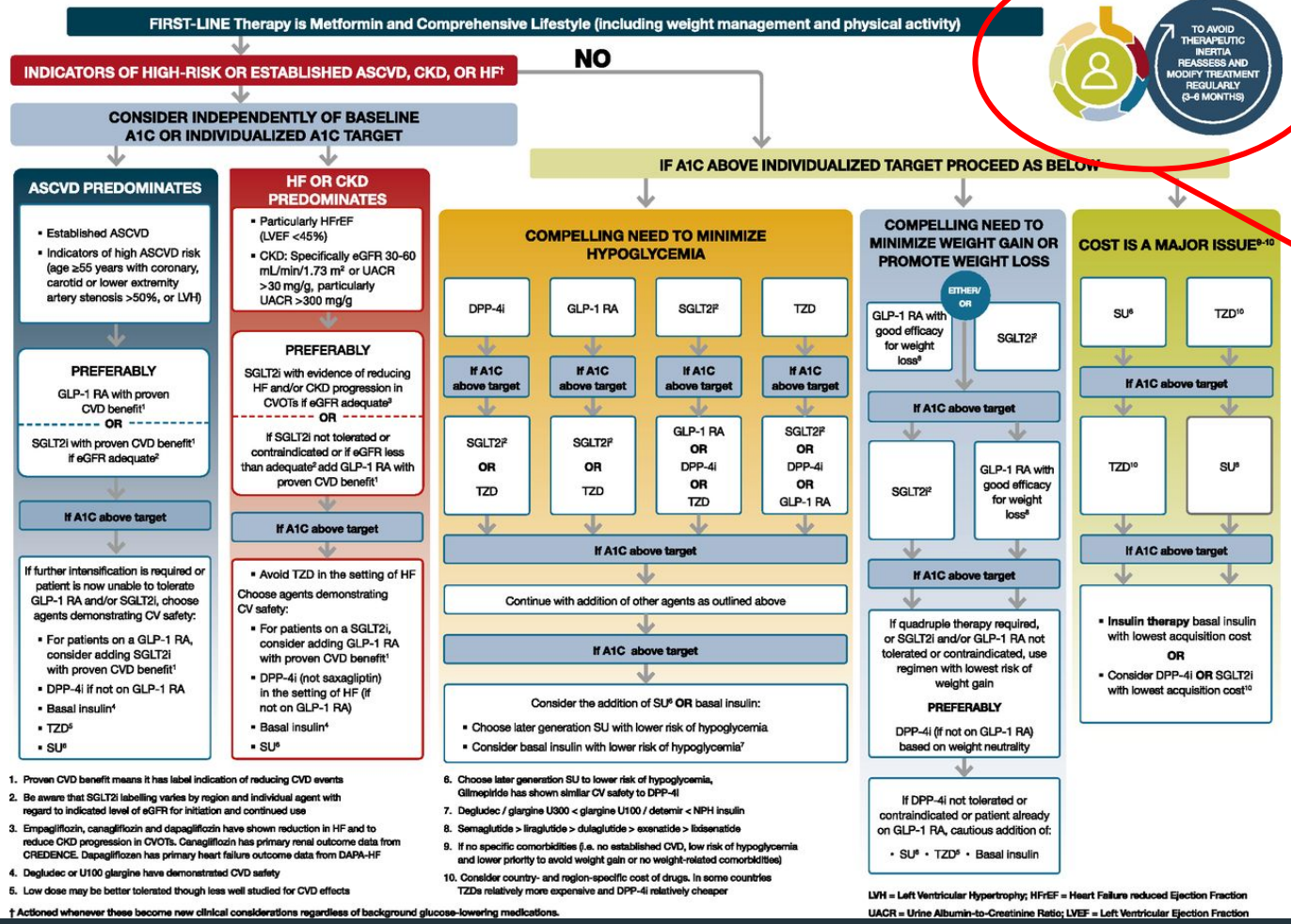
Collection Date & Time	02/05/2020 20:14	01/27/2020 14:35	08/30/2019 09:57	04/06/2019 13:22
HGBA1C	9.0	8.9	7.4	9.5

- *All other labs and vitals are WNL*

Patient's Previous Appointments

- 3 follow-up appointments (May 2019, September 2019, February 2020) had the same plan:
  - Pt declined medications adjustment and insulin
  - Pt is to work on lifestyle modification
  - Take medication as directed
  - Bring a log to clinic on next visit
  - Do regular physical activities/exercises like walking 30 minutes 5 days a week or total of 150 minutes a week.
  - Cut down on sugar and starch. Avoid concentrated sweets.
  - Check feet daily for skin lesions like wound, rash, callus
  - Report symptoms of hypoglycemia such as shakiness, dizziness. BS<70
  - weight management
  - Complete lab prior to your next appointment

What Would You Recommend?



American Diabetes Association®

Overcoming Therapeutic Inertia

Despite more than 40 new diabetes treatment options being approved since 2005, and the ADA and other organizations developing clear guidelines and treatment algorithms, there has been no measurable improvement in glycemic control. In fact, between 1999 and 2014 the percentage of diabetes patients with an A1C > 9% actually increased. At the root of this problem is therapeutic inertia, **"The failure and to initiate or intensify therapy when therapeutic goals are not reached."**

Through the OTI initiative, ADA is ushering in a ***paradigm shift*** in the care of type 2 diabetes, advancing the ***latest thought-leadership, resources, and tools in overcoming therapeutic inertia*** for primary care. We are working to help physicians, nurse practitioners, physician assistants, pharmacists, dietitians, and diabetes educators more effectively partner with their patients with diabetes to help them ***live longer, healthier lives.***

https://professional.diabetes.org/meeting/other/overcoming-therapeutic-inertia

Assessment and Plan

Detail Type	Description
Assessment	Diabetes type 2, uncontrolled (E11.65).
Impression	Goal A1c: <7% Current A1c: 9.0% (2/5/20) MTM Rationale: Pt with highly uncontrolled type 2 DM. Drug Therapy Problem - Additional Drug Therapy Needed: +Synergistic/Potentiating - insulin education given --> pt agreed to start insulin. Will stop piogltiazone since medication is assoc with long-term conseuqneces and replace with insulin..
Provider Plan	Stop Actos START Novolin N 7 units Q12 hours Cont Metformin 1000mg BID Cont Glimepride 4mg BID START SMBG TID: FBG + Pre-dinner + 2 hr post-dinner

Create a **follow-up plan** for this patient

- Next appointment?
- What resources can you use?

Scheduling Follow-up

- Follow-up Frequency must be ***adaptable***
  1. Initially/more acute: 2-7 days
  2. Less frequent as clinical status improves, usually no less than monthly (every 2-4 weeks per case)
  3. After goals achieved: Clinical pharmacy tech's should check in at least quarterly to maintain gains

- Secret to success of clinical pharmacy programs?
  - **<u>ACCESSIBILITY!</u>**
  - Consider extended hours / more weekend availability if needed to improve accessibility

Identify Your Team

- Collaborate with nurses, health educators, care coordinators, nutritionists, therapist, etc. if available
- Engage family and caregivers when possible
- Consider selective home visits or partnering with healthcare team members who are already visiting the patients at home (e.g., community health workers, social work)

Patient Empowerment

- Use Motivational Interviewing!
  - Use OARS
- Shift from “Savior role” to “Coach role”
  - This shifts responsibility to the patient, they are in control of their circumstances, BUT they are not alone!
- Use positive affirmation!
  - Ex. If patient only checked 2-3 times per week instead of daily as directed, celebrate the win!
- Establish a system for patients to contact pharmacist providers regarding home self-management / monitoring results

Customize Patient-Centered Tools

Name/Nombre:

Medication & Insulin Regimen/Régimen de Medicación e Insulina:

Northeast Valley Health Corporation
a californiahealth center

My Blood Sugar Goals/ Mis Metas de Azúcar en la Sangre	
Fasting& before meals/ En Ayunas y antes de las comidas:	80 a 130 mg/dL
2 hours after meals/ 2 horas después de comer:	<180mg/dl
Bedtime/ Hora De Acostarse:	100 a 140 mg/dL

Exercise/Ejercicio:

30 x 5

Min/Día Día/Semana

My Healthy Plate

Mi Plato Saludable

Date/ Fecha	Breakfast/Desayuno		Lunch/Almuerzo		Dinner/Cena		Bedtime/ Hora de Acostarse
	Before/Antes Fasting/ En Ayunas	2 hours after/ 2 horas después	Before/ Antes	2 hours after/ 2 horas después	Before/ Antes	2 hours after/ 2 horas después	

Virtual-Visits Best Practices

- Delegate someone to call patient for appointment-reminders the day before
- 3 phone call tries is not the golden rule. Call until you reach the patient
- Unscheduled “check-in” phone calls
  - Create a list of patients that have already agreed to “check-in” phone calls
  - Go down the list when you have a broken appointment
- Consider offering video-conferencing
  - Facetime, OTTO health, etc.

Back to our Patient!

- Initial appointment: March 26, 2020

Detail Type	Description
Assessment	Diabetes type 2, uncontrolled (E11.65).
Impression	Goal A1c: <7% Current A1c: 9.0% (2/5/20) MTM Rationale: Pt with highly uncontrolled type 2 DM. Drug Therapy Problem - Additional Drug Therapy Needed: +Synergistic/Potentiating - insulin education given --> pt agreed to start insulin. Will stop piogltiazone since medication is assoc with long-term conseuqneces and replace with insulin..
Provider Plan	Stop Actos START Novolin N 7 units Q12 hours Cont Metformin 1000mg BID Cont Glimepride 4mg BID START SMBG TID: FBG + Pre-dinner + 2 hr post-dinner

2 week follow-up with Family Medicine Care Coordinator (FMCC)

- Follow-up appointment **flip-visit** with FMCC: April 9, 2020

History of Present Illness:

1. DM type 2
   Follow-up appointment with clinical pharmacist for the management of DM type 2.

   Telephone appt d/t Coronavirus Pandemic.
   Flip-call with FMCC:
   Pt started on Insulin last week. Has been able to administer twice daily as prescribed at 7 units . Pt states has noticed a change in her home blood sugar and says she has been doing cardio (video) exercises 3-4x/week at home. Reports the following bs since starting insulin :
   Fasting: 140,138,106,87,130,93,125,97,94,76(today)
   pre-dinner: 153,177,138,93,153,163,160,154
   after dinner: 188,144,106,153,103,148,202 (heavier meal),,118,131,117

   Current DM Medications:
   Metformin 1000mg BID
   Glimeride 4mg BID
   NPH 7 units Q12 hours

#	Detail Type	Description
1.	Assessment	Diabetes type 2, uncontrolled (E11.65).
	Impression	Goal A1c: <7% Current A1c: 9.0% (2/5/20) MTM Rationale: Pt with highly uncontrolled type 2 DM. Drug Therapy Problem - Dosage Too Low: +Dose adjustment recommended - titrating AM dose of NPH to target pre-dinner readings <140.
	Patient Plan	**CONT d/t with FMCC** A blood glucose log and medication list were given to the patient with specific written instruction on how and when to take medications and check/log blood glucose. Instructed patient to bring back this log for every MTM visit. Discussed how to identify and treat low blood sugar (hypoglycemia). Lab results discussed with patient and all questions were answered. Medication therapy plan was extensively discussed including possible adverse drug reactions, drug interactions, and therapeutic effects. Education: Education provided considers health literacy level. Patient states/demonstrates understanding of the assessment, plan, and health education provided.
	Provider Plan	Increase Novolin N 7 units Q12 hours --> 9 units QAM + 7 units QPM Cont Metformin 1000mg BID Cont Glimepride 4mg BID Cont SMBG TID: FBG + Pre-dinner + 2 hr post-dinner

2 week follow-up with PharmD

- Follow-up appointment: April 23, 2020

History of Present Illness:

1. DM type 2
   Follow-up appointment with clinical pharmacist for the management of DM type 2.

   Telephone appt d/t Coronavirus Pandemic.

   FBG: 76, 87, 103, 72, 87, 89, 112, 131, 69, 76, 77, 93, 81, 63, 66
   Pre-dinner: 112, 110, 125, 124, 114, 62, 121, 112, 161, 141, 106, 89, 82
   Post-dinner: 140, 130, 125, 110, 78, 121, 81, 177, 161, 135, 113, 111, 101

   Current DM Medications:
   Metformin 1000mg BID
   Glimeride 4mg BID
   NPH 9 units QAM + 7 units QPM

**Phone number given to patient in case of future hypos

#	Detail Type	Description
1.	Assessment	Diabetes type 2, uncontrolled (E11.65).
	Impression	Goal A1c: <7% Current A1c: 9.0% (2/5/20) MTM Rationale: Pt with highly uncontrolled type 2 DM. Drug Therapy Problem - Dosage Too Low: +Dose adjustment recommended - titrating AM dose of NPH to target pre-dinner readings <140 Drug Therapy Problem - Dosage Too High: +Dose adjustment recommended - cutting SU by 50% to reduce risk of hypos..
	Provider Plan	REDUCE Glimepride 4 --> (1/2 tablet) 2mg BID Increase Novolin N 9 -->10 units QAM + 7 units QPM Cont Metformin 1000mg BID Cont SMBG TID: FBG + Pre-dinner + 2 hr post-dinner Patient was able to explain how to recognize s/sx of hypoglycemia and how to self-treat An interpreter was used for this clinic visit Language: Spanish

1 month follow-up with PharmD

- Follow-up appointment: May 21, 2020

History of Present Illness:

1. DM type 2
   Follow-up appointment with clinical pharmacist for the management of DM type 2.

   Telephone appt d/t Coronavirus Pandemic.

   FBG: 106, 84, 72, 103, 115, 72, 62, 101, 128, 100
   Pre-dinner: 77, 125, 114, 86, 131, 135, 131, 103, 79
   Post-dinner: 124, 106, 128, 83, 151, 110, 119, 98

   RBG: 111

   Current DM Medications:
   Metformin 1000mg BID
   Glimeride 4mg (1/2 tablet = 2mg) BID
   NPH 10 units QAM + 7 units QPM

#	Detail Type	Description
1.	Assessment	Diabetes type 2, uncontrolled (E11.65).
	Impression	Goal A1c: <7% Current A1c: 7.7% (4/28/2020) <-- 9.0% (2/5/20) MTM Rationale: Pt with uncontrolled type 2 DM. Huge improvement with insulin. Drug Therapy Problem - Unnecessary Drug Therapy: +Duplicate therapy/+Treating avoidable ADR - no need for SU now that patient is taking insulin, may be contributing to hypos. Drug Therapy Problem - Dosage Too Low: +Dose adjustment recommended - titrating insulin to compensate for lack of SU..
	Provider Plan	STOP Glimepride 2mg BID Increase Novolin N 10 --> 11 units QAM + 7 --> 8 units QPM Cont Metformin 1000mg BID Cont SMBG TID: FBG + Pre-dinner + 2 hr post-dinner **discharging pt d/t A1c < 8%, PCP appt in 8/2020 for f/u**

**discharge plan included monthly follow-up by FMCC and to report to PharmD any abnormalities

Collection Date & Time	08/03/2020 10:28	04/28/2020 11:56	02/05/2020 20:14	01/27/2020 14:35	08/30/2019 09:57	04/06/2019 13:22
HGBA1C	6.5	7.7	9.0	8.9	7.4	9.5

Pre/Post-Test

1. Which of these is true when scheduling a follow-up appointment for a patient who is on insulin?
   a) A 2-7 day follow-up is appropriate if the patient is reporting nocturnal hypoglycemia
   b) As the patient's A1c improves, 3-6 months follow-ups are recommended
   c) When the patient is at goal, the clinical pharmacy technician should check-up on the patient at least quarterly to assure patient maintains health goals.
   d) Only A and C
   e) All the above

2. Family members are untrustworthy resources to help with a patient's self-management goals and these duties should only be delegated to licensed healthcare professionals.
   a) True
   b) False

3. Which of these statements is true?
   a) Pharmacists should empower patients to solve their own problems when they have questions about their insulin doses and rely on figuring out the answers to their questions themselves.
   b) Pharmacists should encourage patients to call them whenever they think they are having adverse reactions from their medications
   c) Pharmacists should refrain from having their patients follow-up with other care coordinators or health educators and persuade the patient to only follow-up with themselves in order to consolidate and simplify care.
   d) It is better to wait until a patient is able to make an in-person visit than opt for telephone appointments because they are more effective

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Thank You

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