• **Together 2 Goal® Updates**
  – Webinar Reminders
  – September 2017 Monthly Webinar
  – Goal Post August Newsletter Highlights

• **Role of Community Pharmacists in Diabetes Care**
  – Jennifer Humeniuk and Dalga Surofchy of Ralphs Grocery Company

• **Q&A**
  – Use Q&A or chat feature
• Webinar will be recorded today and available the week of August 21st
  – Together2Goal.org Website (Improve Patient Outcomes → Webinars)
  – Email distribution

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
• **Date/Time:** Thursday, September 21, 2-3pm Eastern

• **Topic:** Patient Involvement in Together 2 Goal®

• **Presenters:** Roberta Eis, R.N., B.S.N., M.B.A.; Heather Olden, M.P.H.; and Nicole Crosato of Henry Ford Health System
Together 2 Goal®
Diabetes Symposium

in collaboration with:

American Diabetes Association®
• **August 25:** Deadline for the reduced rate at the Together 2 Goal® Diabetes Symposium

• **September 12-13:** Together 2 Goal® Diabetes Symposium in Indianapolis, IN
GOAL POST NEWSLETTER:
AUGUST RESOURCE OF THE MONTH

Resource of the Month

©2017 AMGA FOUNDATION
TODAY’S SPEAKERS

Jennifer Humeniuk, Pharm.D.
Patient Care Coordinator, Ralphs Grocery Company
Adjunct Professor, Western University of Health Sciences

Dalga Surofchy, Pharm.D.
PGY-1 Community Pharmacy Resident, UC San Diego and Ralphs Grocery Company
The Role of the Community Pharmacist in Diabetes Care

Jennifer Humeniuk, PharmD, APP, BCACP, CDE
Patient Care Coordinator

Dalga Surofchy, PharmD
PGY-1 Community Pharmacy Resident
Speakers

• Jennifer Humeniuk, PharmD
  – Patient Care Coordinator, Ralphs Grocery Company (a division of the Kroger Company)
  – Advanced Practice Pharmacist, Certified Diabetes Educator

• Dalga Surofchy, PharmD
  – PGY-1 Community Pharmacy Resident, Ralphs/UC San Diego
Learning Objectives

• Describe pharmacist attributes that make them well-suited to provide diabetes care in the community setting.
• Review examples of successful community pharmacy-based diabetes care initiatives.
• Discuss possibilities for future collaboration between community pharmacists and other health care providers to improve diabetes care.
• Provide resources for medical providers to facilitate collaboration with community pharmacists.
Why a Community Pharmacist?

• Convenience: most accessible health care professional
• Medication experts
  – Help manage, monitor, and in some circumstances, adjust complex drug regimens
• Can provide more frequent contact than physicians
• Validated results
  – Asheville project, USC CMM pilot, Missouri Pharmacy-Assisted Collaborative Disease Management, APhA Project Impact, etc.
Which of these have you done at a pharmacy...

ONE IN FIVE
HAD BLOOD PRESSURE CHECKED

ONE IN TWO
ASKED QUESTIONS ON MEDICATIONS

OVER ONE IN FOUR
RECEIVED VACCINATIONS

ONE IN SEVEN
TREATED FOR COLD/ILLNESS

NEARLY NINE OUT OF TEN
FILLED A PRESCRIPTION

...in the past 12 months?

Source: National Opinion Elite Internet Survey, Commissioned by NACDS, August 2015

Ralphs Pharmacy

• First Ralphs Pharmacy opened in 1999
• 79 pharmacies in Southern California
• Part of the Kroger Company’s family of 2000+ pharmacies
  – National grocery chain pharmacy
  – 32 divisions across 34 states and DC
Diabetes Care at Ralphs

• Full Service Pharmacy & grocery store
• Personalized counseling
  – Medications and lifestyle
  – APhA Diabetes Care certified pharmacists
• Point-of-Care testing
• Routine immunizations
• Glucometers, supplies, and other diabetes care products
Ralphs Diabetes Coaching Program

• Empowers the patient to better manage DM (and co-morbidities)
• Communicate results and recommendations to primary care provider (PCP) or endocrinologist
  – Can help to overcome clinical inertia by providing monitoring/follow-up between physician visits
• Interventions and education based on ADA guidelines
Patient Assessment

• Point-of-Care Lab Tests
  – A1c (performed every 3-6 months)
  – Fasting Lipid Panel (performed at least yearly)
  – Glucose measurements (as needed)

• Physical assessments
  – Body composition (height, weight, waist circumference, body fat)
  – Blood pressure
  – Comprehensive foot exam
Patient Assessment (cont.)

- Knowledge Assessment
- Quality of Life assessment
- Nutrition and Exercise Assessment
- Injection technique
  - Insulin, GLP-1 agonists, Glucagon (type 1 only)
- Glucose Monitoring technique
- Self-care assessment
  - Are they getting recommended exams to prevent complications?
Visit Structure

- Regular visits with specially trained pharmacist
  - Less-frequent consults with dietitians, in some divisions
- Visits usually occur every 1-3 months
  - Frequency depends on needs of patient
- Last 30-60 minutes
- Occur in the pharmacy
Diabetes Self-Management Education

• Accredited program of standardized education
  – Topics include: Disease process, Medications, Monitoring, Acute Complications, Chronic Complications, Basic/Advanced nutrition, Psychosocial

• Available in some Kroger divisions
  – Ralphs is looking to establish DSME services
DSME versus Coaching Program

**DSME**
- Usually covered by insurance
- Accredited by national organization (e.g. ADA)
- Limited # of longer class sessions (group/individual)
- May be repeated at intervals depending on patient needs
- Mostly education (little physical assessment)

**Diabetes Coaching Program**
- Usually paid for by employer groups
- Internal QA (not accredited)
- Shorter, on-going individual sessions
- Education AND continuing care
Diabetes Care in Community Pharmacy

• Cincinnati Pharmacy Coaching Program (CPCP)

• Diabetes Ten Cities Challenge (DTCC)
CPCP (Cincinnati Pharmacy Coaching Program)

- Anthem BCBS Ohio and Kroger Pilot project
- Pharmacy-based educational services and Point-of-Care Testing at Kroger Pharmacies
- Incentives to eligible BCBS members
  - Diabetes Coaching Program (DCP)
  - Heart Healthy Coaching Program (HHCP)

CPCP -- Background

• Major cost burden for US Health Care System
  – Per ADA in 2008, DM $116 billion annually

• Need innovative cost saving strategies
  – Value-based Insurance Design (VBID)
    • VBID $ incentives (copay waiver, HSA $), prevention, education

• Modeled after successful Asheville Project
  – Validated impact of outreach and education on clinical outcomes.

CPCP -- Methods

- Pre-/post longitudinal study
- Intervention group vs. matched control group
- Intervention group: 607 DM/HTN patients
  - Voluntary participation
  - Regular clinical pharmacist visits (1-3 mo.)
  - Continuous pharmacy management
- No formal collaborative practice agreement
CPCP -- Outcomes

Economic:
CV related medical claims x 2 years

Clinical:
A1C, BP, Lipids

Other:
Med Adherence, Med Change
FIGURE 2
HHCP and DCP clinical goal attainment

- Baseline†
- Post-index

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Post-index</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCP BP goal &lt;140/90 mmHg*</td>
<td>52%</td>
<td>70%</td>
</tr>
<tr>
<td>HHCP LDL-C goal &lt;160, &lt;130, or &lt;100 mg/dL*</td>
<td>71%</td>
<td>84%</td>
</tr>
<tr>
<td>DCP HbA₁c &lt;7%*</td>
<td>44%</td>
<td>62%</td>
</tr>
<tr>
<td>DCP BP goal &lt;130/80 mmHg*</td>
<td>25%</td>
<td>37%</td>
</tr>
<tr>
<td>DCP LDL-C goal &lt;100 mg/dL*</td>
<td>62%</td>
<td>73%</td>
</tr>
<tr>
<td>DCP Non-HDL-C goal &lt;130 mg/dL*</td>
<td>60%</td>
<td>75%</td>
</tr>
</tbody>
</table>

*P<0.05 for all comparisons shown
†Baseline was defined as clinical value obtained on index date or up to 183 days before index date. The latest value of the clinical measure within each time interval, if available, was captured for the analysis.
CPCP--Results

ER costs decreased by 89%

Total medical costs increased 11% vs 300%, tx vs control group (p<0.05)

HTN-related cost reduction 39.2% vs 16%, tx vs control (p<0.05)

Increased rx and outpatient costs in the tx group, offset by CV prevention

Economic Outcomes

Discussion

CPCP demonstrated statistically significant clinical improvements

Adherence improved

CV related cost savings > increase in OP visits and Rx $ increase

Novel insurance models + Pharmacy for Chronic disease mgmt.

Limitations

• Follow-up only 2 years
  – Longer term may be needed for more robust economic outcomes

• Retrospective claims analysis → associations but not causality

• Volunteer Bias

DTCC (Diabetes Ten City Challenge)

- Multistate community pharmacy health management program for patients with DM.
  - Ten distinct employers and community pharmacists
  - Took place between 2006 and 2007
  - 573 volunteer patients with DM
  - Professional clinical pharmacists w/specialized DM training

DTCC Main Objectives

IMPLEMENT:
Employer-funded, collaborative health management program using community-based pharmacist coaching

UTILIZE:
Evidenced-based diabetes care guidelines
Self-management strategies designed to keep patients with diabetes healthy and productive

IMPLEMENT:
Patient self-management assessment and training
Equips patients with the knowledge, skills, and performance-monitoring to manage their own care

PMID: 19357068
DTCC--Methods

• Employers responsible for:
  – insurance cost
  – incentives for patients and pharmacist providers
    • E.g. waived copayments
  – recruiting participants

• Pharmacists:
  – Perform assessments and point-of-care tests
  – Provide personalized self-management education
  – Collaborate with physicians for further work up, medication adjustment, or labs as needed

• Assessed one year of medical and Rx claims

DTCC: Patient Assessment Tool

• The APhA Foundation’s “Patient Self-Management Credential (PSMC) for Diabetes”
  – Validated tool
  – Patient centered and focused
• Measures patient’s ability to manage their diabetes
  – Personalized education/interventions

Clinical and Economic Results
Overview

Table 3. Clinical outcomes for participants in the Diabetes Ten City Challenge

<table>
<thead>
<tr>
<th>Parameter</th>
<th>n</th>
<th>Baseline values Mean (95% CI)</th>
<th>Year 1 values Mean (95% CI)</th>
<th>Change from baseline to year 1 Mean (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C (%)</td>
<td>554</td>
<td>7.5 (7.36, 7.84)</td>
<td>7.1 (7.03, 7.26)</td>
<td>−0.4 (−0.47, −0.24)</td>
<td>0.002</td>
</tr>
<tr>
<td>LDL-C (mg/dL)</td>
<td>528</td>
<td>97.5 (94.76, 100.18)</td>
<td>94.1 (91.36, 96.77)</td>
<td>−3.4 (−5.53, −1.28)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SBP (mm Hg)</td>
<td>551</td>
<td>132.5 (131.12, 133.84)</td>
<td>130.1 (128.67, 131.47)</td>
<td>−2.4 (−3.79, −1.03)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DBP (mm Hg)</td>
<td>550</td>
<td>80.8 (79.21, 80.85)</td>
<td>77.6 (76.78, 78.41)</td>
<td>−2.4 (−3.34, −1.53)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>533</td>
<td>34 (33.33, 34.63)</td>
<td>33.6 (32.96, 34.20)</td>
<td>−0.4 (−0.61, −0.19)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Abbreviations used: 95% CI, lower and upper limits of the 95% confidence interval; A1C, glycosylated hemoglobin; BMI, body mass index; DBP, diastolic blood pressure; LDL-C, low-density lipoprotein cholesterol; SBP, systolic blood pressure.
*P* value determined by applying a two-tailed *t* test for paired data to the mean change data.

![Table 3](image)

Every 1% drop in A1C reduces microvascular complications by 40%.

Every 1% reduction in LDL-C corresponds to a 1.0% to 1.5% reduction in cardiovascular events.

For every 10 mmHg reduction in SBP risk for any CV complication related to diabetes is reduced by 12%.

DTCC--Limitations

• No control group
• Observational review → limiting conclusions and generalizability
• Volunteer bias
  – Participant health status
• Claims data reporting formats
  – Challenging to interpret

Community pharmacist-provided Patient Care Services

• Summary:
  – Community pharmacy-based interventions showed improvements in clinical outcomes as well as economic outcomes.
    • Improved accessibility to care
  – Most studies to date are short-term
    • long term benefits are still unclear

• Communication and collaboration between pharmacist, patient, and physician is vital for success.
What will the future hold for physician-pharmacist collaboration?
Medication Nonadherence

• America’s “other drug problem”
  – 3 out of 4 Americans report that they don’t always take medication as directed*
  – $290 billion in avoidable costs to the health care system annually.*

• Adherence measures included in CMS “Star Ratings”

• Nonadherence could be:
  – Missed doses or excessive doses
  – Inappropriate administration technique
  – Never pick-up a new medication

Pharmacists’ Role In Medication Adherence

• Monitor patterns of use using dispensing software and commercial MTM platforms (e.g. Mirixa, Outcomes).

• Enroll at-risk patients in automatic refill or medication synchronization program

• EQuIPP tool:
  – Monitor rates of adherence for targeted drug classes
  – Track adherence trends over time
  – Identify opportunities for intervention (e.g. gaps in therapy)
Ralphs Physician Detailing Pilot

• Pilot program in select Ralphs Pharmacy locations in southern California
• Collaboration with 84.51°
  – Consumer research and customer engagement firm.
• Objectives:
  – To establish and enhance relationships with community Physician partners
  – Use aggregated patient data to drive more personalized conversations between pharmacists and physicians to drive better health outcomes
  – To enhance relationships with physicians that ultimately help drive script growth and patient outcomes (adherence)
Ralphs Physician Detailing Pilot

- Identify community physicians whose patients currently use Ralphs Pharmacy and have DM
- Pharmacy managers visit each physician to:
  - Outline the types of services offered by the pharmacy
  - Establish relationship
  - Provide a customized “scorecard” to help the physician identify areas of opportunity
Physician Detailing Scorecard

• Leverage the 84.51° scorecard to have a conversation “personalized” to the physician and our shared patients

• Scorecard contains aggregated patient data ONLY (no PHI), such as:
  – Demographics
    • e.g. # of the physician’s patients that use a Ralphs pharmacy, # of physician’s patients with DM that use a Ralphs pharmacy.
  – Quality metrics
    • e.g. % of DM patients on a statin, % of patients filling 90-days for maintenance meds, % of patients with PDC <80% (low medication adherence)
  – Aggregated grocery shopping behaviors
    • e.g. % of patients with a below average nutrition score
Expanded Pharmacist Roles

• SB493: established provider status for pharmacists in California

• Allows pharmacist to
  – independently furnish certain classes of medications
  – Order/interpret laboratory tests
    • Monitor/manage efficacy and toxicity of drug therapies, in coordination with the patient’s primary care provider/diagnosing prescriber.

• Established “Advanced Practice Pharmacist designation.
Expanded Scope of Practice: Advanced Practice Pharmacist (APP)

• Authorized to:

- Perform patient assessments
- Order/interpret lab tests**
- Refer patients to other providers
- Initiate, adjust or d/c drug therapy**
- Participate in evaluation/management of diseases**

**in collaboration with other healthcare providers
Collaborative Drug Therapy Agreements (CDTA)

• AKA “Collaborative Drug Therapy Management (CDTM)” or “Collaborative Practice Agreement (CPA)”

• Formal Agreement between pharmacist(s) and healthcare provider(s)
  – A formal practice relationship
  – Specify what patient care services can be provided by the pharmacist
    • Modification of current drug therapy
    • Initiation of new therapy
    • Ordering labs
    • Performing physical assessment of the patient

http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=14710
Benefits of CDTAs

• Makes drug therapy changes easier and more efficient for the patient, pharmacist and physician
• Helps physicians satisfy unmet needs or unsolved problems of patients
  – Helps overcome “clinical inertia”**
• Extends access to underserved populations where physician access is limited.
• Increases rates of preventive care

Opportunities for Collaboration

• Without a formal CDTA
  – Refer a patient to an existing pharmacy-based coaching program.
  – Refer a patient to a community pharmacy for Medication Therapy Management (if offered)
  – Refer a patient to an accredited DSME program
  – Limitations: Communication barriers, delay in making therapeutic changes, no formally established expectations
Opportunities for Collaboration

• Establish a CDTA (or CPA)
  – Pharmacist able to make drug therapy changes in real-time.
  – Allowable services and expectations outlined in a formal agreement.
  – Communication requirements established in formal agreement

  – Limitations:
    • lack of understanding of how to enter into CPA, finding willing/qualified community pharmacists with whom to collaborate
Barriers to Collaboration

• Communication
  – Pharmacist preference vs. physician preference
  – Phone, fax, e-mail, face-to-face

• Reimbursement
  – Pharmacists are not recognized by Medicare as providers yet
  – Billing for services can be a challenge

• Liability concerns

• Lack of infrastructure

Final thoughts

• It’s all about relationships...
Final Thoughts

• Community pharmacists are well-positioned to provide *high-quality* diabetes care through a variety of payment models.
• Communication between the community pharmacist and the patient’s primary care team is *critical*, with or without a formal collaborative practice agreement.
• Innovation is needed to establish the systems and processes to allow for greater collaboration between physicians and community pharmacists.
Resources


• Collaborative Practice Agreements

• “Collaborative Practice Agreements and Pharmacists’ Patient Care Services: A resource for doctors, nurses, physician assistants, and other providers.”

• National Alliance of State Pharmacy Associations (NASPA) Toolkit. https://naspa.us/resource/cpa/
Questions?

Contact me at:

jennifer.humeniuk@ralphs.com