August 25, 2016

Dear NC CPESN Pharmacy Partners,

This communication contains a DRAFT tool that you could consider using with your pharmacy technicians and pharmacists as part of the monthly medication synchronization process. The goal of this questionnaire is two-fold: 1) to interweave questions about the patient's health status (overall and for specific disease states) into med sync so that it becomes "clinical med sync", and 2) to empower your pharmacy technicians to gather information and drive workflow for the "clinical med sync" process just as they likely do for your dispensing med sync process, yet have a clear way to flag the pharmacist about clinical concerns that require his/her attention and assessment.

You are receiving this DRAFT tool for one of the following reasons:

1) your pharmacy is very engaged in providing CIPA with follow up to your high-risk patients
2) your pharmacy does a lot of medication synchronization
3) your pharmacy has made it known to CCNC that you are actively trying to integrate CIPA with follow up and monthly medication synchronization activities

While there is no expectation that you use this tool, we would like to seek feedback from any of you who do choose to pilot it with your pharmacy technicians while conducting monthly medication synchronization calls to patients. The goal is to have a few of our CPESN stores test drive some or all of these questions during the months of September and October 2016 so that we can seek your feedback, update the form into an official clinical med sync questionnaire, and share it for CPESN general use in November.

Please note that the thresholds/responses that are listed as needing pharmacist review are *general guidance*. *Your pharmacy should review the responses in red and change them, if necessary, to align with the comfort level of your pharmacist staff before piloting the form*.

Please don't hesitate to contact me or Joe Moose if you have questions, comments, or concerns about this DRAFT clinical med sync tool.

Joe: joe@moosepharmacy.com or 704-783-5483
Trista: tpfeiffenberger@n3cn.org or 919-357-1049

Thanks as always for your active partnership!

Best regards,
Trista

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Trista Pfeiffenberger
Director, Network Pharmacy Programs
Community Care of North Carolina

Red – route to pharmacist for review

MONTHLY "CLINICAL" MEDICATION SYNCHRONIZATION CALLS:

N/A	N/A	What new medicines, either prescription or over the counter, have you started taking in the past month?
Yes	No	Have you been to the doctor in the past month? If yes, what doctors did you see? Were any changes made to your medicines? If no, when is your next doctor's appointment? Is it a regular check-up, or have you made the appointment because you are feeling ill?
Yes	No	Have you been to the hospital or emergency department in the past month? If so, why? How are you feeling now? Were any changes made to your medicines? Have you already made those changes to your medicine? Do you have a follow up appointment scheduled with your primary care doctor?
Yes	No	Has the doctor prescribed any medicines that you have not filled? Can you tell me a little bit about why you decided not to fill this medicine?
Yes	No	Did the doctor stop any of your medicines or change the directions or the dose? If yes, ask patient for details about medication changes.
Yes	No	Have you stopped or changed any medicines on your own? If yes, is your doctor aware that you stopped this medicine?
Yes	No	Do you get any prescriptions from other pharmacies? If so, which ones?
N/A	N/A	For medicines that you take only when you need them, such as your _____ [pharmacy staff to give example from the patient's med list - inhalers/creams/etc], how much is left? How often have you used it recently? (Compare to most recent fill date.) Do you need more?
Yes	No	Are you going to be able to pay copays for all of your medicines this month?
N/A	N/A	*For patients receiving packaging:*

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		What day/pack are you currently on? (Consider having delivery driver confirm amount remaining.) *For patients with bottles:* How many tablets remain in each bottle? (Consider having delivery driver confirm amount remaining.)
N/A	**N/A**	Review the patient's list of medications, noting the NAME, STRENGTH, and DIRECTIONS for each. Ensure that the patient is taking the medications as they are written and according to the directions we have on file. Note any differences. If the patient appears to be non-adherent, as the following: How many doses of *[medication name]* have you missed each week? What is causing you to miss your medications? ○ Cannot afford them ○ Concern about side effect(s) ○ Doesn't help me feel better ○ Makes me feel worse ○ Don't believe the medication works ○ Forget to take it ○ Lost the prescription ○ Out of refills ○ Other: _____ **If a patient refuses any CHRONIC medications, the pharmacist should be notified and given any explanation the patient offers for not taking the medication.** Be sure to ask about PRN medications each month. If a patient does not want a PRN medication, this is not considered an adherence concern. ***If any problems, changes, non-compliance, etc are found, the pharmacist should be notified. Consider notifying other care team members as well.***

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DIABETES:

		How often do you check your blood sugars? What was your reading this morning? Do you need testing supplies? What was your highest reading in the last 1-2 weeks? Share with pharmacist if highest reading was > 150 (or > 180 if patient checks blood sugar 1-2 hours after eating) What was the lowest reading in the last 1-2 weeks? Share with pharmacist if lowest reading was < 70
Yes	No	*If the patient reported that their lowest BG reading was < 70:* Did you have any low blood sugar symptoms within the past 2 weeks? *(Symptoms: Dizziness / lightheadedness, blurry vision, being very hungry, confusion, sweating, tremor / shakiness, feeling drunk)*
Yes	No	*If patient reported that their highest BG reading was > 250:* Did you have any high blood sugar symptoms within the past 2 weeks? *(Symptoms: Thirsty a lot, frequent urination, hungry a lot, weakness / tiredness)*
Yes	No	• Do you have any NEW dizziness or headaches?
Yes	No	• Do you have any NEW blurry vision?
Yes	No	• Do you have NEW numbness in your hands and feet?
Yes	No	• Do you have any NEW or un-healing wounds?

HIGH BLOOD PRESSURE:

Yes	**No**	• Do you check your blood pressure at home? What was the most recent result? Share results with pharmacist if systolic > 140 and/or diastolic > 90
Yes	**No**	• Do you have any recent chest pain or palpitations?
Yes	**No**	• Do you have any recent dizziness or lightheadedness?
Yes	**No**	• Have you had any recent headaches?
Yes	**No**	If patient is taking an ACEi: Do you have any dry cough? If "Yes", what time of day does it occur? ○ Morning ○ Afternoon ○ Evening ○ Bedtime ○ All day
Yes	**No**	If patient is taking a diuretic: Do you have any muscle weakness, spasms, or cramping?
Yes	**No**	If patient is taking amlodipine: • Do you have any swelling in the legs or feet?

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HIGH CHOLESTEROL:

Yes	**No**	• Do you have any NEW muscle pain, tenderness, or weakness (not due to exercise or specific injury)?
Yes	**No**	• Does your urine appear dark in color, like tea or Coca-Cola?
Yes	**No**	• Do you have any NEW stomach pain?
Yes	**No**	• Do you have any yellowing of the eyes or skin?

ASTHMA:

Yes	**No**	• Do you measure your peak flow meter? If "Yes": ○ What are your morning readings, when you first wake BEFORE taking any medication? _____ ○ What are your midday (noon to 2PM) readings, AFTER taking albuterol? _____
Yes	**No**	• Have you had to take your oral steroid (such as prednisone) for a bad asthma attack since the last time we saw or spoke to you?
Score: _____		Consider asking patient the 5 questions from Asthma Control Test: www.asthmacontroltest.com/

HEART FAILURE:

Yes	**No**	• Do you weigh yourself every morning? → Instruct to weigh themselves every morning before breakfast and after urinating
Yes	**No**	• Have you gained >2 lbs in one day or >5 lbs in a week?
Yes	**No**	• Have you had recent or current swelling of ankles, feet or stomach that becomes worse, even after rest and leg elevation?
Yes	**No**	• Have you had recent or current shortness of breath that won't going away with rest or is worsening?
Yes	**No**	• Do you recently or currently find it harder to walk long distances or exercise than usual?
Yes	**No**	• Have you felt unusually weak or tired lately for no apparent reason?
Yes	**No**	• Have you been waking up at night recently with shortness of breath or cough, or needing more than usual number of pillows to sit up and sleep?
Yes	**No**	• Have you had to take more of your diuretic (water pill) than your normal dose?
Yes	**No**	• Are you limiting your fluid drinking to no more than 4-6 (8-oz.) glasses of per day (ALL liquids including water, coffee, tea, soups, juices, milk, etc.)
Yes	**No**	• Are you limiting your daily salt intake to less than 2,000 mg (a little less than a 1 teaspoonful) AND not adding salt to foods?

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COPD:

		• Complete COPD Assessment Test (CAT) online (Score: _____)
Yes	**No**	• Have you had worsening of your COPD symptoms that is **beyond normal day-to-day variation** If "Yes": ○ How many times has this happened since the last time we saw or spoke to you?
Yes	**No**	• Have you had to use your rescue inhaler (such as albuterol) more often than usual?
Score: _____		Consider asking patient the ___ questions from the COPD Assessment Test: http://www.catestonline.org/images/pdfs/CATest.pdf

DEPRESSION (PHQ-2 QUESTIONNAIRE):

Yes	**No**	Over the past two weeks, have you been bothered by either of the following problems? Little interest or pleasure in doing things. **YES** or NO Feeling down, depressed, or hopeless. **YES** or NO