PHARMACIST HEALTH COACHING

CARDIOVASCULAR PROGRAM

PROGRAM GUIDE

gsc green shield canada

INTRODUCTION

Heart disease and stroke are among the leading causes of hospitalization and death in Canada. In 2008, nearly 30 per cent of all deaths reported were due to cardiovascular disease. Hypertension, a known risk factor for the development of cardiovascular disease, affects one in five Canadians over the age of 20 while elevated cholesterol, another well-established risk factor, affects approximately 40 per cent of the population.

To control high blood pressure and elevated cholesterol, individuals must commonly rely on a combination of pharmacotherapy and healthy lifestyle changes. Data from 2010 shows that approximately one-third of patients treated for high blood pressure are not under control.* Key factors in improving management of these two conditions include: education on medications, education on lifestyle modifications, and a focus on improving adherence. Evidence suggests that pharmacists can provide these types of patient services to positively influence adherence to both drugs and health behaviours. Furthermore, the accessibility of pharmacies to most patients makes them an ideal setting to perform more frequent interventions with patients to sustain better adherence.**

Green Shield Canada's (GSC's) *Pharmacist Health Coaching* is a cognitive service provided by pharmacists that focuses on cardiovascular health and offers blood pressure and cholesterol management to patients. Its main objective is to empower patients diagnosed with hypertension and elevated cholesterol to take ownership and responsibility for their overall cardiovascular health. To achieve this objective pharmacists will:

1. Provide guidance and support to patients to achieve target blood pressure and cholesterol measurements.
2. Implement strategies that help improve patient adherence to cardiovascular drug therapy.
3. Offer effective coaching and follow-up to help patients adopt healthy lifestyle behaviours that will positively impact their cardiovascular and overall health.

The program is based on the results of a study sponsored by GSC in partnership with the Ontario Pharmacists Association (*Impact of Community Pharmacist Interventions in Hypertension Management on Patient Outcomes: A Randomized Controlled Trial*) which provided clear evidence that a significant percentage of patients who received pharmacist services had lower blood pressure, lower body mass indexes, improved medication compliance, and reduced drug costs.

ELIGIBILITY CRITERIA

The service is available to community-based patients who have a concurrent diagnosis of hypertension, elevated cholesterol, and meet all three of the following criteria:

- ✓ Have GSC extended health and drug benefit coverage
- ✓ Are under 65 years of age

**http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3483991/k.34A8/Statistics.htm.*

***"Impact of Community Pharmacist Interventions in Hypertension Management on Patient Outcomes: A Randomized Controlled Trial" Available at: https://www.opatoday.com/Media/Default/Reports/Hypertension%20Study%20-%20Final%20Report%20(January%208%20 2014).pdf.*

- ✓ Are being treated with a cardiovascular drug regimen that includes at least **one qualifying drug from each of the two categories below OR are being treated with a PCSK9 inhibitor as add-on therapy (regardless of hypertension status).**

1. Antihypertensive agents

- → Thiazide/thiazide-like diuretic
- → Beta-blocker
- → Long-acting calcium channel blocker
- → ACE inhibitor
- → Angiotensin II receptor blocker
- → Renin inhibitors

2. Cholesterol-lowering agents

- → HMG-CoA reductase inhibitor
- → Ezetimibe
- → PCSK9 inhibitor

PROGRAM DELIVERY

IDENTIFY ELIGIBLE PATIENTS

To get started, identify eligible patients based on the criteria outlined above. You can do this by reviewing your patient prescription profiles and contacting patients by phone, or by approaching them in your pharmacy. Please note that patient participation in the program is voluntary.

PREPARATION

Once an eligible patient has agreed to participate, you may choose to either:

1. Book an appointment for the patient to return at a later time; **or**,
2. Provide the service immediately.

When booking an initial or follow-up appointment, ask the patient to bring, if available, this information:

- → Current medication bottles and/or medication list, including vitamins, supplements, and herbal products. This could be a medication list previously generated during a formal medication review or a patient-generated medication list.
- → Home blood pressure measurements
- → Lipid panel
- → Height, weight, and abdominal circumference
- → Family doctor name and contact information

ASSESSMENT AND INTERVENTION

During the **initial visit**:

1. **Document** the patient's demographic information, allergies and intolerances, immunization status, current and accurate medication list, and family physician's name and contact information.
2. **Assess** adherence to medication, blood pressure and cholesterol control, smoking status, diet, level of physical activity, and 10-year cardiovascular risk. If appropriate, consider assessing medication literacy.
3. **Establish** goals for blood pressure and cholesterol control.
4. **Identify** patient goals for lifestyle and behaviour modification. If multiple goals are identified, we suggest focusing on one or two goals initially and adding more goals at follow-up visits as the patient progresses through the program.
5. **Coach** the patient to achieve desired goals.

During **each subsequent follow-up**:

1. **Update** the patient's demographic information, allergies and intolerances, immunization status, medication list, and family physician's contact information **as necessary**.
2. **Assess** adherence to medication, if necessary (e.g., patient with a low-to-moderate adherence score on the initial visit). Please note that although the recommendation to assess medication adherence during the first and second follow-up visits is left to the discretion of the pharmacist, there is a requirement to measure adherence during the third and final follow-up visit.
3. **Assess** blood pressure and cholesterol control and, if not completed on a previous visit, assess 10-year cardiovascular risk.
4. **Review** progress towards achieving goals previously established by the patient.
5. **Identify** new patient goals for lifestyle and behaviour modification, if appropriate.
6. **Coach/educate** the patient to achieve desired goals.

REQUIREMENTS

Education/training

Each pharmacist providing the service is required to complete a short, mandatory orientation and training course available through their provincial pharmacy association. More information is available on the GSC website – providerconnect.ca. Once you have completed the mandatory training, you are expected to stay current and maintain competencies in cardiovascular health management and motivational interviewing.

Location and equipment

You must conduct the sessions in an "acoustically private" area of the pharmacy away from other customers and patients – preferably in a comfortable space where there is a desk and a computer – and this must be a one-on-one meeting between you and the patient. You must have a blood pressure monitor available to measure the patient's blood pressure during each visit. It is also recommended that you have an anthropometric tape measure, or equivalent, available to measure a patient's waist circumference.

Documentation

Documentation must be clear and complete to support adequate patient care and follow-up as well as payment for the service(s) provided to the patient. All documentation must be done using the mandatory forms developed by GSC in collaboration with the Ontario Pharmacists Association and the British Columbia Pharmacy Association:

→ ***Medication Assessment*** **form:** You will initially obtain and subsequently update, if necessary, an accurate medication history for the purpose of evaluating drug therapy for the management of hypertension and hyperlipidemia.

→ ***Risk Assessment, Goals, and Action Plan*** **form:** You will initially document and subsequently update all relevant information gathered during each visit, including established goals for behaviour change and recommendations made. The form initiated during the initial visit will be available during each subsequent follow-up visit to allow continuity of care throughout the program.

→ ***Physician Communication*** **form:** You may determine that it is necessary to communicate to the patient's physician relevant findings, established goals, the action plan, and/or recommendations.

You can attach additional pages to complement any/all of the required forms to ensure continuity of care. For example, you may choose to attach a medication profile report generated using the pharmacy's software program to support/complement the *Medication Assessment* form.

COMMUNICATION

You may identify situations when the *Risk Assessment, Goals, and Action Plan* may be forwarded to the patient's physician or another health care professional involved in the patient's care. It is advisable that you ensure the patient is aware the communication is taking place and that this action is documented on the pharmacy copy.

Establishing and building positive relationships with physicians and other health care professionals will foster collaboration and seamless patient care. Therefore, communication of relevant findings, established goals, an action plan, and/or recommendations using the *Physician Communication* form is encouraged.

PRIVACY

All third parties delivering services on behalf of GSC will agree to comply with provincial privacy legislation and regulations, including the following terms and conditions with respect to privacy:

→ Name an individual to handle all aspects of privacy

→ Identify the purposes for the collection of personal information

- → Seek consent for the collection of personal information and its subsequent use or disclosure
- → Limit the use of all personal information collected to the purposes for which it was collected
- → Retain information for as long as required for the purposes of this program
- → Ensure that all retained information is accurate
- → Use appropriate security measures to protect all personal information
- → Ensure that, upon request, an individual will be informed of the existence, use, and disclosure of their personal information and will be given access to that information
- → Inform individuals who make inquiries or lodge complaints of the existence of, and process for, complaint procedures
- → Acknowledge liability for the use made of all personal information
- → Allow GSC to oversee the third parties' methods of collecting and storing data (by review or audit)
- → Indemnify GSC for any breach of contract

CLAIM FOR PAYMENT

For each participating member, you may submit one initial visit and up to three follow-up visits within one year from the date of service of the initial visit. A claim for payment can only be made online after completing the service and providing the patient with a copy of their *Medication Assessment* as well as their signed and dated *Risk Assessment, Goals, and Action Plan.* For audit purposes, claims are made on the day the service is provided.

The claim submission follows the normal process for submitting claims to the GSC network using the following information:

Initial visit

- → The amount paid is $60.
- → Product identification number (PIN): **991805** *(PHC - Initial Assessment)*

Follow-up visit(s)

- → The amount paid per visit is $20.
- → Product identification number (PIN)

First follow-up:	**991821**	*(PHC - Follow Up 1)*
Second follow-up:	**991848**	*(PHC - Follow Up 2)*
Third follow-up:	**991856**	*(PHC - Follow Up 3)*

When transmitting the claim on our network, the charge for the service provided needs to be entered in the cost field, and the dispensing fee field must be left blank as dispensing fees do not apply to this benefit.

RECORD KEEPING

All documents used to collect and document personal health information during the provision of this program are considered part of the patient record and will be maintained in a computer system where possible. Where that is not possible, documents must be stored in a systematic manner that allows for their easy retrieval and for the period of time specified by the respective regulatory college of pharmacy requirements.

For quality assurance purposes, claims may be subject to audit. Please retain all completed documentation for the period of time required by your regulatory body as described above.

FREQUENTLY ASKED QUESTIONS

1. I have identified an eligible patient, do you have any suggestions for how I should introduce the program?

Let the patient know that their health care benefits plan offers a health coaching program to patients currently taking drugs for high blood pressure and high cholesterol. The program focuses on improving cardiovascular health by helping them take their medications appropriately to get their blood pressure and cholesterol under control. The program will also help them set goals for a healthy lifestyle. There is no out-of-pocket cost for participating, and the cost of the program is covered in its entirety by GSC. Participation in the program is voluntary.

2. My patient has decided to enrol and participate in the program. How can I prepare to make the most efficient use of our time during the initial visit?

We recommend that you schedule an appointment for a time that is convenient for you and your patient allowing sufficient time so you can have an uninterrupted conversation. To prepare for a meaningful interaction, you may want to ask the patient to come prepared with:

→ Current medication bottles and/or medication list, including vitamins, supplements, and herbal products

→ Home blood pressure measurements

→ Lipid panel, if available

→ Height, weight, and abdominal circumference

→ Family doctor name and contact information

3. How is this service different from a provincially funded medication review program?

Where a patient is eligible for a provincially funded medication review, we recommend that you schedule a separate appointment prior to the start of this program to conduct a comprehensive medication review. The main objective of a medication review is to ensure that patients understand how to safely and appropriately take their medication therapy.

While the purpose of the medication assessment portion of this program is to assess adherence to therapy and the appropriateness of antihypertensive and cholesterol-lowering treatment, the broader goal of the program is to provide lifestyle coaching that will support patients in getting their cardiovascular disease under control.

4. **My patient had a medication review done earlier this year. Do I have to gather a new medication history as part of the medication assessment or can I use the medication list generated during the medication review?**

   Yes, you may use the medication list generated during a previous medication review to complete your medication assessment but you must update it, if necessary, to ensure the list is current and accurate.

5. **I have determined that my patient can benefit from a drug therapy change. How do I verify coverage for a drug before I make a recommendation to the prescriber?**

   Patients can verify coverage for drug benefits by using the **Is My Drug Covered?** feature found on **Plan Member Online Services,** which can be accessed from the GSC website at greenshield.ca, or through their **GSC on the Go®** mobile app and choosing the **Drugs on The Go®** option.

6. **My patient would benefit from a formal exercise and/or nutritional counselling program. Are these services covered by GSC as part of this program?**

   Some patients may be eligible for GSC's Dietitian Health Coaching program aimed at helping patients make healthier food choices with a registered dietitian. Ask your patient if their plan sponsor provides coverage for the Dietitian Health Coaching program. Plan members whose benefits plan do not cover the program, can still participate at a discounted cost. Additionally, some health care benefits plans offer health care and/or personal spending accounts that allow patients to claim the cost of these programs as an eligible medical expense. Ask your patient to verify coverage for these services by accessing **Plan Member Online Services**, through the **GSC on the Go** mobile app, or by calling the **Customer Service Centre** at the number listed on the front of their drug card.

7. **My patient has expressed a desire to quit smoking. Does GSC cover smoking cessation programs provided by pharmacists?**

   Some patients may be eligible for smoking cessation services under their plan. Ask your patient if their plan sponsor provides coverage for smoking cessation programs. You may also advise your patient to contact the Government of Canada Pan-Canadian Quit Line at 1-866-366-3667 or to visit their website at healthycanadians.gc.ca/healthy-living-vie-saine/tobacco-tabac/quit-arretez-eng.php to find out which program is offered in their province.

8. **My patient has limited mobility. Can I meet with their caregiver instead?**

   A caregiver may be present during the visit(s) as permitted by the patient. The coaching nature of this program requires the patient to be actively involved in identifying and setting goals for lifestyle modification.

9. **Can I provide this service remotely (i.e., via phone or videoconference)?**

   Recognizing the role of virtual health care during the COVID-19 pandemic and more importantly going forward, GSC is adapting our programs to allow virtual delivery of services. This includes our Cardiovascular Health Coaching, Smoking Cessation Program, Pharmacist Deprescribing Program, and Pharmacogenetic Testing and Counselling.

Canada's pharmacy regulatory bodies and professional associations have issued guidance documents defining the use of virtual services. Pharmacists should contact their applicable provincial college or association for details. It is GSC's expectation that pharmacies will follow their regulatory college guidelines in the delivery of GSC programs.

Pharmacists can assess the most appropriate way to deliver the cognitive services, using virtual care when it is not practical or advisable for the patient to receive services in person. The delivery method and rationale should be documented with each session delivered virtually. This documentation is subject to verification.