ATTACHMENT 5B

MYRX PARTICIPANT FIRST HOME VISIT FORM: DIABETES/HYPERTENSION/DIABETES AND HYPERTENSION

Form Approved
OMB No. 0990-
Exp. Date XX/XX/20XX

FIRST HOME VISIT FORM: HYPERTENSION

TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Date:____

Participant name (Last name, First initial):____________________________________

Client ID #:____

Pharmacist Conducting Home Visit:____

Home Visit Date:____

Section I. Participant Demographics

Pharmacist Step #1: Introduction and collect baseline information.

1. On eligibility form

2. On eligibility form

3. Baseline blood pressure screening:

   ____

4. Wt: |___|___|__|
   lbs.

5. Ht: |__| – |__|__|
   feet inches

6. How long have you had high blood pressure?

   ____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990- . The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments

concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

7. What is your current household income per year?

- ☐ $0 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 or more

Section II. Hypertension Knowledge

Pharmacist Step #2: Ask the participant the following questions and mark their answers.

1. If someone's blood pressure is 120/80, it is…

- ☐ High
- ☐ Low
- ☐ Normal
- ☐ Don't know

2. If someone's blood pressure is 160/100, it is…

- ☐ High
- ☐ Low
- ☐ Normal
- ☐ Don't know

3. Once someone has high blood pressure, it usually lasts for …

- ☐ A few years
- ☐ 5–10 years
- ☐ The rest of their life
- ☐ Don't know

4. People with high blood pressure should take their medicine…

- ☐ Everyday
- ☐ At least a few times a week
- ☐ Only when they feel sick

5. Losing weight usually makes blood pressure…

- ☐ Go up
- ☐ Go down
- ☐ Stay the same

6. Eating less salt usually makes blood pressure…

- ☐ Go up
- ☐ Go down
- ☐ Stay the same

7. High blood pressure can cause heart attacks.

- ☐ Yes
- ☐ No
- ☐ Don’t know

8. High blood pressure can cause cancer.

- ☐ Yes
- ☐ No
- ☐ Don’t know

9. High blood pressure can cause kidney problems.

- ☐ Yes
- ☐ No
- ☐ Don’t know

10. High blood pressure can cause strokes.

- ☐ Yes
- ☐ No
- ☐ Don’t know

Section III. PCCC Survey

Pharmacist Step #3: Ask the participant the following questions and mark their answers.

The statements below describe attitudes and beliefs you may have about the health program you signed up for and your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

	Strongly disagree	Somewhat disagree	Neutral	Somewhat agree	Strongly agree
1. I will learn new information to help me to manage my health condition	☐	☐	☐	☐	☐
2. I will get useful information about my health condition	☐	☐	☐	☐	☐
3. I expect to put what I learn from this program into practice	☐	☐	☐	☐	☐
4. I expect to see positive changes in myself if I do what they teach me	☐	☐	☐	☐	☐
5. I can do something to improve my health condition	☐	☐	☐	☐	☐
6. It is very important to take care of your health	☐	☐	☐	☐	☐
7. I am ready to improve my health	☐	☐	☐	☐	☐

Section IV. Medication Use and Adherence

Pharmacist Step #4: Review the medications that the participant has OR has been prescribed. Create a medication chart with the participant. Fill out attached Appendix A Medication List with the participant.

Questions to ask:

- What medication are you taking including OTC and dietary supplement?
- Why are you taking the medication?
- When do you take this medication?
- When was your last dose?
- Do you have any special instructions for this medication?

11. Medication History:

Medication (Name/Strength)	Purpose	Schedule	Date of Last Dose	Special Instructions
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

Hypertension

12. How often have you forgotten to take your medicine for blood pressure in the past week?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

13. How often do you stop taking your medicine for high blood pressure because you were careless?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

14. How often do you stop taking your blood pressure medicine because you feel better?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

15. How often do you stop taking your medicine for blood pressure when you experience side effects?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

16. Please find the statement that best describes the way you feel right now about taking your high blood pressure medication as directed.

A. No, I do not take and right now am not considering taking my high blood pressure medication as directed. (Precontemplation)
B. No, I do not take but right now am considering taking my high blood pressure medication as directed. (Contemplation)
C. No, I do not take but am planning to start taking my high blood pressure medication as directed. (Preparation)
D. Yes, right now I consistently take my high blood pressure medication as directed.

17. If the answer to question 16 is D, then ask: How long have you been taking your high blood pressure medication as directed?

A. ≤3 months
B. >3 months to 6 months
C. >6 months to 12 months
D. >12 months

Section V. Pharmacist Step #5: Pharmacist Assessment

If the answer to question 16 is D and the answer to question 17 is A or B, then the stage of change is action. If the answer to question 16 is D and the answer to question 17 is C or D, then the stage of change is maintenance.

Area/Stage	Precontemplation	Contemplation	Prepare	Action	Maintenance
Adhere to medication.....	☐	☐	☐	☐	☐

Blood pressure goal is: |________|/|_________|

Today blood pressure is / is not (circle one) at goal.

Assessment Notes:

____

____

____

____

____

____

Section VI. Pharmacist Step #6: Pharmacist Education Checklist

<u>Education Points</u> *****Please make sure you have discussed the following items with the participant by initialing in the next column*****	**Pharmacist's Initials**
I have reviewed all of the participant's medications with the participant.	
I have discussed all potential drug interactions with the participant.	
I have provided disease state education on blood pressure to the participant.	
I have discussed in detail the medications for blood pressure with the participant.	
I have discussed the importance of medication adherence with the participant.	
I have discussed over-the-counter medication use as it relates to blood pressure with the participant.	
I have discussed how to read and understand prescription labels/packaging with the participant.	
I have showed the participant how to use a pillbox for medication maintenance.	
I have discussed when to call in for refills with the participant.	
I have discussed blood pressure goals with the participant.	

Section VII. Pharmacist Step #7: Interventions/Recommendations Made (check appropriate box per intervention and list each intervention)

- ☐ Education on hypertension awareness
- ☐ Diet:______________________________________
  ____
- ☐ Exercise:______________________________________
  ____
- ☐ Medication duplication:______________________
  ____
- ☐ Condition not treated:______________________
  ____
- ☐ Drug-disease interaction:____________________
  ____
- ☐ Drug-food interaction:______________________
  ____
- ☐ Drug-drug interaction:______________________
  ____
- ☐ Inappropriate Dose:________________________
  ____
- ☐ Therapeutic suggestion/alternatives:________
  ____
- ☐ Noncompliant:______________________________
  ____
- ☐ Adverse drug event:________________________
  ____
- ☐ Other (SPECIFY):___________________________
  ____
  ____

Section VIII. Pharmacist Step #8: Follow-up Plan

18. Remind the participant about the upcoming education session. Ask the participant when is a good time for your follow-up telephone call after your education class next month?

    Day:______________________________________
    Date:_____________________________________
    Time:_____________________________________

19. Participant will need more education in the following areas (by phone):

    - ☐ Medication management
    - ☐ Blood pressure self-monitoring
    - ☐ Other (SPECIFY):___________________________

20. Does participant’s PCP need to be notified?

- ☐ Yes
- ☐ No

Why?

____
____
____
____

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of the home visit. Pharmacist will send the completed form to the program coordinator.

Participant Name:____

Pharmacist Name:____

Visit Date:____

The following service(s) have been provided to me today:

- ☐ Baseline Blood Pressure Screening
- ☐ Baseline Knowledge Survey
- ☐ Disease State/Monitoring Education
- ☐ Medication Management Education
- ☐ Other (SPECIFY):____________________________

____
____

________________________________ ________________________
Participant Signature Date

________________________________ ________________________
Pharmacist Signature Date

TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

FIRST HOME VISIT FORM: DIABETES

Date:____

Participant name (Last name, First initial):______________________________

Client ID #:____

Pharmacist Conducting Home Visit:______________________________________

Home Visit Date:____

Section I. Participant Demographics

Pharmacist Step #1: Introduction and collect baseline information.

1. On eligibility form

2. On eligibility form

3. Baseline A1C screening:

   ____

4. Wt: |___|___|__|
   lbs.

5. Ht: |__| – |__|__|
   feet inches

6. How long have you had diabetes?

   ____

7. What is your current household income per year?

- ☐ $0 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 or more

Section II. Diabetes Knowledge

Pharmacist Step #2: Ask the participant the following questions and mark their answers.

1. People with diabetes have a higher risk for heart disease and stroke, compared with people who do not have diabetes.

- ☐ True
- ☐ False

2. Warning signs of eye problems include which of the following:

- ☐ Having double vision
- ☐ Seeing floating spots
- ☐ Having trouble seeing
- ☐ All of the above

3. You can help lower your risk for kidney problems by making the efforts to reach your targeted blood glucose level and blood pressure level.

- ☐ True
- ☐ False

4. Exercise can lower your blood glucose, blood pressure, and cholesterol levels.

- ☐ True
- ☐ False

5. Carbohydrate counting is a method that helps you know what to eat and how much to eat.

- ☐ True
- ☐ False

6. These foods are high in carbohydrates

- ☐ Bread, biscuits, cornbread, tortillas, and crackers
- ☐ Corn, peas, potatoes, and sweet potatoes
- ☐ All of the above are correct

7. The A1C check:

- ☐ Tells you what your blood glucose has been over the last two to three months
- ☐ Tells you how well your diabetes treatment plan is working
- ☐ All of the above are correct

8. If your A1C is 7 or higher:

- ☐ You may need a change in your treatment plan
- ☐ Your diabetes plan is working well
- ☐ All of the above are correct

9. Blood glucose is too high when it is:

- ☐ Higher than 130 before meals
- ☐ 180 and higher 2 hours after meals
- ☐ All of the above are correct

10. Blood glucose is too low when it's below 70.

- ☐ True
- ☐ False

Section III. Baseline PCCC Survey

Pharmacist Step #3: Ask the participant the following questions and mark their answers.

The statements below describe attitudes and beliefs you may have about the health program you signed up for and your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

	Statement	Strongly disagree	Somewhat disagree	Neutral	Somewhat agree	Strongly agree
1.	I will learn new information to help me to manage my health condition	☐	☐	☐	☐	☐
2.	I will get useful information about my health condition	☐	☐	☐	☐	☐
3.	I expect to put what I learn from this program into practice	☐	☐	☐	☐	☐
4.	I expect to see positive changes in myself if I do what they teach me	☐	☐	☐	☐	☐
5.	I can do something to improve my health condition	☐	☐	☐	☐	☐
6.	It is very important to take care of your health	☐	☐	☐	☐	☐
7.	I am ready to improve my health.	☐	☐	☐	☐	☐

Section IV. Medication Use and Adherence

Pharmacist Step #4: Review the medications that the participant has OR has been prescribed. Create a medication chart with the participant. Fill out attached Appendix A Medication List with the participant.

Questions to ask:

- What medication are you taking including OTC and dietary supplement?
- Why are you taking the medication?
- When do you take this medication?
- When was your last dose?
- Do you have any special instructions for this medication?

11. Medication History:

Medication (Name/Strength)	Purpose	Schedule	Date of Last Dose	Special Instructions
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

Diabetes

12. How often have you forgotten to take your medicine for diabetes in the past week?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

13. How often do you stop taking your medicine for diabetes because you were careless?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

14. How often do you stop taking/injecting your medicine for diabetes because you feel better?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

15. How often do you stop taking your medicine for diabetes when you experience side effects?

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

16. Please find the statement that best describes the way you feel right now about taking your diabetes medication as directed.

A. No, I do not take and right now am not considering taking my diabetes medication as directed. (Precontemplation)
B. No, I do not take but right now am considering taking my diabetes medication as directed. (Contemplation)
C. No, I do not take but am planning to start taking my diabetes medication as directed. (Preparation)
D. Yes, right now I consistently take my diabetes medication as directed.

17. If the answer to question 16 is D, then ask: How long have you been taking your diabetes medication as directed?

A. ≤3 months
B. >3 months to 6 months
C. >6 months to 12 months
D. >12 months

Section V. Pharmacist Step #5: Pharmacist Assessment

If the answer to question 16 is D and the answer to question 17 is A or B, then the stage of change is action. If the answer to question 16 is D and the answer to question 17 is C or D, then the stage of change is maintenance.

Check the most appropriate stage according to the readiness to change:

Area/Stage	Precontemplation	Contemplation	Prepare	Action	Maintenance
Adhere to medication.....	☐	☐	☐	☐	☐

Hemoglobin A1C goal is: |________|/|_________|

Today hemoglobin A1C is / is not (circle one) at goal.

Assessment Notes:

____

____

____

____

____

____

Section VI. Pharmacist Step #6: Pharmacist Education Checklist

<u>Education Points</u> ***Please make sure you have discussed the following items with the participant by initialing in the next column***	Pharmacist's Initials
I have reviewed all of the participant's medications with the participant.	
I have discussed all potential drug interactions with the participant.	
I have provided disease state education on diabetes to the participant.	
I have discussed in detail the medications for diabetes with the participant.	
I have discussed the importance of medication adherence with the participant.	
I have discussed over-the-counter medication use as it relates to diabetes with the participant.	
I have discussed how to read and understand prescription labels/packaging with the participant.	
I have showed the participant how to use a pillbox for medication maintenance.	
I have discussed when to call in for refills with the participant.	
I have discussed hemoglobin A1C goals with the participant.	

Section VII. Pharmacist Step #7: Interventions/Recommendations Made (check appropriate box per intervention and list each intervention)

- ☐ Education on diabetes awareness
- ☐ Diet:____
- ☐ Exercise:______________________________________
- ☐ Medication duplication:________________________
- ☐ Condition not treated:_________________________
- ☐ Drug-disease interaction:______________________
- ☐ Drug-food interaction:________________________
- ☐ Drug-drug interaction:________________________
- ☐ Inappropriate Dose:__________________________
- ☐ Therapeutic suggestion/alternatives:________
- ☐ Noncompliant:________________________________
- ☐ Adverse drug event:__________________________
- ☐ Other (SPECIFY):_____________________________

Section VIII. Step #8: Follow-up Plan

18. Remind the participant about the upcoming education session. Ask the participant when is a good time for your follow-up telephone call after your education class next month?

    Day:____
    Date:____
    Time:____

19. Participant will need more education in the following areas (by phone):

    - ☐ Medication management
    - ☐ Diabetes self-monitoring
    - ☐ Other (SPECIFY):_____________________________

20. Does participant's PCP need to be notified?

- ☐ Yes
- ☐ No

Why?

____
____
____
____

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE PROGRAM

Pharmacist will complete.

Directions: Complete this form at the end of the home visit. Pharmacist will send the completed form to the program coordinator.

Participant Name:____

Pharmacist Name:____

Visit Date:____

The following service(s) have been provided to me today:

- ☐ Baseline Diabetes Screening
- ☐ Baseline Knowledge Survey
- ☐ Disease State/Monitoring Education
- ☐ Medication Management Education
- ☐ Other (SPECIFY):__________________________
  ____
  ____

____________________________________ ____________________________
Participant Signature Date

____________________________________ ____________________________
Pharmacist Signature Date

Form Approved
OMB No. 0990-
Exp. Date XX/XX/20XX

FIRST HOME VISIT FORM: HYPERTENSION AND DIABETES

TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Date:____

Participant name (Last name, First initial):__________________________________

Client ID #:____

Pharmacist Conducting Home Visit:_______________________________________

Home Visit Date:____

Section I. Participant Demographics

Pharmacist Step #1: Introduction and collect baseline information.

1. On eligibility form

2. On eligibility form

3. Baseline blood pressure screening:

   ____

4. Baseline A1C screening:

   ____

5. Wt: |___|___|__|
   lbs.

6. Ht: |__| – |__|__|
   feet inches

7. How long have you had high blood pressure?

   ____

8. How long have you had diabetes?

____

9. What is your current household income per year?

- ☐ $0 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 or more

Section II. Hypertension Knowledge

Pharmacist Step #2: Ask the participant the following questions and mark their answers.

Hypertension

1. If someone’s blood pressure is 120/80, it is…

- ☐ High
- ☐ Low
- ☐ Normal
- ☐ Don’t know

2. If someone’s blood pressure is 160/100, it is…

- ☐ High
- ☐ Low
- ☐ Normal
- ☐ Don’t know

3. Once someone has high blood pressure, it usually lasts for …

- ☐ A few years
- ☐ 5–10 years
- ☐ The rest of their life
- ☐ Don’t know

4. People with high blood pressure should take their medicine…

- ☐ Everyday
- ☐ At least a few times a week
- ☐ Only when they feel sick

5. Losing weight usually makes blood pressure…

- ☐ Go up
- ☐ Go down
- ☐ Stay the same

6. Eating less salt usually makes blood pressure…

- ☐ Go up
- ☐ Go down
- ☐ Stay the same

7. High blood pressure can cause heart attacks.

- ☐ Yes
- ☐ No
- ☐ Don't know

8. High blood pressure can cause cancer.

- ☐ Yes
- ☐ No
- ☐ Don't know

9. High blood pressure can cause kidney problems.

- ☐ Yes
- ☐ No
- ☐ Don't know

10. High blood pressure can cause strokes.

- ☐ Yes
- ☐ No
- ☐ Don't know

Diabetes

1. People with diabetes have a higher risk for heart disease and stroke, compared with people who do not have diabetes.

   - ☐ True
   - ☐ False

2. Warning signs of eye problems include which of the following:

   - ☐ Having double vision
   - ☐ Seeing floating spots
   - ☐ Having trouble seeing
   - ☐ All of the above

3. You can help lower your risk for kidney problems by making the efforts to reach your targeted blood glucose level and blood pressure level.

   - ☐ True
   - ☐ False

4. Exercise can lower your blood glucose, blood pressure, and cholesterol levels.

   - ☐ True
   - ☐ False

5. Carbohydrate counting is a method that helps you know what to eat and how much to eat.

   - ☐ True
   - ☐ False

6. These foods are high in carbohydrates

   - ☐ Bread, biscuits, cornbread, tortillas, and crackers
   - ☐ Corn, peas, potatoes, and sweet potatoes
   - ☐ All of the above are correct

7. The A1C check:

- ☐ Tells you what your blood glucose has been over the last two to three months
- ☐ Tells you how well your diabetes treatment plan is working
- ☐ All of the above are correct

8. If your A1C is 7 or higher:

- ☐ You may need a change in your treatment plan
- ☐ Your diabetes plan is working well
- ☐ All of the above are correct

9. Blood glucose is too high when it is:

- ☐ Higher than 130 before meals
- ☐ 180 and higher 2 hours after meals
- ☐ All of the above are correct

10. Blood glucose is too low when it's below 70.

- ☐ True
- ☐ False

Section III. PCCC Items

Pharmacist Step #3: Ask the participant the following questions and mark their answers.

The statements below describe attitudes and beliefs you may have about the health program you signed up for and your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

		Strongly disagree	Somewhat disagree	Neutral	Somewhat agree	Strongly agree
1.	I will learn new information to help me to manage my health condition					
2.	I will get useful information about my health condition					
3.	I expect to put what I learn from this program into practice					
4.	I expect to see positive changes in myself if I do what they teach me					
5.	I can do something to improve my health condition					
6.	It is very important to take care of your health					
7.	I am ready to improve my health.					

Section IV. Medication Use and Adherence

Pharmacist Step #4: Review the medications that the participant has OR has been prescribed. Create a medication chart with the participant. Fill out attached Appendix A Medication List with the participant.

Questions to ask:

- What medication are you taking including OTC and dietary supplement?
- Why are you taking the medication?
- When do you take this medication?
- When was your last dose?
- Do you have any special instructions for this medication?

11. Medication History:

Medication (Name/Strength)	Purpose	Schedule	Date of Last Dose	Special Instructions
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

12. Medication Adherence

Hypertension	Always	Very Often	Sometimes	Rarely	Never
a. How often have you forgotten to take your medicine for blood pressure in the past week?..	☐	☐	☐	☐	☐
b. How often do you stop taking your medicine for high blood pressure because you were careless?..	☐	☐	☐	☐	☐
c. How often do you stop taking your blood pressure medicine because you feel better?..	☐	☐	☐	☐	☐
d. How often do you stop taking your medicine for blood pressure when you experience side effects?..	☐	☐	☐	☐	☐

Diabetes

a. How often have you forgotten to take your medicine for diabetes in the past week?..	☐	☐	☐	☐	☐

b. How often do you stop taking your medicine for diabetes because you were careless?.........
....
....

c. How often do you stop taking/injecting your medicine for diabetes because you feel better?............................
....
....

d. How often do you stop taking you medicine for diabetes when you experience side effects?...........................
....
....

Hypertension

13. Please find the statement that best describes the way you feel right now about taking your high blood pressure medication as directed.

    A. No, I do not take and right now am not considering taking my high blood pressure medication as directed. (Precontemplation)
    B. No, I do not take but right now am considering taking my high blood pressure medication as directed. (Contemplation)
    C. No, I do not take but am planning to start taking my high blood pressure medication as directed. (Preparation)
    D. Yes, right now I consistently take my high blood pressure medication as directed.

14. If the answer to question 13 is D, then ask: How long have you been taking your high blood pressure medication as directed?

    A. ≤3 months
    B. >3 months to 6 months
    C. >6 months to 12 months
    D. >12 months

Diabetes

15. Please find the statement that best describes the way you feel right now about taking your diabetes medication as directed.

    A. No, I do not take and right now am not considering taking my diabetes medication as directed. (Precontemplation)
    B. No, I do not take but right now am considering taking my diabetes medication as directed. (Contemplation)
    C. No, I do not take but am planning to start taking my diabetes medication as directed. (Preparation)
    D. Yes, right now I consistently take my diabetes medication as directed.

16. If the answer to question 15 is D, then ask: How long have you been taking your diabetes medication as directed?

    A. ≤3 months
    B. >3 months to 6 months
    C. >6 months to 12 months
    D. >12 months

Section V. Pharmacist Step #5: Pharmacist Assessment

Hypertension

If the answer to question 13 is D and the answer to question 14 is A or B, then the stage of change is
action. If the answer to question 13 is D and the answer to question 14 is C or D, then the stage of
change is maintenance.

Diabetes

If the answer to question 15 is D and the answer to question 16 is A or B, then the stage of change is
action. If the answer to question 15 is D and the answer to question 16 is C or D, then the stage of
change is maintenance.

Check the most appropriate stage according to the readiness to change:

Area/Stage	Precontemplation	Contemplation	Prepare	Action	Maintenance
Hypertension					
Adhere to hypertension medication...............	☐	☐	☐	☐	☐
Diabetes					
Adhere to diabetes medication...............	☐	☐	☐	☐	☐

Blood pressure goal is: |________|/|_________|

Today blood pressure is / is not (circle one) at goal.

Hemoglobin A1C goal is: |________|/|_________|

Today hemoglobin A1C is / is not (circle one) at goal.

Assessment Notes:

____

____

____

____

____

____

Section VI. Pharmacist Step #6: Pharmacist Education Checklist

Education Points ***Please make sure you have discussed the following items with the participant by initialing in the next column***	**Pharmacist's Initials**

I have reviewed all of the participant's <u>blood pressure</u> medications with the participant.	
I have reviewed all of the participant's <u>diabetes</u> medications with the participant.	
I have discussed all potential drug interactions for <u>blood pressure</u> with the participant.	
I have discussed all potential drug interactions for <u>diabetes</u> with the participant.	
I have provided disease state education on blood pressure/diabetes to the participant.	
I have discussed in detail the medications for blood pressure/diabetes with the participant.	
I have discussed the importance of medication adherence with the participant.	
I have discussed over-the-counter medication use as it relates to blood pressure/diabetes with the participant.	
I have discussed how to read and understand prescription labels/packaging with the participant.	
I have showed the participant how to use a pillbox for medication maintenance.	
I have discussed when to call in for refills with the participant.	
I have discussed blood pressure/diabetes goals with the participant.	

Section VII. Pharmacist Step #7: Interventions/Recommendations Made (check appropriate box per intervention and list each intervention)

- ☐ Education on hypertension awareness
- ☐ Education on diabetes awareness
- ☐ Diet:____
- ☐ Exercise:_______________________________________
- ☐ Medication duplication:___________________________
- ☐ Condition not treated:____________________________
- ☐ Drug-disease interaction:_________________________
- ☐ Drug-food interaction:___________________________
- ☐ Drug-drug interaction:___________________________
- ☐ Inappropriate Dose:_____________________________
- ☐ Therapeutic suggestion/alternatives:__________
- ☐ Noncompliant:__________________________________
- ☐ Adverse drug event:_____________________________
- ☐ Other (SPECIFY):_______________________________

Section VIII. Pharmacist Step #8: Follow-up Plan

17. Remind the participant about the upcoming education session. Ask the participant when is a good time for your follow-up telephone call after your education class next month?

Day:____

Date:____

Time:____

18. Participant will need more education in the following areas (by phone):

- ☐ Medication management
- ☐ Blood pressure self-monitoring
- ☐ Diabetes self-monitoring
- ☐ Other (SPECIFY):____________________________

19. Does participant's PCP need to be notified?

- ☐ Yes
- ☐ No

Why?

____

____

____

____

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of the home visit. Pharmacist will send the completed form to the program coordinator.

Participant Name:____

Pharmacist Name:____

Visit Date:____

The following service(s) have been provided to me today:

Baseline Blood Pressure Screening
- ☐ Blood Pressure
- ☐ Diabetes

Baseline Knowledge Survey
- ☐ Blood Pressure
- ☐ Diabetes

Disease State/Monitoring Education
- ☐ Blood Pressure
- ☐ Diabetes

Medication Management Education
- ☐ Blood Pressure
- ☐ Diabetes

Other (SPECIFY):______________________________
____
____

________________________________ ________________________
Participant Signature Date

________________________________ ________________________
Pharmacist Signature Date