



ASHPOfficial - CGM - Second in Series (Paige C., Diana I., Jacki H. (Ambulatory Care)
Transcript

Speaker 1:

Welcome to the *ASHPOfficial* Podcast, your guide to issues related to medication use, public health, and the profession of pharmacy.

Paige Carson:

Thank you for joining us for the Therapeutics Thursdays Ambulatory Care Pharmacy podcast. This podcast is hosted by the ASHP section of Ambulatory Care Practitioners and provides updates on hot topics in AmCare pharmacy practice. My name is Paige Carson, and I am your host. I work with the population health group at Atrium Health, which we call ambulatory care management. And we have eight regional population health teams consisting of pharmacists, nurse care managers, and health advocates. And we spend at least 75% of our time working with diabetes patients.

Paige Carson:

With me today are Diana Isaacs from the Cleveland Clinic Diabetes Center. She is an endocrinology clinical specialist and CGM program coordinator. We also have Jacqueline Hagarty or Jackie from Banner University Medical Diabetes and Endocrinology Institute in Phoenix, Arizona. Thank you for joining us today, Diana and Jackie. And let's get started talking about today's topic, which is the second CGM podcast in this series. And the title is Continuous Glucose Monitors and Ambulatory Care Pharmacy Practice Billing and Clinical Success Stories. So, our first question for our panel today is to describe how CGMs are presently used in your clinical practice setting. And we'll start with you, Diana.

Diana Isaacs:

Yeah. Sure. So, we use CGM a whole lot. We have a really robust shared medical appointment program, where we utilize professional CGM and that's the type that's owned by the clinic and lent out to a person for typically 7 to 14 days. And we do them in seven day intervals, where we have a part one where we put the devices on people and teach about glycemic targets. And then, we bring people back a week later and review the data together. We've also expanded to do that for personal CGM as well. So, we have a start class for people that are starting the same type of CGM. And then, we also will bring them back, typically after 7 to 14 days, to review what the data meant and any troubleshooting with that. In addition, we actually also have a remote monitoring coordinator now who has been following up with patients who are wearing personal CGMs for more long-term type of management. Those are just some of the ways we utilize them in our practice.



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Jackie Hagarty:

And this is Jackie. Similarly, for us, we use CGMs mostly on a personal basis. So in other words, an individual CGM that the patient owns, we have to get it through their insurance and they use it for self management. And then of course, we use that to make adjustments to their therapy. So we mainly focus on the personal CGMs rather than utilizing the professional CGMs. The providers will start them in clinic and then patients can seek out training on their own or else I, as the pharmacist, or else our fellow CDEs, which we have a nurse practitioner and a dietician also on our team, we will also do individual trainings for patients to get started on a personal CGM.

Paige Carson:

Great. And I have some comments here that you guys sometimes use shared medical appointments. Can you elaborate more on those?

Diana Isaacs:

Yeah. So I, in my practice, so typically I, as a pharmacist, serve as the provider and through collaborative practice agreements can make medication adjustments. And I do this in conjunction with a diabetes educator that's usually a nurse or a dietician. We lead the class and there are usually four to six patients. And then I utilize students to be my scribes and they chart in the back of the classroom. And it works really well having multiple people together because what we found, especially when going through the data is there's a lot of similarities. For example, it's notorious the American breakfast of cereal or oatmeal often causes spikes in blood sugar that go way beyond the target of 180. And so those are things you can talk about together. And we talk about how adding protein at breakfast time can help prevent it from spiking up quite as fast. Also brings into good discussion about dosing insulin, how dosing it before the meal can prevent spikes.

Diana Isaacs:

So there's a lot of similarities between reports that as a group we can discuss together. Another example is I had a person that was really maxed out on all types of oral and non-insulin medications like a GLP-1 SGLT2 inhibitor, Metformin, and just glucose was still running high. And it was clearly insulin was going to be a good next thing to add, but the patient was really reluctant. And then through seeing his CGM report and seeing that he actually really was spiking up pretty high in between meals and overnight, and then just talking to other people in the shared medical appointment who were already taking insulin and who were able to say, hey, it's really not a big deal and I feel a lot better because now my blood sugars are at target. That



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was able to help the person make the decision that it was the right thing to do to start, and he ended up doing a whole lot better and was able to reach his glycemic target. So I think the shared medical appointments are a really great model to use this technology.

Paige Carson:

Great. That's helpful. And can one of you guys also comment on how often you would perform remote monitoring for those patients on CGM, whether that's in the beginning or later on?

Diana Isaacs:

So I think that can be really individualized. I know, in our program, typically we start someone on the device and we want to follow up generally in about seven days. And to build the codes there are certain requirements that you do need to meet in a certain amount of time you need to be reviewing the data. It depends which code you're actually billing because if you're doing the CGM interpretation, like the 95251 that you can only bill once a month, but a person may need more frequent touch points on that versus if you're using the remote monitoring code. Those are a little bit different and require a certain amount of time spent per week reviewing the data so it really varies. We're doing a combination of both right now as we're still getting used to the new remote monitoring codes. But I would say it's just really individualized. In the beginning, I like to follow up with someone more often, and then as they're getting more stable, I think once a month is fine. And some people even can go to once every three months. [crosstalk 00:06:41].

Paige Carson:

That's helpful.

Jackie Hagarty:

Yeah. I have to agree with that. We would individualize it based on however you would follow up with a patient, whether they're on a CGM or self monitored blood sugar, just if they're checking their blood glucose just a few times a day. If they need medication adjustments, you want to follow up on that sooner rather than later.

Paige Carson:

Great. Thank you guys for spelling that out. So what metrics do you use to measure the impact of CGMs?

Jackie Hagarty:



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In order to measure the impact of continuous glucose monitors, we look at quite a few different variables. So the first thing we look at is within the CGM report itself. After a patient's been wearing either professional or a personal CGM, you'll get a report on what their blood sugars are doing so we look at time and range, which for most patients means in between blood sugar of 70 to 180. We look at percent hypoglycemia, so in other words, what percent of the time that they spend below 70% hyperglycemia, which, again, for most patients is going to be percent of the time that they're spend above glucose of 180. Coefficient of variation, which tells us how variable are their blood sugars. Is it stable? Or is it really up and down all throughout the day or throughout the week?

Jackie Hagarty:

We also look at the glucose management indicator, which is similar to A1C in that it gives you a sense of their overall glucose or glycemic control over the past couple of weeks or whatever time period you're looking at the report, typically seven to 14 days. And then another important aspect to look at when you're considering all of these variables is percent sensor wear, so are they wearing the sensor only 30% of the time? And then we should take this data with a grain of salt? Or are they really wearing it 80 to 90%, which would be about our target? In other words, they're wearing the sensor most of the time throughout the day.

Diana Isaacs:

Yeah. And just to add to that. So data sufficiency, it's recommended to be at least 70% over a 14 day period. And that just allows these different statistics, things like the GMI and the coefficient of variation, to have more meaning. I still think even if you don't have all of that data, you can still... Let's say you just had the person's last two or three days. That can still be very valuable and you can walk through what a person ate and what their day was like, their physical activity level, and you can still learn a lot. It's just to make these specific terms more meaningful. Having that amount of data is very helpful. And then a common question I get is, well, why wouldn't someone have a hundred percent sensor wear? Why wouldn't they have all that data sufficiency?

Diana Isaacs:

There's a few reasons why someone might not. So, for example, with the Freestyle Libre, that specific type of CGM requires a person to scan it to have data. I can only remember up to eight hours of information at a time. So let's say a person is sleeping for a long time and goes 12 hours without scanning. That means there will be a four hour gap in data. For other types of systems, you need to be within a certain number of feet of the reader or the receiver. And so if a



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person is out of that range, that can cause a loss of signal. And also all these sensors require them to be changed out somewhere between seven and 14 days. And there's a warmup period every time it's changed or let's say a person just took it off and didn't put a new one on right away.

Diana Isaacs:

So for all those reasons, there could be some missing data. And that's why I think as great as time and range is, and I love time and range, I think A1C, we still do utilize it in practice just because that's been our gold standard for so long. And if you are missing these gaps or you do have these gaps in data, at least you still have the A1C to fall back on.

Paige Carson:

Great. And I know that one of you also commented that you use a survey to measure the diabetes self-efficacy. Can you talk a little bit more about that?

Diana Isaacs:

Yeah. So with our CGM shared medical appointment model, one of the ways we assessed it in addition to A1C was self efficacy. And this is basically a validated tool that asks questions about certain behaviors, like comfort in treating hypoglycemia, or the ability to eat at regular meal times, or how to incorporate physical activity without experiencing hypoglycemia. And so we did a pre and post survey after attending the CGM shared medical appointment and afterwards, and showed a pretty big improvement in self efficacy. And so that's just an indicator that that would improve diabetes self management, and hopefully also have improvements, or ultimately lead to improvements in glycemic targets, as well.

Paige Carson:

And tell me how CGM use has impacted patient satisfaction and also provider satisfaction.

Jackie Hagarty:

Sure. Our patients really love the CGMs for the most part, and I think the only hangup would be if they have trouble applying the sensors, or if there's a sensor error, what do they do? But usually after the first couple times of applying the sensor on their own, then they're really happy with how it's working. It gives patients a lot of good feedback. I think, just as Diana mentioned, really using the information or the data, the metrics that we get to show the patient here's, what's working, here's what's not working. Can we link up what's happening to your blood sugars to what's happening on your daily routine?



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Jackie Hagarty:

That's really eyeopening for patients more so than maybe when they're just checking their finger sticks once or twice a day. So the CGM really improves the patient's self-awareness. A lot of people like the ease of use and that the CGM can really replace those finger sticks. A lot of people complain it's painful. It's a huge barrier to carry around all of your testing supplies all of the time to have to check your blood sugars one to six times a day. And even six times a day it still isn't giving us all of the information that a CGM can give us.

Diana Isaacs:

Yeah. My patients just love it. I mean, I feel like I get the warm fuzzies every day. Because I get to start so many people on CGM and they're like, thank you. Thank you. This has changed my life. This has been incredible. And just for some of the points like Jacqueline mentioned about not having to do the finger sticks all the time, I think that in itself is huge. But also this idea of having... With a finger stick, you just have one point in time. So let's say it says 150. Okay? So 150 with two arrows going down indicating that someone could be crashing within the next half hour versus a steady 150 are two completely different things. And you don't know that with a finger stick unless you compulsively recheck your finger stick every couple of minutes. So to have that type of information at your fingertips, I think it really is incredible.

Diana Isaacs:

And then on top of that, with many of the devices being able to have the alerts, it just gives people the confidence to do things, to be able to go out for that walk, or exercise, or whatever, or get a good night's sleep because they know if they go low that they have this device that's going to beep and alert with them. And then on top of that, the ability to share data with loved ones or other people in their lives, to just have that extra comfort that knowing that someone else can see what's going on. Let's say, if something terrible were to happen and they passed out. Someone else is looking at that data and can call 911, even if they're not with them. So I think just for all those reasons, I've just been such a cheerleader of this technology because I have seen firsthand how much it improves people's lives.

Jackie Hagarty:

Yeah. I wholeheartedly agree. And just to add on another quick example, I have a patient who had type one diabetes and really variable glucose, even on a CGM. It still didn't really quite help us to stabilize out her blood sugars. But using the CGM, we're able to do some advanced self management techniques. So this is not something I go for for everybody. But for some of my



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patients who still have really variable blood sugars, we use the arrows to adjust their correction factor. So in other words, the arrows, if it's one up arrow or two up arrows, depending on which CGM you're using, it can tell you how quickly the blood sugar is rising or how quickly it's dropping.

Jackie Hagarty:

So she could add or subtract units of correction to her bolus insulin dosing, which was really helpful for her. And that really helped her to gain better control of her diabetes compared to if we were just making corrections on that one point in time, the here and now where's her blood sugar at before the meal. Instead, we can see, well where's the blood sugar going to be at in the next 30 minutes and then make correction adjustments based on that. And that's made a huge difference for her.

Diana Isaacs:

Yeah. That's really great. And I would just like to add talking about provider satisfaction because I think this is a mixed bag. I mean, if you ask me, I love it and I like having the extra information. I think it's easier to make adjustments to therapy. Not every provider loves it. And the reason why is because it's something new and in terms of downloading the data, sometimes it's confusing if you're not used to how to download it. For example, when devices started switching to smartphones where people could view it on their phone, immediately our clinic, the people doing intake did not understand how to download it because it wasn't as simple as just plugging in the phone.

Diana Isaacs:

You had to go through a separate system. I think hurdles like that can be alleviated through having a technology expert on the team who can pay attention to these new things happening and make sure that the clinic has the right process. Because if you don't know how to download or look at the data, it can actually be very overwhelming. And when we first started printing out reports, our MAs were printing out 60 pages, which you can imagine if you have a 20 minute visit, 60 pages of data is not going to make a provider happy. So I think there's some steps to work through, but if you can work through those steps, then you will get providers satisfaction.

Paige Carson:

Great. So have you been able to add additional pharmacists to your team or FTEs because of the value and the use of CGM?



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Diana Isaacs:

So I am so happy to report that yes. We are hopefully going to be making an offer very soon. We've been interviewing. We put in a business proposal to have an additional FTE and really the income generated from professional and personal CGM insertions and interpretations is where most of that money came from to justify that additional FTE. So I am thrilled about that.

Paige Carson:

Wonderful. And I can see the need to continue to grow for a lot of practices. Can you both provide insight on how pharmacists can successfully bill for CGM services?

Diana Isaacs:

Yes. There's three CPT codes. The CPT 95249 is for personal CGM starts. This can only be billed once in the life of a device so that is important to know. And when you do the education and training for someone starting a new device, this code can be billed. One of the caveats is you need a download of data of at least 72 hours. So typically I will bring people back for a follow up visit. And then at that visit bill, because now I've got the 72 hours of data. In addition to that, there is a 95250, which is for professional CGM insertion, and download. And so as part of our CGM shared medical appointments, that's the code that we're billing. And then in addition to that, there's the 95251, which is for CGM interpretation. Now this code can go with the professional CGM or with personal CGM and then different insurance companies have different, I guess, variances in how often they cover it.

Diana Isaacs:

I've seen anywhere from once a month up to twice a year. One of the very interesting things is with professional CGM, the coverage is phenomenal. I mean, I would say 99% plus are approved for professional CGM at least twice a year. And I'm talking these are people that may not be taking any medications for diabetes, or maybe only taking Metformin, so the coverage is incredible. Now for personal CGM, the coverage varies certainly a lot more, so not everyone's going to have access to a personal CGM device, but it's improved a lot in recent years. We know now Medicare covers for type one and type two diabetes taking multiple daily injections of insulin, so definitely a lot more access. And so we have a lot of patients on it. And so I've been able to bill for these services. Now with the interpretation, one of the things to know is that Medicare specifies physicians, nurse practitioner, or a physician assistant.

Diana Isaacs:



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They do not say pharmacists, which is unfortunate. Within the state that I practice, in Ohio, pharmacists are able to do this. We've checked with our state board. We have provider status. We have collaborative practice. But to get around this lack of being able to bill, I have my notes co-signed and generally bill under the ordering provider of the service. So that's worked well because the money is still coming back to the clinic. And interestingly the 95250 code for professional CGM is actually reimburses at a much higher rate than this interpretation, which is often a pretty low rate. So it tends to work out well. And you could imagine with a shared medical appointment with five or six people, the amount per person that you're often taking in could be around \$300 for this two part visit. So the revenue can definitely add up.

Paige Carson:

And when you have the shared medical appointment, how many patients are you typically bringing in at a time?

Diana Isaacs:

Usually four to six. That's my happy, sweet spot.

Paige Carson:

Okay. And so just to recap, professional CGM seems to be much more financially viable if the practice has purchased these monitors. Right?

Diana Isaacs:

Right. So professional CGM is definitely going to increase revenue much more than personal CGM. Because personal CGM, you can only build a 95249 once. The 95251, you can bill ongoing, but that code is a little bit less. It pays up to \$89, but often it could be \$40. It just depends on the insurance plan. But one of the things that I've done is our practice was not capitalizing on the CGM interpretation. So we were basically losing money.

Diana Isaacs:

I mean, even if it's only \$40, we were not billing it at all. So what I've actually gone in to do is I've had our MAs when patients come download the data, take a snapshot, and put it into the patient's chart. We have a smart phrase that I can get routed to me. And then I go back in and I do these interpretations, which I can do pretty quickly. So that way, let's say we saw 50 patients that day. I can go in and make sure that those interpretations done. And so you've got 50 times 40. We can at least get back some of that revenue. That can be \$2,000. And my vision is that we have residents and students help staffing this to complete the interpretation. So even though



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it's not a huge amount of money per person, it really adds up when you have that kind of volume.

Paige Carson:

That's helpful. So let's talk about barriers to billing for professional and personal. Can you guys elaborate more on that?

Diana Isaacs:

Yeah. So I think the barrier that I just mentioned about the interpretation and how it calls out NP physician and PA is unfortunate with Medicare. And so it does create some hurdles in that we can't directly bill for that. And we have to have a collaboration with our team, which I think is actually okay. Because I think diabetes care works much better as a team, but that means you have to have those arrangements in advance. Also for the 95249 having to have the 72 hours of data sometimes people don't realize that and try to bill for it and then end up not getting the reimbursement because they didn't have that data. And then I would say a third thing is even though the coverage, especially for professional CGM, is so good, we're fortunate that we do have someone that checks insurance first because every once in a while, you might have one that requires a prior authorization. And the last thing you want to do is bring a patient in and then slap them with a \$400 bill. So those are some of the things that we do.

Paige Carson:

And can you all comment on maybe time or scheduling?

Diana Isaacs:

Yeah. So I think definitely, I would say one of the barriers to CGM interpretation and why we weren't billing is just the time that it takes. The logistics of what you need in the chart and making sure you've got that image pasted into your electronic medical record, and you're going through and finishing that interpretation. And so I think that's why we were leaving a lot of money on the table and our providers weren't finishing it and we weren't billing for it. The second caveat is some patients will have a copay when you bill for CGM interpretation. And so they may not love that. And so you may, if that's something new that you're going to be doing, you have to let your patients know that I think it's like reading an EKG. We're doing the work. We're spending the time to do that. We really should be reimbursed for it, but if someone's been getting something for free for so long, that can be a big change. If they all of a sudden do get a copay for that.



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Jackie Hagarty:

And I'd just like to touch base on some of the barriers that we've had in really ramping up our professional CGM service or program at my clinic is definitely the, I guess, fear or concern that some of our patients have come to have certain expectations regarding office visits and billing. And if we're suddenly adding additional office visits on top of an additional service for them that some patients won't want to do that. So I think the biggest thing is making sure the patients are aware. This is a great service for you. What will really benefit you in the long run.

Jackie Hagarty:

Educating both the provider's office staff and the patients on what to expect from a professional CGM service, and that could help potentially to prevent them from being upset, I guess, about a surprise bill. Something else would be if you have a pharmacist in the clinic to have them taking full responsibility for the entire program, as far as making sure that patients are able to get scheduled for starting up a CGM and then taking it off, having the report interpreted to make sure that patients don't just get lost in the general mix.

Jackie Hagarty:

Sometimes that can happen with especially staffing shortages at a clinic. That's one of the reasons why we were having problems maintaining a professional CGM service is that patients just wouldn't return to clinic with maybe some piece of equipment that the clinic had owned. And then you lose out on both the billing and then any expense that you had with clinic equipment. So it sounds like Diana's service where the pharmacist is more in charge of professional CGM using other clinic staff or other resources maybe, but having that pharmacist or that one centralized person or team oversight to see the whole program probably really helps to coordinate everything.

Paige Carson:

Yeah. There's a lot of things to consider. So would you like to share a patient story related to success with the CGM?

Diana Isaacs:

Sure. So one that stands out to me is I had a 24 year old with type one diabetes who was really checking... I don't know actually how much he was checking his blood sugars because he never brought in his meter at all. So his A1C was around 6.7%. I mean, the team was pretty happy with how he was doing. Prior to this his insulin doses kept being increased and increased because he had a higher A1C, in the eights and nines. And so the thought was, oh, he needs



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more and more insulin. We started with a professional CGM, so he could see what it was like wearing it. And it turned out that he was actually experiencing hypoglycemia with a glucose under 70 25% of the time. And then he was experiencing hyperglycemia over 180 also a pretty significant amount of time.

Diana Isaacs:

And his glucose variability was really high. He was going up and down, up and down. So this really showcases how A1C is limited in that it's an average. And so his average was okay, but he was really not doing great because he was bouncing around all the time. And so we learned some pretty valuable things by talking through the data together. As it turned out, he was on an insulin [inaudible 00:27:27] twice a day regimen. And he was actually missing that second dose at least half of the time. But it wasn't because he was a noncompliant or nonadherent patient. It was because he was experiencing a ton of hypoglycemia and he was probably prescribed way more than he needed. So by wearing this, I was able to adjust his insulin. I like to describe as redesign his insulin regimen so it worked better for him. And ultimately we were able to get him on a personal CGM. So that was very happy with how that turned out.

Jackie Hagarty:

I also had a really meaningful patient experience. I had a 22 year old who has type one diabetes and I'd been following with her for at least six months on adjusting her insulin doses, trying to work with her on her glycemic control. Similar to Diana's patient, her A1C was around the 8%, not really budging. Over the course of about six months, we had tripled her insulin doses with hardly any change in her blood sugars. We were trying to get her on a CGM, but we had some struggles there trying to figure out which one is covered by her insurance and how to get it covered. When we were finally able to start her on a CGM, we quickly realized that the very first visit when I saw her back, I could visibly see her blood sugars rapidly increasing. And then it would tell me when she checked her blood sugar.

Jackie Hagarty:

Okay. That was after she already had an increase in blood sugar. So despite telling me that she had been compliant, checking her blood sugar before the meals, and giving her Humalog before the meals, the CGM actually showed a different story. So I was able to use that with her and have her visually see what was going on and determine that she was actually checking her blood sugar after she was eating. So, again, we were able to back down on the insulin doses so that she wouldn't have hypoglycemia. And then another thing that it improved for her was it improved her adherence to her long acting insulin. So she was skipping her long acting insulin



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at night if her blood sugar was normal at bedtime because she assumed that she would go low. So this made her feel so much more comfortable and so much more at ease that, okay, I'm going to have an alarm or something that's going to wake me up if I do start to go low.

Jackie Hagarty:

Again, we went over the data together. I showed her what her blood sugar was actually doing throughout the night. And she could see, okay, it's stable when I get my long acting insulin. And when I don't get my insulin, it's just going up throughout the night, which starts my day off on a bad note in the first place. And I'm having to give more correction and we're just chasing our tails. So this really was a good patient education tool, but then also made the patient just feel much more comfortable. So she's done a lot better ever since getting on her own personal CGM.

Paige Carson:

This is helpful. I think so many of these patients just were missing out all that variability that you're getting with the CGM, the data. And hopefully they're feeling a whole lot better. So what is the one piece of advice that you'd give to AmCare pharmacists taking to initiate CGM services or for pharmacists that are seeking to expand their services to include CGM information?

Diana Isaacs:

Yeah. If you can convince your clinic to invest in professional CGM, I think that's such a great place to start, especially because Libre Pro is about \$60 per sensor. So it's a really low investment cost. You need a reader, which is \$65. You make it back. I mean, one patient you've already made a profit. And then Dexcom G6 Pro should be available very soon and that's going to be also a disposable. Hopefully it's expected to be a comparable price. So I think that's just such a good way to start. And I think also working with the reps in your area. And if you don't know who your rep is for the different CGM companies usually, you can find that online. And I think they're very helpful. If you get the opportunity to try wearing one yourself, that's really the best way to learn and it's fascinating. And that way you can really get used to looking at those reports and everything. But those I think are great ways to get your feet wet.

Jackie Hagarty:

Yes. I definitely agree with that. I think those are really good suggestions for any pharmacist looking to get into this area. And then I think really emphasizing both the patients and providers that this is a really good patient self management tool. So I think a lot of times we think of CGM as we get all this data and that's really great for us, but also seeing that patients, a lot of times,



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their A1Cs will just improve just by switching over from finger sticks to a CGM. So realizing that just more self-awareness, as long as they're being engaged, this can be a really good tool for them even without making any other adjustments to their medication regimen.

Jackie Hagarty:

So I think using the CGMs' reports and making sure that we are sharing those with patients or helping them to understand what they're really looking at, rather than saying, okay, this is something that we just put in their chart, but remembering to go over the data in detail at the patients, I think is really helpful.

Paige Carson:

Thank you. So that's all the time we have today and I want to thank Dr. Isaacs and Dr. Hagarty for joining us today and really sharing their experiences to discuss CGMs and AmCare pharmacy practice and sharing on billing and clinical success stories. Thank you. Join us here every Thursday where we will be talking with ASHP member content matter experts on a variety of clinical topics.

Speaker 1:

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