PROJECTIMPACT
IMPROVING AMERICA'S COMMUNITIES TOGETHER

About Project IMPACT: Diabetes

Launched in 2010 by the APhA Foundation in partnership with the Bristol-Myers Squibb Foundation's *Together on Diabetes* initiative, Project IMPACT: Diabetes is the first national research initiative to improve people's health by integrating pharmacists into diabetes care teams in 25 communities that are underserved or highly affected by diabetes.

More than 2,000 patients who are uninsured, under-insured, homeless and/or living below the poverty line are receiving care from community-based interdisciplinary teams that include pharmacists, physicians, diabetes educators and other members of the health care team.

Participating organizations include community and university-affiliated pharmacies, self-insured employers, Federally Qualified Health Centers (FQHCs), free clinics and others that have the opportunity to leverage unique stakeholders, existing programs, creative ideas, and additional resources to effectively adapt and implement similar models of care. The APhA Foundation provides communities with tools, resources, guidance and support to facilitate local success.

Project IMPACT: Diabetes is modeled after several other highly successful APhA Foundation programs that produced positive clinical, humanistic and economic outcomes, including the Diabetes Ten City Challenge (2005-2009); the Patient Self-Management Program for Diabetes (2003-2005); and the APhA Foundation's cholesterol management program, Project ImPACT: Hyperlipidemia™ (1996-1999).

Objectives

- Expand proven community-based models of care to patients who need it the most in communities across the U.S.
- Improve key indicators of diabetes care in selected communities
- Strengthen local models of care by establishing community peer-to-peer networking and mentoring relationships
- Establish a sustainable platform for permanent change by embedding the following guiding principles:
    - Identification and support of disproportionate share populations
    - Implementation of collaborative care programs engaging pharmacists
    - Establishment of continuous quality improvement processes
    - Utilization of patient self-management credentialing
    - Collection and regular reporting of minimum data sets

Target Population

- People in geographic areas with a high incidence of diabetes
- People with A1C levels > 7.0 and other outcomes
- People with limited access to quality diabetes care
- Communities with socioeconomic challenges and other factors that impact people's access to care

APhA FOUNDATION

Bristol-Myers Squibb Foundation
Together ON Diabetes
Communities Uniting to Meet America's Diabetes Challenge

How Project IMPACT: Diabetes Works

Project IMPACT: Diabetes has successfully scaled previous APhA Foundation collaborative care programs for 25 communities that are disproportionately affected by diabetes. Over a one-year patient care period, health care teams saw statistically significant improvements in the clinical outcomes of their patients and dramatic improvements in their patients' ability to manage their diabetes. This success is due in large part to the adaptability of the care model to fit local needs.

Within each community, stakeholders came together at the start of the project with an aligned goal of improve caring for people with diabetes. The APhA Foundation educated each community about the proven care model that placed the patient on the health care team and inserted the pharmacist a valued health coach.

Additionally, the APhA Foundation provided training and access to the Patient Self-Management Credential for Diabetes and a clinical data management tool that were core components of the project. The clinical data management tool standardized the dataset that all 25 communities collected throughout the project. The Patient Self-Management Credential for Diabetes is a provider resource that was successfully used in the APhA Foundation's Diabetes Ten City Challenge and the Patient Self-Management Program for Diabetes.

The Patient Self-Management Credential for Diabetes helps pharmacists identify each patient's knowledge strengths and areas for improvement, which allows the providers to customize the education they provide to each individual and address the biggest knowledge gaps first. Pharmacists also are able to use each patient's credential level to recognize achievements in self-management

Once the care model and tools were in place within each community, local stakeholders began providing care to people with diabetes. One-on-one consultations with pharmacists are the cornerstone of many local implementations. Other aspects of local care models include group educational classes, grocery store food tours, exercise programs, and joint visits where pharmacists and physicians meet with patients at the same time.

Communities are encouraged to find ways to incentivize patients to stay motivated about diabetes self-management. Some incentives include bus passes, food store gift cards, discounted or free healthy lunches at employer worksites, discounted co-payments, or simply the ability to continue to have a health care provider focus time on helping the patient.

Advisory Committee

An Advisory Committee of industry leaders provided input and guidance to the project. The group includes representatives from:

- American Pharmacists Association
- Center for Health Value Innovation
- Giant Food Stores
- National Diabetes Education Program
- U.S. Health and Human Resources (HHS) Office of Women's Health
- U.S. Health Resource Services Administration – Pharmacy Services Support Center
- Walgreens