PROJECTIMPACT
IMPROVING AMERICA'S COMMUNITIES TOGETHER

History of Project IMPACT: Diabetes

1996
The APhA Foundation created **Project ImPACT: Hyperlipidemia™**, the first collaborative care program designed to show how pharmacists, physicians and patients with high cholesterol can work together to make lifestyle changes and improve medication adherence to achieve cardiovascular goals. Over a three-year period, nearly 400 people with high cholesterol in 12 states, working together with 26 pharmacies, participated in this landmark program. The results, published in 2000, showed that 93.6% of patients stayed on their medications and 62.5% reached the National Cholesterol Education Program (NCEP) treatment goals. The Foundation's first national demonstration project was a landmark study that showed the value of an innovative point-of-care technology combined with a process of care that includes collaboration among patients, pharmacists, physicians and other health care providers.

1997
The Asheville Project, the first diabetes self-management program, was first offered to employees, dependents and retirees in the City of Asheville, N.C., in partnership with the North Carolina Center for Pharmaceutical Care. Long-term results of the Asheville Project, published in the *Journal of the American Pharmacists Association*, showed improved A1C levels; employers had lower total health care costs; employees had fewer sick days and increased satisfaction with pharmacist services; and pharmacists developed thriving patient care services.

2002
Project IMPACT: Osteoporosis, a regional osteoporosis screening, referral, and monitoring pilot designed by the APhA Foundation, demonstrated the significant impact that community pharmacists can have in identifying and referring at-risk patients to physicians for appropriate diagnosis and intervention. The final data showed that 70% of the 532 patients screened were at high or moderate risk for future fracture; 78% of patients screened indicated that they had no prior knowledge of their risk for future fracture; and more than 30% of patients participating in pharmacy-based Bone Mineral Density screenings initiated medication or lifestyle changes (diet & exercise).

2003
The Patient Self-Management Program for Diabetes, based on the Asheville and Project ImPACT: Hyperlipidemia models, was initiated in four states at five employer sites with more than 300 patients. The results were published in 2005 with compelling findings that indicate the ability to replicate the clinical results and expand the scale of the Asheville model in diverse settings, including an average decrease in total health care costs of $918 per patient in the first year.

2004
The APhA Foundation completed development of the **Patient Self-Management Credential for Diabetes**, the first and only credential that recognizes individual patients for their achievement in various areas of diabetes self-management. The Patient Self-Management Credential was used as an integral part of the Patient Self-Management Program for Diabetes.

2005
Through the **Diabetes Ten City Challenge**, 29 employers in ten cities established a voluntary employee health benefit, provided incentives through waived co-pays for diabetes medications and supplies, and helped employees, dependents and retirees manage their diabetes with help from a pharmacist in collaboration with physicians and diabetes educators.

APhA FOUNDATION

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

2006

Project ImPACT: Depression assessed the clinical and economic impact of a patient-centered, depression management program that included pharmacist-provided care and a point-of-care health questionnaire. Sixty-eight percent (68%) of patients responded to the pharmacist-provided interventions and 56% of patients went into remission. Annual medical costs decreased from an average of $6,351 per enrollee per year to $5,876, and there was an average net savings of $983 per person per year.

2009

The **Diabetes Ten City Challenge** final economic and clinical data were announced, showing an annual savings of nearly $1,100 per patient per year compared to projected costs if the program had not been implemented; significant improvements in the number of people achieving the American Diabetes Association goal of A1C level < 7.0; an increase in the number of participants achieving nationally recognized National Cholesterol Education Program goals for LDL; an increase in the number achieving recognized goals for systolic blood pressure goals; and an increase in the number of patient with current flu vaccinations, and foot and eye exams.

2010

The APhA Foundation received a $4.3 million grant from the Bristol-Myers Squibb Foundation's Together on Diabetes initiative to implement **Project IMPACT: Diabetes**, a three-year program that aims to improve the health of people with limited access to quality care in 25 communities disproportionately affected by diabetes utilizing the Foundation's collaborative care model.

2013

The APhA Foundation announced the interim results for **Project IMPACT: Diabetes**, which showed statistically significant improvements across key diabetes indicators including A1C (blood sugar) control, systolic blood pressure, LDL Cholesterol, and Body Mass Index (BMI).