HISTORY OF THE DIABETES TEN CITY CHALLENGE

The following milestones and research have paved the way for the Diabetes Ten City Challenge:

1996 The APhA Foundation creates 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 the *Journal of the American Pharmacists Association* in 2000, showed that more than 90% of patients stayed on their medications and 67.5% reached the National Cholesterol Education Program (NCEP) treatment goals.

1997 The diabetes management program, the Asheville Project, is first offered to employees, dependents and retirees in the City of Asheville, N.C., in partnership with the North Carolina Center for Pharmaceutical Care. The program starts with 47 initial participants.

1998 Mission-St. Joseph's Hospitals and the Blue Ridge Paper Company add the diabetes management program for beneficiaries in their health plans. It grows to more than 300 people with diabetes over the next three years.

2003 Long-term results of the Asheville Project**,** published in the *Journal of the American Pharmacists Association*, showed that patients improved A1C levels (key diabetes indicator), 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. Asheville Project results also appeared in *Business Insurance* and *The Washington Post*.

2003 The APhA Foundation begins follow-up research based on the Asheville Project and Project ImPACT: Hyperlipidemia™ to assess the feasibility of expanding the model to multiple employer types and geographic locations. The Patient Self-Management Program for Diabetes[SM]**,** based on the Asheville model, is initiated in four states at five employer sites with more than 300 patients.

(more)

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2004 The APhA Foundation completes development of the Patient Self-Management Program for Diabetes [SM] Credential, the first and only credential for education in diabetes that can be awarded to individual patients for completing study in diabetes and its management as part of the Patient Self-Management Program for Diabetes [SM] program research.

2005 The Patient Self-Management Program for Diabetes [SM] results are published with compelling findings that indicate the ability to replicate and expand the scale of the Asheville model in diverse settings, including a $918 decrease in average cost per patient in the first year.

2005 The Diabetes Ten City Challenge is announced in October, inviting participation from employer groups that want to seize the opportunities for improved patient health and cost savings. The Northwest Georgia Healthcare Partnership, based in Dalton, GA, and the Pittsburgh Business Group on Health are the first two employer groups selected to participate.

2006 The APhA Foundation announces the final ten cities and employers selected to participate in the Diabetes Ten City Challenge: the Pittsburgh Business Group on Health and Giant Eagle in Pittsburgh; the Northwest Georgia Healthcare Partnership in Dalton; the Hawaii Business Health Council in Honolulu; the City of Milwaukee; six employers in Charleston and Spartanburg, S.C.; the University of Southern California in Los Angeles; the Western Maryland Health System in Cumberland; and the City of Colorado Springs.

2007 The DTCC exceeds its enrollment goal of 1,250 participants with additional employees still joining. As part of its overall goal to make the DTCC model available to employers nationwide, the APhA Foundation announces HealthMapRx™, a new initiative designed to reduce employer costs and improve the health of employees with diabetes, cardiovascular conditions, asthma, depression and other chronic diseases.

2008 The DTCC interim results are announced, showing significant increases in the number of participants who felt their overall diabetes care was "very good to excellent" and the number of people with nutrition, weight and exercise goals. The results also showed that participants with at least three months in the program improved across all key clinical indicators.

2009 The DTCC final economic and clinical data are 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 A1C, LDL cholesterol and blood pressure goals; and increases in the number with current flu vaccinations, and foot and eye exams.

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