Multiple Partnerships and The Emerging Role of Pharmacists and Pharmacies

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Diabetes Management Innovations
Hyatt Regency McCormick Place
May 13-14, 2014 • Chicago, IL
Presentation Overview

- Project IMPACT: Diabetes and the other pharmacy cases profiled in this session have transformed health care delivery in local communities and improved patient outcomes.

- Patients became better informed and learned how to self-manage their condition, which results in an improvement in overall health and risk reduction for major complications associated with diabetes, including kidney disease, amputations and blindness.

- Project IMPACT: Diabetes
  - National Perspectives and Background

- Diabetes Care at Kroger
  - Kroger Mid South Division Services and Experience

- Central Ohio Diabetes Association
  - Integrating Pharmacists into Patient Care

- Reactor Panel
Multiple Partnerships and The Emerging Role of Pharmacists and Pharmacies

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Project IMPACT: Diabetes Objectives

- Scale successful efforts from the Asheville Project, Patient Self-Management Program for Diabetes, and Diabetes Ten City Challenge in communities across the United States
- Establish a nationwide program utilizing the APhA Foundation’s structure and process model in an effort to reach communities that are the most affected by diabetes
- Project IMPACT: Diabetes Principles:
  - Disproportionate share populations
  - Collaborative care with pharmacists
  - Continuous quality improvement
  - Patient self-management credentialing
  - Minimum dataset reporting

IMPProving America’s Communities Together
Participating Communities

- 25 communities
- 17 states
- 2,000+ patients
- 80+ pharmacists

Getting quality diabetes care to patients who need it most…
About the APhA Foundation’s Process Model

- Health Care Services that are:
  - Patient-centered
  - Pharmacist-supported
  - Inter-disciplinary

Resources and support provided to patients and pharmacists throughout the care continuum.
Community Resources

- Knowledge Base (online database)
  - Rich, role-based source of sample forms and tools
  - Patient education resources

- Patient Self-Management Credential
  - Hard-copy forms available through knowledge base resources
  - Adobe Flash Application documentation

- IMPACT Care Database
  - Microsoft® Access Database > SQL Server Database
  - Collects/reports minimum and maximum IMPACT datasets

- IMPACT Technical Advisory Services
  - Community Coordinator providing mentorship
  - 800 number and e-mail address with 24/7 access
**Patient Self-Management Credential for Diabetes**

- Used in APhA Foundation’s Patients Self-Management Program for Diabetes and Diabetes Ten City Challenge
- Used in 25 Project IMPACT: Diabetes communities:
  - May not reach Skills or Performance with some patients in first year – keep trying to improve on areas of weakness during each visit
- Assessments point to resources in Knowledge Base to supplement the time spent with the patient
Implementation Across 25 Communities

**Pharmacist Collaboration**
- Physicians
- Nurse Practitioners
- Dietitians
- Students (medical/pharmacy)
- Diabetes Educators
- Medical Assistants
- Community Health Workers
- Promotoras
- Dentistry
- Podiatry
- Ophthalmology

**Practice Setting Variety**
- Community Pharmacies
- Employer Worksites
- FQHCs
- Free Clinics
- Homeless Clinics
- County Health Departments

**Consistent Measurement**
- Self-Management Assessments
- Minimum Data Set Reporting
- Qualitative Assessments
Project IMPACT: Diabetes Interim National Results

Selected Clinical Indicators (mid-point measures ± SD)

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>N</th>
<th>Starting</th>
<th>Most Recent</th>
<th>Change</th>
<th>P Value</th>
<th>Days</th>
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<tbody>
<tr>
<td>A1C</td>
<td>1064</td>
<td>9.5 ± 1.9</td>
<td>8.5 ± 1.79</td>
<td>-1.0 ± 2.0</td>
<td>&lt; 0.001</td>
<td>188 ± 90</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>978</td>
<td>131.5 ± 17.6</td>
<td>129.9 ± 16.7</td>
<td>-1.6 ± 18.6</td>
<td>0.004</td>
<td>185 ± 90</td>
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<tr>
<td>Diastolic BP</td>
<td>978</td>
<td>78.8 ± 10.3</td>
<td>78.5 ± 9.6</td>
<td>-0.3 ± 10.3</td>
<td>0.192</td>
<td>185 ± 90</td>
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<tr>
<td>LDL-Cholesterol</td>
<td>579</td>
<td>102.1 ± 50.3</td>
<td>92.0 ± 35.1</td>
<td>-10.1 ± 47.8</td>
<td>&lt; 0.001</td>
<td>202 ± 94</td>
</tr>
<tr>
<td>BMI</td>
<td>974</td>
<td>34.9 ± 8.2</td>
<td>34.7 ± 8.2</td>
<td>-0.1 ± 2.1</td>
<td>0.021</td>
<td>186 ± 90</td>
</tr>
</tbody>
</table>

*Interim results include patients with 2 or more values reported as of October 1, 2012.*

Patient Self-Management Knowledge Assessments

<table>
<thead>
<tr>
<th>N</th>
<th>Baseline</th>
<th>Most Recent</th>
<th>Change to Date</th>
<th>P Value</th>
<th>Days Experience</th>
</tr>
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<tbody>
<tr>
<td>Beginner A1C</td>
<td>462</td>
<td>9.71 (SD = 1.99)</td>
<td>8.61 (SD = 1.94)</td>
<td>-1.10 (SD = 2.14)</td>
<td>&lt; 0.001</td>
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<tr>
<td>Proficient A1C</td>
<td>442</td>
<td>9.41 (SD = 1.84)</td>
<td>8.44 (SD = 1.67)</td>
<td>-0.97 (SD = 1.89)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Advanced A1C</td>
<td>160</td>
<td>9.16 (SD = 1.69)</td>
<td>8.31 (SD = 1.65)</td>
<td>-0.84 (SD = 1.76)</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>
Physician Perspective

“How am I going to do this for only one year? I want this forever!’ We’re thinking about sustainability… because the patients are excited, the staff members are excited. This is a dream team for diabetes. When I came up, a pharmacist was a pharmacist and a doctor was a doctor. You didn’t work together. Now we’re bringing up a new generation of [health care] providers so they can learn to co-manage patients together.”

– Dr. Price-Stevens, MD
Patient Perspective

“And sure enough, I’m cutting my weight. My blood sugar is in control, and I’m feeling more energized. It’s like I’m 18-19 years old again. When I walk out of the office, I come out of there with confidence. I get the confidence that I can do it, and it shows because I’m doing it now. [better diet, exercise, blood sugar monitoring, medication adherence]”

– Adrian J.
Community Resources

- Knowledge Base (online database)
  - Rich, role-based source of sample forms and tools
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Health Matters at Kroger

Our Health and Wellness Focus

- Pharmacy
  - Diabetes Self-Management Education Program (DSME)
  - Diabetes Control and Prevention Recognition Program (DPRP)
  - Coaching Programs
  - Medication Therapy Management
  - Immunizations
  - Biometric Health Screenings

- Dietitians
  - “Expert in the Aisle”
  - NuVal System
  - Pharmacy Programs

- The Little Clinic (TLC)
Kroger DSME Program and Pearls

- American Diabetes Association (ADA) recognized program
- Individual Visits with pharmacists and dietitians
- Four group classes that consist of:
  - Diabetes Overview
  - Medications
  - Monitoring
  - Diabetes Complications
  - Sick Day Management
  - Stress/Coping
  - Nutrition
  - Goal Setting
  - Physical Activity

- Pearls
  - One of two programs in Lexington
  - Location
  - Accessibility
  - Other services available
Kroger Diabetes Prevention Program

- Established by the Centers for Disease Control (CDC) as part of the National Diabetes Prevention Program
- Designed to deliver type 2 diabetes prevention lifestyle interventions
- 12-month program
  - 16 one-hour core sessions
  - At least 6 post-core sessions
Kroger Coaching Programs

- Patients meet face-to-face with pharmacists and dietitians for an individualized treatment plan.
- Some programs are available in a group setting.
- Programs offered:
  - Fitness, Nutrition, Weight Management
  - Diabetes Management
  - Heart Healthy
  - Smoking Cessation
  - Medication Therapy Management (MTM)
About Our Cincinnati Community and Patients

- **Community**
  - Self-insured employer group
  - Large-chain supermarket community pharmacy
  - Health system
  - Pharmacy Benefits Manager
    - Partnership focused on overcoming existing challenges and working together to improve the cost-effectiveness of medication therapy and obtain the best possible therapeutic outcomes for patients

- **Patients**
  - 136 patients enrolled
  - Previous barriers:
    - Disinterested or unaware
    - Failing to meet goals

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Average/Percent</th>
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</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>60.7 years</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female:</td>
<td>62.5%</td>
</tr>
<tr>
<td>Male:</td>
<td>37.5%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Caucasian:</td>
<td>51.5%</td>
</tr>
<tr>
<td>African American:</td>
<td>47.1%</td>
</tr>
</tbody>
</table>
Process of Care & Role of Pharmacists

- Patient recruitment
  - Healthy Lifestyles Program- Health fairs, letters, etc.
  - Pharmacist identification at the counter
  - Physician recommendation/referral
  - Peer-referral program
  - Investigated Cues to Action

- Physician Engagement
  - “MD Detailing”
  - Top-down leadership engagement
  - Effective communication
  - Promotion of MyChart
Process of Care & Role of Pharmacists

- **Patient Experience**
  - Patients schedule via call center/online scheduler/at the pharmacy
  - All appointments in private room at the pharmacy
    - Every 1-3 months; POCT available
  - Includes dietitian visit(s) and grocery store tours
  - Connect to community and employer resources

- **Patient Self-Management Credential**
  - Incorporated for all patients
  - Maintenance Program
## Our Project Results

<table>
<thead>
<tr>
<th></th>
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<th>Baseline</th>
<th>Most Recent</th>
<th>Change to Date</th>
<th>P Value</th>
<th>Days Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1C</strong></td>
<td>136</td>
<td>8.4</td>
<td>7.8</td>
<td>-0.5</td>
<td>&lt;0.001</td>
<td>373.2</td>
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<tr>
<td><strong>BMI</strong></td>
<td>136</td>
<td>36.2</td>
<td>36.1</td>
<td>-0.1</td>
<td>0.333</td>
<td>369.0</td>
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<tr>
<td><strong>Systolic BP</strong></td>
<td>136</td>
<td>129.8</td>
<td>129.6</td>
<td>-0.2</td>
<td>0.432</td>
<td>370.2</td>
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<tr>
<td><strong>Diastolic BP</strong></td>
<td>136</td>
<td>74.1</td>
<td>74.6</td>
<td>0.5</td>
<td>0.315</td>
<td>370.2</td>
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<tr>
<td><strong>LDL-C</strong></td>
<td>125</td>
<td>91.1</td>
<td>83.4</td>
<td>-7.8</td>
<td>0.005</td>
<td>322.0</td>
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<tr>
<td><strong>HDL-C</strong></td>
<td>124</td>
<td>44.2</td>
<td>44.5</td>
<td>0.3</td>
<td>0.382</td>
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<tr>
<td><strong>Triglycerides</strong></td>
<td>124</td>
<td>156.7</td>
<td>146.6</td>
<td>-10.1</td>
<td>0.117</td>
<td>322.4</td>
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<tr>
<td><strong>Total Cholesterol</strong></td>
<td>124</td>
<td>164.5</td>
<td>157.3</td>
<td>-7.2</td>
<td>0.018</td>
<td>322.4</td>
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</tbody>
</table>
Impact of *Project IMPACT: Diabetes*

- IMPACT has changed our community
  - More “COMMUNITY” feel
    - Increased collaboration and understanding
    - Working toward referral trigger and electronic referral
  - Expansion
    - Sites and space
    - Increased Enrollment
    - Pharmacist providers
    - Programs
  - Continued use of the Patient Self-Management Credential
  - Refreshed focus on clinical outcomes and goal achievement
Impact of *Project IMPACT: Diabetes*

- **Sustainability of the care model**
  - City pleased with clinical results and recent satisfaction surveys
    - 87% feel they need to continue in the program to be successful in managing their condition
    - 85% feel their physician is supportive of their participation
      - 74% discuss the goals they have set with their pharmacist at doctor visits
    - 97% very satisfied with the program
    - 93% would recommend program to others
  - Full ROI analysis planned
  - Building relationship with new PBM
Star Ratings

- CMS rates health and prescription drug plans based on specific safety and quality measures
- Helps the public compare the value between various plans
- The higher the rating, the better the plan

Pharmacy performance measures are large contributors to Star Ratings
- Contribute more than 40% to a plan’s rating

CMS monitors claim data to know which pharmacies are high-performing

Areas of Focus:
- High-Risk Medications
- Omissions in Care for Patients with Diabetes
- Adherence Issues
  - Cholesterol medications
  - Hypertension medications
  - Diabetes medications
Multiple Partnerships and The Emerging Role of Pharmacists and Pharmacies

Lindsey Matz, MSW, LSW
Patient Navigator
Central Ohio Diabetes Association
About the Community and Patients

Community
- Independent, local, non-profit that provides Diabetes Self-Management Education and Support (DSMES) to residents of Central Ohio and the surrounding communities
- Funded by United Way of Central Ohio and Franklin County
- Partners with YMCA, Columbus Neighborhood Health Centers, Kroger

Patients
- 25 total patient participants
- 15 Caucasians, 8 African Americans, 1 Pacific Islander, and 1 other
- 11 female participants & 14 male participants
- Barriers to care include: uninsured, underinsured, several have unmet needs that demand more immediate attention that diabetes education, transient, lack of resources
Process of Care & Role of Pharmacists

- **Patient Recruitment** – Engaged once a patient attends a DSMES Assessment with the licensed social worker
  - Referred by their physicians and other community programs
  - Identified through community diabetes screenings

- **Use of Patient Self-Management Credential**
  - Knowledge assessment was administered in the beginning, when a patient was filling out their registration forms for a Diabetes Educational Assessment

- **Patient Experience**
  - All new patients were assessed to determine their level of knowledge, to gather information, and place them in the appropriate diabetes class
  - During our DSMES class series, a pharmacist delivers a 20 minute presentation about building a pharmacist-patient relationship, and what the role of the pharmacist is on the diabetes care team
  - Pharmacist provides private, one-on-one consults to individuals for medication reviews
  - 3 month follow-up occurs after a patient has been through the DSMES
Process of Care & Role of Pharmacists

- Pharmacist interactions with patients
  - During the DSMES series:
    - The pharmacist would discuss the role of a pharmacist on the diabetes care team, the training and scope of practice of a pharmacist, and how different diabetes medications work
  - During the one-on-one consultations with the pharmacist:
    - The pharmacist conducts a complete review of the patient’s medications
    - Review how their diabetes medications work, what the medications are used for, how to take them, and potential side effects
    - Review all other medications for adherence, duplicate therapy and potential interactions
    - Discuss the importance of glucose logs for monitoring
    - Address any questions the patient had
IMPACT of *Project IMPACT: Diabetes*

- Nurse (Medical)
- Dietitian (Nutrition)
- Social Worker (Emotional)
- Pharmacist (Medications)
IMPACT of *Project IMPACT: Diabetes*

- Positive learning opportunity for our patients, reflected in our client surveys
- Has increased our client’s awareness of the pharmacist’s role in the diabetes care team
- We continue to offer the Registered Pharmacist piece and one-on-one consultations as a part of our DSMES due to how valuable it has been for our patients
- We have an established infrastructure that now includes the pharmacist in our diabetes education team and continue to include them in our overall education for our patients
Sustainability of the Care Model

- The Central Ohio Diabetes Association plans on incorporating the pharmacist piece in our educational efforts as long as funding support exists.

- Costs include:
  - Paying the pharmacist for their time working with our agency and participants
  - Marketing efforts
  - Social Worker and Director of Diabetes Education expenses
  - Any indirect expenses associated
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