Project IMPACT: Diabetes
IMProving America’s Communities Together

Central Ohio Diabetes Association
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Patient Navigator

Introduction

Project IMPACT: Diabetes
- Designed to improve the health of underserved populations in 25 communities disproportionately affected by diabetes

Key Objectives for Project IMPACT: Diabetes
- Scale successful efforts from the Asheville Project, Patient Self-Management Program, and Diabetes Ten City Challenge by implementing collaborative care programs engaging pharmacists on diabetes care teams in communities across the United States
- Establish a nationwide program utilizing the American Pharmacists Association (APhA) Foundation’s structure and process model in an effort to reach communities that are the most affected by diabetes
- Improve key indicators of diabetes in selected communities
- Establish a sustainable platform for permanent change by embedding guiding principles in each community

Methodology

Study Design
- Multi-site, observational study, pre-post comparison
- Approved by The Western Institutional Review Board

Selection of Communities
- 25 communities in 17 states were selected through a competitive application process
- Selected communities included community and university affiliated pharmacies, Federally Qualified Health Centers, self-insured employers, free clinics, & other community-based organizations
- The Central Ohio Diabetes Association was selected for its innovative model of care where pharmacists were being integrated into the care team providing the Diabetes Self-Management Education and Support (DSMES) class series

Targeted Patient Population
- Areas with a high incidence of diabetes
- Patients with hemoglobin A1C >7
- Patients with limited access to quality diabetes care
- Communities with socioeconomic challenges and other factors that impact access to care

Central Ohio Diabetes Association Model of Care

The Central Ohio Diabetes Association (CODA) is an independent, local, non-profit organization that provides a variety of diabetes-related services to Columbus, Ohio and its surrounding communities including, but not limited to, the Diabetes Self-Management Education and Support class series.

Patient Experience
- Patients were referred to CODA by their primary healthcare provider, retail pharmacist, or other community resource
- A Licensed Social Worker completed a full assessment of each client upon referral
- Patients meeting the inclusion criteria were recruited to participate in Project IMPACT: Diabetes
- At baseline, each participant in the project completed the Patient Self-Management Credential Knowledge Assessment to gauge how knowledgeable they were regarding diabetes
- Each participant completed the Diabetes Self-Management Education and Support class series
- During DSMES, a pharmacist delivered a 20-minute presentation about building the patient pharmacist relationship and described the role of pharmacists on the diabetes care team
- As a follow-up to the DSMES class series, the pharmacist provided private one-on-one consultations for individual participants to conduct comprehensive medication reviews
- A three-month follow-up occurred after the participant completed the DSMES class series

Clinical data was collected at baseline and quarterly throughout the study period
- Twenty-five CODA patients completed one-on-one consultations

Project IMPACT: Diabetes Interim Results

Aggregated data was compiled from all 25 Project IMPACT: Diabetes communities and reported on participating patients who had baseline and interim clinical data through July 31, 2012.

The interim data below was released in October 2013

<table>
<thead>
<tr>
<th>Patient Demographics</th>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>58.3</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>41.7</td>
<td></td>
</tr>
</tbody>
</table>

Ethnicity

- Caucasian: 41.2
- African-American: 24.2
- Hispanic: 21.3
- Native American: 4.2
- Asian: 0.8
- Pacific Islander: 0.7
- Other: 1.5

Not specified: 6.2

Interim clinical results from Project IMPACT: Diabetes showed statistically significant improvements across all recognized diabetes standards of care,

<table>
<thead>
<tr>
<th>A1C</th>
<th>BMI</th>
<th>Systolic BP</th>
<th>Diastolic BP</th>
<th>LDL-C</th>
<th>HDL-C</th>
<th>Triglycerides</th>
<th>Total Cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.0</td>
<td>35.1</td>
<td>121.9</td>
<td>78.0</td>
<td>95.5</td>
<td>44.3</td>
<td>215.2</td>
<td>187.3</td>
</tr>
</tbody>
</table>

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Acknowledgements

Project IMPACT: Diabetes transformed health care delivery in local communities and improved patient outcomes.

Health care teams that included pharmacists saw improvements in their patients’ ability to manage their diabetes.

Specifically, patients at Central Ohio Diabetes Association experienced:
- Positive learning opportunities related to their medication therapy (as reflected in client surveys)
- An increased awareness of the pharmacist’s role on the diabetes care team

Implications for Central Ohio Diabetes Association

The Central Ohio Diabetes Association has continued to include the pharmacist on the DSMES program team where she offers both classroom instruction and one-on-one consultations with agency patients.

“Even after Project IMPACT comes to an end, the Central Ohio Diabetes Association plans to continue including pharmacists on our diabetes education team. Having the opportunity to design and implement a pharmacy program, watch how our patients respond to it, and then obtain the basic data that shows clinical improvement gives us reason to go forward with providing this intervention. Involvement in this project has proven to be really good for us and for our patients”

Jeanne C. Grothaus, MA
Executive Director, Central Ohio Diabetes Association

References