



Applying Clinical Pharmacy Services in the Care of Patients with Diabetes

March 27, 2014

Zufall Health Center – A Federally Qualified Health Center serving Morris, Warren, Sussex, Hunterdon and Somerset Counties



- ▶ Established in 1990 in church basement in Dover by Dr. Zufall and volunteer physicians
- ▶ FQHC since 2004; providing entire range of primary medical, dental and enabling services
- ▶ Have 6 sites including a mobile medical van
- ▶ Serving uninsured, underinsured, homeless, residents of public housing, farm workers
- ▶ Open 7 days a week, extended hours
- ▶ Bilingual staff and on call services

Facts and Statistics 2013

Served over 21,000 patients with over 68,000 visits

Patients with diabetes under control: 86%

However, there is still room for improvement...

- ▶ 65% of adults either overweight or obese
- ▶ 13% have diabetes, 16% have hypertension, 85% of patients are taking more than one medication on a regular basis
- ▶ Many patients taking duplicate medications/not taking medications as directed

Continue to offer interdisciplinary team care including a pharmacist to high risk patients.



Patient Safety and Pharmacy Services Collaborative (PSPC)

- ▶ Joined in 2008, now in our 5th year
- ▶ Providing Clinical Pharmacy Services to patients with chronic diseases
- ▶ Pharmacist is integrated in primary care/team work/coordinated care
- ▶ Have seen over 3,000 patients, the majority with diabetes out of control
- ▶ Seeing consistent improvements in all health and safety measures



Project IMPACT – Diabetes – from the APhA Foundation

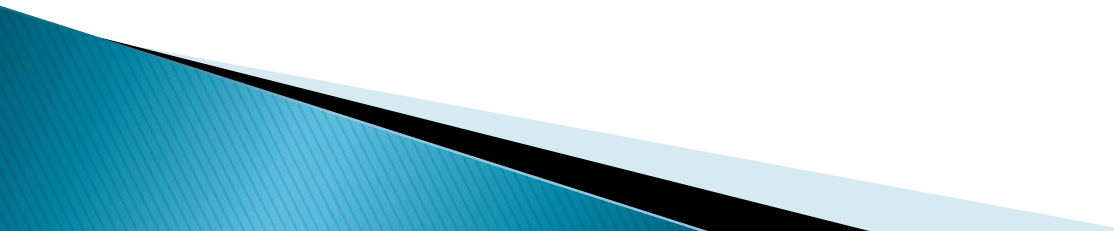
- ▶ One of 25 organizations selected due to our success with the PSPC
- ▶ Used our established process of integrated care
- ▶ Included diabetes education and self-management curriculum
- ▶ Collected health measures and reported data on a monthly basis



Zufall Project IMPACT–Diabetes

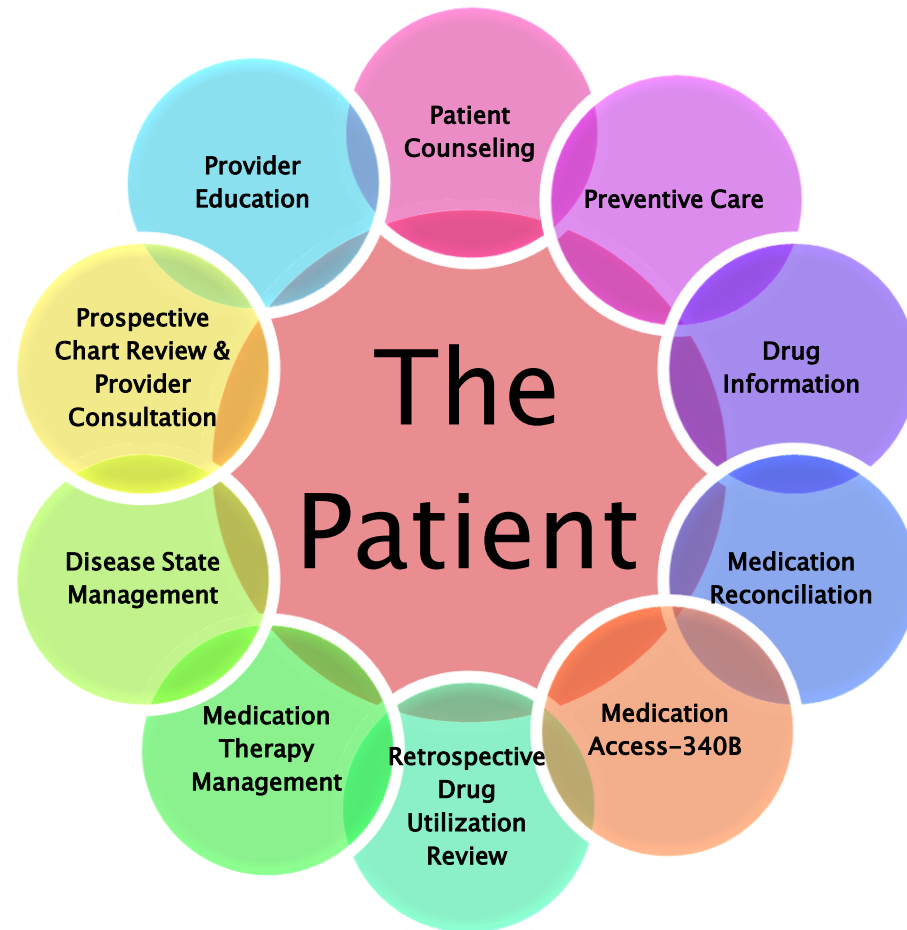
- ▶ Enrolled and followed 84 patients for one year
 - Visits with the pharmacist, MTM and referrals– average 4 times/patient
 - More >50% received action plans
- ▶ Results
 - HbA1c levels significantly reduced by 0.9% ($p=.0002$).
 - Improvements were seen in cholesterol and blood pressure ($p=0.164$, $p=444$)
 - Adherence to medications improved
 - 65.2% had eye exams, 84.2% had foot exams, and 70% received their flu vaccine
 - 28.6% of patients that smoked cigarettes quit smoking

What worked?

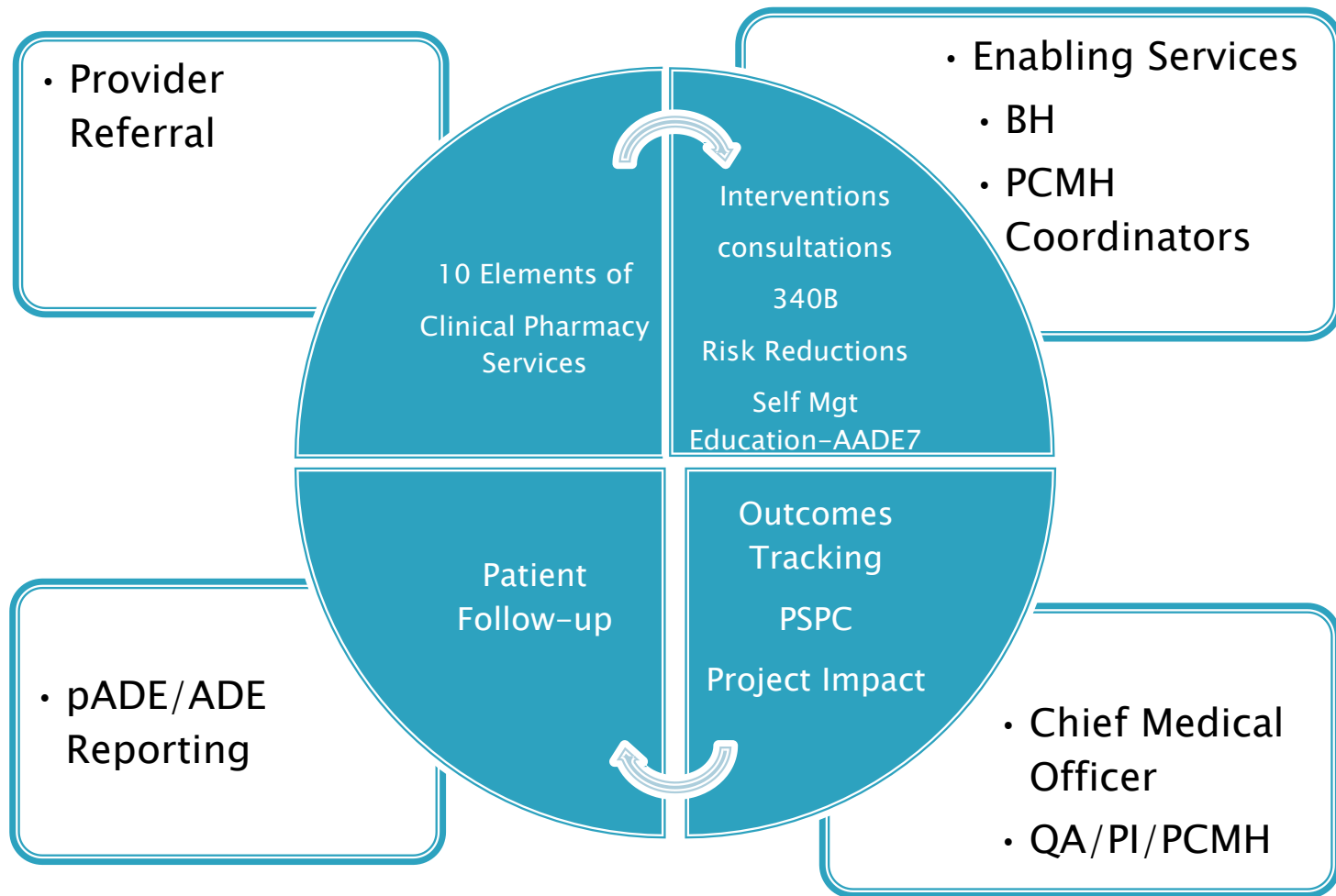
- ▶ Trusting patient– pharmacist relationship
 - ▶ Patient centered
 - ▶ Face to Face encounters–30 minutes to an hour
 - ▶ Frequent follow-up as needed
 - ▶ Targeted interventions
 - Disease-specific
 - Culturally competent
 - Health literacy conscious
 - Barriers identified
 - ▶ Collaboration with clinical team for coordination of care
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CLINICAL PHARMACY SERVICES

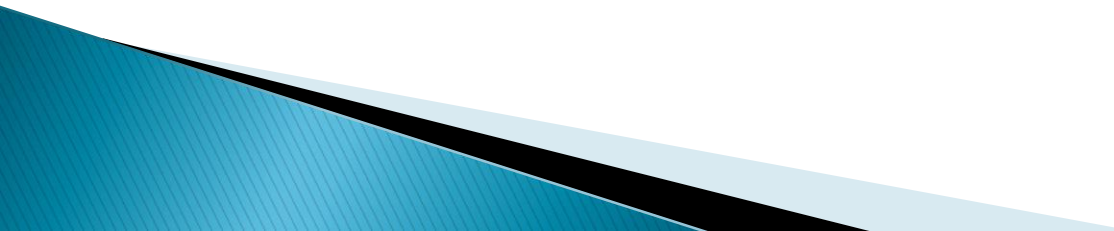
PROJECT IMPACT–Diabetes



Coordination of Care – our Delivery Model



A pharmacist in care team results in:

- ▶ Increased medication adherence
 - ▶ Increased patient safety
 - ▶ Improved access to medications
 - ▶ Enhanced self-management by the patient to accept drug and lifestyle changes regimen
 - ▶ Increased efficiencies in the health care delivery model
 - ▶ Improved screening and prevention services
 - ▶ Added value to care
 - ▶ Decreased ED visits and hospitalizations
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Value to New Jersey–700,000 People Living with Diabetes

- ▶ Medication misuse–
>\$200B=8% costs
- ▶ CDC– non-adherence
costs \$2K/pt/physician
- ▶ CDC– improved self
management cost to
savings 1:10
- ▶ 2025– costs projected
to double
- ▶ Represents– >\$2B for
NJ
- ▶ Represents – >\$1.4B in
visits in NJ
- ▶ Represents potential
savings of >\$14B
- ▶ Double all numbers
above

Reality

Savings

Barrier to Access of Clinical Pharmacy Services

- Not a billable service under Primary Care– Ambulatory Practices
- Provider status is necessary for both pharmacists and CDEs– to enhance access to self management training