Integrating pharmacists into diverse diabetes care teams: Implementation tactics from Project IMPACT: Diabetes

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Abstract

Objective: To describe local implementation tactics used by the 25 Project IMPACT: Diabetes communities and partnering organizations to help patients who are disproportionately affected by diabetes.

Setting: Care was delivered in 25 communities within 17 states at federally qualified health centers, community pharmacies, free clinics, employer work sites, medical clinics, physician offices, and other settings.

Practice description: In addition to pharmacists, practices included physicians, nurse practitioners, dietitians, physician assistants, social workers, behavioral therapists, and other types of health professionals. Insurance status and the predominant ethnicity of patients differed between communities. Each community had at least one community champion responsible for leading local implementation who was supported by an American Pharmacists Association Foundation community coordinator and Foundation staff.

Practice innovation: The key innovations within each of the 25 communities were the integration of pharmacists on diabetes care teams, use of the Patient Self-Management Credential for Diabetes at baseline, and collection of a standardized minimum dataset. Communities deployed other practice innovations to support the care model, including group education classes, grocery store tours, joint provider visits, and provision of patient incentives.

Evaluation: The specific components of each community's implementation and innovation were aggregated via postproject surveys. Clinical and process measures were also collected and are published separately.

Results: Each community is characterized based on the people involved and the care delivered. Aspects of the communities described include health care provider teams, population characteristics, practice settings, care components, data collection methods, incentives provided, and self-reported service sustainability.

Conclusion: Pharmacists can be integrated successfully into a diverse array of practice settings and teams to help a wide variety of patients through the provision of team-based, patient-centered care. Flexibility in implementation strategies allows for customization of the care provided to best meet population needs.

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Project IMPACT: Diabetes was designed to integrate pharmacists into diabetes care teams in 25 communities to help patients who are disproportionately affected by diabetes. High-risk or disproportionately affected areas included those with the following:

- Incidence of diabetes higher than the state average
- Patients with uncontrolled A1C (i.e., >7%) and other outcome measures
- Patients with limited access to diabetes care due to geographic, financial, or other barriers
- Communities showing need, through lack of focused resources or diabetes-related programming, for implementation of enhanced diabetes care

Consistent with previous APhA Foundation initiatives,[1–3] Project IMPACT: Diabetes deployed the Foundation's model of collaborative, team-based care, use of patient self-management credentialing, and collection of a minimum data set to facilitate successful project implementation within diverse communities. Communities also chose how to integrate unique aspects of care delivery into their local processes to best meet the needs of their patients.

At a Glance

Synopsis: A companion article to a Research study published in this issue, this Experience paper describes strategies that enabled success of Project IMPACT: Diabetes. The American Pharmacists Association (APhA) Foundation issued a formal request for proposal and selected 25 communities and partnering organizations for the project. Maximum real-world flexibility was permitted in these communities to allow a community champion and other members of local health care teams to incentivize and care for their patients with diabetes, most of whom were uninsured or underinsured, and to integrate pharmacists into health care teams. Flexibility in local implementation, including customization through population-specific tactics, seemed to empower communities to build new or adapt current services that are now sustainably embedded into routine care within their communities.

Analysis: *Project IMPACT: Diabetes deployed the Foundation's model of collaborative, team-based care, use of patient self-management credentialing, and collection of a minimum data set to facilitate successful project implementation within diverse communities. It demonstrates that integration of the pharmacist into routine care of patients with diabetes—the basis of the Asheville Project and studies conducted by the APhA Foundation—can succeed in a wide variety of communities and practice types. By applying the approaches used in Project IMPACT: Diabetes in a customized manner, communities and health care teams can work with pharmacists to improve diabetes care across the United States.*

This manuscript describes local implementation tactics employed by each of the 25 Project IMPACT: Diabetes communities to help readers identify customization strategies that should be considered for inclusion within their local diabetes management services. The Western Institutional Review Board approved the study and granted a waiver of informed consent. The final results of Project IMPACT: Diabetes are published elsewhere in this issue.[4]

Setting

The 25 implementing communities were selected through a competitive application process that began in February 2011. The APhA Foundation hosted a series of webinars to describe the initiative and issue a formal request for proposals. Applicants were requested to share information about the lead organization, the surrounding community and partners, the patient population who would be receiving care, existing diabetes programs, any local resources available including data management capabilities, and strategies for meaningfully integrating pharmacists into routine care. Each proposal was evaluated based on the community's access to appropriate patient populations, physical and human resources, data and information, education and training for staff, and ability to align incentives for all involved in the implementation. The communities were also assessed on their motivation to participate, the organizational and project leadership, and previously demonstrated success implementing innovative care models.

A total of 25 diverse communities, located within 17 states, were selected to participate. The manuscript that describes the results of Project IMPACT: Diabetes includes a full list of the communities and their locations.[4] The settings in which care was delivered varied between communities and included sites such as federally qualified health centers (FQHCs),[5] community pharmacies, free clinics, employer work sites, medical clinics, and physician offices, among others. Communities were encouraged to form local partnerships that would expand patients' access to diabetes services, which resulted in unique care settings available within each community.

Practice description

Each community designated at least one community champion responsible for leading local implementation. The majority of the champions were pharmacists, but benefits administrators, a physician, and a social worker also took on the role. Each community champion was supported by an APhA Foundation community coordinator and APhA Foundation staff throughout contracting, patient enrollment, patient care, and data collection. The community coordinators typically interacted directly with the community champion but also provided