Working Together to Improve Outcomes: Physician-Pharmacist Collaborative Agreement for Uncontrolled Type 2 Diabetes

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BACKGROUND

- Diabetes affects over 30 million people in the United States[1]
  - 1 out of every 10 people have diabetes
  - 7th leading cause of death
- Clinical Inertia[2]

Patient	Physician	Health Care System
• Difficulty managing too many medications • Medication costs	• Lack of time • Lack of information on new treatment options	• No clinical guidelines • Lack of multidisciplinary care teams

- Physician-pharmacist collaborative practice agreements (CPAs) allow pharmacists to adjust medication regimens, avoid clinical inertia and improve patient outcomes[3]

OBJECTIVE

- To determine the impact of pharmacist interventions on clinical outcomes (i.e., change in A1C) in adult patients with uncontrolled type 2 diabetes (DM2)

METHODS

Population	Intervention	Monitoring
• Non-pregnant adult patients with uncontrolled DM2 taking at least one antidiabetic medication • Excluded if followed by endocrinology	• Pharmacists modified antidiabetic medication regimens via a physician-pharmacist CPA, provided diabetes self-care education, assessed barriers to medication adherence, and placed referrals to other care team members (i.e., social worker, dietician)	• Follow-up visits every 1 to 12 weeks, as needed, for possible medication adjustments • Measured outcome: change in A1C from baseline

RESULTS

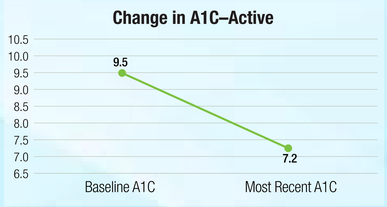

Figure 1. Change in A1C - Active. Includes all patients who met with a pharmacist > 1 time, had > 1 repeat A1C and were not lost to follow-up (n=26). Change in A1C 2.3%.

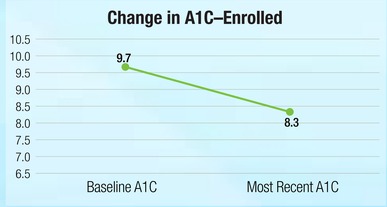

Figure 2. Change in A1C - Enrolled. Includes all patients who met with a pharmacist > 1 time and had > 1 repeat A1C (n=53). Change in A1C 1.4%.

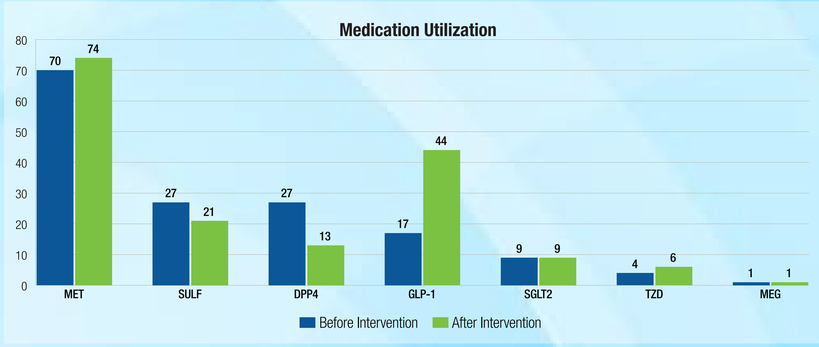

Figure 3. Medication Utilization Before and After Intervention.

CONCLUSIONS

- Physician-pharmacist CPAs improve clinical outcomes in adult patients with DM2
  - Increase physician face to face time with patients
  - Decrease non-billable physician time
  - Decrease time to therapeutic goals
  - Improve pay-for-performance quality metrics
- Limitations
  - Lack of clinician buy-in
  - Limited pharmacist FTE
- Future Directions
  - Continue to improve utilization of preferred medications
  - Streamline pharmacist workflow / improve efficiency
  - Expansion of pilot and future integration with other service lines

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[3] Eric J. Ip, Bijal M. Shah, Junhua Yu, James Chan, Lynda T. Nguyen, Deempal. C. Bhatt. Enhancing diabetes care by adding a pharmacist to the primary care team. AJHP, 2013;70(10):877–886.

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