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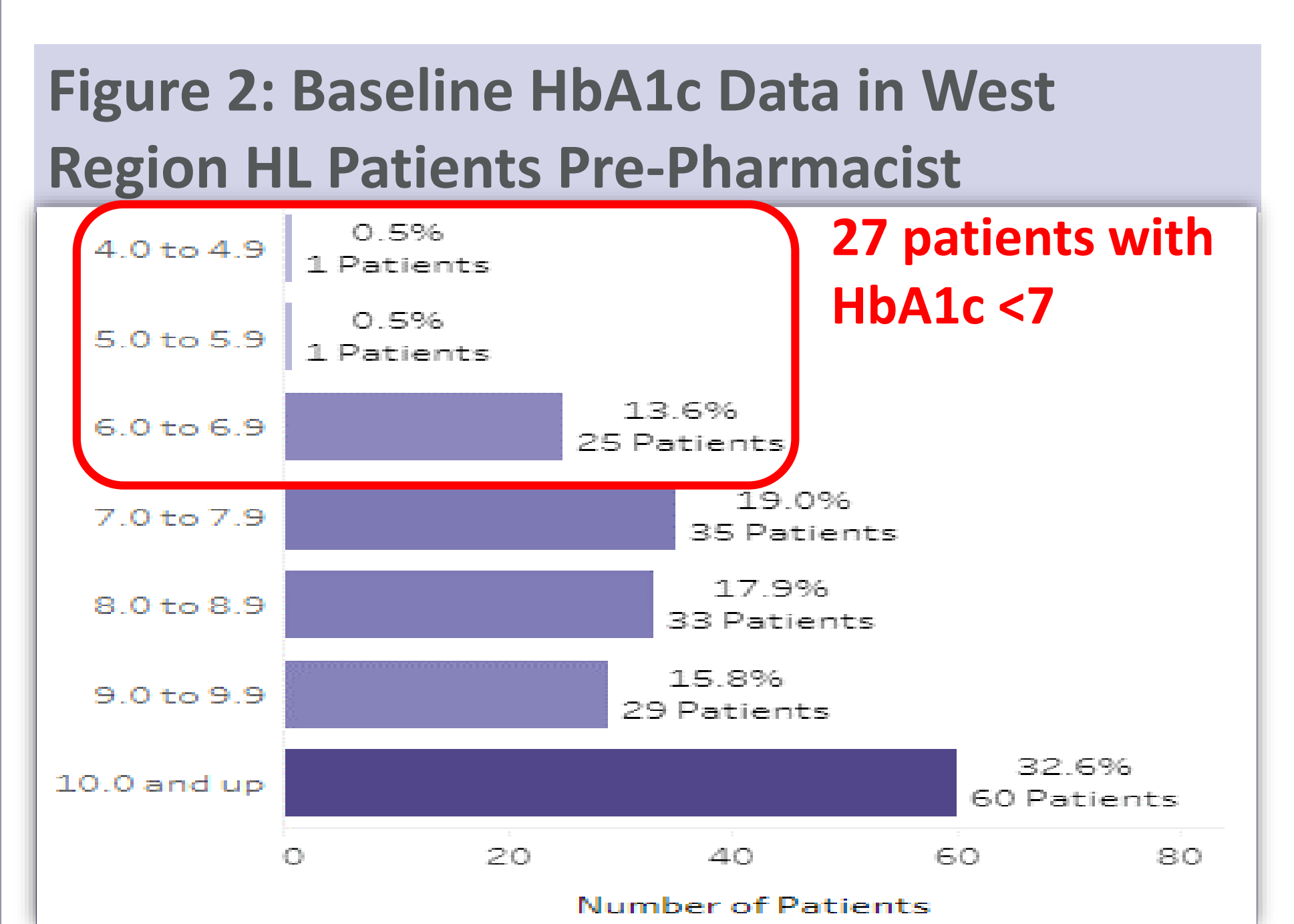
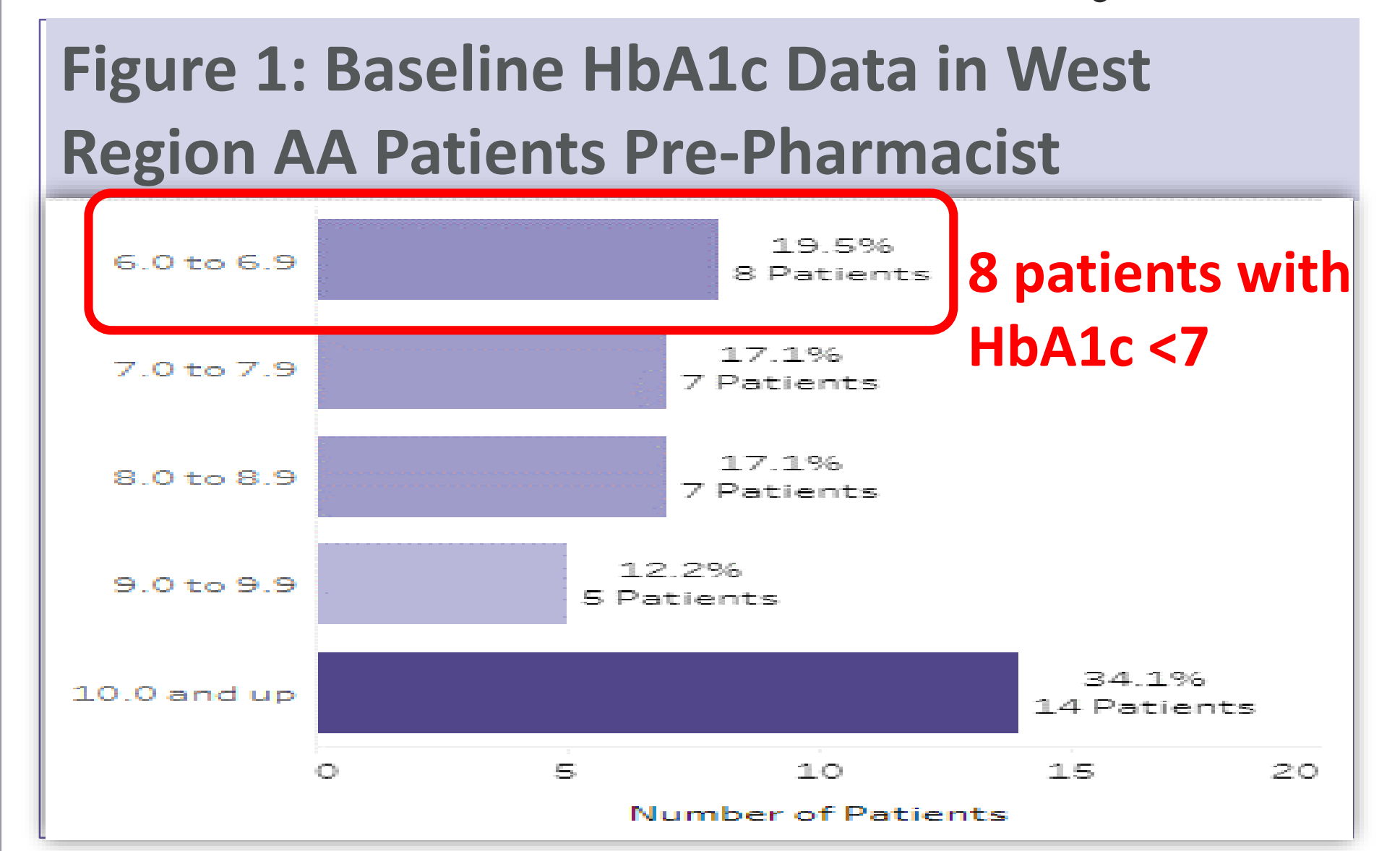
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76.4% of African American and Hispanic/Latino patients with diabetes managed by a clinical pharmacist experienced a lowering of HbA1c by ≥ 0.5 percentage points versus 43.2% of patients that did not have a pharmacist on their Care Team.

BACKGROUND

Problem Statement:

- Ethnic minorities, including African Americans (AA) and Hispanics/Latinos (HL), in the U.S. are disproportionately affected by most diabetes-related complications.¹
- AA with diabetes are more likely to develop kidney disease and kidney failure requiring dialysis than non-Hispanic whites.²
- HL with type 2 diabetes exhibit poorer glycemic control, greater disease severity, and worse outcomes than non-Hispanic whites.³
- Hemoglobin A1c (HbA1c) is a widely used and accepted test for the diagnosis of prediabetes and diabetes and the assessment of glycemic control in patients with diabetes. The American Diabetes Association (ADA) goal for most adults with diabetes is a HbA1c of $< 7\%$.



METHODS

- For this project, three clinical pharmacists were embedded in RMG Wheaton/Winfield IM, RMG St. Charles IM, and RMG Aurora IM practices.
- Signed collaborative practice agreements between providers and pharmacists to provide services were established prior to program initiation (Figure 3, Tables 1-2).
- Data was collected from January 2019 until March 2022.

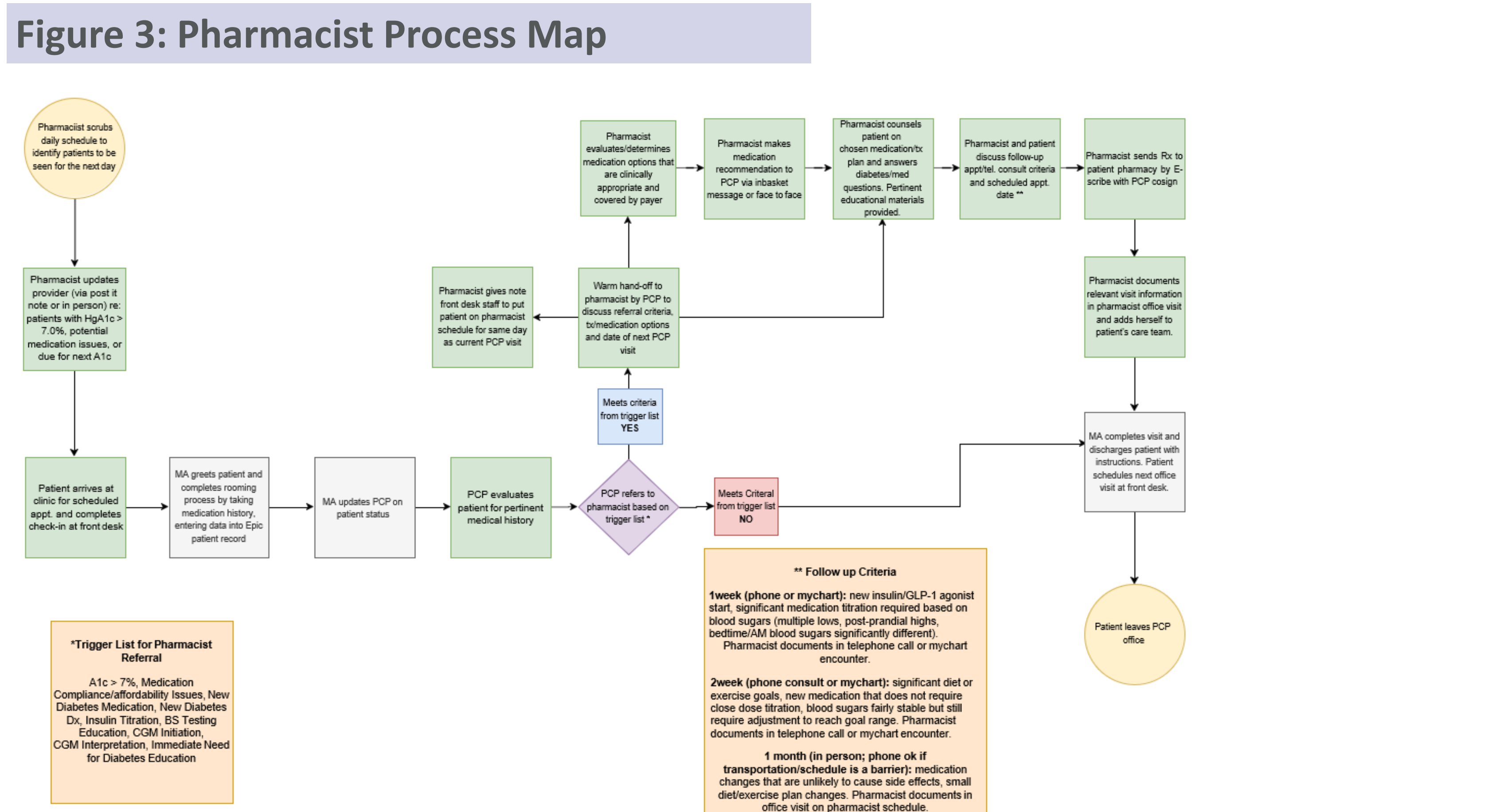


Table 1: Top Pharmacist Interventions

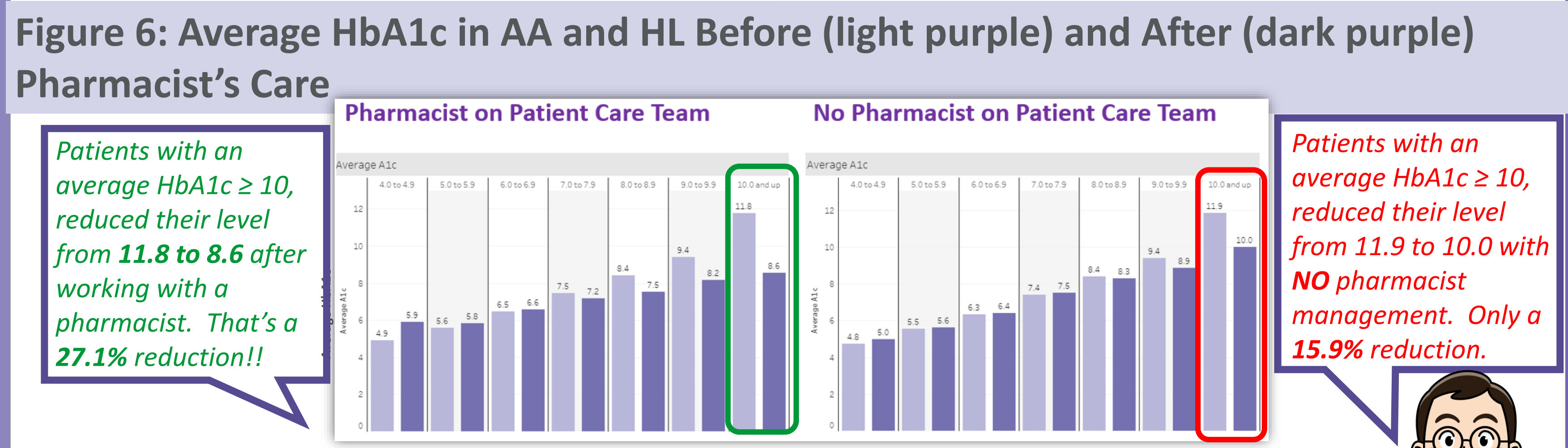
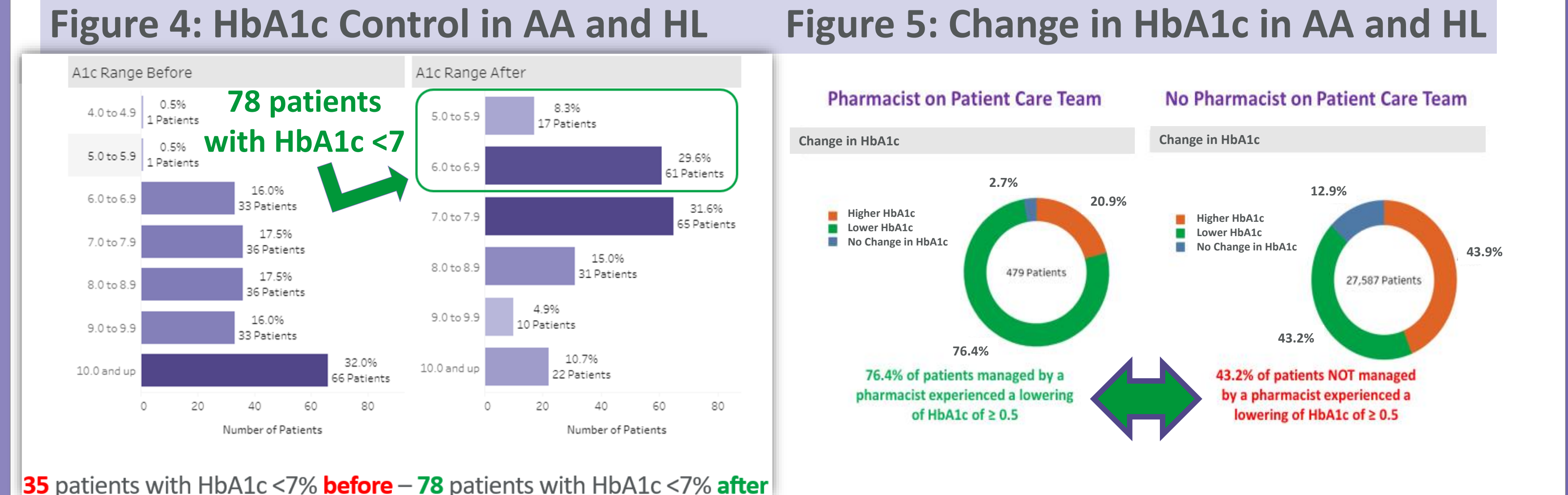
Intervention Type	Number of Interventions
Monitoring Needed	520
Cost/Formulary Issue	240
CGM Management	195
Change in Dosage	186
Medication Selection	142

Table 2: Pharmacist Follow Up Criteria for Patients

- 1 week (phone or MyChart):** new insulin/GLP-1 agonist start, significant medication titration required based on blood sugars (multiple lows, post-prandial highs, bedtime/AM blood sugars significantly different). Pharmacist documents in Telephone Encounter or MyChart encounter.
- 2 week (phone or MyChart):** significant diet or exercise goals, new medication that does not require close dose titration, blood sugars fairly stable but still require adjustment to reach goal range. Pharmacist documents in Telephone Encounter or MyChart Encounter.
- 1 month (in person; phone OK if transportation/schedule is a barrier):** medication changes that are unlikely to cause side effects, small diet/exercise plan changes. Pharmacist documents in Office Visit on pharmacist schedule.

RESULTS

- Prior to working with a pharmacist, there were 35 AA and HL patients with HbA1c $< 7\%$. After working with a pharmacist, there were 78 AA and HL patients with HbA1c $< 7\%$ (Figure 4). **An increase of 43 patients.**
- Of AA and HL patients managed by pharmacists, 76.4% experienced a lowering of HbA1c of ≥ 0.5 vs. 43.2% of patients **NOT** managed by a pharmacist (Figure 5).
- AA and HL patients with a pharmacist on their care team had an average HbA1c lowering in all groups, some as dramatic as **greater than 3 points** (Figure 6).



CONCLUSIONS

- Addition of clinical pharmacists to AA and HL patient Care Teams improved HbA1c outcomes.
- Pharmacist interventions leading to improvement were: 1) patient and medication monitoring, 2) resolving cost/formulary issues, 3) continuous glucose monitor (CGM) initiation/interpretation/management, 4) changing of medication to the appropriate dosage, 5) optimal medication selection, and 6) facilitating HbA1c testing.
- Next steps include implementing pharmacist billing for services and program expansion.

REFERENCE

- Cowie CC, Port FK, Wolfe RA, Savage PJ, Hawthorne VM: Disparities in incidence of diabetic end-stage renal disease according to race and type of diabetes. *N Engl J Med.* 1989;321:1074-1079.
- Young BA, Pugh JA, Maynard C, Reiber G: Diabetes and renal disease in veterans. *Diabetes Care.* 2004;27(Suppl. 2):B45-B49.
- Harris MI. Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes. *Diabetes Care.* 2001;24:454-459.