Provider-Community Pharmacist Team Management of Hypertension and Diabetes

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Iowa Background

- Provider-pharmacist team management of hypertension & diabetes is successful when team members are in a clinic
  - Many communities don’t have pharmacists in a clinic

- An IDPH initiative was begun in 2012 to foster teams of providers & community pharmacists to manage high blood pressure

- Initial focus was in micropolitan and rural areas, but expanded to include larger communities in 2013-2014

- Further expansion to diabetes in 2014-2015
Community-Based Team Management of HTN & Diabetes

Form teams of providers in clinics and pharmacists in community pharmacies

Virtual Team Approach

Virtual team – a group of people who interact through interdependent tasks guided by a common purpose

Being used more in healthcare (E.g. telehealth, health networks)

Use VT principles in forming provider-pharmacist teams
Virtual Team Attributes

1. Agreed upon goals
2. Clear roles
3. Usable communications
4. Trust among members
5. Getting work done

Agreeing Upon Goals

1. Discuss focus of team activities
   - What outcomes?
   - Which patients?

2. Determine how the team care will work
Establishing Clear Roles

1. Determine roles for providers
2. Establish roles for pharmacists
3. Set roles for staff members

Setting Communications

1. Develop and implement a communications process
   A. What to communicate
   B. When to communicate
   C. How to communicate
2. Tailor to team preferences and resources
Building Trust

1. Demonstrate competence
2. Create familiarity
3. Keep promises
4. Support awareness

Getting Work Done

1. Start new activities in each practice’s workflow
2. Establish team processes between the practices
3. Commit time and resources to do the team care
4. Resolve obstacles that arise
Project Objectives

1. Foster provider-community pharmacist teams to manage HTN or diabetes
2. Evaluate team development
3. Assess team care processes & outcomes

Project Overview

1. Team recruitment
2. F2F team building sessions
3. Team managed BP or diabetes
4. Evaluation & reporting
Team Recruitment

1. Contacted pharmacies and physicians
2. Recruited member named by other member
3. In Years 2-3, new and ongoing teams

Team Building

1. 60-minute F2F facilitated session
2. Team worksheet to tailor team approach
3. Shared decisions on worksheet
4. Each member given toolkit (HTN & diabetes)
   a. JNC & ADA guidelines
   b. Suggestions for working as a team
   c. Patient education materials
5. Follow-up phone calls with teams
## Team Building Worksheet

1. Discuss vision for team approach to BP/diabetes management
2. Establish roles for practitioners
3. Set up communications
4. Build trust

### Team Building Worksheet Example

<table>
<thead>
<tr>
<th>Prescriber's Roles</th>
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<tbody>
<tr>
<td>• Coordinate medication therapy</td>
</tr>
<tr>
<td>• Refer patients to pharmacist – prn</td>
</tr>
<tr>
<td>◦ Early referrals of borderline diabetes</td>
</tr>
<tr>
<td>• Respond to pharmacist inquiries &amp; recommendations</td>
</tr>
<tr>
<td>• Prescriber provides diabetes education</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacist's Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify shared patients taking HTN and/or diabetes medications</td>
</tr>
<tr>
<td>• Conduct visits with patients for HTN and/or diabetes</td>
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<tr>
<td>• Meter training with demonstration</td>
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<tr>
<td>• Prevent gaps in insulin therapy</td>
</tr>
<tr>
<td>◦ Encourage pick-up of insulin, do reminders, adherence</td>
</tr>
<tr>
<td>• Communicate with physicians – prn</td>
</tr>
<tr>
<td>• Send meter downloads to clinic</td>
</tr>
<tr>
<td>• Discuss patients who have challenging insulin dosing</td>
</tr>
<tr>
<td>• Patient education – prn</td>
</tr>
<tr>
<td>• Patient education for patients not covered</td>
</tr>
<tr>
<td>• Charting/PHARMACY LOGS</td>
</tr>
</tbody>
</table>
Team Management of BP

1. Pharmacists conduct BP checks, patient education on medication adherence and lifestyle
2. Communication with providers as needed
3. Follow-up visits typical

Team Management of Diabetes

1. Pharmacists conduct diabetes visits: Discuss BG control/testing, medication adherence and lifestyle; Patient education
2. Communication with providers as needed
3. Follow-up visits typical
Evaluation

Multi-case design
Focused on team development and care

1. Practitioner surveys: baseline & post
2. Pharmacy logs & other materials
3. Case report for each team, then cross-case comparisons

Results

Year 1
- Recruited 11 teams – Categorized into 3 types
- 4 Worked Well: Team care, 22-33 BP visits
- 5 Limited Success: Some team care, 3-12 BP visits, Low patient interest, Workflow issues
- 2 No Team: Team care absent, 0-2 BP visits, No system established, Patient & workflow issues
Results

Year 2
- Recruited 8 teams
- 5 New teams – 3 Ongoing teams
- 5 teams established team approach, with 3 teams providing care for at least 10 patients
- Barriers included difficulty in identifying mutual patients, commitment to team care, and use of mail order pharmacies

Results

Year 3
- Recruited 9 teams: 6 New teams, 3 Ongoing teams
- Diabetes care – Pharmacist assist with blood glucose monitoring (SMBG), Adherence
- Plan to run team care until late 2015 or beyond
Discussion

• Successful teams: Closer BP Monitoring, Medication changes, Addressed non-adherence

• Initial team building needed more support F/U sessions, Tools for patients & workflow

Future Issues

Sustaining team management needs work
  – Pharmacist reimbursement
  – Infrastructure

Expanding team management
  – Diabetes
  – Other conditions

Health system and pharmacy chain involvement
Care Coordination Pilot

• Care Coordination Coalition of Iowa City
  – Involves UIHC, VNA, 2 clinics, community pharmacy

• Will use Iowa Health Information Network (IHIN) to share patient information between hospital, clinics, pharmacy, VNA

• Could support team care being promoted here

Further Information

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Iowa’s Million Hearts Initiative Case Report on ASTHO Million Hearts web site
http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Case-Study-IA/