Pharmacist in Practice Improved Glucose Control

BY M. ALEXANDER OTTO

FROM A CONFERENCE ON PRACTICE IMPROVEMENT

SAN ANTONIO – When pharmacists enter the exam room to educate patients about diabetes, physicians save time and diabetes control improves.

At least that's what happened at the Cabarrus Family Medicine clinic in Concord, N.C., according to Sandy Robertson, a Cabarrus Pharm.D.

At a time when clinics across the country are adding pharmacists to patient-centered medical home teams, the Concord experience indicates what works, and what does not.

The story there began in July 2009, when Dr. Robertson volunteered to counsel patients on 2 half-days per week, taking time off from her usual teaching duties in Cabarrus's residency program. She and managers at the 11-clinic family medicine chain wanted to see if pharmacist counseling would improve care. Dr. Robertson worked primarily with diabetes patients, she said in an interview.

To prepare for the visits, she scanned the clinic's electronic health records to identify diabetic patients who needed extra help – those with hemoglobin A_{1c} values above 9%. Dr. Robertson then asked doctors to schedule her with struggling patients during upcoming visits. Patients, she found, were happy to talk so long as she was first introduced by a doctor. The initial visits almost always took a half hour or longer. Meanwhile, doctors would see other patients, popping back into the exam room in about 30 minutes.

"I did a lot of listening. My job was to find out why they were having problems. I certainly didn't have a canned diabetes talk," Dr. Robertson said. "Some patients didn't even understand how to take their insulin, and asked me the most elementary questions. Some were well educated about their diabetes, but were choosing not to follow [recommendations] because they're too hard," she said.

In the latter cases, Dr. Robertson would say something like, " 'Okay, let's make a deal. Instead of eating a whole bowl of ice cream every night, will you shake my hand and promise me that you'll only eat half a bowl? I am going to try to negotiate with you.' They would respond to that," she said.

Much of the time, Dr. Robertson was a cheerleader, telling patients, for instance, " 'You're going to have to come back in 3 months and your numbers are going to be great, and your doctor is going to be so pleased with you,' " she said.

Dr. Robertson also called patients between visits to remind them of upcoming appointments, and to encourage them to take better care of themselves; physicians in Concord simply didn't have time for such hand holding, she said.

Her methods worked.

At the conference, sponsord by the Society of Teachers of Family Medicine, Dr. Robertson presented data from her 9 toughest patients out of the 130-plus she counseled. Each dropped their HbA_{1c} levels within the first 3 months. One patient's HbA_{1c} fell from 14% to 5.8%, another's from 11% to 7%, and a third's from 10.8% to 6.8%.

"We don't have enough data yet to do any kind of statistical analysis, [but] I feel really good about" the outcomes, she said. Physicians did, too. After a while, they were simply pulling Dr. Robertson into exam rooms to talk with newly diagnosed patients.

When Dr. Robertson's pilot project ended, Cabarrus hired another pharmacist to do similar work full time, and then another several months later.

Polled about the new pharmacist, 9 of the 12 doctors at the clinic strongly agreed that patients appreciated her attention and that she improved patients' medication knowledge, overall chronic disease management, and physicians' satisfaction in managing challenging patients.

During her pilot project, Dr. Robertson was paid out of the residency program. The two new pharmacists are also on salary. Only about half of third-party payers are reimbursing their efforts – billed mostly as medication management – at about $35-$75 per half hour. "We are billing what we can," Dr. Robertson said.

The conference was also sponsored by the American Academy of Family Physicians. ■

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