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EXPERT INSIGHT

Q&A with a clinical pharmacist: Reimagining diabetes care

AUTHORS

Rachael Peroutky
Research Consultant

Mason Maynard
Senior Research Analyst

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In this Q&A, a clinical pharmacist shares recommendations for how to design and achieve buy-in for multidisciplinary diabetes care. While multidisciplinary care is essential for managing diabetes and related cardiometabolic conditions, health systems often struggle to overcome silos and secure leadership support. Read more to understand practical strategies to build effective care teams, gain buy-in from administrators and clinicians, and shape the future of diabetes care.

Introduction

As we learn more about the interconnectedness of cardiometabolic health, health system leaders are looking for ways to break silos, especially for patients with diabetes. Patients with type 2 diabetes rarely present with diabetes alone — they frequently face comorbidities such as cardiovascular disease, kidney disease, and obesity.[1] Often, these conditions are managed by separate specialists on different care teams. When specialists are siloed, critical decisions can stall for months, leaving patients vulnerable to complications. To solve this problem, some systems are moving towards a more multidisciplinary approach to care.

Clinical pharmacists often serve as the linchpin to multidisciplinary diabetes models through their ability to adjust medications, educate patients, and coordinate across teams. In this Q&A, we share practical strategies from a clinical pharmacist who helped bring inpatient multidisciplinary learnings to an outpatient setting. She shares why multidisciplinary care matters, how to gain leadership buy-in, and what steps health systems can take to design effective team-based approaches for diabetes and cardiometabolic health.

Why is a multidisciplinary approach so critical for diabetes care?

A multidisciplinary approach is critical to avoid potential gaps in treatment. For example, a patient's blood pressure may remain uncontrolled because their endocrinology team hesitates to adjust medications outside its scope, while cardiology waits for clearance from nephrology on anything outside of their domain. These delays can compound over time, contributing to preventable complications.

As one expert emphasized, "You can't treat diabetes without treating weight and cholesterol — you need the whole team working toward the same outcome."

A multidisciplinary model brings all stakeholders together under a shared goal: To improve overall cardiometabolic health. When pharmacists, dietitians, diabetes educators, and physicians collaborate, they can make timely medication adjustments, align treatment plans, and provide consistent patient education. This coordination ensures patients understand how therapies work together to protect their heart, kidneys, and metabolic health.

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Which role is one of the most critical to a multidisciplinary diabetes treatment?

Pharmacists are extremely critical because they frequently act as the linchpin — they bridge clinical decisions with patient understanding and ensure care plans are executed effectively. At some organizations* pharmacists have a broad scope of practice that allows them to start, stop, and adjust medications and lab orders within their credentialed disease state. This broad role enables rapid treatment changes that drive better weight and glycemic outcomes — such as switching from one drug to another without waiting for specialist clearance in some cases.

Beyond medication management, pharmacists serve as educators. They explain how therapies interact, and how some diabetes drugs also protect heart, kidney, and metabolic health. This level of engagement helps patients understand the “why” behind treatment decisions and may improve adherence. Pharmacists often write detailed instructions, remind patients of next steps, and even coordinate prior authorizations to ensure access to therapies.

What other roles are important?

Dietitians, diabetes educators, nurse practitioners, social workers, and specialists such as cardiologists and endocrinologists are also critical. When these roles work in concert, patients receive more timely interventions, clearer guidance, and better long-term outcomes across all aspects of cardiometabolic health.

What are the biggest barriers to implementing coordinated diabetes care?

Health system silos — impacting everything from budgets to scheduling processes — make coordinating multidisciplinary care difficult. Most health systems separate their budgets by medical and pharmacy, and then again by individual service lines. The medical and pharmacy leaders each manage their own resources and reimbursement streams. This structure makes it difficult to fund shared initiatives or create integrated clinics because no single department wants to absorb the cost.

In addition, it’s hard to justify additional spending for these programs because it’s difficult to demonstrate short-term ROI. Non-physician roles such as pharmacists and dietitians, which are critical to multidisciplinary care, are often undervalued in budget planning because they generate less direct revenue. While coordinated care reduces long-term complications and hospitalizations, those benefits may take years to materialize. In the meantime, leadership sees only the upfront costs.

Financial barriers are also compounded by logistical hurdles. Coordinating schedules for multiple specialists, securing clinic space, and aligning workflows require significant planning. Even when teams agree on a shared vision, practical constraints such as limited availability or competing priorities can stall progress. Inpatient settings offer natural collaboration points because all clinicians are in one place but replicating that level of integration in outpatient care requires intentional design and sustained investment.

*The ability to start, stop, and/or adjust medications by a pharmacist depends on regulations which vary by state and, most commonly, the existence of a Collaborative Drug Therapy Management agreement.

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How do you gain buy-in for multidisciplinary care?

Getting the right leaders aligned and using available data to show impact are two key steps to adopting multidisciplinary care. Engage administrative leaders early to secure funding and allocate resources, especially for roles like pharmacists and dietitians that are critical to care but often under-reimbursed. Clinical managers and division directors play a key role in determining how these non-physician positions fit into the budget and workflow.

Finding physician champions can help bring specialists together across cardiology, endocrinology, nephrology, and other divisions, to create a unified vision for patient care. As one expert noted, "You need a physician champion — someone who's going to bring a doctor from all these different divisions together as a joint venture." These champions advocate for shared goals and help overcome cultural barriers that arise when teams operate in silos.

To ensure long-term support from leadership, collect data to show the impact of the new approach. Outcomes data — such as improved A1C levels, reduced 30-day readmissions, and lower hospitalization rates — can demonstrate both clinical and financial value. It's worth noting that it is not always possible to capture the full impact of multidisciplinary care cleanly. These conditions are complex, and benefits such as reduced complications or improved cardiometabolic health often take years to materialize, making it difficult to demonstrate ROI.

What is your vision for diabetes care in the future?

In the future, I hope that diabetes care models will mirror the inpatient experience, where all relevant specialists work together in one setting to enable real-time collaboration and comprehensive treatment. In this model, patients would have access to a range of specialists during a single visit, eliminating delays and ensuring that care plans are aligned from the start.

We've seen this model in practice at some organizations that have experimented with shared medical appointments. For example, the VA has successfully implemented team-based visits that include a nurse practitioner, dietitian, and pharmacist who all work side by side. Similarly, bariatric clinics often provide a glimpse of this approach by offering patients access to physicians, pharmacists, dietitians, and exercise physiologists in one location. These models demonstrate how integrated care can accelerate decision-making and improve outcomes.

While this level of coordination is rare in outpatient settings today, it is achievable with intentional design and leadership support. Moving toward multidisciplinary clinics will require breaking down financial silos, aligning schedules, and investing in infrastructure. The payoff can be faster treatment, better patient experience, and improved long-term outcomes for those living with diabetes and related cardiometabolic conditions.

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Endnote

1. American Diabetes Association. Standards of Medical Care in Diabetes—2025. Section 4: Comprehensive Medical Evaluation and Assessment of Comorbidities. Diabetes Care. 2025;48(Suppl. 1):S49–S67.

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