

# Leading Diabetes Care in a New Direction

AMGA's National Summit on Quality Accountability in Diabetes: Alignment for Success

The healthcare community is acutely aware of the growing prevalence of diabetes. What can the multitude of stakeholders involved in diabetes care do to improve the quality and cost-effectiveness of patient care and help millions of patients live healthier lives?

This article offers insights gleaned at the Summit and serves as a starting point in confronting challenges to treatment.

To examine this question, the American Medical Group Association (AMGA) extended its efforts to identify best practices for diabetes management by hosting the National Summit on Quality Accountability in Diabetes: Alignment for Success (the Summit), held in conjunction with the AMGA 2009 Annual Conference in Las Vegas. Attendees from more than 30 member groups attended the Summit, which featured presentations by Beth Averbeck, M.D., Health Partners; Becky Cherney, Florida Health Care Coalition; Jack Mahoney, M.D., Pitney Bowes; Bruce McCarthy, M.D., Allina Medical Clinic; and Kenneth Schaecher, M.D., SelectHealth; and was moderated by Schumarry Chao, M.D., M.B.A., SHC & Associates. The goals of the

Summit were to bring stakeholders together to discuss strategies that address challenges in delivering quality diabetic patient care, and to serve as a launching vehicle for AMGA programs to advance the alignment of stakeholders. This article offers insights gleaned at the Summit and serves as a starting point in confronting challenges to treatment.

## Barriers to Quality Diabetes Care: Setting the Stage

Barriers to quality diabetes care identified in the literature and from a survey conducted by AMGA can be segmented into three major areas of focus:

1. Treatment guidelines and A1c goals
2. Systems that support clinical goals
3. Patient-centered care

## Treatment Guidelines and A1c Goals

Agreement on an optimum clinical guideline is the first step physician practices can take in improving diabetic patient care. Guidelines are constantly changing and it is important that patient care is keeping pace.

### *Glycemic Control: Quicker to Target A1c*

The traditional approach to the primary component of diabetes management—glycemic control—has been a conservative stepwise approach (i.e., lifestyle changes, oral therapy, combination oral therapy,

insulin therapy). Depending on how much time passed between each step, this approach could result in patients experiencing hyperglycemia for long periods of time, often years.<sup>1</sup> Today there is greater appreciation for the vascular damage caused during prolonged periods of hyperglycemia. Data has consistently shown the benefit of glycemic control for reducing the risk of microvascular complications. The association of glycemic control and macrovascular complications is less clear; however, the latest data analyses suggest glycemic control has more long-term cardiovascular benefit in those patients who are still early in the course of diabetes, before vascular damage has started to occur.<sup>2,3</sup> Therefore, aggressive treatment is now being recommended from initiation of therapy.

Leading organizations—the American Diabetes Association (ADA), the American College of Physicians (ACP), the American College of Cardiology (ACC), and the American Heart Association (AHA)—recommend an A1c goal of <7% for most patients.<sup>4-6</sup> The majority (94%) of AMGA members who responded to the AMGA survey reported using an A1c target of <7%.

Appropriate management of diabetes has been redefined. Guidelines now recommend medication for most patients upon diagnosis, as lifestyle changes alone often fail to meet or maintain glycemic goals. For patients who are not achieving their clinical targets with initial therapy, ADA, the American Association of

Clinical Endocrinologists (AACE), and the European Association for the Study of Diabetes (EASD) recommend allowing only two to three months of elevated glucose levels before changing therapy.<sup>7,8</sup> For example, the first step in the 2009 ADA/EASD algorithm is both lifestyle changes and metformin; the second step is the addition of either basal insulin or a sulfonylurea. Insulin is recommended for patients with higher glucose levels, as it is the “most effective at lowering glycemia.”<sup>9</sup>

#### *Other Important Components: CV Risk Factors and Depression*

Blood glucose is not the only component that physicians need to monitor in their diabetic patients. To reduce the risk for serious vascular complications, physicians also need to monitor other risk factors in diabetic patients, especially their blood pressure and cholesterol. Adults with diabetes also are more likely to experience depression than those without diabetes, and depression can interfere with efforts to reach diabetes management goals.<sup>10</sup> Therefore, assessment of the patient’s psychological and social situation should be incorporated into routine diabetes care.<sup>11,12</sup> When patient adherence to a prescribed treatment regimen is poor, that may be an indicator that attention to the patient’s psychological status is especially warranted.<sup>13</sup>

#### *Physician Education*

Diabetes care has changed drastically in recent years, with a variety of new treatment options. Physician education around a consensus guideline and currently available therapies is critical to the effective management of patients with diabetes.

For example, although insulin’s efficacy at treating hyperglycemia is recognized within the guidelines, in real practice, insulin therapy is often reserved as a last resort; especially by primary care physicians.<sup>14</sup> Surveyed AMGA members reported that a large barrier to achieving A1c goals

in a timely manner is an aversion to insulin use, on the part of both physicians and patients. At the live Summit meeting on March 1, 2009, responses from AMGA participants revealed a wide disparity as to how quickly physicians prescribe insulin for patients not achieving their glycemic goals. When patients are not at goal more than six months after diagnosis, 50 percent of respondents said they initiate insulin more than half of the time, while 40 percent said they initiate insulin only 10–25 percent of the time.

Improvement in the way in which care is delivered is imperative to improving patient outcomes.

Any aversion to insulin needs to be overcome if we are to succeed in managing this disease. An important step is educating physicians regarding the efficacy and safety of newer formulations of insulin, as well as the improvements in supplies and devices. Safety concerns, especially the fear of hypoglycemia, can be allayed with clear data: hypoglycemic events are relatively low with insulin use in type 2 diabetes and can be avoided with regular self-monitoring of glucose levels.<sup>15</sup>

#### **Systems That Support Clinical Goals**

ADA believes that a major contributor to the diabetes management problem is “a delivery system that too often is fragmented, lacks clinical information capabilities, often duplicates services, and is poorly designed for the delivery of chronic care.”<sup>16</sup> The delivery of quality care is impeded as a result. Improvement in the way in which care is delivered is imperative to improving patient outcomes.

#### *Quality Improvement in Healthcare Delivery*

Industrial organizations have

paved the way in quality improvement, and those lessons are commonly applied to health care. Quality improvement materials are now available to help guide medical practices. For example, the MacColl Institute for Healthcare Innovation recently issued a chronic care quality improvement toolkit for the Agency for Healthcare Research and Quality, based on the Institute’s (Wagner’s) chronic care model.<sup>17</sup>

#### *Hardwiring Guidelines into Processes*

The chronic care model includes the use of clinical practice systems or processes designed to ensure that the necessary information and services are provided to patients at the appropriate times. By “hardwiring” all the components of the clinical guidelines into the practice’s daily operations, care delivery can be more consistent and simpler to manage—and result in increased guideline adherence and improved patient outcomes.<sup>18</sup> Examples of recommended diabetes care processes include treatment algorithms with an A1c goal of <7%, automated reminder systems to ensure testing for risk factors and complications is completed, planned care visits, pre-visit preparation, and post-visit patient communications. Health information technology can play an important role in diabetes care processes providing access to patient data and decision-support tools, patient education and self-management support activities, and quality improvement monitoring.

#### *Using Diabetes Care Teams Effectively*

Successful diabetes management requires coordinated care by multiple providers including primary care physicians, physician assistants, nurses, endocrinologists, dietitians, diabetes educators, pharmacists, and mental health professionals.<sup>19</sup> Even within each medical practice, an important component is having a multidisciplinary diabetes care team. Every member of the team needs to understand the group

practice's approach to diabetes care and play a defined role with assigned processes to provide that care to patients. Systems work is already being done with measurable success by leading medical groups (such as HealthPartners and Allina Medical Clinic, to be profiled in a future article).

### *Physician Accountability for Outcomes*

Another best practice for improving the quality of care is to have physicians be accountable for their patients' health outcomes. Quality performance data can be used to monitor and provide feedback to individual physicians, showing each where improvement can be made.<sup>20</sup> A step above that is to share individual physician performance data within the medical group. Sharing data not only ensures that each physician has a sense of accountability, but also offers an environment of friendly competition in which physicians have the opportunity to compare themselves with and learn from their peers. Making data transparent to the public has been shown to improve performance in physicians, medical groups, and even entire health systems.

### *Reimbursement for Quality*

A strategy to improve quality performance is to tie provider reimbursement to the quality of care provided.

**Pay for Performance:** A growing trend is for payers to reward providers who follow established evidence-based clinical guidelines. In addition to pay-for-performance (P4P) programs offered by payers, medical groups can incorporate quality measures into their staff payment structures. Adherence to guidelines, such as regular testing of blood glucose levels, however, does not always result in meaningful clinical outcomes. Many current P4P programs are limited in that they recognize only whether or not a provider has provided the recom-

mended services. It is now being recommended that P4P incentives be tied to patient outcomes.<sup>21,22</sup> Some organizations are starting to give outcomes-based financial incentives to their physicians, but not all agree that they are the most effective way to create better outcomes.

It is critical for providers to support each patient according to that patient's particular set of circumstances.

### **Pay for Care Coordination:**

Most P4P programs do not address care coordination activities, which are critical for chronic patients. Many essential care coordination services—such as communicating with patients and their families outside of the office visit and discussing patient care with other healthcare providers—are not currently reimbursed.<sup>23,24</sup> Reimbursement concepts that encourage better care coordination are being discussed and piloted as another way to improve patient outcomes and reduce costs.<sup>25,26,27</sup> One concept that recognizes the additional time and effort required for care coordination is that of the “medical home”—in which a primary care physician coordinates a patient's care and the patient has better access to healthcare professionals, including contact other than office visits.<sup>28,29,30</sup> Reimbursement for the medical home is being tested in a number of pilot programs.<sup>31</sup>

### **Patient-Centered Care**

#### *Patient Engagement*

Even when patients receive the highest quality care, it is ultimately up to them to take ownership for their health. At the live Summit meeting, 82 percent of responding participants said healthcare providers are the stakeholders with the greatest impact on diabetic patients' willingness and ability to improve

their health outcomes. Therefore, it is critical for providers not only to customize recommendations to each patient based on clinical measures, but also to support each patient according to that patient's particular set of circumstances.

### *Disease and Self-Management Education*

Many patients with diabetes do not understand the disease, its risk factors, or its potential complications. For diabetic patients to become active in managing their own health, they must understand the disease, acquire new skills and habits, and be confident in their ability to make decisions about their health care. An important responsibility of care team members is to be effective in communicating information to patients about their disease and their care.

Patient literacy levels, language, and cultural factors greatly influence efforts to improve diabetes management. Age, ethnicity, and literacy factors must be considered in the design and delivery of information for patients. As the MacColl toolkit states: “Because patients and families carry out much of the management of chronic illness, collaborative self-management support with patients is key to any effort to improve health outcomes. This effort can be seen both as a set of techniques useful in partnering with patients and as a cultural shift in the delivery of health care that places patients' goals, beliefs, preferences, and capacities at the center of care.”<sup>32</sup>

### *Increasing Therapy Adherence*

In patient non-adherence discussions, out-of-pocket expenses and ability to pay are often the focus. Cost also is a factor for providers. At the live Summit meeting, 57 percent of respondents believed the greatest plan-related barrier to better patient outcomes in their practice was uncovered services. In addition, a panelist shared information showing increased patient access to insulin and patient-preferred testing

supplies increased insulin adherence. Collaborations between health plans and payers can address access issues to reduce barriers and improve patient adherence. A future article will describe how this is being done successfully in the employer arena.

### *Overcoming Resistance to Insulin Therapy*

Insulin poses a special set of challenges for diabetic patients. Patient resistance to insulin therapy may stem from:

- Anxiety about self-injections (or needles in general)
- Perceived complexity of regimen
- Fear of regimen's interference with routine, quality of life
- Presentation as a "last resort" after all other therapies have failed<sup>33</sup>

Effective and timely communication with the patient about the effectiveness of insulin and improvements in insulin therapies, testing supplies, and devices will help patients deal with their anxieties. If providers explain early on that insulin is needed by many diabetic patients at some point in their therapy and that it is an effective therapy, they can help eliminate that psychological barrier for patients.<sup>34</sup> Unfortunately, managed care has made it challenging for providers to spend the necessary time educating patients about their diabetes.

### **Getting Started**

Improving diabetes outcomes on a national scale will require alignment of stakeholders who impact patient care and support. Health plans, providers, employers, business organizations, public health, government and community leaders, service organizations, families, and the patients, themselves, all have a stake in the outcomes. Improving provider practices, care processes, patient adherence, and cost-effective care are certainly critical and can be addressed immediately by providers. But that is only a piece of the

fragmented puzzle. Collaborations among other stakeholders are key to reducing the barriers to quality diabetes care. In the next article in this series, learn the degree to which medical groups, health plans, and employers collaborate today to build a case for greater alignment efforts.

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