Health Plans and Employers: Helping Providers and Patients Improve Diabetes Outcomes

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

To identify best practices for diabetes management, the American Medical Group Association (AMGA) hosted the National Summit on Quality Accountability in Diabetes: Alignment for Success earlier this year. The goals of the summit were to bring stakeholders together to discuss strategies for delivering quality diabetic patient care, and to serve as a launching vehicle for AMGA programs to advance the alignment of stakeholders. As described in the first article of this series,[1] the summit identified three major areas of improvement for diabetes outcomes: treatment guidelines and A1c goals, systems that support clinical goals, and patient-centered care. The second article[2] focused primarily on treatment goals and the systems medical groups have implemented to support those goals (e.g., ensuring patients are receiving recommended tests, tracking clinical measures). This article explores how other stakeholders—health plans, employers, professional and advocacy groups—can support providers in their efforts to improve diabetes care, as well as help patients more successfully manage their own health.

This article describes steps to help improve diabetes outcomes taken by the following organizations:

- HealthPartners Health Plan, in Minnesota, has more than a million members, approximately 30,000 of whom have diabetes. Beth Averbeck, M.D., associate medical director, primary care, represented HealthPartners at the summit.
- SelectHealth, in Utah, is a non-profit HMO with more than half a million commercial lives, including approximately 15,000 members with diabetes. SelectHealth was represented by its medical director, Kenneth Schaecher, M.D.
- Pitney Bowes is a Fortune 500 mail and document management company with more than 35,000 employees across 130 countries. At the summit, Pitney Bowes was represented by Jack Mahoney, M.D., the company's former director of strategic health initiatives.
- The Florida Health Care Coalition (FHCC) represents more than a million employees of public and private organizations in the state of Florida. The president and CEO of the coalition, Becky Cherney, participated in the summit.

The Foundation: Aligned Goals and Guidelines

Why do health plans and employers care about improving diabetes outcomes? Not only is it the right thing to do; it's also the smart thing to do. Diabetes is one of the highest-cost therapeutic areas, and poorly managed diabetes is much more expensive than well-managed diabetes. Many of diabetes' costs stem from its complications, which can be avoided, or at least postponed, with earlier, more-aggressive treatment.[3,4]

The National Committee for Quality Assurance (NCQA) estimates that if patients maintained target A1c levels, thousands of deaths and up to $1.3 billion in hospital costs could be avoided.[5] Improving outcomes can prevent devastating health complications for patients and reduce costs at the same time.

This article explores how stakeholders can support providers in their efforts to improve diabetes care.

However, before outcomes can be significantly improved, there must be agreement among stakeholders—including providers, health plans, payers, community organizations, and national associations—as to the clinical goals and treatment guidelines for diabetes. Dr. Averbeck explains that working with community organizations—specifically, the Institute of Clinical Systems Improvement (ICSI) and Minnesota Community Measurement—has helped give the provider groups and health plans in Minnesota confidence that they are all working toward the same goals and will be measured against the same criteria. How providers perform is made public through the Minnesota Community Measurement's website, www.thed5.org, which tracks the percentage of patients who meet all five main treatment goals of ICSI and the American Diabetes Association (ADA):

- Hemoglobin A1c < 7%
- LDL cholesterol < 100 mg/dL
- Blood pressure < 130/80 mmHg
- Daily low-dose aspirin (for patients ≥ 40 years)
- Tobacco free

Summit Learnings

Summit panelists had important messages for the medical group audience as they pursue collaboration and alignment with stakeholders to improve quality of care and outcomes for their diabetic patients.

"Employers need to continually push the system. Health plans are not going to respond unless the person who writes the check begins to demand different performance criteria, whether it's who they contract with, how they contract, or how the outcomes are looking."

—Jack Mahoney, M.D., Consultant,
Strategic Health Initiatives, Pitney Bowes

"Only through collaboration on quality goals and quality metrics, which are there to achieve improved health outcomes, are you likely to get the results you're looking for, from a financial perspective or from a health management perspective. So the key takeaway is: recognize what you can do; who can you collaborate with; and move it forward."

—Kenneth Schaecher, M.D.,
Medical Director, SelectHealth

"Employers need to work with physicians to get that physician and consumer engagement. We need to know from physicians what is working and what is not. We need to know from you when we are the problem. We will react to what the medical community tells us we need to. If we need to change plan designs, we will. We know, ultimately, higher quality will mean lower costs. We'll change what we need to if there is a reason to."

—Becky Cherney, President and CEO,
Florida Health Care Coalition

"It's relationships. It's relationships with employers. It's relationships with health plans. It's relationships with leaders. And then, it's relationship with patients. I think sometimes when we work on our systems improvement and we get stuck, we might try to guess why we're stuck. At that point it's really a nice opportunity to bring in patients and say, 'Help us. What could we do better?' What you might assume and what they tell you aren't necessarily the same thing."

—Beth Averbeck, M.D.,
Associate Medical Director,
Primary Care, HealthPartners Medical Group

"This would be controversial, but I would hope that everyone would endorse public reporting, as imperfect as it is, and build community collaborations that can move us more quickly to better patient care; focus on processes and the power of nursing to get to where you need to go."

—Bruce McCarthy, M.D., M.P.H.,
Chief Medical Officer,
Allina Medical Clinic

Supporting Delivery of Quality, Coordinated Care

Motivation to Improve Outcomes

As shown in Minnesota, community organizations can measure provider performance against aligned goals and, with public reporting, motivate providers to improve their patients' outcomes. In fact, the state of Minnesota, an early innovator in public reporting of quality data, has had transparent performance data for more than 10 years. Health plans can also act individually to motivate their providers with reporting and financial incentives. SelectHealth currently keeps its provider quality data private, but intends to implement public reporting soon, recognizing the impact of publicizing the data.

For health plans, quality ratings are critical; therefore, plans tend to focus their management efforts on HEDIS measures (see "2009 Diabetes Care HEDIS Measures").

Update: New Diagnosis Method for Diabetes Recommended[1]

Of course, as new evidence emerges, the guidelines change. This June, the American Diabetes Association (ADA), the International Diabetes Federation (IDF), and the European Association for the Study of Diabetes (EASD) jointly recommended using hemoglobin A1c to diagnose diabetes: specifically that an A1c of 6.5% or greater should be diagnosed as diabetes. The committee recommended this departure from the use of plasma glucose measurement for diagnosis because the A1c test is more standardized, more stable, and easier for patients. There is a disadvantage, however: the A1c test is more expensive. That means the change in diagnosis method will need the support of payers (e.g., health plans, employers) to be used and reimbursed appropriately.

1. D.M. Nathan, et al. 2009. International Expert Committee Report on the Role of the A1C Assay in the Diagnosis of Diabetes. *Diabetes Care*, 32: 1327-1334.

2009 Diabetes Care HEDIS Measures[1]

- HbA1c testing
- HbA1c poor control (>9.0%)*
- HbA1c control (<8.0%)†
- HbA1c control (<7.0%)‡
- Retinal eye examination
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Monitoring nephropathy (kidney disease)
- Blood pressure control (<130/80 mm Hg)
- Blood pressure control (<140/90 mm Hg)

* Lower score is better on this measure.
† This is a new measure in 2009.
‡ The < 7.0% measure was reinstated, but with exclusion criteria: NCQA now considers this measure too stringent for patients ≥ 65 years or with certain co-morbid conditions, based on NCQA's analysis of ACCORD and ADVANCE data.

1. National Committee for Quality Assurance. *HEDIS 2009, Volume 2: Technical Update*. October 1, 2008. Accessed July 6, 2009 at www.ncqa.org/tabid/784/Default.aspx.

Dr. Schaecher points out that plans can use those same HEDIS measures to assess providers' performance and create performance incentives. Both SelectHealth and HealthPartners reward their participating providers through pay-for-performance (P4P) incentives. In addition, HealthPartners has tiered provider networks. The plan assigns each provider group to a specific tier based on quality of care, patient experience, and cost data. Patients are given incentives—usually lower co-pays—to see providers in the more favorable tiers.

Many patients are covered by employer-sponsored insurance, which means employers are frequently the ultimate payers of healthcare costs. Employers also want their employees at work and productive. For these reasons, employers are highly invested in patient outcomes. One action employers can take to improve patient outcomes is to include quality requirements in their contracts with health plans. Pitney Bowes, instead of simply looking for the lowest health insurance premiums, bases its contracting decisions on health plans' efficiency and performance on quality metrics, specifically their ability to manage chronic conditions. If plans don't meet Pitney Bowe's standards, they aren't selected. According to Jack Mahoney, "Health plans are not going to respond unless the person who writes the check begins to demand different performance criteria."

Clinical and Operational Support

When goals and guidelines are aligned, it's easier for health plans to design programs to support providers. For example, SelectHealth provides free yearly CME for its participating providers to keep them updated on current ADA recommendations and the plan's care process model. The plan also provides a regular forum for high-performing providers to share their best practices, so they can help others improve the quality of care they provide to patients. SelectHealth's care management team trains providers and gives them materials, including monofilament fibers for foot exams, foot education videos, and wallet cards that list treatment goals and steps to take in case of hypoglycemia.

To improve diabetes outcomes, health plans, like medical groups, must have multidisciplinary care teams (e.g., RNs, dieticians, certified diabetes educators, mental health professionals) that are able to address the different aspects of diabetes as well as manage multiple co-morbid conditions. Ideally, disease management and care management teams collaborate behind the scenes to support patients, as do health plans and provider groups. Also, as discussed previously in this series, having systems in place to accomplish these goals is important. The use of an electronic medical record (EMR) helps capture important process and outcomes data within organizations. EMRs also improve coordination of critical tasks among stakeholders, including sharing patient data for better management and facilitating provider reimbursement. SelectHealth gives provider groups without coordinated electronic systems key data elements in paper format.

Many medical groups participate in multiple health plan networks, and when those plans' goals and

guidelines are not aligned, it can be confusing. The most typical approach is to uniformly apply the guidelines of the health plan with the largest percentage of the group's patients. Dr. Schaecher says medical groups can help their patients and also benefit financially by coordinating closely with their largest payers to develop programs. He notes, "Successful health plans have strong collaborations with either highly affiliated or networked provider groups, or are part of integrated systems. Only through collaboration on quality goals and quality metrics, which are there to achieve improved health outcomes, are you likely to get the results you're looking for from a financial perspective or from a health management perspective."

Another example of collaboration is an FHCC program with a major employer. To help primary care physicians (PCPs) manage their patients with diabetes, patient data are downloaded directly from the PCP office to the University of Florida's endocrinology department. When there's an opportunity to improve care, the university calls the PCP to offer suggestions. Ms. Cherney reports that PCPs love the program. It helps improve outcomes for those specific patients as well as educate the physicians in a confidential and non-threatening manner.

Helping Patients Play Their Part

More Patient Engagement

Of course, outcomes are not determined solely by the quality of care delivered. Patients must be fully engaged in managing their own health. As Ms. Cherney says, getting patients to take responsibility for their own health is often the biggest challenge.

While healthcare providers play an important role in influencing their patients' actions, they are limited in effecting ongoing change because they see patients only occasionally, even when patients keep all their scheduled appointments. Therefore, organizations that have more-frequent contact with patients—such as health plans and, to a greater extent, employers—are necessary to engage patients in their health care. SelectHealth helps educate its diabetic members, participating in health fairs, providing members with booklets and medication management handouts, as well as coordinating with medical groups to provide glucometer training. HealthPartners, in addition to providing multidisciplinary clinical support, including depression screening and management, tries to help members make healthy behavior changes by offering a variety of options, including online courses and telephonic support from counselors and health coaches (see "Sample of HealthPartners' Patient Behavior Change Courses").

With a captive audience for about 40 hours every week, employers are in a great position to engage patients and influence behavior. Employers can offer their own disease management and wellness programs to supplement or replace their health plans' offerings. Employers can easily disseminate newsletters and e-mail messages explaining employee benefits and educating employees about how to live healthier lives. In addition, they can support healthy behaviors at the worksite by changing the environment, for example, by offering healthy choices in the cafeteria and vending machines at lower prices than the unhealthy choices, or entirely eliminating the unhealthy choices. Some large employers can also offer worksite clinics to provide their employees convenient access to healthcare services. Pitney Bowes operates nine clinics at its larger sites, and each clinic has a nurse educator on staff to help employees learn how to manage their health.

Local and regional organizations, because of their experience with the patient community, are good sources of information regarding what is effective when trying to engage patients. Ms. Cherney shares these lessons learned by FHCC:

Sample of HealthPartners' Patient Behavior Change Courses

- Back to Health®
- Solutions for High Blood Pressure℠
- Solutions for High Cholesterol℠
- Get Moving, Get Fit℠
- Partners in Quitting®
- Healthy Lifestyles, Healthy Weight®
- Healthy Eating, Healthy Life℠
- 10,000 Steps® program

Using Benefit Design to Eliminate Cost Barriers for Patients

- Medical Services
- Preventive: low cost or no cost
- Routine: first-dollar coverage (no deductible)
- Major: choice of deductible and coinsurance maximums
- Drug Formulary
- Medications for target conditions on tier 1
- Pre-deductible for CDHP plans

- A penalty may be more effective than a reward (e.g., taking away a monthly wellness payment, making the patient pay for a doctor visit if noncompliant with medication).
- Multilingual materials and multiple methods of communication are required in multicultural areas.
- Collaborating with and learning from cultural organizations and leaders can help healthcare organizations reach patient communities more effectively (e.g., determining which family member is the best one to target regarding healthcare decisions, and selecting the venue that is most likely to result in good attendance).

Better Compliance Through Benefit Design

Once patients are engaged in managing their own health, they are more likely to follow physician advice. Another contributing factor in compliance is the amount of patients' out-of-pocket expense. By making the appropriate healthcare products and services less expensive for patients, health plans and self-insured employers can increase adherence to therapy. A benefit design that reduces cost barriers to recommended services, pharmaceuticals, and supplies, in alignment with evidence-based medicine, can help improve diabetes patient outcomes.

Based on the belief that increased adherence to appropriate medication will decrease overall healthcare costs, Pitney Bowes wanted to improve its employees' compliance with chronic medications. To reduce the impact of out-of-pocket expenses, in 2002, the company moved all branded diabetes medications to tier 1 of the pharmacy benefit. In 2006, recognizing that diabetes patients often have medications for multiple co-morbidities, Pitney Bowes also moved statins, ACE inhibitors, and ARBs to tier 1 for those patients. Supporting these formulary changes were changes in service coverage (e.g., deductible no longer applied to routine services) as well as an active educational campaign about the importance of compliance with therapy.

Between 2001 and 2007, the employees' out-of-pocket costs decreased and medication adherence increased. Pitney Bowes learned that patients wanted less-invasive diabetic testing equipment and made that equipment free, along with testing supplies. Insulin adherence increased 30%. Of course, with medication adherence improvement, drug costs increase. However, Pitney Bowes saw a cost offset of approximately 14%, with its diabetes-specific cost trend holding to 3%, compared to 7% for overall healthcare costs. The company also saw a 50% reduction in its diabetic short-term disability rate, as well as a 60% cost reduction per disability case as patients experienced less-severe illness.

FHCC followed Pitney Bowes' lead and implemented a similar benefit design change at Siemens, putting diabetes medications on tier 1, providing free supplies, and educating patients through a disease management program. The results were similar to those at Pitney Bowes. Adherence to medications, especially insulin, increased, as did compliance with recommended tests and office visits. Medication costs went up, and emergency room and hospitalization costs went down, for a net cost reduction of approximately 12%. Ms. Cherney says that, in addition to the savings in direct medical costs, self-reported data indicated employees are feeling better and are more productive.

Dr. Mahoney and Ms. Cherney both emphasize that cutting copays isn't enough; working with health plans to ensure quality of care and communicating with employees about managing their health are vital components. Success requires a multipronged, collaborative approach.

Moving Forward, Together

Since early in this decade, when decision makers began studying the impact of patient behaviors on health outcomes, innovative organizations have demonstrated that better alignment of goals and greater collaboration can result in significant improvement in patient outcomes and reduction of overall costs. These findings need to be applied on a broader scale. Actionable items that can support this goal include:

- Aligning patient messages across medical groups, health plans, and employers to ensure consistency. Collaboration can benefit patients as well as these stakeholders, contributing to their individual success.
- Working with coalitions and other community organizations and associations to align expectations. Healthcare groups can also share best practices and learn from one another about how to effectively care for patients and engage patients so that they can help themselves.
- Involving other stakeholders critical to successful alignment and outcomes. Academic institutions can supply clinical expertise, research, and data analysis. Retail pharmacists are in an ideal position to educate patients and consult with physicians on their behalf. Government agencies and legislative bodies must also play a role: for example, by mandating public reporting as another approach to improving the quality of care.

With alignment and collaboration among all the stakeholders, it is possible to improve the quality and cost-effectiveness of diabetes patient care and help millions of patients live healthier lives.

Acknowledgements

This article was prepared by these members of the summit planning committee: Julie Sanderson-Austin, R.N., Vice President of Quality Management and Research, AMGA; and Gary Branning, President, Steven Bauwens, Pharm.D., and

Susan Smith, Managed Market Resources, with permission of summit panelists Beth Averbeck, M.D., Associate Medical Director, Primary Care, HealthPartners Medical Group*; Kenneth Schaecher, M.D., Medical Director, SelectHealth; Jack Mahoney, M.D., Consultant, Strategic Health Initiatives, Pitney Bowes; and Becky Cherney, President and CEO, Florida Health Care Coalition.

In preparation for the summit, the planning committee commissioned research, including an extensive literature search and an e-survey of AMGA members. The committee also conducted two webcasts for AMGA members. Highlights of the webcasts and the live summit are topics of this three-part series.

The planning committee acknowledges the following individuals for their efforts during the preliminary activities and the live summit: Summit Moderator Schumarry Chao, M.D., M.B.A., President, SHC & Associates; Cheryl A. Hermann, R.N., Vice President, Operations, Allina Medical Clinic; Joyce Jones, Quality Program Coordinator, AMGA*; Samuel Lin, M.D., Ph.D., M.B.A., Consultant for Medical Affairs, AMGA*; Bruce McCarthy, M.D., M.P.H., Chief Medical Officer, Allina Medical Clinic; and Rae Ann Williams, M.D., Regional Assistant Medical Director, HealthPartners Medical Group.

The planning committee also thanks medical writer Carmen Walsh for editorial services in preparing the article series.

**Planning Committee Member*

References

1. Leading Diabetes Care in a New Direction, AMGA's National Summit on Quality Accountability in Diabetes: Alignment for Success. *Group Practice Journal*, 58(6): 8-15.
2. Medical Groups: Improving Diabetes Outcomes, AMGA's National Summit on Quality Accountability in Diabetes: Alignment for Success. *Group Practice Journal*, 58(7): 24-31.
3. J.S. Skyler, R. Bergenstal, R.O. Bonow, et al. 2009. Intensive Glycemic Control and the Prevention of Cardiovascular Events: Implications of the ACCORD, ADVANCE, and VA Diabetes Trials. A position statement of the American Diabetes Association and a scientific statement of the American College of Cardiology Foundation and the American Heart Association. *Diabetes Care*, 32: 187-192.
4. R.R. Holman, S.J. Paul, M.A. Bethel, et al. 2008. Ten-Year Follow-Up of Intensive Glucose Control in Type 2 Diabetes. *New England Journal of Medicine*, 359: 1577-1589.
5. National Committee for Quality Assurance. 2008. *The State of Health Care Quality 2008*. Washington, DC.

The National Summit on Quality Accountability in Diabetes: Alignment for Success was supported by sanofi-aventis. For more information, contact Julie Sanderson-Austin, R.N., AMGA vice president, quality management and research, at (703) 838-0033, ext. 356 or jsanderson-austin@amga.org.

Join Leading Physician Practices

Stand Up for Patient Safety

It Begins with a Single Decision

10% DISCOUNT for AMGA members!

The American Medical Group Association has collaborated with the National Patient Safety Foundation to offer you a special discount on the *Ambulatory Stand Up for Patient Safety*™ program, which delivers practical, real-world patient safety tools and information carefully crafted for physician practices and outpatient centers. The program's useful and easy-to-implement resources, include:

- *robust team Resource Guide modules plus DVDs and brochures*
- *password-protected website and virtual Guide*
- *audio-web conference series hosted by leaders in the field*
- *web-based discussion forum*
- *National Patient Safety Awareness Week promotional tools*
- *marketing material designed to promote your organization's commitment to patient safety*
- *publications, literature alerts, and much more*

The National Patient Safety Foundation is pleased to offer the *Ambulatory Stand Up for Patient Safety* program to **AMGA members** for an annual fee of only $899, a special ***10% discount*** rate.

The decision is yours. Stand up for patient safety.

Join leading physician practices as a member of the groundbreaking *Ambulatory Stand Up for Patient Safety* program. To learn more and enroll, visit *www.npsf.org/StandUp-AMGA* or call 617.391.9900.

National Patient Safety Foundation® • 268 Summer Street, Sixth Floor • Boston, MA 02210 • ***www.npsf.org***