Business, Medicine Team Up to Improve Diabetes Care

Save to myBoK

by Irv Pikelny, RHIA

Analysis of Medicare data suggests that Chicago-area diabetes care problems are even more severe than those of the nation as a whole, according to the results of a regional quality improvement project. As a result, members of the Midwest Business Group on Health (MBGH), an employer coalition, are joining forces with the medical community to improve the quality and cost effectiveness of health services related to diabetes.

The group used the *Dartmouth Atlas of Healthcare 1999 Viewer* to benchmark local diabetes care against national care. Results demonstrated that the care of diabetic beneficiaries in the Chicago hospital referral region is compromised by problems of both underuse (of recommended monitoring and preventive services) and overuse (of inpatient admissions). For routine monitoring that is appropriate for 100 percent of diabetic patients, Chicago diabetics:

- received annual HbA1c tests at a rate 40 percent below the rate for the United States as a whole
- had annual monitoring of blood lipid levels 18 percent below the national rate
- received annual eye exams at a rate 7 percent below the national rate

Diabetes is considered an ambulatory-sensitive condition, for which, given adequate ambulatory care, hospital inpatient admissions should be extremely rare. Chicago hospital referral region inpatient admissions for diabetes were found to exceed the national rate by 35 percent.

MBGH also examined the National Committee for Quality Assurance's 2000 *Quality Compass* to obtain similar measures of comprehensive diabetes care. Chicago health plans' rates of annual diabetic eye exams ranged from 20 percent to 58 percent, annual HbA1c monitoring ranged from 60 percent to 87 percent, lipid level monitoring ranged from 51 percent to 79 percent, and diabetic nephropathy monitoring ranged from 23 percent to 51 percent. All diabetic patients (100 percent) should have all these levels monitored at least annually, according to American Diabetes Association guidelines (1999).[1]

Taking Action in Chicago

MBGH is now working in collaboration with the Institute of Medicine of Chicago, which was named by the Commercial Club of Chicago as the convener of the Regional Health Committee for the Metropolis 2020 program, a major initiative to improve the viability and economic competitiveness of the Chicago region. With the Regional Health Committee, the plan is to build upon the MBGH diabetes project by conducting an Institute for Healthcare Improvement-style collaborative on diabetes for the Chicago region commencing in early 2002.

Teams from 30 leading Chicago area medical practices and clinics will be enrolled in a seven-month learning collaborative. The series includes three two-day intensive learning sessions and intervening work periods, with close monitoring and coaching by collaborative faculty and close communication among participating clinical practice teams.

Teams will implement the key change concepts of the Chronic Care Model, a project designed by Ed Wagner, a physician and director of the Improving Chronic Illness Care program of Seattle, WA. The model identifies the essential elements of a system that encourages high-quality chronic disease management, (including community, the health system, self-management support, delivery system design, decision support, and clinical information systems).[2] Focusing on these components fosters productive interactions between patients, who take an active part in their own care, and providers, who are backed up by resources and expertise. The model can be applied to a variety of chronic illnesses, healthcare settings, and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings throughout the system.

MBGH's joint business and medical initiative will supplement the Institute for Healthcare Improvement's Breakthrough Series compendium of change concepts with employer value purchasing principles and a commitment to provide incentives and information that will enable employees and providers to choose excellent care. The Institute of Medicine of Chicago will

identify local physician opinion leaders from its membership, both to participate directly and to support the spread of the change concepts across the medical community. In this way the project will seed the region with demonstrations of high-quality primary care for diabetes.

In addition, a comprehensive clinical database (diabetes registry) will be developed and maintained. The database will include information about the care provided and will be used to:

- support and improve the actual evidence-based care process
- facilitate responsible patient self-management
- provide feedback to participating purchasers and physicians/clinics about the impact of the changes made in their care processes
- support purchasers' development and testing of innovative payment methods and other incentives that promote quality care of chronic conditions
- assess the overall improvement on the project's quality indicators

Additionally, the diabetes registry provides a method for tracking and reporting the progress of participating clinical teams. Initial goals for the patient population typically include the following:

- 70 percent or more will have collaborative goal setting documented in the treatment plan
- 70 percent or more will have a blood pressure less than 135/85
- 70 percent or more will have a dilated eye exam documented annually when clinically indicate
- 90 percent or more will have a foot exam documented at least annually
- 90 percent or more will have two or more HbA1c tests documented annually
- 80 percent or more of most recent HbA1c tests will be less than 9.0

Research shows that the vast majority of participating teams make significant progress toward these patient outcomes and another significant portion achieve "outstanding sustainable results."

Coupled with the communications network established by the collaborative, the participation and enrollment of the medical and business communities in an ongoing partnership will create fertile ground for continued spread of change and improvement. In the future, they may perhaps even reach what author Malcolm Gladwell calls the crucial "tipping point" at which these improvements-until now limited to local successes-will spread thoroughly and rapidly throughout the region's healthcare system.

Notes:

1. American Diabetes Association. "Clinical Practice Recommendation 1999." *Diabetes Care* 22 (Supplement 1): S1-114, 1999.

2. Available at the Improving Chronic Care Web site, www.improvingchroniccare.org/change/model/smsupport.html.

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