DPAC Diabetes Care Management Report

(DPAC – Diabetes Partners in Action Coalition)
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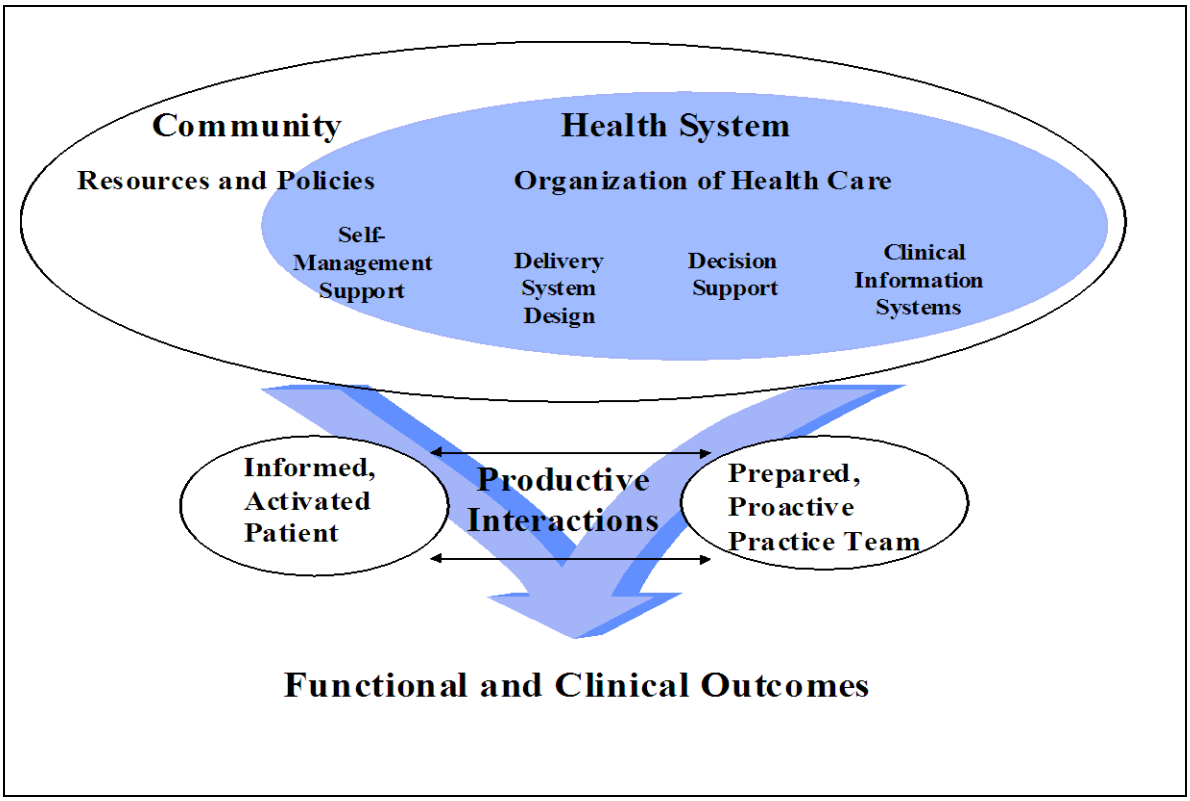
Chronic Care Model

Using the Chronic Care Model as a framework, the DPAC Advocacy and Policy Workgroup has reviewed programs and initiatives currently in the literature, or being piloted in Michigan or other parts of the nation, to address access to care and quality of care for people with chronic diseases. While we have looked at these programs for their impact for people with diabetes, their benefits may extend to people with other chronic diseases and to the broader health care system.

The Chronic Care Model is based on key underlying principles that include an informed, activated patient and a prepared, proactive practice team working together to achieve optimal functional and clinical outcomes. The components of this model reflect the key role of patients in their own health care and the impact of the community and health systems where health care is delivered.

- Chronic Care Model Components
  - Community Resources and Policies
  - Health Systems Organization
  - Self-Management Support
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems



Chronic Care Model Outcomes can improve process and outcome measures for diabetes.

Created by the DPAC Advocacy and Policy Workgroup
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Essential Elements of Effective Diabetes Care

that should be explored to benefit people with diabetes in Michigan

Deliver care that is patient centered & culturally appropriate

Can be achieved by implementing:

- *Patient Centered Medical Home
- *Improving Practice in Practice (IPIP)
  http://www.michigan.gov/mdch/0,1607,7-132--185030--,00.html

Utilize ALL members of the health care team

Can be achieved by including:

- Patients
- Certified Diabetes Educators
- Case Managers
- Dietitians
- Pharmacists
- Etc.

Practice evidence-based medicine

Can be achieved by utilizing:

- *Michigan Quality Improvement Consortium (MQIC) Guidelines for Diabetes
  http://www.mqic.org/guid.htm

Strive for Continuous Quality Improvement (CQI)

Can be achieved by implementing:

- *Improving Practice in Practice (IPIP)

*Provide diabetes self-management education and support to all patients

Can be achieved by contacting:

- Michigan Department of Community Health
  http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2980-13791--,00.html
- Michigan Organization of Diabetes Educators
  http://www.modeonline.org/
- Personal Action Towards Health program
  www.MIpath.org

Provide patient incentives

Can be achieved by implementing:

- Value Based Insurance Design (VBID) …..especially designs that provide medication payment support
  http://www.sph.umich.edu/vbidcenter/

*Use Health Information Technology

Can be achieved by implementing:

- *Medication Therapy Management (MTM)
- *Patient Centered Medical Home
- *Improving Practice in Practice (IPIP)

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Programs/Models of Essential Elements of Effective Diabetes Care

~descriptions and outcomes when available~

Patient-Centered Medical Home

The Patient-Centered Medical Home is not a building, house or hospital. It is an approach to providing comprehensive primary care that is accessible, continuous, comprehensive, patient/family centered, and compassionate. Care is coordinated and/or integrated by the primary care physician who leads the medical team and arranges care with specialists. Care is evidence-based, utilizes Health Information Technology, is culturally appropriate, whole person oriented and patients participate in decision making. The primary care physician provides health care at all stages of life; acute care, chronic care, and end of life care. Quality and safety are hallmarks of the Medical Home. Enhanced Access – expanded hours, online appointment-making, etc. provides new options for doctor/patient communication. The Patient Centered Medical Home utilizes the Chronic Care Model and is integrated within the Improved Performance in Practice (IPIP) pilot project in Michigan.

Outcomes:

- Community Care of North Carolina was implemented in the North Carolina Medicaid system and saved the state $231 million dollars in fiscal year 2005 and 2006. Primary care physicians served as a medical home and coordinated patient care. *(N.C. Office of the Governor News Release – www.governor.state.nc.us/NewsFullStory.asp)*

Improving Performance in Practice (IPIP)

Improving Performance in Practice (IPIP) will educate and assist primary care physicians in implementing improved processes for higher quality and more cost-efficient patient care. "Each of us will benefit when primary care is able to provide the patient-centered medical home that we need," said Janet Olszewski, Director of the Michigan Department of Community Health (MDCH) and head of the consortium. “Michigan intends to make that happen through the efforts of the consortium and this new grant."

The Automotive Industry Action Group (AIAG) Health Focus Group will act as fiduciary for the IPIP grant and share in hands-on participation. AIAG will be sharing with the health care community its expertise in developing standards, guidelines and training programs in quality management and process improvement.

Michigan Quality Improvement Consortium (MQIC)

MQIC develops clinical practice guidelines and performance measures and through a collaborative approach. By utilizing MQIC guidelines, Michigan health plans will achieve consistent delivery of evidence-based services and better health outcomes. MQIC membership is diverse and includes physicians, health plan administrators, researchers, quality improvement experts, and specialty societies.

Diabetes Self-Management Education (DSME)

Patients who learn to self-manage their diabetes through formal DSME programs can stay healthier and have improved quality of life. Multiple studies demonstrated that Diabetes Self Management Education increases the patients’ knowledge of their disease; empowers patients to make positive behavior changes; improves A1C and other metabolic outcomes; helps prevent the complications from diabetes; and is cost effective. Quality DSME is measured through meeting state and national DSME Standards.

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Outcomes:

- A study published in the Journal of the American Medical Association indicated that a sustained reduction in A1c among adults with diabetes was associated with a cost reduction of $685 to $950 less per person with one to two years of improved glycemic control. *(Wagner, E.H., et al. (2001) Effect of improved glycemic control on health care costs and utilization. JAMA 285, 182-189).*
- Managed care patients with type 2 diabetes, who improved or achieved glycemic control, saved $369 per patient per year in total diabetes related costs as compared to those with higher A1c levels. *(Shetty, S. (2005) Relationship of glycemic control to total diabetes related costs for managed care Health Plan members with type 2 diabetes. Journal Managed Care Pharm, 11(7): 559-64)*

Value Based Insurance Design (VBID)

VBID encourages the use of services when the clinical benefits exceed the cost and likewise discourages the use of services when the benefits do not justify the cost.

Outcomes:

- University of Michigan MHealthy – overwhelming employee support *(American Journal of Managed Care Vol. 12, Special Issue, December 2006, SP5-SP10)* Financial Outcomes pending.
- Asheville Project – patients with diabetes showed improvement in clinical diabetes health care measures and employers saw a decline in projected medical costs with an average cost saving of $918 per patient per year. (also see Medication Therapy Management) *(Pharmacy Times Supplement, June 2005, pages 13-14)*

Health Information Technology

Health information technology (Health IT) will allow comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of health IT will: improve health care quality; prevent medical errors; reduce health care costs; increase administrative efficiencies; decrease paperwork; and expand access to affordable care.

Medication Therapy Management (MTM)

MTM is a way to optimize therapeutic outcomes and help reduce the risk of adverse drug events through ongoing review of patient medication records and consultation through patient interviews. MTM demonstrates improved care and cost savings.

Outcomes:

- MTM provided a 2.5:1 return on investment for Medicare Part D in 2006. *(Based on data from Walgreen's Medicare Part D clients (N: 100,000+)*
- Minnesota Blue Cross BlueShield – provided MTM to patients in six ambulatory clinics. The reduction in total annual expenditures exceeded the cost of providing MTM services by more than 12 to 1. *(Journal of the American Pharmacists Association, Special Feature, March/April 2008, 48:2, pages 1-8)*
- Asheville Project – patients with diabetes showed improvement in clinical diabetes health care measures and employers saw a decline in projected medical costs with an average cost saving of $918 per patient per year. (also see Value Based Insurance Design) *(Pharmacy Times Supplement, June 2005, pages 13-14)*

COMPONENTS OF THE CHRONIC CARE MODEL

Community	Health System	Health System	Health System	Health System	Health System
Resources & Policies	"The System"	Self Management Support	Delivery System Design	Healthcare Delivery Decision Support	Clinical Information Systems
•Programs to supplement and support chronic disease care	•Strong leadership •Culture & mechanisms that promote safe high quality care •Open & systematic handling of errors and quality problems	•Diabetes Self-Mgt Education (DSME) support	•Ongoing DSME support •Effective, efficient, evidence-based, culturally sensitive care •Individual & shared medical appts. (SMA) for self-management & empowerment •Define roles & tasks of health team	•Clinical care consistent with evidence-based guidelines woven into patient care •Professional reminders •Integrate specialist and primary care	•Database/registry of key info •Reminders to providers & patients •Identify sub-populations for proactive care •Monotor performance of providers & system
STRATEGIES FOR DIABETES CARE BASED ON CURRENT ACTIVITIES IN MICHIGAN - LISTED UNDER THE CHRONIC CARE MODEL CATEGORIES					
Strategies listed in red print are focused on the uninsured.					
Personal Action Towrads Health (PATH)	Create a culture of continuous qulality improvement	Diabetes Self-Management Education (DSME)	MHealthy Focus on Diabetes and Focus on Medicnes at Univ. of Michigan	Utilization of MQIC (Michigan Quality Improvement Consortium) guidelines	Interactive electronic registries, electronic medical records
Referral to Community Based Health Care Programs	Community and institutional linkages to reduce health care disparities in minority		Pathways to Health in Battle Creek	Improving Performance in Practice (IPIP) program (includes Patient Centered Medical Home)	Reports to providers on exams, testing, monitoring and HEDIS scores
Faith Based Lay Health Education	Quality of life and satisfaction surveys		Multi-disciplinary team approach - including the patient		Patient reminders regarding care management & testing
Federally Qualified Health Centers (FQHC's)			Culturally sensitive interventions to reduce health care disparities in minority populations		Physician Quality Incentive Program
			Individual case management		
			Educational mailings		
			Shared Medical Appointments (SMA's)		Michigan Health Information Network (MiHIN) - MDCH
			Access to diabetes web sites		

AGREED UPON BEST PRACTICES FOR DIABETES (AND CARDIOVASCULAR DISEASE, AND KIDNEY DISEASE)					
Diabetes Self Management Training					
One pneumococcal vaccine					
Annual dilated eye exam					
Annual foot exam					
Annual dental exam					
Annual influenza vaccination					
Twice per year A1c testing					
Twice per year lipid testing					
Kidney Disease Monitoring					
•GFR testing					
•Microalbumineria screening					
Cholesterol/Hyper-Lipidemia Management					
•LDL less than 100					
•Use of statin Rx's					
High Blood Pressure Management					
•Blood pressure at or below 130/80					
•ACE and ARB Rx's					
•Low-dose Aspirin					
Lifestyle Assessment and Modification / Healthy Behavior Changes					
•Regular physical activity					
•Better nutrition / weight reduction					
•Smoking cessation					