Optimal Care for Diabetes and Vascular Disease

Lessons from the Field

By Angeline Carlson, R.Ph., Ph.D., Kris Soegaard, and Maren Fustgaard, M.A.

ABSTRACT

Minnesota has led the nation in development of evidence-based guidelines and in public reporting of performance on quality measures. A recent qualitative study explored what 21 Minnesota clinics and their affiliated medical groups are doing to provide patients with optimal diabetes and vascular care. This article reports the practices medical directors and administrators identified as contributing to the successful management of patients with these conditions.

Despite broad recognition of the cost and health implications of uncontrolled chronic disease, there is still a gap between the outcomes that people with such diseases should achieve as a result of care and the outcomes they actually do experience. Two of these diseases, vascular disease and diabetes, are associated with significant declines in quality of life and ever-increasing costs to patients, employers, and society as a whole.

Minnesota has led the nation in developing evidence-based guidelines for optimal diabetes and vascular disease care and in measuring and reporting provider performance based on those guidelines. Since 2007, medical groups have voluntarily provided clinic-level data to MN Community Measurement, which tracks health care providers’ performance on a variety of measures. Data from MN Community Measurement show that performance ratings for care of patients with both diabetes and vascular disease remain low despite the fact that providers have access to guidelines that spell out how to deliver that care (Table). According to data reported to MN Community Measurement in 2009 that reflects care provided in 2008, only 18.9% of patients received optimal diabetes care and 33.8% received optimal care for vascular disease on average. A review of the data posted on the MN Community Measurement website (www.healthscores.org) showed both significant differences in performance between medical groups and variability among the individual clinics within a medical group.

With the long-term goal of improving care for patients with these and other chronic diseases, the Buyers Health Care Action Group, a coalition of private and public health care purchasers, sponsored a study in 2009 designed to identify clinical practices and other significant factors associated with higher and lower performance on measures of optimal diabetes and vascular care. The focus of this study was clinics, but many of the findings can be applied to medical groups.

Efforts were made to include clinics that had higher and lower performance ratings, that are large and small, that are located in urban and rural settings, and that are independent and owned by larger organizations. Thirty-nine medical directors and administrators from 21 clinics took part in 30-minute, semi-structured telephone interviews conducted by an independent research organization in August and September of 2009. They were asked about the resources and activities that assist them in and prevent them from achieving optimal management of their patients with diabetes and vascular disease. The following are highlights from those interviews.
Factors that Contribute to Optimal Management

According to the medical directors and clinic administrators who took part in the interviews, the single most important factor in achieving a higher level of performance is the use of a patient registry. A registry is an electronic or paper list of all patients with a specific chronic disease such as diabetes, vascular disease, or asthma. A registry that is integrated into an electronic medical record system is ideal, as the medical record system can make available recent laboratory values and other pertinent information; alert providers to the status of individual components of the composite measures of care; and automatically generate standard performance reports for both individual physicians and the clinic. However, administrators and medical directors agree that even a paper registry is better than no registry.

Clinics with higher performance ratings consistently “worked” the registry. This involves identifying patients who have not been seen in the clinic for some time, making contact with them, and encouraging them to come in to review the status of their condition and their management goals. Staff in higher-performing clinics also tend to review the registry monthly or quarterly to monitor progress and identify patients who may need to schedule appointments for laboratory tests and blood pressure readings. In most of the clinics, nurses were the ones responsible for working the list. In some, the responsibility is shared among reception, scheduling, and nursing staff. In a few, physicians work the registry. This proactive approach was found to have benefits beyond those related to clinic performance. For one thing, many patients appreciate the phone calls and perceive them as a sign of well-meaning concern, which leads to their feeling satisfied with their care. Another benefit is that it makes patients aware of the goals for managing their disease, thereby motivating them to improve and then maintain their health.

Taking a team approach to care delivery is another factor common in higher-performing clinics. With a team approach, every person in the office has a role to play in ensuring that patients meet their goals. And any visit to the clinic, regardless of the patient’s reason, is an opportunity for team members to connect with them and help them do what they need to do to manage their disease. Having a clinical protocol is also crucial for capitalizing on these opportunities. Such a protocol should ensure that the medical record for every patient with diabetes and vascular disease is flagged, a progress report on the components of the measure is readily accessible in the medical record, and clinic staff review the patient’s status on individual components of the measure.

Pre-visit planning also contributes to higher-performance. Before a clinic visit, a patient’s laboratory results should be reviewed; those with results that are not up to date should be scheduled for lab tests. Standing orders facilitate this process by empowering care team members to order lab tests prior to appointments. Having the results before the office visit gives the physician a chance to review them, revise the care plan, and prepare for discussions with the patient.

Strategies for Improving Care Performance

- **Use a patient registry and “work” the list.** Identify patients who have not been seen in the clinic recently and make contact with them in order to request an appointment to review their status.
- **Use an electronic medical record system in conjunction with the patient registry.** Such systems make it easier to retrieve information on components of optimal care, alert providers to any health issues or needed tests, and generate reports that can help monitor progress.
- **Engage in pre-visit planning.** Perform necessary lab tests before medical appointments so physicians have results before they see the patient.
- **Provide standing orders to facilitate care processes.** Nurses should be authorized to provide services such as scheduling laboratory tests according to physician-approved protocols prior to an office visit.
- **Rely on clinic personnel, not just physicians.** Take a team approach to care delivery in which all staff members play a role in monitoring patients’ progress and following up with them.
- **Capture the moment.** Use every possible opportunity to monitor patients’ progress and discuss with them their goals for managing their disease.
- **Internally monitor performance.** Measure individual physician and clinic-level performance continuously and display results in an area accessible to clinic staff and physicians.
- **Make an organization wide commitment.** Staff from all levels within the organization should be aware of goals and processes and be committed to quality improvement.

Regularly monitoring performance (most often monthly) is important as well. Higher-performing clinics calculate performance rates for individual providers and care teams and display results over time in an area that is visible to staff. The participants interviewed noted that posting the performance scores allows physicians to compare themselves with their colleagues, inspiring competition both within the clinic and between clinics, within medical groups, or in a geographic area. It also creates opportunities for providers to discuss care strategies and learn from each other. Sometimes, a medical director might initiate these discussions; other times individual providers might start them. Respondents said evidence-based guidelines, published clinical literature, clinic and medical group protocols, care pathways, and personal experience should be included in the discussions.

Medical directors and administrators from clinics that performed better agreed that commitment to performance measure-
ment—both on the part of the individual clinic and the larger medical group—is a factor in their success. They demonstrate this commitment by dedicating resources to the creation and maintenance of patient registries, investing in an EMR, monitoring performance rates, discussing optimal care during clinic staff meetings, endorsing the use of standing orders, and providing staff time to attend meetings related to quality-improvement initiatives. In addition, larger medical groups hold regular system-wide meetings at which staff from various clinics come together to discuss interventions that have and have not been successful, brainstorm ideas for change, and get motivated to do better. Smaller independent clinics can share best practices by developing relationships with other clinics.

Participants noted that keeping quality improvement on the radar screen is essential. Medical directors and administrators from higher-performing clinics have observed that staff are interested in seeing how their efforts translate into improved performance over time. Without this visibility, performance improvement initiatives can be forgotten: out of sight, out of mind.

Challenges to Optimal Management

Representatives interviewed reported having a large group of patients for whom optimal disease management is difficult. Respondents said patient motivation is a challenge. Patients need to accept responsibility for their health and understand the effect smoking, being overweight, and not exercising have on their ability to control high blood pressure, for example. At the same time, clinic staff are responsible for trying to motivate patients to make lifestyle changes. They said creative strategies are needed to reach some patients. For example, rather than nagging them to quit smoking, it may be more useful to introduce the idea of cutting down their use of tobacco, make suggestions about the lifestyle factors that may hinder their ability to quit, or recommend stress-reducing exercises as a first step toward smoking cessation.

Respondents said that health plans also must play a role in motivating patients. In addition to providing general information about diabetes and vascular disease in member newsletters and direct mailings, they should provide information about the specific components of optimal diabetes and vascular care, the importance of making progress toward meeting targets for each component, and strategies to help patients achieve those goals. Member-directed communications from health plans can help reinforce the care team’s efforts to get patients to make the changes needed to manage their condition.

Respondents said effective patient education materials also are needed. Clinics that serve recent immigrants, for example, need culturally appropriate, patient-oriented disease management information. They emphasized that this goes beyond just translating existing materials into languages other than English; rather, the materials need to be written in a way that acknowledges cultural beliefs and traditions. Clinics also need to provide information about food options and nutritional counseling that recognizes various traditions and religious practices.

Medical directors and clinic managers acknowledged that understanding the unique challenges individual patients face in trying to achieve goals and engaging them in shared decisions about disease-management strategies is time-consuming and, thus, difficult to do during the average office visit. Medical directors and clinic administrators point out that the adoption of the strategies discussed in this article will eventually help to ease this burden.

Finally, reimbursement was mentioned as a challenge to providing optimal care. Low reimbursement for the labor-intensive, time-consuming activities that are critical to providing high-quality care makes it difficult to maintain staffing levels adequate to supporting and sustaining it. Respondents said that changing the current reimbursement system so that it rewards quality outcomes would help alleviate those concerns.

Conclusion

In summary, a number of factors contribute to a clinic’s success in optimally managing patients with diabetes and vascular disease. The goal of sharing these strategies and practices with the wider medical community is to accelerate the rate of improvement in health outcomes for all patients with these and other chronic conditions. Although applying these strategies and approaches will not guarantee success with every patient, doing so makes it more likely that more patients will be getting the best care possible.

Angeline Carlson is director of research at Data Intelligence Consultants. Kris Soegaard is chief operating officer at the Buyers Health Care Action Group. Maren Fustgaard is assistant director for Midwest regional outcomes research at Novartis Pharmaceuticals, Inc.

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