



## *Executive Summary — USMI Roundtable Discussion*

### *Improving Diabetes Care: Delineating A Plan for Action*

Washington, D.C.     December 1, 2005

The incidence of diabetes mellitus in the United States has reached epidemic proportions, intensifying concern that more must be done to promote therapies and life-style changes capable of keeping diabetes in check. Numerous studies have shown that the relatively simple step of controlling blood sugar levels produces huge reductions in disease burden, yet target goals are not being attained.

To ascertain which approaches might offer most promise as models for diabetes care, the nonprofit **U.S. Medicine Institute for Health Studies**, in partnership with the **Veterans Health Administration** (VHA), convened a roundtable discussion involving federal and private-sector participants. All agreed that VHA is in the forefront of addressing diabetes, in large part because it is a *system* in which performance standards can be developed and compliance with them measured. A major factor in VHA's effective approach to diabetes care is its electronic medical record: The EMR provides clinical reminders for glycosolated Hemoglobin A1C, blood pressure, cholesterol and other monitoring factors and allows data analysis essential for internal and external performance comparisons, as well as for research.

Because the U.S. healthcare system in fact is not really a *system*, translating VHA's approach cannot be done specifically. Instead, the group determined, VHA can be considered a "best practice model" that can help set standards and parameters used by accreditation bodies — in effect serving as a "laboratory" to help determine the most cost-effective ways to improve diabetes care. Reimbursement entities also can take advantage of VA's "system" capabilities to learn how to provide financial incentives for more effective diabetes care.

Roundtable participants urged a more coordinated approach to diabetes care among medical specialists and use of peer-groups to help patients comply with recommended lifestyle changes.

### **Background**

There are 17 to 18 million Americans with diabetes, and incidence of the disease is increasing. Helping to fuel this epidemic is the rapidly rising rate of obesity in the United States: Currently, 64.5 percent of U.S. adults age 20 and older are overweight and 30.5 percent of these are obese. Diabetes is a leading cause of blindness, kidney failure, cardiovascular disease and premature death. While newer medications and insulin-delivery systems are improving care for diabetics, fewer than half of those with diabetes achieve accepted treatment targets. Care of diabetes costs the U.S. economy about \$132 billion a year, consuming one-seventh of healthcare dollars.

### **Summary of discussion**

Roundtable participants agreed that although the burgeoning epidemic of diabetes — mostly type 2 diabetes mellitus — is now receiving increasing attention because of its human and fiscal costs, many Americans are not yet being appropriately treated for the major risk factors that contribute most to disability and death. While glucose control has been shown to have major impact on the disease and its attendant conditions, most patients with type 2 diabetes do not attain sufficient reduction in blood sugar levels to avoid the consequences of diabetes. The major cause of mortality in diabetics is cardiovascular disease. Consequently, the group urged greater attention in clinical practice to blood pressure and cholesterol control in conjunction with glucose control, as recommended by multiple federal and professional society guidelines.

Key to success in diabetes treatment is measurement, participants said — giving providers data on how well they are doing in treating their diabetic patients. However, most providers in the U.S. treat patients "one at a time" and have little feedback as to how well their patients as a group are doing or how their efforts in controlling patients' diabetes compares with those of other providers. How to remedy this? The answer, participants agreed, is a systematic approach that includes an electronic registry with data that can be used for comparisons — an area in which VHA excels. For example, VHA's EMR includes mandatory clinical reminders that clinicians now consider "vital" to diabetes care.

*Other points made during the roundtable discussion:*

- VHA is an integrated healthcare system with an infrastructure that supports many elements of a chronic care model, such as multidisciplinary team approach, clinical information systems, care coordination, and clinical decision support, as well as an electronic medical record. The leadership commitment, responsibility and accountability using the performance measurement system have been major contributors to enhancing diabetes care.
- VHA has a different incentive from the private sector in that its system benefits financially by preventing the development of diabetes and its subsequent complications. In the private sector, financial reimbursement is generally greater for treatment rather than preventing or monitoring of disease. "If providers take the extra time to provide preventive care for patients, they need to be rewarded," the group agreed. The best way to achieve this, they said, is to use VHA as a "laboratory" for demonstrating the cost-effectiveness of its healthcare system in controlling blood-sugar levels, blood pressure, cholesterol levels and the attendant conditions that are more likely to develop if such control is not attained.

There also needs to be financial incentive in the private sector for "going electronic," participants agreed. At present, they noted, most private-sector electronic systems are designed for billing rather than for clinical care.

- A team approach is needed, with greater linkages between the care delivered by cardiologists and endocrinologists. Some at the roundtable urged development of specialized care teams devoted to glucose control. "One size does not fit all in diabetes care" it was noted: While some patients need frequent monitoring, others may need only periodic assessment (for example, a 75-year-old with COPD versus a 25-year old who begins exercising regularly). Since many persons with diabetes have other diseases as well, a coordinated approach is essential to provide patient-centered care.
- Peer support and pressure can help diabetics achieve glucose control and adhere to recommended lifestyle changes. "If the patient isn't a player, his or her prognosis won't change." A group approach, similar to that used by Alcoholics Anonymous, was suggested. VHA is addressing the role of the patient on several fronts: Its MOVE program, now being put in place, will emphasize diet and set exercise standards. Its My Health eVet program gives patients control of their medical records, allowing them to become full partners in their medical care.
- Body mass index (BMI) should be made a vital sign, so those at risk of diabetes can make lifestyle changes that will prevent development of the disease. For example, a 30-minute walk five days a week can reduce the risk of developing diabetes, and is more effective than medications. VHA is incorporating BMI into its electronic record. It also maintains a high-risk foot registry that arrays patients by risk category and identifies those not being seen regularly. "Those who are not being seen are the ones we worry about."
- The home can become the focus of patient-centered care. For example, VHA has a tele-health program allowing patients to measure blood pressure and blood sugar levels, which then are wirelessly downloaded to the electronic medical record. "The patient with chronic illness usually fails at home...This is a win/win strategy that improves quality and reduces cost." Tele-health is also being used to make screening for diabetic eye disease more accessible in rural and primary care sites.

*Participants in this roundtable: Madhulika Agarwal of VHA; Cynthia Bascetta of GAO; Linda Bennett of the House VA Committee; Bill Cahill of the VA Committee; Nathaniel Clark of the American Diabetes Association; William Daniel of Roche Diagnostics; Adam Darkins of VHA; Linda Dunbar of Johns Hopkins HealthCare; William Duncan of VHA; Susan Edgerton of Vietnam Veterans of America; Barbara Fleming of VHA; Sheldon Gottlieb of Johns Hopkins University School of Medicine; David Harlan of NIH; Richard Hodge of Sanofi-Aventis; Eve Kerr of VHA; Elizabeth Coller of CMS; Tracy Malone of the U.S. Family Health Plan Alliance; Michael J. Miller of VHA; James Pessetto of Sanofi-Aventis; Leonard Pogach of VHA; Barbara Rector of Sanofi-Aventis; Sheila Roman of CMS; Dee Simons of Roche Diagnostics; Bruce Taylor of Roche Diagnostics; and Rick Weidman of Vietnam Veterans of America. The roundtable was moderated by Michael Hash of Health Policy Alternatives, Inc. USMI Managing Director is Nancy Tomich [www.usminstitute.org].ww*