Diabetes Best Practices: Fostering Excellence in the Outpatient Care of Patients with Diabetes
The task I have been given today:

• Describe the nature of diabetes care in the trenches of primary care from the point of view of a solo primary care physician.

• Define the barriers faced by patients and physicians in dealing with this metabolic derangement.

• Describe and discuss best practices we have utilized in the outpatient setting to help decrease the impact of uncontrolled diabetes in the patients seen at Stockton Diabetes Intervention Center.
“Diabetes is the most demanding chronic illness. It challenges every fiber of a patient’s body and spirit and demands a system of care that ministers to the biological, social, and psychological aspects of the illness. It takes a village to accomplish this task”

Edward J. Shahady, MD

Edward J. Shahady, MD
So Why Does Diabetes Continue to Command Our Attention?

Because EVERY 24 HOURS there are:

- **4,100** new cases of diabetes,
- **810** deaths due to diabetes,
- **230** amputations,
- **120** kidney failures, and
- **55** new cases of blindness

Diabetes Care in Primary Care

Barriers to adoption of evidence based practice guidelines
Solo and Small Group Physician Practices in California
Part 1: Background
Prepared by Marina Acosta & Chaunterree Washington
January 2015

Solo and small group (fewer than 10) physician practices are an important piece in California’s healthcare landscape. They serve as access points for consumers to receive healthcare services, emphasize relationship-based continuity of care and serve the geographically and socio-economically underserved. More specifically, solo and small group physicians commonly serve ethnically diverse communities, presenting patients with culturally sensitive and competent care. In terms of access to care, nearly 70% of all ambulatory visits are to medical practices with five or fewer physicians and nearly one-third of U.S. physicians practice in solo and two-physician practices. These statistics indicate the high volume of individuals that utilize solo and small group physician practices for their healthcare needs. Also, the type of care provided by private physician practices is built on patient-provider relationships that develop as a result of ongoing care provided by a single physician. The physician may be more informed of a patient’s family life and general living environment. Recent studies have illustrated that solo and small group practitioners have lower re-hospitalization rates than larger practices; the point being that this aspect of care provided by private physicians may lead to better patient outcomes. Finally, solo and small group practices serve a large portion of underserved Californians. For example, 60% of Medi-Cal consumers receive care from solo and small group practices and between 49% and 85% of primary care physicians participate in Medi-Cal (depending on the region). Additionally, approximately 15% of rural Medi-Cal patients seek care from private physicians or physician groups. The availability of solo and small group physicians to Medi-Cal recipients has a large impact and must not be overlooked. It is these characteristics, as well as access, continuity of care, and a commitment to the underserved that make solo and small group practices a vital part of California’s healthcare mosaic.

However, it has become increasingly difficult for solo and small group physicians to practice medicine due to financial barriers, administrative demands and lack of adequate resources. The difficulties associated with opening and maintaining a practice has led to the downward trend of solo and small group private physician practices. Responses from graduating medical students show only 11% of graduates are interested in solo practice medicine. Also, only 3% of physician job searches were for solo practice placements. This data demonstrates the waning interest in solo physician practice over the years. This trend will have broad implications for access to care for many individuals.

As the health system continues to evolve, so does the private practice model. Physicians are joining larger medical practices, closing their practice to specific insurance types (e.g. Medi-Cal), experimenting with new payment models, and retiring. The issues that solo and small group physicians face must be addressed in order for these practices to not only remain a feasible option in California’s healthcare
However, it has become increasingly difficult for solo and small group physicians to practice medicine due to financial barriers, administrative demands and lack of adequate resources. The difficulties associated with opening and maintaining a practice has led to the downward trend of solo and small group private physician practices.
Responses from graduating medical students show only 1.1% of graduates are interested in solo practice medicine.

Also, only 1% of physician job searches were for solo practice placements. This data demonstrates the waning interest in solo physician practice over the years.

This trend will have broad implications for access to care for many individuals.
Solo-Small Physician Groups

- One third of all USA physicians are in 1-2 physician practices.
- 90% of patients with diabetes in this country are looked after by primary care physicians.
- Solo-small group practices serve a large portion of underserved Californians.
- 60% of Medi-Cal consumers receive care from solo-small group practices.
Solo-Small Physician Groups

• 49% - 85% of primary care physicians participate in Medi-Cal (depending on region).

• In order to consistently translate current best evidence/practice into the primary care of diabetes we need to change the way we do things.
Adult Care: Projected Generalist Supply vs. Population Growth/Aging

Shortage of 40,000 by 2020

Demand: adult pop. growth/aging, ACA, diabetes/obesity

Supply: family med, general internal med

Colwill et al., Health Affairs, 2008:w232-241
Barriers – Patients with diabetes

- Significant challenge and frustration to patients.
- Lack of diabetes education.
- Lack of empowerment.
- Complete reorientation of a patients life.
- Dealing with multiple medications.
- Needle sticks.
- Some food restrictions/culture/socioeconomics.
- Incorporating a daily exercise “ritual”
- Multiple visits to various doctors.
Barriers to best practices – Physicians caring for patients with diabetes in the trenches of primary care

• Time ! Time !! Time !!!.
• Primary care was for “simple” things.
• Knowledge of Pathophysiology.
• Diabetes in 2017 - More complicated pharmacotherapy.
• Staff – not trained/Diabetes Care Coordinators.
• Physicians need to understand the social and psychological aspects of diabetes.
• Physician Burnout – impact on diabetes care.
• A disease known as “Clinical Inertia”.
Diabetes in San Joaquin County
Diabetes - San Joaquin County

The California Department of Public Health, Health Status Profiles showed that out of 58 counties, San Joaquin County had the **THIRD** highest death rate for diabetes, the **FOURTH** highest coronary heart disease death rate and the **TENTH** highest stroke related death rate in the state.
Diabetes Care in California
CA Health Plan Trends: Blood Sugar Control (<9) for Patients with Diabetes

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>2006</th>
<th>2007</th>
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<td>National Average</td>
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Source: NCQA Quality Compass © 2012
# Diabetes Care: Blood Sugar Controlled (HbA1c<8)

70.80 = National 90th Percentile for 2011 Performance Year

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<table>
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<th>National Top 10 Plans (2011)</th>
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<td>HealthAmerica Pennsylvania</td>
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*HbA1c <8 measure is new to Right Care as of 2011. Previously, the HbA1c>9 measure was emphasized.

Source: NCQA Quality Compass © 2012
# CA vs. National Top 10 Plans: Lipid Control for Patients with Diabetes

## Diabetes Care: LDL-C Controlled (<100)

58.39 = National 90\(^{th}\) Percentile for 2011 Performance Year

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Source: NCQA Quality Compass © 2012
Patient Centered Practice Redesign
- Medical Home
- Team-Based
- Web Supported
- High-Tech Enabled
  - Continuous Care—Not Episodic

Patient Activation for Self-Care
- Patient incentives for nutritious eating, physical activity, smoking cessation & medication adherence
- Evidence-based patient education (e.g., Project DULCE; Stanford Patient Self-Management)
  - Motivational Media Messaging

Medication Protocols
- ALL/PHASE (Kaiser)
- Nationally Endorsed Guidelines (AHA, ADA)
- European Union Guidelines

Clinical Pharmacist on Care Team
- HRSA.gov/patient safety
- The Asheville Project

Right Care Promising Interventions to Reach HEDIS Quality Goals
Best Practices - Outpatient

ACCESS TO CARE
Diabetes Best Practice – Outpatient: ACCESS TO CARE

- Still too many practices insisting on making appointments for patients.
- Doctor shortage of about 130,000 in 2025.
- No show rates – 12% -50%!
- Same day rates significantly less that appts made 2-3 weeks in advance.
- **Open Access is key** - feast or famine = satisfied patients.
Diabetes Best Practice – Outpatient: ACCESS TO CARE

• So what are we doing about access at the Stockton Diabetes Intervention Center?

• Same day no show rates significantly less that appts made 2-3 weeks in advance.

• If you call, the question asked is: “Do you want to come in NOW”

• Open Access is key - feast or famine = satisfied patients.
Diabetes Best Practice – Outpatient: ACCESS TO CARE

The Future of Family Medicine Project identified the need for patient-centered care that eliminates access barriers and improves quality, outcomes and practice finances.

Group visits -
• Diabetes Day = Wednesdays/CDE present.
• Diabetes Care Coordinators – train all medical assistants
Diabetes Best Practice – Outpatient: PATIENT EDUCATION

The three things I have learned about diabetes that make the most impact:

1) EDUCATION
2) EDUCATION
3) EDUCATION
PATIENT EDUCATION

• The current state of diabetes education is "horrifying," with less than 7% of patients referred to diabetes educators.

• "Diabetes Self-management Education and Support in Type 2 Diabetes [DSME/S]: A Joint Position Statement of the ADA, AADE, and the Academy of Nutrition and Dietetics“ 2015
PATIENT EDUCATION

• So what was your last A1c?
• Response: “Anyone see who”?
• So what are we doing about patient education at the Stockton Diabetes Intervention Center?
• Education room
• Support from Pharma – nil from health plans/health insurance groups.
Diabetes Best Practice – Outpatient Medical Assistants as Diabetes Care Coordinators

• Teamlet approach important in primary care.
Diabetes Best Practice – Outpatient:

Share the Care

- Non-clinicians assuming responsibility for care that does not require a MD/NP/PA level of training

- A great way to start sharing the care is allowing MA’s to do more.

- Unfortunately very few practices are actively training MA’s
Sharing the care through panel management

- Medical assistants use preventive care and chronic disease registries to identify patients overdue for routine services and arrange for those services to be performed
  - Preventive care: immunizations, cancer screening (cervical, breast, colorectal)
  - Chronic care: e.g. diabetes, making sure all lab tests done on time
- **Standing orders** needed to empower medical assistants
- Quality of preventive services improves (Chen and Bodenheimer, Arch Intern Med 2011;171:1558)
- An estimated 50% of all preventive care activities could be shared with medical assistants (Altschuler et al, Annals of Family Medicine 2012;10:396)
- Capacity is increased
Best Practices – Outpatient: Pharmacotherapy of diabetes

Biomimicry/Individualization of therapy
• Best practices in the outpatient management of diabetes should extend to community-wide efforts to prevent and promote awareness of the disease.
• Patient education and engagement efforts are key to the success of primary care attempts to enhance diabetes care – an informed, empowered patient is a solution and not a problem.
• Adoption of the chronic care model is key in ambulatory practice of diabetes care.
CONCLUSIONS/SUMMARY

• Access to timely and coordinated care is crucial in preventing uncontrolled diabetes related complications.

• Type 2 diabetes may be the most challenging and frustrating disease faced by primary care physicians.
CONCLUSIONS/SUMMARY

• Excellent evidence exists that reaching goals for hemoglobin A1c, low density lipoprotein cholesterol and blood pressure significantly reduces uncontrolled diabetes related complications and costs.

• Office and personnel “redesign” structured to educate and empower patients can help improve and attain treatment goals in the outpatient care of patients with diabetes.