

Improve Diabetes Outcomes

HealthPartners: Minneapolis, MN

Today more than 30 million people in the U.S. have diabetes, though as many as 25 percent of them don't even know they have it. The seventh leading cause of death in the U.S. — and thought to be underreported — diabetes has more than tripled in the past 20 years as Americans grow older and more overweight.¹

Diabetes puts patients at higher risk for heart disease and stroke and is the leading cause of kidney failure, lower limb amputations and adult-onset blindness. It is estimated that the cost of medical care and lost work and wages due to diabetes totals \$245 billion annually.²

Diabetes is actually a group of diseases resulting from the body's inability to make or use insulin. Clinicians who care for patients with diabetes must stay abreast of the latest evidence-based care guidelines and pay attention to a cluster of symptoms and screenings for possible complications.

Using Data to Drive Improvement

As one of the founders of Minnesota's Institute for Clinical Systems Improvement (ICSI), HealthPartners and its leaders understand that continuous quality improvement—especially in a condition as complex as diabetes—requires a long view. In 1997, Health Partners Medical Group launched a system-wide project to create an “enhanced primary care” approach to diabetes management. The effort resulted in significant population-based improvements in diabetes care.³ Additional efforts have followed.

The health plan helps drive the system's improvement efforts by providing comprehensive diabetes care data based on claims rather than solely on medical records. Physicians also receive regular data on their personal performance both clinically and in terms of patient satisfaction, and scores are also shared at the work unit level and the clinic level. Clinic data is not blinded and is comparative so that quality leaders are identified and can share insights with others.

Standardizing Care and Benefit Design

HealthPartners has worked hard to standardize clinic workflows in diabetes care. Steps in the

“*Medical groups can't necessarily see the complete picture of utilization, cost, or morbidity from their own records. Health plans have that data from claims, and sharing it with provider groups really helps to set the priorities for quality improvement.*”

Beth Averbeck, MD, Senior Medical Director,
HealthPartners Medical Group

diabetes care model process specify roles and responsibilities before, during and after the patient visits, as well as between visits.

The health plan also covers phone and e-visits, which saves both time and money for patients, thereby reducing barriers to care. Benefit design can help shape care and adherence: An arrangement with one large employer waived copayments for medications that help manage diabetes.

Embedding Experts and Using “Telementoring” to Build Skills

The health plan embeds pharmacists in many care clinics — or makes them readily available on a regional basis — to consult with primary care clinicians and specialists on diabetes care, including management of lipids, hypertension and glycemic levels. Clinics also rely on certified diabetes educators and registered dietitians as consultants.

HealthPartners uses a range of additional methods to educate clinicians in its network, including meetings, handouts and webinars. Recently, the organization has used the ECHO model of learning which deploys a “hub-and-spoke knowledge-sharing network.”⁴ The hub and spoke network enables specialists to train a dozen primary care clinicians to care for patients they might otherwise refer to specialists. This method promotes multi-directional learning and fosters learning communities that can continue to support one another.

According to ECHO founders, the model—often called “telementoring,”—has been shown to result in care by primary care clinicians that is as safe and effective as that of specialists.⁵ At HealthPartners, primary care physicians have participated in ECHO learning groups in endocrinology and psychiatry to build their knowledge and skills in caring for patients with diabetes.

Sophisticated Tools to Support Best Practice

HealthPartners supports clinician health improvement activities by creating registries that identify patients who are in need of specific services. The organization currently has registries for a range of conditions, including asthma, hypertension, depression and diabetes. The registries, updated quarterly, provide data that may not be in the electronic health record, including hospitalizations, diabetic eye exams and emergency department visits.

HealthPartners’ custom-designed, home-grown and powerful electronic decision support tool, called Wizard, runs on its electronic health records platform. Wizard matches data in a patient’s medical record with the latest research about the appropriate next steps for care, supporting care decisions that are both evidence-based and customized to the individual patient.

Wizard identifies a patient’s 10-year cardiovascular risk and prioritizes risk factors based on the potential benefit to the individual. This helps both patients and clinicians make more informed decisions and has been shown to improve outcomes for people with diabetes.⁶

Engaging Patients

In coordination with the HealthPartners Medical Group, the health plan sends personalized letters to members with reminders about screenings and other preventive care services when they are due,

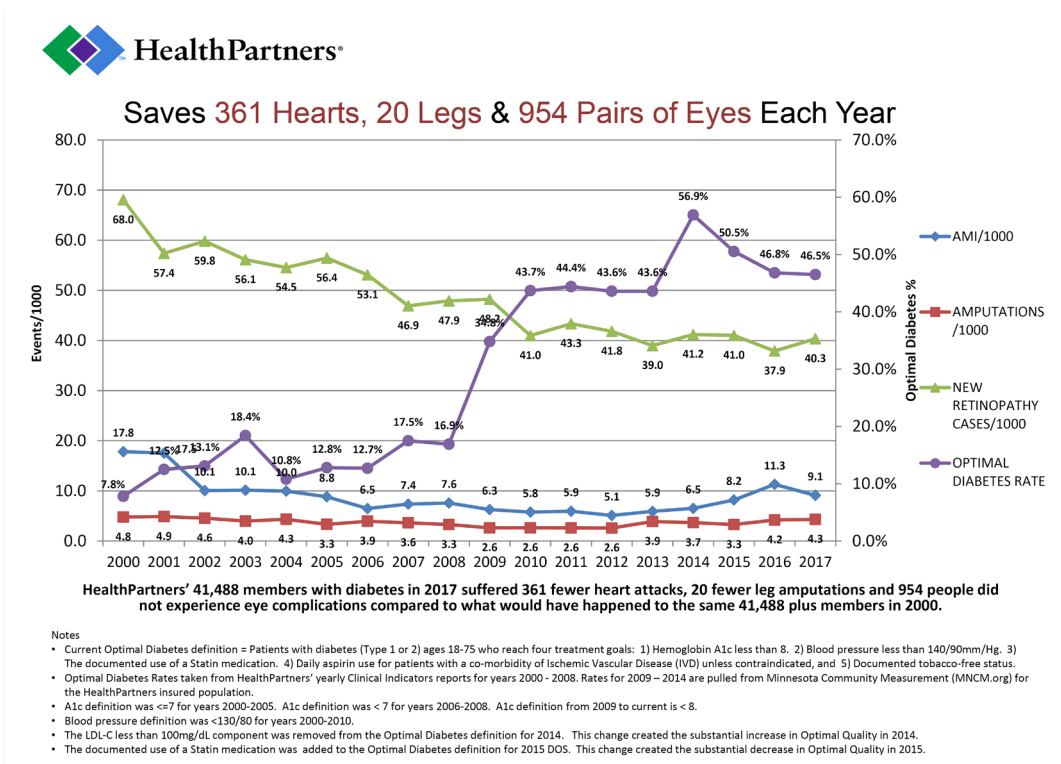
as well as reminders about specific condition-related services. For example, members with diabetes receive reminder letters to schedule A1c screenings, as well as diabetic eye exams. Certified diabetes educators and registered dietitians are also available to help educate patients.

Results

In 2017, HealthPartners' rate for Optimal Diabetes Care as measured by Minnesota Community Measurement's bundled diabetes measure was 49.7 percent compared to a statewide average of 44.7 percent.

In addition, NCQA rates HealthPartners 4.5 on a 5.0-point scale for diabetes care.

Improving diabetes care and outcomes is long-term work. The graph below shows the preventive value of evidence-based diabetes care over 16 years.



Sources

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