CHCS Center for Health Care Strategies, Inc.

Case Study

Rochester *Regional Quality Improvement* Initiative Supports Providers in Diabetes Care

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Across the country, only 40% of people age 40 and over with diabetes receive the screening services recommended for proper disease management each year.[1] Research has shown that adoption of chronic care guidelines may require more time than primary care physicians have for patient care, leading many Americans to not receive needed health care services.[2]

This represents a critical missed opportunity, given that proper diabetes management can largely prevent related complications in the more than 23 million people with the disease in the U.S.[3] For example, tight control of blood sugar levels for Type 1 diabetics reduces risk of kidney disease by two-thirds and eye disease by one half.[4] Supporting physicians in better diabetes care delivery can have a significant impact on clinical outcomes, patient quality of life and health care related expenses.

With these goals in mind, a cross-payer coalition of health plans, state and county health departments, and other stakeholders in Monroe County, N.Y., formed the Rochester *Regional Quality Improvement (RQI)* Initiative for Diabetes Care. This coalition was led by a Medicaid health plan, but required the participation of multiple parties to improve the quality of diabetes care in primary care practices by working together to help physicians achieve recognition under the Diabetes Physician Recognition Program (DPRP) of the National Committee for Quality Assurance (NCQA).[5]

Providing appropriate care for patients with diabetes is vital given the risks of life-threatening and debilitating complications. For example, the risk of stroke is two- to four-times higher among people with diabetes, and the disease is the leading cause of kidney failure and of new cases of adult blindness each year.[6]

Rochester *RQI* was one of four regional programs (others were in Arkansas, North Carolina, and Rhode Island) in the Center for Health Care Strategies' (CHCS) *RQI* initiative to improve chronic care at the primary care site. CHCS designed *RQI* to align purchasers — public (e.g., Medicaid and state employers), commercial, self-insured, and others — and health plans to target common chronic conditions, adopt common performance measures, and develop consistent reimbursement to support a single set of provider interventions. It was built on the premise that aligning quality improvement efforts across purchasers and plans throughout a region increases the message providers receive around quality improvement priorities, tools, and strategies. The program was supported with funding from the Robert Wood Johnson Foundation (RWJF).

Rochester *RQI* In Brief

This collaborative effort of health plans, state and county health departments, and other stakeholders in Monroe County provided participating physician practices with financial and technical assistance to apply for the Diabetes Physician Recognition Program of the National Committee for Quality Assurance. Plans offered practices a multi-payer patient registry, a forum for sharing best practices, and other support to evaluate and improve their care processes for patients with diabetes. The program was part of CHCS' *Regional Quality Improvement* initiative, funded by the Robert Wood Johnson Foundation, to improve chronic care at the primary care site.

Project Overview

With an 8% prevalence in New York State and Rochester's Monroe County,[7] diabetes was identified as a major public health issue by the county and state departments of health, which includes the Medicaid program in New York. In response, each of the health plans serving the city of Rochester had developed its own program to improve diabetes care and measure performance annually. Yet, despite these efforts, statewide data showed only slight improvements in diabetes measures of care.[8]

Through *RQI*, state and local stakeholders decided to work collaboratively, leveraging the community's history of cooperation between health insurers and businesses. To improve care for patients with this costly and potentially debilitating chronic disease, they designed a cross-payer initiative involving both Medicaid and commercial insurers. The initiative provided primary care practices with:

- Consulting services to assist in improving processes for managing patients with diabetes;
- A diabetes registry of each practice's patients that incorporates data from all participating insurers;
- Collaborative meetings to allow practices to share successful strategies with one another; and
- Financial and technical assistance for applying for DPRP recognition (*see sidebar for DPRP criteria*).

NCQA's Diabetes Physician Recognition Program Criteria

In partnership with the American Diabetes Association, NCQA developed the DPRP to recognize physicians who use evidence-based measures and meet specific standards when delivering care to patients with diabetes. To be recognized as a DPRP provider, physicians must meet the following criteria:[9]

Criteria	Standard
Blood glucose (HbA1c) control	
HbA1c < 7.0%	40% of patients
HbA1c > 9.0% (poor control)	<15% of patients
Blood pressure control	
BP > 140/90mmHg (poor control)	<35% of patients
BP <130/80mmHg	25% of patients
Cholesterol control	
LDL >130mg/dL (poor control)	<37% of patients
LDL <100mg/dL	36% of patients
Eye exam	60% of patients
Foot exam	80% of patients
Nephropathy assessment	80% of patients
Smoking status and cessation advice or treatment	80% of patients

The cross-payer initiative was directed at safety-net providers who together care for almost 20% of the region's covered lives. Close to 60% of patients served by these providers are racially/ethnically diverse — populations which generally experience more barriers to care, a greater incidence of chronic disease, lower quality of care, and higher mortality than the general population.[10] Furthermore, about 40% of the patients served by these practices are Medicaid beneficiaries, a group that faces a greater gap in quality of care compared to those with commercial coverage.[11] Since *RQI* served a large proportion of this high-need population, it had strong potential to have a meaningful impact on health in the region.

Program Leadership and Governance

The lead organization for Rochester *RQI* was the Monroe Plan for Medical Care, a health management organization serving low-income individuals. Joining Monroe in the effort were two nonprofit health insurers (Excellus BlueCross BlueShield and Preferred Care), the New York State Department of Health (NYSDOH), the Monroe County

Department of Public Health, the American Diabetes Association, the Finger Lakes Health Systems Agency, and the Rochester Business Alliance. A steering committee chaired by Joseph A. Stankaitis, MD, chief medical officer of the Monroe Plan, led the project. Committee members included the medical directors from Excellus and Preferred Care, and representatives from the participating organizations.

Rochester *RQI* in Practice

From 2006 through 2008, Rochester *RQI* provided eight practices representing 38 physicians in Monroe County with the following practice site improvement and financing assistance:

Practice Supports

1. *Consulting Services* – A practice transformation expert assisted practices with an initial performance assessment, development of an improvement work plan, and assistance in improving processes for diabetes care management in compliance with DPRP guidelines.

2. *Patient Registry* – The collaborative developed a diabetes registry for each practice that contained centralized information about patients with diabetes to help practices monitor care. The health plans contributed to this registry with claims data on each practice's patients with diabetes, and the services these patients received. The NYSDOH provided comparable information on Medicaid fee-for-service patients, representing the first time this type of information was shared with physicians. According to Stankaitis, information on Medicaid beneficiaries in fee-for-service arrangements was, in the past, a "big black hole." Facilitating ready access to this data helped physicians identify which patients were in need of services, a critical step in treating those with chronic illness.

   "Physicians are committed to adhering to diabetes care guidelines," Stankaitis explained. "If patients are out-of-sight, meaning not coming in for office visits, they are out-of-mind. Having a registry helps physicians know which patients are getting the care they need, and which are not."

3. *Collaborative Meetings* – During quarterly meetings of the program's practice site advisory committee, physicians from each practice discussed strategies that helped them improve diabetes care. For example, participating physician Dr. William Bayer explained that any time a patient with diabetes came for an office visit, his staff would have the patient wear blue booties as a visual reminder to the doctor to do a foot exam. This sharing of best practices added to the value of the collaboration.

4. *Support for DPRP Recognition* – Rochester *RQI* provided both financial and technical assistance to support practices in achieving DPRP recognition. The collaborative paid the practices' DPRP application fees to NCQA, and gave an annual honorarium of $1,000 per physician. Technical assistance included up to 40 hours of consulting time for each practice, as described above, to help meet the DPRP criteria.

   One area addressed by technical assistance was documentation of patient eye exams. Prior to the initiative, primary care physicians (PCPs) did not receive reports from ophthalmologists who had done eye exams for patients with diabetes, leaving the PCPs without the requisite documentation for DPRP recognition.

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>
> *– Joseph Stankaitis, MD, Monroe Plan for Medical Care*

A focus group of local ophthalmologists revealed that many did not have the physicians' fax numbers. To remove that barrier, the collaborative asked the local medical association to provide fax numbers of all PCPs in the community — helping practices achieve the DPRP recognition in this area.

Practice Requirements

To apply for DPRP recognition, those practices that had complied with the guidelines for diabetes care conducted a review of their charts from 25 consecutive-visit patients with diabetes. The practitioner chose any date and then pulled the charts of 25 patients with diabetes, either going backward or forward in time.

The physician had to achieve a score of 75% or greater, reflecting compliance with most of NCQA's diabetic care criteria, including controlling patients' blood glucose (i.e., HbA1c levels), blood pressure, and low-density lipoprotein levels (*see DPRP criteria sidebar*). After submitting compliance data to NCQA, a physician typically gets a response within 30 days.

For participating physicians, the chart review not only contributed to DPRP recognition, but shed light on gaps in service delivery. "You may think you did all the testing that's needed, but when you look at the record, you may find out some tests were not ordered," Stankaitis said.

Results to Date

By December 1, 2008, 38 Monroe County physicians had achieved DPRP recognition. The collaborative shared this achievement with the community through a press release and news conference, generating positive exposure for the practices. Other physicians in the region, seeing the advantage that DPRP recognition gave their competitors in attracting patients, subsequently became interested in the program.

"Physicians who have DPRP recognition are positioned very strongly in the market, particularly for seniors," observed Stankaitis. "They are very interested in serving older patients, who have a higher incidence of diabetes. So, they view this recognition as a real positive for their practice."

Program Challenges

The program's success was achieved despite a number of implementation challenges. For example, some participating physicians found that the registry, comprised of claims data and gaps-in-care reports, was sometimes incomplete or not timely. Furthermore, claims data sometimes did not provide adequate detail about the services delivered during each visit, such as whether a diabetic patient's feet were examined. In addition, there was variability in the insurers' lab test results reporting, an important element when managing patients with diabetes.

Another area for improvement was the process of chart review. "The one drawback of this patient selection method is that you choose 25 of the patients who have come in for patient care. So, those

people who are not coming in are not part of your measurement criteria," noted Michael D. Nazar, MD, a family physician who achieved DPRP recognition through the program, and vice president for primary care and community services at Unity Health System, an *RQI* participant. "We have proven to ourselves that we are providing excellent care to those people who come in. Our bigger challenge now is to reach out to those people who are not making it in the door."

Looking Ahead

The organizers of the initiative hope that its demonstrated value will prompt future multi-payer, multi-plan collaboration in the region. In fact, some of the participating plans and physicians, including those at Monroe Plan and Unity, are now pursuing a collaborative around the patient-centered medical home (PCMH), a team-based model of care that replaces episodic treatment based on illness with coordinated care and a long-term relationship with providers.[12]

"We are entering into a longer-term initiative that aims to have every one of our primary care practices certified as a patient-centered medical home," said Nazar. "We have begun that pilot project already with two practices and are hoping to have at least two more practices with PCMH certification by the end of 2009."

"The success of this program is a testament to the type of physicians we have in our community, with so many willing to go above and beyond when caring for patients with diabetes," offered Norm Lindenmuth, MD, vice president and chief medical officer for quality for Excellus BlueCross BlueShield. "We now have doctors and patients working more closely together to better manage a disease that can be debilitating. The result is better care for the patient and improved outcomes."

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Endnotes

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