

Assessment of Community Diabetes Management

Local committee established to coordinate standards of care

by Ashley A. Schields, PharmD

In 2002, the prevalence of diabetes mellitus in the United States was estimated to include 6.3% of the population (18.2 million). Of this number, 5.2 million people were undiagnosed. The costs of treatment and loss of productivity was estimated to be \$132 billion in 2002 alone. Diabetes is currently the sixth leading cause of death in the United States, and patients have a two to four times higher risk for the development of heart attacks and stroke compared to nondiabetics.^{1,2} In response to these estimates, strict glycemic control in type 1 and type 2 diabetes mellitus patients has been incorporated into numerous diabetes guidelines. Tight control is supported by evidence of reductions in diabetic complications that include neuropathy, nephropathy, and retinopathy, among others. Success depends on many patient factors, not the least of which is the ability to follow treatment regimens. Successful management also relies on effective collaboration among all health care providers in order to make patient follow-up as cohesive as possible.

Diabetes management requires physician and patient education concerning monitoring and treatment, including an emphasis on the importance of lifestyle modification. Application of this knowledge should be included in a process that supports timely interventions and patient follow-up. Patients should be made to feel empowered rather than criticized during every step of this process. In addition, the ability to format outcomes for quality assessment and determination of future goals both for the patient and the health care practice is important.

There are many barriers and inefficiencies to overcome with current diabetes management practices. A chronic disease like diabetes mellitus, which affects a

large population and involves significant health care and societal costs, is a major target for new practices and innovations. Some management obstacles to overcome include timely identification of therapeutic advances and assessment of treatment process efficiency. Another issue is the need for effective information exchange among peers concerning new modalities and practices. The question also arises as to what is the best way to apply what is learned. It can be difficult with patient load and time constraints to efficiently manage a chronic disease such as diabetes in an often acute care focused health care system.

COMMITTEE ESTABLISHED IN 2000

A local response to these issues was the establishment of the Diabetes Clinical Quality Coordinating Committee (DQC) in 2000. The University of Wisconsin Health Quality Care and Management Committee initiated this group in order to coordinate standards of care for patients with diabetes mellitus. The intent was to facilitate collaboration of system-wide diabetes administration efforts among management groups. Specifically, the committee functions in the pursuit of

future standards while avoiding duplication of services. Committee goals and activities include involvement in the approval of diabetes guidelines and the implementation process, the establishment of provisions for staged diabetes care and provider education, the improvement of documentation consistency, and assessment of outcomes based on effective data retrieval. Membership currently includes representation from health care organizations and managed care providers from UW Hospital and Clinics, UW Medical Foundation, Physicians Plus Insurance Company, Unity Health Insurance, Meriter, Dean Health Plans and Group Health Cooperative. The committee includes practitioners from multiple disciplines including physicians, nurses, pharmacists, certified diabetes educators, and administrators.

The DQC meets every other month and functions well as a platform for discussion on the various initiatives and practices underway across the multiple organizations. Committee projects have included the establishment and dissemination of a yearly update of diabetes medications with a treatment algorithm included to provide practitioners with detailed information concerning oral glucose lowering agents, insulin, antihypertensive drugs and medications for dyslipidemia. In addition to clinical information, the update provides economic information and managed care formulary designations.

A second initiative involved the need for the development of a diabetes registry to provide a listing of patients, providers and clinical information for the identification of improvement areas based on

ADA Practice Guidelines

Each January, the American Diabetes Association (ADA) publishes a supplement to its journal, *Diabetes Care*. This supplement contains the ADA's Clinical Practice Recommendations that are updated annually. One surprise for 2004 is an update for more aggressive treatment of hyperlipidemia in diabetes due to the 2003 publication of the Heart Protection Study. Another interesting tidbit relates to storage of insulin in pre-drawn syringes.

To discover the details of these issues and others, readers may view the recommendations which are available *FREE* online in both Acrobat file and HTML formats. Visit the ADA's Web home page and click on "For Health Professionals and Scientists" on the left sidebar.

The next Web page will contain a new left sidebar. Place your cursor over the "Journals" button, and a menu will slide out. Click on "Clinical Practice Recommendations."



ADA HOME PAGE
WWW.DIABETES.ORG/HOMEPAGE.JSP

patient outcomes. Member involvement in a statewide collaborative project assessing the use of MetaStar database software and a separate diabetes collaborative project through the University of Wisconsin Hospital and Clinics provided information on both success and barriers in redesigning diabetes management practice. Potential improvements in diabetes care goals as well as the practicality of process functions and staff satisfaction were issues brought under consideration by the committee.

Current committee projects include the formation of a subgroup to evaluate urine microalbumin screening processes. The goal of this group is to provide a community standard for diabetic nephropathy screening through coordination of area laboratories and adjustments to automated lab orders for urine microalbumin to include such features as a calculated creatinine ratio. Other issues to be addressed include the need for increased awareness of screening and proper follow-up of patients. The goal is to coordinate interventions associated with positive screening results using laboratories and automated orders. Once processes are standardized, the committee intends to provide educational material concerning the application of urine microalbumin laboratory results.

For the upcoming year the DQC will continue to function as a forum for the discussion of new practices throughout the health care system. As diabetes therapy evolves, the committee will continue to strive in the endeavor of providing organized and comprehensive efforts toward improvement in diabetes care. ●

Ashley A. Schields is a drug information specialist and clinical pharmacist within the Center for Drug Policy and Clinical Economics at the UW Hospital and Clinics and a member of the Diabetes Clinical Quality Coordinating Committee.

The author gratefully acknowledges Pam Kittleson, PharmD for her contribution to this paper.

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