Program Lifts Quality of Diabetes Care

BY MICHELE G. SULLIVAN

FROM WONCA 2010, THE CONFERENCE OF THE WORLD ORGANIZATION OF FAMILY DOCTORS

CANCÚN, MEXICO — Feeling the squeeze from government cutbacks and the need to wean itself from big pharma dollars, the Mayo Clinic has found a new source of support for resident education: the Physician Quality Reporting Initiative (PQRI) program.

Launched last year, a program aimed at tracking key measures of diabetes care has helped the Mayo Clinic of Jackson- ville, Fla. turn around its strong performance in diabetes care into a revenue stream for the residency program while also improving the consistency of care and giving residents an invaluable window on the logistics of conducting quality improvement projects.

From the outset, however, the goal was on improving diabetes care, Dr. Jerry Sayre emphasized.

The project was spurred by a request from the leaders of Mayo’s family medicine department to create a diabetes care improvement program. “In Florida, we spend more than $12 billion each year for care with patients with diabetes,” Dr. Sayre said.

These patients use more health care resources than non-diabetic patients in the clinic’s family medicine sector and cost 42% more to care for than non-diabetic patients. Nearly one-quarter of patients hospitalized each year at the Mayo Hospital in Jacksonville have diabetes as a primary diagnosis or comorbidity.

Consistently good preventive care really pays off for this group, Dr. Sayre said. “A hemoglobin A1c that’s decreased by 1% decreases diabetic complications by 35% and keeping LDL and blood pressure [in normal ranges] decreases cardiovascular morbidity by 50%.”

Using the American Board of Family Medicine’s 2010 Diabetes Module, physicians at the clinic identified their most consistently implemented care measures and pinpointed those that needed improvement, he said.

Data collected for the ABFM module can be used to fulfill requirements for the PQRI. Under that program, physicians who meet certain clinical quality standards for data 30 individual Medicare patients can earn an incentive payment of 2% of their total allowed charges for Medicare Physician Fee Schedule—covered professional services.

In the Mayo Clinic’s case, that incentive payment amounts to $86,000, which Dr. Sayre plans to funnel back into resident education projects.

In addition to providing an alternative means for fulfilling PQRI requirements, the ABFM’s Diabetes Module provides data for generating research and satisfies certification and continuing medical education requirements, said Dr. Sayre.

The module measures how often six clinical tests are performed against what the ABFM considers benchmark rates for patients each year:

- HbA1c (benchmark 9%), LDL cholesterol control (94%), hypertension control (100%),
- diabetic eye exams (60%), microalbumin testing for diabetic neuropathy (80%), and diabetic foot exams (visual, monofilament, and pulses 77%)

Patient records must contain documentation that each measure was performed in the prior year.

Data were collected on 600 patients seen in Mayo’s family medicine clinic during 2009 and were compared with data from a fee-for-service regional medical clinic and national benchmarks.

Mayo physicians were doing “a pretty consistently good job” in most areas, exceeding the benchmark goal for each parameter, Dr. Sayre said. However, “we could have done better in some areas,” such as diabetic foot exams, which were performed 93% of the time. Mayo’s goal is to perform it at every visit.

As it turned out, the key reason for the short fall was the lack of monofilament in every office. “So we purchased monofilaments for each exam room.”

Other measures included:

- HbA1c testing documentation (98%), LDL testing (97%), blood pressure control (99%), eye exam (68%), and microalbumin testing (92%).

Scores at the regional medical clinic were almost identical, although two were slightly higher than they were at Mayo: blood pressure control (100%) and eye exams (71%).

Once the data were available, Dr. Sayre and his Mayo Clinic colleagues, Dr. Scott Simmons and Dr. Ramon Canino, “created a kind of ‘doctor report card’ to show patients how their doctors are measuring up to these goals,” he explained.

The report shows how each patient’s doctor compares with the overall picture of care at the facility and also against national benchmarks.

Dr. Sayre reported having no relevant financial conflicts.

Hypoglycemia Common in Elderly, Even With High HbA1c

BY MIRIAM E. TUCKER

FROM THE ANNUAL MEETING OF THE AMERICAN DIABETES ASSOCIATION

ORLANDO — Hypoglycemic episodes were common despite high hemoglobin A1c levels among 40 elderly community-dwelling adults with diabetes who underwent continuous glucose monitoring.

“Raising A1c goals may not be adequate to prevent hypoglycemia in this vulnerable population,” Dr. Medha N. Munshi said.

Guidelines from the American Diabetes Association and the American Geriatric Society recommend a target hemoglobin A1c level of 7% or less for elderly patients who are on complex insulin regimens. “Even a high A1c doesn’t preclude lows. He- moglobin A1c measures the mean. There are wide fluctuations in this population,” Dr. Munshi noted.

There was a total of 102 hypoglycemic episodes, with a mean duration of 3 hours per patient. Nocturnal episodes lasted for a mean of 2.5 hours. “The duration of episodes was quite concerning,” she said.

Surprisingly, more than half (58%) of the 102 hypo- glycemic episodes occurred among the 16 patients with type 2 diabetes, with a mean duration of noctural hypoglycemia nearly twice that of the hypoglycemia in the type 1 patients (2.9 vs. 1.6 hours). “Even the type 2 patients had wide glycemic excursions,” Dr. Munshi commented.

Also of concern, the majority of episodes (95 of the 102) were not recognized by fingerstick testing or by the patients’ symptoms. Moreover, there were no sig- nificant relationships between severity of hypoglycemia and age, type of diabetes, duration, HbA1c treatment, or living alone.

In a follow-up interview, Dr. Munshi cited a previous study she and her colleagues published last year, showing that simplification of complex insulin regimens by using C-peptide to assess whether patients could elim- inate or reduce the amount of insulin taken, so that oral agents could be used instead, reduced hypoglycemic episodes without deterioration of glycemic control (Am. J. Med. 2009;122:395-7).

“I believe that elderly patients with other comor- bidities are unable to follow complex insulin regimens appropriately and end up having wide fluctuations in their glucose values. If a treatment regimen is designed with consideration for an elderly patient’s self-care abilities, risk of hypoglycemia can be reduced,” she said in the interview.

And when available, CGM can be extremely helpful for elderly patients. “I think CGM can be a great tool for pattern recognition and assessment of risk of hy- poglycemia in elderly patients who are on complex insu- lin regimens without consideration of glycemic control,” Dr. Munshi said.