

## Quality Improvement Report

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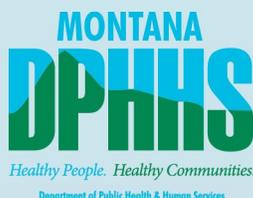
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# The Affordable Care Act: Implications for Diabetes

The Affordable Care Act (ACA) includes opportunities to offer better prevention, screening, care, and treatment of diabetes. The ACA includes the previously developed Catalyst to Better Diabetes Care Act of 2009 to enhance diabetes surveillance and quality standards nationwide.<sup>1</sup>

### **Increased Access to Prevention, Screenings, and Insurance Coverage**

#### **Diabetes Prevention Programs**

The ACA includes several provisions to promote diabetes prevention services. The ACA established the Center for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (National DPP) as a public-private partnership of community organizations, private insurers, employers, health care organizations, and government agencies.<sup>1</sup> Montana currently has 13 organizations included in the National Registry of Recognized DPPs, which indicates their use of an evidence-based curriculum that meets duration, intensity, and reporting requirements to CDC. Montana DPPs are also implementing the Medicaid Incentives to Prevent Chronic Disease Program (Section 4108 of the ACA).

#### **Medicare Preventive Services, Payment, and Prescription Coverage**

Medicare benefits are strengthened by the ACA by lowering costs to make the program more sustainable and improving the quality of care for seniors and people with disabilities on Medicare. Some of the improvements are already in practice such as cost free preventive services including wellness visits and cholesterol tests. The Centers for Medicare & Medicaid Services (CMS) reimburses providers for meeting quality standards, investing in patient safety, and delivering coordinated care. Additionally, the ACA will progressively close the prescription drug "donut hole" coverage gap for Medicare recipients until completely closed by 2020.<sup>2</sup>

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## Criteria on Screening

Beginning on January 1, 2011, Medicare was required to pay for some preventive services for diabetes including screening tests and outpatient self-management training. The ACA will cover preventive services based on A or B recommendations by the US Preventive Services Task Force. Currently, screening for type 2 diabetes is recommended only in asymptomatic adults with diagnosed high blood pressure.<sup>3</sup>

## Insurance Coverage

Beginning in January of 2014 insurance companies can no longer deny coverage to adults because of preexisting conditions or drop coverage for people who are diagnosed with a new condition or illness, such as diabetes.<sup>3</sup>

## Quality of Care

### Health Information Technology

Practices are required to use technology tools to reach the ACA's goals for high quality care. This includes data sharing, EHRs, registries and available apps for tracking diabetes self-management. Health information technology is now essential to use for quality improvement in such areas as blood pressure control, blood glucose control, and cholesterol reduction.<sup>4</sup>

### Clinical Quality Measures and Reimbursement

As a result of healthcare reform, healthcare providers and systems will be measured on quality, safety and value and paid according to value-based care. Those who perform well can gain additional bonus payments; however, others can stand to lose both dollars and reputation given the increasing transparency of performance. Another change in reimbursement for providers is bundled payments for all services within a particular episode of care. Diabetes is one of the 48 conditions to have bundled payments. The Physician Quality Reporting System (PQRS) was initiated in 2011 and was updated in 2013. By reporting on the PQRS measures, physicians

can earn incentive payments above the Medicare B rates. In 2015, physicians who do not participate will be subject to penalties. Several measures are related to diabetes including A1C, blood pressure, and cholesterol control; eye and foot exams; and urine screening for microalbumin.<sup>5</sup>

## Meaningful Use

Meaningful use of the EHR is continuing to be rolled out and the expectations increase from stage 1 to stage 2 criteria. The 3 stages are implemented over from 2011 to 2016. There is a drive to increase the availability of patient portals where patients will be able to access relevant parts of the medical record such as lab values with the intention to empower the patient to become more involved in their care.

## Accountable Care Organizations

The creation of Accountable Care Organizations (ACOs) is one of the largest structural changes as a result of the ACA. Criteria to be designated an ACO include high quality care, care coordination and information sharing. Providers are held accountable to the total cost of care and can benefit from any shared savings and the best outcomes at the lowest cost.<sup>6</sup>

## Conclusions

We encourage you to research and consider what the ACA implementation means for diabetes prevention, screening, care, and treatment and your role in it. You may want to monitor the effects of the ACA on your clinical practice and be prepared for both increased services to diabetes patients and changes in reimbursement.

## References

1. Centers for Disease Control and Prevention. *Diabetes Report Card 2012*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2012.
2. (April 23, 2012) "The Affordable Care Act: Lowering Medicare Costs by Improving Care" Retrieved from <http://www.cms.gov/apps/files/ACA-savings-report-2012.pdf>
3. (April 10, 2011) "The Affordable Care Act: A Brief Summary" Retrieved from <http://www.ncsl.org/portals/1/documents/health/HRACA.pdf>
4. (February 13, 2013) "Examining The Impact of the Patient Protection and Affordable Care Act in North Carolina" Retrieved from <http://www.nciom.org/wp-content/uploads/2012/05/Full-Report-Online-Pending.pdf>
5. (September 26, 2012) "Montana Chronic Disease Improvement Guide" <http://www.dphhs.mt.gov/publichealth/ChronicDiseaseImprovementGuide.pdf>

# Diabetes Care Indicators

## Primary Care Practices and Diabetes Education Programs

Figure 1. Diabetes care indicators from primary care practices in Montana participating in the DQCMS, 2nd Quarter (April—June 2013). N = 30 clinics; 9,270 patients.

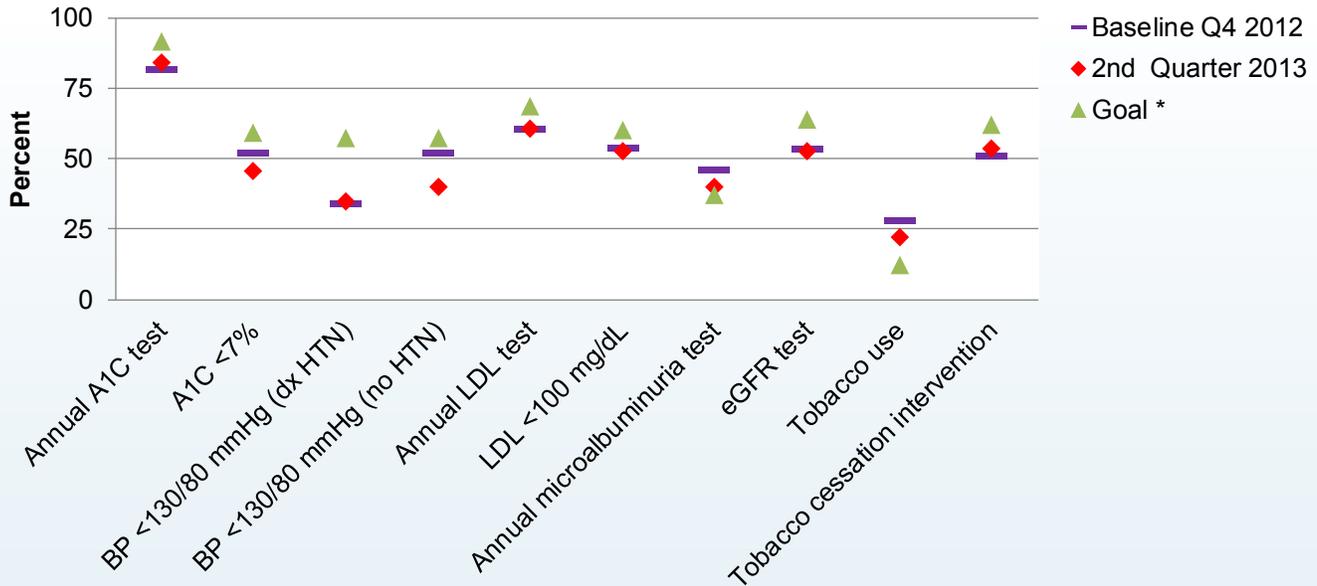
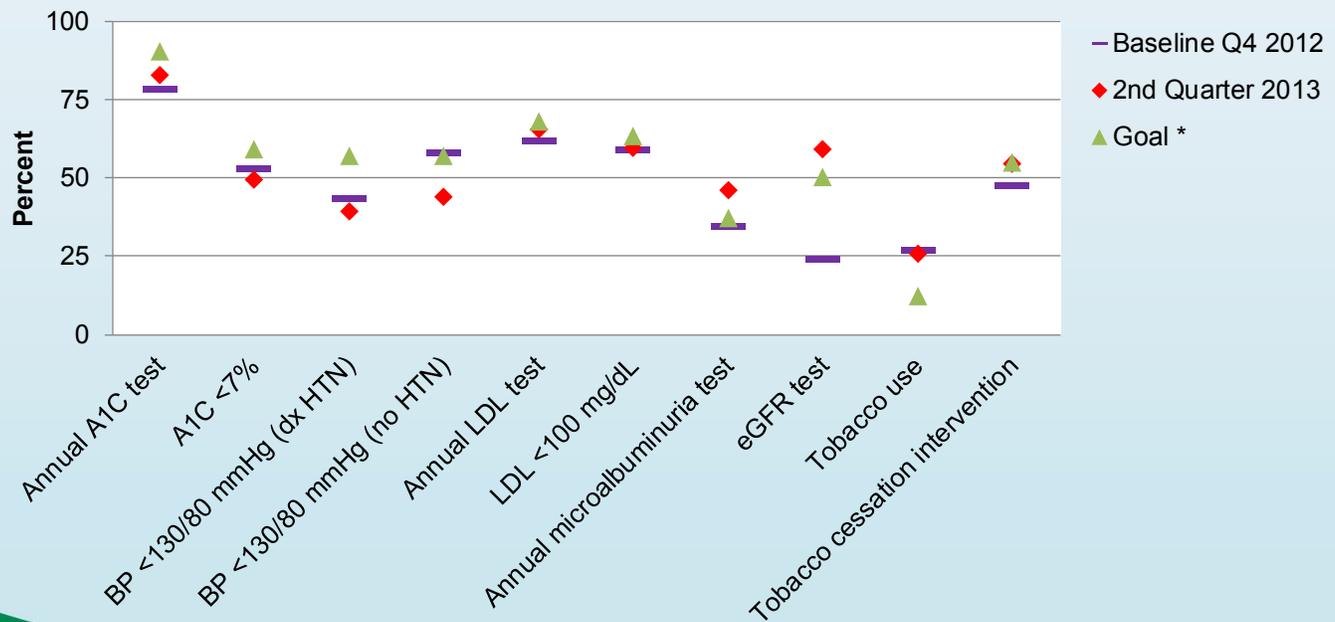


Figure 2. Diabetes care indicators from diabetes self-management education and support programs in Montana participating in the DQCMS, 2nd Quarter (April—June 2013). N = 6 sites; 3,725 patients.



DQCMS = Diabetes Quality Care Monitoring System. Data presented here are for adult patients with diabetes seen within the last year. Montana's statewide quality improvement goals for diabetes were updated in 2013 based upon Healthy People 2020 targets or a 10% improvement from baseline.

# Success Story

## Tracking Diabetes Standards of Care 2008-2013

The Montana Diabetes Program was established in 1994 and is approaching its 20<sup>th</sup> anniversary.

Over the past 20 years, we have seen many changes in the diabetes field; however, our public health goals essentially remained the same:

- Reduce the morbidity and mortality of diabetes and its complications
- Improve the quality of life of all Montanans with diabetes

In 2008, a new goal was added to:

- Prevent or delay the development of type 2 diabetes

The strategies used to obtain these goals include:

- Surveillance of diabetes, complications and risk factors
- Prevention of diabetes and related chronic diseases
- Quality improvement (QI) of diabetes preventive services and clinical care in primary practice
- The Quality Diabetes Education Initiative to increase access to quality diabetes self-management education
- Partnerships to coordinate resources and increase the scope and effectiveness of interventions

In 1997, five primary care practices reported to the Montana Diabetes Program on 689 patients. Today there are up to 45 primary care practices and diabetes education programs reporting on nearly 13,000 patients.

This article identifies the trends in major diabetes care indicators over the past 5 years in relation to the clinical practice goals, and it discusses the QI projects that were conducted by participating sites.

### A1C and Blood Pressure Control

Overall trends in A1C and blood pressure levels are shown from 2008 to 2013 (Fig. 1A). State averages in both A1C and blood pressure levels improved in education sites, but decreased in primary care sites.

To improve A1C levels, two types of QI projects were implemented. The first project used the DQCMS feature that generates “ABC” letters, which include customized action steps to control A1C, blood pressure and cholesterol levels, which were mailed to patients. The second project used an A1C patient education kit developed in July 2011. Participating sites conducted an advanced search in DQCMS to generate a list of patients with an A1C >9%.

These patients were given post cards to send in and request an education kit from the Montana Diabetes Program. The baseline A1C was compared with a 6-month follow-up A1C. A1C improvements were greater among sites that provided intensive education and support compared to those whose patients used the education kit independently and without the support of an educator. The sites that set up specific education sessions with their patients reviewed diet, exercise and lifestyle changes to manage the blood glucose levels. An analysis of outcomes showed significant improvements ( $p<0.01$ ) in A1C levels with mean decreases of 0.2% to 0.4% from baseline to follow-up for the 123 patients from the six participating sites.

To improve blood pressure control, we partnered with the Montana Cardiovascular Health Program on a hypertension QI project to help patients achieve a blood pressure that meets the standards of care targets. We conducted chart audits to identify average blood pressure levels, changes in medications and comorbid chronic diseases as well as distributed blood pressure cuffs for self-monitoring blood pressure.

### Chronic Kidney Disease (CKD) Testing

The CKD QI project was conducted in partnership with Mountain-Pacific Quality Health Foundation and included education for providers and their staff along with a variety of patient educational materials. Education programs showed an improvement in annual albumin testing, but primary care sites showed a slight decline in annual albumin testing. Both education programs and primary care sites showed a significant improvement for eGFR tracking (Fig. 1B).

### Preventive Services: Seasonal Influenza Vaccinations and Comprehensive Foot Exams

QI for increasing seasonal influenza vaccinations is an annual project. DQCMS has a built-in feature to generate vaccination reminder letters. While many patients receive their influenza vaccination from places other than the clinical setting, it can still be promoted by clinicians and documented in a patient history. A targeted project in 2010 supported sites in reminding patients about seasonal influenza vaccinations and documenting their vaccination status. Sites sent out self-addressed post cards to patients asking them to report if they received their

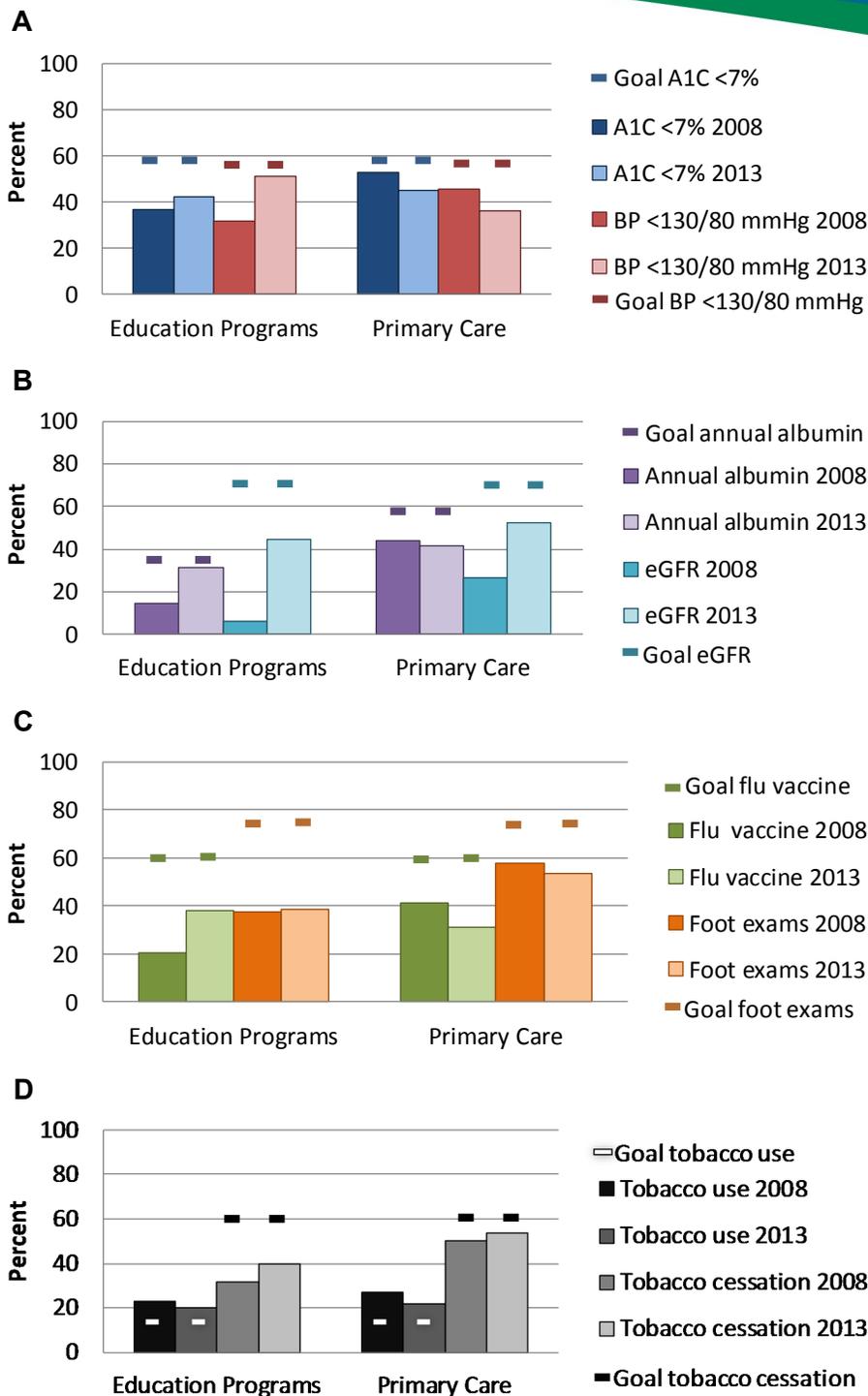


Figure 1. Statewide mean rates in 2008 and 2013 for education programs and primary care in Montana for the following diabetes health indicators: A) A1C and blood pressure at target levels, B) CKD testing, C) annual influenza vaccinations and comprehensive foot exams, and D) tobacco use and cessation counseling.

**More information about using DQCMS for quality improvement is available at [www.risprojects.org/dqcms](http://www.risprojects.org/dqcms)**

seasonal influenza vaccination. The lesson learned was to promote three simple steps: remind, ask, and document for this preventive service. Education sites continued to improve in documenting vaccinations whereas primary care sites decreased over time (Fig. 1C).

The QI project for comprehensive foot exam included on-site staff education and training on how to perform a foot exam. A tip was to have patients remove their shoes at every visit. Education sites showed a small increase, while primary care sites showed a small decrease in this preventive service (Fig. 1C).

### Tobacco Use & Cessation Counseling

This QI project has been ongoing and in partnership with the Montana Tobacco Use Prevention Program to reduce tobacco use and promote tobacco cessation for current tobacco users. Media including TV and radio commercials, billboards, posters and brochures were developed specifically to target tobacco use among people with diabetes. There was an improvement documented in decreased tobacco use and an increase in cessation counseling for both education and primary care sites (Fig. 1D).

### Summary of Findings

This review of major QI activities and trends in health indicators from the past five years shows that although we have made some progress in meeting the standards of care there is still room for improvement. A limitation of the data collection methods are that each data point includes different sites and patients. As sites adopt EHRs, there has been some difficulty in documenting and reporting population-level health indicators and managing double data entry.

We encourage individual sites whose data improved in areas where the state aggregate data did not to consider sharing your approach on how this was achieved within your facility. It is noteworthy that sites with team-based care, where clinicians and educators partner together, often demonstrated improvements in data and patient care.

## Report Highlights

- **The Affordable Care Act: Implications for Diabetes**
- **Diabetes Care Indicators: Primary Care Practices and Diabetes Education Programs**
- **Success Story: Tracking Diabetes Standards of Care 2008-2013**

## Upcoming Events

### Diabetes Advisory Coalition Meeting

January 17, 2014  
Helena, MT

*For more information,  
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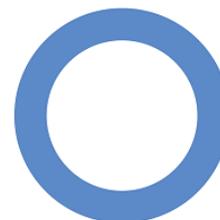
## Online Resources

[www.diabetes.mt.gov](http://www.diabetes.mt.gov)

- Montana Diabetes Program State Plan 2009-2014
- Report on the Burden of Diabetes
- Archived Diabetes Quality Improvement Reports and Surveillance Reports from 1998 to present
- Resources for clinicians, diabetes educators, and schools

## DQCMS Information

[www.risprojects.org/dqcms](http://www.risprojects.org/dqcms)



world diabetes day

14 November

## Announcements

### Welcome to the DQCMS

- Benefis Health System

### Congratulations on ADA-recognition for Diabetes Self-Management Education

- Bozeman Deaconess, Bozeman, MT
- Madison Valley Health Center, Ennis, MT

### Congratulations on NCQA-recognition for the Diabetes Recognition Program

- Bozeman Deaconess Diabetes Center, Bozeman, MT
- Billings Clinic in Billings, Miles City, and Columbus, MT

### CDC Cooperative Agreement Received by DPHHS

- State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health DP13-1305

### Organizations Awarded to Deliver the Montana Cardiovascular Disease & Diabetes Prevention Program

- Central Montana Medical Center, Lewistown, MT
- Community Hospital of Anaconda, Anaconda, MT
- North Valley Hospital Foundation, Whitefish, MT