

How Managed Care Organizations Contribute to Improved Diabetes Outcomes

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Managed care organizations (MCOs) are uniquely positioned to make significant contributions to diabetes care. Most MCOs have information systems that collect various types of data from internal data sources (ie, paid claims), as well as selected external sources (ie, pharmacy benefit management companies, laboratories, and disease management vendors). MCOs aggregate and analyze this data, allowing for the identification and stratification of populations of individuals with certain chronic clinical conditions, such as diabetes. After populations have been identified, MCOs apply various interventions designed to close gaps in care identified by analysis of the data, such as failure to get an HbA1C test or noncompliance with prescribed medications.

The impact on clinical outcomes of these programs, collectively known as disease management programs, depends on a number of things, including:

- *Robustness of the aggregated data*
- *Validity of the algorithms used to identify and stratify the populations*
- *Design of the interventions*
 - Do they target clinically meaningful gaps in care?
 - Do they help foster behaviors that are tied to improved outcomes?
 - Are enough resources deployed to reach a significant number of people who would benefit from the intervention?
- *Cost-effectiveness of the program*
 - If it costs more to intervene than it saves, program funding may be discontinued.

Recently, several papers have questioned the effectiveness of disease management programs, particularly whether such programs impact intermediate outcomes rather than just processes of care.¹ It also has been difficult to establish the financial impact of disease management programs, in part because of the inherent difficulty of trying to establish a mean-

ingful comparator in the real-world business of healthcare. In addition, not enough attention has been paid to systematically improving the efficiency of these programs by eliminating marginally effective interventions (eg, generic educational mailings) and incorporating less expensive, possibly more effective interventions (eg, targeted automated outbound telephonic reminders). Disease management process improvement is beginning to be implemented by some organizations, but there is still room to streamline these programs.

Fostering Innovative Practices

MCOs are in a good position to foster innovations in chronic illness management as illustrated in papers in this issue of the *Journal*. MCOs, particularly staff and group models, have an organizational infrastructure that facilitates design, implementation, and payment for delivery system enhancements that provide a better care experience for individuals with chronic illnesses, such as diabetes. Group visits are one such example.

Group visits allow a cohort of patients with similar conditions to meet on a regular basis over time. Physicians, nurses, dietitians, and/or other health professionals moderate the group visits, provide targeted education, and perform routine health tests, such as blood glucose and blood pressure. The group visit also fosters peer-to-peer learning and support. Group visits are usually longer and occur more frequently than regularly scheduled one-on-one physician visits provided in traditional office practices; therefore, they may not be a viable alternative for all individuals with chronic illness. Group visits result in good patient satisfaction, better clinical outcomes, and a reduction in healthcare utilization.²

Clancy and colleagues, in this issue of the *Journal*, document that group visit patients show reduced emergency department use and lower total charges compared with usual care patients.³ After controlling for endogeneity (the potential of unobserved patient characteristics to affect adherence to the intervention), group visit patients have

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lower outpatient costs, primarily attributable to a reduction in specialty care visits.

Other innovative MCO practices include multidisciplinary visits where diabetic patients can have all of their diabetes-related needs attended to on a one-stop basis with consultation with a cardiologist, neurologist, nephrologist, podiatrist, certified diabetic educator, and/or dietician as needed. Nurse case management,⁴ peer-led support groups,⁵ and same-day appointment protocols⁶ are other delivery system innovations that have been developed and/or honed in MCOs. Because MCOs are organized systems of care that provide healthcare to defined populations within a defined budget, we can anticipate that experimentation and testing of new delivery system designs will continue as MCOs try to balance the need to achieve good clinical outcomes and patient satisfaction with the reality of having to provide care with resource limitations.

Payment Practices That Reward Improvements in Care and/or Outcomes—Pay for Performance

As a significant payer of healthcare, MCOs are able to use a variety of reimbursement schemes to influence practice patterns. The impact of prior authorization and other utilization-related payment rules has been shown to reduce the utilization of targeted drugs or services.⁷ Recently, payment schemes have been developed under the moniker of “pay for performance” (P4P). These programs are designed to pay practitioners a bonus for achieving certain clinical targets, as measured by achievement of standardized metrics. While the jury is still out on the overall impact of P4P programs, I am hopeful that continued experimentation in this arena will lead to a performance-based payment mechanism that can replace, or at least enhance, the current, pay-for-services approach.

Health Services Research

MCOs have contributed to health services research in a number of ways. First, MCOs provide a rich source of data that can be analyzed to assess the effectiveness of practice patterns. Several examples of the usefulness of MCO data appear in this issue of the *Journal*. Young and colleagues used data from a large nonprofit health maintenance organization to design and test the predictive power of a Diabetes Complications Severity Index (DCSI).⁸ Dailey and Strange, in their paper examining hypoglycemic risk of insulin glargine versus NPH in type 2 diabetes, point out that “insurance claims data provide another important source for evaluating not only the incidence of severe hypoglycemic events, but also their economic impact.”⁹ Several of the studies cited in this paper are based on data from MCOs.

A number of MCOs have health services researchers on staff and some even have their own research departments or organizations. Their research has contributed significantly to our knowledge of the effectiveness (or lack thereof) of many medical practices.

Finally, it is important to acknowledge the contributions to diabetes knowledge of the ongoing Translating Research Into Action for Diabetes (TRIAD) study (www.triadstudy.org). TRIAD is a national multicenter study that was created to determine how managed care systems influence the processes and outcomes of diabetes care. Ten health plans and 66 provider groups have participated in the TRIAD study. This collaboration has resulted in the publication of more than 25 high-quality research papers covering the impact of diabetes on individuals as well as many aspects related to the quality of care provided to diabetic patients.

Private Sector Public Health

I believe an area in which MCOs can contribute substantially to improved diabetes care, as well as diabetes prevention, is what I call lobbying for health. By using their individual and collective (eg, America’s Health Insurance Plans) political clout to sway legislators and policymakers on issues that impact health, ranging from the Farm Bill to healthy school foods legislation and improved physical education programs, MCOs can help decrease risk factors that are fueling the twin epidemics of obesity and type 2 diabetes. Many MCOs have community giving programs that are used to support various health-related nonprofit organizations, such as the local chapters of the American Diabetes Association, but few are front and center in the legislative debates over issues that relate to food, school, and work-life policies that could slow and even reverse the prevalence of obesity and diabetes. The potential impact of an organized MCO-driven private sector public health approach to complement our inadequately funded public health system could be enormous.

Conclusion

MCOs have and will continue to contribute to improved diabetes care and diabetes prevention programs.

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