healthfirst

Spectrum of Health

Dear Colleague:

Initiating and maintaining effective treatment plans for adults living with type 2 diabetes mellitus is a challenge. According to the American Diabetes Association (ADA), in 2012, 29.1 million Americans (9.3% of the population) were diagnosed with diabetes. One million seven hundred thousand were newly diagnosed and 8.1 million were undiagnosed. Eighty-six million Americans age 20 and older had prediabetes, with an A1c value of ≥ 5.7% but less than 6.5%. These patients face multiple challenges for which we need your help:

- Too few patients with prediabetes are receiving counseling on the lifestyle changes—7% weight loss and physical activity of at least 150 minutes/week—that can reduce the likelihood of progression to diabetes[i]
- Disparities exist in screening, with asymptomatic ethnic minorities (African Americans, Latinos, Asian Americans, or Pacific Islanders) at high risk for type 2 diabetes—overweight (BMI > 25kg/m^2), physical inactivity, history of gestational diabetes, hypertension, or low HDL cholesterol level)—less likely to be screened based on risk factors than are non-Hispanic white patients[ii]
- Medications such as glucocorticoids and antipsychotics are known to increase the risk of type 2 diabetes[iii]

This Spectrum of Health bulletin is to provide a foundation for you to join me and my colleagues at Healthfirst in identifying and managing patients with prediabetes who are at increased risk for developing type 2 diabetes and for heart disease and stroke, and those with established type 2 diabetes.

What does this mean for you? Implementation of the updated 2014 ADA Clinical Practice Recommendations[iv]

As the trusted physician or PCP for our members, we look to you to motivate and support patient adherence to an evidence-based, holistic treatment protocol that meets the standard of care and achieves control (A1c < 7% for most patients) as quickly as possible. A1c is the primary predictor of complications due to diabetes.

Metformin, if tolerated and if not contraindicated, should be the initial pharmacological agent for type 2 diabetes. Its benefits are well known—metformin is efficacious, safe, inexpensive, and may reduce the risk of cardiovascular events[v].

If the A1c target is not achieved or not maintained over three months with a maximal dose of noninsulin monotherapy, the recommendation is to add a second oral agent, such as a sulfonylurea or a GLP-1 receptor agonist, or insulin. Addition of a new class of noninsulin agents is expected to lower A1c around .9–1.1%.

The medication regimen will include a statin and aspirin for those with a history of CVD, and ACE-I/ARB for patients with hypertension and/or diabetic kidney disease[vi]. There is a strong recommendation that antihypertensive medications be administered at bedtime.

Living with type 2 diabetes is not an easy journey for patients and families, so caring for our members living with diabetes requires innovation, collaboration, and a multidisciplinary approach. Thank you for your partnership in caring for our members.

Warm regards,

Susan J. Beane, MD

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Dear Practice and Quality Administrator:

When it comes to improving the health of patients with type 2 diabetes, you, the practice staff, can be of real assistance to physicians and practitioners. Patients have many concerns when they come into your office but have trouble telling their doctors everything on their minds. Many patients and caregivers of patients with diabetes are reluctant to take medications prescribed to them. **Too many Healthfirst members living with diabetes are missing their medications and not taking them regularly**.

What does this mean for you?

There are three important ways that you can help your patients living with diabetes:

1. Working to ensure that patients have regular appointments;
2. Motivating and supporting adherence to a treatment protocol that meets the standard of care and achieves control for type 2 diabetes. That would be an A1c ≤ 7 for most patients. The medication regimen requires regular refills for their diabetes medicines, their medicine for hypertension and/or kidney disease (ACE-I/ARB for most patients), and their medicine for high cholesterol (a statin); and
3. Inspiring your patients to incorporate the lifestyle changes that can ensure that the medicines are effective. This is critical, and is called managing the metabolic syndrome. The metabolic syndrome is associated with patients who have increases in LDL cholesterol levels, increases in triglyceride levels, an increase in waist size, and an increase in blood pressure.

Managing the metabolic syndrome can improve the patient's ability to respond to diabetes medication and can reduce the number of cardiovascular and other complications. These lifestyle changes include:

- Agreed-upon approach to diet
- Physical activity
- Smoking and alcohol cessation

Finally, patients who receive educational information about diabetes, including informational sessions, may be able to better take care of themselves at home, school, and work. Healthfirst provides useful material on our website at *www.healthfirst.org/get-diabetes-control-life.html*.

If the Network Management and Provider Relations team can be of help in providing more information about this Spectrum of Health bulletin, please do not hesitate to get in touch.

Best wishes,

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SUMMARY OF HEDIS REQUIREMENTS FOR MEASURES RELATED TO IMPROVING COMPREHENSIVE DIABETES CARE

NOTE: ANY MEDICAL RECORD REVIEW OF LAB RESULTS MUST INCLUDE A NOTE INDICATING THE DATE PERFORMED AND THE RESULT OF FINDING

HbA1c TESTING

An HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data or medical record review.

HbA1c POOR CONTROL > 9%

The most recent HbA1c level (performed during the measurement year) is > 9.0%, is missing, or was not done during the measurement year, as identified by claim/encounter or automated laboratory data or medical record review.

HbA1c CONTROL < 8%

The most recent HbA1c level (performed during the measurement year) is < 8.0%, as identified by claim/encounter or automated laboratory data, or medical record review.

HbA1c CONTROL < 7% FOR A SELECTED POPULATION (i.e., removing members with comorbid conditions)

The most recent HbA1c level (performed during the measurement year) is < 7.0%, as identified by claim/encounter or automated laboratory data or medical record review.

EYE EXAM

An eye screening for diabetic retinal disease, as identified by claim/encounter or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eyecare professional (optometrist or ophthalmologist) in the measurement year, or
- A negative retinal or dilated exam (negative for retinopathy) by an eyecare professional in the year prior to the measurement year.

MEDICAL RECORD—At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP, or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eyecare professional, the date the procedure was performed, and the results, or
- A chart or photograph of retinal abnormalities indicating the date the fundus photography was performed and evidence that an eyecare professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

MEDICAL ATTENTION FOR NEPHROPATHY—Measurement met by one or more of the following tests or evidence:

A nephropathy screening test during the measurement year or evidence of nephropathy during the measurement year, as identified by claim/encounter or automated laboratory data or medical record review.

1. Medical record nephropathy screening test—a urine microalbumin test

2. Evidence of nephropathy

Any of the following meet the criteria for evidence of nephropathy:

- Documentation of a visit to a nephrologist
- Documentation of a renal transplant
- Documentation of medical attention for any of the following (no restriction on provider type): diabetic nephropathy, ESRD, CRF, chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), dialysis, hemodialysis, or peritoneal dialysis

3. A positive urine macroalbumin test

4. Evidence of ACE inhibitor/ARB therapy

The most recent BP level (taken during the measurement year) is < 140/90 mm Hg, as documented through administrative data or medical record review.

To learn more about your practice's current HEDIS performance for this or other measures, or for assistance in compliance with the HEDIS guidelines, contact Laisha Washington, VP, Clinical Quality, at 1-212-801-6186 or at LaWashington@healthfirst.org.

Please reach out to our Healthfirst Spectrum Care Management team by calling our toll free number at 1-866-237-0997.

Frequently Asked Questions Regarding Improving Outcomes for Type 2 Diabetes

1. Are there any tips for helping my patients achieve their blood glucose goals?

Help your patients understand what their A1c level means in terms of their average blood glucose. This can encourage honest discussion about their challenges, concerns, and questions concerning blood glucose testing and how to achieve the best level of control. *For example: This means that to achieve an A1c of < 7.0%, preprandial "fingerstick" glucose should be between 70 and 130 mg/dl, while peak postprandial glucose should be < 180 mg/dl.*

2. When should I refer my patient to an endocrinologist?

The ADA guidelines recommend stringent glycemic goals for certain individuals[vii]. For example:

- Newly diagnosed patients and those who are not advanced in age
- Patients who are neither frail nor have advanced atherosclerosis, vascular complications, or major comorbidities and who, therefore, have a long life expectancy
- Patients with low risk for hypoglycemia

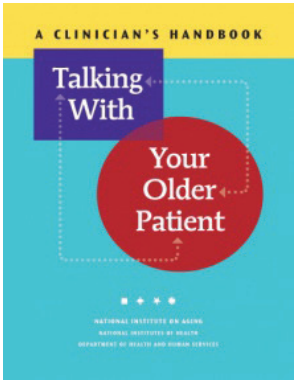
Strongly consider consultation with a diabetologist or endocrinologist for these patients, especially when there is difficulty managing postprandial blood glucose levels.

3. What is an example of a best practice to promote patient adherence to lifestyle recommendations?

Best Practice: Diabetes Information Sessions
A recent study[viii] conducted in New York City demonstrated that information sessions by community health workers, offered to an immigrant population of patients, led to improvements in knowledge about diabetes, exercise and diet to control diabetes, frequency of checking feet, medication compliance, and self-efficacy of health and physical activity. Additionally, there were decreases in A1c, weight, and BMI.

Consider adding to your practice information sessions for patients, giving an overview of diabetes, including myths and facts, disease-specific information, including the following topics: nutrition, physical activity, diabetes complications, stress and family support, and access to quality healthcare.

4. How can I encourage patients and families to adhere to their diabetes treatment plan?



As a first step, Healthfirst recommends that you have a nonjudgmental discussion with your patients and families living with diabetes at every visit. This CMS publication has great scenario-based ideas around enhancing communication for patients both old and young:

"Keep medication plans as simple and straightforward as possible. For example, minimize the number of doses per day. Tailor the plan to the patient's situation and lifestyle, and try to reduce disruption to the patient's routine. Indicate the purpose of each medication. Make it clear which medications must be taken and on what schedule. It is helpful to say which drugs the patient should take only when having particular symptoms.

After proposing a treatment plan, check with the patient about its feasibility and acceptability. Work through what the patient feels may be obstacles to maintaining the plan."

i. American Diabetes Association. Standards of medical care in diabetes—2014. Diabetes Care 2014; 37(suppl 1):S20.
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iii. Erickson SC, Le L, Zakharyan A, et al. New-onset treatment-dependent diabetes mellitus and hyperlipidemia associated with atypical antipsychotic use in older adults without schizophrenia or bipolar disorder. J Am Geriatr Soc 2012; 60:474–479.
iv. professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160.
v. Holman RR, Paul SK, Bethel MA,Matthews DR, Neil HA. 10-year follow-up of intensive glucose control in type 2 diabetes. N Engl J Med 2008; 359:1577–1589.
vi. American Diabetes Association. Standards of medical care in diabetes—2014. Diabetes Care 2014; 37(suppl 1):S27.
vii. Ismail-Beigi F, Moghissi E, Tiktin M, Hirsch IB, Inzucchi SE, Genuth S. Individualizing glycemic targets in type 2 diabetes mellitus: implications of recent clinical trials. Ann Intern Med 2011; 154:554–559.
viii. Islam NS, Wyatt LC, Patel SD, et al. Diabetes Education. Evaluation of a Community Health Worker Pilot Intervention to Improve Diabetes Management in Bangladeshi Immigrants with Type 2 Diabetes in New York City. 2013 July–Aug; 39(4): 478–493.

Paul Isikwe, PharmD candidate from Touro College of Pharmacy, assisted with the writing of this bulletin.