



2007 DIABETES QI FUND PROJECT

The purpose of the HMO Diabetes QI Fund Project is to improve the quality of diabetes care by increasing the percentage of physicians who provide recommended diabetes services and track diabetes care using diabetes flow sheets or electronic medical records. The 2007 goals for the diabetes indicators were:

- HbA1c Control <7.0%: Establish baseline
- Eye Exam: ≥50%
- LDL-C Control <100 mg/dL: ≥50%
- Blood Pressure control <140/90: Establish baseline
- Blood Pressure control <130/80: Establish baseline
- Screening for Depression: ≥55%
- Medical Attention for Nephropathy: ≥65%
- Overall Diabetes Care: ≥15%

In 2007 the population for the Diabetes QI Fund Project increased by more than 10,000 members, (resulting in a >50% increase) by incorporating IPA encounter data. This additional data source identified newly diagnosed members, members who may have been diet controlled, and those members who only had episodic visits to PCP.

The 2003-2007 Network results are outlined in the following table.

Diabetes Indicator	2003	2004	2005	2006	2007
HbA1c Testing	73% (14,084/19,272)	78% (15,335/19,664)	81% (15,381/18,895)	86% (16,201/18,862)	N/A
HbA1c Control <9.0%	N/A	65% (12,738/19,664)	68% (12,905/18,895)	71% (13,454/18,862)	N/A
HbA1c Control <7.0%	N/A	N/A	N/A	N/A	39% (11,369/29,036)
Eye Exam	44% (8,404/19,272)	50% (9,790/19,664)	52% (9,858/18,895)	58% (10,923/18,862)	56% (16,147/29,036)
LDL-Cholesterol <130 mg/dL	60% (11,467/19,272)	68% (13,328/19,664)	74% (14,020/18,895)	76% (14,301/18,862)	N/A
LDL-Cholesterol <100 mg/dL	37% (7,140/19,271)	44% (8,591/19,661)	51% (9,609/18,895)	51% (9,615/18,862)	46% (13,454/29,036)
Blood Pressure Control <140/90	N/A	N/A	N/A	N/A	62% 18,125/29,036)
Blood Pressure Control <130/80	N/A	N/A	N/A	N/A	32% (9,169/29,036)
Screening for Depression	N/A	29% (5,386/18,580)	49% (8,543/18,895)	58% (10,222/17,647)	57% (15,630/27,252)
Medical Attention for Nephropathy	N/A	N/A	66% (12,476/18,895)	75% (14,182/18,862)	74% (21,443/29,036)
2004-2006 Overall Diabetes Care: • HbA1c <9.0% • Eye exam • LDL <130 mg/dL • Medical Attention for Nephropathy	N/A	N/A	30% (5,729/18,895)	36% (6,762/18,862)	N/A
2007 Overall Diabetes Care: • HbA1c <7.0% • LDL <100 mg/dL • Medical Attention for Nephropathy	N/A	N/A	N/A	N/A	20% (5,850/29,036)

Identified Barriers to Diabetes Care:

Members:

- May not be aware of importance of diabetes management in reducing the risks of complications
- May not be aware of national recommendations for diabetes care
- May not be aware that diabetes services (i.e., eye exam, glucose meter supplies, etc.) are a covered benefit
- May be non-compliant with PCP recommendations
- May not seek routine care

Physicians:

- May lack systems to promote recommended diabetic care for members
- May not provide care in accordance with BCBSIL Diabetes guideline
- May find it challenging to cover all the diabetes care services when members are coming in only for acute care

IPAs:

- May find it difficult to motivate physicians to utilize flowsheets or track services in electronic medical records (EMR)
- May find it difficult to get practitioners to routinely screen members with diabetes for depression

Interventions Implemented to Address Identified Barriers:

Members:

- Provided online resources, including Personal Health Manager and Ask a Nurse
- Educational materials were distributed to members identified with a diagnosis of diabetes through quarterly reminder cards. The topics covered in 2007 and the number of members who received the information are summarized in the following table.

2007	Number of Members
Healthy lifestyle	29,954
Diabetes and Kidney Disease	34,511
Hypertension	31,032
Glucose monitoring and meter offer with diabetes program description	29,692
High Strata mailing: Preventive Care – Kidney Disease	4,722

Glucose Meter Program:

- Glucose meters were offered to members identified with a diagnosis of diabetes free of charge through a special mailing. The number of meters distributed in 2007 is summarized below.

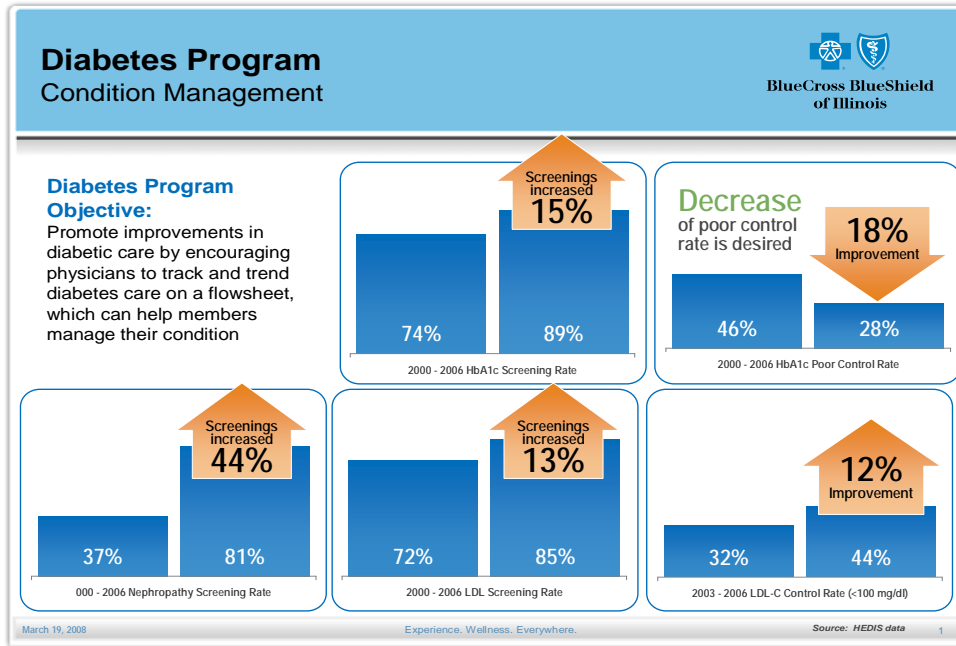
2007	Number of Members
Total Number of Glucose Meters Distributed	2,149

Physicians/IPAs:

- A Diabetes Blue Star was awarded to IPAs meeting at least four of seven payment thresholds.
- A QI Fund payment was made to IPAs with project results that met or exceeded established thresholds.
- The BCBSIL Guidelines for the Prevention and Early Detection of Complications of Diabetes Mellitus were made available to all network physicians.
- A sample flowsheet for tracking diabetes care is available on the Provider section of www.bcbsil.com.
- Quality Improvement staff conducted educational trainings for IPAs as requested.
- The Diabetes QI Project was completed with the QI Fund paid.
- Feedback provided to the IPAs included IPA results, patient specific reports and network results.
- The IPA HMO QI Fund Training was conducted in March 2007.
- The Quality Improvement staff hosted quarterly QI Forums.

The criteria for three indicators from the 2007 Diabetes QI Fund Project became more stringent and results are not trendable. There was one new indicator, Blood Pressure Control; these results are baseline data. Goals were met for seven of the eight indicators. LDL-C <100 mg/dL was slightly below the goal of $\geq 50\%$ at 46%.

2007 HEDIS results (2006 reporting year)



In 2007, a sub-analysis was done for a cohort of diabetic members who had diabetes claims each year from 2002 to 2006 and who were included in the diabetes project each year from 2003 through 2006. There were significant improvements in each of the diabetes quality indicators from 2003 to 2006 for this cohort of members. The Diabetes QI Fund Project has stimulated improvements in quality that are associated with lower utilization and improved the quality of care for members with diabetes. The current analysis has shown that the cohort of diabetic members with most consistently managed diabetes in terms of:

- HbA1c control < 9 in all 4 years (2003 – 2006),
- LDL control < 130 mg/dL in all 4 years (2003 – 2006) and
- Overall Diabetes Care in 2 years (2005 – 2006)

have a 27% to 47% lower likelihood of an ER visit and a 22% to 28% lower likelihood of a hospital admission, compared to those who were not controlled in any of the four years.

The following slide depicts the 5-Year Outcomes from this sub-analysis.

Diabetes Program Outcomes



Outcomes:

For the 9,993 diabetic patients enrolled each year from 2002-2006, those whose diabetes was more consistently controlled **achieved better health outcomes**

