

Building a Coordinated Care Model for Diabetes Management

A significant public health issue with serious medical complications and substantial financial implications, diabetes is the quintessential “poster child” among chronic conditions. The complex nature of the condition presents challenges for patients and their physicians – challenges that are not amenable to single solutions or straightforward treatments. Emerging patient-centered, outcomes-driven, coordinated care models provide the framework for improved clinical quality and cost effective diabetes management.

On October 21, 2009, the Jefferson School of Population Health convened a one-day policy forum moderated by David B. Nash, Dean of the School. The forum focused on care coordination as an effective model for managing care and improving health outcomes for patients with diabetes. Various organizations, programs, and initiatives that demonstrate quality and coordinated care were featured, and perspectives of key stakeholders (e.g., clinicians, administrators, policy experts) were discussed.

Keynote speaker Tom Valuck, MD, JD, Senior VP, Strategic Partners, National Quality Forum, pointed out that care coordination is critical to achieving each of the National Quality Forum’s six National Priorities. He described an ongoing shift in orientation from provider-focused to longitudinal,

patient-focused episodes of care and associated measures to monitor patient level outcomes, processes of care, and cost/resource use.

Richard Baron, MD, of Greenhouse Internists, PC, discussed the promise and pitfalls of implementing the Patient Centered Medical Home (PCMH). Although a Commonwealth Fund study found practices doing well with existing resources, the lack of reimbursement for efforts associated with positive change continues to be an issue for many.

Edwina Rogers, Executive Director of the Patient-Centered Primary Care Collaborative (PCPCC) described the work of PCPCC, a broad based coalition (i.e., providers, purchasers, payers, and patients) dedicated to advancing the PCMH model, gathering information, and publishing guides on model types and effectiveness. To date, 27 multi-stakeholder PCMH pilots have been rolled out in 18 states. In addition, 8 State Medicare pilots are in the planning stages, and 44 states and the District of Columbia have either passed PCMH related legislation or engaged in PCMH activity.

Cyndy Nayer, MA, President and CEO, Center for Health Value Innovation observed that population health and the economy are intrinsically linked. The Center has published *Leveraging Health*, a

book describing “levers and dividends” in value based design. It identifies 107 levers that cause change in consumer behavior.

John Miller, Executive Director, MidAtlantic Business Group on Health, discussed coordinated care from an employer/purchaser perspective, noting that the root of all discussion is return on investment. Attention to health care costs has shifted perceptibly from benefits administrators to CFOs, and value based purchasing has come to the forefront. A health plan assessment tool (eValue8) has been implemented to articulate employer expectations.

Carey Vinson, MD, VP for Quality and Medical Performance Management, Highmark, Inc. described Pennsylvania’s Chronic Care Initiative and shared some early results. An important new parameter gauges the degree to which patients are involved in their care. There is some evidence that patients are beginning to take responsibility for their conditions.

The forum ended with expert panelists Carey Vinson, MD, Andrea Silvey, PhD, MSN, and Samuel Lin, MD, PhD, MBA, MPA, MS responding to questions. ■

Program materials and a video recording for this forum can be accessed at:
http://jdc.jefferson.edu/jsph_diabetes_management/2009/