

Team-Based Diabetes Care Improves Outcomes

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A new team-based approach to care has helped physicians and their staffs in the Abington Physician Network achieve goals for blood pressure, cholesterol levels, and hemoglobin A_{1c} levels in their diabetic patients.

It's not that physicians in the network are working harder or longer, but that they are working with the rest of their staff as a team, said Dr. Keith Sweigard, medical director and chief of internal medicine at Abington (Pa.) Memorial Hospital.

Earlier this year, practices within the Abington network reported performance above the National Committee for Quality Assurance (NCQA) criteria for HbA_{1c} levels, blood pressure, LDL cholesterol levels, and yearly ophthalmology visits. But only a few years ago, Dr. Sweigard declined even to apply for NCQA recognition in diabetes because practices in the network were below criteria in all areas.

What's different now is that the practices have new tools in the form of a team-oriented care approach, he said. Several teams—comprising a physician, office manager, and a nurse or medical office assistant—from the Abington network attended a series of training sessions in team-based care that were provided by the American College of Physicians.

The "Closing the Gap" training sessions, which were held most recently in 2006, focused on elements of the chronic care model, which uses teams of providers rather than relying on individual physicians. The elements of the model include using decision support, providing patients with self-management support, redesigning systems to involve other staff members in providing care, and using clinical information systems.

Following the diabetes training, members of the Abington network returned home with a mission to set clear goals for care and to share their experiences with colleagues. Dr. Sweigard and his colleagues set two networkwide goals to begin the process: controlling both blood pressure and LDL cholesterol levels. Individual practices were then free to choose other benchmarks for their offices, such as HbA_{1c} values; the use of ACE inhibitors and aspirin therapy; yearly podiatric exams; and influenza and pneumonia vaccine administration.

To get to their goals, each office designed its own system and assigned roles for everyone in the practice, from the receptionist to the physician. For example, in some practices, the receptionist places a green dot on the charts of all diabetic patients. Other ideas included having the medical office assistant or nurse ask diabetic patients to remove their shoes and socks before the physician sees them, thereby prompting the physician to perform a foot exam.

The members of the Abington network achieved their goals with room to spare:

- ▶ NCQA criteria call for 80% of patients to have an HbA_{1c} less than 9%; nearly 90% of Abington patients have achieved that goal.
- ▶ According to NCQA criteria, at least

36% of patients should have LDL cholesterol levels less than 100 mg/dL; 65% of Abington patients do.

- ▶ Yearly ophthalmology visits should be completed by 60% of patients, according to NCQA; 78% of Abington patients now see their eye doctor annually.

- ▶ NCQA criteria require 65% of patients to have blood pressure less than 140/90 mm Hg; in the Abington network, 89% have blood pressure lower than that.

But one process does not fit all. Larger


practices that have more than 10 physicians plus phone operators, managed-care coordinators, nurse practitioners, and office managers may take one approach, whereas physicians with solo practices will need a different one.

For those in solo practice, Dr. Sweigard recommended collaborating with other physicians to share what works and what does not. In the case of smaller offices, one person may have multiple roles, whereas the challenge in a large office is making

sure communication is clear, he said.

One of the lessons learned by studying practices as they go through these changes is that physicians need to delegate responsibility to the rest of the staff, said Dr. Vincenza Snow, director of clinical programs and quality of care at the American College of Physicians.

Although this can be a difficult transition for physicians, the staff is usually eager to take on responsibility when it comes to improving clinical care, Dr. Sweigard said. ■



High expectations

for lowering

very high triglycerides (≥ 500 mg/dL)

Important Safety Information:

1. LOVAZA is contraindicated in patients who exhibit hypersensitivity to any component of this medication.
2. Before instituting LOVAZA therapy, it should be confirmed that TG levels are consistently abnormal.
3. LOVAZA should be used with caution in patients with known sensitivity or allergy to fish.
4. The patient's TG, LDL-C and ALT levels should be monitored periodically during LOVAZA therapy. In some patients, LOVAZA increased LDL-C. LOVAZA therapy should be withdrawn in patients who do not have an adequate response after 2 months of treatment.
5. Some studies with omega-3-acids demonstrated prolongation of bleeding time, which did not exceed normal limits and did not produce clinically significant bleeding episodes. Patients receiving treatment with both LOVAZA and anticoagulants should be monitored periodically.
6. There are no adequate and well-controlled studies in pregnant women. Use LOVAZA during pregnancy only if the potential benefit justifies the potential risk to the fetus; and use with caution when administering LOVAZA to breastfeeding women.
7. LOVAZA was well-tolerated in controlled studies. The most common adverse events reported were: eructation, infection, flu syndrome, dyspepsia, rash, taste perversion, and back pain.
8. Please see full prescribing information.

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