The Need to Focus on Diabetes

Marilyn Staniland, CDE, MBA, MSN
Executive Director, Field Medical Affairs West
AGENDA

1. Current state of diabetes
2. Stages of the disease continuum & interventions
3. Barriers to diabetes treatment
4. Importance of two specific NDHI components
Why we need to address diabetes – Human Toll

- 29.1 million with diabetes
  - 8.1 million are undiagnosed
- 86 million with prediabetes
  - One in eight knows they have it
- By 2050, one in three Americans will have diabetes
Why we need to address diabetes – Economic Toll

- Diabetes costs the U.S. $322 billion annually
- 1 in 3 Medicare dollars is spent on people with diabetes
- Healthcare costs are 2.3 times higher for people with diabetes
Despite Improvement in Glycemic Control, 48% of Patients Are Not at ADA A1C Goal of <7%

Figure adapted with permission.
Gaps in the quality of diabetes care persist: treatment goals

% of diabetes patients who met treatment goals from 2006-2009

- Another analysis found that complications resulting from inadequate control of these parameters may account for as much as 20% of total diabetes spending

Defined Goals: A1C<7%; BP<130/80 mmHg; LDL-C<100 mg/dL; Composite: Combined all three

Why aren’t patients achieving their goals?

**DIABETES MYTHS**

- Language barriers
- Poor family support
- Needles phobia
- Injection anxiety
- Poor social support
- Poor health literacy
- Patient-physician disconnect
- Myths about insulin
- Dietary customs
- Myths about insulin
- Insurance coverage
- Physician lack of knowledge

**FEAR**

- Fear
- Cost

**LANGUAGE BARRIERS**

- Language barriers
- Cost

**CULTURAL BELIEFS**

- Cultural beliefs
- Time

**TIMES MYTHS**

- Timeliness

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**Component 1.2:** Comprehensive care planning should include the use of care coordinators to address the multitude of daily issues facing persons with diabetes.

- Assess treatment adherence
- Coordinate with providers about patient treatment needs
- Provide health education
- Manage care transitions
- Reduce hospital readmissions
High Adherence is Associated with Lower Diabetes Related Medical Costs and Hospitalization Risk

Diabetes-Related Medical Care Costs

- 1-19: $8,812
- 20-39: $6,959
- 40-59: $6,237
- 60-79: $5,887
- 90-100: $3,808

* Indicates a value that is significantly higher than the 80 – 100% adherence group (p< 0.05)


Diabetes-Related Hospitalization Risk

- 1-19: 30%
- 20-39: 26%
- 40-59: 25%
- 60-79: 20%
- 80-100: 13%

* Indicates a value that is significantly higher than the 80 – 100% adherence group (p< 0.05)
Improving Adherence and Outcomes in Individuals with Diabetes and Depression

- 12 week- Randomized Controlled Trial (n=180)
- Intervventional group vs Usual Care
- Inclusion Criteria:
  - Type 2 Diabetes Mellitus and Depression
  - Current antidepressant therapy and oral hypoglycemic agent
- Interventional Group:
  - Integrated care manager as supplement to primary care visits
  - Addressed patient level non-adherence factors such as depression, chronic medical conditions, function, cognition, social support, cost of medications, side effects, and past experiences with medications

Improving Adherence and Outcomes in Individuals with Diabetes and Depression

Patients who received the intervention were more adherent to OADs

Patients who received the intervention were more likely to achieve A1c < 7%

* p < 0.01   ** p < 0.001
Manage Care Transitions

- To improve transitions of care, efforts have been made to re-engineer the discharge process via a variety of interventions

- One classification of interventions includes
  - **Pre-discharge interventions**
    - Patient education, discharge planning, medication reconciliation, scheduling a follow-up appointment¹
  - **Post-discharge interventions**
    - Follow-up phone calls, communication with ambulatory health care providers, home visits¹ and Telemonitoring²
  - **Bridging interventions**
    - Transition coaches, patient-centered discharge instructions, physician continuity between inpatient and outpatient settings (i.e., transition clinics)¹

**Component 2.1:** Care planning should promote screening and identification of risk factors for patients all along the disease spectrum.

<table>
<thead>
<tr>
<th>2008 USPSTF risk factors</th>
<th>2015 USPSTF risk factors</th>
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<tbody>
<tr>
<td>High blood pressure</td>
<td>40-70 &amp; overweight/obese</td>
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<tr>
<td></td>
<td>Family history</td>
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<td></td>
<td>GDM or PCOS</td>
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<td>Ethnic/racial minority</td>
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New USPSTF guideline
Details and Implications

• Health plans must cover cost of screening test with no co-pay
• USPSTF guideline is now more closely aligned with ADA and other guidelines, which means less confusion at the practice level.
• A1c is now recognized as a valid screening test: “Because hemoglobin A1c measurements do not require a fasting state, it is more convenient than using fasting plasma glucose or the oral glucose tolerance test.”
• For the first time ever, USPSTF recommends screening for prediabetes.
• Lifestyle intervention is recognized as evidence-based resource and the “first line of therapy for the prevention of IFG, IGT, and diabetes”
New USPSTF guideline
Millions More Could Get Screened

Source: Analysis by Tim Dall for NNI, IHS Global insights, November 2014, Based on study published in American Journal of Preventive Medicine
Thank You
masd@novonodrisk.com