Advancing Care

with NCQA's Diabetes Recognition Program

NCQA's Diabetes Recognition Program (DRP) Summit:
Leaders Advancing Quality of Care for Patients with Diabetes
May 18, 2012, Washington, D.C.

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Introduction to the DRP

Providing Quality Diabetes Care: The Diabetes Recognition Program

Diabetes poses a major healthcare challenge in the United States. The disease leads to many serious complications, including kidney failure, limb amputation, blindness, heart disease, and stroke—and it's the nation's seventh leading cause of death. The CDC estimates that in 2010, 8.3% of the U.S. population was affected by diabetes—including 11.3% of people 20 years and older and 26.9% of people 65 years and older. That's 25.8 million people[1]—up from an estimated 23.6 million people, or 7.8% of the population, in 2007.[2] In addition, the CDC estimated that in 2010 approximately 35% of Americans 20 years and older (79 million) had prediabetes—which means they are at risk for developing type 2 diabetes and cardiovascular disease.[1] Unfortunately, the treatment of individuals with diabetes often falls short of the recommended guidelines. For example, while the rates of HbA1c screening and attention for nephropathy has improved over the past several years, LDL cholesterol screening has decreased. The percentages of patients with diabetes receiving the recommended eye exams have increased, but they are still low (i.e., ranging from 45.5% in commercial PPOs to 64.6% in Medicare HMOs in 2010).[3]

In 1997, the National Committee for Quality Assurance (NCQA) and the American Diabetes Association (ADA) developed the Diabetes Physician Recognition Program to provide physicians with tools to support the delivery and recognition of consistent, high quality care. The Diabetes Recognition Program (DRP) was developed to "recognize clinicians and groups that deliver excellent care to people with diabetes."[4] For the DRP, licensed clinicians—physicians (M.D., D.O.), nurse practitioners, and physician assistants—volunteer to submit a sample of their patient records, which are assessed on 10 nationally accepted evidence-based measures, including both process and outcome measures. Clinicians who score at least 75 points receive DRP recognition for 3 years.

DRP Measures For Adults (Patients 18–75 Years)[4,6]

DRP measure	% of patients in sample required to earn points*	Points earned
HbA1c: Poor control (>9%)	≤15%	12
HbA1c: Control <8%	60% ➔ 65% (July 2012)	8
HbA1c: Control <7%	40%	5
Blood Pressure: Poor control ≥140/90 mm Hg	≤35%	15
Blood Pressure: Control <130/80 mm Hg	25%	10
Eye Examination	60%	10
Smoking Status and Cessation Advice or Treatment	80% ➔ 85% (July 2012)	10
LDL: Poor control ≥130 mg/dl	≤37% ➔ ≤35% (July 2012)	10
LDL: Control <100 mg/dl	36% ➔ 50% (July 2012)	10
Nephropathy Assessment	80% ➔ 85% (July 2012)	5
Foot Examination	80%	5
	Total Points Possible:	100
	Points Needed for DRP Recognition:	**75**

*Effective July 1, 2012, the NCQA strengthened the rigor of some of the DRP measures by changing the percentage of patients who must meet the threshold requirement.[6]

There are numerous advantages to the DRP's methodology for assessing excellence in diabetes care. A Composite quality assessment approach enables a small patient sample size to yield improved statistical significance by bundling multiple metrics from each patient.[12] The scoring system does not expect "perfection"- for instance, credit is given to physicians to meet the criteria for minimizing poor HbA1C control (>9%) by defining it as having no more than 15% of the sample population with an HbA1C >9%. This helps makes the measurement process more relevant for physicians and increases buy-in. Finally, the composite system allows for individual metrics to be updated as new evidence arises. The concern that metrics, in general, are transient due to changes in medical evidence is mitigated by the fact that multiple metrics are used in the composite approach. If one metric is "out of date", chances are that the vast majority are still timely, thereby minimizing the impact of the "out of date" metrics in between guideline updates.

Does DRP Recognition Make a Difference?

According to a retrospective analysis of claims from a database of approximately 14 million commercially insured members in the United States, patients with type 2 diabetes who saw DRP-recognized physicians had more office and outpatient visits and fewer inpatient and emergency department visits than those patients who saw non–DRP-recognized physicians.

In addition, patients managed by DRP-recognized physicians were prescribed more oral antihyperglycemic drugs and statins. Not surprisingly, with fewer emergency room and inpatient visits, the annual healthcare costs for patients managed by DRP-recognized physicians were lower.[5] Based on an annual per patient savings of $673, a million-member plan with a 15% rate of diabetes would save more than $100 million a year.

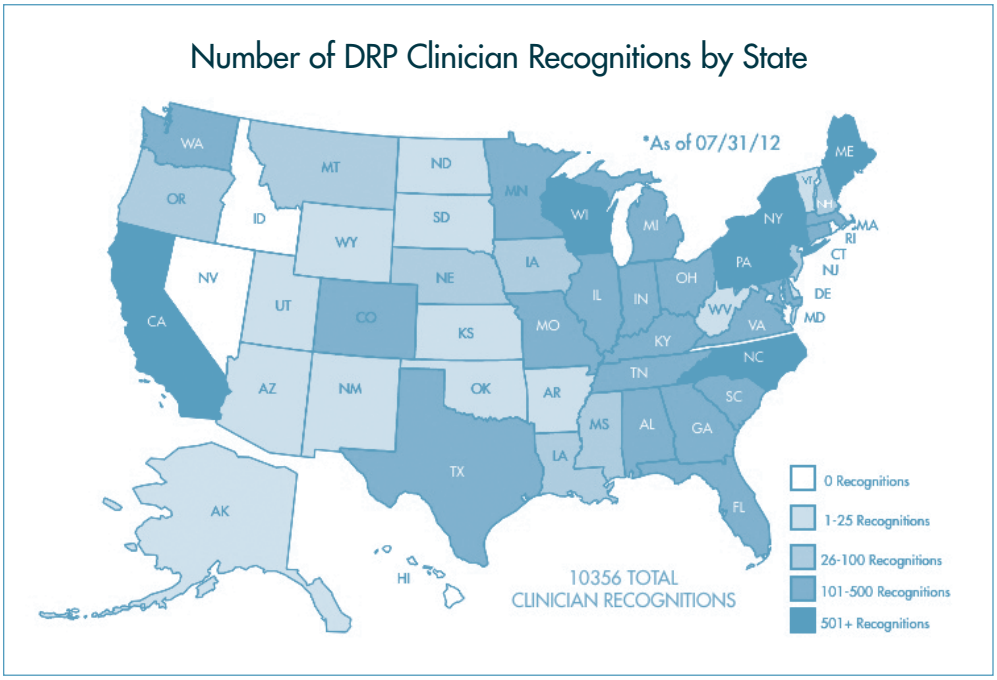
Impact of DRP-Recognized vs. Non–DRP-Recognized Physicians[5]

Comparison Aspect per patient per year (PPPY)	Patients managed by DRP-recognized physicians (N=3,836)	Patients managed by non–DRP-recognized physicians (N=4,175)	P-value
Office Visits	4.69	4.44	P < .001
Outpatient Visits	0.93	0.85	P < .001
Inpatient Visits	0.08	0.10	P = .02
Emergency Department Visits	0.04	0.07	P < .001
Oral Antihyperglycemic Prescriptions	5.84	5.52	P < .001
Antihypertensive Prescriptions	7.46	7.60	P = .02
Statin Prescriptions	2.81	2.68	P = .003
Diabetes-related healthcare expenditures	$3,424		
$4,097–$3.424 = $673 PPPY			
$673 savings x 150,000 (1 million members @ 15% diabetes rate) = $100,950,000 savings			

Clinician Participation in the DRP

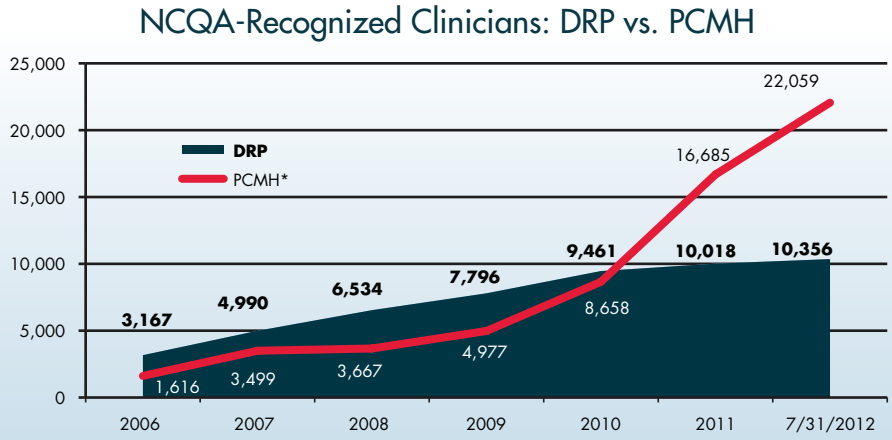
According to this NCQA map, as of July 31, 2012, there were 10,356 clinicians recognized by the DRP. DRP recognition is for 3 years; therefore, clinicians must submit new data to maintain their recognition status. Idaho and Nevada previously had recognized clinicians, but thus far they have failed to reapply for recognition.

DRP-Recognized Clinicians as of July 31, 2012



Participation in the DRP has certainly increased since the program's inception in 1997; however, recent increases have been modest. For example, DRP clinician recognitions increased only 6% from 2010 to 2011, compared to NCQA's programs related to the patient-centered medical home (PPC, PPC-PCMH, and PCMH), which nearly doubled in 2011. As of the same date in July 2012, there were more than twice as many clinicians recognized by the PCMH programs than by the DRP. One concern about participation reported by NCQA is that more than 2,000 DRP recognitions expire every year.

NCQA-Recognized Clinicians, 2006–2012: DRP Vs. PCMH



*In this chart, PCMH includes all related NCQA recognition programs: PPC, PPC-PCMH, and PCMH.

To identify potential ways to accelerate the positive impact of the DRP, the NCQA hosted the *DRP Summit: Leaders Advancing Quality of Care for Patients with Diabetes* (the "Summit") in Washington, D.C., on May 18, 2012. The Summit was funded by a grant from Sanofi, a supporter of the DRP since 2009, through its Partners in Patient Health (PiPH) division. By focusing on critical health issues such as diabetes, PiPH strives to help improve the health of patients by connecting people, ideas, and solutions—networking with advocates representing national patient, provider, payer, quality, science, and innovation groups. In addition to representatives of NCQA and Sanofi's PiPH, the Summit was attended by a dozen healthcare leaders, including clinicians, from medical groups, business coalitions, and other health organizations.

MAY 2012 DRP SUMMIT LEADERS

Kathy Brieger, MA, RD, CDE
Hudson River HealthCare (HRHCare)

Randall Curnow, MD, MBA, FACP, FACHE, FACPE
Summit Medical Group

TJ Dube
Health Improvement Collaborative of Greater Cincinnati

Ronald Harris, MD
Endocrinologist Geisinger Health System (formerly with Geisinger Health Plan)

Nan Holland RN, BSN, MPH, CPHRM
Novant Medical Group

Tom Knight, MD
St. David's Healthcare (formerly at Novant Medical Group)

Karen Linscott
National Business Coalition on Health

Jacqueline Martinez
New York State Health Foundation

John Miller
MidAtlantic Business Group on Health

Mindy Smith, BS PHARM, R.PH.
American Pharmacists Association (APhA) Foundation

Melissa Stewart, DNP, RN, CPE
Organization of Patient Educators

Dennis Urbaniak
Sanofi

Ron Whiting
Wichita Business Coalition on Health Care

Challenges to Augmenting the Impact of DRP Recognition

There are some healthcare organizations that have embraced the DRP process and incorporated it into their standard operating procedures. Randall Curnow, Executive Vice President and Chief Medical Officer for Summit Medical Group in Tennessee, said his organization, as part of its quality improvement initiative, uses the DRP process to evaluate every one of its physicians, every year. Jacqueline Martinez, Senior Program Director at the New York State Health Foundation, said the foundation chose the DRP as part of its program to improve the clinical management of diabetes in her state because the DRP is based on patient outcomes. But in other organizations and areas, the DRP has not yet been valued and adopted as a tool for improving the quality of care provided to patients with diabetes.

Jacqueline Martinez:

"Our goal is to get 3,000 providers recognized by 2013. We have 1,200 so far."

The Summit panel identified the following challenges to augmenting the impact of the DRP:

- Lack of clinician awareness:
  - Clinicians aren't aware that their performance could be improved.
  - They aren't aware of the benefits of DRP recognition.
  - They don't understand the requirements of DRP recognition.
  - They don't realize the synergy between the DRP and other initiatives.
- Burden of data collection and submission on clinician offices ("hassle factor"):
  - Clinician offices don't have the manpower to handle tasks beyond the normal workflow. They need to avoid rework and duplication of work.
  - Many offices don't have adequate technology, including electronic medical record (EMR) software, to track and retrieve patient data.
- Inconsistent support and conflicting incentives from other stakeholders:
  - Clinicians usually work with multiple payers (e.g., state Medicaid organizations, commercial health plans, employers). When each payer has its own separate quality incentive program, clinicians have to deal with multiple sets of requirements.
  - Payers' quality recognition programs tend to change every few years.
  - Although diabetes programs are widespread, many organizations' efforts in diabetes do not include the DRP or collaboration with NCQA.
  - While some payers provide incentives related to recognition programs, some may provide incentives for the initial 3-year recognition but not subsequent recognitions.
- Exclusion of specialists and other care team members from the DRP
- Need for better patient engagement and self-management

To overcome some of these challenges, the Summit leaders discussed the following approaches:

- Educate clinicians and employers about the DRP to increase participation.
- Educate consumers about the DRP so they know to look for DRP-recognized clinicians.
- Work with additional stakeholders, including associations, EMR vendors, and pharmacists.
- Consider expanding the DRP to other provider types.
- Help with patient engagement (e.g., communication training, health literacy tools).

Educate Clinicians About the DRP

Ron Whiting, Executive Director at the Wichita Business Coalition on Health Care, commented that clinicians need to become aware that there's a problem with the quality of their performance before they will be interested in doing anything differently. He said the clinicians in the Wichita area don't believe they need to do anything differently than they are now. He said only two clinicians in Kansas are DRP-recognized—not because the clinicians aren't providing good care but because they aren't interested in the recognition. They need to understand that there's some benefit in it for them before they'll pursue DRP recognition.

Benefits of DRP Recognition

Clinicians could be encouraged to participate in the DRP program by educating them about the benefits of recognition. Each of these benefits will resonate with some clinicians more than others, but all clinicians should find something appealing in this list to get them to look into the program.

DRP RECOGNITION: BENEFITS FOR CLINICIANS

Improved patient outcomes

Positive publicity with consumers, payers, and peers

Credit toward maintenance of certification

Financial incentives

Step toward NCQA PCMH recognition

Improved Patient Outcomes

Most importantly, by pursuing DRP recognition, clinicians could improve the health of their patients with diabetes. Nan Holland, Senior Director of Clinical Resource Services for Novant Medical

Nan Holland:

"I think that the DRP is really right at the point of care, it's right where the patients live, and it's critical that we get there."

Group, said pursuing a higher rate of DRP recognition gave Novant a great opportunity to closely look at its provision of evidence-based care and enable it to provide better care. It was suggested that clinicians share their stories about how they provide better patient care because of the increased attention with the DRP process.

Tom Knight, Senior Vice President and Chief Medical Officer at St. David's Healthcare, a six-hospital system in Texas, said clinicians provide great care primarily because they want to help their patients. He commented that people with diabetes are the most difficult patients that clinicians see: the patients have multiple co-morbidities, and their health is highly dependent on their level of engagement (i.e., their self-management skills and disease knowledge). He said clinicians would gladly do "the right thing" for these patients—if we can make "the *right* thing to do the *easiest* thing to do" (e.g., with better point-of-care tools and support systems). And as engaged patients experience positive health outcomes, their example could encourage better engagement and more positive outcomes for other patients.

If clinicians think they're already doing the best they can with their patients, comparative performance reports could shed a different light. Even if patient outcomes are deemed satisfactory, clinicians may be enticed to participate in the DRP by the additional benefits described below.

Positive Publicity with Consumers, Payers, and Peers

When recognized by the DRP, clinicians are listed on the NCQA website. Lists of recognized providers are also communicated to health plans, employers, and consumers through various media, including local newspapers. Melissa Stewart, Executive Director at the Organization of Patient Educators, suggested a website and a smartphone application enabling patients to easily look up recognized providers in their area. The DRP recognition can also help clinicians when they are contracting with health plans and other payers, showing that they provide quality care.

Clinicians are often competitive by nature. Simply having peers publicized as DRP-recognized could drive clinician interest in the program. For example, when a physician group in Kansas City put up a billboard announcing that they had received the recognition, the billboard created a lot of interest among other clinicians.

Credit Toward Maintenance of Certification

With recognition, clinicians may be able to get credit toward their maintenance of certification with their medical specialty board (e.g., American Board of Family Medicine). Nan Holland said both states and clinicians in her region were much more engaged after learning that DRP recognition could provide credit for the performance improvement module for their maintenance of certification. DRP would gain additional momentum if the American Board of Internal Medicine provided direct recognition, as well.

Medical boards have different approaches toward the use of DRP recognition and data. Clear communication regarding how the DRP recognition and/or data can be used with each board's recertification process may be helpful information for clinicians and drive their interest in DRP recognition.

Financial Incentives

Many health plans offer clinicians rewards for DRP recognition, including financial incentives such as higher reimbursement rates and payment of the clinicians' DRP application fees. Kathy Brieger, Chief of Human Resources at Hudson River HealthCare (HRHCare) and Executive Director of the Planetree HRHCare Training Institute, pointed out that health plans will sometimes pay the application fee for the initial DRP recognition but not subsequent recognitions. She said that is a factor in why some clinicians don't apply again after their initial 3-year recognition. NCQA's participant surveys have confirmed this: When asked what would influence them to renew, the majority of clinicians stated simply, "Incentives."

Kathy Brieger, on why clinicians don't reapply after initial DRP recognition:

"When we survey them: a lack of incentive. They received an incentive for coming through the first time, and it was no longer there."

Randall Curnow:

"We went from 40% of our doctors to 75% of our doctors in a year, and there was only one variable and that alignment with physician compensation."

Several of the leaders agreed that health plans are an important link, motivating providers with their reward programs. They said health plans are paying a lot more attention to accountability and the quality of care clinicians provide than they have in the past, so this is a good time to approach plans on this topic. Nan Holland said there is a lot more payer interest in NCQA recognitions in the last 6 months than there has been in the past. Jacqueline Martinez said the New York State Health Foundation has had four payers agree to do pay-for-performance programs centered around DRP recognition, and the programs have been working well.

One challenge with payer programs is inconsistency. As clinicians usually work with multiple payers, having multiple incentive programs can be confusing and create more work; the programs may also conflict. The group said there needs to be consistency across payers regarding incentives. Jacqueline Martinez said her organization struggles with competing with what the New York Medicaid organizations are doing (e.g., their incentives for medical home recognition). If possible, incentives should be built into payer processes and systems, rather than adding another layer.

In addition, the DRP can help clinicians earn financial incentives through quality-focused programs offered by other organizations. For example, using the DRP data system may help clinicians submit their Medicare quality data to the Centers for Medicare & Medicaid Services (CMS), through the Physician Quality Reporting System (PQRS).[7] Most certainly,

the work clinicians do to meet the DRP requirements would qualify them for incentives from PQRS and programs such as Bridges to Excellence. Unfortunately, the same data submission cannot be used for DRP and PQRS assessment. Effective in 2011, CMS changed its PQRS requirements so that data can be submitted for Medicare fee-for-service (FFS) patients only—requiring a data collection separate from the DRP data for NCQA.[8]

John Miller, about physicians' attitude toward health plans:

"They hate the idea of cooperating with this monolithic bean-counter entity that abuses and disrespects them."

Financial incentives don't work for all clinicians, however. John Miller, Executive Director at the MidAtlantic Business Group on Health, said despite incentives offered by health plans, his area saw very poor uptake of the DRP. According to focus groups the coalition conducted with the physicians, the larger groups that did get recognized were unaware of any financial incentives: that is not why they pursued recognition. He reported that physicians in these focus groups disliked the health plans and complained that the health plan programs change year to year. Likewise, Novant Medical Group had 85% of its primary care physicians recognized in the DRP before any incentives were implemented.

Step Toward PCMH Recognition

The steps necessary for clinicians to achieve DRP recognition correspond with the requirements of NCQA's patient-centered medical home (PCMH) recognition program. In fact, as explained during the Summit, clinicians can use their DRP recognition in their pursuit of NCQA PCMH recognition. If 75% of the clinicians within a practice are DRP-recognized, that recognition can provide the practice with credit toward factors within these seven elements of the PCMH program:

- **3A:** Implement evidence-based guidelines
- **3C:** Care management
- **6A:** Measure performance
- **6C:** Implement continuous quality improvement
- **6D:** Demonstrate continuous quality improvement
- **6E:** Report performance
- **6F:** Report data externally

For those individuals and groups with neither recognition yet, the majority of the Summit leaders believed the most sensible order would be to pursue DRP first and then PCMH. They thought DRP recognition would be easier to achieve—and then could help with the PCMH recognition, as described above. They also thought this was the order usually followed in the real world, although some exceptions (e.g., HRHCare) were mentioned. The New York State Health Foundation is communicating to clinicians that DRP is a step toward PCMH recognition.

There is also good news for those practices that have already achieved PCMH recognition but have not yet pursued DRP recognition. Jacqueline Martinez commented that DRP recognition should be easy for clinicians after PCMH "because they've done all that's necessary in terms of the process of care." For example, once a practice has implemented evidence-based diabetes guidelines (PCMH Element 3A), the practice can audit each clinician for achievement of the DRP thresholds. In addition, the DRP data can demonstrate to providers that all the process improvements they make to achieve the PCMH recognition result in not only decreased waste of healthcare resources but also improved patient outcomes.

Regardless of which recognition is pursued first, it's valuable for providers to be aware of the linkages between the programs. The Summit leaders pointed out that it's likely that different staff members would be working on the DRP and PMCH recognition steps—or, in a small practice, the same person may be working on both but would be so overwhelmed that he or she wouldn't make connections between the two programs. TJ Dube, Manager of Performance Measurement and Quality Improvement for The Health Improvement Collaborative of Greater Cincinnati ("the Collaborative"), said the Collaborative has created materials to educate clinicians regarding the linkage between the two recognition programs and to provide clinicians with resources to help them in their pursuit of recognition.

It may be helpful to compare DRP and PCMH recognition lists to see which clinicians are already recognized by both programs and which could be engaged on one or the other. Perhaps NCQA could ask clinicians why they chose to pursue one or the other recognition first.

A note about ACOs: The newest NCQA accreditation program—for Accountable Care Organizations (ACOs)—was mentioned during the Summit. The general consensus seemed to be that there needs to be more time for PCMH to grow and ACOs to be tested before any real consideration can be given to ACOs and their potential impact with the DRP. For the most part, PCMH and ACO were considered together for purposes of the Summit discussion.

TJ Dube:

"I don't think people recognize enough that these are building blocks into each other."

Ron Whiting:

"What good is the designation for PCMH or ACO if you cannot achieve DRP recognition?"

DRP Requirements

The Summit leaders said clinicians have a lot of misconceptions about the DRP requirements. To address the "hassle factor" of the recognition process, clinicians need to be educated as to what exactly the program requires.

John Miller: Focus groups conducted by his coalition revealed that small practices are

"woefully ignorant… They thought you had to have an electronic medical record. They thought you had to submit 100 patients. They thought it took a week or two weeks of a person's effort to put this stuff together and submit it…. They thought that the information came from claims data, not from chart data."

They May Be Doing Much of It Already

As discussed earlier, the DRP measures overlap with other quality incentive programs. Perhaps the most pervasive of the quality-focused initiatives is the Health Care Effectiveness Data and Information Set (HEDIS), which is used by most U.S. health plans to measure the care and service of healthcare providers. The DRP outcome and process measures are consistent with the HEDIS comprehensive diabetes care measure; therefore, clinicians may already be pursuing the goals included in the DRP.

There's Not Much Risk

Some clinicians have complained that it costs a lot to participate in the DRP. According to the June 2010 pricing sheet, the license fee for NCQA's web-based data collection and submission tool used for the DRP (known as the "Data Collection Tool" or "DCT") is $80 per practice site. When a clinician is ready to submit data and apply for recognition, there's a $500 application fee per clinician, capped at $3,000 per practice up to 100 clinicians.[9]

Another challenge mentioned during the Summit was clinicians who won't pursue recognition if they don't think they'll succeed—simply because they don't want to fail at anything. However, after licensing the DCT, clinicians can complete a "readiness evaluation" to confidentially estimate their scores before they apply to have NCQA review their data. They would not pay the application fee until they decide they are ready for the formal DRP review.[4]

It Needs to Be Easy

The requirements of the recognition program need to be integrated into the normal flow of the physician office, to avoid any kind of rework or duplication of work. Ronald Harris, an endocrinologist with the Geisinger Health System, said the best way to do that is to work with the other members of the care team, as the physicians don't typically remember to deal with all the tests, etc., that are tracked in the DRP.

Ron Harris:

"You talk to the nurses—encourage them to document the foot exam as well as check the boxes for microalbumin and the A1c, so the doctors don't have to do those. The nurses do the chronic care while the doctor does the acute intervention."

The MidAtlantic Business Group on Health conducted some focus groups and found out that patient records were a mess. The coalition developed a chart insert with a treatment algorithm based on physician input (including early insulin use) and a patient visit checklist

of all the guideline elements. The coalition hoped this would prompt doctors to adopt an EMR system—to avoid the rework of recording data on hard copy and then inputting it into the electronic system. (John Miller said many of the physicians equated EMR with PCMH.)

Ron Whiting said many practices don't have electronic records yet, but a perfect time to get clinicians interested in DRP recognition is when they are in the middle of implementing an EMR system—because they can sync up the systems and processes with the diabetes care steps, all at one time. He was surprised at how clinicians welcomed the chance to do that, rather than viewing the DRP as just another thing to add to the list while they were in the midst of the EMR transition.

Kathy Brieger pointed out that EMR offers clinicians another benefit: it enables them to do population management. They need a system to access all that data if they want to keep better track of their patients, including tools such as reminders that patients are due for tests or visits. Plus, population management is required in the PCMH recognition program.

Educate Employers About the DRP

Many employers aren't aware of the NCQA recognition programs. Karen Linscott, the Chief Operating Officer for the National Business Coalition on Health, pointed out that healthcare is not the primary concern of most companies; therefore, companies need to be shown why they should care about things like DRP and PCMH recognition. Companies need to be shown that these types of programs will result in better outcomes for their employees and perhaps cost savings too.

Ron Whiting: Employers are surprised to find out about the physicians'

"lack of awareness about the degree to which they provide the recommended care to their patients with diabetes… They're kind of taken aback at it."

Certainly, the value of the healthcare dollar they spend can be improved. When companies contract with health plans for their employees, they are paying for those health plans' provider networks. It seems intuitive that employers would prefer to pay for providers who have demonstrated a high quality of performance. Employers, especially small employers, don't have a practical way to reward high-quality care. They need help establishing a reimbursement pathway based on quality—as Ron Whiting said, "to draw a direct line between what you pay for and what you get."

Educate Consumers About the DRP

With so much information about diabetes available in the public domain now, patients would likely appreciate having a resource they know they can trust. The panel agreed that patients need to better understand what the DRP recognition means. By raising public

awareness of the DRP, patients may start to rely on DRP provider lists when they want to look for a clinician. Better informed and empowered consumers could be a powerful tool for spreading the influence of the DRP, as patients and caregivers frequently share their knowledge and experiences. If awareness can prompt the consumers to demand DRP-recognized clinicians, that could increase both clinician and payer interest in the recognition program.

Nan Holland said her organization ran a full-page ad in the newspaper listing all of the DRP-recognized clinicians and practices. Patients of the unlisted clinicians started calling their physician offices, saying "I need to find a doctor who can take care of my diabetes." She said that got clinicians very interested in getting recognized. Another suggestion for creating public demand was to use patient leaders to spread the word: for example, people who go on social networks and ask questions like "Is your doctor recognized to give you the best diabetes care possible?" JCAHO was cited as an example of an organization that has done a good job of educating consumers so that they will shop for providers with accreditation in mind.

In addition to simply raising awareness of the DRP, patients could be educated as to what they should expect of their clinicians, in alignment with the DRP requirements—so they know what to request if it's not happening. This type of education could lead to better clinician-patient communication and perhaps, as patients become more informed consumers, better clinician choice as well.

Work with Additional Stakeholders

Partner with Associations

Mindy Smith:
"We should be talking and knocking on the door saying, 'Hey, can we help?'"

The group recommended partnering with any associations that deal with high-risk patients, such as the ADA and the AARP. These associations could get the word out about the DRP to their target audience and members. Melissa Stewart commented that groups like the AARP want their members to be healthy, and they have the time to communicate with their members about these types of issues. Organizations that contribute to resources for chronic care management and are engaged with NCQA also can act as messengers.

Collaborate with Pharmacists

To help raise public awareness of the DRP, Mindy Smith, Executive Director of the American Pharmacists Association (APhA) Foundation, suggested working with the public relations group of the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC). She also said that pharmacists need to be educated about the recognition program. Pharmacy

professionals have frequent interactions with patients, opportunities to carry the message about recognized clinicians and to encourage patients to more fully engage in their own health. She suggested that DRP-recognized clinicians and pharmacists collaborate to improve patient outcomes.

Collaborate with EMR Vendors

The Summit panel was happy to hear that NCQA is working with EMR vendors and recommended some specific actions to improve the use of electronic data systems regarding the DRP process. It seems the first step should be to educate the EMR vendors about the DRP. Some of the leaders reported that many vendors, or at least some of their employees, are not well informed about the recognition programs. For example, John Miller talked to some Centricity representatives at a family physician meeting, and they had never heard of DRP or of any synergies between their products and NCQA's programs—even though Centricity's EMR was the first and only system certified by NCQA for submitting data electronically for the DRP.

Kathy Brieger:

"You have to have a standard template that's also done in structured data so you could have reports on it."

Kathy Brieger suggested urging the major EMR vendors to use standard templates. She said HRHCare uses eClinicalWorks (ECW). One major challenge her organization faces is that ECW doesn't have a standard template for all the diabetes-related data. She also said only a few people could use the system at once. Therefore, HRHCare couldn't do reports from the system and had to purchase external reporting tools. TJ Dube agreed that the challenge is to get the data in a structured format. To persuade vendors to use a standardized EMR tool, the group offered the following suggestions:

- Give the applicants extra points on PCMH recognition if they use an NCQA-approved EMR, just as they receive extra points for using an accredited CAHPS survey tool.
- Convince the vendors that they'll have a competitive advantage if they offer a program that easily relates to the DRP and meaningful use and that works for the whole community. (The Summit leaders said meaningful use is of great interest right now. For example, New York regional extension centers are asking providers to use the DRP as way to demonstrate meaningful use of EMR.)
- Leverage the power of very large groups (i.e., those with ~3,000 providers) with the vendors.
- Make it easy for the vendors. NCQA could give them a template: here are the codes to use, this is how you report the information, etc. (Currently, vendors are showing NCQA the reports they have already developed, and then NCQA gives them feedback.).

Karen Linscott:

"If you want anybody to do anything, you make it easy for them to do it."

Ron Whiting said that although many EMR systems have the capability to act as patient registries, the physician practices often don't know how this function works. He suggested urging vendors to show the office staff members how to use the EMR as a registry. In addition, as more alternative patient registries are approved by CMS for PQRS submissions, the vendors of these registries should be engaged to provide DRP submission as a value-added capability. In addition, Kathy Brieger wondered if anonymous patient experience data from the CAHPS survey could be linked to the diagnosis code and integrated into the same system as DRP. These data should be considered for inclusion if NCQA can steer the EMR vendors to use standard templates.

The beginnings of these EMR collaborations are demonstrated by the experience of the Health Improvement Collaborative of Greater Cincinnati with its diabetes data reporting program. The following page contains a summary of the information TJ Dube presented at the Summit, including benefits the program provides to clinicians as well as some of the data challenges and opportunities.

HEALTH IMPROVEMENT COLLABORATIVE OF GREATER CINCINNATI'S DIABETES DATA PROJECT

The Collaborative started a diabetes data reporting program 3 years ago. Physicians voluntarily report their data on nationally accepted diabetes measures, including the DRP elements. Data are submitted by paper, electronically, or a combination of the two. All the data are gathered into an Excel file and uploaded to a private portal. The Collaborative thoroughly audits all the data for quality. For the past 1.5 years, the Collaborative has worked with NCQA to align the program with the DRP. The Collaborative uses the data in the following ways, which benefit clinicians while also serving the community:

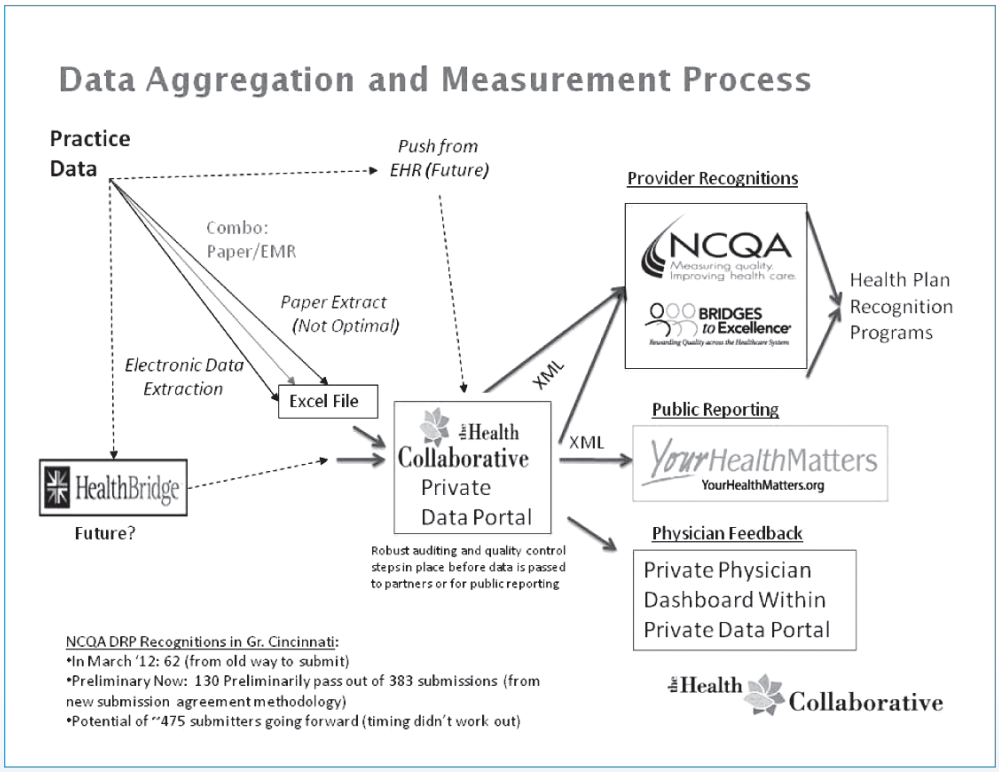
- **Public reporting:** Data on the D5 measures (i.e., A1c <8%, blood pressure <140/90 mm Hg, LDL <100 mg/dl, tobacco-free, aspirin as appropriate)8 are publicly reported through the website YourHealthMatters.org—where consumers can obtain clinical data to help them choose providers.
- **Performance feedback:** DRP measures, including those not included in the D5, are reported back to providers so they can see how they score individually and how their scores compare with their group practices, their health system, and the Greater Cincinnati area as well.
- **Incentive program data submission:** The Collaborative can submit data on physicians' behalf for the DRP and Bridges to Excellence. Therefore, physicians are meeting multiple goals with this one initiative and having some of their administrative burden lifted.

CURRENT STATUS AND RESULTS

Approximately 500 physicians are participating. Only one group has its own data warehouse; most are doing a combination of EMR and paper, and a small percentage still use all paper. About 30% of patients with diabetes are meeting all the D5 goals within the calendar year. It's estimated that through the program, the number of participating physicians recognized by the DRP has doubled.

FUTURE POTENTIAL

With its data quality audit, the Collaborative could be a partner to help speed up the recognition process. It also has the potential to submit data for other pay-for-performance programs. As the use of EMR grows, the Collaborative hopes it will be able to pull data directly from the EMR. HealthBridge, a health information exchange vendor, would like to develop a community registry.



Consider Expanding the DRP to Other Provider Types

The Summit leaders pointed out that most people with diabetes have multiple clinicians, not just a primary care provider. These patients are frequently seeing specialists, especially if they are in need of targeted care management. Therefore, to have a more significant impact on outcomes, the DRP may need to engage specialists to a greater extent.

Beyond the primary care clinicians and specialist physicians, patients with diabetes are cared for by many other individuals: diabetes educators, dieticians, nurses, pharmacists, etc. With a team-based approach, all the team members need to provide excellent care if patient outcomes are to improve. Randall Curnow commented that Summit Medical Group's successful DRP improvement program places great emphasis on process improvement and work flow changes of the physicians support staff instead of the physicians themselves.

Nan Holland said one challenge in rewarding quality of care for chronic conditions is the issue of training, especially as patient care moves away from the more formal settings and various team members are being asked to work together on behalf of patients. She pointed out that, in many cases, the care team has expanded to include members who are not licensed in any specific category: some may have only on-the-job training. The team member who is available to talk with the patient may not be "well versed in how to communicate" about things like what the patient's hemoglobin A1c number means and why it's important to get foot and eye exams. Being an effective change agent requires the use of communication techniques that may not have been included in the training of these team members. Nevertheless, Mindy Smith said clinician groups need to establish best practices and make sure that everyone on the team is practicing collaboratively and at the highest level of his or her license/education.

Nan Holland:

"I think these programs are wonderful, but they continue to highlight some of the real issues in the healthcare system."

Tom Knight:

"Diabetes is one of those conditions where most diabetics have six or seven doctors involved in their care. So can we begin to recognize some of those continuum of care as well as the population management capabilities in the recognition program?"

Tom Knight pointed out something else to consider: If the DRP includes multiple provider types, should it also include some team-based care aspects, which are currently in the PCMH recognition program? (Should the recognition programs overlap more? Should they be combined?)

Help with Patient Engagement

Because outcomes in diabetes are so dependent on patients' understanding and management of their disease, if clinicians were better at educating and engaging patients in their care, the DRP's impact could increase. Providing support to help patients care for themselves is also a component of the PCMH recognition program.

TJ Dube said focus groups revealed patients felt they were to blame, not their physicians, for poor outcomes: they didn't think their physicians should get penalized. He said the challenges for a community organization are how to reach and teach the clinicians to help them engage their patients and how to reach and engage the patients better. While

diabetes self-management education programs are covered by Medicare, the benefit is woefully underutilized by patients.

Train Clinicians in Communication Techniques

Melissa Stewart said most clinicians are not truly being patient-centered. For example, even with knowledge about how memory works, clinicians often overload patients with information and don't do anything to help patients engage so that the information can get into their long-term memory. Both she and Ron Harris mentioned motivational interviewing as a critical part of the process and said not enough clinicians understand it. They need to pay more attention to the emotional and behavioral needs of their patients to effect any significant change in their patients' health outcomes. Clinicians need to explain to patients *why* they need to do whatever it is they're telling them to do (e.g., weigh themselves, take certain medications).

This greater attention to patients' individual needs and motivations will help clinicians as well as patients. Once clinicians learn how to help their patients verbalize their perspective on the importance of their treatment goals and how capable they feel to take the necessary actions, patient's will feel much more empowered. Clinicians often report that they don't feel they have the necessary tools to engage non-compliant patients.

Provide Patient Education and Materials

In Cincinnati, the Collaborative does patient education (e.g., Know Your Numbers, explaining the measures and guidelines, setting expectations) to try to help patients feel more comfortable talking with their clinicians.

A few of the Summit leaders described the patient engagement and educational tools they've developed:

- Melissa Stewart described her Understanding Personal Perspective (UPP) tool, which was used in the CMS Care Transitions pilot and received an award for being an outstanding contribution to the field of healthcare. The UPP evaluates a patient's perception of his or her understanding of the information and his or her ability to act upon that understanding. Cloud and sun icons, based on a 5-point Likert scale, indicate how clear the patient's understanding is.[11] Earlier this year, McGraw-Hill published a book about her work, entitled *Practical Patient Literacy: The Medagogy Model.*

Melissa Stewart:

"What we found is people think they know it, but they don't think they can do it. That's what's draining our system: they get home, and it gets confusing, and they can't handle it. So that's when we need to access them again."

- Mindy Smith described a tool developed by the APhA Foundation—a patient self-management credential to assess and improve the patient's knowledge, skills (e.g., giving insulin shot), and performance (e.g., eye exam, foot exam). The patient has to pass the knowledge portion before moving on to the other two sections. There are three rating levels: beginner, proficient, and advanced. She said pharmacists have worked with clinicians using the tool and have seen good results—with clinicians gaining a much better understanding of their patients and how to help them.
- Ron Harris described a diabetes Bingo card listing the "critical elements" in diabetes care. He said patients would take the card to the clinician office, which could prompt them to follow up on the listed items and hopefully help to improve patient-clinician communication. He believes when a patient is more engaged, the clinician will in turn become more engaged.
- John Miller described a patient guideline (i.e., the ADA guideline written at a second-grade level) with space for patients to write the names of their diabetes care team members. It reminds the patients to bring their action plan and the list of all their providers to their visits with their primary care clinician. With the guideline at their fingertips, patients can ask clinicians about the expected tests. He commented that the only thing different about this tool from others he has seen is the plain and simple language used. For example, next to blood pressure on the checklist it says "High blood pressure makes your heart work too hard, which may lead to strokes or other problems."
- In addition to a variety of patient education channels (e.g., community education days, individual counseling, Web-based education), HRHCare has used the tool the National Diabetes Education Program has for community health workers. These non-licensed individuals are trained in basic care management so that they can provide patient support and link the provider with the patient. As community workers, they understand the issues patients may face (i.e., cultural, language, and literacy barriers).

Similarly, Melissa Stewart said in a CMS pilot, a team of non-licensed and licensed individuals was used to educate patients. In the pilot, both groups were trained on how to teach patients. She said this team approach worked well. The licensed provider understood the disease and its clinical symptoms. The non-licensed person, without the challenge of "white coat syndrome," was able to communicate better with patients to motivate them to change their behavior.

Conclusion

The incidence of diabetes in the United States continues to increase, with all of its alarming health and financial consequences. It's clear that to conquer this formidable enemy, multiple approaches will be needed. One approach is to improve the quality of care that clinicians provide to patients. Increasing the number of clinicians recognized by NCQA's Diabetes

Recognition Program (DRP) will help ensure that more individuals with diabetes receive the level of care described by the program's process and outcome measures. In addition, it may help reduce diabetes-related healthcare expenses.

To increase the number of DRP-recognized clinicians, NCQA should take steps to raise awareness of the program, including its requirements and benefits and how it relates to other quality initiatives. Important audiences to reach include the clinicians eligible to participate in the program as well as other stakeholders, including payers, employers, consumers, and EMR vendors. Several approaches are suggested to raise awareness of the program:

- NCQA should emphasize that the DRP is a step toward the PCMH recognition. This may be an effective way to quickly increase the number of recognized clinicians, as there are currently twice as many clinicians recognized by the PCMH program than the DRP and the PCMH processes support the DRP requirements.
- Clinician leaders can tell other clinicians how their patients' outcomes improved after the heightened awareness stimulated by the DRP process.
- Medical boards could promote DRP recognition and data for their provider recertification processes more consistently.
- Payers should be encouraged to provide incentives for renewal of recognition as well as for the initial recognition. Also, payer incentive programs should be consistent, if possible, to make it easier for clinicians to participate.
- NCQA could establish a national diabetes campaign to inform consumers about the DRP and encourage patients to seek quality care from recognized clinicians. Associations that serve high-risk patients, such as the ADA and AARP, could be valuable partners in getting the word out to drive consumer demand for recognized clinicians.
- NCQA should continue to collaborate with EMR and registry vendors, educating them about the recognition program elements and requirements, to ensure that data systems work optimally with the DRP.

Many practices still do not have EMR in place. For those that do, structured data has been a challenge as they are currently out of alignment with the DRP elements. NCQA could support the development of patient registry and reporting capabilities through a series of recommended standardized templates across EMR vendors. Because of the synchronization between EMR and DRP elements, it may be most efficient for practices to implement both at the same time. Perhaps when a practice is about to implement an EMR system, that could trigger a look into the practice's DRP standing—with follow-up if the clinicians are not already recognized.

Patients with diabetes are cared for by a team of healthcare professionals (e.g., primary care clinicians, nurses, diabetes educators, dieticians, specialists). Therefore, a recognition program that includes only the primary care provider can have only a limited impact. For

a greater impact, NCQA may want to consider the expansion of the DRP to specialists and other provider types that play a role in caring for patients with diabetes. With that, there may be more overlap with the PCMH recognition program (e.g., team-based care).

Of course, better care does not guarantee better patient outcomes, especially in a disease that requires such a strong level of patient engagement. To maximize the impact of the DRP, NCQA may want to look at ways to help clinicians better engage and educate their patients, such as health literacy tools and training in more effective communication techniques to address patients' emotional and behavioral needs.

As Randall Curnow said during the Summit, advancing the care of patients with diabetes is "not about doctors doing a better job or educators doing a better job or [pharmaceutical companies] doing a better job. It's about an entire community doing a better job."

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