

December 2, 2008—DMICC meeting minutes

DIABETES MELLITUS INTERAGENCY COORDINATING COMMITTEE (DMICC)

**USING DATA FROM MANAGED CARE SYSTEMS TO DRIVE
IMPROVED THERAPY OF DIABETES**

Bethesda, Maryland

December 2, 2008

NIH Campus, Bldg 31C, Conference Room 6

12:30 – 4:30 PM

SUMMARY MINUTES

WELCOME AND GOALS OF THE MEETING

Dr. Judith Fradkin, Director, Division of Diabetes, Endocrinology, and Metabolic Diseases, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH)

Dr. Fradkin welcomed DMICC members and guests. She asked attendees to introduce themselves, including those participating by conference phone. It was noted that she had conferred with the NIH Office of Federal Advisory Committees and was informed that the DMICC is not a Federal Advisory Committee Act (FACA) committee; therefore, the DMICC may determine whether to hold open or closed meetings. Unless there is a compelling reason to do so, the DMICC will hold open meetings with DMICC meetings advertised on the NIDDK website as well as in the Federal Register. The only guidance that was given is that only DMICC members or speakers who are not DMICC members but have pre-arranged permission will be allowed to speak. As the need arises during a meeting, guests may be asked by the Chair to address specific issues before the committee.

Dr. Fradkin recounted that at the last DMICC meeting topics were suggested that the members would like to hear about. Topics suggested were on best practices for diabetes management, how to improve health care and disparities, and how the DMICC might address specific treatment issues such as amputation rates. There also was a discussion of surveillance and how accuracy can be improved and made timelier. In response to the later, this meeting will focus on how data are being collected in managed care settings and how the data are being used to improve quality of care and prevention of diabetes.

THE MILITARY HEALTH CARE SYSTEM: LESSONS FROM TRICARE

COL John Kugler, Deputy Chief Medical Officer, Office of the Chief Medical Officer, TRICARE Management Activity (TMA), U.S. Department of Defense (DOD)

COL Kugler discussed the Department of Defense's (DOD's) quality program and how diabetes care and surveillance are related. The burden of diabetes in the DOD's health care system includes approximately 230,000 people with diabetes between the ages of 18 and 64 years. The

direct care facilities serve more than 100,000 more people with diabetes. COL. Kugler provided a schematic of the quality care system and how diabetes care is prominent in various sectors, especially in the area of Healthcare Effectiveness Data and Information Set (HEDIS) measures, on both the care and network sides. Coordination of the system involves various sectors of the health care system in a Quality Forum, which meets regularly to review data and report up the chain of command to those who can decide on programs and working groups needed to improve the system.

Quality metrics are collected throughout the DOD health system, with most diabetes measures collected through the HEDIS scorecard. Because the DOD uses an electronic medical record (e-Record) system, it is relatively easy to collect data. Two recent quality improvement studies being conducted by the Department in the area of Diabetes include how well blood pressure is being controlled in patients with diabetes and whether a recent change in the formulary in the availability of specific angiotensin-converting enzyme (ACE)-inhibitors has made any difference in blood pressure control in diabetics.

DOD also has a program to provide education to physicians, nurses, and patients; this program includes diabetes education. Another program in concert with the education program includes on-site visits to assess the impact of education on quality measures.

DOD has been in close partnership with the Veterans Health Administration (VA) for several years in a program that facilitates the development of evidence-based medicine (EBM) clinical practice guidelines for use in both health care systems. A website is available to browse for the guidelines developed in this program, including one for diabetes (see <https://www.qmo.amedd.army.mil/pguide.htm>). An important innovation that is in active development is the use of the e-Record and an enhanced ability to translate clinical guidelines to the point-of-care. The innovation allows real-time data on the status of the patient, recommendations on treatment based on the status of the patient, and a system of scheduled reminders.

The Pay-for-Performance (PFP) system is different in the federal health care system than for private insurers, but many of the measures are the same. The DOD system is based on outcome measures, including HEDIS measures, quality, satisfaction, and access. Reimbursement to facilities is based on specific percentage attainment of the measures and on measured degrees of improvement. The program is early in its development and is just beginning to assess the impact of a PFP model on changing specific outcomes.

DOD has been conducting disease management programs for several years. Recently DOD has launched pilot studies designed to evaluate best practices and are targeted primarily at adults in the non-Medicare age group with specific diagnoses, including diabetes. Most of the patients in the pilots have been identified as high-utilizers of the health care system that may benefit from a directed disease management program. The primary intervention for patients with diabetes is focused on identification and education. Data on best practices may be available in the spring of 2009. Other disease management areas currently being assessed include asthma and congestive heart failure in addition to diabetes.

Discussion

Dr. Garfield asked about the hierarchy of reporting on quality and outcomes and the PFP program. He stated that the DOD program sounded like managed care, except the DOD system is worldwide. He asked how DOD manages the system. COL Kugler confirmed that this is a very complicated system to manage (9.2 million beneficiaries worldwide), but the main strength for the military health care system has traditionally been the military culture of mission orientation and commitment. He pointed out that this frequently allows more to be done centrally than in the civilian sector.

In response to a question about the PFP system, COL Kugler explained that individual physicians are not paid, just their facilities or systems. Dr. Roman asked if DOD has considered PFP for the beneficiary. COL Kugler responded that this is a target of one of the pilot programs being considered. Dr. Raggio Ashley asked if patients who seek care outside the DOD system (i.e., network care) are tracked. COL Kugler said that this is difficult to do, but DOD has a few pilot programs looking at the ability to track these patients. Currently, for diabetes care in network patients, DOD is able to track when a patient has a test done for A1c but is not able to get the results of the test. DOD patients in direct care facilities, however, are able to have available tracking for both the test being done and the results of the A1c.

Dr. Fradkin commented that a strength of the VA has been its research infrastructure. She asked what research infrastructure exists within DOD to look at quality improvement interventions to see what impact they are having. COL Kugler responded that while quality improvement research is done, it is fairly challenging to implement system-wide research within DOD because of the on-going readiness mission requirement. There are opportunities for multi-center studies, but it is more difficult to coordinate within DOD than within the VA. Dr. Fradkin added that the VA partners with the NIH and the Centers for Disease Control and Prevention (CDC) for the TRIAD trial, and wondered if it would be possible to have DOD included in that study.

THE VA HEALTH CARE SYSTEM: ASSESSING PROGRAMS TO IMPROVE OUTCOMES

Dr. Len Pogach, National Program Director, Diabetes; Veterans Administration Central Office [Office of Patient Care Services, Medical Surgical Services]

Dr. Pogach, presenting by conference phone, provided an overview of the VHA (VA), which is the largest integrated health care system in the United States, with a FY09 budget of approximately \$41 B, with approximately \$31 B in direct medical care. Approximately 7 M patients are enrolled in the VHA health care system, although there is cross-over with Medicare or private insurers. Although the average age of veterans is about 64 years, there are an increasing number of younger veterans in the system due to the current conflicts. The population of patients with diabetes in the VA system is approximately 1.3 M; an analysis in 2000 updated in 2005, found that although approximately 25 percent of veterans have diabetes, the adjusted age distributions are similar to those in the non-VA population.

The VHA is committed to the development (shared with the Department of Defense) of clinical practice guidelines through a highly structured evidence-based process; these are utilized for policy as well as practice. Dr. Pogach presented the guidelines used by the VA for glycemic control, but there also are guidelines for lipid control, hypertension, kidney disease, and amputations, each of which impacts diabetes outcomes. The VHA developed a risk stratified approach to glycemic control that recommends individualization of target values for glycemic control based upon patient factors (such as life expectancy, concordant conditions, side effects of medication) and shared decision making. For individuals with a reasonable life expectancy with no contra-indications the VHA has recommended a target goal of less than 7 percent for glycemic control (A1c) since 1997. A recent review by the American College of Physicians published in the *Annals of Internal Medicine* (Qaseem, 2007) indicated that the VHA-DOD and American Society of Geriatrics Guidelines had markedly higher scores for an evidence based process (based upon GRADE) than guidelines by the American Diabetes Association (ADA) and the American College of Clinical Endocrinologists. Not to belabor the point, Dr. Pogach indicated that trying to take very complex issues with various outcome measures and extrapolating that to simple “one size fits all patient care” can lead to patient harms and preferences. For example, the ADA guideline for blood pressure (130 mm/Hg systolic), which is based upon “C” level evidence, may not be appropriate for a patient already on three antihypertensive medications; in this case, the physician must think about individualizing care.

Dr. Pogach described quality improvement at the VHA, which relies at the facility level upon an electronic health record (Computerized Patient Record System) and is deployed nationwide. A demonstration of the record ensued and showed the tools available for tracking and improving care, such as clinical reminders and reports; improvements are added regularly.

More recently, the VHA Office of Patient Care Services has developed a Diabetes Clinical Cohort. Each VHA facility transmits clinical data to the VHA Corporate Data Warehouse in Austin, Texas. Data are sent regularly and integrated so it can be used in research or operational studies. A wealth of information is gathered and warehoused in these databases. The data can be analyzed for special populations, such as women or users of mental health services. The data include specific diabetes measures, such as the number of patients receiving glucose tests, insulin or no insulin, or a specific type of therapy. The information can be accessed—using privacy safeguards—by facilities to evaluate the care and intermediate outcomes at their site, and to assist in formulating action plans to improve care delivery. One of the primary issues that the VA would like to have addressed—and could be addressed by the DMICC—is a better definition of how to access population health using measures of A1c. A recently published article from the VHA looked at treatment of individual patients to determine what range exists between absolute benefit and absolute harm. Results indicated that this range is between 7.0 and 7.9 percent, but as the treatment goal moves up or down along the range, there are different winners and losers depending on the age of the patient or other factors. Emphasis on a < 7 percent “optimal measure” as an indicator of population health is not consistent with the clinical epidemiology of diabetes.

Recent research analyses of veterans, presented at the Centers for Disease Control Translational Conference in May, 2008, looked at long-term trends (1999-2005) in glycemic outcomes. Factors such as duration of diabetes, age, and coexisting illness severity impacted attained mean

values and trends over time. The VHA has collaborated with many NIH institutes and other agencies, such as the CDC and DOD, and anticipates collaborating in the future.

Discussion

Dr. Garfield compared the DOD and VHA presentations. DOD described data from active military personnel and retirees; the VHA described data from veterans. He asked if retirees are veterans and if there is overlap in the system. COL Kugler responded that DOD patients are active military, their families, or those who retired after at least 20 years in the service. The VHA veterans are those military personnel who served in the military and were honorably discharged, but whom did not retire from the military.

Dr. Fradkin asked if Dr. Pogach had analyzed the distribution of A1c measures in people by duration of diabetes or medications. Dr. Pogach indicated that the analyses will be presented at the VHA HSRD meeting, and will indicate that A1c levels of < 7 percent are achieved more frequently and maintained in individuals with newly diagnosed disease, and are harder to achieve in individuals on insulin. This is consistent with the literature and a recent article from NIDDK using NHANES data (Bainbridge et al, *Diabetes Care*, 2008). This points out that there are differences in A1c control that are dependent on patient factors, and therefore may not represent disparities in care.

Dr. Ashley noted that according to HEDIS, even if a patient achieves an A1c of 7.1 percent (the measure is 7.0 percent), the care system fails that patient. This penalizes those physicians who are able to bring very ill patients from A1c levels of 11.0 to 8.0, when compared to a physician who only sees patients who have entry A1c values of 8.0 and they are able to achieve a drop to 7.0. Dr. Pogach responded that this exemplifies what he was saying about simple bromides for complex issues. He said he agrees that different populations need to be treated differently and there should be different standards for those patients. Dr. Albright added that the dilemma is that we do not know the number of patients who will suffer hypoglycemia with A1c levels less than 7.0 percent.

Dr. Pogach commented that it is possible for facilities to develop teams to determine the insulin/A1c goal for individual patients. He reiterated that no one can adequately explain to him how the goal of 7.0 percent for many, but not all persons with diabetes, has come to be considered “a standard of care.” For example, the National Glycosylated Standardization Program has indicated that because of acceptable laboratory variation (Coefficient of Variation of 7 percent), a single A1c of 7 percent could actually be between 6.5 percent and 7.5 percent. Thus, treating a patient who’s recorded A1c is higher than actual could result in hypoglycemia (for insulin). An understanding of laboratory accuracy should alert physicians to the need for individualized treatment. Dr. Albright agreed that it is wise to use knowledge from physicians, pharmacists, nurses, and other diabetes care professional workers to develop individual goals. Dr. Pogach added that the VHA emphasizes individualization of appropriate goals using shared decision making; doing so well is very important in the care of patients with diabetes, especially those with long-duration diabetes.

Dr. Fradkin asked what should be the recommendation to physicians regarding A1c goals, and whether there are accurate algorithms to guide treatment. Dr. Pogach responded that the VHA has an algorithm to guide professionals in setting individualized goals within a range. Algorithms for glycemia are more complex than for blood pressure and lipids. He added that once a physician has a patient on two oral agents and is significantly away from their goal, insulin treatment, rather than a third agent is a preferred option.

Dr. Albright commented that internationally, American guidelines are not respected because others think our goals are too high or too lenient. Dr. Pogach responded that treatment is somewhat of an art form, not really knowing what the impact is of lowering blood pressure, lipids, and A1c concurrently in an individual patient. Dr. Fradkin interjected that the ADA guidelines also are not perfect, but they have been developed based on results of various clinical trials.

Dr. Fradkin asked if the VHA uses the e-Record for quality measurement. Dr. Pogach responded that VHA facilities use the electronic record for auditing charts for outcomes for quality measurement. In this way, the VHA can assess patients for flu shots, foot screening (monofilament), eye screening, and many other factors. COL Kugler asked if the audit program has led to falling amputation rates or complications of surgery. Dr. Pogach agreed that the VHA has demonstrated a downward trend in amputation rates; while it is not possible to demonstrate directly, he believes that performance measures for screening definitely contributed to the improvement. He noted that at one time the use of a monofilament for sensory examination was a measure, with about 85-90 percent adherence.

TRANSLATING RESEARCH INTO ACTION FOR DIABETES (TRIAD): WHAT WE HAVE LEARNED AND WHAT'S NEXT

Dr. Ed Gregg, Chief, Epidemiology and Statistics Branch, Division of Diabetes Translation, CDC

Dr. Gregg provided background information on the Translating Research Into Action for Diabetes (TRIAD). TRIAD is a multicenter trial at 10 health care systems, in partnership with CDC, NIDDK, and the VA, with oversampling for minorities. Approximately 12,000 participants with diabetes enrolled in the study in 2000, with a 10-year follow-up time period planned. TRIAD was designed to test whether system factors influence processes of care (quality of care) and, in turn, lead to better health outcomes. System factors included health system structure, disease management strategies, management of referral care, clinician payment and incentives, and cost-containment strategies. Quality of care measurements included A1c test frequency, blood pressure assessment, lipid testing frequency, retinal examinations, microalbuminuria testing, foot examinations, smoking cessation counseling, and aspirin prescription. Health outcomes included health status, quality of life, glycemic control, cardiovascular disease (CVD) risk factor control, foot problems, retinopathy, nephropathy, CVD, mortality, and utilization and costs.

Key Findings in the area of Health System and Structural Factors include the following:

- Disease management is strongly associated with processes of care but not risk factor control.
- Processes of care at the provider group level are related to patient satisfaction and perceived quality, but not A1c or systolic blood pressure levels.
- The intensity of diabetes disease management reduces disparities in processes of care but not outcomes.
- For quality of care, A1c and low-density lipoprotein cholesterol (LDL-C) control was substantially better in the VA system than in TRIAD centers.

Findings in the area of Patient Factors include the following:

- Processes of care differ little by race/ethnicity, but non-whites have higher A1c and African Americans have higher blood pressure.
- Greater out-of-pocket costs (through co-pays and/or non-coverage) are associated with lower rates of retinal exams, health education, and self-monitored blood glucose.
- Cost-related medication underuse is much higher in people of lower income.
- Cost concerns, trust in physicians, current smoking, and physical inactivity are key predictors of control of risk factors.
- Young patients with diabetes (i.e., 25 to 44 years of age), with less than a high school education, are much more likely to smoke.
- Patients with diabetes are under-treated with ACE/angiotensin II receptor blockers (ARB) after screening for microalbuminuria.
- Younger age, lower income, and less co-morbidity are associated with long-term persistent lapses in recommended care.
- Women with diabetes are less likely than men to be on aspirin and statins.
- Depression was a strong predictor of poor risk factor control in African Americans.

Conclusions from TRIAD show that greater integration (better data systems, aligned incentives, and effective communication) appears to lead to better processes and possibly to better outcomes. Processes are easier to influence than outcomes; new generation process measures should be more closely linked to outcomes. Cost-shifting to patients reduces adherence and outcomes, and patients of younger age, with better health, and from lower income levels may need targeting. One interesting conclusion from TRIAD is that although racial/ethnic disparities in outcomes persist, they are not as intense in a managed care system as they are in other care systems.

During the past few years, sub-studies have been conducted in TRIAD to examine some of the findings and develop natural experiments for addressing some of the areas of the study that could improve patient outcomes with readjustment of approach. Examples of these sub-studies include a health plan copayment reduction program at the Michigan TRIAD site, a greater focus on disease management and prevention of chronic kidney disease, a program to fill the Medicare Part D coverage gap, a program for PFP, and a program for use of a mail-order pharmacy.

For the future, TRIAD will continue to provide data for numerous studies and sub-studies. There may be a TRIAD legacy study if funding can be acquired. What are needed next are new mechanisms to study innovations in systems and organizations of care, and research platforms

that permit efficient study of natural experiments. There is a need for studies of health system-patient interactions to address some of the questions raised by TRIAD. There also is a need to have the application of health services research to primary prevention and behavioral change. And finally, information systems, such as the e-Record, should be explored for health services research.

Discussion

Dr. Pogach referred to the findings from TRIAD showing that there was a leveling off of smoking after age 65 years. Dr. Gregg noted that some of these older smokers may have quit or died. Dr. Fradkin asked why this was seen in TRIAD but not in national data. Dr. Gregg said he was not able to look at this in the National Health and Nutrition Examination Survey (NHANES) with enough statistical power to show the same trend. It is clear that smoking is higher in younger people in the low-income stratum. Dr. Ashley said she has seen the same trend in other datasets.

Dr. Avilés-Santa (National Heart, Lung, and Blood Institute) commented that the United States health care system is very fragmented, and asked whether a change in health care systems would require policy changes. She added that this may take a nationwide, uniform surveillance system. Dr. Gregg responded that everyone in TRIAD was insured, which makes it different than the rest of the country; therefore, TRIAD may not be generalizable to the rest of the country. Dr. Ashley noted that the Agency for Healthcare Research and Quality (AHRQ) has approximately 1 M uninsured people with diabetes in their data, and they see that there are problems getting these people care, especially across specialties for the same visit. These people do not get the referrals they need because many of hospitals will not accept them.

Dr. Fradkin said she was struck by the data showing that the VA is doing better regarding processes of care and better intermediate measures and intensity of intervention. She asked Dr. Pogach to explain this. Dr. Pogach answered that the VA, as COL Kugler described for the DOD, has a mission and culture that are conducive to high satisfaction; also, the VA has their patients forever, which is a different view than that seen in managed care organizations.

Dr. Albright noted the difference in CVD issues and women, with the results from TRIAD showing less use of aspirin and less aggressive use of statins in women. She said this information needs a program to translate this to the population of women so they can receive the benefits shown for these interventions. Dr. Pogach added that there is a difference in the VA on these same issues. It may be that doctors are not getting the message that women benefit as much, or more, than men from these interventions.

USING CMS DATA TO DRIVE IMPROVED DIABETES CARE

Dr. Michael Rapp, Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality, Centers for Medicaid and Medicare Services (CMS)

Dr. Rapp, presenting by conference phone, introduced colleagues at CMS who would discuss specific areas of diabetes care. Dr. Theresa Casey from the Quality Improvement Organization

(QIO) Program presented information on quality in diabetes care, and Dr. Dan Green, CMS Medical Officer, presented information on the Government Performance and Results Act (GIPRA) and the Physician Quality Reporting Initiative (PQRI) regarding diabetes.

Dr. Teresa Casey, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality, CMS

CMS contracts with 53 quality improvement organizations across the nation to improve care. CMS directs the areas for improvements and provides guidance on QIO. There are two sub-national tasks that are underway through the QIO program. The first is a Prevention of Disparities Task in five states. The goal is to work with participating practices, target underserved patients, and increase the number of patients participating in diabetes self-management programs. Community health workers are used to implement the program. Clinical measures to gauge success of the training include A1c and LDL levels, blood pressure control, absence or presence of diabetic nephropathy, and a communication measure to target interactions between the patient and physician regarding diabetic neuropathy.

The second task is underway in 10 states, and there are three areas of clinical focus: increasing detection (and annual testing for microalbuminuria) of chronic kidney disease (CKD) among the diabetic population; increasing frequency of treatment of high blood pressure with ACE-inhibitors and ARB in patients with diabetes; and dialysis access issues among both patients with and without diabetes. The CKD focus is claims based.

Discussion

Dr. Fradkin asked if CMS is limited because of the claims data, which may not allow looking at the level of control of blood pressure in patients with CKD. Ms. Casey responded that they do not have access to blood pressure levels. In CKD, the improvement targets are state-wide.

Dr. Albright asked if the disparities task is the same as the current program that provides diabetes self-management training at no cost. Ms. Casey said that all diabetes training is free under current programs. Dr. Albright asked if the purpose of this program is to widen the scope of recruitment for patients, and is it the same program that is being implemented by the Area Administration on Aging and the ADA? Ms. Casey said she believed this was the same. Dr. Albright added that the purpose for asking the questions was to consider the possibility of coordinating the services of CDC and other DMICC organizations with the CMS programs. Ms. Casey added that the services of the QIO also are free regarding helping practitioners or providing quality improvement interventions. Dr. Albright noted that the programs are appearing in publications that target African Americans.

Dr. Rapp noted that Ms. Casey presented information on programs that use claims data and do not have access to laboratory data or other data that may be useful for some types of research. The next presentation will include data that can be based on biologic parameter data, such as levels of blood pressure or A1c.

Dr. Daniel Green, Medical Officer, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality, CMS

In PQRI, 2007 data had three diabetes measures; in 2008 this was increased to five diabetes measures, including A1c levels, LDL levels, blood pressure control, diabetic eye screening, and urine screening for nephropathy. In 2009, a diabetes foot exam will be added to the five 2008 measures. For 2008 data and beyond, it will be possible to report this information for registries; for example, the registries will be able to get the actual levels of A1c, LDL, and blood pressure.

The GIPRA goals include one for diabetes: the number of patients who receive A1c testing as well as the rate of LDL testing. Targets are set by state, by aggregate, and nationally for quality improvement. These measures are complemented by the PQRI and QIO.

Discussion

Dr. Fradkin requested an explanation of the levels of A1c that were discussed. Dr. Green responded that the measure is designed to tell which patients are in poor control for A1c. There are two different measures that can be reported. One is on a scale (> 9.0, between 7.0 and 9.0, and < 7.0), and the other is just indicating that the patient is “in control” or “not in control.” Dr. Fradkin asked how the data are used. Dr. Green indicated that it is pay-for-reporting, so if the physician reports at least 80 percent of the data on his or her patients, the physician satisfies their measure. Dr. Green added that there is a difference in the measures. Although the A1c quality control measure is how many patients have “good control,” by submitting the claims data using the scale, it is possible to see where the aggregate of patients is on the spectrum.

Dr. Fradkin asked if claims data are consecutive. Dr. Green indicated that physicians must report on 30 consecutive patients in addition to reporting on 80 percent of their aggregate patients. Dr. Fradkin followed up by asking if Dr. Green knew what percentage of patients have poor control, and how much room there is for improvement. Dr. Green responded that data from 2007 indicate that approximately 15 percent of patients had “poor control.” For LDL and blood pressure, physicians reported approximately 70 percent and 60 percent, respectively, had “good control.” These data are taken from what physicians reported, not from claims data. It is not possible to tell from these data what type of treatment the patients were on or what factors are involved; that would have to be determined from the quality improvement program.

Dr. Rodgers asked if CMS is capturing anything about the characteristics of the practice involved with the provision of care for these patients. Dr. Green indicated that this could be done with these data but it has not been done yet. Dr. Rodgers followed up with a question about the possibility of geotagging (e.g., ZIP code or region of the country) the data to understand the environment in which the patients are receiving care. Dr. Green responded that these are patient-level data, so it is possible to get at least some of this information, such as ZIP code, because that is in the claims data.

Dr. Fradkin asked if the data will be de-identified and made available to researchers outside of CMS. Dr. Green indicated that the data are available to the research community through the normal channels for requesting CMS data.

ANALYZING MANAGED CARE DATA TO IDENTIFY EFFECTIVE STRATEGIES AND OPPORTUNITIES FOR COLLABORATION

DMICC Members

Dr. Fradkin opened the discussion by asking for comments on whether DOD could be a potential partner in the next phase of TRIAD. COL Kugler responded that DOD does not have a research purpose, but it could be considered through the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, MD. If there are specific ideas, there may be opportunities to collaborate. Dr. Garfield commented that he was intrigued by USUHS having access to the DOD data because they are part of the overall system. He asked if there is a way to involve them. COL. Kugler advised that they are a research institution but DOD cannot tell them what to do regarding research. He suggested that they could be a link between DOD, VA, and CDC. He added that he views the DMICC as a good forum for trying to pull each of the links together.

Dr. Gregg commented that there are gaps in data, such as more real-time surveillance of care, determining how care affects aggregate outcome, and others. At the same time, there should be a way to pool data together to address the biggest gaps, whether in the area of surveillance of care and outcome or in the area of studies of effectiveness. He asked if there is a demonstration project that could be conducted to answer these questions. Dr. Fradkin clarified that the pilot projects could be conducted to see if the data are useful and clean enough. Dr. Gregg responded that this was the dream of TRIAD. Dr. Albright reiterated that data are collected for different purposes, such as for quality improvement versus research. There should be some crossover in the data that can be used for either purpose. There are a lot of problems in the collection of data from any population. COL Kugler added that even with the e-Record there will be problems with the data unless they are validated.

Dr. Albright asked that the discussion return to collaborations, especially with the potential health reform that may be on the horizon. Dr. Fradkin said that with reform, it is likely that there will be a push toward e-Records. This may be a time to consider a pilot program to see what can be done with the e-Record. Dr. Albright added that the e-Record could spur development of better measures for assessing quality of care and other quality measures. Dr. Gregg hypothesized that the e-Record will be standardized in the future, which will mean the data collected will concentrate on those data useful for the clinic rather than for researchers. It will not be too long before these decisions will be made, and it is important to have public health researchers begin involving themselves in the development process.

Dr. Fradkin commented that one of the areas that could be built on from TRIAD is the effect of co-pays on treatment. This would have a huge impact on the health care system if it could be demonstrated. She asked if the Health Resources and Services Administration (HRSA) has the ability to show how co-pays influence care. Dr. Ashley stated that HRSA does have data on co-pay. It may not be such a barrier for primary care but could be a major barrier for referrals. This can be a rate-limiting factor. Dr. Fradkin asked what this meant for foot referrals. Dr. Ashley responded that there are more problems with ophthalmology and end-stage renal disease regarding referrals. Dr. Albright added that CDC has Congressionally-mandated programs on CKD and eye health that are not diabetes-specific, but are largely diabetes-related. She said she

will need to make sure some of the problems with referrals mentioned do not impact those programs.

Dr. Pogach commented on the issue of cost benefit and the concept of “optimal” care. He said it is important to look at the larger picture, because diabetes is not the only health problem within the VA. He said it is important to consider the opportunity costs for all conditions, but it is logical that if people with severe health problems are not managed correctly, it will cost more in the future. A study in the VA found that people who lost sight were people who were screened on time but did not come back. It may be that an effort on follow-up care could have avoided some of these consequences. He said that it is important to find out where the small pot of dollars could be spent to have the greatest effect, which leads to the need for risk stratification. Dr. Fradkin added that this may be a good topic to consider for a future DMICC meeting. She said that diabetes prevention is an important issue.

Dr. Fradkin closed the discussion by requesting that DMICC members who have ideas for topics for future DMICC meetings should contact her.

UPDATE ON STRATEGIC PLANNING FOR RESEARCH IN DIABETES

Dr. Fradkin

Dr. Fradkin described the process for developing the Diabetes Strategic Plan. Emails have been distributed in the past few months to get input from DMICC members and others on chairs and working group members for each of the 11 topic areas of the plan. Chairs have been designated and topic area working group members are being added. Work on the plan will occur mainly through conference calls between January and March, 2009. It is anticipated the final draft will be completed by next summer, at which time it will be posted on the NIDDK website for public comment. Dr. Fradkin asked DMICC members to let her know if they are interested in taking part in the plan as a member of one of the 11 sub-groups. Dr. Fradkin thanked Dr. Eleanor Hoff (NIDDK) for playing a role in organizing the strategic plan working groups.

Dr. Fradkin also announced that the DMICC brochure is nearing completion. She thanked Drs. Mary Hanlon and Julie Wallace for taking the NIDDK lead in this effort. The brochure is in the final stages of graphic layout and editing and will be available by January 20, 2009. DMICC members will be able to review the final laid-out version before it goes to print.

NEW BUSINESS/UPDATES/ANNOUNCEMENTS

Dr. Fradkin announced the following meeting to evaluate preclinical programs and consortia. This meeting is similar to the one held by NIDDK last spring on clinical programs and consortia. A flyer was distributed at the meeting.

- The *Ad Hoc* Planning and Assessment Meeting on Preclinical Research Supported by the *Special Statutory Funding Program for Type 1 Diabetes Research* will be held on June 17–18, 2009, at 6001 Executive Boulevard, Conference Room C, Bethesda, MD. DMICC

members are encouraged to attend. Additional information will be distributed to DMICC members.

ADJOURN

Dr. Fradkin adjourned the meeting at 4:05 p.m.