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Study demonstrates care managers in PCMHs increase improvements in diabetes patients

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Patient centered medical homes (PCMHs) have been found to be an effective way to help care for patients with chronic diseases such as diabetes. Dr. Robert Gabbay, M.D., Ph.D., FACP, Chief Medical Officer and Senior Vice President at Joslin Diabetes Center, and his team conducted a study that shows the strategic placement of care managers in PCMHs can further improve patient outcomes for high-risk diabetes patients.

The study, conducted in southeastern Pennsylvania, compared different models of care management and how they impacted diabetes outcomes in three practices with 25 primary-care PCMHs. The identity of the care managers varied among the sites: with some positions filled by nurses or nurse practitioners, while others used social workers or medical assistants.

Each center was evaluated on how well patients fared in the ABCs of diabetes: A1C, blood pressure and cholesterol level. Mean baseline data was determined for each site for the percentage of patients achieving A1C levels less than seven percent, blood pressure less than 130mg Hg and low-density lipoprotein levels less than 100mg/dl.

"The practices that demonstrated the greatest diabetes improvement described more patient-centered care manager duties, better use of the electronic medical record (EMR) for messaging and patient tracking,

and stronger integration of the care manager into the care team," said Dr. Gabbay. "Practitioners and patients both preferred embedded nurse care managers that were typically a nurse in order to focus wholly on the patient and their medial needs critical for the the highest risk patients."

Conversely, the centers that ranked in the lower-tertile for patient achievement of goals spent more of their time on administrative or supervisory duties.

The managers in the lower ranking centers either did not have access to an EMR or felt the EMR was not user friendly. In addition, a greater amount of interaction between physicians, office staff and the care managers was associated with better outcomes.

Care management involves concentrating services where they are needed the most; around high-risk individuals in an effort to reduce costs. It is traditionally done over the telephone by registered nurses employed by insurers, but can be used in both community and primary care settings as demonstrated in the study.

"Diabetes is a common chronic disease to study in PCMH transformation, as the diabetes population is a perfect example of patients that already require care coordination," explained Dr. Gabbay. "Specialty care, such like that at Joslin, can serve as the prime example of care coordination and used as a 'best practice hub' to teach primary care practices how to best meet clinical quality goals for diabetes patients."

Dr. Gabbay came to Joslin from the College of Medicine Division of Endocrinology, Diabetes and Metabolism at the Pennsylvania State University College of Medicine, where he was a Professor of Medicine and Director of the Penn State Institute for Diabetes and Obesity and Penn State Hershey Diabetes Institute.

"We at Joslin have a long tradition of caring for high risk patients with diabetes and are currently expanding models of care utilizing care management to better service patient. needs- here in Boston and nationally through our affiliates," he said.

Provided by Joslin Diabetes Center