Responding to the Challenges of Primary Diabetes Care Through the National Diabetes Education Program

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In this issue of *Diabetes Care*, the article by Paddison et al. (1) provides valuable information that furthers our understanding of the primary care patient experience for people with diabetes. Using the English General Practice Patient Survey (GPPS), the authors compare the primary care experience of 85,760 survey responders with self-reported diabetes with 820,818 responders without diabetes across three domains of care delivery: access, continuity, and communication. Individuals with diabetes reported primary care experiences that were as good as or better than people without diabetes across most domains of care. The authors point out that the concept of family practice in England is not dissimilar to that of the patient-centered medical home (PCMH) articulated in the U.S. Primary care practices in both countries identify patient populations and both share some degree of financial risk for keeping their patients healthy. Despite the similarities, several findings do not broadly generalize to the U.S. health care system.

Patient satisfaction surveys reflect perceptions as well as the capabilities of a health care delivery system, but the realities faced by U.S. and U.K. patients are different. In the 2014 National Committee for Quality Assurance annual summary of assessments from U.S. health plans, 94.5% of patients reported that their doctors usually or always explained things, listened carefully, showed respect, and spent enough time, and 86.7% of patients reported that access to care was good, comparing favorably with the GPPS results (2). However, only 67.6% of these patients indicated that they were very satisfied with their overall health care, a substantial difference from the 91% of satisfied National Health Service responders. Real and perceived individual costs alter patient expectations and confound direct comparisons between U.S. and U.K. patients in ways difficult to predict.

U.S. health care providers are asked to improve quality of care while controlling costs, a challenge that has been longstanding in England. It is still too early in the development of patient-centered approaches such as the PCMH to understand the consequences, and associated changes have only recently begun a transformation in U.S. primary care practice (3). The changes associated with patient-centered transformation represent more than the development of patient panels or disease registries but demand fundamental change in care delivery that extends beyond the primary care practice. An essential aspect of PCMH transformation is the incorporation of multidisciplinary teams to better coordinate diabetes care, integrate community resources, and improve outreach to home and work environments.

Paddison et al. (1) do not relate the patient experience to team care or electronic health records, essential components in the rapidly changing U.S. health care system, but they do provide us with an alert to similar concerns about caring for people with diabetes and comorbidities in the U.S. In particular, people over 65 with diabetes have higher rates of premature death, functional disability, and coexisting illnesses, such as hypertension, coronary heart disease, and stroke, than those without diabetes (4). Older adults with diabetes are at greater risk than other adults of similar age for common problems, including depression, pain, and polypharmacy. Nearly half of U.S. adults with diabetes have diagnosed arthritis and they are twice as likely as people without diabetes to experience depression (5,6). Comorbidities impact self-management capabilities and call for increased communication and coordination of care by the health care team.

Primary care clinicians and health care professionals from a wide variety of disciplines joined with the National Diabetes Education Program (NDEP), a joint program of the National Institutes of Health and the Centers for Disease

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Control and Prevention, to support practice change in diabetes care. Extending the comprehensive NDEP web resource (yourdiabetesinfo.org), "Practice Transformation for Physicians and Health Care Teams" (yourdiabetesinfo.org/practicetransformation) provides an open-access resource for tools and materials for health care professionals to more easily establish high-quality diabetes care in accord with national standards and performance initiatives.

Sponsored by the National Institutes of Health and Centers for Disease Control and Prevention, "Practice Transformation" presents a considered and unbiased approach to the essential components of patient-centered care that can be introduced into primary care over time. It offers tools and resources to support the health care team. For example, new methods of team-based care provide the strongest evidence for improving quality and reducing cost of health care for the community (7). Distribution of care responsibilities to meet individual patient needs increasingly involves contributions from nursing, education, nutrition, physical activity, pharmacy, podiatry, dentistry, ophthalmology, and mental and behavioral health. Further, moving from an authoritative to a facilitative collaborative practice model promotes contribution from team members, diminishes hierarchical and cultural barriers, and promotes a common understanding of a patient's needs among staff. "Practice Transformation" guides the development of a stronger health care team with videos on structuring team meetings.

Improved care models can better address the complexities of diabetes care in the presence of long-term comorbidities. Because successful treatment of depression is an essential component of diabetes management, the NDEP resource provides the Patient Health Questionnaire-9, a depression screening tool, to enhance depression screening in primary care settings and promote management (8).

Paddison et al. (1) uncovered the need for improvement in communication during a clinical visit. Communication can positively influence health outcomes including emotional health, symptom resolution, function, physiologic measures such as blood pressure and blood glucose, pain control, and adherence (9). Yet it has been estimated that physicians interrupt patients, on average, within 23 s as they try to explain their problems (10). Strategies for improving communication can be identified, such as simply beginning an office visit with an open-ended question such as "What would you like to accomplish in the visit?" or "What issues, concerns, or questions would you like to address before you leave today?" Frameworks for structuring office visits, such as the Four Habits Model, can engage patients and staff (11). Other approaches, such as shared decision making, promote more active participation of patients in their care through informed choices. A work sheet entitled "I Wish I Had Asked That!" promotes implementation of shared decision making during clinical encounters.

Community-wide education and diabetes care efforts can improve patient self-care practices. Better access to community resources diminishes the perceived burden of disease by individuals and is independently associated with lower community averages for waist-to-hip ratio (12). Improving access to public services builds healthier communities and plays an important role for reducing population-based risk of diabetes. "Practice Transformation" presents nine steps for developing community partnerships and identifying community-based team members. Mobile and Internet capabilities can further improve home care and enhance communications between patients, families, communities, coordinators, and providers.

Health care policy in the U.K. and the U.S. stresses the importance of patient-centered care in quality diabetes care. Paddison et al. (1) identified areas of improvement needed in primary care, including patient access to care, communication with care providers, and management of comorbidities including depression. Building patient-centered approaches through interprofessional teams, care coordination, patient engagement, and better utilization of local services and resources may offer practical steps toward improving primary care and the patient experience in both the U.K. and the U.S.

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References

1. Paddison CAM, Saunders CL, Abel GA, et al. How do people with diabetes describe their experiences in primary care? Evidence from 85,760 patients with self-reported diabetes from the English General Practice Patient Survey. Diabetes Care 2015;38:469–475
2. National Committee for Quality Assurance. The state of health care quality 2014 (prepublication copy) [Internet], 2014. Available from http://www.ncqa.org/Portals/0/Newsroom/2014/SOHC-web.pdf. Accessed 11 January 2015
3. Stanek M. State Health Policy. Shared resources to sustain primary care transformation: strategies for federal and state policymakers [Internet], 2014. Available from http://www.nashp.org/sites/default/files/Shared-Resources-to-Sustain-Primary-Care-Transformation_0.pdf. Accessed 11 January 2015
4. Kirkman MS, Briscoe VJ, Clark N, et al. Diabetes in older adults. Diabetes Care 2012;35:2650–2664
5. Cheng YJ, Imperatore G, Caspersen CJ, Gregg EW, Albright AL, Helmick CG. Prevalence of diagnosed arthritis and arthritis-attributable activity limitation among adults with and without diagnosed diabetes: United States, 2008-2010. Diabetes Care 2012;35:1686–1691
6. Egede LE, Zheng D, Simpson K. Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. Diabetes Care 2002;25:464–470
7. Lobach D, Sanders GD, Bright TJ, et al. Enabling health care decision making through clinical decision support and knowledge management. Evid Rep Technol Assess 2012 (203):1–784
8. Anderson RJ, Freedland KE, Clouse RE, Lustman PJ. The prevalence of comorbid depression in adults with diabetes: a meta-analysis. Diabetes Care 2001;24:1069–1078
9. Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ 1995;152:1423–1433
10. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA 1999;281:283–287
11. Stein T, Frankel RM, Krupat E. Enhancing clinician communication skills in a large healthcare organization: a longitudinal case study. Patient Educ Couns 2005;58:4–12
12. Stafford M, Marmot M. Neighbourhood deprivation and health: does it affect us all equally? Int J Epidemiol 2003;32:357–366