

Diabetes, Patient-Centered Medical Homes, and Accountable Care Organizations, Oh My!

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Between 2007 and 2010, only 52.5% of people with type 2 diabetes mellitus achieved a hemoglobin A_{1c} level of less than 7.0%.¹ This statistic is alarming. Inadequate glycemic control not only puts a patient at risk for cardiovascular disease, it also remains the leading cause of blindness, kidney failure, and nontraumatic lower-limb amputations in the United States.² The total estimated cost of diagnosed diabetes in 2012 was \$245 billion, including \$176 billion in direct medical costs and \$69 billion in reduced productivity.³ This cost is not sustainable. If we continue to approach diabetes management in the same manner, we will simply continue to observe the same outcomes. Without a significant change in the way we approach patients with diabetes, our country will not be able to withstand the staggering costs associated with diabetes management, especially given that the prevalence of type 2 diabetes mellitus continues to rise, now estimated to affect more than 19.1 million people in the United States, including 8.1 million who remain undiagnosed.³ Changing the way we approach patients with diabetes, as well as those with other chronic health conditions, starts with transforming the model in which we administer health care.

Movement away from the traditional fee-for-service model of reimbursement has been long overdue, as this method has failed to improve health outcomes or rein in the ever-increasing cost of health care. The fee-for-service model

of reimbursement led to a fragmented, inefficient, and poorly coordinated health care system. The new models of health care emphasize improving health outcomes and reducing cost through care coordination.

The patient-centered medical home (PCMH) model strives to create a strong partnership between the patient and primary care physician, focusing on disease prevention and improving patient safety and the quality of care (ie, improving outcomes), all while reducing cost. In this model, the primary care physician leads the health care delivery team. The accountable care organization (ACO) model has similar goals to that of the PCMH model; however, the ACO reach is much broader, incorporating hospital systems, specialists, and home health care providers. Only time will tell if these models of health care delivery will be effective in reducing the cost of health care and improving access without compromising patient safety and quality of care.⁴ Although there is much uncertainty surrounding these models of health care delivery, one issue appears very clear: identifying and overcoming the barriers to achieving glycemic targets will become ever-more important, not only to prevent diabetes-related complications, but also to ensure reimbursement for the medical care associated with diabetes management as health care organizations begin to assume greater shared financial risk in the newer payment models.

The role of the patient is also changing. Patients are becoming "health care

consumers” as we shift toward a model of value-based care (high-quality/low-cost care). This evolving role from patients to health care consumers may help to improve their engagement, which seems paramount for either the PCMH or ACO models to work.

In the current supplement, Ciervo et al⁵ discuss how the principles of osteopathic medicine may be leveraged in our quest to improve diabetes outcomes in the current era of health care reform. In addition, the authors⁶ put the PCMH into context in a roundtable discussion, allowing readers to become more familiar with this model of health care.

All of the authors effectively summarize and highlight the changes and

challenges we are facing and how they will affect the care of our patients with diabetes. (doi:10.7556/jaoa.2015.056)

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Learning Objectives

On completion of this activity, participants should be able to:

- outline opportunities with new health care models to improve outcomes for patients with type 2 diabetes mellitus.
- identify the necessary collaborations, processes, and systems that will drive success in a complicated new accountable health care ecosystem.
- apply key methods of new health care models by identifying best practices and implementing solutions that advance community-based collaboration to improve outcomes for patients with type 2 diabetes mellitus