



Diabetes as a
Cardiovascular Disease:
**Strategies &
Partnerships to
Improve Health**

Proceedings

July 2009



Diabetes as a Cardiovascular Disease – Strategies & Partnerships to Improve Health

A Symposium Held on June 29, 2009

By
The California Medical Association Foundation
Advancing Practice Excellence in Diabetes Initiative

July 2009

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Table of Contents

Diabetes as a Cardiovascular Disease: Strategies & Partnerships to Improve Health A Symposium Held on June 29, 2009 Proceedings

I. Executive Summary

II. Acknowledgements

- Symposium Planning Committee
- Speakers, Facilitators, Moderators, Reactors
- CMA Foundation Diabetes Symposium Sponsors
- CMAF Staff
- Sierra Health Foundation

III. Symposium Content and Discussions

- Objectives
- Morning Presentations
- Reactors' Feedback
- Breakout Sessions
- Key Themes

IV. From Strategies to Tactics

- Potential CMA Foundation/APEX Project Ideas

V. Appendices

- Symposium Agenda
- Invitation List
- Executive Summary, Quality Collaborative
- Background
 - California Medical Association Foundation
 - Antecedents to Advancing Practice Excellence in Diabetes, APEX
 - Development of APEX
 - Development of the Quality Collaborative: Regional Pilot Projects
 - Other Quality Collaborative Component

Symposium Overview

On June 29, 2009, the California Medical Association Foundation held a symposium at the Sierra Health Foundation, Sacramento, entitled, “Diabetes as a Cardiovascular Disease: Strategies and Partnerships to Improve Health.” The daylong symposium brought together over 100 attendees to collaborate in the creation of a plan for improved diabetes care in California.

Symposium objectives are listed in the table below.



Symposium Learning Objectives
1. Describe strategies and best practices that have been identified to minimize diabetes/cardiovascular complications in solo/small group practice settings.
2. Identify key roles and resources needed for primary care staff to be stronger members of the care team.
3. Describe best practices in patient self-management and identify strategies to more effectively link primary care practices with community resources.
4. Articulate best practices in patient/physician communications regarding self-management and medication adherence.

By the end of the symposium, certain key themes emerged regarding patient self-management and medication adherence as well as approaches to spread the best practices and lessons from the CMA Foundation’s Diabetes Quality Collaborative.

Symposium Content and Discussions

Three presenters spoke on best practices in diabetes care, as follows:

- **Elissa K. Maas, MPH**, *Advancing Practice Excellence in Diabetes: Overview and Accomplishments*
Ms. Maas presented the findings of the CMA Foundation’s Diabetes Quality Collaborative; at the end of this pilot project, quality improvement was evident in clinical measures (HbA1c values, cholesterol and blood pressure) and in office procedures.

- Karen Adams, PhD**, *“National Priorities Partnership: Patient and Family Engagement as a National Priority for Transforming America’s Healthcare”*
 Dr. Adams presented information on the National Priorities Partnership, convened by the National Quality Forum, providing an overview of the National Priorities Partnership and its focus, “It’s about the patient!” and encouraged the Foundation to convene a California group of stakeholder’s to develop a statewide set of goals to improve healthcare quality.
- Peggy Yelinek, MBA**, *“Understanding Adherence: Putting the Patient First”*
 The theme of Ms. Yelinek’s presentation was empowering patients to become more actively involved in their therapy, thus motivating them to stay adherent to their prescribed therapy. Dialoguing with patients as “consumers” must be engaging, appealing and empowering to be effective; health literacy is remarkably low; consumers always need an incentive/feedback; streamline important information and tools for easy consumer navigation.

A reactor panel from various sectors of healthcare arena responded to the self-management and medication adherence presentations. Common to all reactors was the concern for improved diabetes care, with the patient as the focal point for quality improvement initiatives. The reactor panel was moderated by Victoria Rollins, MHA, RN, The Doctors Company, and was comprised of four individuals:

Reactor Panel Members	Organization
Gerry Bishop, MD	Aetna
Jared Garrison, DO	Family Care Clinic, Glenn Medical Center
Richard Sun, MD, MPH	CalPERS
Liz Helms	California Chronic Care Coalition

Key “take-aways” from the reactor panel were:

- Health plans must encourage medication adherence.
- Physicians, office staff and pharmacists should work together as a patient care team.
- Patient interventions might be studied to understand which provide the best outcomes at the least cost and which are sustainable.

Five breakout sessions in the afternoon provided an opportunity for symposium participants to give input on the morning’s presentations and reactor panel and to respond to a series of questions on the topic of diabetes care improvement. A critical question posed at each of the breakout sessions was –

“What is the role of the CMA Foundation in this area?”

Session	Facilitator	Organization
1	Ron Sanui, PharmD	California Department of Health Care Services
2	Jerry Penso, MD, MBA	Sharp Rees-Stealy Medical Group
3	Mike Negrete, PharmD	California Pharmacy Foundation
4	Liz Helms	California Chronic Care Coalition
5	Dexter Louie, MD, MD, MPA	CMA Foundation, Chair, Board of Directors

From Strategies to Tactics

Thanks to symposium participants, CMA Foundation staff and its Advancing Practice Excellence in Diabetes (APEX) project partners, many tactics were suggested to address the CMA Foundation’s three strategic directions of the project.

Strategic Directions	Suggested Tactics
<p>Prevention and Management of Diabetes & Cardiovascular Complications</p>	<ul style="list-style-type: none"> • Provide office staff training, including communication training, and training regarding the diabetes/cardiovascular disease link. • Engage medical students in diabetes education projects, using the existing vehicle of CMA Foundation medical student mini-grants. • Provide avenues for peer education among physicians, using a variety of formats. • Distribute the APEX “Diabetes as a Cardiovascular Disease Reference Guide.” • Disseminate Foundation’s Diabetes Quality Collaborative findings. • Undertake a social marketing campaign, targeting key populations focusing on hypertension, cholesterol management and blood sugar control. • Develop multilingual and multicultural patient education resources addressing diabetes and its cardiovascular complication.
<p>Health Plan Partnership</p>	<ul style="list-style-type: none"> • Share best practices among health plans from the Diabetes Quality Collaborative regarding how to more effectively work with smaller practices. • Establish a partnership with the California Department of Health Care Services and the California Department of Managed Health Care on a statewide diabetes quality improvement project. • Provide diabetes care training on best practices from the Quality Collaborative improvement information to healthcare plans. • Convene a partnership for providers and health plans (using the CMAF’s Alliance Working for Antibiotic Resistance Education, AWARE, as a model) to discuss and analyze various topics such as successful interventions to raise HEDIS measures.
<p>Patient Self Management & Medication Adherence</p>	<ul style="list-style-type: none"> • Create high quality, educational materials (multi-format, low and high literacy). • Develop, test and disseminate patient and physician (standardized) educational materials. • Develop patient education programs. • Develop resources for medical office staff to strengthen their role in practice and system change. • Create patient and provider education tools for dissemination via the CMAF website. • Create website outlining best practices (similar to “Practice Management” magazine). • Provide recognition of practices demonstrating best practices; this could be web-based. • Offer CME, including physician/patient communication training.

A number of other recommendations were developed at the Symposium, many focusing on the Foundation’s experience and success as a convener and another set focusing on patient and provider education. These recommendations included:

Convening Role -

- Coordinate stakeholders in quality improvement effort.
- Convene a forum on healthcare systems change by developing a partnership among California healthcare stakeholders. The goal of this partnership is improvement of diabetes care through definition of state level priorities. This forum would tackle the questions of care coordination, accountability, incentives, interventions, among other topics.
- Establish a collaborative partnership between all stakeholders; the partnership, not the resources, is what is lacking.

Provider & Patient Education Resources -

- Produce a “diabetes practice monograph” which highlights the successes of the Quality Collaborative participant physicians and staff.
- Expand the CMA Foundation website to included web-based resources on culturally responsive diabetes care.
- Make existing, non-branded, educational materials available to consumers.
- Provide resources, education and training for solo and small group practices, including technology issues.

Next Steps

The next steps for the CMA Foundation in moving these recommendations forward will include identifying funding opportunities and partnerships to support the efforts of the Foundation’s staff. Staff will also reconvene the APEX Expert Panel to further discuss recommended next steps and areas for focus. And, finally, the project will move from a set of regional pilot projects to a multi stakeholder, statewide initiative.



The California Medical Association Foundation acknowledges the following organizations for their support in putting on this event:

***Aetna Foundation
AstraZeneca
Daiichi Sankyo
The Doctors Company
Lilly USA
Novo Nordisk***

The California Medical Association Foundation acknowledges the help and support of many individuals and organizations who helped make the Symposium a success.

Symposium Planning Committee

Members of the Symposium Planning Committee provided their insights regarding improvement of diabetes care through the creation of a comprehensive agenda. The following individuals are acknowledged here:



- Kwabena Adubofour, MD, East Main Clinic, Stockton CA
- Cathy Coleman, RN, OCN, Lumetra
- Peggy Yelinek, MBA, McKesson
- Tami MacAller, MPH, California Diabetes Program, CA Dept. of Public Health
- Ronald Sanui, PharmD, CA Dept. of Health Care Services
- Ana Perez, APRN, CDE, California Diabetes Coalition
- Mike Zimmerman, MD, Affinity Medical Group, Alameda CA

Speakers, Facilitators, Moderators, Reactors

The success of the CMA Foundation’s Diabetes Symposium is due in large part to the speakers, facilitators, moderators, and members of the reactor panel who are thanked for their time and talents. These individuals are:

Name	Affiliation
Dexter Louie, MD, JD	CMA Foundation, Chair, Board of Directors
Elissa K. Maas, MPH	CMA Foundation
Carol A. Lee, J.D.	CMA Foundation
Karen Adams, PhD	National Quality Forum
Peggy Yelinek, MBA	McKesson
Victoria H. Rollins, MHA, RN	The Doctors Company
Gerry Bishop, MD	Aetna
Jared Garrison, DO	Family Care Clinic, Glenn Medical Center
Richard Sun, MD, MPH	CalPERS
Liz Helms	California Chronic Care Coalition
Ronald Sanui, PharmD	California Department of Health Care Services
Jerry Penso, MD, MBA	Sharp Rees-Stealy Medical Group, San Diego
Mike Negrete, PharmD	California Pharmacy Foundation

CMA Foundation Diabetes Symposium Sponsors

The CMA Foundation would like to thank the following organizations for their support in making the Diabetes Symposium possible:

**Aetna Foundation
AstraZeneca
Daiichi Sankyo
The Doctors Company
Lilly USA
Novo Nordisk**

CMA Foundation Staff

The hard work of all CMA Foundation staff is acknowledged here for making the Symposium a team effort! These individuals are Carol Lee, Elissa Maas, Sandra Navarro, Nela Lee, Sarah Newman, Lynn Godward, Shelley Tirsbeck, Phoua Moua, Shannon Eldridge, Anna Gutierrez, Leslie Barron, and Yvette Espinosa.

Sarah I. Newman, Project Assistant, Advancing Practice Excellence in Diabetes, is thanked for her outstanding job in conference planning, coordination and material design.

Sierra Health Foundation

A thank you is extended to the Sierra Health Foundation, a private independent foundation that supports health related activities in 26 northern California counties through grant-making and targeted initiatives. Sierra Health Foundation provided the meeting space as well as morning and afternoon refreshments.

This day-long symposium brought together key healthcare leaders in an interactive forum to collaborate in the creation of a plan for improved diabetes care in California. Each segment of the symposium generated consistently key issues. This report captures these “take-aways” and offers direction for the next phase of Advancing Practice Excellence in Diabetes.

Symposium Objectives

A core practice of the CMA Foundation is to engage in making a change that makes a difference. The CMA Foundation supports the creation of a sustainable partnership model that equips healthcare providers to provide the best care possible and empower patients to better manage their diabetes. This also enables physicians to appreciate their patients’ understanding of their chronic diseases and the behaviors needed for improved health.

In 2006, the California Medical Association (CMA) Foundation initiated its Advancing Practice Excellence in Diabetes’ Quality Collaborative. The overall goal of the initiative was to help improve the quality of diabetes care provided in solo and small group practices. In California, these healthcare providers represent approximately 60% of all primary care physicians, providing care to approximately 800,000 adult patients with type 2 diabetes. Because of the high rates of diabetes in ethnic communities, elimination of healthcare disparities was also a key focus of the collaborative.

The symposium provided a fundamental step in this direction. The symposium was a bridge linking the lessons of from the CMA Foundation’s Diabetes Quality Collaborative with future planning and bringing focus to include self management and lifestyle adherence.

In the US, medication adherence averages only 50-65% for common chronic conditions such as diabetes and hypertension. Approximately one in three people never even fill their prescriptions. Patients may be uncertain about their diagnosis or fear that they will lose control over some part of their life because of their chronic illness. Patients may have concerns about the possible side effects of the medication, difficulty in medication administration or uncertainty as to whether the medication is making a difference. Many patients also struggle with maintaining the lifestyle changes recommended by their healthcare provider.

The overall purpose of the symposium was to build from these strategies, by identifying possible tactics (or, potential APEX program activities). The CMA Foundation hoped to answer the question, “What are the best approaches to improve diabetes care in California, based on what was learned from the Quality Collaborative?” Moving forward, APEX hopes to incorporate what is known about patient self-management and medication, while focusing on diabetes and its cardiovascular complications.



The objectives for “Diabetes as a Cardiovascular Disease: Strategies and Partnerships to Improve Health” are presented below.

Symposium Learning Objectives
1. Describe strategies and best practices that have been identified to minimize diabetes/cardiovascular complications in solo/small group practice settings.
2. Identify key roles and resources needed for primary care staff to be stronger members of the care team.
3. Describe best practices in patient self-management and identify strategies to more effectively link primary care practices with community resources.
4. Articulate best practices in patient/physician communications regarding self-management and medication adherence.

Agenda and Invitees

The agenda for this statewide symposium included the following components:

- Advancing Practice Excellence in Diabetes Overview and Accomplishments
- Dual perspective presentations (two speakers defined the drivers, key issues and best practices associated with patient self-management and medication adherence)
- Reactor panel (four “reactors” from various sectors of healthcare arena responded to the self-management and medication adherence presentations)
- Networking lunch (attendees shared their thoughts with the each other about the symposium’s morning activities)
- Breakout sessions (participants in five breakout sessions brainstormed questions related to patient self-management and medication adherence)
- Wrap-up (spokespersons highlighted next steps in formulating the CMA Foundation’s plan to expand its APEX initiative, as a statewide plan to improve diabetes (as a cardiovascular disease) care.

The symposium agenda is provided in the appendices section.

As with all CMA Foundation projects, focus was centered on partnership. The list of symposium invitees is included in the appendices section.

Morning Presentations

At the CMA Foundation's Diabetes Symposium, three presenters spoke to best practices in diabetes care, as follows:

- Elissa K. Maas, MPH, "Advancing Practice Excellence in Diabetes: Overview and Accomplishments"
- Karen Adams, PhD, "National Priorities Partnership: Patient and Family Engagement as a National Priority for Transforming America's Healthcare"
- Peggy Yelinek, MBA, "Understanding Adherence: Putting the Patient First"

Elissa Maas, MPH: In her presentation, Elissa Maas provided an overview of the CMA Foundation's Advancing Practice Excellence in Diabetes (APEX). The first phase of has been completed. Known as the "Diabetes Quality Collaborative" (or, "Quality Collaborative"), this project focused on quality improvement of diabetes care within smaller medical practices in California. (The Power Point slides for this presentation are included in this report's appendices section.)



The regions targeted in this project included Butte and Glenn Counties (northern California), San Joaquin County (central California) and Riverside and Riverside and San Bernardino Counties (southern California). Twenty-four solo and small group practices began the project. Blue Shield of California, Health Plan of San Joaquin, Inland Empire Health Plan, and Molina Healthcare provided assistance in recruitment, communication with offices, and provision of stipends for participating practices.

Methodology used in the project included:

- Benchmarking diabetes care and clinical measures
- Identification of goals by each practice through a practice action plan
- Adaptation of the Chronic Care Model
- Provision of DocSite Registry to participating practices
- Training and technical assistance
- Final evaluation and exit interviews

At the end of the pilot project, quality improvement was evident in clinical measures (HbA1c values, cholesterol and blood pressure) and in office procedures.

Examples of practice improvements are as follows:

- Prepared, proactive team (regular staff meetings, morning/pre-visit "huddle"), medical assistants performing routine visual foot exams or preparing patient for these)

- Clinical information system (diabetes screening of all patients, patient charts with flow sheets and pre-filled lab slips)
- Delivery system design (in-language patient education materials)
- Decision support (combined diabetes and cardiovascular disease visit flow sheet)

Karen Adams, PhD: Dr. Adams presented information on the National Priorities Partnership, convened by the National Quality Forum. Dr. Adams’ talk, “National Priorities Partnership: Patient and Family Engagement as a National Priority for Transforming America’s Healthcare,” provided an overview of the National Priorities Partnership and its focus, “It’s about the patient!”

The vision of this project regarding patient and family engagement is, “We envision care that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to differing cultures, languages, and social backgrounds.” Areas of focus include:



- Patient experience of care
- Patient self-management
- Informed decision-making

The vision of the National Priorities Partnership with regard to care coordination is, “We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professionals accountable for their care.”

Areas of focus include:

- Medication reconciliation
- Preventable hospital readmissions
- Preventable emergency department visits

Five key dimensions of care coordination are endorsed by the National Quality Forum: healthcare “home,” proactive plan of care and follow-up, communication, information systems, and transitions (or hand-offs). The National Quality Forum’s Care Coordination Project endorses a set of preferred practices and performance measures for care coordination that will move the field toward shared accountability across providers and systems, and identifies high-priority research areas to advance the evaluation of care coordination as a quality improvement tool.

Peggy Yelinek, MBA: “Understanding Adherence: Putting the Patient First” was the topic addressed by Peggy Yelinek. The theme focused on empowering patients to become more actively involved in their therapy, thus motivating them to stay adherent to their prescribed therapy.

The main messages of Ms. Yelinek’s presentation are summarized here:

- Non-adherence is a multi-faceted problem, and each patient has their own story.
- Identifying a patient’s readiness to engage in their journey to wellness is step one.
- Behavioral models can be strategic road maps, where physician/patient concordance is critical to patient adherence.
- Patients faced with the prospect of health behavior change will undergo a process called “decisional balance.”
- Dialoguing with patients as “consumers” must be engaging, appealing and empowering to be effective; health literacy is remarkably low; consumers always need an incentive/feedback; streamline important information and tools for easy consumer navigation.

Additionally, Ms. Yelinek shared the guiding principles for successful adherence programs, as follows:

- Build from an understanding of patient attitudes, beliefs and concerns.
- Segment and target at-risk populations.
- Address major barriers to adherence (financial, clinical and behavioral).
- Personalize approach to patient’s situation.
- Set aggressive but realistic goals and define expected outcomes.
- Recognize the difficulty of achieving impact by building in redundancies and reinforcing actions.
- Provide incentives/rewards for expected outcomes, initiation and maintenance.
- Involve multiple stakeholders, including patients, physicians, nurses, pharmacists, payers, etc.
- Create new connections between stakeholders to help them align and improve impact.

Reactor Panel Feedback

As mentioned above, a reactor panel (“reactors” from various sectors of healthcare arena) responded to the self-management and medication adherence presentations. The reactor panel was moderated by Victoria Rollins, MHA, RN, The Doctors Company, and was comprised of four individuals:

Reactor Panel Member	Organization/Business
Gerry Bishop, MD	Aetna
Jared Garrison, DO	Family Care Clinic, Glenn Medical Center
Richard Sun, MD, MPH	CalPERS
Liz Helms	California Chronic Care Coalition

Ms. Rollins asked the panelists these questions:

- What are you seeing in your practice (at the local level) that resonates with our speakers’ presentations?
- What role might a health plan play in promoting medication adherence?
- What are some misconceptions about medication adherence (such as patient stereotypes)?

- These are not simple issues...how can we work more collaboratively to deal with these issues? (How do we break down the “silos”?)

Discussion involved the following key concepts:



- **Health plans** must encourage medication adherence. This effort should include provision of appropriate (socio-cultural and literacy variables) and engaging health education materials. Participants felt that clinical care would improve with feedback from health plans. “Value-based insurance design” might be considered where there is a sliding scale for patient copayments based on ability to pay, in order to encourage the refilling of prescriptions. However it is achieved, affordable healthcare should be a primary goal. Additionally, consistency in treatment across health plans might lead to greater patient trust.
- **Physicians, office staff and pharmacists** should work together as a patient care team, with the mutual goal of providing the patient with tools for empowerment. Better communication and motivational skills would enhance healthcare professionals’ ability to improve diabetes care.
- **Patient interventions** might be studied to understand which provide the best outcomes at the least cost and which are sustainable. The patient must be the focus when comparing interventions. Interventions should encourage the patient to participate in wellness activities such as nutrition and exercise programs. Emphasis should be placed on prevention (goals setting and education) rather than on threats of future complications. Internet communication can be employed successfully. However, patient education is not achieved through information overload. Finally, there are no substitutes for face-to-face meetings and continued follow-up.
- **“Silos” should be eliminated.** The National Quality Forum provides an example for goal-setting. Similar processes might be useful on the local and state levels. Along this line is the “Right Care Initiative,” sponsored by the California Department of Managed Health Care; this is a local priorities partnership with the goal of promoting self-management, focusing on the patient.

Breakout Sessions

Five breakout sessions in the afternoon provided an opportunity for symposium participants to give input on the morning’s presentations and reactor panel and to respond to a series of questions on the topic of diabetes care improvement (patient self-management and medication adherence). Questions posed at the sessions were as follows:

Session	Key Questions of Breakout Sessions
1	How can health plans play a stronger role in supporting physicians and patients to strengthen care, improve self-management and medication adherence?
2	How can the office be redesigned to strengthen diabetes/cardiovascular disease care, self-management and medication adherence?
3	How can medical practices have stronger connections to resources and partners in their communities?
4	How can consumers be most effectively reached with messages about self-management and medication adherence, helping patients to make the behavioral changes needed?
5	Who are the key agencies at the federal, state and local levels that need to be engaged to improve diabetes care, and how can they work most effectively with one another and external stakeholders?

Findings and highlights of participant discussion from each of the breakout sessions are provided here.

Session 1: How can health plans play a stronger role in supporting physicians and patients to strengthen care, improve self-management and medication adherence?

Facilitator: Ron Sanui, PharmD, California Department of Health Care Services

Breakout session participants' comments are highlighted below:

- **HEDIS outcomes** are improved by appropriate interventions (educational tools, workshops, etc.). Medi-Cal Managed Care utilizes HEDIS measures and has utilized state-required quality improvement projects. Measures are publically accessible, and plans are rewarded based on the number of defaults obtained.
- **All groups of healthcare professionals** must be welcomed to the table. The perspectives of pharmacists and quality improvement (QI) managers are extremely valuable. Another group of helpful change agents are “physician champions.” The keys are partnership as well as agreement on needs and challenges.
- **Best practice interventions** include use of patient education vehicles, provision of coupons, follow-up surveys of patients, use of medical assistants, and mailing information to patient. Wellness programs for employees are important, with employees having input regarding how these programs are structured. Use of new social networking technology provides a new and innovative opportunity for intervention.
- **Models of self-management** include the Ashville Project which addresses medical therapy management and which involves pharmacists. The California Department of Managed Health Care’s “Right Care Initiative” is also targeting quality improvement. Models must be outcome-

based so that interventions (including provision of incentives and removal of barriers) can be tested. (The group acknowledged that best practices for large medical groups may be difficult to implement in solo and small group practices.)

Potential roles for the CMA Foundation suggested by Breakout Session 1 include:

- Convene a partnership of providers and health plans (using the CMAF's Alliance Working for Antibiotic Resistance Education, AWARE, as a model) to discuss and analyze various topics such as successful interventions to raise HEDIS measures.
- Provide diabetes care improvement training and resources to healthcare plans.
- Create patient and provider education tools for dissemination via the CMAF website.
- Make existing, non-branded, educational materials available to consumers.

Session 2: How can the office be redesigned to strengthen diabetes/cardiovascular disease care, self-management and medication adherence?

Facilitator: Jerry Penso, MD, MBA, Sharp Rees-Stealy Medical Group

Dr. Jerry Penso, the facilitator of this group, led participants in an exercise to highlight differing points of view among patients, physicians and office staff). Results were as follows:

- **Patient Point of View:** Patient education materials should be “user friendly.” What is needed is a simple, one-page reference written in layman’s terms that is customized to the particular “patient’s moment.” Physicians should be more positive, less vague and should explain procedures, medications, labs, and so forth. Discussion included:
 - Personalized education materials (e.g., check boxes)
 - Patient satisfaction data (e.g., confidential visit surveys) to create healing environment
 - Patient advisory council to identify issues and provide constructive criticism (e.g., Johns Hopkins model)
- **Physician Point of View:** Physicians observe that often patients have multiple issues which are given more importance than diabetes. Physicians do not have enough time for teaching, explanation and support. Many patients do not take medications appropriately and do not schedule follow-up visits. Physicians acknowledge lack of reimbursement for phone calls and emails to patients. Office staff lack of time and turnover (with resultant ongoing need for staff training) is also recognized. Related ideas were:
 - Follow-up of patient by health plans’ membership services departments
 - Use of diabetes care coordinators
 - Better reimbursement (pay for visit preparation time, phone calls, emails)
 - Patient incentives for adherence and follow-up
 - Need for standardization of diabetes care by health plans (tests, medications, equipment)
 - Increased collaboration between practices and health plans

- **Office Staff Point of View:** Efficiency is a concern (electronic health record, patient flow, and patient registry). Staff request more respect, education about diabetes, increased pay, and rewards/incentives. Strengthening the office team would be valuable (with staff having input into decision-making). Patients should arrive on time; physicians should follow the schedule. Customer service training would be helpful. Brainstorming identified the following:



- Need for staff training on common diseases, leading to more support for the practice and the physician
- Staff training by pharmacy representatives
- Newsletter for office staff
- Identified contact people for patients (to help with follow up)
- Daily staff huddles for information exchange

Potential roles for the CMA Foundation suggested by Breakout Session 2 include:

- Create high quality, educational materials (multi-format, low and high literacy).
- Create web resource outlining best practices (similar to “Practice Management” magazine).
- Coordinate stakeholders in quality improvement effort.
- Provide office staff training, including communication training.
- Provide recognition of practices demonstrating best practices; this could be web-based.
- Offer CME, including communication training.

Session 3: How can medical practices have stronger connections to resources and partners in their communities?

Facilitator: Mike Negrete, PharmD, California Pharmacy Foundation

Discussion from this breakout session is summarized as follows:

- **Health education** has traditionally been the domain of non-profit healthcare organizations, including public health departments. (The Diabetes Information Resource Center, DIRC, www.caldiabetes.org, is an excellent on-line resource.) A key component to medication adherence is social marketing, how to get messages to target audiences.
- **Partnerships** between health plans, payers, medical groups, non-profit healthcare organizations, and foundations should result in increased education for patients and office staff. Health care community partners for improved diabetes care should consider such professionals as pharmacists and optometrists. Collaborative partnership between all stakeholders is what is lacking.

- **Communication between health care professionals** might be enhanced by community “memorandum of understanding” and healthcare information technology.

Potential roles for the CMA Foundation suggested by Breakout Session 3 include:

- Provide resources, education and training for solo and small group practices, including technology issues.
- Establish a collaborative partnership between all stakeholders; the partnership, not the resources, is what is lacking.
- Undertake a social marketing campaign, targeting key populations.

Session 4: How can consumers be most effectively reached with messages about self-management and medication adherence, helping patients to make the behavioral changes needed?

Facilitator: Liz Helms, California Chronic Care Coalition

Participants in Breakout Session 4 discussed these items:

- **Cultural and linguistic competency** is vital to healthcare delivery, aiding physicians and office staff in understanding beliefs, values and behaviors. Prevention and treatment information directed to the patient must be appropriate for that patient. Self-management and medication adherence are tied to patients’ needs, wishes and goals which are, in term, related to socio-cultural factors.
- **Informational avenues** other than physicians (who have limited time) should be accessed (e.g., patient classes, support groups, diabetes care coordinator, health coach). On the individual level, diabetes care can be improved with postcard reminders. On the community level, billboards and signs at bus stops are used as to relay health messages. Consider use of communication technology (e.g., iPhone applications), using simple messages.
- **Consumer awareness** could be studied with regard to the current H1N1 situation. What can be learned from this? Investigate why consumers do or do not seek illness prevention strategies (e.g., the role of denial, anger, etc.). Investigate what works in prevention and treatment follow up (e.g., “scare tactics” vs. incentives).
- **Employers** sometimes involve their human resources departments in promoting wellness. Absenteeism is measurable; healthcare benefits have defined costs. Improvement of productivity is an important incentive for business in this regard.

- **Policy changes** would play a role in improving diabetes care. For instance, create policy so that farmers' markets are able to accept food stamps; tax consumer products (tobacco is the model) to support healthcare programs.

Potential roles for the CMA Foundation suggested by Breakout Session 4 include:

- Develop, test and disseminate patient and physician (standardized) educational materials.
- Engage medical students in diabetes education projects, using the existing vehicle of CMA Foundation medical student mini-grants.
- Advertise local wellness resources such as farmer's markets; teach consumers how to cook wholesome food from farmers' markets.
- Work with policy makers to tax consumer products (tobacco is the model) to support healthcare programs.

Session 5: Who are the key agencies at the federal, state and local levels that need to be engaged to improve diabetes care, and how can they work most effectively with one another and external stakeholders?

Facilitator: Dexter Louie, MD, JA, MPA, CMA Foundation, Chair, Board of Directors

Breakout Session 5 differed from the other breakout sessions in that it focused largely on policy. Discussion from this breakout session is summarized as follows:

- **Payment plans** should be reviewed for their impact on health care quality improvement. What is considered "standard" across health plans? What is "extra"? Is capitation the best strategy towards improving patient outcomes? Is fee-for-service an outdated model?
- **Data collection** is an important function provided by health plans. Are the right data being collected which will help physicians track patient outcomes? How is data distributed? Are the right people getting the right information? Medi-Cal Managed Care providers constitutes a group that could help rectify this matter.
- **Reimbursement strategies** have major impacts on the success of healthcare delivery systems. What is the best health plan structure for disease prevention? Should we look beyond the individual patient to include family members? Should primary care be emphasized, rather than specialty care? Consider the Integrated Health Assessment Model which focuses on outcome, where payment is made for outcome improvement. Consider applying managed care best practices (accountability, incentives) to the fee-for-service environment. It is recognized that there are few system incentives for chronic disease management. Public reporting may help with this.



- **Policy making** has a role to play in disease prevention and wellness promotion (e.g., tax unhealthy substances, food and drink). Local policies should support access to nutritious food. What have county public health departments accomplished in this area? The California Department of Healthcare Services plays a critical role in review of public health and healthcare legislation.

Potential roles for the CMA Foundation suggested by Breakout Session 5 include:

- Convene a forum on healthcare systems change by developing a partnership among California healthcare stakeholders. The goal of this partnership is improvement of diabetes care through definition of state level priorities. This forum would tackle the questions of care coordination, accountability, incentives, interventions, among other topics.
- Report to federal health policy makers that healthcare change (reform) is needed.
- Provide avenues for peer education among physicians.
- Develop patient education programs.
- Identify examples of best practice models that can be shared with Federal policy makers and Federal health agencies.

By the end of the symposium, the overall direction of the project was apparent. We will broaden its focus to a statewide campaign, building on what has been learned in the Quality Collaborative. We will continue to concentrate on the diabetes/cardiovascular disease link and address healthcare disparities. *Advancing Practice Excellence in Diabetes* will initiate work in the areas of patient self-management and medication adherence. Content areas will include clinical education, best practice dissemination, strengthening the care team, and patient education.



Potential CMA Foundation/APEX Project Directions

Thanks to symposium participants, CMA Foundation staff and APEX project partners, many ideas have emerged for consideration for future APEX program activities.

In this section, suggested tactics relevant to the CMA Foundation’s four defined strategies (management of diabetes and its cardiovascular complications, health plan partnership and patient self-management) are presented. There may be duplication of ideas due to similarity of suggestions arising in multiple breakout sessions.



Strategic Directions	Suggested Tactics
<p>Prevention and Management of Diabetes & Cardiovascular Complications</p>	<ul style="list-style-type: none"> • Provide office staff training, including communication training, and training regarding the diabetes/cardiovascular disease link. • Engage medical students in diabetes education projects, using the existing vehicle of CMA Foundation medical student mini-grants. • Provide avenues for peer education among physicians, using a variety of formats. • Distribute the APEX “Diabetes as a Cardiovascular Disease Reference Guide.” • Disseminate Foundation’s Diabetes Quality Collaborative findings. • Undertake a social marketing campaign, targeting key populations focusing on hypertension, cholesterol management and blood sugar control. • Develop multilingual and multicultural patient education resources addressing diabetes and its cardiovascular complication.
<p>Health Plan Partnership</p>	<ul style="list-style-type: none"> • Share best practices among health plans from the Diabetes Quality Collaborative regarding how to more effectively work with smaller practices. • Establish a partnership with the California Department of Health Care Services and the California Department of Managed Health Care on a statewide diabetes quality improvement project. • Provide diabetes care training on best practices from the Quality Collaborative improvement information to healthcare plans. • Convene a partnership for providers and health plans (using the CMAF’s Alliance Working for Antibiotic Resistance Education, AWARE, as a model) to discuss and analyze various topics such as successful interventions to raise HEDIS measures.

Patient Self Management & Medication Adherence

- Create high quality, educational materials (multi-format, low and high literacy).
- Develop, test and disseminate patient and physician (standardized) educational materials.
- Develop patient education programs.
- Develop resources for medical office staff to strengthen their role in practice and system change.
- Create patient and provider education tools for dissemination via the CMAF website.
- Create website outlining best practices (similar to “Practice Management” magazine).
- Provide recognition of practices demonstrating best practices; this could be web-based.
- Offer CME, including physician/patient communication training.

A number of other recommendations were developed at the Symposium, many focusing on the Foundation’s experience and success as a convener and another set focusing on patient and provider education. These recommendations included:

Convening Role -

- Coordinate stakeholders in quality improvement effort.
- Convene a forum on healthcare systems change by developing a partnership among California healthcare stakeholders. The goal of this partnership is improvement of diabetes care through definition of state level priorities. This forum would tackle the questions of care coordination, accountability, incentives, interventions, among other topics.
- Establish a collaborative partnership between all stakeholders; the partnership, not the resources, is what is lacking.

Provider & Patient Education Resources -

- Produce a “diabetes practice monograph” which highlights the successes of the Quality Collaborative participant physicians and staff.
- Expand the CMA Foundation website to include web-based resources on culturally responsive diabetes care.
- Make existing, non-branded, educational materials available to consumers.
- Provide resources, education and training for solo and small group practices, including technology issues.

Next Steps

The CMA Foundation will broaden its focus to a statewide campaign, building on what has been learned in the Quality Collaborative. We will continue to concentrate on the diabetes/cardiovascular disease link and address healthcare disparities. *Advancing Practice Excellence in Diabetes* will initiate work in the areas of patient self-management and medication adherence.

The next steps for the CMA Foundation in moving these recommendations forward will include identifying funding opportunities and partnerships to support the efforts of the Foundation's staff. Staff will also reconvene the Project's Expert Panel to further discuss recommended next steps and areas for focus. And, finally, the project will move from a set of regional pilot projects to a multi stakeholder, statewide initiative.

Appendices

- Symposium Agenda
- Stakeholder Invitee List
- Background
 - California Medical Association Foundation
 - Development of Advancing Practice Excellence in Diabetes
 - Development of the Quality Collaborative: Regional Pilot Projects
- Executive Summary, Diabetes Quality Collaborative





Symposium Agenda

Diabetes as a Cardiovascular Disease – Strategies & Partnerships to Improve Health

June 29, 2009

Sierra Health Foundation
1321 Garden Highway, Sacramento

8:15 a.m. – 8:45 a.m.	Continental Breakfast/Registration/Exhibit Tables Open
8:45 a.m. – 9:00 a.m.	Welcome Dexter Louie, MD, JD, MPA Chair, CMA Foundation Board of Directors <ul style="list-style-type: none">▪ Purpose of the Symposium & Review of the Agenda and Goals for the Day.
9:00 a.m. – 9:30 a.m.	Advancing Practice Excellence in Diabetes: Overview and Accomplishments Elissa K. Maas, MPH, Vice President, Programs, CMA Foundation <ul style="list-style-type: none">▪ Project Summary▪ Methods▪ Evaluation▪ Outcomes▪ Lessons Learned
9:30 a.m. – 9:45 a.m.	Moving Forward – Addressing Patient Self-Management and Medication Adherence Carol A. Lee, Esq, President and CEO, CMA Foundation
9:45 a.m. – 10:00 a.m.	BREAK
10:00 a.m. – 11:15 a.m.	Aligning National Priorities and Innovative Approaches for Patient-Centered Diabetes and Cardiovascular Care Moderator: Carol A. Lee, Esq., President and CEO, CMA Foundation National Priorities Partnership: Patient and Family Engagement as a National Priority for Transforming America's Healthcare Karen Adams, PhD, MT National Quality Forum Understanding Adherence: Putting the Patient First Peggy Yelinek, MBA McKesson
11:15 a.m. – 12:00 p.m.	Reactor Panel – Putting this into Practice Moderator: Victoria H. Rollins, MHA, RN, The Doctors Company

Panelists:

Gerry Bishop, MD
Aetna

Jared Garrison, DO
Glenn Medical Center – Family Care Clinic

Richard Sun, MD, MPH
CalPERS

Liz Helms
California Chronic Care Coalition

12:00 p.m. – 1:00 p.m.

Networking Lunch

1:00 p.m. – 1:15 p.m.

The Afternoon Breakout Sessions – Purpose & Framework – Elissa Maas, MPH

1:15 p.m. – 2:45 p.m.

Afternoon Breakout Sessions

Breakout 1 - How can health plans play a stronger role in supporting physicians and patients to strengthen care, improve self-management and medication adherence?

Facilitator: *Ron Sanui, PharmD, California Department of Health Care Services*

- What are some of the key partnerships opportunities?
- What can be changed to be more effective; what role can your organization play?
- What are some key policy issues?
- What are some likely starting points?
- How can these interventions be funded?
- When a doctor wants to make changes to help a patient get to goal, how can a health plan be a stronger partner?
- What is the role of CMA Foundation in this area?

Breakout 2 - How can the office be redesigned to strengthen diabetes/ CVD care, self-management & medication adherence?

Facilitator: *Jerry Penso, MD, MBA Sharp Rees-Stealy Medical Group*

- Why are self-management and medication adherence important to better diabetes care?
- How can we better help patients with diabetes accept their diagnosis (e.g., peer-to-peer communication)?
- What is the best use of the office team members to achieve improved self-management and medication adherence?
- What are some key factors in strong patient/physician/care team communication?
- How do we share best practices that are working and lessons learned?
- What role can your organization play?
- How can these interventions be funded?
- How do we help the physician/care team recognize that it's time to change, to get the patient to goal?
- What is the role of CMA Foundation in this area?

Breakout 3 - How can medical practices have stronger connections to resources and partners in their communities?

Facilitator: *Mike Negrete, PharmD, California Pharmacy Foundation*

- How can offices be better organized to refer patients to these resources and identify if patients are linking with them?
- How do we more effectively link medical practices, community pharmacy, hospital resources and community based organizations?
- What are some likely starting points; what role can your organization play?
- How can these interventions be funded?
- What is the role of CMA Foundation in this area?

Breakout 4 - How can consumers be most effectively reached with messages about self-management and medication adherence, helping patients to make the behavioral changes needed?

Facilitator: *Liz Helms, California Chronic Care Coalition*

- What types of messages will have the greatest impact?
- Who are strong messengers?
- How can we more effectively reach out and work with business in consumer activation?
- What are some likely starting points; what role can your organization play?
- How can these interventions be funded?
- What is the role of CMA Foundation in this area?

Breakout 5 - Who are the key agencies at the federal, state and local levels that need to be engaged to improve diabetes care and how can they work most effectively with one another and external stakeholders?

Facilitator: *Dexter Louie, MD, JD, MPA, CMA Foundation*

- Are there policy areas that, if addressed, can improve patient care, self-management or adherence?
- What are some likely starting points; what role can your organization play?
- How can these interventions be funded?
- What is the role of CMA Foundation in this area?

2:45 p.m. – 3:45p.m. **Report Back from Breakout Groups – Facilitators**

3:45 p.m. – 4:00p.m. **Close and Next Steps in the CMA Foundation Advancing Practice Excellence in Diabetes Statewide Campaign and Plan**
Elissa K. Maas, MPH, Vice President of Programs, CMA Foundation
Sandra Navarro, PhD, MPH, Director of Clinical Quality Improvement, CMA Foundation



Stakeholders Invited to Attend

Diabetes as a Cardiovascular Disease: Strategies & Partnerships to Improve Health A Symposium Held on June 29, 2009

In addition to the physicians who completed the APEX Diabetes Quality Collaborative, representatives from the following organizations and businesses were invited to the symposium:

100 Black Women	Electronic Data Service
Aetna	Health Net of California
American Association of Clinical Endocrinologists, California Chapter	Health Plan of San Joaquin
American College of Physicians, California Chapter	Inland Empire Health Plan
Anthem Blue Cross	Kaiser Permanente
Asian Pacific Islander Health Forum	Latino Coalition for a Healthy California
AstraZeneca	LA Care Health Plan
Blue Shield of California	Lifescan, Inc.
California Academy of Family Physicians	Lilly USA
California Academy of Physician Assistants	Lumetra
California Association of Nurse Practitioners	McKesson
California Association of Physician Groups	Med Impact
California Black Health Network	Merck
California Conference of Local Health Officers	Molina Healthcare
California Department of Healthcare Services	National Consumers' League
California Department of Managed Health Care	National Quality Forum
California Diabetes Program	National Medical Association
California Healthcare Foundation	Novartis
California Latino Medical Association	Novo Nordisk
California Medical Assistants Association	Network of Ethnic Physician Organizations
California Medical Association County Medical Executives	New America Media
California Pharmacy Foundation	NorCal
California Primary Care Association	Novartis
CalPERS	Novo Nordisk
Chinese Community Health Resource Center	Pacific Business Group on Health
Chinese Health Plan	Pfizer
Coached Diabetes Care	Sacramento Latino Medical Association
Daiichi Sankyo	Sharp Rees-Stealy Medical Group
Diabetes Coalition of California	United Healthcare
The Doctor's Company	University of the Pacific, School of Pharmacy
	Vietnamese American Medical Association
	Vision Y Compromiso
	Wyeth

California Medical Association Foundation

The CMA Foundation is a nonprofit organization that serves as a link between physicians and their communities. The Foundation champions improved individual and community health through a partnership of leaders in medicine, related health professions, and the community.

CMA Foundation projects are developed to address pressing public health issues by:

- Providing leadership in crucial and emerging health issues
- Enabling physicians to provide the best care possible to their patients through various outlets including training opportunities and access to cutting edge materials and resources
- Building the capacity of physicians and physician organizations to work collaboratively to improve health
- Strengthening the ability of physicians to work with diverse communities



The CMA Foundation was established in 1963 as a charitable arm of its parent company, the California Medical Association. CMA realized the importance of supporting California's future physicians through their educational years and created the Foundation to handle grant and loan disbursement for medical students. Between 1963 and 1995, the Foundation distributed more than \$1 million dollars in aid.

In 1995 the Foundation began a transformation at the recommendation of then-board chair, Rolland C. Lowe, MD, who urged the Foundation to expand its function to encompass community health. The board of directors adopted this new direction, and the Foundation began community health efforts in 1996 and 1997 with tobacco education and reduction projects, as well as a physician leadership recognition dinner. Through ComPACT—a tobacco education project, and the Pharmacy Partnership Project that rallied pharmacies to remove tobacco products from their stores, the CMA Foundation began to establish its position in the community as the leader in public health initiatives.

In 2000, the Foundation initiated its community involvement with the launch of the AWARE Project—the Alliance Working for Antibiotic Resistance Education. The project gained national recognition and earned several prestigious awards, including Blue Cross and Blue Shield Association's Best of Blue Award, and the Centers for Disease Control and Prevention's award for Innovation in Appropriate Antibiotic Use Programs in the Community.

With the success of the AWARE Project, the Foundation was able to further its community involvement efforts with new projects including the Network of Ethnic Physician Organizations, Advancing Practice Excellence in Diabetes, and the Obesity Prevention Project. Shortly after, the Foundation took on

women's health with a Cervical Cancer and HPV Project and today continues to grow and expand all of its community health efforts.

Over the past decade, the CMA Foundation has become a leader in community health improvement efforts. As pressing public health issues continue to evolve and change in California, the Foundation will continue to develop strategies to address them.

In 2002, the CMA Foundation began a project for ethnic physicians to identify and strengthen California's ethnic physician organizations. The Network for Ethnic Physicians Organizations (NEPO) identified more than 50 ethnic physician organizations throughout California, with members totaling over 10,000 physicians. In 2002, the Foundation launched a project addressing diabetes and obesity in adults and youth, with a major focus on the reduction of racial and ethnic health disparities associated with type 2 diabetes. This project pointed up a need to focus on the topic of healthcare disparities.

In January 2004, NEPO embarked on an effort to address health disparities by developing a framework for action. NEPO adopted a diabetes health disparities plan of action in November 2004. Diabetes was chosen as the first condition to address because of its disproportionate impact within ethnic communities.

The CMA Foundation also held meetings to identify the key roles it could play to strengthen its efforts to address diabetes. Included in these meetings were specialty medical societies, ethnic physician organizations, health plans, provider organizations, academic medical centers, public health practitioners, diabetes care management organizations, consumer and community-based organizations, and policy makers.

Physician interviews were conducted with thought leaders about provider education, disease management and health disparities reduction to further define how the CMA Foundation could utilize its infrastructure of 40 county medical societies, 25 specialty medical societies, 50 ethnic physician organizations, and other partnerships to improve diabetes care. This information resulted in the CMA Foundation's focus on improving diabetes care in small physician offices. In partnering with ethnic physician organizations, CMA Foundation attempted to create a culturally responsive model to reduce diabetes health disparities.

Development of Advancing Practice Excellence in Diabetes Project

In 2005, the CMA Foundation began to build a multiyear statewide project with two goals: to decrease the prevalence of type 2 diabetes and obesity and to reduce racial and ethnic health disparities associated with the care and treatment of type 2 diabetics. Funders were sought to initiate a process to develop and disseminate clinical best practices and educate primary care providers, particularly those in solo and small group practice, about quality diabetes care management and team based diabetes care. The hope was that this proposed project would serve as a national model to engage solo and small group practice physicians to improve diabetes care and thus reduce health disparities.

This focused effort by the CMA Foundation became known as Advancing Practice Excellence in Diabetes.

Recognizing that some of the highest rates of diabetes in California were found in San Joaquin, Butte, Riverside, San Bernardino, and San Joaquin Counties, three regional collaboratives were envisioned to

develop best practices among solo and small group primary care physicians. A culturally appropriate team care model was a key component of the proposed project.

The CMA Foundation then, as now, followed strategies of partnership and collaboration. In 2005, this brought together the CMA Foundation and a number of clinical and health plan partners. The collaborative outlined its roadmap:

- Tailor the chronic care model and team-based care to small physician offices.
- Ensure that this model is culturally appropriate.
- Integrate office practice with community-based resources so that greater integration occurs between primary care physicians and other members of the diabetes care team.
- Collapse the time frame for initiation of treatment.
- Establish consistent guidelines regarding the measurement of A1C and initiation of treatment.
- Develop the application of diabetes registries to the small office setting in order to collect data to track office practice and patient outcomes.
- Use decision support tools that help clinicians and patients make informed decisions about diabetes care.
- Increase understanding of diabetes care in ethnic communities.

Development of the Quality Collaborative: Regional Pilot Projects

In 2006, the California Medical Association (CMA) Foundation initiated its Advancing Practice Excellence in Diabetes' Quality Collaborative. The overall goal of the initiative was to help improve the quality of diabetes care provided in solo and small group practices. In California, these healthcare providers represent approximately 60% of all primary care physicians, providing care to approximately 800,000 adult patients with type 2 diabetes. Because of the high rates of diabetes in ethnic communities, elimination of healthcare disparities was also a key focus of the collaborative.

The Quality Collaborative was focused on the following two questions:

- Is practice and patient improvement possible in smaller primary care practices?
- What does it take to make and sustain these improvements?

As planned, the collaborative was conducted in three regions: Butte/Glenn Counties, San Joaquin County and Riverside/San Bernardino Counties. APEX staff selected a regional model knowing that medical practice is greatly influenced by local health care culture. Twenty-four solo/small group practices started in the collaborative, with 16 of these primarily safety-net practices. Each committed to a two-year cycle.

At the completion of the Quality Collaborative in 2008, participating practices achieved both systems improvement and improved patient outcome among their patients with diabetes. An executive summary of the Quality Collaborative is posted on the CMA Foundation's website (www.thecamfoundation.org). Presentation of the outcome data was provided at the Diabetes Symposium.

Other Quality Collaborative Components

In addition to the regional pilot projects, other Quality Collaborative components are:

- Multicultural Patient Education Materials Database (includes culturally and linguistically appropriate patient education materials related to diabetes, www.thecmafoundation.org)
- Community Resource Directory (identifies programs and resources for individuals at risk for overweight, obesity and type 2 diabetes, www.thecmafoundation.org)
- “Diabetes as a Cardiovascular Disease Reference Guide” (presents diabetes care information for providers, patient education materials and patient self-management materials, coming soon to www.thecmafoundation.org)
- Culturally Responsive Diabetes Care Web-Based Resource for Providers (Provides culturally responsive resources for clinicians and office staff to improve diabetes care delivered to diverse patient populations, coming soon to www.thecmafoundation.org)



Executive Summary, Quality Collaborative

See the following document.