Senior Leaders and the Strategic Alignment of Community Benefit Programs: The Example of Diabetes

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By Patsy Matheny, Community Benefit Consultant. Sugar Grove, Ohio

Moving community benefit from purely reporting numbers to strategic alignment as a core function of the organization requires, first and foremost, commitment from the CEO and other senior leaders. Yet, getting senior leaders to understand community benefit and see the business value is no easy task.

Let's make some assumptions. What keeps hospital leaders up at night are: 1) financial challenges, 2) physician relationships, 3) community pressure, and 4) clinical report cards.

With these challenges in mind, there is no better issue than diabetes to demonstrate to senior leaders the value of community benefit programs to the organization. A productive discussion with senior leaders would show how community benefit programs linked into the care continuum for people with diabetes can:

- Position the hospital as a leader in addressing a chronic disease by recognizing and addressing a disease that is professionally and personally experienced by board, senior leaders, physicians, employers, and the general public;
- Reduce hospital costs by redirecting care to less costly community resources;
- Build relationships with community physicians by freeing their time;
- Increase collaborative partnerships with others in the community by expanding the care continuum; and
- Improve the health of people in the community by providing high quality preventive and primary care.

Before you run to have this conversation though, let's look at some diabetes facts and the role that community benefit programs can play with respect to diabetes.

Diabetes: An Identified Community Need

Diabetes is a costly disease in both physical and financial terms for individuals, employers, the community, and health care providers. Everyone knows someone with diabetes, often experiencing first hand the daily attention required for monitoring and treatment.

The good news is that progression to diabetes among those with pre-diabetes (Fasting Plasma Glucose between 100 – 126 mg/dl) is not inevitable. Studies have shown that people with pre-diabetes who lose weight and increase their physical activity can prevent or delay diabetes and return their blood glucose levels to normal.

The Diabetes Prevention Program Research Group, a large prevention study of people at high risk for diabetes, showed that lifestyle intervention reduced developing diabetes by 58 percent over three years.

Also, many people with type 2 diabetes can self-manage and control their blood glucose by following a healthy diet and exercise program, losing excess weight, and taking oral medication.

Chances are that you know at least some of the major diabetes facts. If you would like additional statistics to help you make the case for addressing the disease with community benefit programs, see the blue text at the end of this article.

Roles for Community Benefit Programs

Community benefit programs are ideally positioned to help prevent and control diabetes.

Positioning the hospital as a leader in addressing a disease of epidemic proportions resonates well with board members, senior leaders, employees, and the public.

Community benefit programs that provide prevention, early detection and treatment, and promote self management of diabetes can be instrumental in addressing primary, secondary, and tertiary care. Through a variety of activities, community benefit programs can raise awareness, increase knowledge, change attitudes, motivate and support changes in behavior. By providing education and access to care, programs can focus on self-care behaviors, such as healthy eating, being active, monitoring blood sugar and taking medications if prescribed. Community benefit programs can also link community resources into the care continuum, thereby increasing access to appropriate and timely services.

Where to begin: some questions to ask

Once you have the facts about diabetes, the next step is to understand and state the relevance of diabetes to your own organization and its partners.

- Is diabetes a clinical focus for reducing length of stays? For reducing nonsocomial infections in critically ill patients? For reducing operative and postoperative morbidity and mortality?
- Is your outpatient diabetes self management program trying to increase the number of people served?
- Can a significant portion of your charity care dollars and Medicare shortfalls be attributed to patients with diabetes?
- Is your health plan monitoring HEDIS measures on diabetes care?
- Is your hospital/health system pursuing the American Diabetes Association Education Recognition Program or JCAHO's Disease Specific Certification in Diabetes Care Management?
- Can you free up time for physicians by linking to community benefit programs that could provide their patients with diabetes education, behavior change encouragement, and self monitoring resources such as feet checks?
- Can community benefit programs help your physicians receive NCQA/ADA Diabetes Provider Recognition status?
- Did contract negotiations with third party payers focus on patients with diabetes?
- Are community employers, including your own organization, trying to reduce self insurance costs?

Where to begin: internal conversations

Begin by initiating individual or group conversations with internal staff working with diabetes and those who may have answers to the questions above.

Diabetes service line directors, diabetes educators, and dieticians will have a wealth of information on the impact of diabetes on your organization. Talk with staff in quality improvement, the health plan, and nursing. Approach the medical director and physicians from the cardiac, neurology, ophthalmology service lines, as well as podiatrists, pharmacists, and exercise physiologists.

Community benefit response: what you can offer

A range of community benefit services can be linked into the diabetes strategy, either through hospital-run programs or by participating in community sponsored programs.

Community benefit programs can provide self care programs on nutrition and exercise to prevent diabetes or to prevent progression of pre-diabetes to diabetes. Programs can support people in self managing their care through life style behaviors and medications. Community benefit programs can also make the linkage between providers to help ensure access to appropriate care.

There is no shortage of pertinent community benefit interventions on this topic, delivered to the broader community with an emphasis on vulnerable populations. You might consider some of the following, depending on your community's and your organization's unique characteristics, resources, and needs:

- General diabetes education through multiple communication vehicles, such as radio, TV, newspapers, and Web sites;
- Presentations on diabetes for the community at large and at-risk audiences;
- Continuing education for community health care providers;
- Research papers prepared by staff for professional journals or presentations;
- Telephone information services such as 'ask a nurse';
- Support groups;
- Nutrition and exercise programs;
- Screenings: blood pressure, cholesterol, glucose, depression;
- Smoking cessation;
- Foot care: exams, foot hygiene, proper footwear;
- Eye exams;
- Obtaining medications and supplies for the un- and under-insured;
- Accessible primary care delivered through schools, store fronts, parish nursing, local employers;
- Linkages to other providers and services, including the local diabetes association, diabetes educators professional group, ophthalmologist association;
- Transportation to services for vulnerable populations;
- Recruitment of endocrinologists to underserved areas; and
- Enrollment assistance in public programs.

Conclusion: Time to Meet with the CEO

Community benefit approaches and programs can help hospitals and health systems tackle diabetes in ways that truly improve both people's lives and the health care system. Opportunities exist to help those with: 1) diagnosed diabetes, to self-manage the disease; 2) undiagnosed diabetes, to become diagnosed and begin treatment; and 3) pre-diabetes, to prevent or delay progression to diabetes.

Community benefit services weaved into the diabetes care continuum can also demonstrate to the CEO and other senior leaders the value of community benefit as a strategic and mission-focused business activity, not just a reporting of numbers to justify tax exemption.

Now that you are armed with general diabetes facts, seek out practitioners in your organization and further educate yourself on how diabetes affects your organization. Once the organization's objectives are known, you can easily identify or create community benefit programs that are integral to an overall strategy for reducing diabetes.

Now, it's time to have that conversation with the CEO.

Arm Yourself with More Facts about Diabetes

Prevalence

The Centers for Disease Control and Prevention (CDC) have predicted that 1 in 3 babies born in the year 2000 will develop diabetes in their lifetime. As of 2007, 7.8 percent of the population in the U.S., approximately 23.6 million children and adults, have diagnosed and undiagnosed diabetes. This is a 13 percent increase over 2005. Plus, an additional 57 million people have pre-diabetes.

- Diagnosed: 17.9 million people, and growing by 1 million people per year
- Undiagnosed: 5.7 million people

The disease significantly impacts ethnic and minority populations:

- 14.2% of American Indians and Alaska Natives
- 7.5% of Asian Americans
- 10.4% of Hispanics
- 11.8% of non-Hispanic blacks
- 6.6% of non-Hispanic whites

Complications and Co-Morbidities

Diabetes is a chronic disease with devastating complications for the quality of life of patients and their families. In particular, diabetes:

- Elevates heart disease death rates two to four times;
- Increases the risk for stroke two to four times;
- Is the leading cause of new cases of blindness among adults aged 20–74 years;
- Is the leading cause of kidney failure;
- Accounts for more than 60 percent of non-traumatic lower-limb amputations occurring in people with diabetes; and

- Is listed as the 7th leading cause of death, although considered grossly underreported because diabetes is often a secondary cause of death. The risk for death among people with diabetes is about twice that of people without diabetes.

Costs to the Health Care System and Hospitals

One out of every five health care dollars is spent on people with diabetes, and one in ten health care dollars is attributed to diabetes. Diabetes is an expensive disease with a total estimated cost 2007 of $174 billion, including $116 billion in excess medical expenditures and $58 billion in reduced national productivity due to increased absenteeism and reduced productivity while at work.

Two million people with diabetes have no medical insurance, and of those with coverage, approximately half are covered through the government programs.

Direct Costs of Diabetes **=** $116 billion:

- $17 billion for care to directly treat diabetes
- $58 billion to treat the portion of diabetes-related chronic complications that are attributed to diabetes
- $31 billion in excess general medical costs

Fifty percent of medical expenditures attributed to diabetes is hospital inpatient care.

A patient with diabetes has an increased risk of admission and a longer length of stay regardless of the reason for admission. Studies have shown that patients admitted for general medical conditions where diabetes is listed as a secondary diagnosis have a 50 percent longer average length of stay (14 days) than would occur if diabetes were not a complicating factor.

Costs to Employers

Indirect Costs of Diabetes = $58 billion (a 32 percent increase since 2002):

- 15 million work days absent
- 120 million work days with reduced performance
- 6 million reduced productivity days for those not in the workforce
- 107 million work days lost due to unemployment disability (445,000 cases) attributed to diabetes
- $26.9 billion in lost productivity due to premature death

Sources:

CDC National Diabetes Fact Sheet, 2007

Diabetes Care, Volume 31, Number 3, March 2008, American Diabetes Association *Diabetes Care*, 25:2165-2171, 2002, American Diabetes Association

Guide to Community Preventive Services: Diabetes, CDC

The views expressed in this article are the author's and do not necessarily reflect the positions or policies of the Association for Community Health Improvement.

