Participation in the NCQA Diabetes Recognition Program: An Esteemed Quality Standard for Improved Patient Outcomes and Prestige for Your Practice

Caring for chronically-ill patients in the US is a significant part of a healthcare system often characterized as inefficient, reactive, fragmented, and marked by out-of-control costs. The American healthcare system is also described as being in dire need of the widespread adoption of evidence-based quality improvement measures, which are particularly important in light of the prevalence of chronic illnesses and the large, aging baby boomer population. According to the National Committee for Quality Assurance (NCQA), improving public health and implementing more cost-effective approaches to chronic illness care are top goals to help keep costs from rising to unsustainably-high rates. The NCQA further advises that holding health plans accountable through accreditation and performance measurement is necessary to achieving these goals.¹

The Milken Institute’s 2007 report states that more than half of all Americans suffer from one or more chronic diseases. Major improvements in therapy and treatment notwithstanding, the rates of chronic disease continue to rise. The Milken report estimates current and future treatment costs and lost productivity for 7 of the most common chronic diseases: diabetes, several types of cancer, hypertension, stroke, heart disease, pulmonary conditions, and mental disorders, with the following notable figures²:

- A total of 162 million cases affect more than 109 million Americans who report having at least 1 of the 7 chronic illnesses
- $277 billion is spent annually on treatment
- In an optimistic scenario, assuming modest improvements in prevention and treatment of disease, 40 million cases of chronic disease could be avoided by 2023
- Lower obesity rates alone could avoid $60 billion in treatment expenditures per year
The Agency for Healthcare Research and Quality (AHRQ) reports that spending to treat patients with mood disorders, diabetes, heart disease, asthma, and hypertension—along with the other illnesses that those chronic-condition sufferers tend to have—amounted to 49% of total healthcare costs. Expenses for people with one chronic condition were twice as great as for those without any chronic conditions. The prevalence of diabetes in particular is alarming. The Centers for Disease Control (CDC) reports that 8.3% of Americans have diabetes and that, each year, approximately 1.8 million new cases of diabetes are diagnosed in people over the age of 18. The CDC also states that diabetes was the seventh-leading cause of death listed in 2007.

Adults suffering from chronic conditions currently only get about half of recommended care as reported by Rand Health’s Community Quality Index Study, which has been called the most comprehensive assessment of American healthcare quality. The research evaluated performance on 439 clinical quality indicators for 30 acute and chronic conditions. Also among its findings is the fact that all sociodemographic groups are at risk for poor care. Solutions presented are centered on system-wide investments in health information technology, monitoring of performance, and incentives for improvement.

In an effort to better manage costs associated with chronic disease, the federal government penned a healthcare reform law in March 2010, known as the Affordable Care Act, designed not only to control the costs of healthcare, but also to improve the quality of care. In light of this law, comprehensive solutions to the nation’s systemic healthcare problems and escalating expenses are continually proposed by leaders and policy influencers in the forward-looking movement toward better care quality. Major themes are the strong emphasis on preventive care and wellness programs, better management of chronic disease, and the use of evidence-based medicine. Also, health plans and employers are looking for ways to keep their benefit costs down and workforce productivity up as they help create an agenda for higher-quality and higher-value care for their enrollees. Many have recognized their role in empowering and financially incentivizing their enrollees, sponsoring and contracting with providers who have achieved NCQA distinctions, such as the Diabetes Recognition Program (DRP), and forming coalitions to achieve their goals.

“Diabetes patients have become more engaged. The number of no-shows has decreased noticeably. When these patients experience this high level of care coordination, they recognize it as a different, caring environment that’s been created for them. They want to come back to it.”

–Christian Nasr, MD, FACE, FACP

“In this age of transparency—primarily due to the Internet—communities and patients seem to have a greater awareness of the doctors who are NCQA certified. I believe that most people with diabetes would prefer to be cared for by professionals who have gone through a certification program and have developed well-designed processes to take care of them.”

–Barry Malinowski, MD

“Employers increasingly recognize that the use of physicians who have completed the Diabetes Recognition Program will likely result in an improved overall quality of health and wellness for their employees, along with better disease-specific preventive care. This can result in fewer late-stage diabetes complications, which would otherwise significantly increase their overall health care costs.”

–Charity Rausch, RPh
Significant Quality Efforts in the American Healthcare Movement

Federal and state governments, nonprofit institutions, private insurance companies, clinician organizations, and employer coalitions have established entities devoted to improved patient outcomes. A number of regular publications offer comprehensive solutions for the improvement of American healthcare and reports to quantify these solutions, one of which is the Institute of Medicine’s seminal report from the committee on the Quality of Healthcare in America. It calls for fundamental change to close the quality gap and provides overarching principles for specific direction for policymakers, healthcare leaders, clinicians, regulators, purchasers, and other healthcare institutions. The report further recommends that improving the quality of care of chronic diseases should be a timely priority of the US government.

Recognizing their influence as a powerful driving market force, many insurers and employers have taken part in “value-based purchasing,” which the Mid-Atlantic Business Group on Health (MABGH) describes as “a strategy that purchaser coalitions are using to reform the healthcare system, community by community.”

The NCQA, as a nonprofit organization dedicated to the improvement of healthcare quality, is a driving force in the improvement of American healthcare. It develops performance measures for health plans, physicians, hospitals, and other healthcare institutions, with its clinician Recognition Directory placing a strong emphasis on better management of chronic disease. Its vision is “to transform healthcare quality through measurement, transparency, and accountability.”

The NCQA has made getting started with programs like its DRP as simple as possible with clear instructional material and free training. Its Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely-reported set of performance measures in the industry and is used by health plans, medical groups, and federal and state governments.

“By involving our patients in their care through patient engagement, they become active partners in the choices that are being made for their health. We’ve found that this results in improved compliance and greater participation in the treatment decisions.” – Armand Krikorian, MD

“We’ve always strived to make sure that we reinforce with patients exactly what needs to be done in terms of their treatment and why they need to do it. This knowledge empowers them. What I’ve seen evolve is the patients’ greater understanding of the reasoning behind their care and what can be done to help prevent further complications.” – Kevin Wietecha, DO

“When we received NCQA certification, it reaffirmed that we were doing good work with our chronic care collaborative and that the hard work was worth it. Further, I think recognition of a job well done is always energizing for the staff.” – Bonnie Mozingo, MSN, RN
Value-Based Purchasing

According to the NBCH, many businesses in America experience a competitive disadvantage because of 2 major issues in healthcare—the continually-rising costs of health insurance benefits and poor-quality care.15

The vision of the NBCH is to achieve “health system reform, through value-based purchasing, community by community.”16 A major requirement in the realization of this vision is ensuring that patient care is measurably improved. MABGH is currently focusing on the issue of patients with diabetes receiving recommended care only about 50% of the time as an area for improvement. Considered as one of the successes in value-based purchasing, MABGH’s corporate members Aetna® and CareFirst® BlueCross BlueShield® incorporated the Bridges to Excellence (BTE) Physician Reward Initiative into their physician incentive systems.17

The mission of the BTE quality initiative is to “help the best clinicians build their practices, help patients get healthier, and help insurers and employers manage costs better.”18 It uses its own chronic care and other recognition programs for participating clinicians, based on nationally-accepted measures, including NCQA’s, with an emphasis on intermediate outcomes where available. Measures are scored to provide an overall program score where 60 is most frequently the passing grade, representing a significant accomplishment for a clinician or practice.19 BTE is an NCQA Recognition Program sponsor.20

Four Pillars of Value-Based Purchasing

Value-based purchasing is based on15:

1. Standardized measurement

   Standardized measurement is the foundation upon which value-based purchasing rests. Areas for measurement include consumer behaviors such as lifestyle choice, medical services and interventions, health plan performance, hospital performance, physician group performance, and individual clinician performance

2. Transparency and public reporting

   Standardized performance measurements should be converted into information for purchasers, payers, and consumers that will enable them to make informed decisions, particularly regarding payment and choice

3. Payment reform

   This is concerned with 2 complementary tenets; first is the principle of differential reimbursement based on demonstrated performance. Second is the need to align economic incentives with desired outcomes by redesigning payment methodologies.
With the latter, the NBCH believes that the quality of care one gets is largely dependent on how one chooses to pay for healthcare. The NBCH is in favor of encouraging high-quality services and new models of care delivery by experimenting with different payment methodologies.

4. Informed choice
Health plans and employers help create the “activated consumer” by encouraging them to make informed choices in the areas of lifestyle, treatment intervention, compliance with treatment regimens, health plans when options are available, and hospital and physician. Strategies to urge consumer choice encompass wellness and behavioral programs that help limit healthcare utilization, information dissemination, such as through employer/staff communication channels, and evidence-based benefit design, including approaches like using co-pay incentives to steer individuals toward effective treatments and high-value providers.

“I think it’s a deep personal satisfaction that one gets from the implementation of the Diabetes Recognition Program (DRP), because their efforts are being acknowledged and rewarded. In addition, for these health care professionals, there is generally more awareness and appreciation in the community of that practice’s dedication to high-quality health care by meeting the standards and clinical measures of the DRP.”

–Armand Krikorian, MD

“Early on, we created a Diabetes Report Card, which basically ensures that a diabetes patient’s weight, blood pressure, hemoglobin A1c, and cholesterol are being maintained and recorded, and tracks whether their eye exam, immunizations, cancer screening, and foot exam are up to date. These can be checked off for a patient’s overall grade, and that helps us rate our level of care.”

–William Smucker, MD

“I think our diabetes care has been taken to the next level in terms of being more alert and proactive. Everybody in our office has always strived to do that, but the Diabetes Recognition Program allows for continuity and reinforcement of that process.”

–Kevin Wietecha, DO

Table 1. 2009 DRP Adult Measures—Performance Criteria and Scoring

<table>
<thead>
<tr>
<th>Clinical Measures</th>
<th>Criteria</th>
<th>Points</th>
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<tbody>
<tr>
<td>HbA1c Poor Control &gt;9.0%*</td>
<td>≤15% of Patients in Sample</td>
<td>12.0</td>
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<tr>
<td>HbA1c Control &gt;8.0%</td>
<td>60% of Patients in Sample</td>
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<tr>
<td>HbA1c Control &gt;7.0%</td>
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<tr>
<td>Blood Pressure Control ≥140/90 mm Hg*</td>
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<td>15.0</td>
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<tr>
<td>Blood Pressure Control &lt;130/80 mm Hg</td>
<td>25% of Patients in Sample</td>
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<tr>
<td>Eye Examination</td>
<td>60% of Patients in Sample</td>
<td>10.0</td>
</tr>
<tr>
<td>Smoking Status and Cessation Advice or Treatment</td>
<td>80% of Patients in Sample</td>
<td>10.0</td>
</tr>
<tr>
<td>LDL Control ≥ 130 mg/dl*</td>
<td>≤37% of Patients in Sample</td>
<td>10.0</td>
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<tr>
<td>LDL Control ≥ 100 mg/dl</td>
<td>36% of Patients in Sample</td>
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</tr>
<tr>
<td>Nephropathy Assessment</td>
<td>80% of Patients in Sample</td>
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</tr>
<tr>
<td>Foot Examination</td>
<td>80% of Patients in Sample</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>Total Points</strong></td>
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<td>100.0</td>
</tr>
<tr>
<td><strong>Points Needed to Achieve Recognition</strong></td>
<td></td>
<td>75.0</td>
</tr>
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*Denotes Poor Control
NCQA Recognition: Elite, Voluntary Programs for Physicians and Other Clinicians

The NCQA offers 5 voluntary recognition programs in the following care areas:

1. Diabetes
2. Back pain
3. Physician Practice Connections®
4. Physician Practice Connections®
5. Heart/stroke

An added benefit for clinicians who achieve recognition in these programs is that they are listed on the NCQA Web site. The listings are public and searchable by state and recognition program. Recognized clinicians are provided with NCQA logo seals for use in marketing assistance.

Diabetes Recognition Program

To provide physicians and other clinicians with resources supporting the delivery and recognition of consistent, high-quality care, the NCQA and the American Diabetes Association (ADA) created the Diabetes Recognition Program (DRP). The DRP recognizes those who use evidence-based measures and provide excellent care to their patients with diabetes. Physicians, nurse practitioners, and practices can submit clinical data based on 10 standard diabetes-care measures for a 25-patient sample.

The program’s clinical quality requirements represent nationally-accepted, evidence-based measures of care for patients with diabetes.

Getting Started With the Diabetes Recognition Program

The process for achieving DRP Recognition is presented step-by-step in the NCQA application materials. Office staff can be assigned tasks for the data-upload software license, official application, and submission of abstracted patient data. The use of electronic medical records is not required, and applicants have up to a year to complete their data submission from the time they purchase the license. For more information and further assistance, the NCQA also offers free, frequently held Web- and teleconference-based training for the DRP.

Free training sessions for the application and data submission processes are also offered multiple times and follow the Eastern Time zone. The training available for the DRP includes:

- Introductory audio conference on standards. In this teleconference, the NCQA staff discusses the basic standards and eligibility requirements
- How to use the Data Collection Tool (DCT). In this live WebEx demo of the DCT, the NCQA staff demonstrates how to complete the set-up and how to use the tool.
Below is a step-by-step overview of how to get started with the NCQA Diabetes Recognition Program:

1. Order the free application packet through www.ncqa.org/drp or by calling 888.275.7585
2. Purchase the license for the web-based Data Collection Tool (DCT) software and Standards and Guidelines ($80)
3. Identify patient sample, enter the abstracted data into the DCT, and review performance score generated by the DCT
4. Mail in signed and dated agreements and application fees (application fees cover an entire practice)
5. The NCQA is notified electronically once the online application form and data are submitted
6. Clinicians who meet NCQA requirements will have their names and practices posted on the NCQA web site as “Recognized”

* Current as of Aug. 2009

### Table 2. DRP Recognition Program Fee Schedule (exclusive of $80 for the DCT license)

<table>
<thead>
<tr>
<th># Clinicians Applying for Recognition</th>
<th>Application Fee Schedule</th>
<th>Discount Application Fee Schedule a</th>
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<tbody>
<tr>
<td>1</td>
<td>$500</td>
<td>$400</td>
</tr>
<tr>
<td>2</td>
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<td>4</td>
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<td>$1,600</td>
</tr>
<tr>
<td>5</td>
<td>$2,500</td>
<td>$2,000</td>
</tr>
<tr>
<td>6</td>
<td>CAP $3,000</td>
<td>$2,400</td>
</tr>
<tr>
<td>7</td>
<td>$3,000</td>
<td>$2,800</td>
</tr>
<tr>
<td>8-100</td>
<td>$3,000</td>
<td>CAP $3,000</td>
</tr>
<tr>
<td>&gt;100</td>
<td>$10 surcharge for every clinician &gt;100</td>
<td></td>
</tr>
</tbody>
</table>

a – The Discount Fee Schedule (20%) pertains to sponsored clinicians and clinician groups only; it does not apply to multi-site or multi-program applications. Sponsors are organizations that promote the Recognition Programs to clinician groups. Examples of sponsors include coalitions like BTE, health plans, associations, state and federal initiatives, etc.

“The Diabetes Recognition Program promotes a process that helps a practice follow their diabetic patients closely throughout the treatment course. It facilitates the development of registries to ensure that diabetic patients are following through on their lab work, eye exams, foot exams, and flu shots. Frankly, it promotes a process that can be utilized for other chronic diseases.”

–Barry Malinowski, MD

“When it comes to overall improvement of health care, I think physicians need to look at the Diabetes Recognition Program as a measure of where they stand and where they can improve their quality of care delivery. The process will make them aware of the changes needed to benefit their patients and the health of their community.”

–Charity Rausch, RPh

“When implementing the Chronic Care Model, it helps to adhere to the NCQA targets. Essentially, the practice is being reorganized, and the NCQA targets help to show the Chronic Care Model’s progress in meeting its goals.”

–William Smucker, MD
Participating in the NCQA DRP in Canton

**DRP Recognition Fee Structure & Discount Program†**

The DRP fee structure is based on the price of the DCT license and the number of clinicians seeking recognition in a clinician group. A group of clinicians in one practice site, practices or practice sites in a legal arrangement, a staff model network where clinicians are employed, or a corporate entity that owns clinician practices is referred to as a clinician group. A clinician group with more than one practice site is allowed to purchase one DCT for data submission from all of its practice sites for all associated clinicians, provided each practice site can be bound by the same Business Associate Agreement.20

The NCQA offers a 20% discount on its recognition program fees for sponsored clinicians. However, the discount applies to sponsored clinicians and clinician groups only; it does not apply to multi-site or multi-program applications. Fees are subject to change and are not refundable.20

The NCQA defines a sponsor as an organization that promotes its recognition programs to clinician groups and urges its network of physicians, members, or program participants “to achieve NCQA recognition in return for an additional recognition, promotion, or reward.” Sponsor types include health plans, government entities, business coalitions, collaborations of plans and companies, professional organizations, and disease-awareness organizations.26 On the other hand, some are funded by grants or legislation and are part of a broader healthcare strategy.26

**Benefits of Achieving NCQA DRP Recognition**

Clinicians who achieve recognition through the DRP benefit from enhanced exposure. The Recognition Directory on the NCQA Web site is publicly available and widely distributed to health plans, employers, and other healthcare institutions.24 According to the NCQA, clinicians who are DRP-recognized are perceived by their peers, patients, and others in the diabetes community as members of an elite group publicly recognized for its excellence in providing the highest level of diabetes care.23

Payers continue to incorporate NCQA accreditation metrics into innovative provider payment models. Payment efforts include direct pay-for-performance (P4P) metrics tied to accreditation standards, accreditation application fee reimbursements, and/or provider recognition such as special labeling on provider directories designed to attract patients.27 The role of accreditation will also become an increasingly important part of the Medicare-based compensation.
algorithm as the CMS (Centers for Medicare & Medicaid Services) continues to develop and implement P4P structures. For example, physicians who participate in CMS’s Physician Quality Reporting Initiative—recently renamed the Physician Quality Reporting System (PQR)—and report eligible quality metrics may earn an incentive payment equal to 1.0% of their total estimated Medicare Part B Physician Fee Schedule (PFS)-allowed charges for covered professional services furnished during that same reporting period.28

The Chronic Care Model
In addition to government-level reform, publications, quality institutions, and private-sector coalitions, the quality in healthcare movement has also produced a specific, system-based approach to treating chronic illness called the Chronic Care Model (CCM). The bottom line result promised by the CCM is “healthier patients, more satisfied providers, and cost savings.”29

The CCM was developed in the 1990s by the MacColl Institute for Healthcare Innovation housed at the Group Health Research Institute in Seattle. The MacColl Institute is the home of The Robert Wood Johnson Foundation’s Improving Chronic

Standard Diagram of the CCM

Adapted from the MacColl Institute
©ACP-ASIM Journals and Books

When redesigning one’s practice using the Chronic Care Model, the most important thing to have first is a reliable registry. If the patients with diabetes are identified and documented, in addition to some of their outcomes such as A1c and LDL and eye visits, their care can be better managed.”

–William Smucker, MD

“With the Chronic Care Model in place, we’re more organized now with our provision of care: everybody knows how the process works and how to get the diabetes patient involved. When more people are responsible and accountable for these patients, then I think the care improves all around.”

–Bonnie Mozingo, MSN, RN

“CIS or EMR puts the complete patient chart in front of you. This has been of tremendous help when treating chronic diseases, such as diabetes, because it gives us everything we need to know to be able to treat them. It also helps us avoid errors when we reconcile medications.”

–Christian Nasr, MD, FACE, FACP
The Chronic Care Model that’s part of the Diabetes Recognition Program is a safeguard. It permits a practice to constantly ensure that the chronicity of the disease and the things needed for a patient’s complete care are done. That includes things that the patient may not even be focusing on at that time. So it allows for the acute visit to be handled appropriately while not letting the chronic issues get lost.”

–Kevin Wietecha, DO

“The Chronic Care Model is relatively easy to follow, and we apply it to other diseases, not just diabetes. Before, when we treated diabetes patients, we sometimes didn’t know who they were and what their complete data profile was. The Chronic Care Model helped us organize their treatment and data, resulting in improved care.”

–Bonnie Mozingo, MSN, RN

“More can be done during a patient’s appointment if some prep work is completed before the visit. Our staff makes sure that they are fully ready for each patient visit, and I feel this is a more satisfying and complete way to treat, both for patients and for providers.”

–William Smucker, MD

Illness Care (ICIC) program. Since 1998, ICIC has been involved in continually developing, evaluating, and disseminating CCM-based clinical improvement efforts.30

The CCM focuses on 6 components: patient self-management support, decision support, delivery system design, use of a clinical information system (CIS), organization of healthcare, and community. It advocates for more productive interactions between patients and their care teams and describes how its components work to create a patient-centered team that can provide proactive, highly-coordinated care.31

In a study conducted by Dorr et al, early results from the application of the CCM showed improved patient outcomes as well as improved physician productivity.32 The CCM calls for33:

1. Self-management support
   The chronically-ill patient is enabled to play a much more empowered role in managing his or her own care

2. Decision support
   Treatment choices are based on proven guidelines that are supported by at least 1 defining study.

Healthcare organizations should integrate those proven guidelines into everyday practice.

3. Delivery system design
   Care delivery with well-defined roles and tasks; all clinicians are to have the most current information about the status of the patient, and follow-up is standard

4. A clinical information system
   A registry or information system should be used to track individual patients as well as populations

5. Organization of healthcare
   Healthcare systems should create an environment in which organized efforts improve care

6. Community
   Healthcare organizations should make an effort to form powerful alliances and partnerships within communities

In 2003, the CCM was refined due to advances in the field of chronic illness care. Its creators also took into account important research literature and data from the many healthcare systems that implemented the CCM in their improvement efforts. In consideration of more recent evidence, 5 additional themes were incorporated into the CCM34:

1. Patient Safety in the Health System
2. Cultural competency in Delivery System Design
3. Care coordination in the Health System and Clinical Information Systems
4. Community policies in Community Resources and Policies

5. Case management in Delivery System Design

Conclusion

The outlook for reform in the US healthcare system is a bright one thanks to the many entities involved in quality improvement—both on the supply and demand side of healthcare.

According to the NCQA, holding health plans accountable is necessary to keep healthcare costs under control. Approximately 49% of healthcare costs are spent on the treatment of mood disorders and co-occurring chronic conditions, so much so that expenses for people suffering from at least 1 chronic condition are twice as great as for those without chronic conditions. Currently, adults suffering from chronic conditions only get the recommended care 50% of the time, prompting various healthcare institutions and practitioners to call for a systemic modification in healthcare methodologies through value-based purchasing and the CCM.

The theory of value-based purchasing holds health plans accountable for both the cost and quality of care. However, the NBCH calls for all healthcare providers and stakeholders to share in this accountability and, in so doing, contribute to the improvement of American healthcare. Value-based purchasing also focuses on reducing inappropriate care and identifying and rewarding providers who perform well. Ultimately, its goal is to bridge the gaping chasm between patient and provider, by helping patients make informed choices and encouraging providers to provide high-quality care.

The CCM, on the other hand, was developed in an effort to obtain “healthier patients, more satisfied providers, and cost savings.” It advocates patients and their care teams to work together and create a patient-centered team that can provide proactive, coordinated care. The developers of the CCM firmly believe that it can achieve productive interactions between an informed patient and a proactive care team.

For their patients with diabetes, physicians and other clinicians providing quality care can achieve even better patient outcomes and enhance their visibility and prestige through NCQA Recognition. Given the prevalence of diabetes and continuation of newly-diagnosed cases, the NCQA Diabetes Recognition Program is an excellent starting place for enhanced practice efficiency and participation in the ever more successful movement toward exceptional, high-value healthcare in America.

“It’s been shown that the patients of NCQA-certified doctors have better HbA1cs and cholesterol values, and they have fewer visits to the emergency room. It just makes sense for people who have diabetes to seek out professionals who have gone through this certification process.”

—Barry Malinowski, MD

“As health care professionals, we all strive for excellence, but we need to have measures of our care delivery. With health care reform mandating those measures, the NCQA program gives us the opportunity to objectively quantify the quality of our health care in a measurable, data-supported way.”

—Armand Krikorian, MD

“The care coordination that has evolved in our office in conjunction with the NCQA involvement has positively impacted physicians’ nurses and office staff. The program identifies exactly what can be improved to assist with the overall care for the diabetic patient.”

—Charity Rausch, RPh
References