

The Role of Primary Care Professionals in Managing Diabetes

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No one in the know doubts that most diabetes care is done by primary care providers. No more than 20% of people with diabetes ever see an endocrinologist, and there are not nearly enough endocrinologists to handle the ever-increasing number of people with diabetes. The vast majority of diabetes management is, and in my view should be, in the hands of generalists.

This said, how are we all doing, and why should we worry about doing better? The sad fact is that health care providers—primary care and specialists alike—are not managing our patients with diabetes as well as we should be. Some data put the average hemoglobin A1c (A1C) of people with diabetes in the United States at 9%, which is clearly unacceptable. Diabetes remains an enormous contributor to cardiovascular disease, particularly among women, as well as the most common cause of working-age blindness and the most common cause of end-stage renal disease.

Until the American health care system starts doing a whole lot better on diabetes care, no one can honestly say that diabetes is not a serious disease. No one can or should tell a patient, “You only have a touch of diabetes.” A touch of sugar may be alright when you’re ordering coffee, but not when you’re talking about diabetes.

It is especially alarming that the grim statistics remain despite incontrovertible evidence that management matters—not just blood glucose control, but overall diabetes management. Adequate glycemic control prevents retinopathy, nephropathy, and neuropathy. Control of risk factors for cardiovascular disease—

smoking, dyslipidemias, and high blood pressure—are especially important in preventing the two- to fourfold increase in myocardial infarction and the similarly disturbing rate of stroke and peripheral vascular disease among those with diabetes.

I recently gave a presentation before a managed care group on the theme “Diabetes is a Manageable Disease.” The topic got me thinking, and not just about the sequencing of medications or handy tricks for using insulin. I was thinking, for once, beyond the day-to-day treatment options and adjustments, to our entire health care system. Among the points I came up with, which may seem obvious to many of you, were the following:

- The evidence is overwhelming that good diabetes care *does* matter, that morbidity and mortality from this terrible disease *can* be reduced or even eliminated. There is nothing inevitable about the complications of diabetes.
- The cost of diabetes is in its complications. Any expense paid up front that results in better management of glycemia or cardiovascular risk factors will pay off handsomely in the long run.
- The tools needed for good diabetes care already exist. Although time- and energy-consuming for both health care professionals and patients, finding the right combination of lifestyle and pharmacological therapies is worth the effort.
- No diabetes management tool—no new oral agent, insulin, or medical device—is as important as the services of a certified diabetes educator

(CDE). This relatively new health care profession has added immeasurably to the provision of good diabetes care.

- The degree of difficulty in successfully managing diabetes varies enormously from one patient to another. Whereas many cases of diabetes are appropriately managed by primary care providers, a significant number of patients, including most of those with type 1 diabetes, need the help of a specialist.
- The assessment tools available for diabetes are accurate and easy to use. As a practitioner, I believe that each patient with diabetes should have a target A1C level and that that target can vary from person to person. If patients in primary care can achieve and maintain A1C results within their target range with their current diabetes regimen, great. If not, good management dictates a therapeutic adjustment and consideration of consultation with a specialist.
- Finally, it is incumbent on us all to fight to ensure adequate compensation for all health care professionals involved in diabetes care and adequate supply and equipment reimbursement for all people with diabetes. At least in the United States, insurance reimbursement is essential to the proper functioning of our health care system.

So what can the American Diabetes Association (ADA) do to help you, the primary care providers, succeed in caring for your patients with diabetes? The ADA is committed to being the timeliest, most accessible, and most reliable source of information about diabetes. I want everyone who cares for people with dia-

betes to know about all the help available to them.

First, there is www.diabetes.org, the ADA's newly redesigned Web site, offering easy access to information and useful references for health care professionals. Another extremely helpful source of information is the ADA's Clinical Practice Recommendations, which are updated and published each January as a supplement to the journal *Diabetes Care*. The Association also offers many professional meetings for diabetes care providers.

Because good diabetes care depends on good patient self-care, people with diabetes must know a great deal about their own condition and its management to achieve their diabetes management goals. The ADA offers an enormous number of books, publications, and other information resources for people with diabetes. Many of these resources are available in Spanish as well as English, and the ADA also offers diabetes information in culturally appropriate formats for a variety of ethnic groups.

The patient information sources are accessible through www.diabetes.org or by calling the ADA information center at 800-CALL-DIABETES.

Good diabetes management is doable and well worth the effort. As you seek ways to improve the care of your patients with diabetes, please remember that the ADA is here to help.

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