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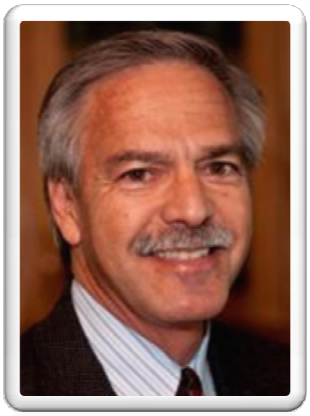

Is Oregon failing those with diabetes?

By Dr. Richard Aguilar

Richard Aguilar, M.D., is an Oregon internal medicine physician and founding member of Diabetes Nation, (http://www.diabetesnation.com/doctors.php) a national organizing that brings awareness to better clinical models of treatment. In 2006, Dr. Aguilar was named the Director of Diabetes Care for a group of primary care providers in Bend, Oregon practice.

Often I review my patients' chart data to ensure that my medical team is helping each patient implement the appropriate health and lifestyle efforts so they can live with and thrive with diabetes. In Jackson and Josephine Counties, one in every 12 and 11 county residents, respectively, are affected.

I know that in reality, patients with diabetes don't just have the disease when they are in my exam room. I may see them in my office for 20 minutes, but they have to live with it. They live, eat, breathe, play, work and struggle with it.

Like almost every physician, the conversations I have with my patients comprise all the strategies they can use to manage their disease, such as diet, insulin, exercise, and weight watching. Often they are on several additional medications for other medical problems commonly found in patients with diabetes such as hypertension or high cholesterol. But one conversation I'm having all too often with my patients is the struggles I am having with their health insurers. It's about the obstacles I am having to go through to get them getting approved for the medicines I am trying to prescribe for them.

More and more Oregonians are being diagnosed with this disease. According to the Oregon Department of Human Services, approximately 262,000 Oregon adults already have diabetes, a condition that costs $1.4 billion annually to treat. An additional 592,000 Oregonians have a pre-diabetes condition.

More than likely, patients who have diabetes aren't just dealing with that condition. They have accompanying issues such as heart disease, vision loss, obesity and circulation problems, such as diabetic peripheral neuropathy (DPN).

Those with DPN, a common link to diabetes, experience problems with their nerves, muscles, and the ability to have normal body functions such as digestion. These attending conditions require sometime complex therapies or medicines.

But is Oregon failing those with diabetes by allowing insurers to force doctors to use "fail first" or step therapy practice? Step therapy or "fail first" means that patient have to try and fail on certain medicines before a health plan will approve the therapy the physician would initially prescribe.

Such restrictions prevent patients from getting access to treatments which I deem the most appropriate medicine for diabetes or the accompanying conditions. These can be due to health plan rules and policies, many of which aim to save costs, but actually hinder access.

For physicians, providers and patients, fail first protocols mean many more time trying to get the most appropriate treatment. That lost time is spent in successive, follow-up appointments and in the relentless efforts spent by me and my staff persuading the insurer to eventually approve the indicated medicine.

At the end of the day, such barriers impact treatments that providers want their diabetes patients to try, and the overall quality of care. Patients suffer with failing therapies, instead of the most appropriate medicine I recommend. Medicine that could be more effective and often with a fewer side effects are delayed weeks or months away, tied up in insurance wrangling and case management red tape. My patients and I are frustrated with hearing insurers respond that the patient has "to fail these treatments first," before they can access the treatment I wanted to prescribe earlier.

Not surprising, programs and benefits that do not use fail first or step therapy, i.e. those that reduce barriers and increase access to medicines, actually save money. For example, City of Springfield (Oregon) employees with diabetes took part in an innovative program a few years ago that removed the barrier of co-pays for their diabetes medicines, while providing pharmacist counseling. The results confirmed waiving co-pays and co-insurance fees for medicines and for doctor visits improved compliance and overall health of participating city employees. Test showed employees' blood glucose levels declined by an average of 40 percent. Sick leave time also decreased dramatically.

In Oregon, we now have the chance to remove the barriers and access to treatments by eliminating practices and protocols that hinder patients from getting the right medicine and treatment at the right time. These values-based, benefit designs for insurers show that employer groups who preserved open access to medications and services – i.e. reduced barriers to care – achieved cost savings.

In this 2011 legislative session, I'm working with more than a dozen physician practices across the state to help patients get the medicines they need, save employers money and target cost savings for Oregon businesses. Let's eliminate specialty tier medicine pricing and fail first protocols that put needed medicines out of the hands of the patients that need it most.

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