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Review Article

Quality of Care for Elders with Diabetes

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ABSTRACT

The focus of high-quality care is essentially defined by general clinical recommendations for risk factor management in diabetes that are centred on the prevention and treatment of microvascular and macrovascular diseases. This emphasis on specific therapy targets has a number of drawbacks, too. One difficulty is that guidelines and recommendations for treating cardiovascular risk factors in diabetic patients are provided by a diverse range of stakeholder groups, and recommendations frequently vary; cooperation between guideline production groups has improved but is still far from ideal. Additionally, focusing just on the "ABCs" of A1c, blood pressure, and cholesterol for improving diabetes care may not be acceptable for many individuals, especially when linked to treatment aims. Other actions could include, among others, the avoidance of infections, hypoglycemia, patient satisfaction, quality of life, diabetes, or recurrent hospitalizations [1].

Keywords: Diabetes; Elders Care

INTRODUCTION

One of the earliest known medical writings contains what may be the first therapy recommendations and the forerunners of quality measurements. Edwin Smith found a papyrus from ancient Egypt in 1862 that included medical advice that predated Hippocrates by at least a millennium. There was good medical advice in the papyrus. For instance, it advised the doctor to remove brain splinters following head trauma before bandaging. The papyrus also had some dubious advice: following a skull fracture, the doctor was advised to apply a smashed ostrich egg topically. Notably, the papyrus urged the physician to choose which of 3 prognoses best suited the patient before outlining the advised course of action for each of the 48 specified diseases. According to the condition, doctors should notify patients that they will either [2].

Today, moral, legal, and geographical restrictions make it illegal to deny care to patients in need, and methods for evaluating the quality of care have developed from informal provider reputations to systems that are carefully quantified. Among senior patients in the United States, Medicare quality metrics are likely the most significant quality measurement tools. These metrics rate quality using a 5-star scale depending on how well they performed in previous years. The programme uses tangible rewards to boost success, including reputational rewards tied to the star rating itself, monetary rewards tied to bonus payments, and recruitment rewards tied to wider enrollment windows. 2,3 In the evaluation of high-caliber performance, diabetes is one of, if not the most, significant medical problems. Diabetes is on a small list of chronic illnesses in the Medicare Shared Savings Program (MSSP) for accountable care organisations, which is crucial to the Medicare programme [3].

DESCRIPTION

Diabetes presumably scores highly due to the condition's large prevalence, the high cost of treatment, and the all-encompassing approach to the disease that those who create quality measures try to promote. Furthermore, the HHS believes that effective performance metrics should be applicable, quantifiable, accurate, and practicable; the management of diabetes lends itself to measures that meet these 4 requirements. As part of the shift to value-based care and alternative payment models, the quality indicators themselves are derived from treatment guidelines. Treatment recommendations emphasise glucose control as a key component of diabetes management as part of an all-encompassing strategy to reduce the risk of complications from diabetes. Most patients should aim for a glycemic target of 7% glycated haemoglobin (A1C), according to a joint statement from the American Diabetes Association and the European Association for the Study of Diabetes. 6 However, the guidelines advise adjusting this goal based on patient and disease characteristics, such as the severity of the illness, how long it will last, and the dangers of hypoglycemia. As a result, an elderly patient with diabetes that has been present for a long time may choose a less demanding goal.

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Although they suggest individualization of targets, the American Association of Clinical Endocrinologists and American College of Endocrinology specify an A1C level of less than or equal to 6.5% as the standard goal [4].

This article's goal is to demonstrate how crucial patient-centered care is when treating elderly people with type 2 diabetes (T2D). Best practises, monitoring, assessment, and an interdisciplinary team approach are all included in the paper. There are currently no approved treatment guidelines or glycemic goals for older persons with T2D. When it comes to medical therapy for older persons, there is no one-size-fits-all prescription. Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, as well as the costs, effectiveness, and side effects of each drug, should be taken into account when determining the best course of treatment, with the objective of preventing hypoglycemia rather than achieving an ideal level of glycosylated haemoglobin. After discharge, a patient must be transitioned to a regimen, which presents special difficulties. With limited resources, healthcare systems around the world are battling to enhance the health of their populations. These systems are increasingly using new value-based finance strategies that reward or penalise organisations and providers based on the level of care they deliver (1,2). As a result, defining and evaluating the quality of healthcare is crucial to attempts to enhance the functionality of healthcare systems, guarantee the effective utilisation of healthcare resources, and ultimately enhance population health. Individual patients and clinicians who are deciding on daily course of therapy and diagnostic testing also require benchmarks of quality [5].

CONCLUSION

Pharmacy decision-makers rely on clinical trial data and cost-effectiveness models soon after the introduction of a new drug. The expected health and economic effects of various treatment courses are included in these economic models, which extrapolate clinical trial data and incorporate outcomes of interest to decision-makers. 10 However, in a market where patients may switch insurers, these models fall short of fully capturing the short- to mid-term requirements of a US pharmacy director looking to assemble a competitive benefit package at a competitive price. For US decision-makers, the predicted quality measure success of various pharmacological treatment routes over a shorter time horizon may also be important. Using this methodology, sitagliptin and canagliflozin were compared using a "cost-efficiency" model. 11 Importantly, present or probable future diabetes patient quality measures.

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