

# Changing Systems, Changing Lives: Improving the Quality of Diabetes Care

## Preface

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Editor

### **The Right Care, For Every Patient, Every Time**

The goal of health care professionals is to provide the right care to every patient at every clinical encounter. This aphorism reflects the dedication that providers bring to their practice. However, although their intentions are good, their implementation is imperfect. Is the poor implementation a result of a lack of dedication, knowledge, or effort? Absolutely not. Diabetes providers are among the most knowledgeable, committed, and hard working of all health care professionals. The problem is not the people; the problem is the system.

The operating assumption of the medical system is that providers' competence is the primary determinant of health care quality. Providers graduate from accredited programs, pass certifying examinations, and must satisfy continuing education and other professional licensing requirements. Their competence extends to their knowledge of the standards of care that have been established by their professional organizations. Providers are aware of the standards of care and are largely in agreement with those standards. Despite their knowledge and competence, poor outcomes still exist.

Why hasn't the competency of individual professionals translated into excellent clinical care? The answer lies in the lack of system capability to support providers in doing what they know should be done. This *Diabetes Spectrum* From Research to Practice section focuses on our belief that optimal clinical outcomes are produced when individual competency is implemented through a capable system.

In our first article (p. 92), David K. McCulloch MD, FRCP, and his col-

leagues at the MacColl Institute for Healthcare Innovation at Group Health Cooperative in Seattle, Wash., discuss the Chronic Care Model. The model details the elements of a capable medical system.

### **Quality is Not Optional**

Today, active participation in quality improvement is as central to the practice of medicine as proper assessment, diagnosis, and treatment. Data on provider performance are compiled by payers and, increasingly, are being made available to the public. Further, rates of reimbursement for professional services in the future may be tied to performance data.

Documentation of quality improvement efforts is required of diabetes education centers. Both the recognition process of the American Diabetes Association (ADA) and the regulation authorizing reimbursement for education services from the Centers for Medicare and Medicaid Services require participation in quality improvement efforts. Physicians participating in the ADA's Provider Recognition Program face increasingly rigorous standards for recertification that can only be met by continuously improving both process and clinical outcomes. All of these requirements underscore providers' professional obligation to constantly improve the system of care and the results it produces.

### **Every System Is Perfectly Designed to Produce Its Current Results.**

Improving diabetes care requires competent providers to be actively involved in quality improvement in order to build a system capable of translating their knowledge into optimal outcomes for their patients. The

effort required to improve outcomes should not be underestimated. Improving outcomes requires a fundamental redesign of the system that produces them; minor modifications to existing systems will not achieve the desired improvements.

Past efforts to improve outcomes have focused on the development of standards of care, clinical practice guidelines, and professional education programs. Unfortunately, these efforts have proven to be ineffective. Guidelines do not treat patients, providers do. Knowledge of standards does not automatically translate into action; individual competency is made operational through capable systems.

Clearly change is required for improvement. The old saying is true: "If you always do what you've always done, you'll always get what you've always gotten." However, although all improvement requires change, not all changes result in improvement. Diabetes providers must seek to make changes not for the sake of change, but for the sake of people.

Providers need direction as they endeavor to redesign their systems of care. The Institute for Healthcare Improvement (IHI), based in Boston, Mass., has provided direction to providers since 1991. The institute's Breakthrough Series (BTS) model for collaborative learning and achieving improvement is described in our second article (p. 97) and has been applied in a variety of settings and to a broad range of medical conditions. The Chronic Care Model and the BTS approach provide the conceptual framework for quality improvement efforts. The remaining articles of our section describe how they are practically applied to improving patient care.

### Profession-Based Practice

The idea of participating in quality improvement efforts is overwhelming to many providers. After all, clinical practice already takes 100% of their time. Two goals must be accomplished to move health care providers to willingly participate in quality improvement efforts. First, they must be educated about Dr. Brent James' concept of profession-based practice.<sup>1</sup> Second, they must have the advantages of developing a more capable

system demonstrated to them.

Currently, most providers participate in "craft-based" practice. In a craft-based system, each provider handcrafts a customized solution for each patient based on his or her core ethical commitment to the patient and personal knowledge. This system produces poor outcomes and offers no opportunity to define best practices or foster collaborative learning.

In a "profession-based" system of practice, providers who treat similar patients develop and implement evidence-based care processes. Providers then customize the processes to each patient's specific needs. Strong support for profession-based practice is found in the work of the Bureau of Primary Health Care (BPHC) collaborative, which is reported in the third and fourth articles of this section (p. 102 and p. 107). The results confirm that profession-based practice produces better outcomes and reduces cost. Profession-based practice also puts health care professionals back in control of care delivery and serves as a foundation for the development of useful shared electronic data.

### Clinical Efficacy Versus Clinical Effectiveness

Ultimately, quality improvement is about translation. It is the mechanism by which clinical efficacy (outcomes associated with interventions under ideal circumstances) is translated into clinical effectiveness (outcomes associated with interventions in the real world). The translation process is necessary if people with diabetes are to realize the benefits of research.

It has been a decade since the results of the Diabetes Control and Complications Trial were reported, making the clinical efficacy of intensive diabetes management indisputable.<sup>2</sup> However, the majority of people with diabetes continue to have hemoglobin A<sub>1c</sub> (A1C) results above 7%. The national average for A1C is reported to be between 8.6 and 8.9%.<sup>3</sup> The clinical effectiveness of intensive diabetes management is, therefore, suboptimal. The need for achieving clinical effectiveness is further demonstrated by studies showing that < 8% of people with diabetes are simultaneously reaching the treatment goals for A1C, blood pressure, and lipoproteins.<sup>3-5</sup>

Applying the principles and practices of quality improvement in clinical settings permits the systematic translation of clinical research to achieve optimal outcomes. The process translates cutting-edge research into daily clinical practice, thereby achieving clinical effectiveness. The reports in this issue from Hupke et al. of the BPHC collaborative demonstrate how applying these principles could increase the percentage of people with A1C results < 7%.

Like politics, all quality improvement (and clinical effectiveness) is local. Each organization, each clinic, each practice must engage in the process of translation for their unique population of patients. What works for a large, urban health maintenance organization will not necessarily work in a rural clinic. Strategies that work in a specialty diabetes center may not be readily exported for use in primary care practices.

Every provider has the professional obligation to participate in quality improvement initiatives because this is how the best possible outcomes will be achieved for people with diabetes. This is, by definition, profession-based practice. This is how we can achieve the ADA's stated mission "to improve the lives of all persons affected by diabetes." This is what every person with diabetes deserves.

### References

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