Toward Common Ground

The study by Ho et al. (1) raises the issue of whether diabetic patients should be cared for by a generalist or a specialist. The issue is as old as specialty care itself (e.g., when and which patients to refer in either direction). Previously, solutions were developed by generalists, specialists, and patients choosing their relationships, and there was little incentive to evaluate the costs or quality of care in these choices. Now, a new group, the managed care organization, has joined these discussions. Despite our cringing at the demands of managed care to conserve the costs of patient care, there is now strong motivation to obtain objective data for solutions to these questions. Hopefully, solutions would be for the best outcomes of our patients, our common ground.

In today's rapidly changing health care systems, managed care decisions are made quickly to remain competitive. The motivation for Ho's report (1) was a managed care decision to shift diabetic patients from specialty to primary care to contain costs. This decision prompted investigators to determine if the quality of diabetic care for patients might be adversely affected by this shift. They found that the quality of diabetic care for patients in the specialty clinic was better, compared with a primary care clinic, according to accepted guidelines. Although not from a randomized controlled trial, the results are convincing, and additional data on structure support the rationale for the findings. Further, the results are consistent with what one might have predicted (2). Thus, we are able to provide the managed care organization with evidence that the guidelines on diabetic care would be less frequently followed if the shift to primary care were made.

Most managed care organizations welcome this type of information, because they now recognize that they have to be competitive in both costs and quality of care. However, they will need further information on how to maintain and/or improve the quality of care within their cost containment strategy. As Ho et al. (1) outlined, generalists may require additional knowledge and system resources to improve compliance with guidelines. Their report may have implied that the primary care site would require resources available in the specialty clinic (e.g., a diabetes physician specialist, an eye specialist, a podiatrist, and a diabetes nurse educator). Such information would put off the managed care organization as they figure the added costs of these resources for improved quality of care. Just given the information on quality and the added costs to maintain quality, the managed care organizations would be confronted with the choice of 1) not making the shift and letting low quality in primary care continue; 2) making the shift and providing no additional resources, which would increase the number of diabetic patients receiving a low quality of care; or 3) making the shift and providing additional resources that would improve quality, but likely have little impact on costs. These are not very good choices.

Fortunately, there is a large and growing literature on effective and ineffective methods to improve compliance with guidelines. For example, we now know that improvements in knowledge through traditional continuing medical education programs are not very influential in changing provider behavior (3). We also now know that some improvements in compliance with guidelines can be obtained with little cost. For example, instructing nurses to have patients take off their shoes and socks before the physician arrives in the exam room increases examination of the feet from 15 to 70% of visits in a primary care clinic (4). A review of the literature in 1993 (5) found 55 reports of interventions that result in significant improvements in compliance with clinical guidelines.

Certainly, some interventions to improve compliance with guidelines require additional system resources. One example of those requiring additional resources is computer-generated reminders at the time of the office visit (6). Most of the guidelines mentioned in the study by Ho et al. (1) could be easily implemented as computer-generated reminders (e.g., no urinalysis in the past year, so consider ordering a urinalysis; no HbA_{1c} in the past year, consider ordering an HbA_{1c}; no eye clinic visit in the past year, consider scheduling an eye clinic appointment). Although managed care organizations may get a nervous cough at the cost of such computer systems, they can be supplied with data on early estimates (7), which indicate that much of the cost is offset by other savings. Additionally, such computer systems implement interventions, monitor the quality of care, and can easily be extended to all clinics and conditions, not just patients with diabetes in a primary care clinic. Ho et al. (1) provided evidence of the importance of this extension to all clinics and all conditions. They found that the primary care providers, more frequently than specialists, asked patients about their cardiovascular health. Clearly, methods to improve compliance with guidelines is universally needed. Unfortunately, many managed care organizations may not be aware of information on newer methods to improve compliance and are not rapidly moving toward providing such support.

There are many features of this study that provide optimism for our finding "common ground" in a rapidly changing health care system. First, the managed care organization appropriately did its job by indicating a potential way for reducing costs. Second, both generalists and specialists actively participated in looking for the potential impact of change on the quality of both diabetic and general patient care. Third, through their efforts, they provided some useful information for the managed care decision-makers. We now need to provide more information to managed care organizations on effective methods for improving compliance. We do not know how the results of this study will affect decisions on moving patients from specialty to primary care or the effect on the quality of care in both specialty and primary care clinics. However, if managed care organizations, specialists, primary care providers, and patients are active in providing information or finding new information through research, solutions to reaching a "common ground" for excellence in patient care will be reached.

With this end in mind, we should remember the words of Oliver Wendell Holmes, who wrote, "I find the great thing in this world is not so much where we stand, as in what direction we are moving: To reach the port of heaven, we must sail

Downloaded from http://diabetesjournals.org/care/article-pdf/20/4/467/584145/20-4-467.pdf by guest on 29 February 2024

sometimes with the wind and sometimes against it . . . but we must sail, and not drift, nor lie at anchor" (8).

DAVID M. SMITH, MD

From the Indiana University School of Medicine, Indianapolis, Indiana.

Address correspondence to David M. Smith, M.D., Regenstrief Institute, 6th Floor, 1001 West Tenth St., Indianapolis, IN 46202.

References

1. Ho M, Marger M, Beart J, Yip I, Shekelle P: Is the quality of diabetes care better in a diabetes clinic or in a general medicine clinic? *Diabetes Care* 20:472–475, 1997
2. Marrero DG: Evaluating the quality of care provided by primary care physicians to people with non-insulin dependent diabetes mellitus. *Diabetes Spectrum* 9:30–34, 1996
3. Haynes RB, Davis DA, McKibbon A, Tugwell P: A critical appraisal of the efficacy of continuing medical education. *JAMA* 251:61–64, 1984
4. Cohen SJ: Potential barrier to diabetes care. *Diabetes Care* 6:499–500, 1983
5. Grimshaw JM, Russell IT: Effect of clinical guideline on medical practice: a systematic review of rigorous evaluations. *Lancet* 342:1317–1322, 1993
6. McDonald CJ, Hui SL, Smith DM, Tierney WM, Cohen SJ, Weinberger M, McCabe GP: Reminders to physician from an introspective computer medical record: a two year randomized trial. *Ann Intern Med* 100:130–138, 1984
7. McDonald CJ: Use of a computer to detect and respond to clinical events: its effect on clinician behavior. *Ann Intern Med* 84:162–167, 1976
8. Holmes OW: *The Autocrat of the Breakfast Table* [1858]. Quoted from Bartlett J: *Familiar Quotations*. 14th ed. Beck EM, Ed. Boston, Little Brown, 1968, p. 633

Downloaded from http://diabetesjournals.org/care/article-pdf/20/4/467/584145/20-4-467.pdf by guest on 29 February 2024