

Diabetes Report Card — Time for a Winning Streak

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Despite a major national effort to build the case for improved quality in diabetes care, the recent report card on our national performance that appears in this issue of the *Journal* suggests that we have reached a plateau. Ali et al.¹ surveyed participants from the National Health and Nutrition Examination Survey and the Behavioral Risk Factor Surveillance System between 2007 and 2010 and compared the results with those of prior report cards from two other time periods (2003–2006 and 1999–2002). The results document continuous incremental improvements in achieving glycemic and blood-pressure targets, with a more robust change in reaching lipid targets; rates of smoking cessation were unchanged. Such periodic reviews help to identify areas that are particularly difficult to change; in the present study, in spite of modest improvements in the achievement of individual targets, only 14% of participants met all three targets and the goal of smoking cessation.

Although there is reason to celebrate the modest improvement in performance suggested by these data, there's a long way to go to deliver the quality of diabetes care that truly meets our patients' needs. Excellence in providing long-term care has lagged behind the advances in acute care, and that needs to change. The management of chronic disease is laborious and requires a dedication to a goal that is measured predominantly by the absence of the complications that define an uncontrolled condition. As compared with acute illness, victories in chronic illness are harder to perceive, for both patients and doctors.

The “chronic care model” offers some hope. In this model, health care teams that include physicians and other professionals collaborate collectively to care for a panel of patients. Patients need to become collaborators in this model, and physicians need to become comfortable with sharing responsibility. Furthermore, models for communication, accountability, and incentive allocation between clinics and providers need to be defined.^{2,3}

In the chronic care model, an effective health care team uses information technology and regular team meetings to communicate and strategize about the care of their panel between epi-

sodes of care. The most effective practices have worked to define the roles of team members, hold team members accountable, improve documentation, integrate care with electronic health records systems, and expand access.⁴ Quality of care is tracked, and continuous improvement is prioritized. Practices that successfully implement such elements of the chronic care model appear to produce health outcomes that are far better than those of conventional practices.^{3,5,6}

Curricular changes across the continuum of training are helping new physicians to develop the skills required to facilitate these changes in practice, including the skills needed to work collaboratively and interprofessionally, to use information technology well, to manage a patient population, to engineer change, to coordinate care, and to think systematically.^{7,8}

Incentives can drive performance improvement,⁹ and the task of creating incentives for performance improvement in diabetes care has largely rested on defining thresholds for acceptable control of intermediate variables such as systolic blood pressure or level of glycated hemoglobin. But the achievement of minimum thresholds fails to capture the substantial health benefits of improvement. For diabetes care, we would like to see that improvement is not only tracked but rewarded, even if the thresholds have not been met. For example, providers should receive at least as much credit for lowering a patient's glycated hemoglobin level from 11% to 9% as they would for helping a patient improve from 7.6% to 6.8% to meet a 7% threshold. In addition, there might be an exemption from being scored on patients in the panel for whom the goals are clearly inappropriate.

An increasing recognition of the importance of patient-centered care implies that beyond measures of quality of care, patient-reported measures of well-being, empowerment, satisfaction, and access to care should be tracked in the next iteration of the report. Incentives for physicians and others in the health care team may be financial, but other rewards, such as public profiling, or the provision of credits in a program that allows continuous maintenance of certification, may also be motivational.

Just as science evolves, so should clinical care. **The next wave of improvement in the delivery of diabetes care will probably come through intensive quality improvement and a movement away from episodic care toward the chronic care model and panel management.** A new report card should capture change and improvement, not only whether thresholds were reached. If incentive systems reward such improvements, perhaps then we'll be on a winning streak.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. Ali MK, Bullard KM, Saaddine JB, et al. Achievement of goals in U.S. diabetes care, 1999–2010. *N Engl J Med* 2013;368:1613-24.
2. Bojdziewski T, Gabbay RA. Patient-centered medical home and diabetes. *Diabetes Care* 2011;34:1047-53.

3. Stellefson M, Dipnarine K, Stopka C. The chronic care model and diabetes management in US primary care settings: a systematic review. *Prev Chronic Dis* 2013;10:E26.
4. Porter ME, Pabo EA, Lee TH. Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Aff (Millwood)* 2013;32:516-25.
5. Bodenheimer T. Interventions to improve chronic illness care: evaluating their effectiveness. *Dis Manag* 2003;6:63-71.
6. Tsai AC, Morton SC, Mangione CM, Keeler EB. A meta-analysis of interventions to improve care for chronic illnesses. *Am J Manag Care* 2005;11:478-88.
7. Chang A, Bowen JL, Buranosky RA, et al. Transforming primary care training — patient-centered medical home entrustable professional activities for internal medicine residents. *J Gen Intern Med* 2012 September 21 (Epub ahead of print).
8. Crosson FJ, Leu J, Roemer BM, Ross MN. Gaps in residency training should be addressed to better prepare doctors for a twenty-first-century delivery system. *Health Aff (Millwood)* 2011;30:2142-8.
9. Epstein AM. Will pay for performance improve quality of care? The answer is in the details. *N Engl J Med* 2012;367:1852-3.

DOI: 10.1056/NEJMe1302610

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