

Improving Diabetes Care in Community Health Centers

“Quality of Diabetes Care in Community Health Centers,” by Chin et al.,¹ can be appropriately understood only when it is set in context. This context includes 2 major factors: (1) how care of patients with diabetes in community health centers compares to care patients with diabetes receive from other providers and (2) the existence of an initiative by the Bureau of Primary Health Care and the Centers for

Disease Control and Prevention to improve diabetes care in community health centers.

Although all health care providers should strive to meet evidence-based standards of care, in the real world most fall short.² This is the case with adherence to the American Diabetes Association’s norms for diabetes care.³ For glycosylated hemoglobin (HbA1C) testing, Chin et al. found a rate of 70% in community health centers; in comparison, a study of Medicare claims found 16%,⁴ an independent practice association reported 44%,⁵ and physicians self-reported 43%.⁶ For eye examinations, Chin et al. found a referral rate of 26% in community health centers, compared with 22% in an independent practice association,⁵ 38% in the National Committee for Quality Assurance reports,⁷ and 46% for Medicare patients.⁴ It should be noted that the patients in the latter 3 studies had health insurance that covered ophthalmologic examinations, whereas more than 40% of the patients in community health centers are uninsured.

Although community health centers have performed at or above the levels of other providers of care for patients with diabetes, we at the US Public Health Service do not believe that these levels are sufficient for our patients, who have a high incidence of diabetes and its sequelae. Accordingly, we have sponsored the Diabetes Collaborative Initiative. In collaboration with the Institute for Healthcare Improvement and the Centers for Disease Control and Prevention, the initiative seeks to delay or decrease the complications of diabetes through a care model developed at the Sandy MacColl Institute for Healthcare Innovation.

The evidence-based model, pioneered by Edward Wagner at the University of Washington, has 5 basic elements: patient self-management, clinical decision support, delivery system redesign, clinical information system, and strong partnerships with local government and community organizations. Eighty-three community health centers have participated in the program, as have 15 state diabetes control programs. In 2000 a second group of 120 community health center teams began participating in the initiative, along with 22 state programs. Preliminary results from the first year’s program show substantial improvement in glycosylated hemoglobin testing and other measures of diabetes care.

It is important to openly assess quality of care and then institute programs to correct deficiencies. We are pleased that community health centers are engaging in both efforts. □

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