Combining the chronic care model with process and outcome indicators to measure quality of care for diabetes in Belgium: a unique way toward a comprehensive view on quality of care.

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Purpose
In Belgium, as in other countries, accessibility and quality of diabetes services are suboptimal. Primary care was originally built to serve acute diseases, and practice organisation for chronic diseases is lagging behind. The Chronic Care Model (CCM) provides guidance on how to improve. Although it is a robust model, it only focuses on structure indicators, whereas process and outcome indicators are needed to capture the complete picture. Therefore, our hypothesis is that practices in Belgium scoring higher on the implementation of the CCM for diabetes also score higher on process and outcome indicators.

Design and methods
66 primary care practices were sampled. They had different organizational types and different team compositions. The Assessment of Chronic Illness Care (ACIC), based on CCM was used to measure the quality dimension structure. Health insurance data and lab data were used to measure process and outcome indicators. Multilevel logistic regression models with patients nested within GP practices were estimated.

Results
When looking at the dimension structure, multidisciplinary and capitation-based practices scored considerably higher than traditional monodisciplinary fee-for-service practices on the overall ACIC score. However this was not directly reflected in the process and outcome indicators, possibly due to lack of power. The preliminary results do show a higher overall ACIC score was associated with higher odds of appropriate follow-up and better treatment.

Conclusion
We managed to create a comprehensive view on the multidimensional quality of care for chronic diseases, which is innovative and important for policy makers and

practitioners to scale-up quality of care of diabetes. Analyses show that the degree of implementation of the elements of the CCM is related to follow-up and treatment success. This suggests that organizing a primary care practice different can be important for the lives of patients with chronic diseases.