California Academy of Family Physicians
Diabetes Initiative Care Model Change Package

Introduction

The Care Model (CM) is a unique and proven approach for implementing proactive strategies that are responsive to both patient and provider needs. Developed by Improving Chronic Illness Care (ICIC), a national program of the Robert Wood Johnson Foundation, the model integrates community, organizational, practitioner, and patient systems. Based on published results, the Care Model promotes “continuous healing relationships” characterized by planned sets of interactions and interventions over time to optimize quality and delivery of more efficient and effective health care.\(^{(1,2)}\)

Using the Care Model is a common sense and practical approach to improving care management. The CAFP Diabetes Initiative uses the following testable ideas to support the implementation of each of the six components of the Care Model.

\(^{(1,2)}\): Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients With Chronic Illness.\(^{JAMA.2002:288:1775-1779.}\)
Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients With Chronic Illness. The Chronic Care Model, Part 2.\(^{JAMA.2002:288:1909-1914.}\)

Materials originally developed by Lumetra, California’s Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS).
Six Key Elements are Defined in the Model

Community

Resources and Policies

Self-Management Support.

Health System

Organization of Health Care

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Improved Functional and Clinical Outcomes

Prepared, Proactive Practice Team
1 Care Model Component: Delivery System Design

Transform a reactive system into a proactive one by clarifying roles, delegating tasks, and organizing patient visits to enhance continuity of care.

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<th>Change Concepts and Strategies</th>
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| 1.1 Identify your diabetes patient population. | 1. Identify your patients with diabetes by using an existing system that has “markers” to identify patients with diabetes (i.e., billing, pharmacy or lab systems).
2. Develop a card file/notebook/electronic file that can be used to build a tracking system for patients with diabetes.
3. Use patient stickers to identify charts of patients with diabetes.
4. Embed evidence-based guidelines into routine diabetes care management to assure preventive and maintenance care is routinely assessed.
5. Use patient tracking system to identify patients who need labs, eye or dental exams, and send letters to patients requesting they get the appropriate tests. |
| 1.2 Use standardized procedures for routine referral and care. | 1. Integrate standardized nursing procedures to provide uniform management of patients with diabetes and develop skill levels of nursing staff.
2. Integrate evidence-based guidelines into daily practice. |
| 1.3 Bring multidisciplinary services together to promote continuity of care through individual or group planned visits. | 1. Assign roles, duties, and tasks for planned visits to a multi-disciplinary team.
2. Establish group visits in which patients see a pharmacist, nurse and doctor, and participate in group education and support all within a periodic visit to your office.
3. Identify patients’ needs on flow sheet/visit note/encounter note to prepare for a positive interaction.
4. Develop a process to ensure communication occurs between care management team and community resources.
5. Establish a daily care team meeting to prepare for the day’s planned visits.
6. Develop a process for patients to have lab draws completed in advance of appointments so that lab results and consultations are available at the time of the appointment. |
| 1.4 Cross-train staff and expand capabilities to improve diabetes case management. | 1. Train providers, nurses and medical assistants in patient assessment skills, self-management goal setting and follow-up, etc., and periodically check staff competencies with tasks.
2. Obtain senior leader support for training staff in new roles and tasks. |
| 1.5 Incorporate case management, promotoras, and other programs to help with managing patients and follow-up. | 1. Create an effective process to prioritize patient needs and status of illness or wellness for multidisciplinary team management.
2. Designate staff to be responsible for case management follow-up. |
2 Care Model Component: Clinical Information Systems

Optimize care management and outcomes measurement by using effective systems to collect, categorize, and monitor patient data and provide timely provider feedback.

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| 2.1 Implement electronic tracking system for proactive management of your diabetes patient population. | 1. Develop a system for data entry and utilization of electronic tracking system including who will perform entry and when it will be done.  
2. Use the clinical information system to proactively review needed care for individuals and populations.  
3. Give population-based or individual key measure feedback to providers. |
| 2.2 Use clinical information systems to provide protection against errors | 1. Link lab and imaging ordering to patient’s problem and medical list.  
2. Use approved abbreviation and definition lists. |
| 2.3 Develop flow sheets for provider/patient interaction and care management | 1. Use flow sheets to track diabetes management over time.  
2. Develop a process to consistently enter necessary data. |
### 3 Care Model Component: Decision Support

*Incorporate proven guidelines, tools, and strategies into daily clinical practice to improve quality of care, communication, and collaboration.*

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| 3.1 Embed current evidence-based guidelines into daily clinical care.| 1. Provide pocket cards with guidelines.  
2. Design a system for collaboratively monitoring and controlling A1C.  
3. Establish a protocol for retinal screening.  
4. Incorporate guidelines into flow sheets, protocols, and pre-printed orders.  
5. Post guidelines on the back of flow sheets.  
6. Develop a process to routinely review guidelines and disseminate to staff.  
7. Implement office tracking or reminder systems, and office initiated notification system for diabetes care management.  
8. Implement protocols or pre-printed orders for preventive tests and vaccinations. |
| 3.2 Provide ongoing care management feedback to providers and team. | 1. Use flow sheets or registry to track diabetes management over time and share findings with providers and staff.                                                                                                                                                                                                                                                                      |
| 3.3 Integrate specialist expertise into primary care settings through increased communications | 1. Create and use agreements communicating specific elements related to patient care among providers.  
2. Provide alternative ways for communication between specialist and primary care physician.  
3. Establish templates for specialist and primary care communication via email.  
4. Develop a fax back form from specialist to PCP.  
5. Establish a service agreement and guidelines for specialty care referrals.  
6. Coordinate group visits with specialists.  
7. Use appointment cards with referral place, time, dates, and consent to send results to PCP. |
| 3.4 Use proven provider education modalities.                        | 1. Provide ongoing education based in guidelines and skill acquisition.  
2. Establish bi-monthly case conferences.  
3. Hold mini clinics with specialists.  
4. Teach goal setting skills at team meetings.  
5. Recognize physician performance for improved care management through achievement awards. |
| 3.5 Use care management, or team conferences to raise patient issues | 1. Enhance staff responsibilities through standards of care protocols.  
2. Dedicate staff to case management and follow-up with patients with abnormal results.  
3. Convene regular team meetings to coordinate care.  
4. Use standardized phone or email follow-up protocols to identify patients needing stepped-up care. |
<p>| 3.6 Educate patients about guideline                                | 1. Schedule an encounter at least annually to discuss current recommended guidelines and self- |</p>
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<th>Management Opportunities</th>
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<td>2. Involve patients in setting care expectations through “care pathways.”</td>
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<td>3. Post educational materials in exam rooms and lobby.</td>
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<td>4. Develop interactive educational materials for the office website.</td>
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<td>5. Offer personal health record tools.</td>
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## Care Model Component: Self-Management Support

Develop a care team that emphasizes the patient’s active and central role in managing illness, preventing complications and motivating effective behavioral change at every patient contact.

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| **4.1 Train (educate) providers and other key staff to help patients set self-management goals.** | 1. Provide training to the care team to employ techniques that emphasize the patient role in managing diabetes.  
2. Develop standardized approach for multidisciplinary care management and supporting self-management goals.  
3. Develop a procedure to collaboratively assess potential barriers to achieving self-management goals.  
4. Develop a resource guide to services that decrease barriers to self-management goals. |
| **4.2 Empower patients to manage their health by involving them in all goal setting and health care decisions, and by emphasizing their central role in this process.** | 1. Routinely reinforce the practice for patients with diabetes to commit to one or more diabetes management goals.  
2. Initiate flow sheets to track patient progress toward goals; keep sheets in medical record.  
3. Distribute patient pocket cards and self-management information sheets.  
4. Develop process to create, document and follow-up on patients’ self-management goals at each visit.  
5. Describe the patient’s role in managing his/her health at each encounter and provide them with tools to assist them.  
6. Provide glucose self-monitoring devices or assist patients in acquiring these devices.  
8. Provide and maintain internal and community resources for ongoing self-management support to patients.  
9. Include a hard copy of “Diabetes Self-Management” goals in each patient’s chart to facilitate patient/provider goals. |
| **4.3 Emphasize the patient’s role in managing his/her diabetes.** | 1. Reinforce the patient’s role in managing his/her diabetes at each visit.  
2. Initiate scheduling of office visits with patients in need of routine screening.  
3. Establish a system to collaboratively set goals with patient.  
4. Provide patients with wallet cards for preventive care history.  
5. Advise patients by providing specific information about health risks and benefits of changing behaviors.  
6. Improve patient understanding and self-management through the use of a variety of patient tools. |
| 4.4 Offer group visits to educate and provide support. | 1. Implement a program for diabetic group visits which includes RDs, CDEs, and/or nursing staff  
2. Arrange for billing staff to investigate coverage/reimbursement for group visits  
3. Identify other mechanisms for linking patients with peers, such as buddy systems or phone partners. |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------|
| 4.5 Use culturally-appropriate, standardized educational materials. | 1. Have culturally-appropriate and literacy-appropriate diabetes self-management and patient education materials visible and accessible.  
2. Recruit and train culturally-competent health care professionals. |
| 4.6 Identify and utilize community resources to achieve patient self-management goals. | 1. Develop a policy that routinely refers patients to community-based diabetes education and self-management classes  
2. Create, maintain, and distribute an up-to-date resource guide for community resources. |
### 5 Care Model Component: Community Resources and Policies

Build partnerships with community-based organizations to provide access to key services, avoid duplication and promote evidence-based health programs.

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| **5.1 Identify and address socioeconomic barriers to care:**  
- Lack of knowledge about resources  
- Under or uninsured patient populations  
- Inability to access or finance care | 1. Designate a staff member in your practice to become a diabetic insurance coverage benefit resource/expert.  
2. Designate a staff member in your practice to become a community resource liaison.  
3. Create a procedure to assess patient financial barriers to care and refer for low-cost alternatives.  
4. Compile a list of pharmaceutical-related patient assistance programs.  
5. Create a procedure to assess patients for adequate medical coverage.  
6. Prescribe generic or low-cost medications, when appropriate.  
7. Create an assessment tool for diabetes care management that addresses socioeconomic and cultural barriers.  
8. Improve access to care:  
   - Transportation services  
   - Reduced or free costs  
   - Offer scheduling through other venues  
   - Concurrent appointments for preventive care services |
| **5.2 Identify cultural and linguistic opportunities/resources to improve diabetes care management.** | 1. Integrate cultural competence and diversity into your patient needs assessment.  
2. Develop a policy or procedure to address issues related to literacy, language, customs or other identified cultural needs.  
3. Develop a procedure to access timely translation and/or interpretation services.  
4. Identify ethnic and cultural make-up of your practice.  
5. Identify county-specific ethnic or cultural makeup. |
| **5.3 Improve access and participation in community-offered educational classes and support groups.** | 1. Develop a policy that routinely refers patients to diabetes education and self-management classes.  
2. Create a documentation tool or flow sheet that regularly screens patients for adherence to self-management goals and attendance in diabetes education and self-management classes.  
3. Create, maintain, and distribute an up-to-date resource guide that lists available educational programs.  
4. Use your practice website to provide up-to-date electronic links to community educational programs.  
5. Develop a process for which team-based communication between care providers and patients |
| 5.4 Raise community awareness through networking, education, and utilization of lay workers as a link/resource between community and your practice. | will occur to convey consistency and reinforcement for referrals to educational classes and community resources.  
6. Designate a staff member in your practice to become a community services resource. |
|---|---|
| 1. Link patients with community support, etc.  
2. Hold a “project kick-off” and invite your patients with diabetes to attend.  
   - Invite community service organizations related to diabetes to attend.  
3. Plan educational campaigns with media coverage. |
## 6 Care Model Component: Organization and Health Systems

*Develop leadership support for improvement of chronic illness care through visible and measurable goals in the organization’s business and strategic plans, including evidence-based provider incentives.*

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| 6.1 Define and communicate priorities and progress to relevant practice members, senior leaders, and staff on a regular basis. | 1. Recruit a project champion to take ownership of the project.  
2. Align project goals with organizational mission/goals.  
3. Design a system to provide routine project progress reports to key leaders, managers, and staff. |
| 6.2 Integrate chronic disease management into the strategic, business, and quality improvement plans for your practice. | 1. Align project goals with organizational goals and annual plan.  
2. Create multi-disciplinary disease management team defining individual roles and responsibilities.  
3. Include all levels of staff participation in quality improvement and disease management projects.  
4. Develop a process to routinely review the QI plan with all staff and define roles and responsibilities. |
| 6.3 Develop and promote the business case for your project as it relates to clinical, operational, and financial goals and outcomes. | 1. Integrate assessments, treatments, and services into the system of care delivery through the use of protocols that explicitly state what needs to be done for patients, by whom, and at what intervals.  
2. Regularly assess outcomes, satisfaction and cost compared to performance to remain aligned with business care plans. |
| 6.4 Create strategies to spread successful changes to other clinical conditions, sites, providers, and teams. | 1. Document all successful interventions and strategies as initiated in preparation for spreading later; plan ahead. |
| 6.5 Empower teams to create and sustain systems changes. | 1. Conduct regular employee staff meetings.  
2. Align quality improvement projects with organizational goals.  
3. Integrate interventions into existing established procedures. |
| 6.6 Actively participate in the development of community health policies to improve diabetes. | 1. Develop a plan with employer groups, medical groups, health plans, Independent Practice Associations (IPAs) or other payors to ensure coverage for diabetes education and case management benefits.  
2. Coordinate services with hospital services organizations and health plans for free or low-cost diabetes education programs.  
3. Actively participate in a local or statewide diabetes collaborative. |