

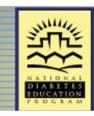
Better Diabetes Care



Chronic Care Model

(adapted from MacColl Institute ICIC Chronic Care Model)

Health Systems This applies to your CHC structure and day-to-day operations:	Y N Is there a method in the system for integrating clinical expertise from generalists and specialists?
Check one Y N Does your current Health Care Plan (grant) include - Diabetes Care? - Chronic Disease Management? Y N What are your Health Care Plan goals? Y N Does your CEO/ Medical Director understand the Model? (If no, what are your team's plans to educate?)	□Y □N Does the care team work to maximize cooperation and apply the guidelines and protocols? □Y □N • If no, is there a plan in plan to improve the cooperation and application? 3. Clinical Information System
 Y □N Is the CEO/ Medical Director committed (visit times/ scheduling, money & resources for education, etc.) to meeting the needs of patients with chronic illness? □Y □N Do you have a plan to better enlist support of the CEO/ Medical 	This applies to the center's IS System AND the Diabetic Registry: Check one Y N Is the registry developed? Y N Is there a plan to include ALL of your diabetic population in the
Director, other providers and staff? Y N Is there currently an ACTIVE patient education and services for your ENTIRE population? Y N What is your current performance improvement model? (QA, QI	registry? Y N Is there a person assigned to update the registry on a regular basis? Y N Is there a method for obtaining the data to enter into the registry? Y N Is there a plan for reminder system for patient and team of follow up
program) Y N • Is it actively in use? Y N • Is there a QI team or committee? Y N • Do they meet regularly?	needs? Y N Is there a plan in place for the team to regularly review data from the registry? Y N Is there a system in place to allow for care planning?
□Y□N • Does the current program effectively improve anything? • Are there plans to incorporate the Senior Leader report as part of the QI meeting	4. Delivery System Design This applies to the delivery of care provided for diabetic patients: Check one
□Y □N Outcomes, costs and satisfaction of a sample of diabetic population are analyzed regularly (i.e. monthly) to access the performance of the system of care for the population. □Y □N Does the team understand the PDSA Model well enough to teach it to the rest of the staff? If not, what are the plans to get that done?	N Are there visits specifically designed for Diabetic patients at regular intervals? (As opposed to ALL acute care episodes?) N Is there a method in place for the practice to anticipate problems and provide services to maintain quality of life and function for the patient?
Y N Are there incentives for providers to support chronic illness goals?	Describe the care team of the patient with diabetes: How does the care team work together with the patient?
2. Decision Support This is about the Standards of Care developed/adopted by your CHC to care for DIABETIC patients that come to your center: Check one Y N Do you have evidence based Diabetes guidelines integrated into clinical practice? Y N Do you have clinical protocols for diabetes?	■Y ■N Does the care team meet regularly to review their diabetic population and how well the care provided is impacting the patient? ■Y ■N Is the system designed for regular communication and follow up with the patient?



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5. Self Management Support PLEASE NOTE: self-management is NOT the TRADITIONAL approach to education of the patient. Self-management involves methods to make the PATIENT responsible for their disease process rather than the provider. This sections addresses that aspect of the model	
Check one Y N Does the program you have (or are developing) EMPHASIZE the patient's role in managing the illness?	
\square Y \square N Is there a method to ASSIST the patient in setting personal goals?	
■Y ■N • Is there a method to document these for the patient and the medical record?	
\square Y \square N Are there methods to measure progress and provide feedback to patients on their progress?	
■Y ■N • Are there aids & programs to assist in changing behaviors? (smoking cessation programs, walking groups, etc.)	
Y N Are there patient group meetings (peer support)?	
Y N Is there a plan to assist patients in improving communication with providers about their healthcare?	
6. Community Resources & Policies This addresses the community aspects of the model - what's available and can it be linked back to the patient:	
Check one	
☐Y ☐N Do you know what your needs are?	
Y N Are there possible community resources to support diabetes care? (neighborhood groups, church, senior centers, work sites, other diabetes projects, etc.)	
List the community service agencies.	
☐Y ☐N Are they accessible for the patients?	
Y N Are there commonalities between you and them?	
Y N Have you met with them to discuss common goals?	
What is your plan for involving the community?	
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