Chronic Care Model

(adapted from MacColl Institute ICIC Chronic Care Model)

1. Health Systems

This applies to your CHC structure and day-to-day operations:

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 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 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 program)

☐Y ☐N • Is it actively in use?

☐Y ☐N • Is there a QI team or committee?

☐Y ☐N • Do they meet regularly?

☐Y ☐N • Does the current program effectively improve anything?

☐Y ☐N • Are there plans to incorporate the Senior Leader report as part of the QI meeting

☐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?

_____

_____

☐Y ☐N Are there incentives for providers to support chronic illness goals?

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 Are they regularly used?

☐Y ☐N Is there a method in the system for integrating clinical expertise from generalists and specialists?

☐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

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 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 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?

4. Delivery System Design

This applies to the delivery of care provided for diabetic patients:

Check one

☐Y ☐N Are there visits specifically designed for Diabetic patients at regular intervals? (As opposed to ALL acute care episodes?)

☐Y ☐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?

Describe the care team of the patient with diabetes:

_____

_____

How does the care team work together with the patient?

_____

_____

☐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?

☐Y ☐N Are there educational resources available to increase patient knowledge, confidence and skill in managing their illness? (Self-Management materials as well as traditional educational materials)

☐Y ☐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?

☐Y ☐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 Have you made contact with your local hospital to discuss the program and how it could be mutually beneficial?

☐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?

_____

_____