Organizational Capacity for Diabetes Self Management in Primary Care

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DIABETES SELF MANAGEMENT IN PRIMARY CARE SETTINGS

Because primary care systems were designed to respond well to acute medical conditions, treatment of chronic conditions presents challenges. Faced with a growing number of patients with chronic conditions such as diabetes, traditional primary care systems are exploring ways to improve their capacity to provide quality care for people with long-term health conditions.

Self management support is a key component of the Chronic Care Model and essential for quality chronic illness care. Six primary care self management demonstration projects were funded by the Advancing Diabetes Self Management (ADSM) Program of the Robert Wood Johnson Foundation Diabetes Initiative.

ADSM projects demonstrated that comprehensive approaches to diabetes self management can be delivered in "real world" primary care settings and can significantly improve patient outcomes. Using their projects as learning laboratories, ADSM grantees identified eight characteristics of organizational support that improve capacity for self management. These include:

1. CONTINUITY OF CARE

Continuity of care is supported by systems that ensure: assignment of patients to a provider; scheduling of planned visits; tracking and follow-up of patient visits and lab tests. Team members work together to meet patient care guidelines.

2. COORDINATION OF REFERRALS

Coordination of referrals is accomplished by having systems in place to track referrals and follow-up with patients and/or specialists as needed to complete referrals. The patient care team documents and monitors referrals and coordinates with specialists to adjust the patient's care plan as needed.

3. ONGOING QUALITY IMPROVEMENT

Ongoing quality improvement happens when a team uses data to identify trends and initiate actions to make improvements. Systems that support quality improvement generally have a registry or electronic medical record that can be used to routinely track key performance indicators. They also have structured and standardized processes for quality improvement, accountability for improvements, and management support.

The **Diabetes Initiative of the Robert Wood Johnson Foundation** includes 14 projects around the United States, all demonstrating that self management of diabetes is feasible and effective in diverse, real-world settings. Specific lessons learned from the Initiative include:

- The importance of Community Health Workers in diabetes self management
- Approaches to depression, negative emotions and healthy coping in diabetes self management
- Approaches to providing ongoing follow up and support for self management, since diabetes is "for the rest of your life"
- How to develop effective partnerships between clinical and community organizations
- System and organizational factors to support self management programs in primary care settings

For more information, protocols, publications, and other materials, visit: ***www.diabetesinitiative.org***

4. System for Documentation of Self Management Support Services

Documentation includes charting patient care plans and self management goals. This allows all team members and providers to access the information for care planning. In comprehensive diabetes care systems, self management goals are an integral part of the patient's medical record, where they are easily accessible to all team members and organized to show progression.

5. Patient Input

Patient input can be achieved in a variety of ways including focus groups, surveys, membership on advisory councils, etc. In patient-centered systems, patients are made aware of mechanisms for input and encouraged to participate in decisions regarding patient care practices and service delivery. Their input is considered essential to decision-making processes, and the information provided is used to improve care practices.

6. Integration of Self Management Support into Primary Care

Care for patients with chronic conditions will improve when self management support becomes part of usual care for all patients with chronic conditions. Evidence of integration includes: attention to self management in the practice strategic plan, routine monitoring for quality improvement, and leadership support.

7. Patient Care Team

The team at each site may vary according to available resources, and may include providers, clinical, and non-clinical support staff. Well functioning teams have cross-trained members whose roles and responsibilities are complementary, well defined, and clearly understood. In systems that value this approach to care, the team concept is part of the system culture and supported and rewarded by senior leadership.

8. Education and Training of the Care Team in Self Management

Self management support depends on a team who has been trained to use accepted and consistent approaches to patient self management. Commitment to excellence is evidenced by a system that supports continuing education, includes self management skills in job descriptions, and assesses and monitors performance.

Assessing and Evaluating the System of Care

The Diabetes Initiative developed an instrument to help primary healthcare settings assess their current levels of organizational and patient care supports for self management and identify areas for quality improvement. This tool, the Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS), is designed for use in a variety of primary care settings and across different chronic illnesses. It is available from the Diabetes Initiative Web site.