Title of Intervention: Improving Chronic Illness Care (ICIC) Model

Website: http://www.improvingchroniccare.org/

Intervention Strategies: Environments and Policies, Provider Education, Group Education

Purpose of the Intervention: To improve the quality of diabetes care

Population: Residents in family practice clinic and diabetic patients of the clinic

Setting: Family practice center; health care facility-based, worksite-based

Partners: University and family practice center, multidisciplinary diabetes disease management team

Intervention Description:

- Environments and Polices: A registry was developed so that important data could be collected and shared at the point of service for patients with diabetes. The ICIC model identified the essential elements of a health care system that encouraged high-quality chronic disease care. These elements were the community, the health system, self-management support, delivery system design, decision support and clinical information systems.
- Provider Education: The education intervention targeted certain skills of health care providers, including how to plan a group visit, self-management education, motivation and incorporating stress management into the process. Providers were also trained in the elements of the ICIC model.
- Group Education: Diabetes teaching clinics (nutrition, general management classes and one-on-one teaching) and group visit models were developed in the family practice center. Six to ten patients were gathered for each group visit conducted by a resident. During the session, the patients were prepared for a brief, approximately 10-minute, individual visit with the resident and faculty.

Theory: Not mentioned

Resources Required:

- Staff/Volunteers: Multidisciplinary team- physician faculty, behavioral science faculty, a certified diabetes educator, practice manager, clinic director, and computer programmer
- Training: ICIC and disease management curriculum
- Technology: Computer/database resources
- Space: Health clinic
- Budget: Not mentioned
- Intervention: Not mentioned
- Evaluation: Survey

Evaluation:

- Design: Pre- and post-test
- Methods and Measures: Surveys gathered descriptive assessments of the educational intervention.

Outcomes:

- Short Term Impact: Residents felt more successful in explaining diabetes care in a way that patients could understand and feel able to take care of their diabetes. Long Term Impact: Not measured

Maintenance: Community partnerships were created to develop resident education, delivery system design, decision support and clinical information systems. Partnerships were also created to provide self-management support.

Lessons Learned: Disease management teams have been reported to improve outcomes for conditions such as diabetes.

Citation(s):

Nuovo, J., T. Balsbaugh, et al. (2004). "Development of a diabetes care management curriculum in a family practice residency program." Dis Manag 7(4): 314-24.