Title of Intervention: Chronic care model for improvements in diabetes care and education

Intervention Strategies: Provider Education, Group Education, Supportive Relationships

Purpose of the Intervention: To improve providers' diabetes care practices and patient outcomes in a rural practice setting

Population: Health care providers, patients with Type 2 diabetes

Setting: A large family practice in a Pennsylvania county bordering Appalachia; worksite-based, health care facility-based

Partners: University medical center

Intervention Description:

- Provider Education: The basis of the education was the American Diabetes Association standards of care and guidelines. Health care providers completed several problem-based learning case studies to demonstrate the implementation of guidelines and the incorporation of diabetes self-management education into a plan of care.
- Group Education: The diabetes self-management program was presented to patients on "diabetes days." The program consisted of a series of five, 2-hour group sessions that included goal setting and behavioral change strategies.
- Supportive Relationships: Family members and other support people attended the group sessions. The diabetes educator made follow-up support calls following the intervention.

Theory: Not mentioned

Resources Required:

- Staff/Volunteers: Diabetes educator
- Training: Chronic care model guidelines and diabetes self-management education components
- Technology: Not mentioned
- Space: Meeting space for group sessions
- Budget: Not mentioned
- Intervention: Educational materials for both providers and patients
- Evaluation: Patient charts, questionnaires, materials to test blood glucose

Evaluation:

- Design: Cohort
- Methods and Measures:
    - Patient chart reviews were conducted to assess adherence to recommended guidelines.
    - Questionnaires assessed physicians' attitudes toward diabetes, barriers to care, patient empowerment and knowledge.
    - Blood glucose was monitored.

Outcomes:

- Short Term Impact: Providers significantly improved adherence to guidelines. Patient knowledge and empowerment scores also significantly improved after the intervention.
- Long Term Impact: Patients had significant improvements in blood glucose levels.

Maintenance: Strategies to create a sustainable, self-supporting model was integrated into the design. Currently, billing and reimbursement are being monitored so that continued salary support will be maintained. Marketing efforts are under way to communicate available services.

Lessons Learned: Not mentioned

Citation(s):

Siminerio, L. M., G. Piatt, et al. (2005). "Implementing the chronic care model for improvements in diabetes care and education in a rural primary care practice." Diabetes Educ 31(2): 225-34.