NDEP National Diabetes Education Program

NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations.

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Practice Transformation

- Engage Leadership & Assess Practice
- Evidence-Based Care
- Information Systems
- Improve Practice Quality
- Clinical Decision Support
- Team-Based Care
- Patient-Centered Interactions
- Patient Care Coordination

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The Health Improvement Institute recently named NDEP as the recipient of its 2013 Annual Aesculapius Award, recognizing Practice Transformation for Physicians and Health Care Teams website for excellence in the communication of reliable information about healthy lifestyles, disease prevention, and health care treatments. *Read more*.

Practice Transformation for Physicians and Health Care Teams

This Practice Transformation site, formerly called Better Diabetes Care, is designed to help physicians, health care professionals and health care administrators across the country who want to change the system of health care delivery around diabetes. NDEP believes that practice change is essential to provide the type of evidence-based care recommended by the Patient-Centered Medical Home (PCMH) model to effectively manage diabetes, prevent its serious complications, and delay or prevent type 2 diabetes. The PCMH incorporates dimensions of patient-centered care presented by the Institute of Medicine and the Chronic Care Model. This site is organized according to those dimensions.

Engage Leadership and Assess Your Practice

Provide Evidence-Based Care

Use Information Systems

Improve Practice Quality

Use Clinical Decision Support

Practice Team-Based Care

Enhance Patient-Centered Interactions

Improve Patient Care Coordination

Practice change is made up of a relatively small number of specific interventions that are interrelated. These changes are reflected by the principles of the PCMH that are becoming the centerpiece of efforts to reform U. S. health care and improve the value of primary care. Accountable Care Organizations (ACOs) are playing a large role in reforms and the PCMH principles are being incorporated into ACOs.

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Practice Transformation

- Engage Leadership & Assess Practice
  - Review Leadership Tasks
  - Identify Needs & Set Priorities
  - Align Payment Policies
- Evidence-Based Care
- Information Systems
- Improve Practice Quality
- Clinical Decision Support
- Team-Based Care
- Patient-Centered Interactions
- Patient Care Coordination

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Engage Leadership and Assess Your Practice

This section helps users to review the tasks that effective leaders can undertake to ensure the successful transformation of a practice into a patient-centered medical home (PCMH). The process of self-assessment to assess needs and develop priorities stimulates communication, helps to organize and monitor improvements, and identifies needed resources. Eight change concepts are presented that practices need to embrace to effectively transform into a PCMH. Access to resources and program assessment tools is provided. A table presents optimal patient clinical outcomes aligned to best practices by provider and appropriate reimbursement for care.

Practice Transformation

- Engage Leadership & Assess Practice
- Evidence-Based Care
  - Principles and Limitations of EBDM
  - Comparative Effectiveness
  - Numeric Results
  - Evidence Base in Practice
  - Resources
  - References
- Information Systems
- Improve Practice Quality
- Clinical Decision Support
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Provide Evidence-Based Care

Experienced clinicians use a wide range of judgments, decisions, actions, and recommendations in the practice of medicine that include knowledge, past experience, empathy, compassion, respect for the patient's wishes, an appreciation of common care practice patterns within the community, and an understanding of human biology.

The practice of evidence-based decision-making involves integrating these elements with the best available clinical evidence from a systematic review of research. However, a literature search only informs the clinician of the available evidence and says nothing about helping the clinician make the best decision in light of the patient's preferences and values.

This section provides an overview of ways an evidence base can guide clinical decision-making. It includes principles and limitations of evidence-based decision-making, differences in numeric presentation of results, ways to integrate an evidence base into daily practice. Resources include current diabetes-specific practice guidelines and recommendations.

Practice Transformation

- Engage Leadership & Assess Practice
- Evidence-Based Care
- Information Systems
  - Functions of an Information System
  - Population Health
  - Medicare Payment Programs
  - References
- Improve Practice Quality
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Use Information Systems

Information technology is one of the most rapidly changing areas of health care and is substantially altering the ability of health care providers to support the delivery of better diabetes care. Allowing enhanced capabilities for self-management, monitoring, improved access, and better communication between patients and providers, as well as improving access to educational opportunities, makes the introduction of new technology an important driving force behind improving health. This section focuses on fundamental technological advances with known effectiveness in clinical systems for improving the process of care delivery and providing better clinical outcomes.

Practice Transformation

- Engage Leadership & Assess Practice
- Evidence-Based Care
- Information Systems
- Improve Practice Quality
  - Transform Practices
  - Use Evaluation Strategies
  - Incorporate Diabetes Programs, Services, and Physician Accreditation
- Clinical Decision Support
- Team-Based Care
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Improve Practice Quality

This section addresses how to go about transforming a practice into a patient-centered medical home (PCMH). It provides practical information about the use in clinical settings of rapid cycle improvements that involve small-scale local tests of change in physician offices or health care organizations. This section also will help users identify evaluation needs related to improving the delivery of diabetes services and how to implement evaluation measurements. A number of resources address how a practice could incorporate diabetes recognition programs, other professional services, and physician accreditation.

- Transform Practices to Improve Care
  - Ensure Commitment
  - Establish an Improvement Team
  - Identify Gaps and Set Goals
  - Use the Plan-Do-Study-Act (PDSA) Cycle
  - Example of Successful Quality Improvement Implementation
  - Resources and References
- Use Evaluation Strategies
  - Principles for Using Data to Support Clinical Improvement
  - Differences Between Quality Improvement and Clinical Research
  - Resources and References
- Incorporate Diabetes Programs, Services, and Physician Accreditation
  - Diabetes Recognition Programs
  - Education and Nutrition Services
  - Diabetes Certification, Accreditation, Recertification, Competencies, and Continuing Education

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Practice Transformation

- Engage Leadership & Assess Practice
- Evidence-Based Care
- Information Systems
- Improve Practice Quality
- Clinical Decision Support
  - Diabetes Prevention
  - Cardiovascular Disease Risk Management
  - Diabetes Management
  - Review National Surveys and Major Clinical Research
  - References
- Team-Based Care
- Patient-Centered Interactions
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Use Clinical Decision Support

A review article suggests that clinical decision support systems provide clinicians with patient-specific assessments or recommendations to aid clinical decision making. [1] Examples include manual or computer based systems that attach care reminders to the charts of patients needing specific preventive care services and computerized physician order entry systems that provide patient-specific recommendations as part of the order entry process. Such systems have been shown to improve prescribing practices, reduce serious medication errors, enhance the delivery of preventive care services, and improve adherence to recommended care standards.

On a practical level, the findings imply that clinicians and other healthcare stakeholders should implement clinical decision support systems that (a) provide decision support automatically as part of clinician workflow, (b) deliver decision support at the time and location of decision making, (c) provide actionable recommendations, and (d) use a computer to generate the decision support. [1].

This section on Clinical Decision Support provides a wide selection of resources and tools that support diabetes prevention and management. Selected resources could be integrated into computer based systems. Resources and tools for each section are organized under key categories identified by the Chronic Care Model: Clinical Information Systems, Community Resources, Decision Support, Practice Redesign, and Self-management Support.

- Diabetes Prevention
  - Community Resources
  - Decision Support
  - Self-management Support
- Cardiovascular Disease Risk Management
  - Decision Support
- Diabetes Management
  - Clinical Information Systems
  - Community Resources
  - Decision Support
  - Patient Self-Management Support
  - Practice Redesign
- Review National Surveys and Major Clinical Research
  - National Surveys
  - Major Clinical Research
  - Studies in Progress
- References

Practice Team-Based Care

Patient-centered care is an approach to "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."[1] In this context, the management of diabetes and comorbidities can be pursued within a multifactor risk reduction framework and can incorporate optimal strategies for the best benefits and outcomes for each person with diabetes.

The patient-centered medical home model encourages a proactive approach to health promotion, disease prevention, and chronic disease management through the development of individualized care plans and effective healthcare team member communication and coordination of care. [2]

This section discusses the benefits of team care and useful resources for effective team building.

- Benefits of the Team in Patient-centered Care
- What Makes a Team?
- Team Development
- Examples of Key Elements of Team Building
- Resources
- References

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- Team-Based Care
- Patient-Centered Interactions
  - Dimensions of Patient-Centered Care
  - Patient-Centered Medical Home
  - Provide Patient Education and Support
  - Address Health Literacy & Numeracy
  - Cultural Competency
- Patient Care Coordination

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Enhance Patient-Centered Interactions

When informed patients take an active role in managing their diabetes, and care providers are prepared, proactive, and supported with time and resources, their interaction is likely to be productive. [1] This patient-centered interaction can lead to better diabetes care, more efficient and effective practices, healthier patients, and more satisfied patients, families, and providers. The goal is "to customize care to the specific needs and circumstances of each individual, that is, to modify the care to respond to the person, not the person to the care." [2] Because patients are highly variable in their preferences, they and their families need to be involved with the physician and the health care team in diabetes management decision-making. It is the patients who in reality make the important choices that affect their health and well being, and indeed it is the patients who are in control and experience the consequences of their choices. Providers can guide patients to make better choices.

This section presents seven dimensions of patient-centered care as they relate to people with diabetes, numerous resources to help transform a practice into a PCMH, effective ways to provide patient education and support, and suggestions to address health literacy and build cultural competency.

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- Patient-Centered Interactions
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  - Referrals & Transitions
  - Improve Communications
  - Community Partnerships

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Improve Patient Care Coordination

Care coordination involves patient referral for specialized services by a medical/surgical or specialist consultant or community agency or transition between providers or institutions such as hospital to primary care, or pediatric to adult care. Quality chronic care integrates clinic and community-based services in order to address the comprehensive medical and health needs of people who are served. "Such a system provides the comprehensive model on which the quality of both health promotion and chronic illness care depend." [1]

This section addresses ways to improve coordination of care and to enhance community partnerships. Numerous resources are included.

- Improve Referrals and Transitions
- Improve Communications
- Develop Community Partnerships
  - Nine Steps
  - Examples of Community Partnerships
  - Resources and References