Pittsburgh Regional Healthcare Initiative
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Naida Grunden, editor

Diabetes Chronic Care model

Improving Chronic Care from Three Directions

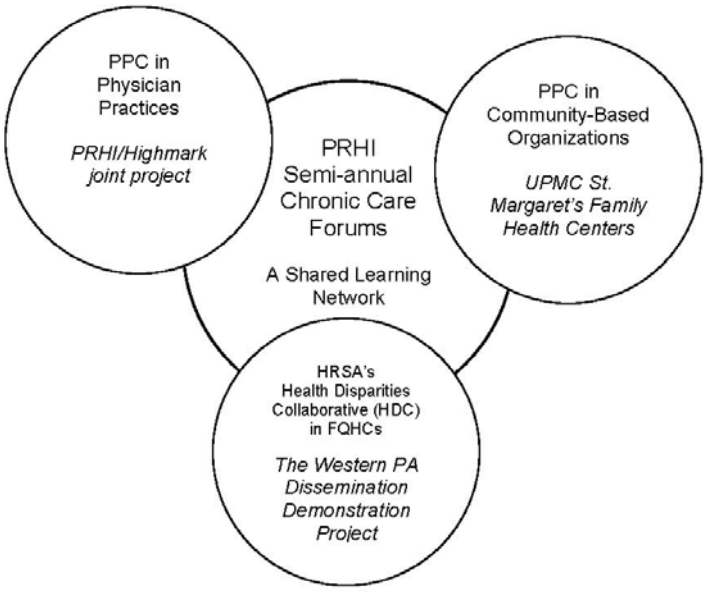
PRHI chronic care partners are engaged in three initiatives to improve the care of patients with chronic conditions in ambulatory settings. These three initiatives are based on the work of PRHI's Chronic Care Model Action Group (CCMAG), the Jewish Healthcare Foundation (JHF), and our region's Federally Qualified Health Centers (FQHCs).

1) PPC for Diabetic Patients in Office-based Care

Starting in summer 2005, in collaboration with Highmark, trained teams will apply PRHI's Perfecting Patient Care™ (PPC) principles to the delivery of evidence-based diabetic care in selected outpatient offices. Using PRHI's approach of patient need as the organizing principle for improvement, they will improve clinical outcomes by: a) learning how to spot problems in work processes; b) experimenting with small improvements; and c)sharing what they learn. Teams will include key personnel at each practice, a Highmark Medical Management Consultant, and a PPC-trained staffer from PRHI.

PPC principles offer a systematic way to use frontline observations of work and a system for identifying and solving problems all the way to their root cause in real time, rather than working around them. Using the principles can increase efficiency, safety and quality for patients and healthcare workers, and reduce cost by eliminating waste from the workplace. PPC relies on frontline personnel who actually do the work to propose and make improvements. It is not a temporary "project" but a fundamentally different way of working. To learn more about PPC and its successes in the Pittsburgh region, please visit http://www.prhi.org/ppc.cfm.

JHF/PRHI Chronic Care Initiatives in Outpatient Settings



2) PPC for Diabetic Patients in Community-Based Organizations

Since 2002, we have applied PPC principles to diabetic patient care at UPMC St. Margaret's Lawrenceville Family Health Center. Many components of the Wagner Chronic Care Model have been put in place:

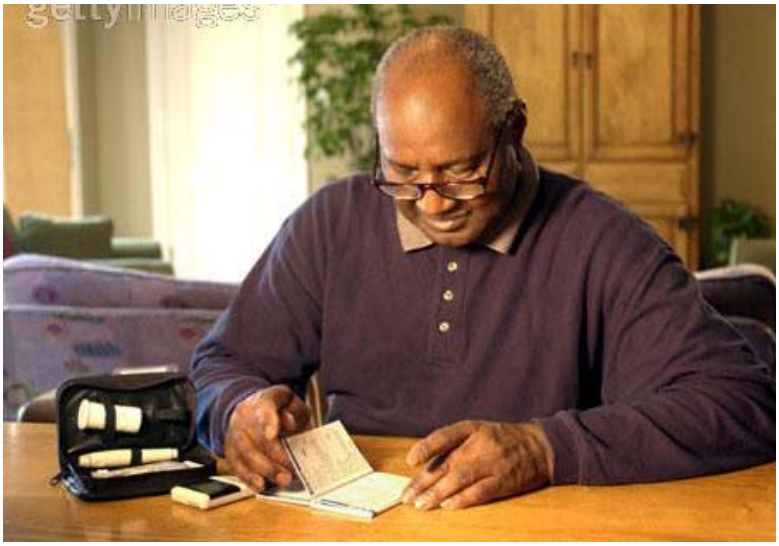
a diabetes registry; planned visits; interdisciplinary teams with a care manager and on-site education groups; indicator measurements; and an emphasis on patient education and self management. The work continues to demonstrate that small changes can transform into major improvements for patients and practitioners. In 2005 this work will spread to the two other family health centers operated by UPMC St. Margaret in Bloomfield/Garfield and New Kensington.

3) HRSA's Health Disparities Collaborative and Western PA's Federally Qualified Health Centers (FQHCs).

In early 2005, with the support of the JHF and the leadership of Will Payne, Executive Director of Primary Health Care Services, Inc., eight FQHCs totaling over 50 different sites in western Pennsylvania received joint approval by the federally mandated Health Disparities Collaborative (HDC) as a collective group. Until now, each FQHC site had applied individually to join one of five regional clusters around the country. This mini-cluster approach is unique and has been designated the Western Pennsylvania Dissemination Demonstration Project.

By working jointly as a region, the FQHCs can leverage training and support resources and create a tight regional learning network. In its first year, the demonstration project will focus on the HDC's diabetes module. The module is designed to help health centers move away from treating every disease as acute, toward a chronic care model.

PRHI is committed to supporting this effort and will work as a regional platform for publicizing and spreading the FQHCs learnings and successes in bringing the chronic care model to diabetic patient care.



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