

“...and your reward is no co-pay for three months!”

During the past year I have attended three learning sessions in the Breakthroughs in Chronic Care Program, The Diabetes and Cardiovascular Care Collaborative, sponsored by the California Cooperative Healthcare Reporting Initiative. These sessions have been 1 or 2 days intensely focused on improving measurable outcomes in the care of the diabetic patient. These collaborative meetings have been different in that the main dialogue has been not about the science of diabetes, which is already widely known, but about those factors that may confound our attempts in managing this disease.

Our office does not yet sport an Electronic Medical Record system, and a diabetic registry was not accessible until just a month ago. What we did have in place, however, was a habit of Planned Visits, 15 minute appointments devoted strictly to the management of the patient’s diabetes. We use a fairly comprehensive Diabetic flow sheet, which includes history items, exam, labs, meds, and treatment plans. The trick was to incorporate newly learned techniques into this existing structure and keep it easy. This initially took additional concentration, but rapidly became second nature.

I tried Action Planning first. This exchange was very useful, easily incorporated into the encounter, and also readily adapted to use with other chronic conditions. As this technique was presented in the BCCP meetings, the recommendation was made to make follow-up contact with the patient by phone or e-mail within one week. This proved impossible. Non-judgmentally allowing the patient to decline a change was an equally important aspect of this exchange. As it was so succinctly said, “You can’t care more than the patient does.”

A planned visit followed immediately by a session with a nurse educator was also very helpful. Diet seemed to be the topic of most interest, including how to shop for groceries. Foot care and stress management were also great subjects addressing problems identified during planned visits. My thanks to the IPA for supplying the nurse educator. The IPA also assisted with an education prescription for on-line information resources.

As I continued experimenting with new techniques, I became more frustrated with the difficulty in moving some patients forward toward LDL and HgbA1C goals, and I still hadn’t solved the problem of Action Plan follow-up. I began to target some patients for 1-month follow-up visits instead of the usual 3 months. I didn’t do the whole flow sheet at these short follow-ups, but concentrated on 1 or 2 specific areas, such as medication adherence and effect, or BP monitoring, and then included the action plan follow-up. Patients translate close follow-up as greater provider caring—as I was reminded in NP school, “Patients don’t care what you know until they know you care.” When my patients had closed in on targeted outcome measures, they then heard that their next appointment was in 3 months instead of 1, and knew their diabetes was now under control.

So to me this past year of learning and experimenting was about improving the provider-patient relationship in order to effect improved chronic care. This improvement was demonstrable with concrete measures such as BP reduction, HgbA1C and LDL to target levels, improved medication adherence, and most importantly for my patients, a feeling of better health and an improved quality of life. To my way of thinking, this approach is an ideal blend of medicine and nursing.