CHANGING PRIMARY CARE PRACTICES FOR BETTER HEALTH OUTCOMES

Relatively small amount of funding leverages big improvements in primary care

Public Health Problem

- Primary care in the U.S. does not effectively address chronic disease due to serious time limitations and the lack of a coordinated system.
- Disease management and systems-based approaches to clinical quality improvement such as the Chronic Care Model are effective but haven't been widely utilized in this country.
- The Chronic Care Model promotes improvements in the whole system of care, including organization, information systems, decision supports, delivery system design, self-management support, and community resources.

Program

- The North Carolina chronic disease section expanded on an existing pilot program to collaborate with important state partners, including North Carolina's Medicaid managed care program, North Carolina Area Health Education Centers, the University of North Carolina School of Medicine and the state's primary care specialty societies, in a national initiative created jointly by the American Board of Medical Specialties, American Board of Family Medicine, American Board of Pediatrics, and the American Academy of Family Physicians and designed to improve the quality performance of primary care practices.
- The initiative is based on the Chronic Care model and emphasizes methods such as the use of Quality Improvement Coordinators working with individual practices, an emphasis on data collection on common measures, collaborative learning, electronic registries, practice-wide care protocols, and strategies to support patient self-management efforts.
- The North Carolina Division of Public Health provided initial financial support and continues its support through contributions from the asthma, diabetes, kidney, comprehensive cancer, and heart disease and stroke prevention programs.

Impact

- Relatively small funding helped leverage very significant quality improvement for primary care patients.
- Patient health outcomes improved. The percent of patients meeting important goals for diabetes control increased by a third and those meeting goals for cholesterol control increased by over twenty-five percent.
- The number of participating practices increased from just sixteen in the first year to an expected 180 practices covering all regions of the state by 2009.
- This statewide initiative is also fostering linkages between state and local health departments and primary care practices to promote better care and to expand the evidenced-based Chronic Disease Self Management Program to patients in participating initiative practices.

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