Example of a Change Package

Change Concepts and Strategies	Evidence-Based Interventions and Testable Ideas — Table 1.2
1.1 Identify your diabetes patient population.	1. Identify your patients with diabetes by using an existing system that has "markers" to identify patients with diabetes (i.e., billing, pharmacy or lab systems). 2. Develop a card file/notebook/electronic file that can be used to build a tracking system for patients with diabetes. 3. Use patient stickers to identify charts of patients with diabetes. 4. Embed evidence-based guidelines into routine diabetes care management to assure preventive and maintenance care is routinely assessed. 5. Use patient tracking system to identify patients who need labs, eye or dental exams, and send letters to patients requesting they get the appropriate tests.
1.2 Use standardized procedures for routine referral and care.	1. Integrate standardized nursing procedures to provide uniform management of patients with diabetes and develop skill levels of nursing staff 2. Integrate evidence-based guidelines into daily practice.
1.3 Bring multidisciplinary services together to promote continuity of care through individual or group planned visits.	1. Assign roles, duties, and tasks for planned visits to a multi-disciplinary team. 2. Establish group visits in which patients see a pharmacist, nurse and doctor, and participate in group education and support all within a periodic visit to your office. 3. Identify patients' needs on flow sheet/visit note/encounter note to prepare for a positive interaction. 4. Develop a process to ensure communication occurs between care management team and community resources. 5. Establish a daily care team meeting to prepare for the day's planned visits. 6. Develop a process for patients to have lab draws completed in advance of appointments so that lab results and consultations are available at the time of the appointment.
1.4 Cross-train staff and expand capabilities to improve diabetes case management.	1. Train providers, nurses and medical assistants in patient assessment skills, self-management goal setting and follow-up, etc., and periodically check staff competencies with tasks. 2. Obtain senior leader support for training staff in new roles and tasks.
1.5 Incorporate case management, promotora, and other programs to help with managing patients and follow-up.	1. Create an effective process to prioritize patient needs and status of illness or wellness for multidisciplinary team management. 2. Designate staff to be responsible for case management follow-up.

Adapted from California Academy of Family Physicians Diabetes Initiative Care Model Change Package