The Use of Knowledge Management in the Health Care: The Implementation of Shared Care Plans in Electronic Medical Record Systems at One Primary Care Practice

A transformation in the way in which primary care is delivered is underway in the United States. Across the country primary care practices are grappling with how to change from the traditional physician-directed model to a more patient-centered collaborative style as part of the effort to curb the rise of chronic disease. To date, few tools or techniques exist to help the individual primary care provider make this difficult and complex transformation. One such tool that has arisen is the shared care plan (SCP). As defined in the TALK/DM study (a NIDDK funded pilot project to implement SCPs in primary care), the SCP of primary care becomes the product of collaboration between the practice and the patients. The SCP is created by combining knowledge management (KM) techniques and motivational interviewing (MI) health counseling methods to form a new knowledge object. This paper focuses on this aspect of the TALK/DM study and takes a case study approach to explore how one primary care practice is implementing the SCP as knowledge object (both a paper document and an electronic record in the EMR system) in its organization. This study adds nuance and insight into how knowledge objects such as the SCP can serve as a tool for collaboration in primary care.

1. Background

1.1. The Shared Care Plan - A New Knowledge Object for Primary Care

The idea of a care plan in healthcare is not new. Formal care plans developed by a treatment team are already common in acute medical care and mental health services, and less formal treatment plans are implicit in provider documentation in primary care. However, care plans that are the product of active collaboration between providers and patients are new. In our recent study, Taking Action for Learning and Knowledge Management to improve Diabetes Mellitus (TALK/DM) one of the primary goals was to study the use of such shared care plans (SCPs) as part of an intervention to improve diabetes care and patient outcomes in primary care practices. In the TALK/DM study, the primary care practice, using knowledge management techniques and behavioral health counseling methods, co-creates the shared care plan via social interaction and discussion with the patient. The shared care plan, in this project, embodies the important processes of collaborative care for chronic conditions (e.g., diabetes, hypertension, obesity). Collaborative care emphasizes and supports patient self-management by incorporating patients' own priorities, values and preferences in working toward treatment targets recommended by the medical providers. For diabetes, these targets include improving medication adherence, home testing of blood sugar, dietary changes and physical activity. This collaborative model contrasts with the traditional approach to care, which has tended to focus on professionals directing care and setting goals without much input from patients. Per Bodenheimer, Lorig, Holman and Grumbach (2002) it is patient input as well as a sense of shared responsibility between the provider and the patient that sets collaborative care apart from traditional care as Table 1 shows.