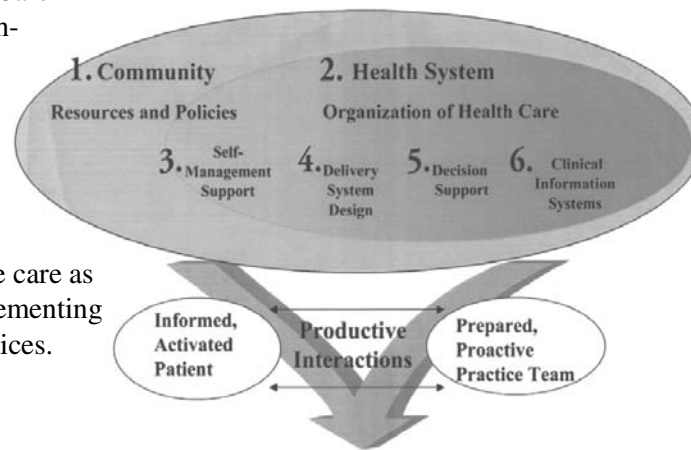




What is it? The Chronic Care Model is a blueprint for high-quality, patient-centered chronic disease care. Clinicians can use the Model to recognize essential elements of a health care system needed for excellent chronic disease care as well as a road map for implementing system change in their practices.

Overview of the Chronic Care Model*



How do I implement it? Access tools and resources to help you determine where to direct improvement efforts in your practice.

Functional and Clinical Outcomes

Why should I do this?

Treatment of chronic diseases is more effective and patient outcomes are better if the office practice has clearly defined strategies, goals and protocols for dealing with chronic disease.

1. Community Linkages Linkages between your practice and community resources play important roles in managing your patients' chronic illnesses.

- Seek community-wide coordination between your office and community agencies in caring for patients.
- Partner with community organizations to develop formal supportive programs and policies across the entire system.

2. Health Care Delivery System Delivering the highest quality of health care is dependent on redesigning care in a fundamental way throughout the entire organization.

- Support improvement from senior leadership down.
- Promote strategies aimed at comprehensive systems change.
- Encourage open, systematic handling of errors and quality problems.

3. Self-Management Support Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness. Patients and families become experts in the management of their chronic disease in partnership with their physician and care team. The patient-centered process can reduce complications and symptoms and improve patients' overall sense of health and well being.

- Emphasize patients' central role in managing their health care.
- Systematically assess patients' self-management needs and use peer support groups routinely.
- Train physicians and staff in behavior change techniques and encourage use of these skills as an integral part of routine care.

*Adapted with Permission from Wagner EH. *Chronic Disease Management: What Will it Take to Improve Care for Chronic Illness? Effective Clinical Practice*. 1998;vol. 1(1):2-4. Visit <http://www.improvingchroniccare.org/index.html> to read more about *Improving Chronic Illness Care (ICIC)* and the *Chronic Care Model*.





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Guide to Implementing the Chronic Care Model (cont'd)



4. Delivery System Design Effective chronic illness management usually requires a continuous healing relationship and changes in the way offices provide care for patients, i.e., changes in your office systems and your way of doing daily business. Teamwork and continuous access are two important elements of effective chronic disease management.

- Implement planned patient care with strategic visits and call reminders, online communication (E-visits), group visits, checking on patients between visits and identifying missed elements of care.
- Coordinate care of patients by oral and written communication between the patient and the office, subspecialists and other relevant providers, all sharing the same complete patient information.
- Install an electronic health record with clinical decision support and a patient portal for their personal health record and for communication with the care team.

5. Decision Support Effective chronic illness management programs assure that physicians have access to evidence-based information necessary to care for patients to assist them in decision making. This might include evidence-based practice guidelines or protocols and other information sources that are readily available at the point of care.

- Integrate evidence-based guidelines into care through reminders and other proven behavior change methods.
- Give patients guidelines with personalized targets for them to achieve and with recommendations about how to achieve the targets.

6. Clinical Information Systems Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.

- Tie patient registry and/or electronic health record information to guidelines and provide prompts and reminders about needed services (lab and other testing).
- Set up reminders for the care team about guideline adherence at the time of individual patient encounters.
- Give timely, specific performance feedback to each physician, by routinely reviewing reports. Correct any deficiencies as rapidly as possible.
- Establish specific treatment targets and goals collaboratively. Include self-management as well as clinical goals. Adjust individual treatment goals and targets frequently with input from patients.

RESOURCES

Web Resources:

- AAFP's Quality Web site – <http://www.aafp.org/quality>
- AAFP's METRIC program – <http://www.aafp.org/metric> - Measuring, Evaluating and Translating Research into Care
- AAFP's Performance Enhancement Forum (PEF) – <http://www.aafp.org/pef>
- Future of Family Medicine Project – <http://www.futurefamilymed.org>
- TransforMED – <http://www.transformed.com>
- Center for Health Information Technology – <http://www.centerforhit.org>
- Disease Management Position Paper – <http://www.aafp.org/online/en/home/policy/policies/d/diseasestatemgt.html>
- Patient Ed – Self-management: Taking Charge of Your Health – <http://familydoctor.org/785.xml>
- Conference on Practice Improvement: Health Information and Patient Education – <http://www.aafp.org/pec>
- ACF 2007 Management of Chronic Illness – <http://www.aafp.org/acfchronicillness>

Live Event: National Course – Chronic Illness: A Case-based Approach to Practical Management – <http://www.aafp.org/chronicdiseasecourse> .