



Guide to Implementing the Chronic Care Model

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.

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



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 with chronic illness.

- 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. Healthcare Delivery System: Delivering the highest quality of health care is dependent on redesigning care in a fundamental way throughout the entire organization.

- Manage quality issues openly and systematically.
- Make appropriate changes to systems.
- Assess your practice.

3. Self-management Support: Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness. It can reduce complications and symptoms, and improve patient's overall sense of health and well-being.

- Self-management support is provided by trained personnel who are trained in patient self-management skills.
- Systematically assess patients self management needs and use peer support groups routinely.
- Physicians and staff are trained in behavior change techniques and use these skills as an integral part of routine care.

4. Delivery System Design: Effective chronic illness management usually requires changes in the way offices provide care for patients, (i.e., changes in your office systems, your way of doing daily business). Team work and follow-up are two important elements of effective chronic disease management.

- Planned patient visits with call reminders, checking on patients between visits, identifying missed elements of planned care
- Coordinate care of patients with subspecialists by oral and written communication between office, subspecialists and other relevant providers

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.

- Evidence-based guidelines are integrated into care through reminders and other proven behavior change methods.
- Give patients guidelines with personalized targets for them to achieve 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.

- Patient registry is tied to guidelines and provides prompts and reminders about needed services (lab and other testing) and/or is an integral function of electronic medical record.
- Care team reminders about guideline adherence are given at the time of individual patient encounters.
- Performance feedback is timely and specific to each physician, by a routine review of reports and efforts to remedy any deficiencies as rapidly as possible.
- Specific treatment targets and goals are established collaboratively and include self-management as well as clinical goals. Individual treatment goals and targets are discussed and adjusted frequently with input from patients.