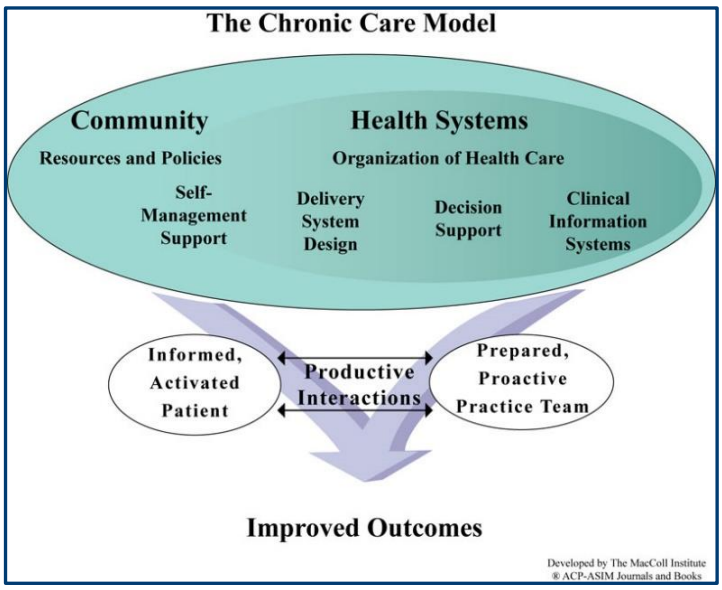
The Chronic Care Model

The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.



The Chronic Care Model can be applied to a variety of chronic illnesses, health care settings, and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

For **citations** concerning the evolution of the Chronic Care Model, please reference this journal article: Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? Eff Clin Pract. 1998;1:2-4. (The Chronic Care Model image first appeared in its current format in this article.)

ACT CENTER
Accelerating Care Transformation

Chronic Care Model: Change Concepts

The Chronic Care Model identifies essential elements of a health care system that encourage high-quality chronic disease care: the community; the health system; self-management support; delivery system design; decision support, and clinical information systems. Within each of these elements, there are specific concepts (Change Concepts) that teams use to direct their improvement efforts. Change concepts are the principles by which care redesign processes are guided.

Health System: create an organization that provides safe, high quality care

A health system's business plan reflects its commitment to apply the CCM across the organization. Clinician leaders are visible, dedicated members of the team.

- Visibly support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

The Community: mobilize community resources to meet needs of patients

Community resources, from school to government, non-profits and faith-based organization, bolster health systems efforts to keep chronically ill patients supported, involved and active.

- Encourage patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies that improve patient care

Self-Management Support: Empower and prepare patients to manage their health care

Patients are encouraged to set goals, identify barriers and challenges, and monitor their own conditions. A variety of tools and resources provide patients with visual reminders to manage their health.

- Emphasize the patient's central role in managing his or her health
- Use effective self-management support strategies that include assessment (physician or self?), goal setting, action planning, problem-solving and follow-up

- Organize internal and community resources to provide ongoing self-management support to patients

Delivery System Design: Assure effective, efficient care and self-management support

Regular, proactive planned visits which incorporate patient goals help individuals maintain optimal health and allow health systems to better manage their resources. Visits often employ the skills of several team members.

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that agrees with their cultural background

Decision Support: Promote care consistent with scientific data and patient preferences

Clinicians have convenient access to the latest evidence-based guidelines for care for each chronic condition. Continual educational outreach to clinicians reinforces utilization of these standards.

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

Clinical Information Systems: Organize data to facilitate efficient and effective care

Health systems harness technology to provide clinicians with an inclusive list (registry) of patients with a given chronic disease. A registry provides the information necessary to monitor patient health status and reduce complications.

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

So What Does All This Mean?

Successful system change means you will redesign care within each of the six components of the CCM; it does not mean tweaking around the edges of an acute care system not capable of handling the needs of the chronically ill. You will be building a new system that works in concert with your acute care processes. You will

accomplish this by testing the above change concepts and adapting them to your local environment. The remaining steps in this manual help focus where you can start making these changes.

Tools That Can Help

After learning more about the chronic care model, there are two things that may assist you in understanding how it directs system change:

- The Assessment of Chronic Illness Care (ACIC) is a diagnostic survey that you and your team can complete together. The ACIC helps you identify that current state of your chronic care; what's working and what is needed to achieve redesign in all components of the CCM.
- The Patient Assessment of Care for Chronic Conditions (PACIC) measures specific actions or qualities of care, congruent with the Chronic Care Model, that patients report they have experienced in the health care delivery system.
- Curing the System: Stories of Change in Chronic Illness Care is a report that provides concrete examples of teams that have redesigned their care based on the CCM. Some of the stories and the practices they represent may resonate with you and your team.