

AHRQ's Primary Care Practice Facilitation Forum

This electronic newsletter continues our efforts toward building a learning network for individuals with an interest in practice facilitation. We will use this listserv to share questions and answers submitted by learning forum members, as well as resources, research articles, and events of interest to the community.

December 12, 2013

Key Concepts in Practice Facilitation: The Care Model

Health care in the United States has traditionally focused on delivering short-term medical treatment for acute health conditions. It has become very clear that health care needs to increase its focus on maintaining health and managing chronic diseases. Therefore, it comes as no surprise that practice facilitators are now commonly being asked to help primary care practices increase their ability to promote patient well-being and management of chronic health conditions. The Care Model (also known as the Chronic Care Model) was developed to serve as an alternative to a health care delivery system focused solely on acute disease care.

As described in Module 16 of the Agency for Healthcare Research and Quality's (AHRQ) [*Practice Facilitation Handbook*](#), "the Care Model depicts three overlapping spheres in which chronic care takes place: community, health systems, and provider organization. The Care Model consists of five core elements: health systems, delivery system design, decision support, clinical information systems, and self-management support. These in turn produce productive interactions between informed, activated patients and prepared, proactive practice teams." The Care Model aligns well with the key tenets of the patient-centered medical home (PCMH), which has become a popular framework for transforming primary care. Accordingly, AHRQ's work is guided by the Expanded Care Model, a model of health care delivery that explicitly connects the Care Model with the central elements of the PCMH. Graphics that depict the original Chronic Care Model, the Expanded Care Model, and other Care Model adaptations can be found at: http://www.improvingchroniccare.org/index.php?p=CCM_Gallery&s=149

Both the Care Model and Expanded Care Model seek to improve patient health by using an organized approach that focuses on particular patient populations, thus ensuring that all patients in those populations receive the best care. These models also promote a team-based model of care rather than care delivered solely by the physician. Evidence indicates that redesigning care using the Care Model improves both patient care and health outcomes¹.

For more information on how the Care Model can improve the delivery of care in primary care settings, see [Module 16](#) of [*The Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers*](#). You can download a [PDF copy of the entire handbook](#) free of

¹ Coleman K, Austin B, Brach C, et al. Evidence on the Chronic Care Model in the new millennium. Health Aff (Millwood) 2009;28(1):75-85. Available at: <http://content.healthaffairs.org/content/28/1/75.full>

charge at the PCPF Resources page of AHRQ's PCMH Resource Center (www.pcmh.ahrq.gov).

Relevant Resource: AHRQ Care Model Toolkit

The Agency for Healthcare Research and Quality (AHRQ) has partnered with other organizations to develop [Integrating Chronic Care and Business Strategies in the Safety Net](#), a toolkit that practices can use to facilitate their implementation of the Care Model. This Care Model toolkit can be used as a resource by both practice facilitators and the practices they work with. The toolkit includes a recommended process for utilizing the Care Model and also contains recommendations for strengthening the financial status of practices while implementing the model.

[Integrating Chronic Care and Business Strategies in the Safety Net](#) lays out four phases of Care Model implementation that contain a total of 12 key changes that practices could pursue. Each key change includes a table with specific action steps and associated tools. Practice facilitators can use the Care Model toolkit to learn about what is needed to help practices adopt the Care Model. The toolkit can also serve as a training curriculum for practices or be used as a reference book in conjunction with facilitation.

You can read more about the Practice Facilitation Handbook, the Care Model toolkit, and other resources to support quality improvement in primary care on [AHRQ's website](#) or [click here](#) to download a PDF version of the Care Model toolkit (all resources are free of charge).

What do you think?

How do you help practices improve their ability to do chronic care management?

Send us your thoughts at PracticeFacilitation@mathematica-mpr.com and we'll feature them in a future newsletter.

Publication of Interest

Michael Stollefson, Krishna Dipnarine, and Christine Stopka. **The Chronic Care Model and Diabetes Management in US Primary Care Settings: A Systematic Review.** *Preventing Chronic Disease* 2013, 10: 120180.

Published Abstract:

Introduction: The Chronic Care Model (CCM) uses a systematic approach to restructuring medical care to create partnerships between health systems and communities. The objective of this study was to describe how researchers have applied CCM in US primary care settings to provide care for people who have diabetes and to describe outcomes of CCM implementation.

Methods: We conducted a literature review by using the Cochrane database of systematic reviews, CINAHL, and Health Source:Nursing/Academic Edition and the following search terms: “chronic care model” (and) “diabet*.” We included articles published between January 1999 and October 2011. We summarized details on CCM application and health outcomes for 16 studies.

Results: The 16 studies included various study designs, including 9 randomized controlled trials, and settings, including academic-affiliated primary care practices and private practices. We found evidence that CCM approaches have been effective in managing diabetes in US primary care settings. Organizational leaders in health care systems initiated system-level reorganizations that improved the coordination of diabetes care. Disease registries and electronic medical records were used to establish patient-centered goals, monitor patient progress, and identify lapses in care. Primary care physicians (PCPs) were trained to deliver evidence-based care, and PCP office-based diabetes self-management education improved patient outcomes. Only 7 studies described strategies for addressing community resources and policies.

Conclusion: CCM is being used for diabetes care in US primary care settings, and positive outcomes have been reported. Future research on integration of CCM into primary care settings for diabetes management should measure diabetes process indicators, such as self-efficacy for disease management and clinical decision making.

Access the full text at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3604796/>

Managing Your Account

If this information was forwarded to you and you would like to subscribe, please email PracticeFacilitation@mathematica-mpr.com and include “subscribe” in the subject heading.