The Care Model © Electronic Tool Kit
Prepared by the Association of Clinicians for the Underserved (ACU) for North American Management
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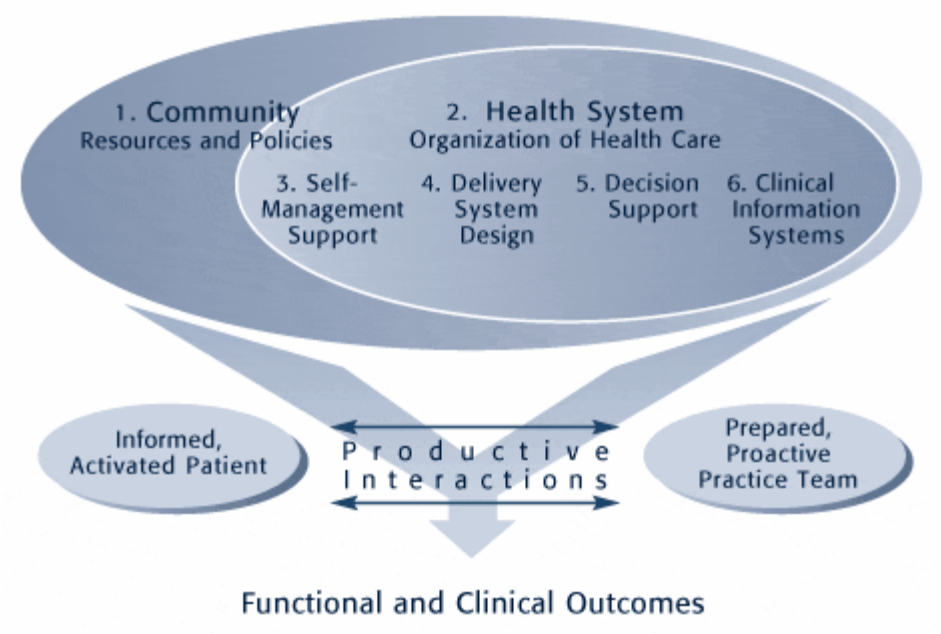
INTRODUCTION

The Care Model ©has been utilized by community health clinics for several years as an effective method of providing comprehensive, efficient, team based health care. This tool kit was designed to provide easily accessible, user friendly resources to assist you in implementing the Care Model into practice. The resources listed are not an exhaustive list, but rather a sampling of forms, tools, power point presentations, articles and training courses, all available on-line, to help implement the Care Model. These tools can be used for orientation and training of staff and be implemented into practice policy and program development. There are many available examples of best practices and programs developed using the Care Model framework.

For starters, to understand the components of the Care Model © and find out how to starting group visits, utilize self-management guidelines and more, see **http://www.improvingchroniccare.org/**

For the rest of this electronic tool kit, the Care Model © will be referred to as the CM.

The CM involves components that promote high-quality health care for people living with chronic illnesses. The CM moves away from reacting to acute-illness to prevention of chronic disease through an organized system approach with involves patients and health care teams.



Source: Adapted from Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effect Clin Pract.*1998;1:2-4. Available at: www.improvingchroniccare.org/change/ model/components.html

Each element of the Care Model is described below. After each description, you can access the documents to help your clinic adapt the CM to practice. *These documents are in the public domain and the authors are listed on the summary page for each section.* You may use these documents for staff training, clinical care or background information. You adapt them to meet the needs of your sites.

Each section has a document that summarizes all the documents in the section

1. Community—resources and policies refers to the utilization of existing community resources for patients and the need health care organizations to form partnerships with these community-based organizations, as well advocate for improvements in services and policies for patients.

1. *Summary of Community Resource Documents*

    1.2 Building Community Connections

    1.3 Health Care Screening Summary

1.4 Planning a Community Based Screening

1.5 How Healthy is our Neighborhood?

1.6 As Asset-Based Approach to Asthma Education

2. *Health system—organization of health care* focuses on systems that promote safe, high-quality care. Providers should work toward comprehensive system change, provide incentives to improve quality of care, and develop systems for coordinating care across organizations. Support from all organizational levels is required.

2. Summary of Health Systems Documents

2.2 Assessing Readiness

2.3 Catalog of PDSA Examples

2.4 Disparities Report

2.5 Organizational Communications Plan

2.6 Orientation for New Team Members

2.7 Project Planning Form

2.8 Sample Meeting Agenda and documentation

3. *Self-management support* promotes activities to empower and prepare patients to manage their health care. This component reflects the patient's central role in care and treatment and stresses use of self-management support strategies, including assessment, goal setting, action planning, problem solving, and follow-up.

3. Summary of Self-Management Support Documents

3.2 Self-Management Goal Setting Orientation for Staff

3.3 Self-Management support: Shared Decision Making

3.4 Supporting Self-Management with the 5 As

3.5 Diabetes Self-Management Curriculum in Spanish

3.6 Asthma Action Plan for Patients

3.7. Diabetes and the Family-A Health Promotora Manual

4. *Delivery system design* ensures delivery of effective and efficient clinical care and self-management support. The system should promote definition of roles among the clinical care team, a structure for communication and service delivery between the team members and clients, and regular follow-up.

4. Summary of Delivery System Design

4.2. Diabetic Foot Exam

4.3. Backlog Reductions Basics

4.4. Backlog Calculation/Reduction Worksheet

4.5. Case Management Check-in

4.6. Clinical Standing Orders

4.7. Planned Care and Group Visits

4.8. Group Visit SOAP Notes

4.9. Efficiency in Office Practice

4.10. Medical Group Visit Starter Kit

5. *Decision support* promotes care that is consistent with scientific evidence and patient preferences. Clinical practice should reflect treatment guidelines. Decision support should use proven methods of provider education and integrate specialist expertise and primary care.

5. Summary of Decision Support

5.2. Asthma Assessment Changes in the 2007 Guidelines

5.3. Diabetes Prevention Program

5.4. Diabetic Retinopathy

5.5. Evidenced-Based Practice

5.6. Medical Assistant Education and Training

5.7. Assessment and Management of Depression in Primary Care Practice

6. *Clinical information systems* should use data to facilitate effective care. Data systems monitor the performance of the care system and provide reminders for both providers and patients.

6. Summary of Clinical Information Systems

6.2. Custom PECS Encounter Form

6.3. Clinical Information Systems

6.4. Data Entry and Maintenance

6.5 Using PECS Report for Mail Merge

6.6 PECS Reporting 101

The information and graphic above are from http://cccm.thinkculturalhealth.org/.

The Texas Association of Community Health Centers (TACHC), the state's primary care association, has a section of its web site dedicated the an overview of the CM. See http://www.tachc.org/HDC/Overview/CareModel.asp

The Health Disparities Collaborative uses the methodology of the Care Model This site provides the centralized portal for communication as well as a forum for sharing the challenges, successes, tools of the trade and lessons learned.
http://www.healthdisparities.net/hdc/html/home.aspx

Links to CME programs:

The American Academy of Family Practice's *Practice Enhancement Forum (PEF)* is a CME activity and quality improvement initiative that provides family physicians and their office staffs with practical tools, skills, and knowledge to implement the chronic care model in everyday practice. www.aafp.org/pef

More information about AAFP's METRIC program is available at www.aafp.org/online/en/home/cme/selfstudy/metric.html.

Health Literacy is important for providers to understand in the context of building patient-provider relationships. **Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency** is a free on-line training to help providers improve patient communication skills, increase awareness and knowledge of issues of health literacy, cultural competency and limited English proficiency. The course may be taken for credit (CEU/CE, CHES, CME, and CNE) or not for credit. It has five modules and takes about 5 hours to complete. You may complete the course at your own pace. See **http://www.hrsa.gov/healthliteracy/training.htm**

The National Center for Cultural Competence has a CME program to learn about incorporating cultural and linguistic competence into the diagnosis and treatment of depression. See http://www11.georgetown.edu/research/gucchd/nccc/projects/cme.html

Studies Utilizing the Care Model:

Challenging the Status Quo in Chronic Disease Care: Seven Case Studies, a report from the California HealthCare Foundation, looks at provider-based strategies outside typical disease management and the clinic-based chronic care model. It examines benefits, limitations, and policy implications of alternative approaches www.chcf.org/topics/chronicdisease/index.cfm?itemID=125226

The Primary Care Development Corporation (PCDC) has identified a set of principles to facilitate learning collaboratives that deploy teams to make changes and test these changes through the Plan-Do-Study-Act process. They focus on ways to create a culture of improvements for better operational or clinical outcomes. Information about this study, funded by the Commonwealth Fund, is at
http://www.pcdcny.org/resources/cmfstudy.html
The entire study is at
http://www.pcdcny.org/resources/documents/CWFsustainabilityandspreadwebsitearticle-FINAL.pdf

The University of Pittsburgh Medical Center (UPMC) has taken steps to implement the CM into its network to **improve diabetes** care processes and outcomes in its practice settings. See http://clinical.diabetesjournals.org/cgi/content/full/22/2/54#BIBL

The CM in Practice

Obesity Prevention:
Media-Smart Youth: Eat, Think, and Be Active! is an interactive after-school education program for young people ages 11 to 13. It is designed to teach about the complex media world, and how it can affect health--especially in the areas of nutrition and physical activity.
http://www.nichd.nih.gov/msy/

CLOCC is a nationally recognized consortium focuses on childhood obesity in Chicago. CLOCC fosters and facilitates connections between researchers; public health advocates and practitioners; corporations; policymakers; and children, families, and communities.**http://www.clocc.net/coo/links.html#med**

Pregnancy/Prenatal Care:
The CenteringPregnancy® Program alters routine prenatal care by bringing women out of exam rooms and into groups for their care. Women have their initial intake into their obstetric care in the usual manner with history and physical examination occurring within the office/clinic space. Then they are invited to join with 8-12 other women/couples/teens with similar due dates in meeting together regularly during their pregnancy. The groups form between 12 and 16 weeks of pregnancy and continue through the early postpartum period meeting every month for the first four months and then bi-weekly.
http://www.centeringpregnancy.com/

The ***Beginnings Guides*** are designed to guide and complement counseling during office and home visits for prenatal care, parent education and family support. Numerous resources are available on this web site in English and Spanish for providers, peer educators and home visitors. The important educational aspects of prenatal education and early childhood development are addressed within the context of health literacy. See http://www.beginningsguides.net/content/

Diabetes:
The National Diabetes Education Program describes in detail how the CM can be utilized for improved diabetes care and outcomes
http://www.betterdiabetescare.nih.gov/HOWchroniccare.htm

HIV/AIDS:
This publication from HRSA focuses on the self-management for patients with HIV/AIDS. **http://hab.hrsa.gov/publications/march2006/**

Quality Improvement:

This is a comprehensive resource offering strategies to promote quality improvement in nurse managed health centers, but can be used in any health care center. It includes information on measuring outcomes and indicators, barriers and QI. Manual written by Kate Fiant, APRN, DNS, FAANP. **To order your copy, click here.** For more information: **http://nursingcenters.org/**

The California Academy of Family Physicians has tools on quality improvement, self-management and more at http://www.familydocs.org/main-categories/quality-improvement

Group Visits:

The American Academy of Family Practice has an article which describes the steps of how to initiate group visits for chronic illness care. Group visits have been utilized in the areas of prenatal care, oral health, diabetes and more. With proper planning, group visits can expand options and increase self-management support.
http://www.aafp.org/fpm/20060100/37grou.html