

Course: The Planned Care Model Reference List

Recommended Preparation Prior to Attendance

It will be helpful for you to take the time to prepare for participation in the Planned Care Model Course at the Institute 2010. There are two topics that are important for you to review prior to arrival: The Chronic Care Model and the Model for Improvement. References are listed below for both of those topics. You can select to read information on line, view a video about the topic, or purchase a book if you desire. You will find that having some fundamental knowledge about the topic before we speak about it will be helpful for you and will provide us with more interesting and challenging dialogue as a group.

The Chronic Care Model

Read on line:

The History of the CCM and 2003 Refinements to the Chronic Care Model ([Link to the Model Content](#))

The content is located at a website that you will find to be very informative in relation to the Model (www.improvingchroniccare.org). You will need to read the content about the history of the development of the Model and the subsequent refinements that were made in 2003. There are specific Model element pages that you will need to go to that will describe the overall strategy for each element and the health system change concepts necessary to achieve improvement in that component.

Watch a Video

The Model Talk ([Link to the Video](#))

Ed Wagner, M.D., M.P.H., director of Improving Chronic Illness Care, delivered the following Chronic Care Model presentation at the 2004 Epidemiology, Biostatistics and Clinical Research Methods Summer Session, co-sponsored by the Seattle VA Epidemiologic Research and Information Center (ERIC) and the University of Washington. The video is 43 minutes long and is free.

The Model for Improvement

Read on line

How to Improve ([Link to the Model for Improvement](#))

This content is found on the Institute for Healthcare Improvement website under "Improvement Methods". You will need to drill down into each of the elements, which will hyperlink you to additional pages for further discussion and understanding. The Model for Improvement, developed by Associates in Process Improvement, is a simple yet powerful tool for accelerating improvement.

Watch a Video

On Demand: An Introduction to the Model for Improvement ([Link to Video](#))

On the IHI website, you will find An Introduction to the Model for Improvement, an On Demand presentation featuring IHI's Executive Director of Performance Improvement, Robert Lloyd, PhD. The video program is 63 minutes and is free.

Read a Book

The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition) ([Link to Book](#)) Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP San Francisco, California, USA: Jossey-Bass Publishers; 2009.

The Model for Improvement, an integrated approach to process improvement that delivers quick and substantial results in quality and productivity in diverse settings, is explored. This updated edition includes new information on accelerating improvement by spreading changes across multiple sites. A practical tool kit of ideas and examples from diverse industries, including health care, and international improvement efforts are shared.

Helpful Articles and Tools That Will Be Referenced in the Course

Day 1

Martin M, Larsen BA, Shea L, Hutchins D, Alfaro-Correa A. **State diabetes prevention and control program participation in the Health Disparities Collaborative: evaluating the first 5 years.** Prev Chronic Dis [serial online] 2007 Jan [date cited]. Available from:

<http://www.cdc.gov/pcd/issues/2007/>

Beginning in 1999, many of the Centers for Disease Control and Prevention's Division of Diabetes Translation State Diabetes Prevention and Control Programs (DPCPs) joined HRSA's Health Disparities Collaborative (HDC) to leverage resources and services. This article speaks to the impact that DPCP involvement with the Collaborative had on aspects of diabetes care at Federally Qualified Health Centers (FQHCs). Results were obtained via an electronic survey that was administered to DPCP coordinators. They were asked about 1) their roles and experience as participants in the Collaborative; 2) the skills and expertise most useful in developing and maintaining an effective collaboration for improved health care for diabetes; 3) which DPCP contributions were viewed as being routine and which were perceived to be essential; 4) the effects of DPCP contributions on the use of the chronic care model under which FQHCs operate; and 5) which health systems improvements played the greatest role in enhancing components of the chronic care model.

Healthcare Quarterly, 7(1) : 73-82 . **The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model ([Link to Article](#))**

Victoria J. Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts, Darlene Ravensdale and Sandy Salivaras.

Given the increasing incidence of chronic diseases across the world, the search for more effective strategies to prevent and manage them is essential. The use of the Chronic Care Model (CCM) has assisted healthcare teams to demonstrate effective, relevant solutions to this growing challenge. However, the current CCM is geared to clinically oriented systems, and is difficult to use for prevention and health promotion practitioners. To better integrate aspects of prevention and health promotion into the CCM, an enhanced version called the Expanded Chronic Care Model is introduced. This new model includes elements of the population health promotion field so that broadly based prevention efforts, recognition of the social determinants of health, and enhanced community participation can also be part of the work of health system teams as they work with chronic disease issues.

Ann Fam Med. 2007 Jan-Feb;5(1):14-20. **Use of Chronic Care Model Elements Is Associated With Higher-Quality Care for Diabetes ([Link to Article](#))**

Nutting PA, Dickinson WP, Dickinson LM, Nelson CC, King DK, Crabtree BE, Glasgow RE

This report explores whether there is a relationship between certain elements of the Chronic Care Model and the care of diabetes patients. The study included 90 clinicians (doctors, nurse-practitioners, and physician's assistants) and 886 patients. The Study found that clinicians' use of certain elements of the chronic care model, such as systems of tracking and following up with diabetes patients, was related to lower hemoglobin A1c (a measure of overall diabetes control) and lower cholesterol levels in diabetes patients, two indicators of good diabetes management.

Innovative Care for Chronic Conditions Framework ([Link to Framework](#))

The Innovative Care for Chronic Conditions (ICCC) Framework is described fully in *Innovative Care for Chronic Conditions: Building Blocks for Action*, © World Health Organization, 2002, ISBN: 9241590173 Produced by WHO's Health Care for Chronic Conditions team (CCH)

Available at: <http://www.who.int/diabetesactiononline/about/iccreport/en/index.html>

The ICCC Framework is an expansion of the Chronic Care Model (CCM), which was developed by researchers from the MacColl Institute for Healthcare Innovation in Seattle, USA. Both models present a "road map" for organizing health care for chronic conditions. To better suit the context of international health care, the ICCC Framework is expanded from the CCM and places emphasis on policy and community level components of good care for chronic conditions.

Improving Care for People with Long-Term Conditions: A Review of UK and International Frameworks ([Link to Review](#)) NHS Institute for Innovation and Improvement

This evidence review was commissioned as an early part of the NHS Institute's workplan to help them gain a greater understanding of current international, national, and local thinking about the different approaches in use. The review suggests that there is a great need to test different approaches, understand which factors make the biggest difference, and spread the knowledge widely. Of use is the description of various models relating to chronic conditions.

The ACT Report ([Link to Report](#))

Accelerating Change Today, or ACT, is a collaborative initiative of the National Coalition on Health Care and the Institute for Healthcare Improvement. It aims to improve the quality of health care in the United States through the identification of "best practices" and administrative and clinical innovations that are: (1) yielding better patient outcomes; (2) making the delivery of care more efficient; (3) increasing access to timely medical care; (4) making the health system easier to use; (5) lowering costs, and (6) reducing medical errors and inappropriate care. The initiative seeks to accelerate the spread of best practices and innovations throughout the health system by publishing them and through presentations at medical meetings and health care and business symposia. The report, third in a series of reports on compelling changes in our health care system, profiles innovative approaches to managing chronic care based on the Chronic Care Model. A variety of communities and diverse health settings from around the country are highlighted - from community health systems to multi-specialty clinics, solo practitioners, health plans, integrated health systems, community based organizations and academic health centers.

Day 2

Steps for Improvement ([Link to Resource](#))

This information represents ICIC's first attempt, in 2004, to assist individual practice teams in improving care for the chronically ill patients they serve. The Steps for Improvement were designed not only to impart information about how to improve, but also to help you to take action on the information you read. The materials are laid out in a step-by-step fashion with "To Do" lists at the end of each section. This link provides a summary of the recommendations, then you must dive deeper into each of the steps.

Integrating Chronic Care and Business Strategies in the Safety Net. ([Link to Toolkit](#)) (Prepared by Group Health's MacColl Institute for Healthcare Innovation, in partnership with RAND and the California Health Care Safety Net Institute, under Contract No./Assignment No: HHS2902006000171). AHRQ Publication No. 08-0104-EF. Rockville, MD: Agency for Healthcare Research and Quality. September 2008.

This toolkit is intended to provide the resources and structure for coaches to use in helping teams in a wide variety of settings improve clinical quality. It provides a step by step approach to change and links the reader with many useful tools.

Reinertsen JL, Bisognano M, Pugh MD. ***Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)***. ([Link to White Paper](#)) IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available on www.IHI.org)

As part of IHI's work of supporting and encouraging leaders of innovative health systems, this white paper presents what we believe to be some important leverage points for leaders who want to achieve dramatic, system-level performance improvement. This set of leverage points is not offered as a tried-and-true method, but as a theory — one that we hope will be useful for individual leaders in planning their work and for us in organizing a support and learning system to share best practices and results across organizations; and from which all of us can learn about what works, and what doesn't in bringing about large-system change in health care.

Greenbook: Outpatient Primary Care ([Link to Workbook](#))

The workbooks provide tools and methods that busy clinical teams can use to improve the quality and value of patient care as well as the work-life of all staff who contribute to patient care. It is a resource for assessing any outpatient primary care setting and determining needs and priorities. These methods can be adapted to a wide variety of clinical settings, large and small, urban and rural, community-based and academic.

Schaefer J, Miller D, Goldstein M, Simmons L. ***Partnering in Self-Management Support: A Toolkit for Clinicians***. ([Link to Toolkit](#)) Cambridge, MA: Institute for Healthcare Improvement; 2009.

The concepts and tools in this toolkit are intended to give busy clinical practices an introduction to a set of activities and changes that support patients and families in the day-to-day management of chronic conditions. Experienced organizations and teams will find tested resources and tools. Practices that are just beginning to reorganize for patient-centered care as well as those experienced in collaborative self-management will find tested resources and tools and high-leverage changes that offer a number of ways to begin trying them with a small number of patients.

Day 3

Nolan TW. ***Execution of Strategic Improvement Initiatives to Produce System-Level Results***. ([Link to White Paper](#)) IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org)

This paper proposes a framework for execution of strategic initiatives aimed at producing system-level results.

Going Lean in Health Care. ([Link to White Paper](#)) IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2005. (Available on www.IHI.org)

Lean thinking begins with driving out waste so that all work adds value and serves the customer's needs. Identifying value-added and non-value-added steps in every process is the beginning of the journey toward lean operations.