



THE CHRONIC CARE MODEL

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Promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings.

Almost half of all Americans, or 133 million people, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. ¹ As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. ^{2,3,4}

Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive – responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible. ^{5,6,7} To speed the transition, Improving Chronic Illness Care has created the **Chronic Care Model**, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels.



Getting started

How you can get started promoting change in your organization.



Check out the model talk

This **presentation** walks you through the Chronic Care Model step-by-step with narration by model developer, Dr. Ed Wagner, national program director, Improving Chronic Illness Care.

This talk was given at the 2004 Epidemiology, Biostatistics and Clinical Research Methods Summer Session co-sponsored by the Seattle VA Epidemiologic Research and Information Center and the University of Washington.