

**Program Element # 28: Chronic Care Model (CCM) Implementation Grants for Asthma, Diabetes, Tobacco, Heart Disease & Stroke**

1. **Description.** Funds provided under this Financial Assistance Agreement for this Program Element shall only be used, in accordance with and subject to the requirements and limitations set forth below, to implement clinical and community-based activities in support of the Chronic Care Model (CCM) at the county or regional level that geographically contains a medical catchment area.

The Chronic Care Model, as defined by the Institute for Improving Chronic Illness Care in July 2003, identifies the essential components and linkages of health care systems and communities that encourage high-quality chronic disease care. CCM activities funded by this Agreement support the components and their linkages by engaging entities within the components in quality improvement activities and strategies. These activities and strategies are intended to create opportunities for patients to improve their health status and disease self-management skills, improve knowledge of and access to community resources for patients and health care providers, and increase cost savings to patients and health systems.

- a. LPHA or designee shall implement CCM activities in each of the following areas:
  - i. **Clinical Component.** Convene and facilitate one or more partnerships with clinical entities to implement the clinical components of the CCM for asthma, diabetes, high blood pressure, and high blood lipids, and link the clinical component with community resources for self-management. Clinical entities are those who have received training in the CCM, have already established a clinic population registry for one or more of the following conditions: diabetes, asthma, blood pressure, and/or blood lipids, agree to expand the registry to all four conditions, and can report clinic population outcomes from registry data. Clinical entities may include private clinics, independent practice associations (IPA), hospitals, health systems, and/or Federally Qualified Health Centers (FQHC). The clinical component must reach at least 100 patients with one or more of the chronic conditions described above.
  - ii. **Community Resources.** Convene and facilitate one or more partnerships with community and health organizations to develop sustainable systems to deliver and promote evidence-based community resources/programs that support the self-management needs of people with asthma, diabetes, high blood pressure, and high blood lipids and link these resources with the participating clinical entities. One or more community organizations should have staff/volunteers already trained in an evidence-based self-management program, such as Stanford's Chronic Disease Self-Management Program, and be offering programs.
  - iii. **Linkage and Referral System.** Develop systems of linkage and referral between the clinical component and community-based self-management resources so that the patient population being served has the support of the full CCM. Funds are to be used to build strong, sustainable referral systems between medical delivery systems and community support systems to empower people to manage their chronic conditions. This project assumes that both the medical delivery system and the community have already developed some level of capacity in their respective components of the CCM.





**Attachment 1**  
**Approved CCM Work Plan**

**Attachment 2**  
**Approved CCM Budget**