THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Check your practice: Chronic care management in the Patient's Medical Home

Best Advice Guide: Quick Reference

There are more patients with chronic diseases now than ever before. Chronic care management is a challenge for our health care system.

Patient-centred primary care improves the health of patients with chronic diseases. Chronic care management can prevent and control chronic diseases, mitigating their social and health impacts.

A well-organized family practice plays a key role in chronic care management. Early intervention by family practice interprofessional teams can keep chronic diseases in check. Following the principles of the Patient's Medical Home (PMH) model is an effective way to manage chronic care.

Consider the following tips for your practice:

Maintain interactions with patients and their families

Patients and their families need to be actively involved in their care. Conversations about education, community support, care modification, goals, and treatment evaluation are empowering. These conversations allow patients to understand their health conditions and physicians to understand patient's goals, in order to together identify the most appropriate treatment options.

Promote self-care

- Provide patients and caregivers with information about community and social services
- Address health literacy
- Empower patients with self-management skills (eg, physical activity, taking medication) and support them in developing an action plan to tackle health-related behaviours

Organize your practice to support chronic care management by:

- **Working in interprofessional teams:** Patients benefit from accessing a range of health professionals, such as nurses, pharmacists, social workers, and nutrition and exercise coaches
- **Using electronic medical records (EMRs):** EMRs can assist interprofessional teams with coordinating care by sharing patient data across health care teams and settings, allowing the best monitoring and management of at-risk patients
- **Offering group visits:** Patients should be involved in setting the agenda and discussing care management during these visits
- **Promoting timely access:** Offering same-day visits, extending office hours, and scheduling appropriate follow-ups provides patients with timely access to care that promotes continuity of care with their primary provider
- **Rostering patients:** Rostering helps interprofessional family practice teams identify patients with chronic diseases, facilitating the provision of preventive and management services

For more information on clinical, community, and population-level strategies to tackle chronic care management challenges in the **Patient's Medical Home**, and for details on resources available to you, please refer to **Best Advice: Chronic Care Management**.

http://patientsmedicalhome.ca/
http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-chronic-care-management

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