Self-management is an essential but frequently neglected component of chronic illness management that is challenging to implement. Available effectiveness data regarding self-management interventions tend to be from stand-alone programs rather than from efforts to integrate self-management into routine medical care. This article describes efforts to integrate self-management support into broader health care systems change to improve the quality of patient care in the Chronic Illness Care Breakthrough Series. We describe the general approach to system change (the Chronic Care Model) and the more specific self-management training model used. The process used in training organizations in self-management is discussed, and data are presented on teams from 21 health care systems participating in a 13-month-long Breakthrough Series to address diabetes and heart failure care. Available system-level data suggest that teams from a variety of health care organizations made improvements in support provided for self-management. Improvements were found for both diabetes and heart failure teams, suggesting that this improvement process may be broadly applicable. Lessons learned, keys to success, and directions for future research and practice are discussed.


INTRODUCTION
More than 100 million Americans currently have one or more chronic illnesses (1). Given our changing ethnic demographics, the aging of the U.S. population, and advances in treatment, the prevalence of chronic illnesses will continue to increase. It is also clear that the quality of care for a variety of chronic illnesses is suboptimal (2). These issues have already begun to tax health care systems, and consequently many “disease management” programs have been initiated. The vast majority of these programs, however, have limitations that lessen their likely long-term impact. Specifically, they are often short term, are not evidence based, are not integrated into primary care, frequently pay only scant attention to self-management support and training, and are almost always directed toward a single chronic illness.

Chronic Illness Care Breakthrough Series Collaboratives (“Collaboratives”) were designed to address limitations of existing disease management programs and to provide an effective model for improving care across a variety of chronic illnesses. The Collaboratives involve health care teams from multiple health care settings using a longitudinal and iterative process for rapid cycle improvement designed by the Institute for Health Care Improvement and Associates in Process Improvement (3–5) to implement system changes shown to improve care. In the 13-month-long Collaboratives, teams attend three 2-day learning sessions during which they learn skills and refine plans to make changes in their systems, alternating with “action periods,” during which they design and test improvement interven-
tions (plan–do–study–act [PDSA] cycles) in their system. Wagner et al. (6–9) previously described the overall Collaborative process and results of the first Chronic Illness Collaborative (6). There are 20 to 30 teams that participate concurrently in each Collaborative, and each addresses one of two different chronic illnesses.

The Chronic Care Model (7–9), which addresses necessary health system changes for improving chronic illness care, was adopted as the framework guiding the Collaboratives. The Chronic Care Model recommends evidence-based interventions within six areas known to improve processes of care and patient outcomes: delivery system design, decision support, information systems, linkages to the community, self-management support, and organization of the health system (7,9,10). As can be seen in Figure 1, self-management support is a central feature of the model because of the centrality of the informed, activated patient to productive patient–provider interactions.

The Chronic Care Model emphasizes several self-management activities drawn from successful programs. First and foremost, providers communicate and reinforce patients’ active and central role in managing their illness. Second, teams make regular use of standardized patient assessments. These assessments include patients’ levels of self-management in different regimen areas, skills to manage their condition, confidence in their ability to manage, barriers to self-management, and supports. The third aspect of a successful self-management system is use of effective behavior change interventions. Peers and professionals use evidence-based programs to provide ongoing support. Finally, successful programs include collaborative care planning and patient-centered problem solving. The practice team develops an individualized care plan with each patient, who has access to support when problems are encountered.

Diabetes and heart failure were the chronic conditions addressed in the second Chronic Illness Collaborative reported in this article. Both of these chronic illnesses have evidence-based guidelines for care (11–14) that are not consistently met by health care professionals or by patients (2,15). These differences between optimal and actual care result in costly and devastating complications and mortality (4,5,16). Closing the gap between recommended and provided care requires changes not only in health professional behaviors but also in patients’ self-management behaviors as well. Changes in the health care system are also needed to provide and encourage initial and ongoing patient self-management education and to facilitate patients’ self-management behaviors through collaborative goal setting and case management.

The purpose of this article is to describe how self-management principles and procedures were integrated into a Collaborative that focused on diabetes and heart failure. Because attention to self-management often plays a minimal or secondary role in disease management programs, and because this is one of the few programs to apply self-management across multiple conditions and across multiple health care settings, it is important to describe the collaborative experience. We describe our approach to self-management and then summarize the collaborative learning process, present both process and organizational change quality-improvement data, and discuss lessons learned and directions for future research and practice on system changes to support chronic illness self-management.

**METHODS**

**Characteristics of Participating Teams**

The Collaborative was advertised nationwide via mailings, announcements through health care organizations, and personal contacts with prior attendees and faculty. Requirements for participation were commitment to making major changes and to support a quality-improvement team of at least 3 persons to participate in the four group meetings and 13-month process.

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**FIGURE 1** Chronic Care Model.