Summary of Wagner Chronic Care Model

Source: McColl Institute, Group Health Cooperative, Seattle

Effective outpatient chronic illness care is characterized by productive interactions between activated patients (as well as their family and caregivers) and a prepared practice team. This care takes place in a health care system that utilizes community resources. At the level of clinical practice, four areas (elements of the care model) influence the ability to deliver effective chronic illness care; These are self-management support, delivery system design, decision support and clinical information systems. The goal is to deliver care that is safe, effective, timely, patient-centered, efficient and equitable. System changes are checked against these criteria.

The major objectives of each element of the Chronic Care Model are listed below. Each bulleted item is a principle for redesigning care. The table on page 3 is organized from conceptual to specific, left to right. Items in **bold** indicate high leverage changes (those that may have the most benefit). *Italics* indicate interrelationships between the different elements of the care model.

Self-management support: Empower and prepare patients to manage their health and health care.

- Emphasize the patient's central role in managing their health.
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.
- Organize internal and community resources to provide ongoing self-management support to patients.

Delivery system design: Assure the delivery of effective, efficient clinical care and self-management support.

- Define roles and distribute tasks among team members.
- Use planned interactions to support evidence-based care.
- Provide clinical case management services for complex patients.
- Ensure regular follow-up by the care team.
- Give care that patients understand and that fits with their cultural background.

Decision support: Promote clinical care that is consistent with scientific evidence and patient preferences.

- Embed evidence-based guidelines into daily clinical practice.
- Integrate specialist expertise and primary care.
- Use proven provider education methods.
- Share evidence-based guidelines and information with patients to encourage their participation.

Clinical information system: Organize patient and population data to facilitate efficient and effective care.

- Provide timely reminders for providers and patients.
- Identify relevant subpopulations for proactive care.
- Facilitate individual patient care planning.
- Share information with patients and providers to coordinate care.
- Monitor performance of practice team and care system.

Health care organization: Create a culture, organization and mechanisms that promote safe, high quality care.

- Visibly support improvement at all levels of the organization, beginning with the senior leader.
- Promote effective improvement strategies aimed at comprehensive system change.
- Encourage open and systematic handling of errors and quality problems to improve care.
- Provide incentives based on quality of care.
- Develop agreements that facilitate care coordination within and across organizations.

Community: Mobilize community resources to meet needs of patients.

- Encourage patients to participate in effective community programs.
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services.
- Advocate for policies to improve patient care