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