Editor's Note: This online data supplement contains supplemental material that was not included with the published article by Katie Coleman and colleagues, "Evidence on the Chronic Care Model in the New Millennium," *Health Affairs* 28, no. 1 (2009): 75-85 (10.1377/hlthaff.28.1.75)

Appendix 1: Chronic Care Model Elements and Goals

CCM Element	Goal	Examples of Changes
Self Management Support	Empower and prepare patients to manage their health and health care.	Counseling around self-management becomes a routine part of encounters. Practice is able to refer patients to effective self-management programs within or outside the system.
Decision Support	Promote clinical care that is consistent with scientific evidence and patient preferences.	Guidelines are embedded into daily practice through alerts, flow sheets, etc. Proven provider education modalities such as academic detailing are utilized.
Delivery System Design	Assure the delivery of effective, efficient clinical care and self-management support.	Visits are planned to meet patient needs, and regular follow-up assured. Non-clinician staff is utilized fully. High risk patients are supported via care management programs.
Clinical information systems	Organize patient and population data to facilitate efficient and effective care.	Proactive care planning identifies patients for outreach. Clinical team uses registry information to plan each visit. Practice regularly receives data on its performance.
Health care organization	Create a culture, organization and mechanisms that promote safe, high quality care.	Organization leaders visibly support continuous improvement. Incentives encourage quality improvement.
Community Resources	Help patients access needed services in the community.	Patients are regularly referred to useful community resources and encouraged to participate. Medical and community organizations establish partnerships to develop and support needed services.

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