Implementing the Chronic Care Model for the Management of Noncommunicable diseases (NCDs) in the Primary Care Setting

Lecture: Expanded Chronic Care Model

Continuing our conversation about the Chronic Care Model, we will now review the Expanded Chronic Care Model, which has been used in several countries. It recognizes the roles of healthy public policy, healthy living environments, healthy communities, reoriented health services delivery, improved decision support for optimum care, enhanced self-care skills of people, partnerships of stakeholders, and information systems that can assess the impact of interventions.

The Expanded Chronic Care Model integrates aspects of prevention and health promotion into the CCM. It Includes elements of the population health promotion field so that broadly based prevention efforts, recognition of the social determinants of health (including housing, income social supports), and enhanced community participation can also be part of the work of health system teams as they work with chronic disease issues.

The expanded CCM includes a “porous” border between the health care system and community, allowing for a flow of ideas, people and resources.

The four circles of self-management support, decision support, delivery system design and information systems now straddle the health care system and community allowing for better integration.

It emphasizes community participation in planning, implementing and evaluating programs and policies and in identifying and addressing barriers to optimum health and health care.

The Chronic Care Model is clinically-oriented while the Expanded Chronic Care Model is public health-oriented. Both emphasize the importance of community care and self-management support and provide a framework for system and organizational change.