Chronic Care Model

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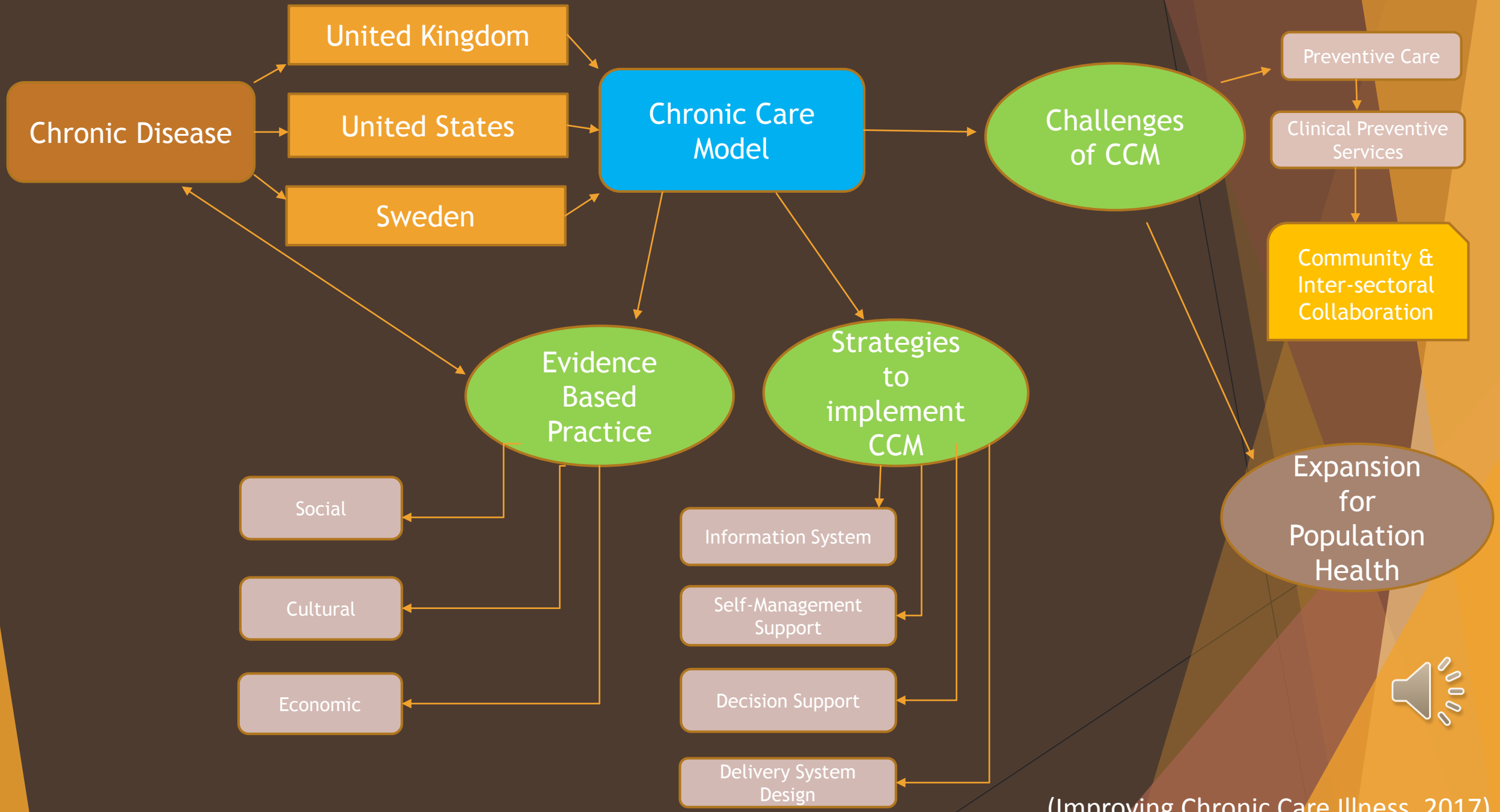
OBJECTIVES

1. To provide an in-depth definition to the Chronic Care Model concept map.

2. To explain what needs to be changed in the Chronic Care Model.

3. To describe who is at a disadvantage and who benefits from the Chronic Care Model.

4. To provide a revised concept map of the Chronic Care Model.

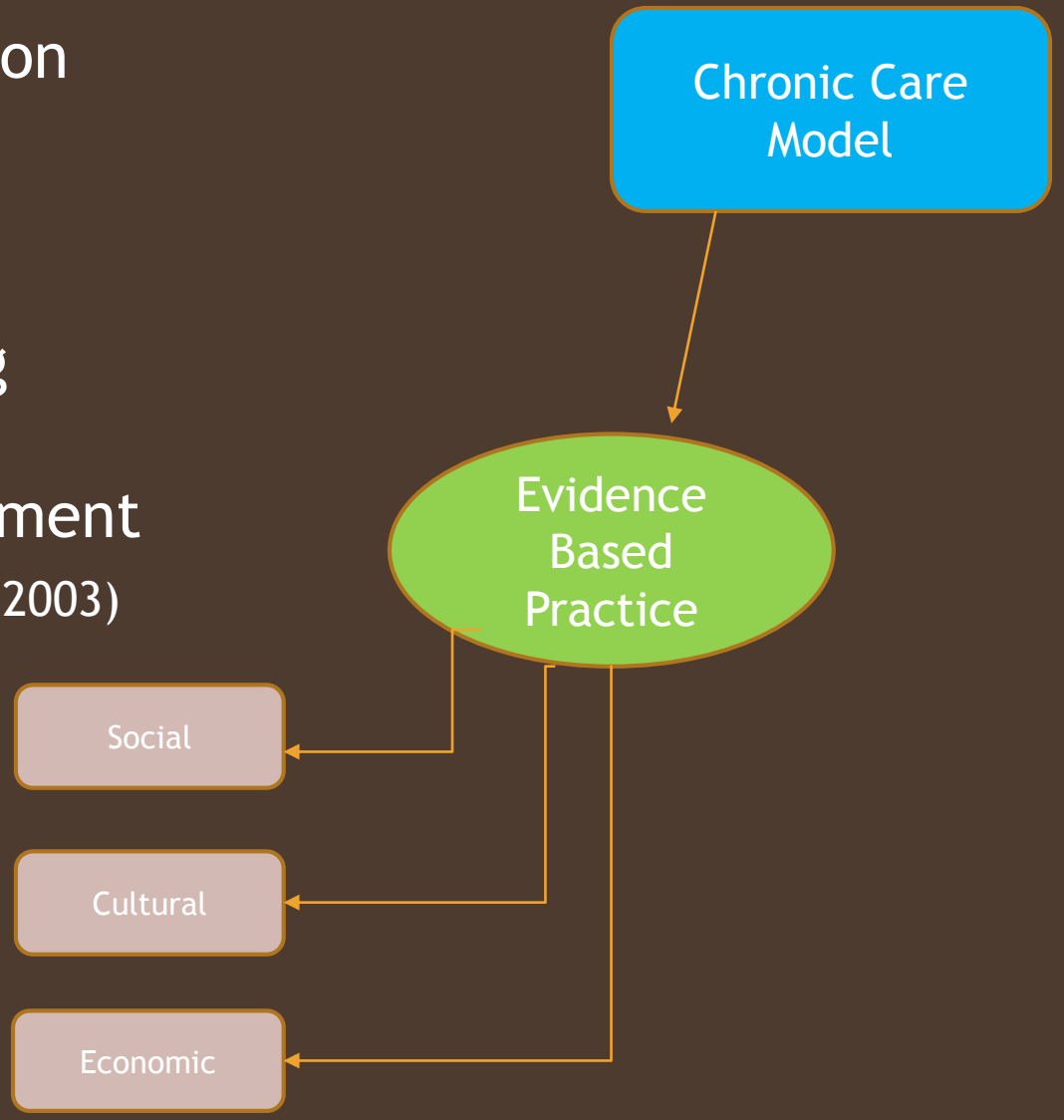


(Improving Chronic Care Illness, 2017)

- Heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis (Center for Disease Control and Prevention (CDC), 2017).
- 117 million people—had one or more chronic health conditions arthritis (CDC, 2017).
- 7 out of 10 deaths in 2014 were related to chronic diseases. Heart disease and cancer— 46% of all deaths arthritis (CDC, 2017).
- Lack of exercise or physical activity, poor nutrition, tobacco use, and drinking too much alcohol (CDC, 2017).
- 86% of the nation's $2.7 trillion annual health care expenditures are for people with chronic and mental health conditions (CDC, 2017).
- The United States, the United Kingdom and Sweden implemented the Chronic Care Model (CCM) (Barr, et al., 2003).

- Education
- Justice
- Housing
- Employment

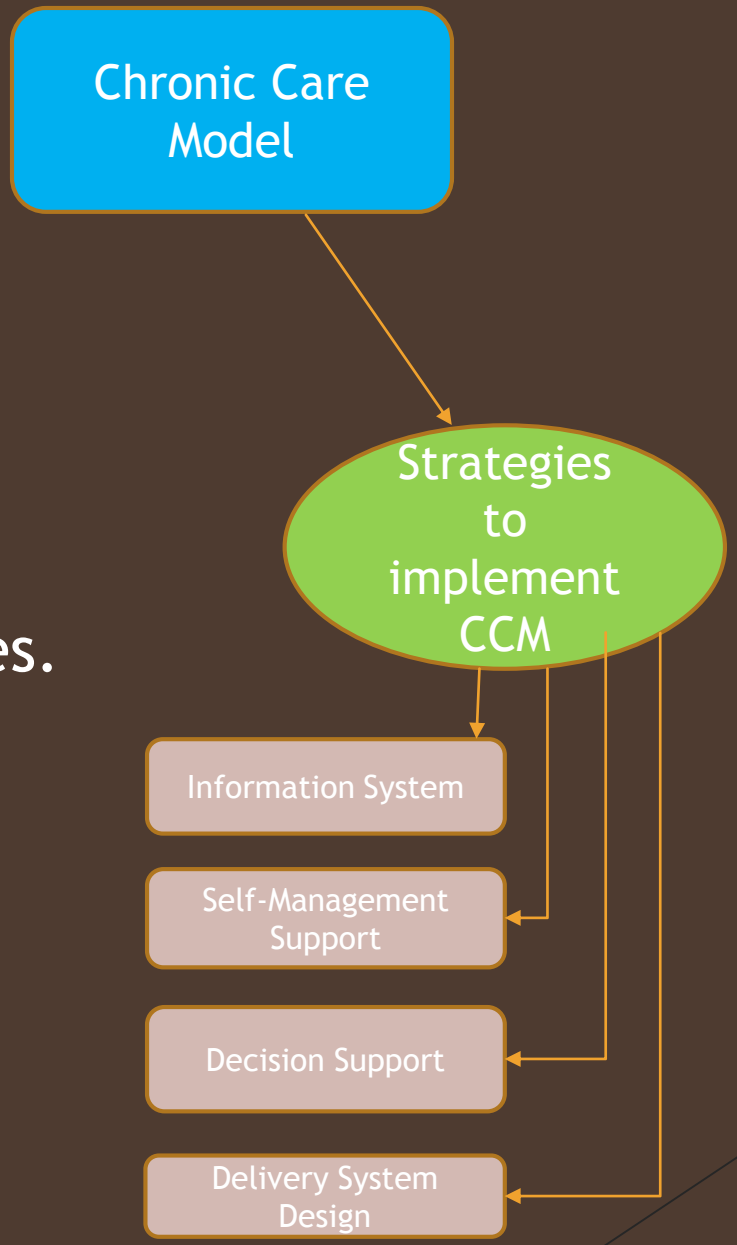
(Barr, et al., 2003)



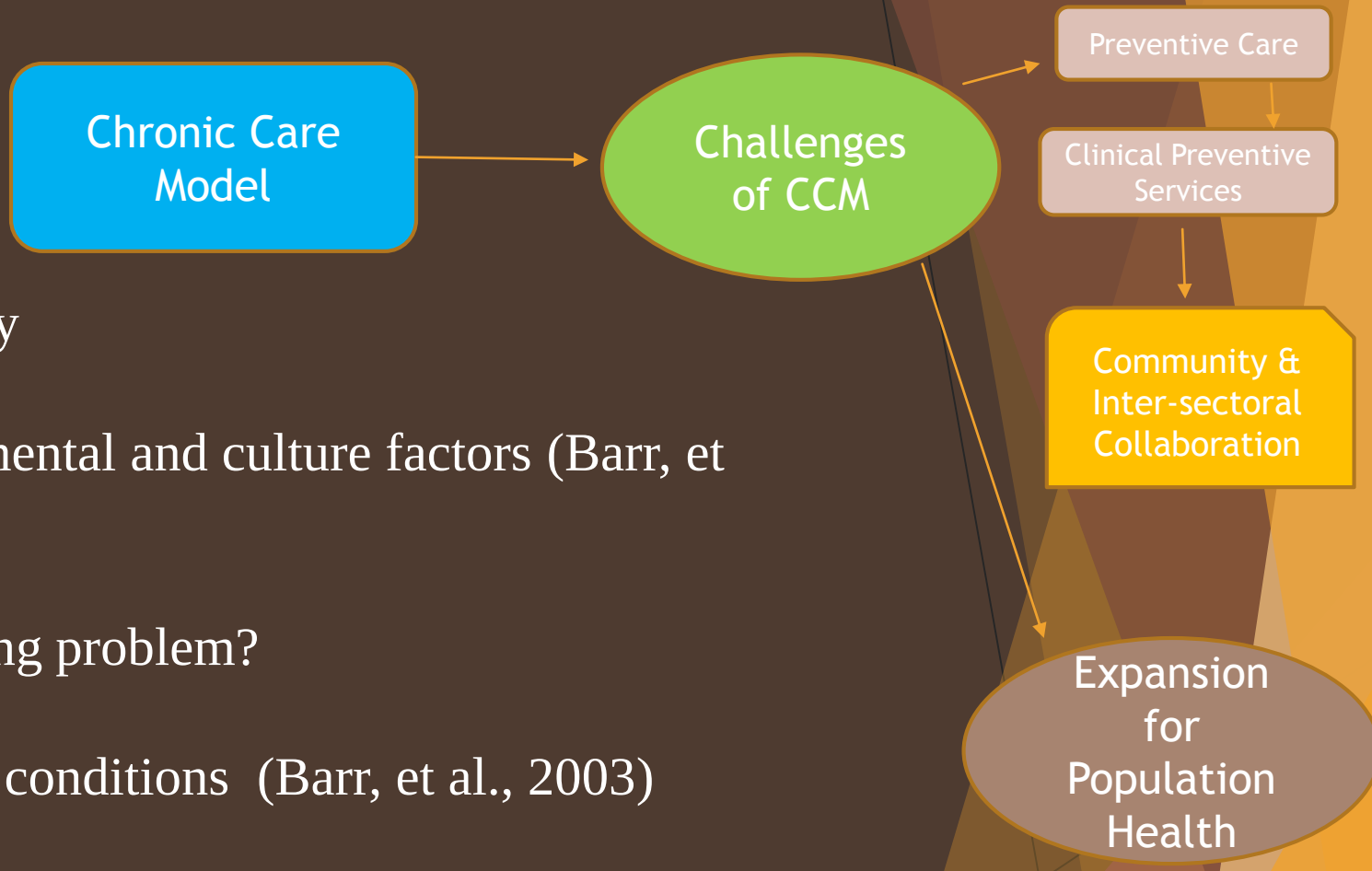
- ❑ Randomized control trials
- ❑ Quality Improvement evaluations
- ❑ Organizational characteristics and quality improvement
- ❑ Cost-effectiveness studies

(Improving Chronic Care Illness, 2017)

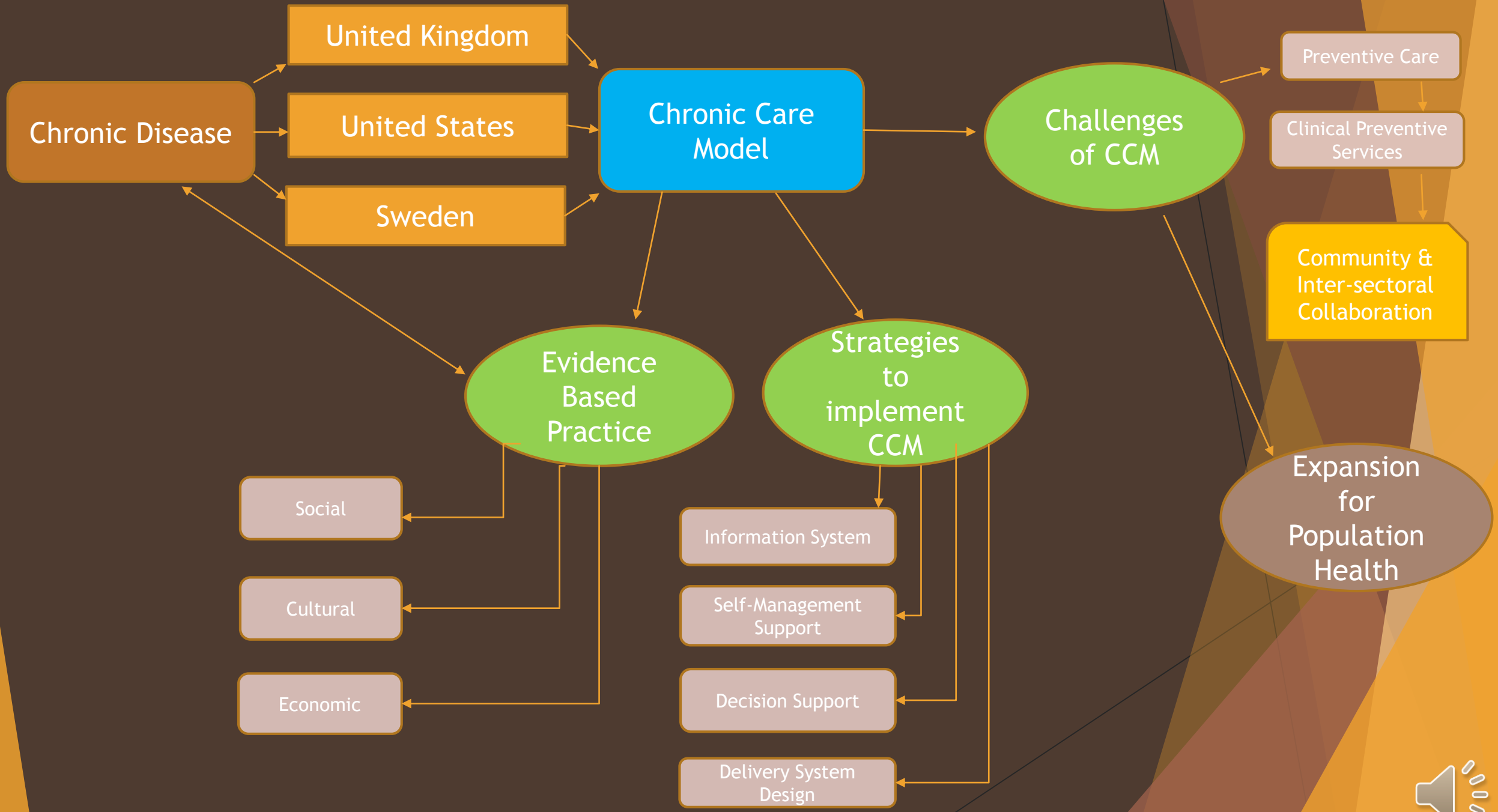
- ❑ Coping with a disease.
- ❑ Personal skills.
- ❑ Re-orientating health services.
- ❑ Social, political, economic, physical environment.

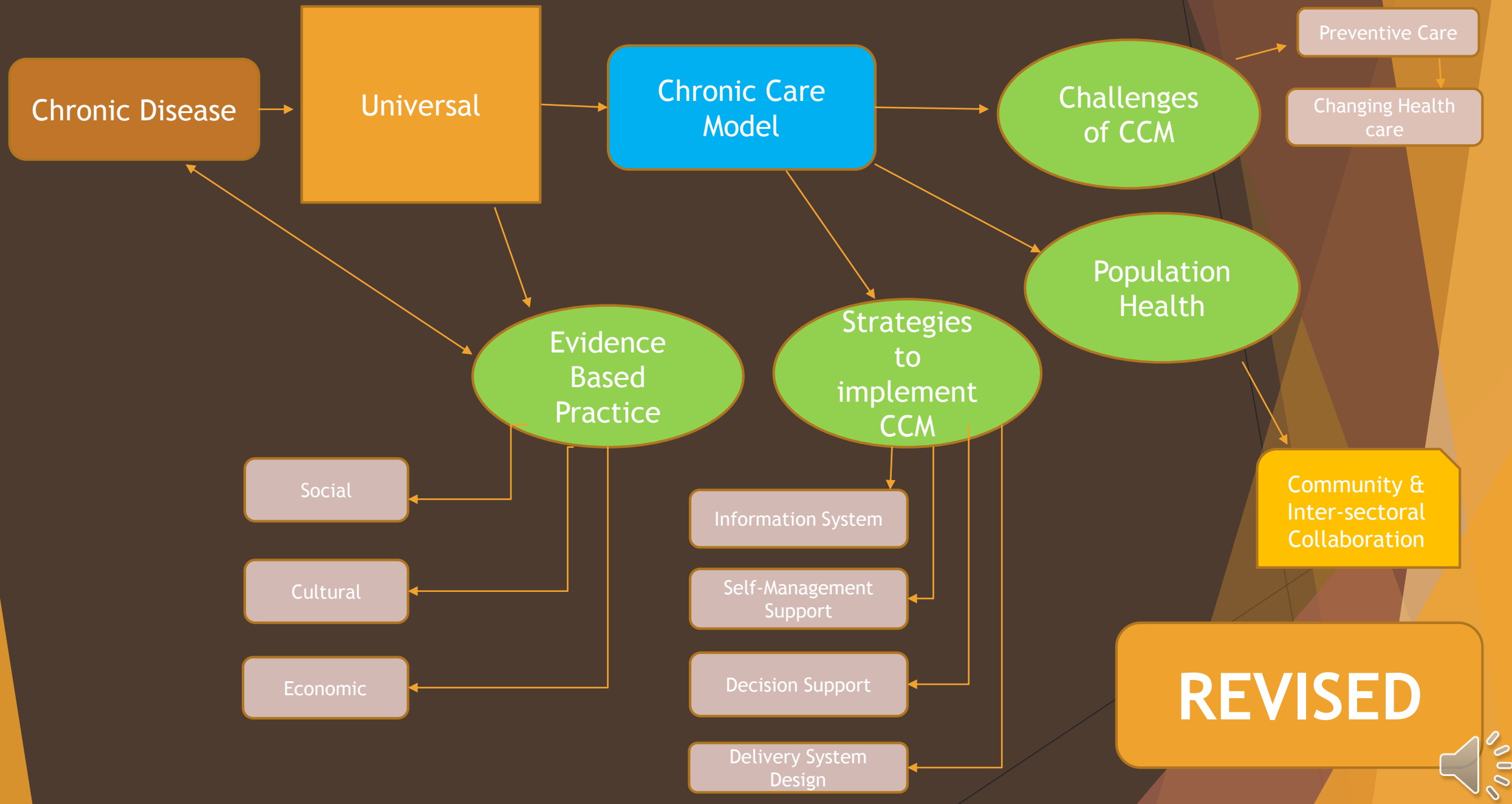


- ❑ New programs
- ❑ Evaluation of established systems
- ❑ Choices which support health and well-being
- ❑ Pairing professionals



- Prevention of disease and disability
- Minor progress in social, environmental and culture factors (Barr, et al., 2003).
- How can we improve the underlying problem?
- Risk behaviors and environmental conditions (Barr, et al., 2003)
- Prevention before it occurs (Barr, et al., 2003).
- Enhanced health and quality of life (Barr, et al., 2003)


United Kingdom
Chronic Disease
United States
Sweden
Chronic Care Model
Challenges of CCM
Preventive Care
Clinical Preventive Services
Community & Inter-sectoral Collaboration
Evidence Based Practice
Strategies to implement CCM
Expansion for Population Health
Social
Cultural
Economic
Information System
Self-Management Support
Decision Support
Delivery System Design


Chronic Disease
Universal
Chronic Care Model
Challenges of CCM
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Changing Health care
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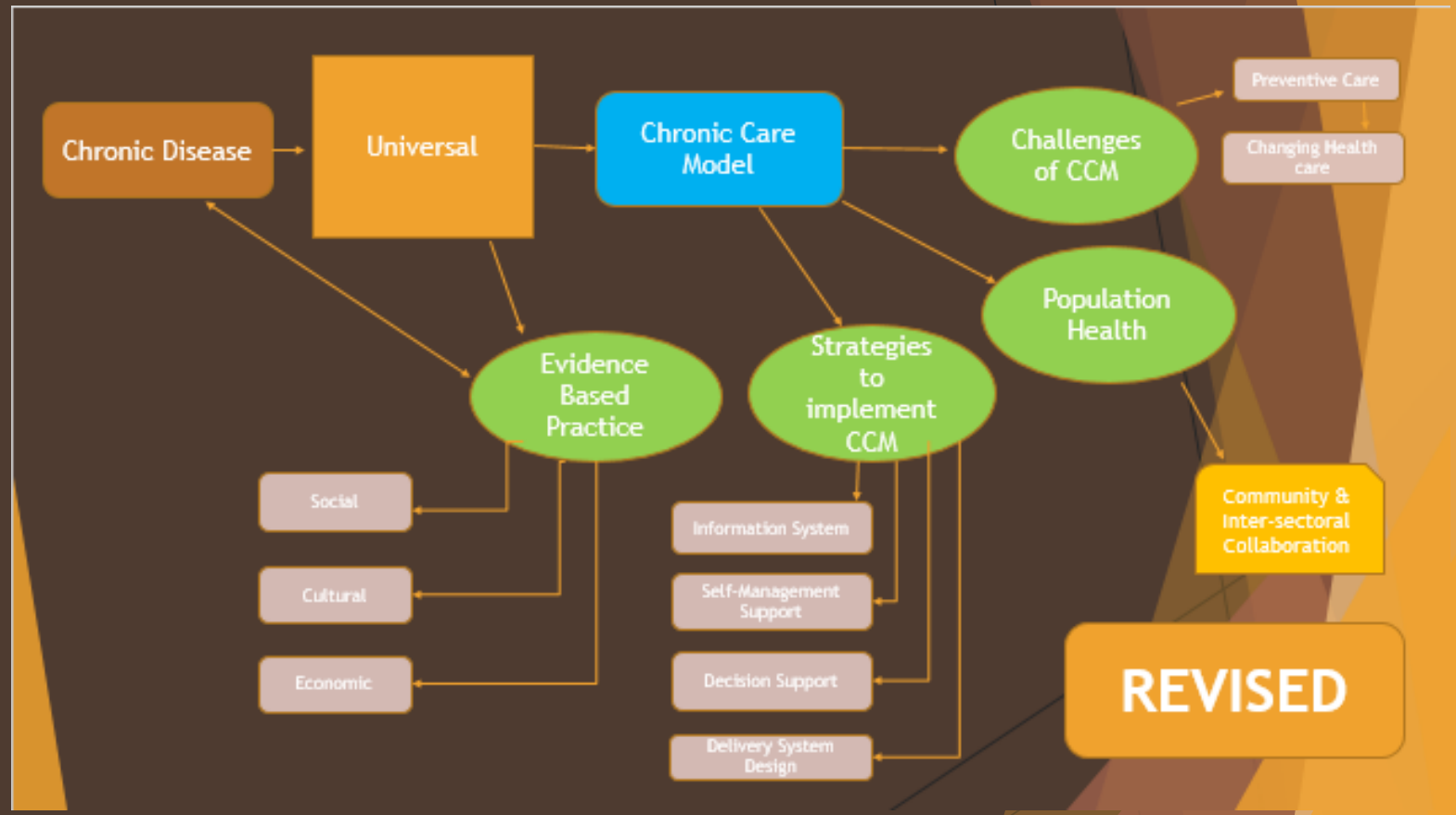
Social
Cultural
Economic
Information System
Self-Management Support
Decision Support
Delivery System Design
Community & Inter-sectoral Collaboration
REVISED

Is this consistent with complex adaptive systems?

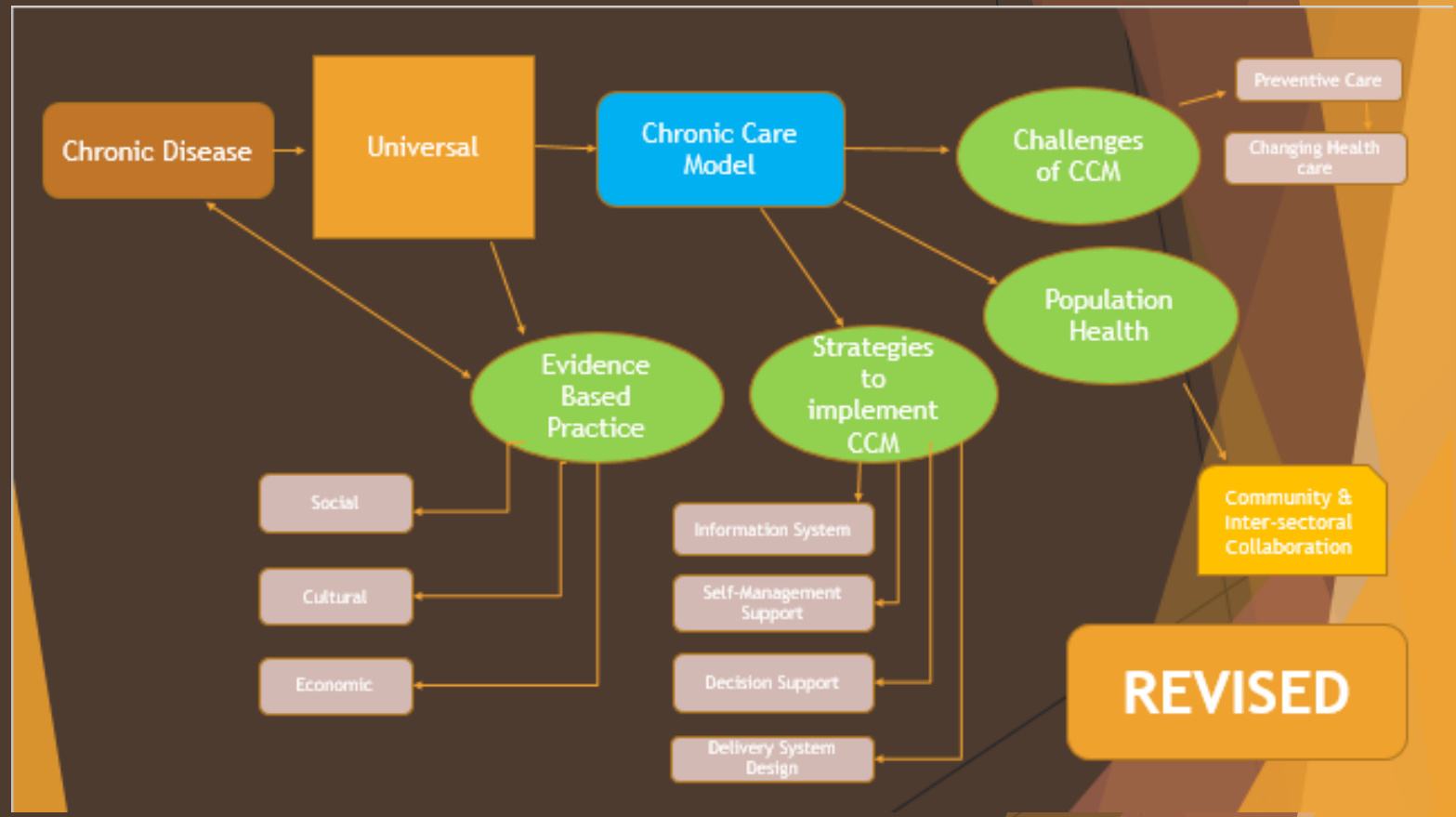
"A complex adaptive system is a system in which a perfect understanding of the individual parts does not automatically convey a perfect understanding of the whole system's behavior" (Wikipedia, 2017).



(Barr, et al., 2003)

Is it current and responsive to practice trends?

“The fields of population health and health promotion, brought together by the term "population health promotion," recognize and work with the broader determinants of health (e.g., housing, income, social supports) that can often serve as barriers for both individuals and communities to maintain optimum health” (Barr, et al., 2003).



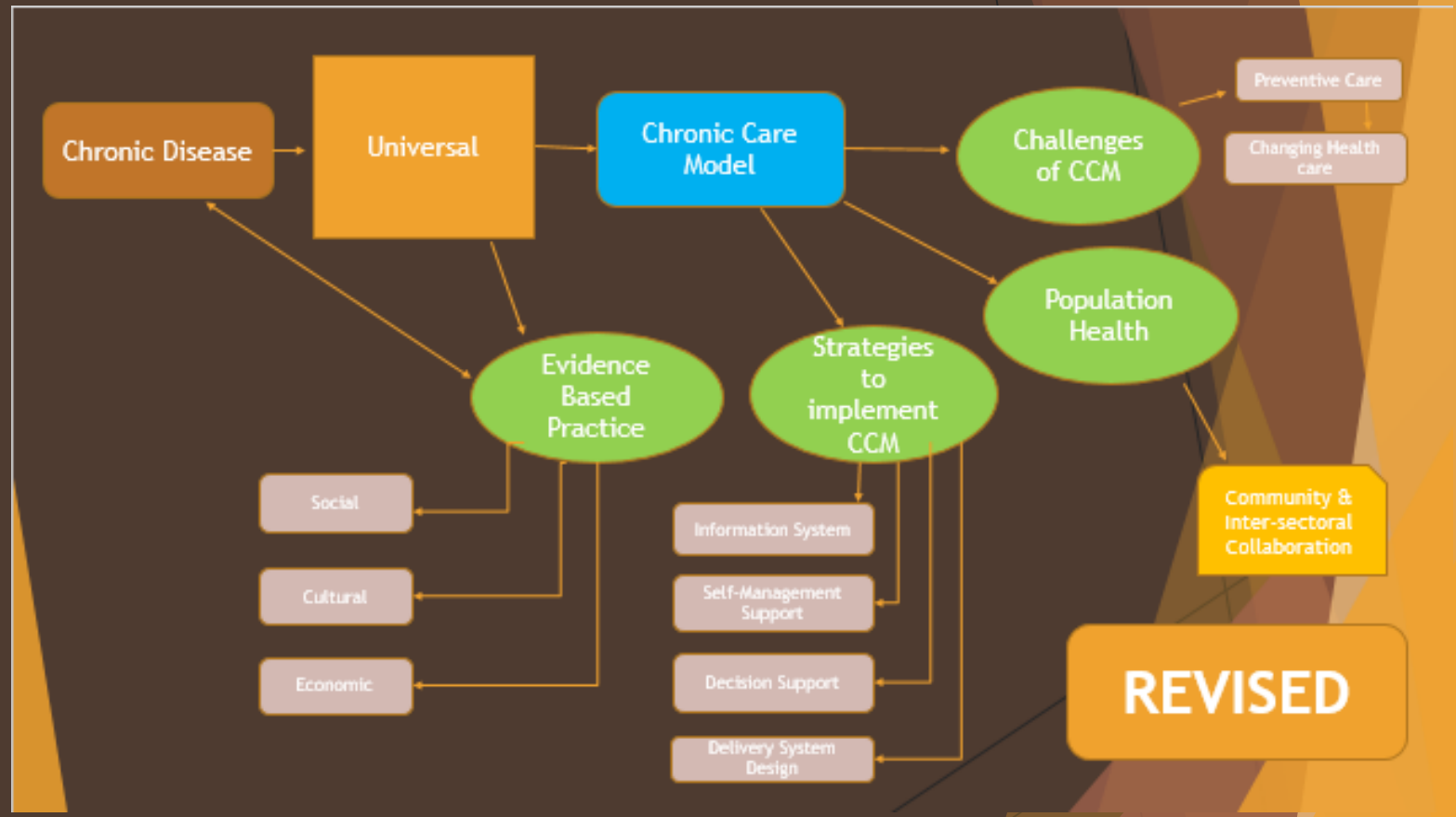
Who benefits or is at a disadvantage from CCN?

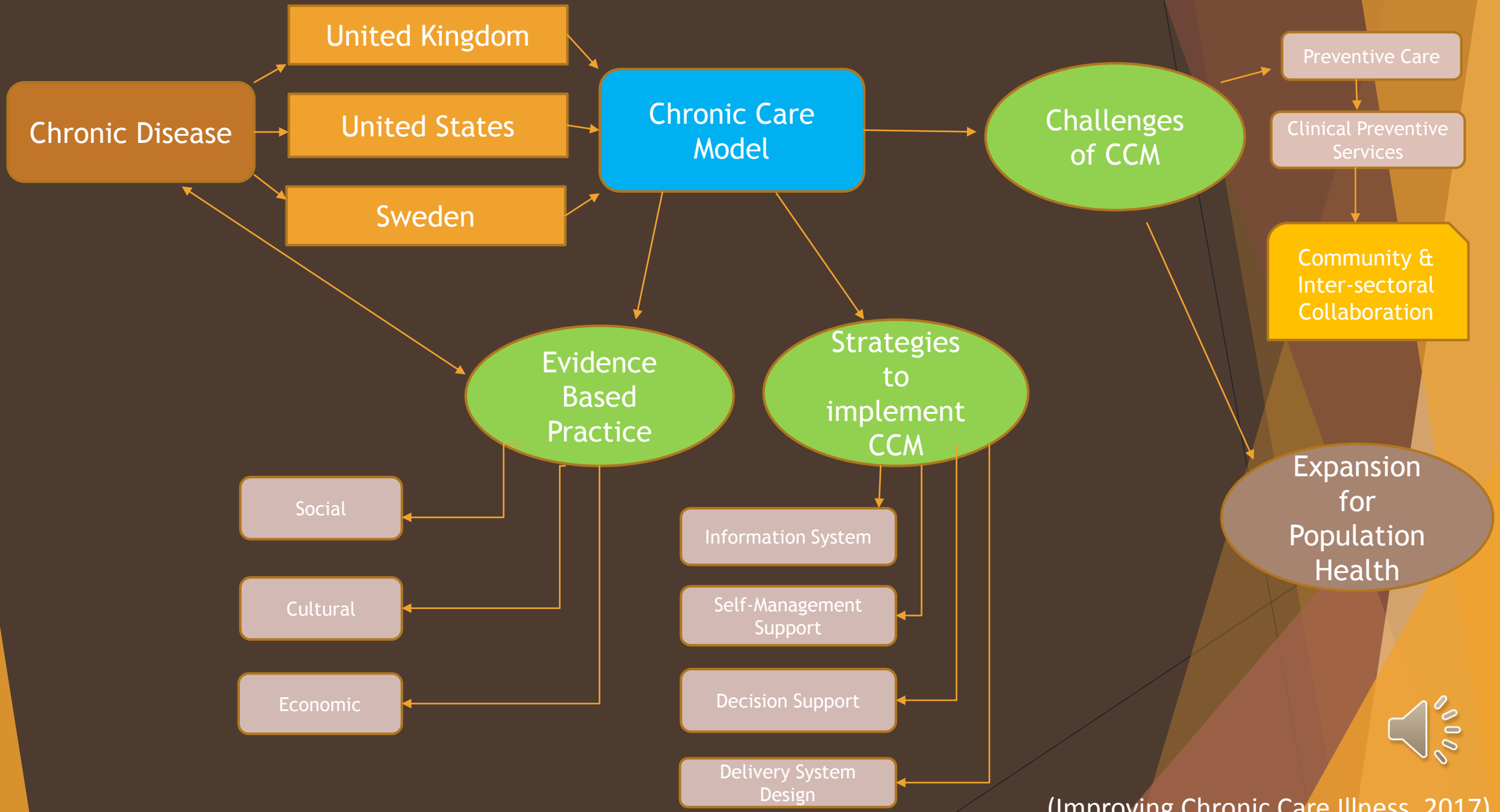
Benefits:

- Success in improving patient satisfaction and communication with care providers, enhancing self-management skills, increasing use of preventive services, and decreasing hospitalizations and medical costs (Vann, 2015).

Disadvantages:

- Organizational readiness
- Implementing multiple components
- Executing the intervention process **(Kadu & Stolee, 2015)**





(Improving Chronic Care Illness, 2017)

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