Institute of Health Policy, Management & Evaluation
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The Self-Management-Focused Chronic Care Model: A Conceptual Framework

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Background

- Chronic diseases will be the epidemic of the 21st Century
- Most health care systems around the world are acute care-focused
  - Care is episodic, segmented, and centred around curative medicine[1]
  - NOT ideal for caring for chronic disease conditions which requires long-term and more maintenance/prevention-focused care[1]
- Discrepancy in patient needs and actual health care provision is causing poor patient outcomes and unnecessary health system costs[2]
- Many jurisdictions are currently adopting models of health care with chronic disease management focus
  - Australia, United Kingdom, United States & Canada[3]

The Importance of Self-Management

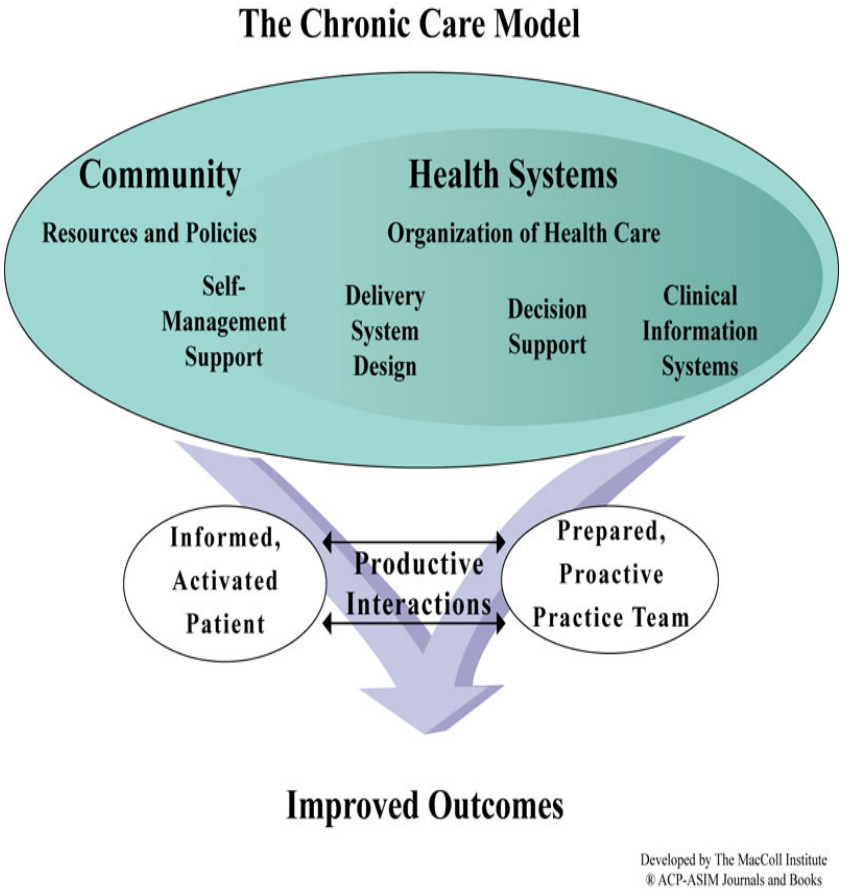
- Patient self-management is considered to be central in chronic disease management[4]
  - Is the formal or informal practice of engaging in activities that enables a person to cope and manage the symptoms, treatment, physical, psychosocial, and lifestyle changes associated with a chronic condition on a day-to-day basis[3]
  - Includes activities related to the medical, role, and emotional management of chronic conditions[5] both in conjunction with and outside the health care system[4]
- However, lack of conceptual clarity on the definition of self-management[6]
  - Without conceptual clarity operationalization of variables for measurement of its success is difficult

Research Questions

- How is successful self-management conceptualized?
- What are some key frameworks that can be used for the measurement of self-management?

The Chronic Care Model (CCM)[7]

- Wagner's CCM has been used by many jurisdictions as the foundation on which to base their chronic disease care paradigms
- Comprises of 6 interdependent components including SM Support
  - Found to be the most effective[3]
  - Is the notion of "collaboratively helping clients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools…and routinely assessing problems and accomplishments"[8]
- Productive interactions between patient and provider result in improve outcomes[11]

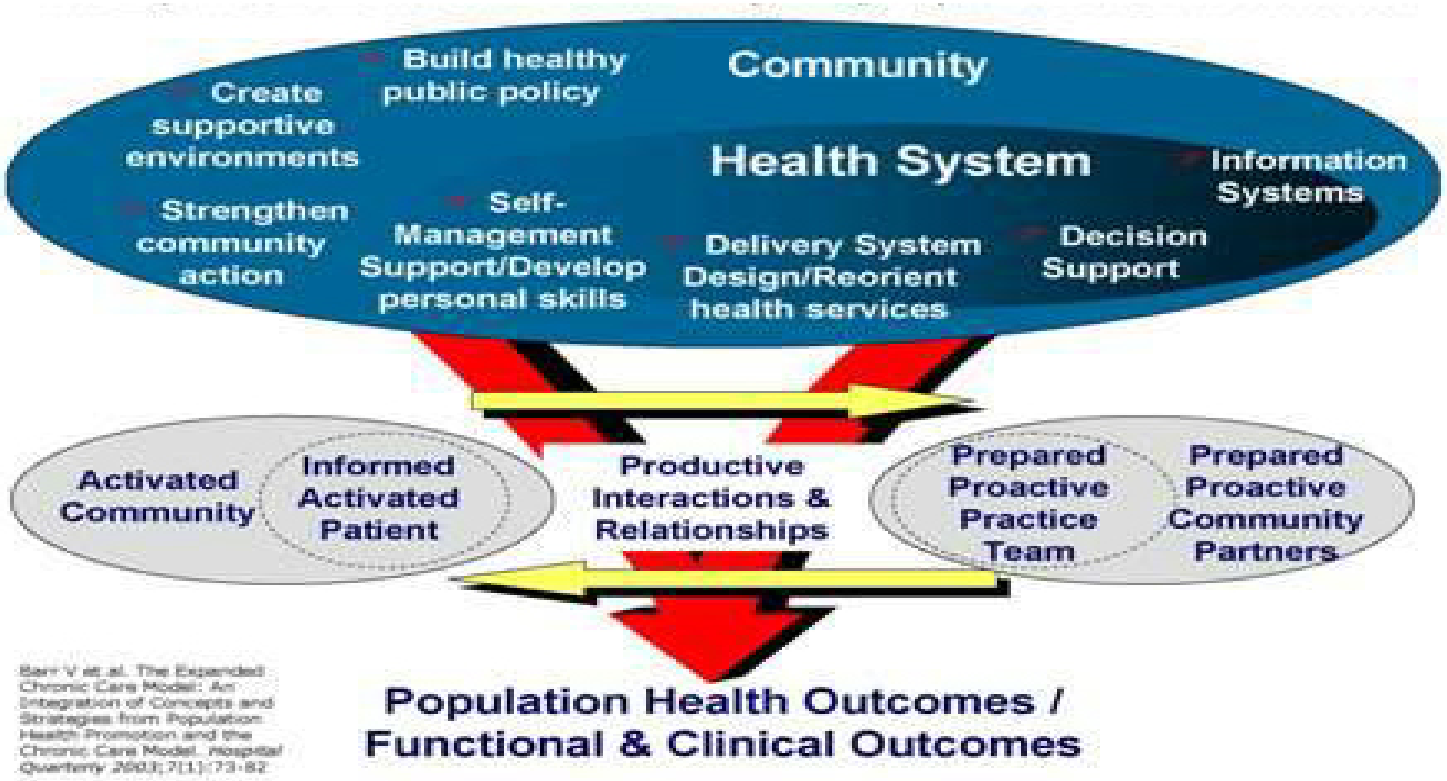


Limitations:

- The CCM is highly clinical in nature[9]
  - Is a framework for providers and health care organizations, not for patients
  - Highlights self-management support but not self-management – patient's perspective in self-management is not present
  - Does not help in understanding dynamic and relationship between self-management support and self-management

B.C.'s Expanded Chronic Care Model (ECCM)[9]

- The ECCM includes elements of population health promotion
- Emphasis on the impact of community and health system

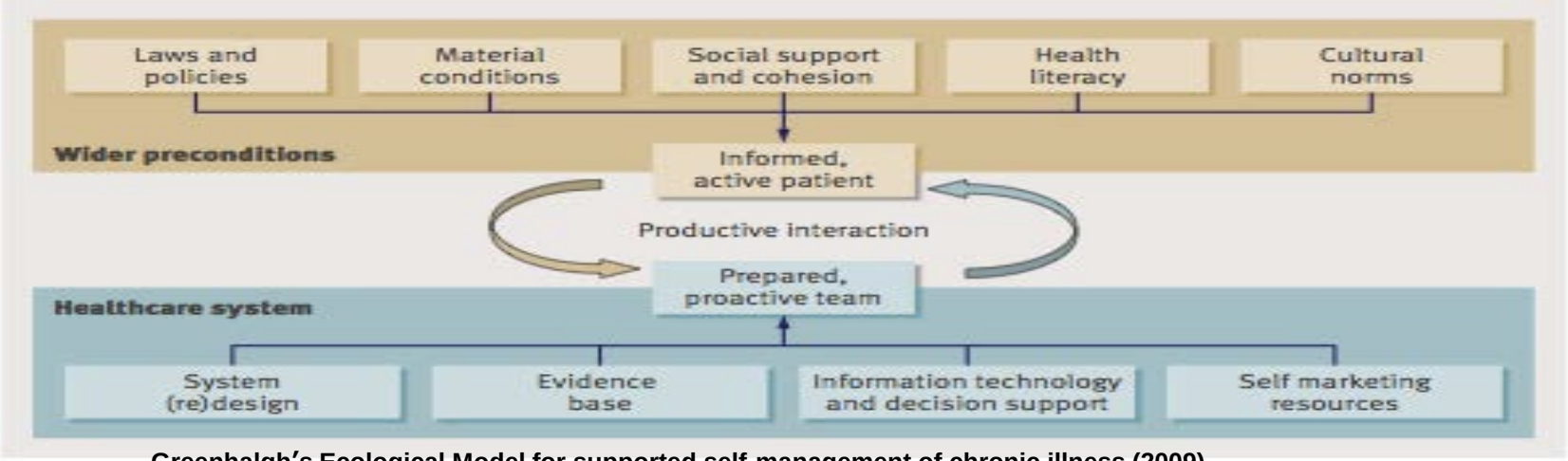


Ontario's Chronic Disease Management Framework (CDPMF)[10]

- Based on B.C.'s model, emphasizing role of population health promotion factors such as the social determinants of health as well as the influence of communities.
- Expands on each element of model and inclusive of families

Patient-Centred SM Models & Theories

- Greenhalgh's Ecological Model for Supported Self-Management of Chronic Illness (2009)[11]
- The Individual and Family SM Theory (Ryan & Sawin, 2009)[12]
- Bandura's Social Cognitive Theory (1986)[13]

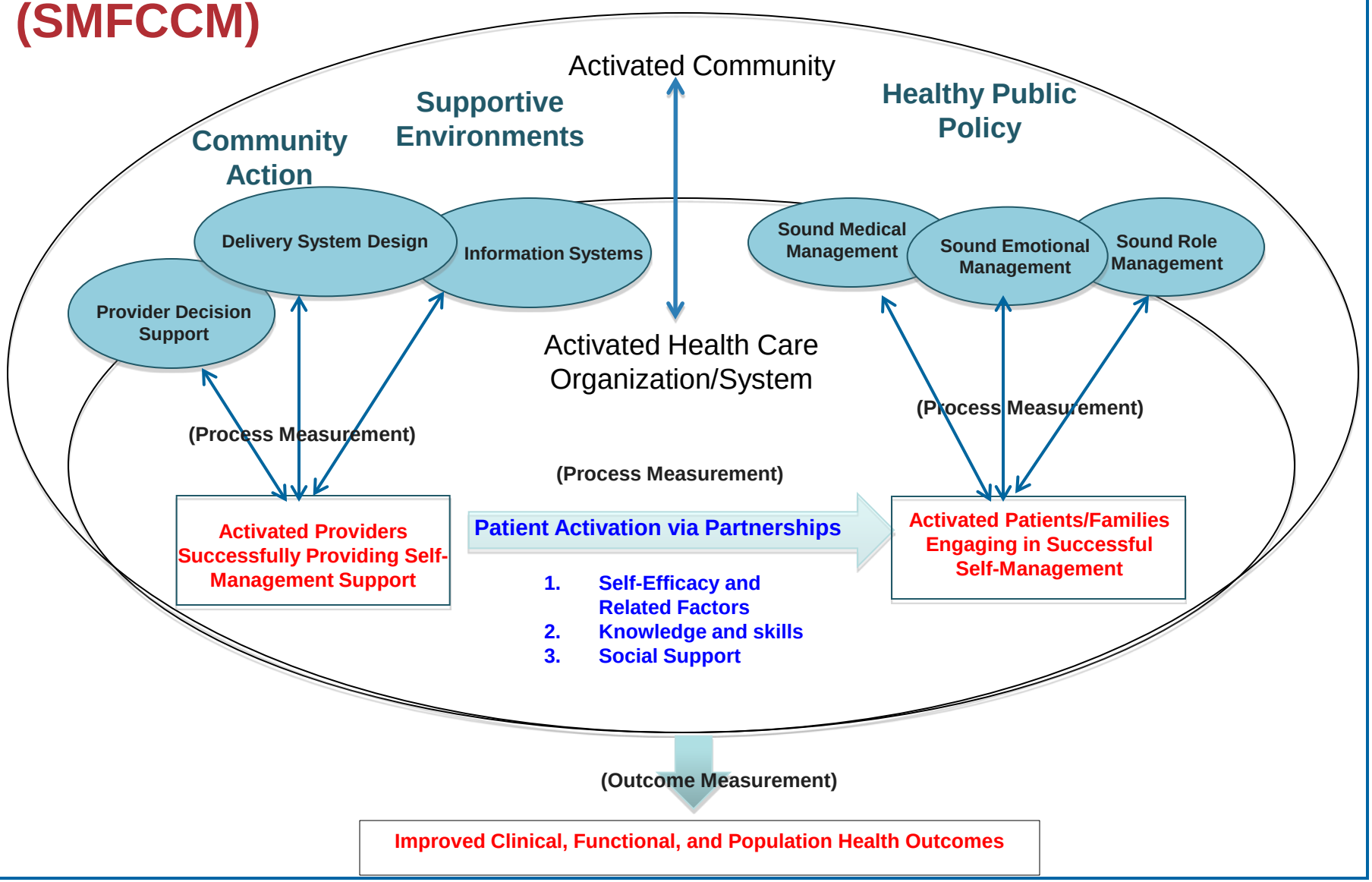


Greenhalgh's Ecological Model for supported self-management of chronic illness (2009)

Challenges

- No one model which:
  - Considered self-management distinctly from self-management support in the context of chronic disease management
  - Delineated the nature of the relationship between self-management support and self-management
  - Incorporated the patient's perspective in chronic disease management
  - Considered ecological factors affecting self-management
  - Defined how to measure successful self-management

The Self-Management-Focused Chronic Care Model (SMFCCM)



Strengths of SMFCCM

- Incorporates self-management as a separate process within chronic disease model and systems
- Incorporates the perspective of the patient and the factors affecting the patient in achieving positive health outcomes
- Hypothesizes the mechanism by which self-management support leads to self-management
  - Via patient activation through partnerships
- Defines what constitutes successful self-management (medical, emotional, and role management)
- Delineates where measurement of success should occur, and classifies measurement types

Limitations of SMFCCM

- Is the model applicable to every chronic disease condition or will it need to be modified for each specific chronic condition?
- Validity of the model is uncertain – based on literature review, but testing of relationships is required
- Need to account for provider factors affecting SM support and patient factors affecting SM (eg. age, sex, education, race etc.)

Next Steps

- Next steps will be to test causal relationship and any intermediate variables between self-management support and self-management (including intermediary variables)
- Delineate provider-specific and patient-specific factors affecting activation for self-management support and self-management

Questions & Feedback

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