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| Nota di contenuto | Cover; Contents; Introduction; 1 Background to the Implementation of Case Management Models for Chronic Long-Term Conditions within the National Health Service; Introduction; Primary care management of long-term conditions; How management approaches have been developed; Developing and delivering care; Future of care; The impact and cost of chronic disease; Identifying patients who require case management; National guidelines and evidence-based practice; Embedding evidence in practice; Making progress in the management of chronic conditions; Modernizing care in the National Health Service Developing case management and care delivery Case management in the National Health Service; Promotion of self-management and self-care; Partnerships and expectations; Conclusion; References; 2 Case Management Models: Nationally and Internationally; Introduction; The context for case management in the NHS; Impact of managed care models; International models of care reviewed; The Alaskan Medical Service; Kaiser Permanente (North California); Group Health Cooperative |

(Seattle, Washington); HealthPartners (Minnesota); Touchpoint Health Plan (Wisconsin)
Anthem Blue Cross and Blue Shield (Connecticut)United Health Europe Ever care; Amsterdam Health Care System (the Netherlands); Outcome intervention model (New Zealand); National model of chronic disease prevention and control (Australia); Guided Care (United States); PACE (United States); Veterans Affairs (United States); Improving Chronic Illness Care (Seattle); Expanded Chronic Care Model (Canada); Pfizer (United States); Green Ribbon Health: Medicare in health support (Florida); What do these models provide?; Models in use in England; Care management in social care
Case management models in the NHSJoint NHS and social care; Data for case management; Evaluation; Conclusion; References; 3 Competencies for Managing Long-Term Conditions; Introduction; Development of the competency framework; What the competencies are expected to deliver; The competencies: what are they?; Domain A: advanced clinical nursing practice; Domain B: leading complex care co-ordination; Domain C: proactively manage complex long-term conditions; Domain D: managing cognitive impairment and mental well-being; Domain E: supporting self-care, self-management and enabling independence Domain F: professional practice and leadership Domain G: identifying high-risk people, promoting health and preventing ill health; Domain H: end-of-life care; Domain I: inter-agency and partnership working; What the competencies aim to do; Developing educational models to develop competencies; Conclusion; References; 4 Outcomes for Patients - Managing Complex Care; Introduction; The areas of competence and deliverables for patients: Leading complex care co-ordination; Identifying high-risk patients, promoting health and preventing ill health; Inter-agency and partnership working; Conclusion References

Sommario/riassunto

The importance of appropriate and effective management of patient with long term chronic conditions cannot be underestimated. Case Management of Long-Term Conditions aims to provide all appropriate practitioners (including nurses, pharmacists, physiotherapists, and social care practitioners) who might be involved in delivery of proactive case management with a practical understanding of how their knowledge and skills can be utilized to improve outcomes for people with chronic long-term conditions. The text contains some broad reflections on care and service delivery based on reviews of