**COMPARISON OF MODELS PAPER**

**Five Segments of Population**

In this assignment, the chosen topic is diabetes. The first segment of population approach will be concerned with different aspects of an individual. An example of such aspects is the physical and emotional state of the body (Nash et al., 2015). These are the aspects that determine the well being of an individual. Social wellness of a person determines his or her ability to be affected by any disease such as diabetes (Nash et al., 2015). The second segment of population approach will be those individuals who are at the risk of being infected with diabetes. This will encompass all populations that can benefit from preventive measures since they can be used to prevent the damage that can be caused by diabetes in the future (Nash et al., 2015). Nash et al. (2015) suggest that preventing disease before it occurs is always encouraged since medical expenses are reduced significantly. Different medical procedures such as biometric screening will be used to identify individuals who are likely to suffer from this disease in the future (Nash et al., 2015).

The third segment of the population will be the individuals who are have suffered from acute illness. The well being of this population can be guaranteed if any cases of acute illness among different individuals is considered seriously. Taking the matter lightly may lead to the eventual spread of a severe disease that may end up affecting the entire population (Nash et al., 2015). The fourth segment of the population will be those individuals who are affected by chronic illness. As stated earlier, diabetes has been chosen for study in this assignment, and since its an example of chronic illness, this segment of the population will be useful. Disease management programs will be used to guide individuals in this population on how to deal with the disease. In these programs, medical care will be offered in the form of referrals to different centers where such care can be provided.

The fifth segment of the population will be focused on those individuals who are at a serious stage of diabetes. Chances of survival for these individuals are minimal, and therefore, a lot of expenses will be required for these chances to be boosted (Wagner et al., 2001). Medical experts must be involved in this case to perform procedures that can offer such individuals the chance of surviving from this situation (Nash et al., 2015). Members in this segment of the population must be provided with special medical care such as nursing assistance, and this is the primary reason why medical expenses are high in this case (Nash et al., 2015).

**Population Health Models**

One of the health models considered in this case is the Chronic Care Model. According to this model, the health condition of patients suffering from different chronic diseases such as cancer is improved by their interaction with care clinicians (Nash et al., 2015). Constant interaction is therefore encouraged in this model since patients are guided and encouraged on how to continue using their medication (Nash et al., 2015). They are also provided with free education on how to take advantage of the healthcare that they are offered for them to improve their medical condition. The care clinicians must also have the capability of providing the best medical care and advice that can be beneficial to the patients (Barr et al., 2003). This model is focused on preventive care since it has been ignored by some people. This is the primary reason why the number of people suffering from chronic diseases continues to rise.

The patient-centered medical home Model is concerned with the expectations of the patients. This model involves the conversion of primary care to match the expectations of the patients suffering from chronic diseases (Nash et al., 2015). Unlike Chronic Care Model, redesigning of primary care is involved in this case. PCMH model involves different activities such as management and design of schedules that are aimed at improving the effectiveness of medical care (Nash et al., 2015). This model provides chronic disease patients the opportunity to maintain the health they receive from medical care, unlike the Chronic Care Model where improvement of health is a primary concern.  However, both models focus on preventive care since its considered as the best method that can be used to prevent more cases of chronic diseases such as diabetes (Wagner et al., 2001).

Hot-spotters model is used to solve the medical condition of patients with high-cost demands (Nash et al., 2015). This model has mainly been applied in Camden where the medical cost of patients is very high (Nash et al., 2015). Medical care of chronic diseases tends to be expensive and, in such cases, the best model must be applied (Nash et al., 2015). This model is used to enable patients suffering from chronic diseases to access quality medical care. It’s the least popular model compared to the other two, and it's not concerned with preventive care.

**Redesign Models**

Incorporation of the practice redesign models would promote the treatment of diabetes. These models can be useful in that they can be used to focus on the special needs of all patients (Piatt et al., 2006). Incorporation of the models would provide relevant details on the requirements of each patient and how they can be incorporated into the medical care (Nash et al., 2015). Diabetes is an example of a chronic disease that requires close monitoring due to the damage it can cause to the victims in case it’s not treated appropriately (Piatt et al., 2006). Practice redesign can allow patients suffering from this disease to receive continuous medical care that is meant to improve their medical condition gradually (Nash et al., 2015). The best examples of models that can be used in this case include Chronic Care Model and patient-centered medical home model (PCMH) (Nash et al., 2015).

 One of the reasons why the incorporation of the practice redesign models would promote the treatment of diabetes is because preventive measures would be provided. This means that patients who are at the early stages of this disease can be provided with the best means of preventing it from spreading to more advanced stages (Piatt et al., 2006). Those who have not suffered from diabetes can also manage to prevent the disease by using either of the models. These models have been recommended by relevant accrediting bodies which means that they are effective at offering preventive measures for individuals willing to improve their medical condition due to the effects of diabetes (Piatt et al., 2006).

  Incorporation of the practice redesign models also means that patients suffering from diabetes would be able to obtain the appropriate access to medical care (Nash et al., 2015). These models provide the access at the right time, and the most applicable medical care is suggested. A combination of the two factors can make it possible for diabetes victims to access quality primary care that can improve their overall medical condition (Nash et al., 2015). When patients understand the nature of the medical care they are receiving, it becomes easy for them to determine whether they can benefit in the future or not. This allows them to seek other alternatives since their health is their first priority (Nash et al., 2015). Incorporation of the models can allow diabetes patients to determine whether the medical care they are receiving is sufficient or not. This understanding can be used to determine whether changes are necessary for the medical care being provided (Nash et al., 2015).

**The Patient-Centered Medical Home Model**

Research shows that this model is effective at improving the health condition of diabetes patients (Nutting et al., 2009). The nature of its primary care allows patients to recover from this disease due to the management practices involved (Wagner et al., 2001). According to studies, most patients suffering from diabetes are unable to keep up with continuous medication in health institutions (Nutting et al., 2009). Most of them are inconsistent while others give up on the entire process especially when there is no progress in their condition. Such cases can be avoided by the application of the patient-centered medical home model. This model aims at improving the satisfaction of patients concerning the medical care they are receiving (Nutting et al., 2009). This is because such care is provided in such a way that it fulfills their demands and it also ensures that they are comfortable with it (Nutting et al., 2009).

This model can provide an appropriate medical plan for patients suffering from diabetes (Rittenhouse and Shortell, 2009). This plan includes simple procedures and management practices that can be followed easily by these patients. The schedules made in the plan are in such a way that they fit the activities of the diabetes patients (Rittenhouse and Shortell, 2009). This means that it becomes easy for them to follow the schedules and ensure continued medication. Lack of continuity has been identified as the major reason why some patients with diabetes have been unable to recover from the disease (Rittenhouse and Shortell, 2009). This model is mainly concerned with this issue, and it's, therefore, clear that it’s the best option for the medical condition in this case.

**Potential Gap in Literature**

Even though PCMH is the best model that can be used by patients suffering from diabetes, some improvements can be still be made to the model. According to Franz and Murphy (2017), the major concern with this model is that its essentials are not clear especially to the patients. This leads to confusion and most patients suffering from chronic diseases suggest that it’s a difficult model to follow. Research shows that most patients have been unable to control this model when they are applying it (Franz and Murphy, 2017). This means that most victims of chronic diseases have no respect for the model. Most of these victims conclude by suggesting that the essentials of the model make it difficult to follow (Barr et al., 2003).

A survey can be carried out to determine the effectiveness of this model to chronic patients who have been assisted in understanding the essentials of this model. In this survey, the number of patients who find the model easy to follow and control can be determined. This number can be obtained after the essentials of the model have been explained in detail to such patients. The aim of the research topic would be to study the reaction of chronic patients once they understand the operation of PCMH model. If it's confirmed in the survey that patients become interested in the model once they understand its requirements, it can be recommended to patients suffering from diabetes and other chronic diseases.

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