Loddon Mallee Region Primary Care Partnerships
Improving the Management of Chronic Conditions and Complex Issues

This paper provides background for those organisations participating in provision of chronic illness care in the Loddon Mallee Region. It gives an overview of the six interdependent elements of the Wagner Chronic Care Model to consider when redesigning care. The paper does so by exploring the elements Expanded Chronic Care Model (Barr et al, 2003), and has been adapted from the DH Hume Region resource (2014). The goal of these models is to deliver care that is safe, effective, timely, person-centred, efficient and equitable. Effective chronic illness care is characterised by productive interactions between activated consumer, family and caregivers and a prepared multidisciplinary health care team.

The double-sided paper **'Expanded Chronic Care Model (ECCM)'** explores the elements of The Health System and The Community. The four areas of clinical practice that influence the ability to deliver effective chronic illness care are also explored; Self Management Support, Delivery System Design, Decision Support and Clinical Information Systems.

The double-sided paper **'The Expanded Chronic Care Model and the Assessment in Chronic Illness Care (ACIC)'** explore the ACIC in conjunction with elements and examples of the ECCM. It also explores the Continuous Improvement concept and explores the 'Plan Do Study Act' (PDSA) Cycle as a tool.

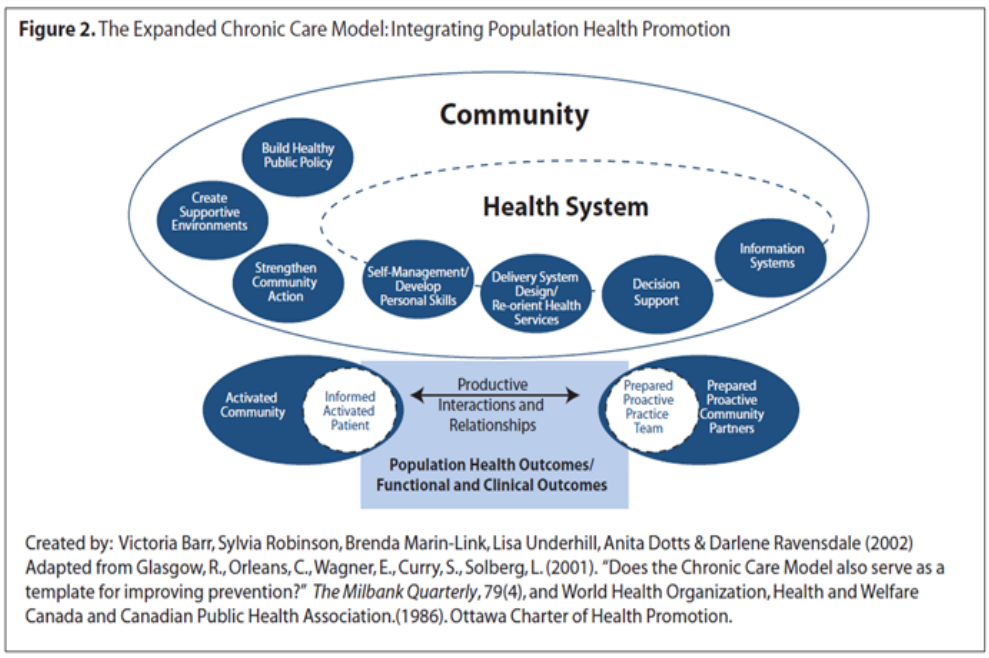

Fig 1. The Expanded Chronic Care Model

Health System

Create a culture, organisation and mechanisms that promote safe, high quality care

- A system seeking to improve chronic illness care must be motivated and prepared for change throughout the organisation, with visible support at all levels of the organisation
- Senior leadership must identify care improvement as important work, and translate it into clear improvement goals and policies that are addressed through application of effective improvement strategies
- Provide incentives based on quality of care and promote effective improvement strategies aimed at comprehensive system change
- Effective organisations have an open and systematic handling of errors and quality problems to improve care. Preventative measures are taken by reporting and studying mistakes and making appropriate changes to their systems
- Develop agreements that facilitate care coordination, communication and data-sharing within and across organisations

The Community

Support and mobilise community resources to meet needs of patients

- Encourage consumers to participate in effective community programs to enhance care for its consumers. A health system might form a partnership with community groups to enhance the health of consumers.
- Form partnerships with community organisations to support and develop interventions that fill gaps in services, enhance the health of the community, and avoid duplication
- Advocate for policies to improve population health, including living and employment conditions that are safe, stimulating, satisfying and enjoyable. Local and state health policies, insurance benefits, consumer rights laws for persons with disabilities, and other health-related regulations also play a critical role in chronic illness care

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Areas of Clinical Practice

1. Self-Management Support

Empower and prepare consumers to manage their health and health care

- Emphasise the consumer's central role in managing their health so they foster a sense of responsibility for their health
- Effective self-management support strategies using a collaborative approach, providers and consumers work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way. (assessment, goal-setting, action planning, problem-solving and follow-up).
- Self-management support includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness—it can't begin and end with a class.
- Organise internal and community resources to provide ongoing self-management support
- Enhance skills for personal health and wellness, recognising that disease control and outcomes influence the degree of effectiveness of self-management
- Strategies in the community to complement strategies in the health system support personal and social development of individuals and groups. This increases options for people to exercise more control over their health (Barr et al. 2003)

2. Decision Support

Promote clinical care that is consistent with scientific evidence and consumer preferences

- Embed evidence-based guidelines into daily clinical practice and strategies to assist communities to stay healthy.
- Discuss and share evidence-based guidelines and information with consumers to encourage their participation, and so they can understand the principles behind their management.
- Integrate specialist expertise and primary care. The involvement of supportive specialists in the primary care of more complex patients is an important educational modality.
- Treatment decisions need to be based on explicit, proven guidelines supported by clinical research. Those making treatment decisions need ongoing training to stay up-to-date on the latest evidence, using best practice models of provider education that improve upon traditional continuing medical education.
- Guidelines must be integrated through timely reminders, feedback, standing orders and other methods that increase their visibility at the time that clinical decisions are made.

3. Delivery System Design

Assure the delivery of effective, efficient clinical care and self-management support

- Support individuals and communities in a more holistic way e.g. single page screener for health and social needs
- Determining the care required for the consumer and then defining key roles and distribute tasks among team members
- Processes to identify complex patients, using planned interactions to support evidence-based care, providing clinical case management services for complex patients
- Ensure regular follow-up by the care team is standard procedure
- Design care that is appropriate to the consumers cultural background and health literacy status

4. Clinical Information Systems

Organise consumer and population data to facilitate efficient and effective care

- A comprehensive clinical information system can enhance the care of individual consumer's by providing timely reminders for needed services, with the summarised data helping to track and plan care
- Data systems that provide timely reminders for providers and consumers; identify relevant subpopulations for proactive care; facilitate individual person centred care planning
- Sharing information with consumers and providers to coordinate care
- Monitor performance of practice team and care system
- Including community data to understand social and economic context within which health and other services are working. An information system can identify groups of consumer's needing additional care as well as facilitate performance monitoring and quality improvement efforts.

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ACIC is a survey tool used to assist organisations to measure themselves against the Chronic Care Model elements. The ACIC provides a guide and focus on quality improvement and helps to track progress over time demonstrating improvements in outcomes for clients with chronic and complex conditions. In 2014, Primary Care Partnerships across Victoria supported their members through this survey, and will do so again in 2016. Table 1 (c.f Barr et al., 2003) outlines the components of the original model to the expanded model of chronic care with examples of how these components may be demonstrated or measured.

Table 1. The *Expanded* Chronic Care Model

Components of the model	Meaning	Examples
Health System-Organisation of healthcare	Program planning that includes measureable goals for better care of chronic illness. Create a culture, organisation & mechanism that promotes safe, high quality care	Formal Agreements with partner agencies. Annual accreditation processes ** Organisation Health literacy policy*
Self-Management Support ***Develop Personal Skills**	Emphasis on the importance of the central role that consumers have in managing their own care ** Enhancing skills and capacities for personal health and wellness.*	Goal directed care planning ** Establishment of community gardens and kitchens.*
Decision Support ***Decision Support**	Integration of evidence based guidelines into daily clinical practice **Integration of strategies for facilitating community's abilities to stay healthy*	National Evidence Based Guidelines for management of Type 2 Diabetes ** Development of Health Promotion & prevention best practice guidelines*
Delivery System Design ***Re-orient Health Services**	Focus on teamwork and an expanded scope of practice to support chronic care ** Expansion of mandate to support individuals and communities in a more holistic way*	Shared care planning ** Emphasis in quality improvement on health & quality of life outcomes* *Eg Victoria use SCTT12 Single Page Screener for Health and Social Needs*
Clinical Information Systems ***Information Systems**	Developing information systems based on population health data to provide relevant client data ** Creation of broadly based information systems to include community data beyond the healthcare system*	Client list and recall process Proactive care for vulnerable groups • *Use of broad community needs assessment considering poverty rates, public transport, crime rates*
Community Resources and Policies ***Build Healthy Public Policy** ***Create Supportive Environments** ***Strengthen Community Action**	Developing partnerships with community organisations that support and meet the needs of consumer's ** Development and implementation of policies designed to improve population health* ** Generating living and employment conditions that are safe, stimulating, satisfying and enjoyable* ** Working with community groups to set priorities and achieve goals that enhance the health of the community*	Linking consumer's to community based programs ** Partner with local council to advocate/ develop smoking bylaws, walking trails, restrict new fast food outlets* ** Development well lit streets & bicycle paths, community gardens* ** Support the community in addressing the need for safe affordable housing.*

Black= included in the original chronic care model ***Orange** = elements added to achieve the expanded chronic care model*

References

Barr, V, Robinson, S, Marin-Link, B, Underhill, L, Dotts, A, Ravensdale, D, & Salivaras, S, (2003), The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model, *Hospital Quarterly*, 7 (1), p. 73-82

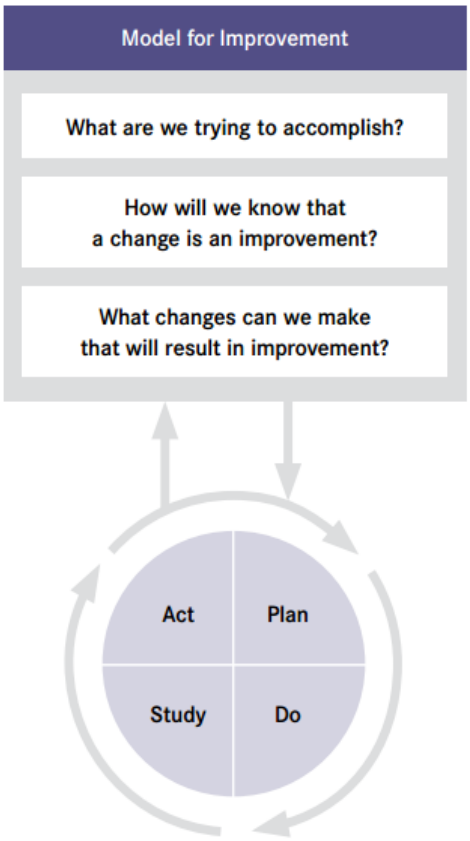
The MacColl Institute. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's Mac Coll Institute for Healthcare Innovation". http://www.improvingchroniccare.org/index.php?p=the_chronic_care_model

Victorian Department of Health; Hume Region (2014) The Expanded Chronic Care Model. Accessed online at http://www.health.vic.gov.au/regions/hume/toolkit.htm

Victorian Department of Health (2012) Continuous Improvement Framework. Accessed online at http://www.health.vic.gov.au/pcps/downloads/continuous.pdf

Quality Improvement

As a result of conducting the ACIC, areas for improvement can be identified. These for improvement can be prioritized and broken down into small Plan Study Do Act (PSDSA) Cycles. For more information on PDSA cycles, see the Continuous Improvement Framework (Victorian Department of Health, 2012)



Reference: Langley G. Nolan K. Norman C. Provost L (1996), *The improvement guide: a practical approach to enhancing organisational performance,* Jossy Bass Publishers, San Francisco.