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

Supporting individuals with chronic conditions and complex issues requires a comprehensive and integrated service system response. E. H. Wagner (1998) describes six essential and integrated elements that underpin system improvements; these are outlined in the MacColl Institute Chronic Care Model (CCM):

Organisational (system) support – create a culture, organisation and mechanisms that support and promote safe, high quality service delivery, e.g. visible senior leadership

Community (capacity building) – mobilise community resources, develop skills, create linkages, and engage the community to build healthy public policy, create supportive and healthy environments, and strengthen community action

Self-management support – create service models and practices that support, include and emphasise the central role of individuals being active in and responsible for their own health

Decision support – provide access to and promotion of current evidence based information and practice guidelines, protocols, and specialist consultations

Delivery systems [re]design – develop practices and processes that transform the system from reactive to proactive with a focus of maintaining health and wellbeing, including: standardised procedures, health literacy, cultural sensitivity and person centred practices

Clinical Information systems – develop systems to enable the collection and organisation of individual and population data, and processes that support and track clinical interventions or management and enable ongoing monitoring, e.g. reminder recalls.

Measuring change is through the lens of the specific 'change concepts' (dot points) within each of the CCM elements. Agencies can audit and monitor the progress of their systems change using the Assessment of Chronic Illness Care (ACIC). 'Improvement Teams' or 'Breakthrough Collaboratives' can collectively drive local change initiatives, refer to Steps for Improvement

Developing an Improvement Action Plan based on the ACIC audit can be supported through the Plan-Do-Study-Act (PDSA) improvement model which utilises 'change teams' and small rapid change and feedback cycles to evoke quality improvement and systems change within organisations. These improvement cycles can be integrated within Accreditation and Quality Improvement activities.

An enhanced version of the CCM, *The Expanded Chronic Care Model*, was developed by Barr et al (2003) which integrates population health promotion, and so expands the model to be inclusive of the health continuum. There are other models such as the *Tri-level model of self-management and Chronic Care* that describe and build on the chronic care model.

The first CCM principle emphasises person-centred approaches: this can provide a lens to focus action and a guide for achieving quality, safety, promptness, effectiveness, efficiency and equity. Feedback surveys, such as the PACIC (Patient Assessment of Care for Chronic Conditions), are key and can be integrated within Accreditation and Quality Improvement activities.

In addition, there are a range of resources that support self-management and consumer engagement, for example the Robert Wood Johnson Foundation and Health Issues Centre toolkits to support the development of consumer advisory committees and involve consumers in health care.

References

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Institute for Health Improvement (IHI), Model for Improvement: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

The Expanded Chronic Care Model: http://www.primaryhealthcarebc.ca/pdf/eccm_article.pdf

The Tri-level Model of Self-Management and Chronic Care: http://www.improvingchroniccare.org/index.php?p=Tri-Level_CCM&s=154

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Health Issues Centre, *A Toolkit for Consumer Participation and Engagement* (2013): http://www.healthissuescentre.org.au/documents/items/2013/08/885165-upload-00001.pdf

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