On Common Ground
an Alliance for Integrating Chronic Disease Management in Hume

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The landscape 2009..

- EliCD funded programs
  - Goulburn Valley Health
  - Northeast Health & Ovens and King CH
  - Moira Consortia – 5 organisations
  - Benalla Health

- Additional ICDM projects
- PCP/HACC/Workforce changing focus..
- A lot of common ground!!
The long view …

- 2009 Initial regional group convened – cross sector representation – PCP, ELiCD, HACC, GP Divisions
  - information sharing
  - opportunities to align effort and messages to sector
  - workforce and skill development
- Realised a complex space
- Lobbied for a regional approach –
  - Think-tank of key stakeholders
  - Evidence of need for strategic approach
- Advocated to Health Service CEOs
- Regional Steering Committee established
- Chronic Care Strategy 2012-2022 developed.
Operational alignment…

- 2011 need **Alliance** of PCP, EliCD & DH
- Meetings reconvened with new focus & membership
- For PCP and EliCD coordinator positions:
  - Reduce duplication of effort
  - Provide colleague support
  - Develop regional approach in best practice
  - Understand EliCD projects/work
- Consistency for all PCPs/agencies
- Facilitate and align effort with ‘one voice’
Alliance Terms of Reference Goals

• Act as reference group for Hume PCP ICDM and EliCD activity
• Support implementation Hume Chronic Care Strategy 2012-22
• Facilitate skills development for ICDM
• Develop regional approach to embed Self Management Support practice
Our Processes

- Face to Face or Teleconference
- Notes of meeting with actions
  Share and delegate roles
- Rotation of meeting organiser, notetaker & convenor
- Shared dropbox created.
- Use of regional WIKI space
- Advocacy with one voice
- Report to Chronic Care Strategy
## Identified areas & outcomes

<table>
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<tr>
<th>Identified area</th>
<th>Outcome/action</th>
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<tr>
<td>Work force capacity</td>
<td>Regional training Aug/Nov 2012&lt;br&gt;Health Coaching: 65 participants&lt;br&gt;West Hume Training: GVPCP, LHPCP Sept 2014&lt;br&gt;Asking Better Questions: 40 participants</td>
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<td>Reporting requirement skills development</td>
<td>Writing skills - Regional workshop PCP staff April 2013 – 32 participants (IHP, ICDM, EOs, DH)</td>
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<td>Lack of standardised information</td>
<td>Hume region ‘help’ sheet CCM &amp; ACIC</td>
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<td>Accountability of services</td>
<td>Regional Reporting Dashboard for Health Services – includes areas of ICDM and e-health – CEO buy in.</td>
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<td>Staff isolation and lack of confidence in driving change</td>
<td>Gap filled through Alliance meetings, collegiate sharing and support, planning together.</td>
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The Expanded Chronic Care Model

The Chronic Care Model was developed by Ed Wagner, and is often known as the ‘Wagner Model’. (Image on the left).

This paper provides an overview of the expanded chronic care approach that considers prevention and health promotion in the model of care.

Effective chronic illness care is characterised by productive interactions between activated patients (family & caregivers) and a prepared practice team.

At the level of clinical practice, four areas (elements of care model) influence the ability to deliver effective chronic illness care; self-management support, delivery system design, decision support and clinical information systems.

The goal is to deliver care that is safe, effective, timely, patient-centered, efficient and equitable.

There are six interdependent elements to consider in redesigning care. These are outlined in summary in this document.

### Health System

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

- Visibly support improvement at all levels of the organisation, beginning with the senior leader.
- Promote effective improvement strategies aimed at comprehensive system change.
- Encourage open & systematic handling of errors & quality problems to improve care (Barr et al. 2003).
- Provide incentives based on quality of care.
- Develop agreements that facilitate care coordination within and across organisations (Barr et al. 2003).

A system seeking to improve chronic illness care must be motivated and prepared for change throughout 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, including use of incentives, that encourage comprehensive system change. Effective organisations try to prevent errors and care problems by reporting and studying mistakes and making appropriate changes to their systems. Breakdowns in communication and care coordination can be prevented through agreements that facilitate communication and data-sharing as patients navigate across settings and providers.

### Table 1. The Expanded Chronic Care Model

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<tr>
<th>Components of the model</th>
<th>Meaning</th>
<th>Examples</th>
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<tr>
<td>Health System - Organisation of healthcare</td>
<td>Program planning that includes measurable goals for better care of chronic illness.</td>
<td>Formal Agreements with partner agencies. Annual accreditation processes.</td>
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<td>Self-Management Support</td>
<td>Create a culture, organisation &amp; mechanism that promotes safe, high quality care.</td>
<td>*Organisation Health literacy policy</td>
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<td>*Develop Personal Skills</td>
<td>Emphasis on the importance of the central role that patients have in managing their own care.</td>
<td>Goal directed care planning</td>
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<td>Decision Support</td>
<td>Integration of evidence based guidelines into daily clinical practice.</td>
<td>*Establishment of community gardens and kitchens</td>
</tr>
<tr>
<td>*Decision Support</td>
<td>Integration of strategies for facilitating community’s abilities to stay healthy.</td>
<td>National Evidence Based Guidelines for management of Type 2 Diabetes</td>
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<tr>
<td>Delivery System Design</td>
<td>Focus on teamwork and an expanded scope of practice to support chronic care.</td>
<td>*Development of Health Promotion &amp; prevention best practice guidelines</td>
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<td>*Re-orient Health Services</td>
<td>Expansion of mandate to support individuals and communities in a more holistic way.</td>
<td>Shared care planning</td>
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<td>Clinical Information Systems</td>
<td>Developing information systems based on patient populations to provide relevant client data.</td>
<td>*Emphasis in quality improvement on health &amp; quality of life outcomes</td>
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<tr>
<td>*Information Systems</td>
<td>Creation of broadly based information systems to include community data beyond the healthcare system.</td>
<td>Eg Victoria use SCTT12 Single Page Screener for Health and Social Needs</td>
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<td>Community Resources and Policies</td>
<td>Developing partnerships with community organisations that support and meet the needs of patients.</td>
<td>Client list and recall process</td>
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<td>*Build Healthy Public Policy</td>
<td>Development and implementation of policies designed to improve population health.</td>
<td>Proactive care for vulnerable groups</td>
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<td>*Create Supportive Environments</td>
<td>Generating living and employment conditions that are safe, stimulating, satisfying and enjoyable.</td>
<td>*Use of broad community needs assessment considering poverty rates, public transport, crime rates</td>
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<td>*Strengthen Community Action</td>
<td>Working with community groups to set priorities and achieve goals that enhance the health of the community.</td>
<td>Partner with local council to advocate/develop smoking bylaws, walking trails, restrict new fast food outlets</td>
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*Orange = elements added to achieve the expanded chronic care model.  
*Black= included in the original chronic care model.
Partnership goal 2013–17
To strengthen collaboration and integration across sectors by 2017

In order to:
- maximise health and wellbeing outcomes
- promote health equity
- avoid unnecessary hospital presentations and admissions.

How

Guiding principles
- Tackling health inequities
- Person and family centred
- Evidence based and informed
- Cross-sector partnership
- Accountable governance
- Wellness focus
- Sustainability

Client and community empowerment
- Support member agencies to deliver the following areas:
  - Meaningful community participation
  - Self management (including Wagner approach)
  - Health literacy
- Enablers:
  - Governance
  - Partnerships
  - Workforce
  - Client and community engagement
  - e-Health
  - Continuous quality improvement

Prevention
- Support member agencies in:
  - Integrated health promotion planning with key agencies – must include local government and community and women’s health
  - Primary and secondary prevention activities
  - Use of integrated health promotion indicators.
- Enablers:
  - Governance
  - Partnerships
  - Workforce
  - Client and community engagement
  - e-Health
  - Continuous quality improvement

What

Early intervention and integrated care
- System focus
  - Integrated system (including the Wagner model)
  - Respond to access demands and community need
  - Service coordination
  - Multidisciplinary care
  - Local agreements
- Enablers:
  - Governance
  - Partnerships
  - Workforce
  - Client and community engagement
  - e-Health
  - Continuous quality improvement

Who

Example stakeholders
- Commonwealth, state and local government
- Health and human services, non-government organisations, peak bodies, researchers, private sector, education providers and others
- Local communities, families, individuals, carers

Where

Social determinants of health
- Upstream
  - Early years
  - Education (including literacy)
  - Food security
  - Employment and working conditions
  - Income
  - Housing
  - Transport
- Prevention priorities
  - Health promotion
  - Tobacco control
  - Oral health
  - Alcohol and drug misuse
  - Sexual and reproductive health promotion
  - Mental health promotion
  - Injury prevention
  - Skin cancer prevention

Priority conditions
- Downstream
  - Arthritis
  - Heart disease
  - Cancer
  - Osteoporosis
  - Stroke
  - Diabetes
  - Depression or anxiety
  - Respiratory conditions (including COPD and asthma)
  - Renal conditions
Challenges & Learnings

• Part-time workers – time challenged
• Struggled at times – drowned in detail…
• Waited and state project lagged…we timed out!!
• Had to get real and say now to lots of great ideas – out of scope, no time, no spare cash !!
• At times one PCP pressed on to deliver work without achieving an ‘all of region approach’

• Always brainstorm options with others
• Always consider other methods or approaches
• It’s better to negotiate and find common ground than to go it alone !!!
• Feels better to share the pain and Celebrate the gain.
Take an eagle’s view … find common ground.
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