The **Systems and Policy** context for delivering chronic care

**CONTEXT**
- Chronic Care Models
- Chronic Care Pyramid
- Balance of Care
  - Professional Care vs. Self-Management
- National Chronic Disease Strategy
- WA Health Models of Care
- WA CC/CCSM Frameworks++
- Health Services (NMHS)
- NGOs, Local Governments…
- Communities

**LEVEL**
- INTERNATIONAL
- NATIONAL
- STATE
- COMMUNITY
The Chronic Care Model (CCM)

The Chronic Care Model (Wagner et al. 1999)

CCM around the World

USA

CANADA

GERMANY

DENMARK

QUEBEC

FINLAND

RUSSIA

Washington USA
• The ICCCF places consumers, carers and health teams at the centre of chronic care.

• The ICCCF provides the basis for WA Health Models of Care

Source: www.who.int/diabetesactiononline/about/ICCC/en

Definitions

**Self-management** is ‘the active participation by people in their own health care’.

**Self-management support** is what health providers, organisations and the community does to assist people living with chronic conditions to better ‘self manage’.
Innovative Care for Chronic Conditions Framework

Positive Policy Environment

1. Consumer
2. Health Care Providers
3. Health System
4. Community

Links

Community Partners

Health Care Organization

Health Care Team

Patients and Families

Self-Management Support

Better Outcomes for Chronic Conditions

www.who.int/diabetesactiononline/about/ICCC/en/
Definitions Continued

The **self-management approach** emphasises the **consumer’s central role** in managing their health anywhere along the care continuum;

**Self-management programs and services** offer consumers the **knowledge, skills and resources** to help them better manage their health.

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Self-management is ‘the active participation by people in their own health care’. Self-management support is what health providers, organisations and the community does to assist people living with chronic conditions to better ‘self manage’.

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**Chronic Condition Pyramid**

Based on: UK Department of Health (2005) Improving chronic disease management [Kaiser Permanente Care Management Institute, California, USA]
**Ideal Balance of Care**

- Complex Care with comorbidities
- Higher Risk Cases
- Diagnosed and Stable
- At Risk, Undiagnosed and Well population

High proportion of professional care
Equally shared care
High proportion of Self Management/Care

Adapted from ‘Shifting the Balance of Care’, Scotland.

**Actual Balance of Care**

- Complex Care with comorbidities
- Higher Risk Cases
- Diagnosed and Stable
- At Risk, Undiagnosed and Well population

High proportion of professional care
Equally shared care
High proportion of Self Management/Care
Paradigm Shift required

1900’s thinking vs. 2000’s mission

"Industrial age" health vs. "information age" healthcare

Time

Limited Resources and Time

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LEVEL

INTERNATIONAL

NATIONAL

STATE

COMMUNITY
National Chronic Disease Strategy

**ACTION AREAS:**

1. **Prevention** across the continuum
2. **Early** detection and treatment
3. **Integration** and **continuity** of prevention and care
4. **Self-Management**
Multi-level, multi-component, system-wide, across the care continuum approach

- Culture
- Awareness
- Services
- Knowledge and Skills
- Tools and Resources

Provide direction and resources
Create referral pathways and ensure access
Programs and services addressing population needs
Build capacity
Evaluation and Research
NMHS CCSM : K.BISCHOFF  
Sept 2013

CCSM PRINCIPLES:
- Holistic practice
- Person-centred approach
- Partnership with HP
- Participation by client, carers
- Shared responsibility for outcomes
- Client empowerment and enhanced capacity
- Co-ordination of care
- Quality Information
- An ongoing, lifelong approach to health and self care.

WA Strategic Framework for Safety and Quality in Health Care 2008 -2013
WA Health Clinical Services

Focus areas include:
- Safety and Quality
  - Client-centred approach
- Address / Redistribute Demand
  - Inpatient
  - Outpatient
  - Emergency Department
- Clinical Services Redesign
- Transitional & Referral pathways
- FINE / OPI
- Sub-acute care services
- Ambulatory care services
- Activity based measures etc.

WA Health Models of Care

Key Focus Areas:
1. Prevention & Promotion
2. Early Detection & Intervention
3. Integration & Continuity of Care
4. Self-Management
WA Health Models of Care

- Multi-level
- Multi-component
- System-wide
- Across the continuum
Safety and Quality Accreditation

NSQHS Mandatory Accreditation Standard

2.6.1 Clinical leaders, senior managers and the workforce access training on
patient-centred care and the engagement of individuals in their care (=Self-Management Support).

NMHS Public Health & Ambulatory Care

... To provide connected, person-centred health care

Progression of Condition

Healthy | Well of Risk | Engaged (Mod) | Engaged (High) | Engaged (Risk) | Engaged (Evolution/Out)

Transitioning and supporting clients to keep healthy at home and in the community
## Context

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### Local Governments, NGOs, Carers, Families and the Community

- Public Health Plans
- Programs & Services
- Peak bodies
- Medicare Locals
- Support Groups
- Promotion/Prevention
- Schools, Centres
- Planning, Parks
- Environment factors
- Resources, Directories
- Media etc
In Summary
Reconciling Agendas

SYSTEM/ORGANISATIONAL LEVEL:
Managing limited resources

CONSUMER LEVEL:
Quality of Life

PRACTICE LEVEL:
Delivering evidence-based quality care

Chronic Care

A multi-level, multi-component, system-wide approach, across the continuum of care.