Stay Well, Stay Home Chronic Conditions Breakthrough Series Collaborative

Charter

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Background information

Chronic disease is one of the greatest burdens on our health care system with 1 in 2 Australians having one or more of the leading 10 chronic conditions [1]. In 2018, 89% of deaths were associated with these 10 leading conditions [1]. Whilst there have been multiple attempts to improve management of chronic disease there continues to be a variation in care received by patients. There is a disproportionate burden of chronic diseases in Aboriginal and Torres Strait Islander communities, rural and remote areas, and in culturally and linguistically diverse minority groups [4,7,8, 9,10]. The National Strategic Framework for Chronic Conditions, 2019, states that the current health care system struggles to optimise the care of long-term conditions [11]. Patients experience uncoordinated and fragmented care resulting in increased complications, hospital admissions and re-admissions, causing a negative impact on quality of life.

The Stay Well, Stay Home Chronic Conditions Breakthrough Series (BTS) Collaborative will focus on asthma, Chronic Obstructive Pulmonary Disease (COPD) and diabetes. These diseases sit within the top ten most prevalent chronic diseases experienced by Australians between 2020-21 [5]. These diseases are associated with high rates of potentially avoidable hospital admissions, 80% of asthma admissions are classified as potentially avoidable, while COPD account for 8%; and diabetes account for 7% of all-cause avoidable admissions, [3, 4, 6]. Whilst these figures have a direct impact on hospitals, they also have a significant impact on the individual with days missed actively participating in life (family, work, leisure). Disease related complications result in irreversible physiological changes, progression of disease and/or increased mortality.

The opportunity to improve systems performance to enhance patients' quality of life and reduce risk of complications is high. For asthma, COPD, and diabetes there is robust research in support of evidence-based guidelines and care plans for each condition that have been shown to facilitate stable disease, slow progression and reduce presentations to emergency departments.

Safer Care Victoria is looking to build on existing improvement efforts in Victoria and to accelerate implementation of best practice. Utilising our partnership with the Institute for Healthcare Improvement (IHI), the Chronic Conditions Breakthrough Series (BTS) Collaborative will further test and spread the success of evidence-based care to reduce avoidable disease-specific complications.

This Collaborative is designed for health services that are committed and ready to improve the management of asthma, COPD, and diabetes. Participation is open to all public, private, primary health services and community health services and is free. A health service can sign up for one condition or all three to meet the capacity and needs of their service. This is an opportunity to embed evidence-based change ideas that improve management and increase time spent in the community for people living with COPD, asthma, and diabetes.

What are we trying to accomplish?

The Stay Well, Stay Home Chronic Conditions Breakthrough Series (BTS) Collaborative will work with health services to test changes within their health service that will reduce variation in the management of asthma, COPD, and diabetes across Victoria.

The aim for this collaborative is:

- By 31 December 2023, we will improve the lives of people living with asthma, COPD, and diabetes in Victoria by reducing avoidable disease specific related complications by 20%. *

Our goal is to:

- Reduce preventable COPD readmissions, asthma emergency presentations, improve the stability of HbA1C in diabetic patients, improve patient experience of healthcare, and improve patient activation (PAM)*

How will we achieve this?

- By focusing on the primary drivers, evidence-informed care, one care team (integrated care), and patient self-management, to enable people to Stay Well and Stay Home.

**The aim and goals will be refined as we test the theory of change and analyse health services baseline data.*

What changes can we make that will result in an improvement?

In this Collaborative, teams will focus on these critical drivers to deliver care and generate their respective change ideas:

- **Evidence Informed Care:** patients receive care through patient focused systems, that aim to reduce the variability in the management of chronic conditions at every point of care, every time. Care is standardised through evidence-based pathways.
- **One Care Team (Integrated Care):** patients, caregivers and staff will be better supported during transitions of care between health providers. Identifying and strengthening local healthcare partnerships to ensure the integration of care will be a priority for this work.
- **Patient Self-Management:** building knowledge, skills and confidence to self-manage their health and navigate the healthcare system, supports the delivery of patient centred care. Validated tools, care planning and shared decision making will be fundamental. Measuring a patient's level of activation enables clinicians to individualise care to support self-management. Safer Care Victoria have obtained a licence for participating health services to freely access and use The Patient Activation Measure (PAM) with their patients. For more information on the PAM, click here.

This Collaborative has patient experience at the centre of its design and joins the expertise of context and content experts together with people who have lived experience. The Collaborative aims to harness the power of a prepared, proactive healthcare team together with informed and activated consumers.

True partnerships between patients, caregivers, community providers, and hospital staff/clinicians will better detect and manage risk factors to prevent avoidable readmissions and will support better management of personal care in patients' home and community settings. A critical aspect of this work is to understand our patients and their lives beyond a 'problem list', understanding their priorities, needs, and what matters most to them to inform care and care planning (based on culture and values). This includes understanding personal, social, financial needs, values and beliefs that may impact their self-care practices. As chronic disease disproportionally impacts older people, culturally and linguistically diverse people, and Indigenous people, it is important that teams identify, understand, and adequately consider the needs of these groups throughout the collaborative. Applying an equity lens will be central to this work.

A family of related measures for the above will be shared and refined by participating services, as measurement is a critical part of the Stay Well, Stay Home Chronic Conditions Breakthrough Series (BTS) Collaborative. These measures will help teams evaluate the impact of the strategies and interventions tested and adapted throughout the initiative and will be used to assess progress toward the Collaborative goals.

How are we going to achieve this together?

Safer Care Victoria will partner with health services to use the Model for Improvement to achieve the Stay Well, Stay Home chronic conditions aim.

A Breakthrough Series (BTS) Collaborative model (Figure 1.) will be used to test and implement evidence-based change ideas to accomplish a common aim. This involves three in-person learning sessions (or equivalent virtual sessions), and three health service-based action periods, where changes are tested and adopted, adapted, or abandoned. Teams maintain continual contact with each other and SCV through virtual calls, web-based platform, online discussions, email, and monthly progress reports.

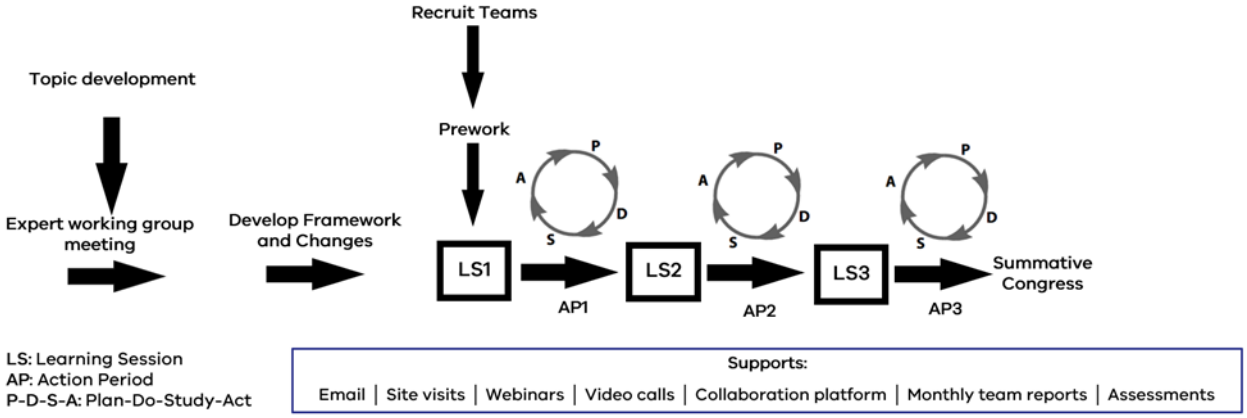

Figure 1: The Breakthrough Series (BTS) Collaborative model

What can you expect from us?

Safer Care Victoria and the Collaborative faculty will:

- Provide a Collaborative Lead, Improvement Advisor, and coaching support in addition to faculty who have expertise in the subject matter and improvement methods.
- Provide information on subject matter, application of that subject matter, and methods for process improvement, both during and between learning sessions.
- Support knowledge management of promising changes and action toward results through Collaborative models (i.e., theory of change, measurement strategy, and evidence-based tools and resources).
- Provide communication strategies to keep teams connected to the Collaborative faculty and colleagues.
- Provide access to an online system for data reporting, access to Collaborative resources and communication.
- Review team reports and analyse data providing guidance and feedback, including overall Collaborative learning and development.
- Foster growth and development of improvement capability and capacity.

What will we expect from you?

Participating organisations are expected to:

- Designate a senior leader as an executive/senior sponsor who will:
  - Connect the goals of the Collaborative to a strategic initiative in their organisation.
  - Support the core team to attend all learning sessions (three, two-day in-person sessions or virtual equivalent) and monthly coaching calls.
- In our experience, optimal results are achieved by:
  - Identify a care team leader
  - Forming a core project team, this team may include clinicians (e.g., medical, allied health, nursing, pharmacy), people with lived experience and members with quality improvement experience and be responsible for identifying champions and driving change on the ground.
  - Forming a wider team who can influence and drive commitment and attention to the work and support frontline staff to test changes, for example managers, health information system members and
  - Complete a health service charter, setting aims and goals for the project team.
  - Hold regular team meetings with you executive/senior sponsor
  - Test changes using rapid Plan-Do-Study-Act cycles.
  - Collect data over time to inform changes.
  - Share ideas and learnings with others.
  - Complete and share reports monthly.
  - Attend monthly virtual calls.
  - Attend and participate in-person learning sessions with other participating services.

High performing improvement teams include:

Role	Responsibility
Executive sponsor/Senior sponsor	• Accountable for your organisation's participation in the initiative, ensuring it aligns with organisational values and strategic plan, and the delivery of project outcomes (ongoing). • Visible champion of the project with the management team and is the ultimate decision-maker, with final approval on all phases, deliverables, and project scope changes.
Team Leader/ Care setting lead	• Leader in the care setting (e.g., ward or cohort), and represents the disciplines involved and works effectively with clinicians, other technical experts, and leaders within the organisation. • We recommend placing the manager of the care area where changes are being tested in this role.
Improvement Advisor (person with quality improvement experience)	• This person supports quality improvement, improvement methodology, measurement strategy and data collection. • This person, and the rest of the team, will be supported in developing their capability in improvement methodology by SCV and IHI Improvement Advisors.
Clinical champions (relevant medical, nursing, allied health staff including pharmacy).	• These individuals may include a General Practitioner, physician, medical staff, nurse, physiotherapist, occupational therapist, social worker, pharmacist, nurse practitioner, clinical nurse specialist. • We strongly encourage interprofessional representation on your team and urge you to enlist more than one clinical champion. • These champions should have good working relationships with colleagues and be interested in driving change. • You will need 3-5 clinical champions to achieve the best outcomes.
Consumer representative/lived experience leader	• We recommend each team partner with a minimum of one person with lived experience.
Wider team members	• Influencers in the organisation who can drive commitment and attention to the work and support the frontline clinicians to test and measure changes. These members do not need to be registered. You will need 6-12 wider team members to achieve the best outcomes

***Team members may hold more than one role.**

The advantage to this team approach is that improvements are designed and implemented by local, frontline teams involved in the day-to-day work to achieve sustainability.

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