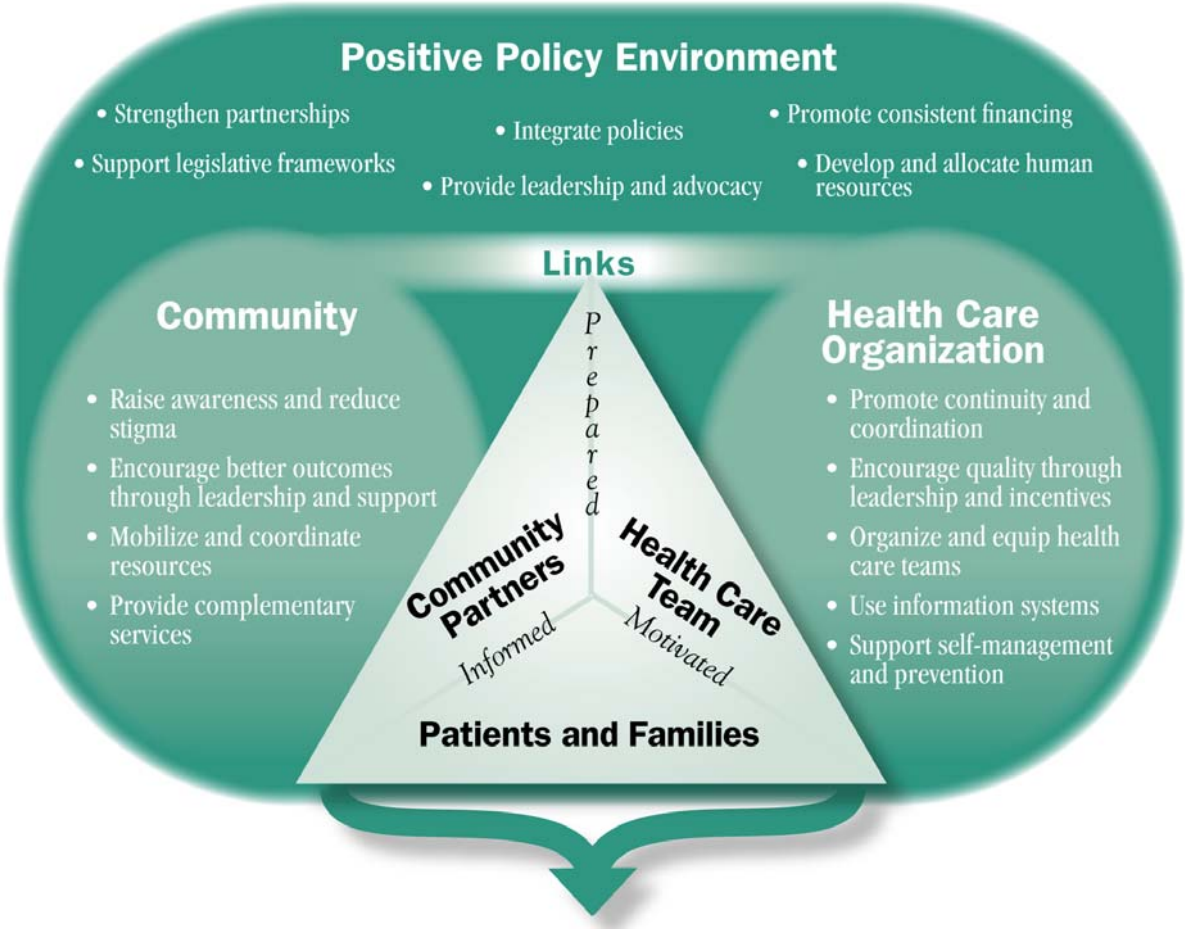
Innovative Care for Chronic Conditions Framework



Building Blocks at the level of the Triad (micro level of care)

The triad at the centre of the *ICCC Framework* consists of the patient and family, community partners, and the health care team. Whereas successful outcomes for acute health problems can occur with a single health care provider, positive outcomes for chronic conditions are achieved only when patients and families, community partners, and health care teams are informed, motivated, prepared, and working together. The triad is influenced and supported by the larger health care organization and by the broader community, which in turn influence, and are influenced by, the broader policy environment.

Building Blocks for the Health Care Organization (meso level of care)

Health care organizations can create an environment in which efforts to improve health care for chronic conditions take hold and flourish. Several organizational factors, including health care workers' skills, personnel mix, visit schedules, information systems and patient self-management make a difference in outcomes.

Promote continuity and coordination.
Patients with chronic conditions need services that are coordinated across levels of care - primary, secondary, and tertiary care - and across providers. Follow-up visits should be scheduled: planned care permits the early detection of complications and the swift identification of decline in patients' health status.

Encourage quality care through leadership and incentives.
Incentives for administrators, health care workers, and patients can be re-aligned; rewards for effective clinical processes that affect management and prevention of chronic problems can be established. Ongoing quality monitoring and quality improvement projects should become routine activities among all health care workers. The quest for quality must emerge as part of the organizational culture. Health care leaders play a pivotal role in creating an environment that values quality.

Organize and equip health care teams.
Health care teams need necessary supplies, medical equipment, laboratory access, and essential medications to provide care that is informed by scientific evidence. Teams require support to make optimal decisions, including written guidelines of care, and diagnostic and treatment algorithms. Health care teams also need special skills and knowledge that extend traditional biomedical training, such as effective communication abilities, expertise to help patients initiate new self-management techniques, adhere to complex regimens, and support patients in their efforts to maintain change over the long-term course of the condition.

Support self-management and prevention.
Effective self-management helps patients and families follow regimens in ways that minimize complications, symptoms, and disability associated with chronic problems. Patients and their caregivers need to be informed about self-management strategies and be motivated and skilled to implement them on a daily basis over the course of time.

Use information systems.
Timely information about individual patients, and populations of patients is a critical feature of effective care for chronic conditions. Information systems gather and organize data about epidemiology, treatment, and health care outcomes.

Building Blocks for the Community (meso level of care)

Community resources are vital to health care systems and to the management of chronic problems. Consider that persons with chronic conditions spend the vast majority of their time outside the walls of a health care clinic, living within their communities. Informed and prepared community resources can fill an important gap in services that are not provided by the health care organization.

Raise awareness and reduce stigma.
Leaders of local and international organizations, NGOs, and support and women's groups are perfectly positioned to raise awareness about chronic conditions and their associated risk factors. Community leaders can be "credible voices" for sensitizing the public to the rising burden of chronic conditions and for reducing the stigma associated with them. Leaders in the community also can lobby their political counterparts to enhance support for chronic conditions care.

Encourage better outcomes through leadership and support.
Recognized structures, such as community development/health boards or village development groups can advocate for better health care for chronic problems. The leaders of these boards and groups are in the position to explore the best strategies to support fellow community members who are living with long-term problems. When communities do not have established structures, other community leaders become involved in the decision-making that can influence care for chronic conditions.

Mobilize and coordinate resources.
Locally generated funds can greatly affect health-related activities at the community level. Health promotion and prevention campaigns, assessment of risk factors, training of community health workers, or supplying health centres with basic equipment and supplies are important activities that can occur through the mobilization of local groups.

Provide complementary services.
Local and international NGOs play an important role in providing complementary preventive and management services for a given community, along with the participation of the community members. Every community has an informal network of providers, such as community health workers and volunteers, who are invaluable in the management and prevention of chronic health problems.

Building Blocks for a Positive Policy Environment (macro level of care)

Policies are powerful means for organizing the values, principles, and general strategies of governments or administrative divisions to reduce the burden of chronic conditions. To optimize health care for chronic conditions, a positive policy framework is essential.

Provide leadership and advocacy.
Decision-makers can influence senior political leaders to advance care for chronic conditions.

Integrate policies.
Policies are most effective when they cut across boundaries of specific diseases, and when they emphasize the management of a defined population over the management of one patient at a time. They also are most effective when they encompass prevention, promotion, and control strategies, and when they make explicit links to other governmental programmes and community-based organizations.

Promote consistent financing.
In all cases, but particularly for chronic conditions, financing is most effective when it is consistent across all divisions of the health care system. It must be integrated across traditionally disparate disease categories, as well as levels of care and care settings such as primary health care and hospital-based care. Finally, financing must be structured so that resources can be maintained over time.

Develop and allocate human resources.
Education authorities have the ability to enhance care for chronic conditions through augmenting health care workers' training. In addition to upgraded curricula, mandated continuing education for health professionals in the specific area of chronic conditions can greatly advance health care for this problem. Policy and service planners, researchers, information technology designers, and support personnel are also needed to improve care for chronic problems.

Support legislative frameworks.
Legislation and regulations can reduce the burden of chronic conditions. Legislation also can protect the rights of people with chronic conditions.

Strengthen partnerships.
Within the policy environment, strong partnerships among government sectors have the potential to influence health and chronic conditions. Nongovernmental health sectors, such as private health care providers and charities can be influential as well. Connections with local governments and community entities such as religious groups, schools, and employers should also be examined and strengthened where necessary. NGOs should also be considered important partners in improving care for chronic conditions.

****

Guiding Principles of the ICCC Framework

- Evidence-based decision making
- Population focus
- Prevention focus
- Quality focus
- Integration
- Flexibility and adaptability

****

Levels for Improving Health Care

****

Eight Essential Elements for Taking Action

1. Support a paradigm shift
2. Manage the political environment
3. Build integrated health care
4. Align sectoral policies for health
5. Use health care personnel more effectively
6. Centre care on the patient and family
7. Support patients in their communities
8. Emphasize prevention

The Innovative Care for Chronic Conditions (ICCC) Framework is described fully in *Innovative Care for Chronic Conditions: Building Blocks for Action,* © World Health Organization, 2002, ISBN: 9241590173

Produced by WHO's Health Care for Chronic Conditions team (CCH)
Available at: http://www.who.int/chronic_conditions/icccreport/en/

The ICCC Framework is an expansion of the Chronic Care Model (CCM), which was developed by researchers from the MacColl Institute for Healthcare Innovation in Seattle, USA. Both models present a "road map" for organizing health care for chronic conditions. To better suit the context of international health care, the ICCC Framework is expanded from the CCM and places emphasis on policy and community level components of good care for chronic conditions.