

CARE FOR COMPLEXITY IN COMMUNITY HEALTH

THE 3C TRIAL

NOVEMBER 2023



Executive Summary

Project Summary

This study focused on new care pathways for people with (multiple) chronic health conditions (CHCs).

Traditionally self-management approaches are used, which focus on building individual capacity and self-efficacy. These can be overwhelming for disadvantaged and low-income populations, and in general for people with few resources.

The role of burden and capacity can help to explicate the challenges faced by this population. People need sufficient capacity, including social support, socioeconomic resources, and adequate mental/physical functioning, to cope with the workload, or burden, associated with living with a CHC, such as self-management tasks, health system interactions and other life demands. Limited capacity (e.g., poverty, social isolation) or overwhelming burden (e.g., multimorbidity) may reduce adherence and lead to disease escalation. In response to disease escalation, healthcare systems typically respond by intensifying treatment, increasing burden further and resulting in 'cumulative complexity'.

Minimally Disruptive Medicine (MDM) is a practical model of care that builds on the

concepts of burden and capacity. The key elements of MDM are: (1) to assess burden and capacity levels and (2) to undertake practical actions designed to reduce burden and/or increase capacity. Healthcare providers are typically trained in the use of this method before it is implemented in practice.

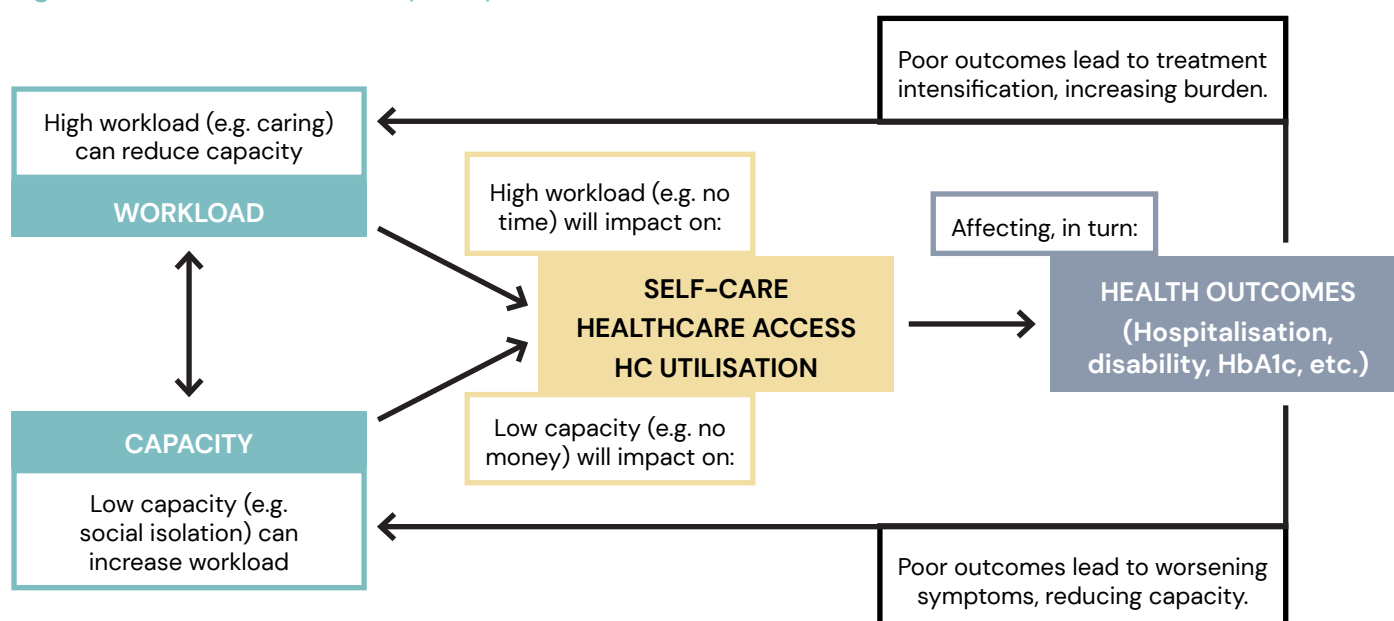
To introduce this new pathway, a trial was developed in Mildura at Sunraysia Community Health Services (SCHS). As a community health service, SCHS provides services for many clients experiencing multimorbidity and socioeconomic disadvantage.

Aims

This study aimed to assess:

1. The feasibility of a training programme for healthcare providers (HCPs) working in Chronic Disease Management, based on the principles of MDM.
2. The feasibility of an MDM approach to chronic disease management for rural community health clients with multimorbidity and social complexity.

Figure 1. The Cumulative Complexity Model



Methods

A two-stage intervention was introduced:

- Healthcare provider training in a model of care based on MDM.
- Trial an MDM model of care with community health clients by utilising several of the upskilled HCPs as care coordinators (CCs).

A feasibility study was undertaken, with mixed methods data collection. Feasibility outcomes were explored using the framework developed by Bowen et al., covering acceptability, demand, implementation, practicality, integration, and efficacy.

Results

Twenty-six clients participated in the trial and three care coordinators were involved. Both qualitative and quantitative data were collected and analysed.

- **Acceptability** was high amongst both clients and clinicians. Both groups stressed the importance of relationship building and clients greatly valued the sense of being cared for, listened to, given time, and befriended. For many clients this provided an increased sense of control over difficult circumstances. Clinicians valued the emphasis on burden and capacity and reported that this approach enabled them to step away from their disciplinary lens and gave them a deeper understanding of their clients' needs and priorities.
- In terms of **demand**, whilst fewer clients engaged than expected, there was a pattern of gradually increasing referrals into the CC program over the 9-month period. Those who engaged were a good fit for the intervention, with high levels of treatment burden, chronic health conditions (especially pain and mental health conditions), social isolation and financial stress reported.
- **Implementation** of the 3C trial was feasible. Review of trial documentation demonstrated fidelity to the burden-capacity focus. This focus was clear to clients and provided direction to clinicians. Important enablers included the supervisions and health literacy resource. Adapting the assessment and burden/capacity tools was discussed, although the overall model was considered to be a good fit for the clients and clinicians.
- The trial appeared to be **practical**. Much of the care coordination happened over the phone rather than face-to-face, and utilizing text and email messaging was helpful for clients and clinicians. Allowance for ongoing indirect time (which was highly variable between clients) and the availability of supervision/case conferencing were important components.
- **Integration** of the trial model into the organization longer term was enthusiastically supported by all CCs. The focus on burden and capacity, rather than care coordination per se, was felt to be the most important element. The focus group reported that skills in rapport building and listening were foundational for the CC role. Specifically, a willingness to step away from one's disciplinary boundaries and be open to the clients' needs and priorities, rather than maintaining preexisting ideas about what constitutes chronic disease self-management, was crucial. Clinicians had many suggestions to help integrate the model into the organization, which are listed under recommendations.
- There was limited exploration of **efficacy** given the small sample size and lack of a comparison group. Clients reported feeling less overwhelmed by their health conditions and experiencing an increased sense of control over their lives. The clinicians concurred with these observations. The quantitative outcome data trends suggest that the benefits described by clients may be helpful in reducing treatment burden and improving quality of life, which could be explored in a larger sample size over a longer time period.



Recommendations

Care coordination using an MDM model of care is feasible in the community health setting. More importantly the results show the importance of an embedded pathway with a focus on burden and capacity for clients with chronic health issues and multimorbidity. The sense of control clients experienced in this trial is exactly what self-management should be about.

Further work to embed pathways and explore how this can be supported and funded in SCHS is recommended. This would include:

- 01** Restructuring the intake process to enable easy identification of clients and direct referral into a CC program.
- 02** Reviewing internal referral processes to ensure that clients involved with CC are given priority access to other services.
- 03** Provide education about the CC role and the MDM model across the organization, especially to other clinicians involved in the clients' care. This could include working more closely and flexibly with teams who provide complementary services (e.g., community paramedicine), or see similar clients (e.g., mental health services).
- 04** Explore increased engagement with GPs and practice nurses. Consider having a referral pathway into a CC program that could be flagged as part of a GP management plan.
- 05** Adapt the care plan and ICAN tool, in conjunction with the CCs and the Mayo clinic, to develop a single tool appropriate for SCHS clients.
- 06** Refresher training in capacity-burden concepts is recommended, bolstered by the learnings on this trial.
- 07** Any CC program should include ongoing allocated time for case conferencing, supervision, and indirect consults to be used flexibly according to client needs.
- 08** Quantitative and qualitative evaluation of this approach should continue and be embedded in the model of care.

The 3C trial project is a post-doctoral project following the PhD undertaken by Dr Ruth Hardman.

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