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Editorial

From organisations to people: improving the prevention and management of long-term conditions in Australian primary health care

In 1996, the Chronic Care Model (CCM) was proposed to guide the health system to better meet the needs of people with chronic conditions (Wagner *et al*. 1996). The CCM describes six elements; delivery system redesign, self-management support, decision support, clinical information systems, community resources and health-care organisation, that are required to ensure that health systems, professionals and people with chronic conditions work proactivity together to improve health outcomes. All of the articles published in this issue further extend our understanding of this model in the Australian primary health-care context.

The commitment of health care organisations to provide proactive preventive care is a feature of the CCM. Hall and Christian (2017) describe a model for a health promoting dental service that involves a shift from a reactive surgical approach to a proactive preventive health approach. The impact of community resources on population wellbeing plans is explored by Alindogan *et al*. (2017), providing insight into the differences in priorities of local government areas and the need for this to inform broader state plans. Food insecurity in urban Aboriginal and Torres Strait Islander communities is discussed by Bramwell *et al*. (2017). They propose that an evidence base is required to inform a primary care approach to supporting Aboriginal and Torres Strait Island people experiencing food insecurity.

Medical professionalism and clinical governance are important features of highly performing health-care organisations. Four principles of medical professionalism in the context of care for Aboriginal and Torres Strait Islander people were identified from a study of the learning experiences of medical students and registrars by Askew *et al*. (2017). Despite being a requirement for Australian health services, Kwedza *et al*. (2017) found that clinical governance is poorly understood by people working in rural and remote primary care.

Delivery system design describes the structures of an organisation that support multidisciplinary teams to provide planned care. Nurses are important members of the practice team. People's experience of nurse case management of long-term conditions is explored by Askerud and Conder (2017). Their results suggest that a person's experience and quality of life is improved when they are case managed by nurses. People's experience of multidisciplinary care is further explored in the context of the person-centred medical home by O'Loughlin *et al*. (2017). Their results are more mixed, with improvements in some areas but not others, leading to a recommendation to improve ways to measure people's experiences. To *et al*. (2017) report on GP's beliefs and practices in relation to case conferences for people with palliative care needs and highlights the need for funding mechanisms to support involvement in multidisciplinary case conferencing.

Decision support describes the integration of evidence into clinical practice, including how this can be achieved through health professional education. Clinical information systems can be used to audit uptake of evidence into practice to enable clinicians to reflect on their performance. Meyer *et al*. (2017) identify that there is a need for community care health professionals to increase their awareness and understanding of evidence-based falls-prevention strategies for people living in the community with dementia. GPs found taking part in a clinical e-audit, quality improvement activity, around best-practice antibiotic prescribing for respiratory tract infections changed their practice and helped to identify topics for further education (Fletcher-Lartey and Khan 2017).

In order for health services to better meet the needs of people with long-term conditions, individuals need to identify their need for care. This may include attending routine screening appointments supported through the Medicare Benefit Scheme (MBS). The uptake of the 75+ assessment is examined in women from the Australian Longitudinal Study on Women's Health by Dolja-Gore *et al.* (2017). The utilisation of MBS items for cardiovascular disease is described by Redfern *et al*. (2017). Finally, in order to attend and utilise a service, people need to be aware of both the service and the potential benefit of this service to their overall health. Anderson *et al*. (2017) report that people with mental health problems, living independently in a residential care setting, may not present to health services because they are concerned about stigma.

The articles in this issue of the *Australian Journal of Primary Health* have highlighted some of the opportunities and challenges facing organisations and health care teams in ensuring that Australians are aware of, and have access to, high quality, evidence-based care to better prevent, identify and manage chronic conditions.

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