

Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services

October 2006

Published by the Victorian Government Department of Human Services,
Melbourne, Victoria

© Copyright State of Victoria 2006

This publication is copyright, no part may be reproduced by any process
except in accordance with the provisions of the *Copyright Act 1968*.

This document may also be downloaded from the Department of Human
Services website at: <http://www.health.vic.gov.au/pchtopics/index.htm>

Authorised by the State Government of Victoria,
50 Lonsdale Street, Melbourne.

Foreword

In Australia, the burden of chronic disease is increasing rapidly. In Victoria, approximately 70% of the total burden of disease is attributable to six groups: cardiovascular disease, cancers, injuries, mental health conditions, diabetes and asthma. Unfortunately, risk factors including lifestyle factors (such as tobacco smoking, physical inactivity, alcohol consumption, diet, unsafe sex and intimate partner violence) and physiological states (such as obesity, high blood pressure and high cholesterol) are responsible for a sizeable proportion of the burden of disease in Victoria.

Victoria's primary health care system must be able to respond in an appropriate and cost effective way to this challenge. This includes prevention, early detection and proactive management of chronic disease.

The funding initiatives for Primary Care Partnerships and Community Health Services, described in this document, are just two Victorian government strategies aimed at intervening on the burden of chronic disease in Victoria. In particular these initiatives are aimed at providing planned, managed and proactive care for people with chronic disease by providing more community based health services and providing services within an integrated health care system.

Contents

Foreword	iii	10. Funding	34
1. Introduction	1	10.1 For PCPs	34
1.1 Audiences	1	10.2 For CHSs	34
1.2 Rationale	2	11. Accountability and reporting	35
2. Policy context	3	11.1 PCP reporting	35
2.1 State level	3	11.2 CHS reporting	35
2.2 Australian Government level	5	12. Evaluation	37
3. Vision for chronic disease management	6	Further information	38
4. Levels of chronic and complex care prevention and management	7	Abbreviations	39
4.1 Explanation of levels	8	Glossary	40
4.2 Integration between levels	9	Appendix 1	
5. Target population for the PCP ICDM and EliCD initiatives	10	The Australian Better Health Initiative (Commonwealth Government funding)	41
5.1 For PCPs	10	Appendix 2	
5.2 For CHSs	10	Definitions of target populations	42
6. The ICDM initiative	11	Appendix 3	
6.1 ICDM framework	11	Guide to initial planning approach	44
6.2 The role of all PCPs in ICDM	12	Appendix 4	
6.3 Engaging DGP and GPs in the ICDM initiative	17	Resources and links to support planning	45
6.4 The role of PCPs in ICDM working with a CHS funded under the EliCD initiative	18		
7. The EliCD initiative	19		
7.1 The first year of EliCD funding	19		
7.2 The role of CHSs in the EliCD initiative	19		
7.3 CDM service model components	20		
8. Deliverables	28		
8.1 For PCPs	28		
8.2 For CHSs funded under the EliCD initiative	28		
9. Planning	30		
9.1 The initial planning approach	30		
9.2 The implementation plan	33		

1. Introduction

Care for people with chronic diseases usually involves multiple health care providers in multiple settings. To provide this care within an integrated system, health care providers must work collaboratively to coordinate and plan care and services. This requires a commitment to working together to achieve shared goals.

People with chronic disease need a responsive person-centred and effective system of care. These planning, implementation and program guidelines have been developed to support Primary Care Partnerships (PCPs) and their member agencies, and Community Health Services (CHSs) in the development of chronic disease management (CDM) across the service system.

The guidelines should be used in conjunction with additional resource materials that will be released over the following months and available at:

www.health.vic.gov.au/communityhealth

www.health.vic.gov.au/pcps

www.health.vic.gov.au/communityhealth/AHPACC

1.1 Audiences

1.1.1 Primary Care Partnerships—integrated chronic disease management

From 2006–07, all PCPs will receive recurrent funding for integrated chronic disease management (ICDM). The level of funding will depend on whether (PCPs) are working with CHSs funded under the Early Intervention in Chronic Disease initiative (EliCD). A focus on ICDM builds on the established PCP role in facilitating service system integration and change management across member agencies.

PCPs have broadened their scope over the past six years, collaborating with the acute sector around Hospital Admission Risk Program-Chronic Disease Management (HARP-CDM) and participating in a range of chronic disease initiatives, including EliCD and Diabetes Prevention—Go for your life¹. This funding builds on this work. It acknowledges that all PCPs have an important role to play in bringing agencies together to develop systems that support a coordinated approach to the planning and delivery of services for clients with chronic disease. ICDM is now a key deliverable for all PCPs.

These guidelines provide all PCPs with a focus for activities for 2006–09 that facilitate service system integration and change management. PCPs are expected to work with the broader service system (including CHSs) to develop integrated systems across agencies to care for people with chronic disease. Work with member agencies relevant to ICDM should include general practice and build on existing PCP activities, especially service coordination. A greater breadth of activities will be expected from PCPs working with one or more CHSs funded under the EliCD initiative. PCPs working with CHSs receiving EliCD funding for the first time in 2006–07 will also be involved in a planning process with the CHS (and other PCP member agencies) to develop a CDM service model.

These guidelines should be read by PCP staff and agencies involved in the PCP systems work, including Divisions of General Practice (DGP).

Just as work on service coordination has been incremental over time, it is expected that activity in ICDM will progress over the next three years.

1.1.2 Community health services—funded under the EliCD initiative

The EliCD initiative builds on the work already being done by CHSs to support people in the community who have chronic disease. It provides additional funding to increase service delivery and build in new components that are consistent with evidence-based chronic care. In addition, CHSs will work on internal system changes to deliver the CDM model of care developed with the PCP and other key agencies.

These guidelines provide information to CHSs newly funded and already funded under the EliCD initiative. For newly funded CHSs, the guidelines provide details about planning a CDM service model in the context of partnerships and implementing the CDM service model within a CHS. For CHSs already funded, the information supports ongoing planning and development of their CDM service models.

1 Go for your life <<http://www.goforyourlife.vic.gov.au/>>

1.1.3 Other agencies with a focus on chronic disease management

Although only 18 CHSs have received funding for the EliCD initiative, all CHSs see significant numbers of people who have one or more chronic diseases. In addition, a number of metropolitan, rural and regional CHSs are involved in delivering services to clients as part of the HARP-CDM program and/or the Aboriginal Health Promotion and Chronic Care (AHPACC) partnership. These guidelines support agencies, especially CHSs, in their work with people with chronic disease and will also be reflected in the updated AHPACC program guidelines.²

These guidelines could apply to other agencies wanting to develop more integrated approaches to the care of people with chronic disease.

1.2 Rationale

Chronic diseases currently make up more than 70 per cent of Australia's overall disease burden due to death, disability and diminished quality of life. This is expected to increase to 80 per cent by 2020³. Evidence suggests that people who participate in chronic disease management programs have a better quality of life, experience fewer complications and reduce their overall use of health care resources.⁴

Strengthening the role of CHSs and PCPs in ICDM responds to the following issues:

- An increasing prevalence of preventable chronic disease.
- CHSs across the State already see many people with chronic and complex conditions (approximately 60 per cent of all registered clients).
- Demand pressures on CHSs challenge their capacity to support multidisciplinary care coordination and integrated service provision for people with chronic disease and complex needs.

- Major public hospital costs in Victoria (2003–04) for four chronic conditions alone—diabetes, chronic obstructive pulmonary disease, chronic heart failure and asthma—suffered by 62,000 people) is estimated at \$200 million.
- Significant evidence in Australia and internationally demonstrates the value of partnerships in improving the delivery of primary health care services and programs.⁵
- The vision for PCPs supports more integrated responses to clients with chronic disease and complex needs.⁶

2 AHPACC partnership:
<<http://www.health.vic.gov.au/communityhealth/AHPACC>>

3 Australian Institute of Health and Welfare (AIHW) 2002, *Chronic diseases and associated risk factors in Australia*, 2001, Canberra.

4 Institute for Public Health Services Research, Monash Medical Centre, and Centre for Community Child Health, Royal Children's Hospital (2000). *Literature review of effective models and interventions for chronic disease management in the primary care sector*. Victorian Government Publishing Service.

5 Gillam, Abbott, Banks-Smith (2001) Can primary care groups and trusts improve health?, *BMJ* 323 14 July 2001. Evans D, Killoran A (2000) Tackling health inequalities through partnership working: learning from realistic evaluation, *Critical Public Health* 10(2) 2000. Rae Walker, *Collaborations and alliances: a review for VicHealth*, Victoria <<http://www.vichealth.vic.gov.au>>.

6 Department of Human Services (2004) *Primary Care Partnerships strategic directions 2004–2006*, Victoria, <<http://www.health.vic.gov.au/pcps>>

2. Policy context

2.1 State level

2.1.1 Care in your community

Aligned with the Government's *Growing Victoria Together* agenda and *A Fairer Victoria* policy, *Care in your community*⁷, launched in April 2006, builds on existing policy directions to provide a coherent whole-of-health framework for the delivery of integrated, community-based health care. It provides a ten-year vision for a modern, integrated and patient-centred health system.

Care in your community builds on established and successful elements of the current health system. The guiding principles aim to maximise access, quality and continuity of care, service flexibility, opportunities for service substitution and diversion as well as optimal use of scarce resources.

Care in your community will equip the Victorian health care system to meet the future needs and expectations of communities and individual users of health care services. It is about refocusing and investing in the best mix of hospital and community-based integrated care services to better meet the needs of Victorians. It builds on existing government health and human services policy and provides a longer-term strategic direction.

To enable the health care system to deliver integrated, community-based health care, specific actions will be undertaken over the next 2–3 years in the following areas:

- funding models
- workforce
- integration tools
- ICT developments
- partnering arrangements.

2.1.2 Primary care

In response to the *Better Access To Services* (BATS) policy, released in 2001, and the introduction of PCPs, PCP member agencies—including CHSs, local governments, Divisions of General Practice, women's health, aged care assessment services, district nursing, ethno specific services, and metropolitan and rural health services—have worked together to develop a stronger, more integrated community-based health and community service sector. Services have come together to look at the way they work, reducing duplicated practices while increasing understanding of referral pathways and how to improve service coordination and deliver better integrated health promotion (IHP) practice. This has included a focus on ICDM consistent with the PCP objective of reducing the number of preventable hospital admissions.

The vision for PCPs includes⁸ includes:

- an integrated health care system based on partnerships, where providers see planning and working together to better meet the needs of their communities as core business
- people with chronic diseases being active partners in their own care, with the system structured around consumers, not agencies or programs
- prevention and management of chronic diseases coordinated across the health sectors
- consumers' needs identified early and appropriate services delivered promptly
- improved service coordination practice enhanced and embedded in agency practice, streamlining assessment and access to services
- consumers' record built on and shared with other practitioners involved in their care with consumer consent.

7 Department of Human Services (2006), *Care in your community—a planning framework for integrated ambulatory care*, Melbourne, Victoria <<http://www.health.vic.gov.au/ambulatorycare/careinyourcommunity>>

8 Department of Human Services (2004), *Primary Care Partnerships strategic directions 2004–2006*, Melbourne, Victoria <<http://www.health.vic.gov.au/pcps/strategy>>

Community Health Services—creating a healthier Victoria policy⁹, released in September 2004, outlined the benefits of strong CHSs. It states the role of CHSs in improving health and diverting patients from acute care through integrated primary health care and disease management programs.

A strategic direction outlined in the policy is to strengthen the role of CHSs to provide:

- integrated disease management programs for people with chronic and complex conditions
- an expanded range of community-based ambulatory care services.

In response to these strategic directions, the Government has invested funding for EliCD for CHSs and extended funding under the PCP Strategy for ICDM. There are now 18 CHSs funded under the EliCD initiative and from 2006–07 all PCPs will receive funding for ICDM to enhance their capacity for facilitating system integration and change management to support people with chronic disease.

2.1.3 Acute

In the late 1990s, Victoria experienced unprecedented growth in demand for public health services. Hospitals faced pressure from the growing number of people presenting to emergency departments. The rising demand for public health care was driven by key factors, including:

- a rise in chronic and complex illness associated with an ageing population
- a reduction in the access to general practitioners (GPs) within the community
- workforce shortages, particularly for nurses
- a shortfall in the number of residential aged care beds
- an increase in the range of new treatment options through advances in medical technology
- a reduction in the availability of informal carers within the community.

As a response, the Victorian Government initiated the *Hospital Demand Management Strategy (2001–2005)*¹⁰ to address:

- emergency demand
- elective surgical waiting lists
- strategies to prevent avoidable hospital use by providing more appropriate care.

Of the overall Hospital Demand Management Strategy, \$150 million was allocated to develop new approaches to patient management, providing more appropriate care for individuals known to have a high risk of health deterioration; thus preventing avoidable hospital use in the future. These new approaches to patient care were funded, monitored and evaluated under the **Hospital Admission Risk Program (HARP)**.

Evaluation of HARP from 2001–04 demonstrated that it successfully reduced the growth rate in demand for acute services for the target client groups. HARP achievements have included:

- improved identification and proactive management of **at-risk** clients
- increased health system capacity
- greater collaboration between acute and community services.

For clients, the benefits of participating in HARP have included:

- improved health outcomes.
- empowerment through education and self-management strategies
- individually tailored care
- the opportunity to stay at home longer.

In 2005–06, \$47 million was recurrently allocated to health services to work in partnership with the community sector to mainstream HARP under the banner of HARP-CDM.

9 Department of Human Services (2004), *Community Health Services—creating a healthier Victoria*, Melbourne, Victoria <<http://www.health.vic.gov.au/communityhealth>>.

10 Additional information about HDM can be found at <<http://www.health.vic.gov.au/hdms/>>.

In 2005–06, the HARP-CDM draft guidelines were released to facilitate the mainstreaming process with the following objectives:

- to improve patient outcomes
- to provide integrated seamless care within and across hospital and community sectors
- to reduce avoidable hospital admissions and Emergency Department presentation
- to ensure equitable access to health care.

2.1.4 Public health

As part of its commitment to improving the health and wellbeing of all Victorians, the Victorian Government launched its Go for your life¹¹ strategy in 2005 to promote opportunities for Victorians to be healthy, active and involved in their community.

The Diabetes Prevention—Go for your life program, one component of the Go for your life strategy, has been developed to trial a community-based intervention to prevent diabetes.

2.2 Australian Government level

The Australian Health Ministers' Advisory Council endorsed a national strategic approach to chronic disease prevention and management in Australia. The *National Chronic Disease Strategy*, released in 2005¹², is a high level generic policy guide that focuses on nationally agreed directions to be taken by the health system at a national level. The strategy recognises that the health sector cannot work in isolation from other sectors and services. It must achieve significant and sustainable change to meet the chronic disease challenge and take a leadership role in advocating, engaging and partnering with other sectors to influence the social and environmental factors that determine the burden of chronic disease. This includes developing more consistent, integrated, evidence-based practice and effective consumer-focused approaches to improve the prevention, detection and management of chronic disease. The strategy focuses on improved outcomes along the whole continuum—health promotion, prevention, detection, management, self-management, rehabilitation and end of life care.

11 <http://www.goforyourlife.vic.gov.au/>

12 *National Chronic Disease Strategy, 2005*, Australian Government Department of Health and Ageing <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pq-ncds>

2.2.1 Australian Better Health Initiative

In response to the trends for chronic diseases in Australia¹³, the Australian Government, in partnership with the states and territories, is strengthening the focus of the health system on prevention and health promotion, and management of chronic disease. From 1 July 2006, the Australian Government and the state and territory governments will begin implementing a five-year, \$500 million national package called the Australian Better Health Initiative (ABHI) to reduce the impacts of chronic disease with a focus on the needs of Indigenous Australians.

The ABHI package will include the following priority areas:

- promoting healthy lifestyles
- supporting early detection of risk factors and chronic disease
- supporting lifestyle and risk modification
- encouraging active patient self-management of chronic disease
- improving the communication and coordination between care services.

Governments will provide incentive funds to appropriate organisations to improve local connections between service providers, including private medical services, CHSs and allied health services, so that patient needs are better met. Further information about this initiative is provided in Appendix 1.

The ICDM and ELiCD initiatives are funded under ABHI and will seek to improve integration between State-funded primary health care services and Commonwealth-funded GPs, consistent with the objectives of the ABHI.

13 Chronic diseases—such as diabetes, heart disease, cancer and arthritis—are estimated to be responsible for nearly 80 per cent of the total burden of disease and injury in Australia, and more than two thirds of all health expenditure. Diabetes and heart disease alone cost the health system more than \$6 billion per annum. These chronic diseases also have a disproportionate impact on some population groups, particularly Indigenous Australians.

3. Vision for chronic disease management

Vision

The guiding vision is for a responsive, person-centred, effective system of care for people with chronic disease.

Aim

A chronic disease management approach¹⁴ should be adopted and aim to:

- demonstrate improved health outcomes and quality of life for people with chronic disease.

Objectives

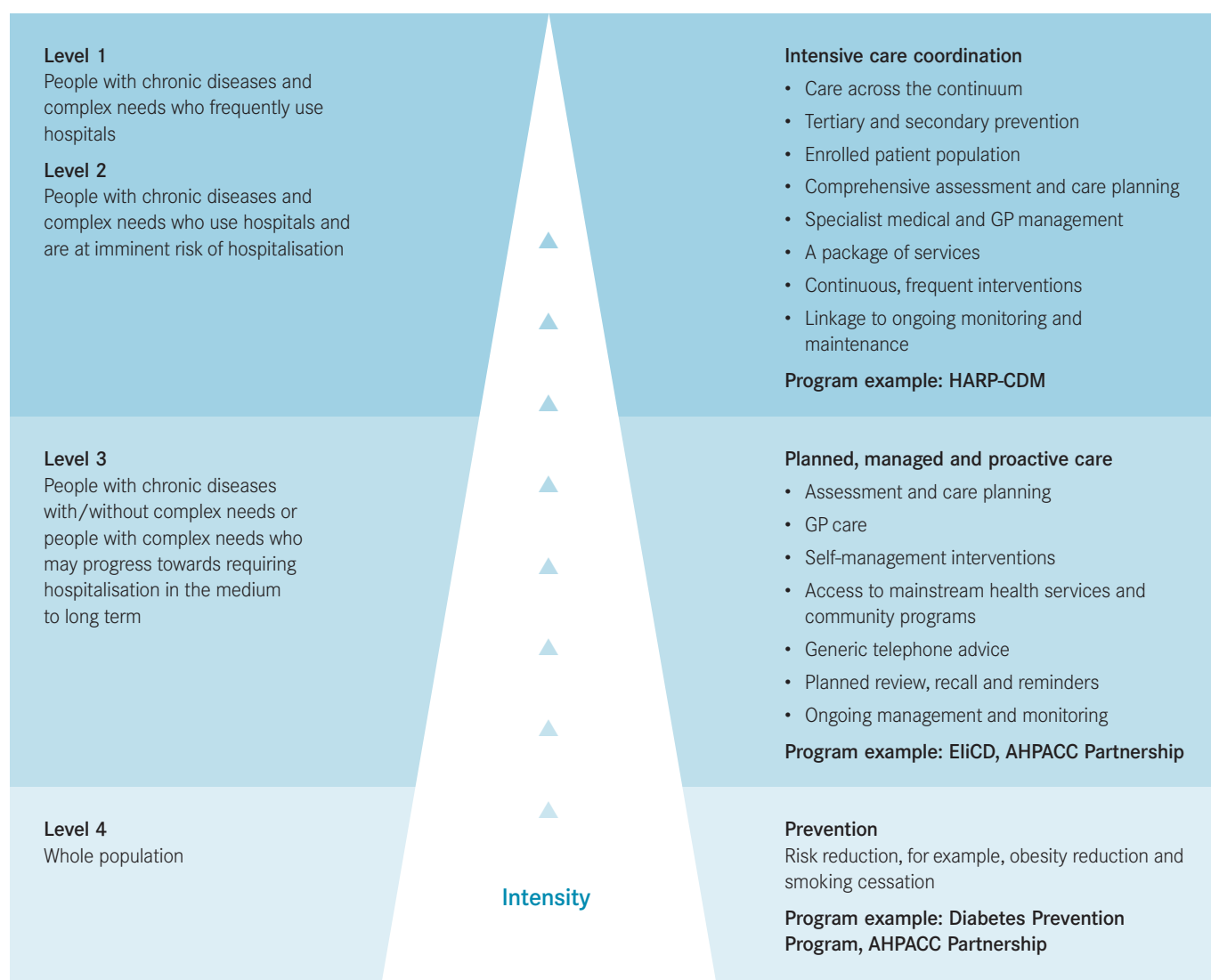
- Slow the rate of disease progression (in the context of the person's clinical condition) while maximising their health and wellbeing within the community.
- Improve access to quality integrated multidisciplinary care across the care continuum.
- Facilitate client and carer empowerment through self-management programs and approaches.
- Promote and encourage protective behaviours (such as healthy eating and physical activity).
- Actively engage GPs as part of a multidisciplinary coordinated approach, including the development of written care plans.
- Reduce inappropriate demands on the acute health care system.
- Demonstrate the contribution CHSs and PCPs (in particular including Divisions of General Practice) can make to the care and management of people with chronic disease.

¹⁴ Department of Human Services (2005) *Improving chronic disease care: learnings from the Integrated Disease Management projects*, Melbourne, Victoria.

4. Levels of chronic and complex care prevention and management

CDM encompasses the continuum of care from prevention through to treatment and care management for people with chronic disease. Diagram 1 provides a visual representation of a schema for CDM, which describes four levels of service intensity for people with or at risk of chronic and complex needs and the target populations for each level.

Diagram 1: Levels of chronic and complex care prevention and management



Adapted from Kaiser Permanente¹⁵

4.1 Explanation of levels

Levels 1 and 2: Intensive care coordination

Target population:

- People who have frequent hospital admissions/presentations or clients identified as being at imminent risk of hospitalisation who are most likely to benefit from integrated care and have the potential to reduce avoidable hospital use.

Service intensity:

- Model responds to acute exacerbations or significant decline in clients' conditions.
- Includes comprehensive assessment, specialist assessment, care planning, specialist intervention, identification of community-based services, access to brokerage and tertiary prevention.

The HARP-CDM is the main funded program within this level. It has two identified streams of care:

- People with complex needs (including people with psychosocial needs).
- People with chronic diseases (including people with chronic heart failure, chronic respiratory diseases, and diabetes Type 1 and Type 2 with complications. These complications may be related directly to the chronic disease; such as in the case of diabetes retinopathy, neuropathy, amputation; or may be other co-morbidities or psychosocial factors impacting on the client's ability to manage their chronic disease).

Further information about the target population for HARP-CDM is provided in Appendix 2, including Table A1: Level of complexity and Table A2: Summary of service models.

Level 3: Planned, managed and proactive care

Target population:

- People diagnosed with a chronic disease/s (especially, but not limited to, diabetes, cardiovascular disease, early stages of respiratory disease, and asthma).
- People with complex needs, particularly in the elderly, **prior to** complications or significant decline in function.
- People who could potentially require hospitalisation in the medium to long term and require a managed and planned approach to reduce risks.

Service intensity:

- Model responds proactively to clients with a chronic disease **prior to** significant complications or significant decline.
- Includes secondary and tertiary prevention, regular reviews, self-management interventions and care planning.

The EliCD initiative is the main funded program within this level. Further details about the target population for this initiative are described later. The chronic disease management component of the AHPACC Partnership is an example of a program that fits in this level.

See website www.health.vic.gov.au/communityhealth/AHPACC for further details.

Level 4: Prevention

Target population:

- People with high risk factors for developing a chronic disease.
- A focus on the social determinants of health and the underlying factors that make population groups at greater risk of ill health.

Service intensity:

- Model aims to improve the health and wellbeing of people prior to the onset of a chronic disease.
- Includes primary prevention, integrated health promotion, risk reduction and whole of population approaches.

The Diabetes Prevention Program is an example of a funded program within this level. It has two major components: detection and intervention. The program aims to identify people with pre-diabetes [impaired glucose tolerance and impaired fasting glucose] and to provide an intervention (Healthy Living Course) to support lifestyle changes to reduce the risk of progression to diabetes.

The program is currently being implemented in three PCP pilot sites, with catchments of approximately 100,000 per site. The health promotion component of the AHPACC Partnership is an example of a program that fits in this level.

See website www.health.vic.gov.au/communityhealth/AHPACC for further details.

4.2 Integration between levels

Through the course of a person's chronic disease, they will move between the levels of chronic and complex care management described in Diagram 1, requiring close cooperation between all service providers.

Where HARP-CDM, AHPACC Partnerships and EliCD services co-exist, programs need to work together to ensure a seamless and integrated model for access to services and movement between services (should client needs change). This will be important for clients and/or carers and also for health professionals (including GPs), particularly those making referrals into the programs. The following strategies may be considered in achieving integration:

- Joint planning across programs.
- Joint governance or steering committee arrangements.
- Workforce development or training opportunities available across programs including cultural respect training.
- Consistency in evaluation indicators and methodologies where relevant.
- Marketing could be undertaken as a joint activity.
- Rotation of staff through EliCD and HARP-CDM or AHPACC Partnership could be encouraged to promote care across the continuum and increase the understanding of the services by health professionals.
- Systems by which intake/service coordination staff for each program can easily cross-refer without duplication of initial need identification.

The HARP-CDM program within the Department of Human Services is keen to develop a risk algorithm to identify the degree to which a client is at risk of hospitalisation, and so assist in determining whether a client is appropriate for the HARP-CDM program. In the interim, HARP-CDM and EliCD services will need to develop close links and effective communication to ensure a streamlined approach to care and to minimise duplication.

5. Target population for the PCP ICDM and EliCD initiatives

Table 1 provides a summary of the information detailed in this section.

Table 1: Target populations

	Community Health Service	Primary Care Partnership
Primary target	<ul style="list-style-type: none"> • People living within the designated local government area (LGA), with a focus on initial target group(s) 	<ul style="list-style-type: none"> • Agencies within the same LGA as the CHS, particularly the Division of General Practice (DGP), who provide services to people with chronic disease
Secondary target	<ul style="list-style-type: none"> • Other people with chronic disease accessing the CHS (not part of the original target) • People living outside the designated LGA wishing to access services from the CHS 	<ul style="list-style-type: none"> • Agencies within other LGAs of the PCP catchment, that provide services to people with chronic disease • Targeted approach for disease specific care pathways

5.1 For PCPs

In supporting service system integration, PCPs will need to work with member agencies that provide services to people with chronic disease. A priority will be working with the local DGP, as best practice for chronic disease always includes GP management.

For PCPs that have a CHS funded under the EliCD initiative, the initial focus of their work will be with the CHS and other agencies within the same local government area (LGA) as the CHS. However, over time it is expected that PCP resources be directed to support activity across the whole PCP catchment. Some work across the catchment may be targeted, for example, where the PCP is working with member agencies to develop disease specific care pathways, or the PCP is working with member agencies to facilitate access to services for people from culturally and linguistically diverse backgrounds.

5.2 For CHSs

The EliCD initiative should be targeted towards clients at level 3 of the chronic and complex care continuum (Diagram 1). Clients will include:

- people diagnosed with a chronic disease/s (especially, but not limited to, diabetes, cardiovascular disease, respiratory disease, asthma, arthritis)
- people diagnosed with a chronic disease **without** complications or significant decline in function
- people who could require hospitalisation in the medium to long term and require a managed and planned approach to reduce risks.

CHSs should focus their EliCD activity on their primary catchment area (the designated LGA for which they received funding). This includes delivering outreach services, if appropriate, within the primary catchment. Consistent with the Community Health Program funding guidelines, CHSs should prioritise population groups and individuals in lower socioeconomic groups, including Neighborhood Renewal areas and AHPACC Partnership sites where applicable.

CHSs should consider people living outside their LGA as a secondary catchment. While CHSs are not expected to deliver outreach services to their secondary catchment, they should not deny clients access to services generally on the basis of where they live. Therefore, if a client from secondary catchment presents for service, the CHS should provide services based on eligibility and priority.

A developmental approach may be taken in the first year and could include focusing on a particular client group. Targeting of client groups may be based on diagnosis, geography or disadvantage and should be consistent with the needs of the local community.

For example:

A CHS may target people with diabetes and cardiovascular disease as evidenced by local population health data and other relevant information. In subsequent years it is expected that generic CDM capacity is developed so that all people with chronic disease can receive improved management.

6. The ICDM initiative

6.1 ICDM framework

The ICDM work of the PCP should be underpinned by the following principles and evidence-based systems model.

6.1.1 Guiding principles

Guiding principles that should underpin local ICDM work include:

- providing person-centred care, including support for carers and/or families of people with chronic disease
- recognising that consumers are active partners in the management of their chronic disease
- increasing choice and control
- providing the right care in the right place at the right time
- proactively promoting health
- targeting population subgroups of greatest need
- building a whole of service system response.

In summary, the above principles are about providing integrated care. Integrated care means health services working with each other and their clients to provide person-centred care that is connected and consistent with their care needs. Fragmentation of the service system exists.

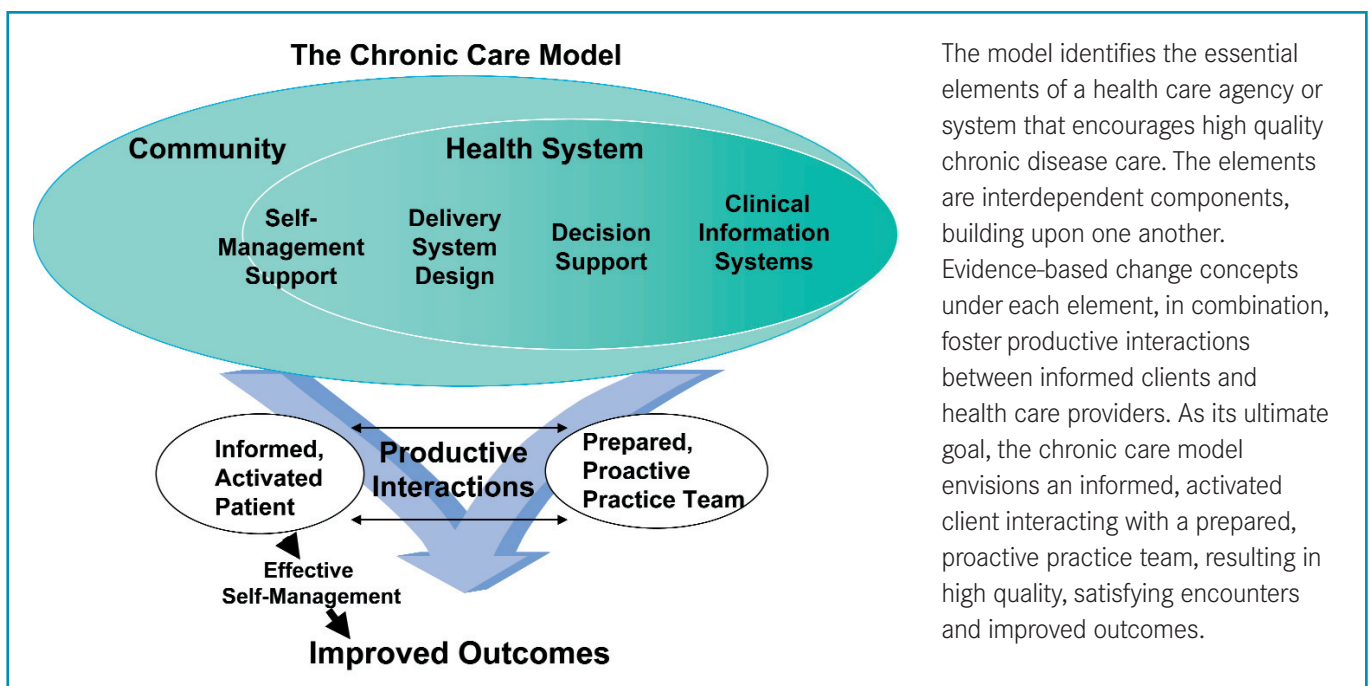
However, agencies working together can help reduce this fragmentation so that a person receives coordinated and integrated services in a timely, efficient and seamless manner. The challenge for the service system is to improve integration and continuity of care for clients over time, through different stages of disease progression.

6.1.2 The Wagner Chronic Care Model

PCPs should base their ICDM work on Wagner's Chronic Care Model. The Chronic Care Model, endorsed by the World Health Organisation, was developed by Edward Wagner and his team at The Robert Johnson Foundation based at the MacColl Institute for Healthcare Innovation (Seattle, USA). Wagner proposes that managing chronic disease requires nothing less than a transformation of health care, from a system that is essentially reactive—responding mainly when a person is sick—to one that is proactive and focused on keeping a person as healthy as possible. It is, therefore, a systems-based model that summarises the essential elements for improving care in health systems at the community, organisation, practice and client levels. The model can be applied to a variety of chronic diseases, health care settings and target populations.

Wagner defines work at the health system level (Diagram 2)

Diagram 2: The Chronic Care Model



as creating a culture and systems that promote safe, high quality care. Examples of this work include:

- supporting senior leaders to be motivated and prepared for change
- encouraging effective chronic disease care to be part of strategic plans
- promoting effective improvement strategies aimed at comprehensive system changes within agencies
- encouraging open and systematic handling of errors and quality problems to improve care
- developing agreements that facilitate care coordination within and across agencies.

For PCPs, this model is appropriate in guiding their work at the health system level and working with agencies to facilitate changes at the organisation and practice levels.

6.2 The role of all PCPs in ICDM

All PCPs will now receive core ICDM funding, which will build on existing PCP service coordination work. Service coordination provides an essential platform for ICDM. Its focus is on consistent approaches to initial contact, initial needs identification, assessment, care planning and referral across PCP member agencies. Common service coordination practice provides the foundation from which agencies can coordinate service delivery for the benefit of their clients.

Work to support a consistent approach to service coordination is occurring. A statewide practices, processes, protocols, systems (PPPS) manual, called the *Victorian Statewide Practice Manual*, is being developed to assist multi-catchment agencies in engaging with PCPs and implementing service coordination; and to define statewide service coordination protocols and practices. The *Victorian Statewide Practice Manual* will combine the common elements from existing local PPPS manuals and will assist in achieving a consistent framework for referral practices between:

- acute services and community and primary health services
- metropolitan and rural services
- GPs and community/primary health services.

PCPs should work with member agencies to implement and embed these statewide service coordination practices and protocols at a local level to support ICDM. Additional local implementation agreements consistent with the statewide PPPS manual may be developed.

For example:

- Agreement around priority of access to services for particular diagnostic groups as a result of initial needs identification.
- Agreement and definition around which clients will receive a multi-agency care plan and have a key worker.
- Systems to support nomination of a key worker and development/review of a care plan.
- Agreement around levels of written service outcome communication required by agencies.

6.2.1 Summary of work

ICDM activity for all PCPs will focus on facilitating service system integration and change management. Table 2 provides a summary of the activities for all PCPs and is consistent with the information provided in the *PCP reporting guidelines 2006–09*¹⁶.

Table 2: Activities for all PCPs

All PCPs will be expected to:

- Map self-management interventions provided by agencies within the catchment. Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.
- Facilitate a process for agencies to define their roles and responsibilities, especially acute and CHSs, in relation to providing self-management interventions for people with chronic disease.
- Implement the BATS framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.
- Work with PCP member agencies, particularly GPs, to develop and define local agreements and systems to identify clients with chronic disease who require comprehensive assessment.
- Work with PCP member agencies, particularly GPs, to develop and define local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning.
- Work with PCP member agencies, particularly GPs, to develop and define local agreements and systems around initiating and coordinating care planning for people with chronic disease.
- Strengthen approaches to address disadvantage and health equality in integrated health promotion, including barriers to participation such as chronic disease.

The activities in Table 2 provide PCPs with direction for their work over the next three years. PCPs may develop the above systems incrementally over time rather than embark on all areas within the first year. However, PCPs should prioritise some components of their work, such as self-management mapping.

Formal reporting on the PCP ICDM activities (Table 2) will be through the Community Health Planning and Implementation Agreement (CHPIA). PCPs are also encouraged to report on this work to their members as part of their commitment to develop and maintain trust and strong collaborative partnerships.

The following provides further information for each summary point in Table 2.

6.2.2 Self-management

Effective CDM includes evidence-based self-management interventions, delivered by suitably trained health care providers and/or consumers. Clients who have adopted self-management approaches are better equipped to maintain optimal health levels and remain in community-based services for a greater period of time. Self-management interventions aim to place the person in control of their life and assist them to be as independent as possible, rather than creating health system dependency.

Self-management is:

The client (and family/carers as appropriate) working in partnership with their health care provider to:

- know their condition and various treatment options
- negotiate a plan of care
- engage in activities that protect and promote health
- monitor and manage the symptoms and signs of the condition(s)
- manage the impact of the condition on physical functioning, emotions and interpersonal relationships¹⁷.

Self-management is the ability of the client to deal with all that a chronic disease entails, including symptoms, treatment, physical and social consequences, and lifestyle changes.

¹⁶ Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*

¹⁷ Flinders University Model of Chronic Condition Self Management <<http://som.flinders.edu.au/FUSA/CCTU/home.html>>

Existing **evidence-based self-management interventions** include:

- Flinders Model¹⁷
- Stanford Model¹⁸
- Self-Management 5As (Kaiser Permanente)¹⁹
- telephone coaching²⁰
- motivational interviewing for behaviour change (Prochaska & DeClemente Model).

Self-management support is the care and encouragement provided to people with chronic disease (and their family/carers as appropriate) to help them understand their central role in managing their condition, making informed decisions about care, and engaging in healthy behaviours. Self-management support goes beyond traditional knowledge-based client education to include processes that develop client problem-solving skills, improve self-efficacy and support application of knowledge in real-life situations that matter to clients.

Providing self-management support:

- requires a focus on building client self-efficacy (as well as client knowledge) and confidence
- includes assessment, goal setting, action planning and problem solving
- includes providing psychosocial support and motivating behaviour change
- can be delivered using flexible approaches.

PCPs are asked to work with agencies to improve their understanding of self-management, map the provision of self-management interventions, and undertake planning to address the identified gaps in self-management interventions. In addressing the gaps, PCPs may need to facilitate a process for agencies to understand and define:

- How are people who need self-management support identified (screening for self-management capacity)?
- Who provides self-management interventions?
- How are good self-managers supported?
- Who provides ongoing management and review? If issues are identified as part of the review, how are people linked back into the system?

The above questions suggest that both health and community services have a role to play. This is consistent with Wagner's Chronic Care Model. The questions also suggest that health services may have different roles. It will be useful to discuss these roles, such as:

- What is the acute sector's role in self-management?
- What is the GP's role in self-management?
- What is the CHS's role in self-management?

6.2.3 Assessment

Better Access to Services—a policy and operational framework describes three types of assessment; service specific, specialist and comprehensive assessment²¹.

Comprehensive assessment is described as:

an extensive process of inquiry that gathers information about medical, physical, social cultural and psychological dimensions of need and assesses restorative options and capacity for improvement. It occurs where consumers have multiple, complex, or unclear needs or with consumers who require long-term and/or intensive service provision

18 Stanford Chronic Disease Self-Management Program
<<http://patienteducation.stanford.edu/programs/cdsmp.html>>

19 <http://jeny.ipro.org/attachment.php?attachmentid=1322&d=1146597543>

20 Linder H, Menzies D, Kelly J, Taylor S, Shearer S, (2003) Coaching for behaviour change in chronic disease: A review of the literature and the implications for coaching as a self management intervention, La Trobe University, *Australian Journal of Primary Care*, Special Issues, The Management of Chronic Diseases in Primary Care Settings, Vol 9, Numbers 2&3 2003.

21 Department of Human Services (2001) *Better Access to Services—a policy and operational framework*, Primary Care Partnerships Victoria
<<http://www.health.vic.gov.au/pcps/publications/index>>

The level and type of assessment required for people with chronic disease will depend on their individual needs. People with chronic disease may benefit from a comprehensive assessment, so this should be considered, particularly if they require service provision over a long term and/or require multiple service interventions from various providers.

PCPs should lead a process to discuss and define which clients require a comprehensive assessment and which agencies are involved in coordinating comprehensive assessments. CHSs with EliCD funding are required to coordinate comprehensive assessments for their clients who are part of the EliCD initiative.

The ICDM work for people with chronic disease should be integrated with the PCP's service coordination work to develop local agreements around assessment more broadly.

6.2.4 Care planning

Better Access to Services—a policy and operational framework describes care planning as a process that:

ensures the needs of consumers are discussed with them, their carers and other relevant parties in the context of possible options, and subsequently worked through to an agreed strategy.

This broadly defines the process of care planning that occurs at an agency level. Care plans at this level may be described as clinical plans, service plans or individual treatment plans. The definition also includes a process of drawing together existing care plans and building in aspects of coordination and communication to develop a cross-disciplinary/multi-agency care plan.

The level and type of care planning required for people with chronic disease will depend on their individual needs. However, at a minimum, clients will require care planning at an agency level and consideration given to cross-disciplinary/multi-agency care planning where multiple agencies are providing services.

Care planning should be a dynamic, consultative process that includes the client (and family/carers as appropriate) and health care providers and aims to meet the client's health needs in a holistic way. Care plans should include the following elements:

- issues/problems
- goals, actions, target dates, responsible agents
- regular review dates
- participants
- checklist—evidence of need
- method of planning.

Where cross-disciplinary/multi-agency care planning occurs, it is preferable that the Service Coordination Plan form (of the Service Coordination Tool Template, SCTT) is used.²²

GPs are an important service provider for people with chronic disease. New items under the Medical Benefits Schedule (MBS) for CDM were introduced in 2005 and apply to people with chronic conditions and complex needs, in particular, asthma, cancer, arthritis, diabetes, heart disease and mental illness.

Three of the new MBS items include:

- preparation and review of a GP management plan
- coordination and review of team care arrangements
- contribution to a multidisciplinary care plan being prepared by another health or care provider.²³
- Aboriginal and Torres Strait Islander Health Check²⁴

PCPs should work with local DGPs and GPs to develop local arrangements that promote the participation of GPs in care planning and care coordination and the alignment of community-based care coordination with planned multidisciplinary care for chronic disease. A shared plan of care is an essential element of effective CDM. It provides structure and coordination of services as the client negotiates the many care episodes characterised by

22 Department of Human Service (2006)
Service coordination tool templates, Victoria
<www.health.vic.gov.au/pcps/coordination/tooltemp>

23 Commonwealth Department of Health and Ageing
www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

24 Commonwealth Department of Health and Ageing,
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-atsiinfo.htm>

long-term care and support. See section 6.3.2 for more information on GPs and care planning.

Within this initiative, PCPs are asked to progress the development of local protocols to identify clients who require cross-disciplinary/multi-agency care planning and systems around initiating and coordinating care planning for people with chronic disease. This should focus on working with GPs.

The ICDM work for people with chronic disease should be integrated with the PCP's service coordination work that will focus on developing local agreements around assessment more broadly.

6.2.5 Communication between agencies

Improved communication between agencies, such as referral acknowledgement, service outcome communication, and communication about coordinating care for clients, will be key to building an effective service system for CDM. PCPs have been supporting agencies to develop internal feedback and communication systems as part of implementing and embedding service coordination. This will also be important as part of PCP ICDM work.

6.2.6 Integrated health promotion approaches

An IHP approach involves agencies and organisations from a range of sectors and communities in a catchment, working in a collaborative manner and using a mix of population-based health promotion interventions and capacity building strategies to address priority health and wellbeing issues.²⁵

PCPs and CHSs have a strong role in leading IHP planning, implementation and evaluation and both PCPs and CHSs receive funding that is targeted towards population-based health promotion. A proportion of this funding is to be used to address catchment-wide priorities identified by the PCP IHP catchment plans. These plans will address one to three of the following statewide health promotion health and wellbeing issues for 2007–12:

- physical activities and active communities
- accessible and nutritious food
- promoting mental health and wellbeing
- reducing tobacco related harm

- reducing and minimising harm from alcohol and other drugs
- safe environments to prevent un-intentional injury
- sexual and reproductive health.

The *PCP reporting guidelines*²⁶ asks PCPs to apply an integrated disease management lens to their IHP planning.

This is not about focusing on chronic disease interventions but rather primary prevention approaches and barriers to participation and access. PCPs are asked to reflect on how issues related to chronic disease have been incorporated within their IHP catchment planning.

The following questions provide a 'lens' or a checklist for discussion:

- How are the IHP approaches and interventions in your IHP catchment being used to prevent and/or delay chronic disease within your catchment? Are specific chronic conditions and underlying social determinants being addressed within priority approaches?
- How are the barriers to participation, inclusion and 'whole of person' optimal wellbeing created by chronic conditions being addressed within IHP planning and implementation?
- What are the broader impacts of chronic disease on your catchment communities and services and how have they been considered in the planning process?
- What strategies are being used to encourage organisations with a 'downstream' focus on chronic disease to include a more 'upstream' approach, where relevant?

25 Department of Human Services (2003) *Integrated health promotion resource kit*, Victoria
<http://www.health.vic.gov.au/healthpromotion/resources_links/integrated.htm>

26 Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*

6.3 Engaging DGP and GPs in the ICDM initiative

6.3.1 Work at a Commonwealth Level

The Australian Government has encouraged GPs to take a multidisciplinary proactive approach to chronic disease through the provision of reimbursement arrangements within the MBS and the Practice Incentives Program (PIP).²⁷

Latest data shows that approximately:

- 58 per cent of GPs in Victoria have claimed a GP Management Plan (MBS Item 721—care plan for patient with a chronic disease developed by the GP)
- 47 per cent of GPs in Victoria have claimed a Team Care Arrangements (MBS Item 723—coordinated care plan with at least two other care providers for patient with a chronic disease and complex care needs)
- 3.6 per cent of GPs in Victoria have claimed a Contribution to a Care Plan (MBS Item 729—contribution to a multidisciplinary care plan coordinated by another provider for patient with a chronic disease and complex care needs)
- approximately 30 per cent of GPs in Victoria have claimed a Diabetes SIP for undertaking annual cycle of care for patient with diabetes
- approximately 20 per cent of GPs in Victoria are eligible to claim a Mental Health 3 Step Plan.

Note: that this data is approximate and that appropriate care may be provided but not claimed for through MBS/PIP.

The implications from this data are that PCPs and CHSs need to consider the local uptake patterns of general practice and how these patterns might inform the development of the CDM service model, in particular, the care planning component.

As part of a Commonwealth initiative, DGPs now report on three domains of chronic disease management: diabetes, asthma and mental health. The DGP program includes data from GPs for each DGP on the proportion of the population estimated to have diabetes, asthma and mental health issues who have received a Diabetes Annual Cycle of Care, Asthma 3 Visit Plan or Mental Health 3 Step Plan. There are

no performance measures related to individual GP's uptake of GP management plans or team care arrangements; however, the uptake data is available by division. It is recommended that consideration is given to these disease domains, as well as current levels of uptake of relevant MBS and PIP incentives as part of planning processes.

6.3.2 Work at the PCP level

GPs have a central role in providing well coordinated care for people with chronic disease and have primary responsibility for the medical management of people with chronic disease. For many people with chronic disease, multidisciplinary interventions are required to complement medical management. The Centre for General Practice Integration Studies²⁸ identified four essential components of general practice capacity for better management of chronic disease:

- effective team work
- information management/information technology (IT/IM) maturity
- appropriate business systems
- effective linkages with external services.

All 30 Victorian DGPs are members of PCPs and have, for the last four years, been working with other PCP member agencies and some individual GPs to develop and implement PPPS to support client referral and communication pathways, including the sharing of client information. DGPs have facilitated improved understanding and relationships between GPs and other health care providers at the local level and will play a central role in developing and implementing CDM approaches (including the EliCD initiative).

All PCPs have a role in working closely with their local DGP to improve the coordination of care (through effective communication, referral and collaborative care planning) for people with chronic disease. To engage GP representatives (through the DGP) in activities such as developing local agreements for the identification of clients requiring cross-disciplinary/multi-organisation care planning, PCPs should consider allocating resources to the DGP.

²⁷ The MBS includes new MBS items for CDM. The Practice Incentive Program (PIP) includes incentives for mental health, diabetes and asthma planned approaches.

See <<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease>>

²⁸ Centre for General Practice Integration Studies <<http://www.cgpis.unsw.edu.au>>

6.4 The role of PCPs in ICDM working with a CHS funded under the EliCD initiative

6.4.1 Summary of work

PCPs working with one or more CHSs funded under the EliCD initiative have additional work in 2006–09. Table 3 lists the activities for these PCPs and is consistent with the information provided in the *PCP reporting guidelines 2006–09*²⁹.

Table 3: Activities for PCPs working with the EliCD initiative

PCPs working with one or more CHS funded under the EliCD initiative will be expected to:

- Support workforce development around approaches to self-management for agencies, particularly CHSs and GPs.
- Support communication and marketing strategies (developed in conjunction with the DGP) that promote the benefits and availability of local self-management interventions to GPs.
- Work closely with the DGP to improve communication and collaborative care planning between GPs and CHSs.
- Support the adoption of disease-specific care pathways to ensure that clients get the right care in the right place, regardless of where they enter the service system.
- Support change management within agencies, particularly CHSs, that are implementing new systems or strengthening existing systems to provide proactive care rather than reactive care, for clients with chronic disease.
- Facilitate a process for agencies to develop and implement consistent approaches to the use of decision support tools to support CDM.
- Disseminate transferable change management lessons in relation to ICDM.
- Comply with the statewide evaluation framework for EliCD.

The activities in Table 3 provide PCPs with direction for their work over the next three years. PCPs may develop the above systems incrementally over time rather than embark on all areas within the first year. However, PCPs should prioritise some components of their work, such as supporting workforce development around self-management for CHSs and GPs who are working with the EliCD initiative.

Formal reporting on the PCP ICDM activities (Table 3) will be through the CHPIA. However, PCPs are also encouraged to report on this work to their members as part of their commitment to develop and maintain trust and strong collaborative partnerships.

PCPs with newly funded EliCD sites will be involved in a planning process to develop a CDM service model. PCPs working with a CHS funded for EliCD in 2005–06 will be involved in supporting the ongoing development of the CDM service model. Section 7 is relevant to all PCPs working with CHSs funded under the EliCD initiative, as it provides additional information for the work summarised in Table 3. Some of the information repeats and builds onto the information provided in section 6.2.

²⁹ Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*

7. The EliCD initiative

The combination of ICDM funding and EliCD funding will provide agencies (particularly PCPs and CHSs) with an increased capacity to work towards achieving the CDM vision.

Each agency will have an important but unique role to play in achieving this vision:

- PCPs will be focused on facilitating service system integration, which includes developing and supporting practice change in agencies that will lead to improved communication, referral and care planning between agencies. PCPs will need to support CHSs and other agencies involved in delivering services to clients with chronic disease.
- CHSs (funded by EliCD) will be focused on internal systems change and delivering a range of additional services (such as allied health and nursing) consistent with good practice in chronic care, with a focus on self-management. In addition to this, a focus on organisational change and partnership development with key agencies in chronic disease prevention and management is key. For those CHSs funded through the AHPACC Partnership, this includes building in the partnership with Aboriginal community controlled health organisations (ACCHOs).
- Other agencies, particularly GPs, providing services to clients with chronic disease will be involved in ensuring that appropriate clients are referred to the EliCD initiative and that coordination and collaborative care planning occurs for clients with chronic disease.

7.1 The first year of EliCD funding

PCPs, CHSs, DGP and other agencies/programs (for example, HARP-CDM, AHPACC Partnerships) should be involved in a planning process to:

- develop a CDM service model that features all of the following core components
- identify the systems changes required to embed the CDM service model in the context of Wagner's Chronic Care Model (see Diagram 2).

It is acknowledged that the rate of development and change across programs within a catchment may vary. For example, the program planning and implementation with HARP-CDM is likely to be different to that of the AHPACC Partnership.

CHSs and PCPs funded under the EliCD initiative in 2005–06 went through a similar process in the first year of their funding. However, it will be useful for these agencies to:

- review and further develop their CDM service model in the context of Wagner's Chronic Care Model (see Diagram 2)
- use the Chronic Care Model to guide continuous quality improvement of their existing local service CDM model.

7.2 The role of CHSs in the EliCD initiative

CHSs are located in every LGA in Victoria and provide a range of health services to many Victorians as well as participating in, and contributing to, their local communities. This strong connection to communities enables CHSs to provide clinical care within the social model of health to maximise outcomes for clients.

The *Community Health policy*³⁰ describes five strategic directions for CHSs:

- provide a platform for delivery of primary health care
- coordinated community-based disease management and ambulatory care
- focus on child and family health
- expanded primary medical care
- leadership in health promotion.

The provision of CDM through the EliCD initiative builds on the work already being done by CHSs to support people in the community who have chronic disease. It provides additional funding to enhance the services and build in new components of care that are consistent with evidence-based chronic care.

CHSs that do not have existing capacity to deliver clinical services, such as allied health and nursing, should work in partnership with local services that currently provide clinical services to people with chronic disease.

To strengthen the quality and safety of services and programs in primary health, a three-year project has commenced to develop, trial and implement a clinical governance framework for CHSs. This framework will include systems that support clients across the continuum of care in the context of Care in your community. CHSs involved in the EliCD initiative will be invited to participate in the

30 Department of Human Services (2004), *Community Health Services—creating a healthier Victoria*, Victoria
<<http://www.health.vic.gov.au/communityhealth>>

development of these clinical governance systems, particularly in relation to reporting to boards, credentialing and scope of practice, and developing clinical indicators for coordinated care for people with chronic disease.

7.3 CDM service model components

CDM service models must aim to deliver a responsive, person-centred and effective system of care for people with chronic disease. The Chronic Care Model will help to identify the systems changes (within the CHS and across the service system) that are necessary to improve the coordination of care for people with chronic disease. Taking a systems approach will be important to ensure the following model components can be delivered.

It is expected that the components directly related to service provision will be the responsibility of the CHSs to plan and implement, given the additional funding to CHSs. PCPs may support other agencies (as part of the PCP change management role) to implement the model components, which represent good practice CDM.

7.3.1 GP liaison

The PCP and CHS should work with GP representatives and key DGP staff to design a CDM service model that ensures:

- processes for GP referral and participation in care planning are realistic and aligned with MBS guidelines
- targets for reach to GPs (how many GPs/general practices to work with) are agreed and realistic
- strategies for informing GPs and their staff about the initiative are appropriate and effective
- strategies for developing general practice capacity needed to participate, for example, to identify eligible patients, share information such as GP management plans or information arising from a relevant SIP service, and liaise effectively with CHS providers.

PCPs and CHSs should consider allocating resources to the local DGP to support strategies for engaging and working with local GPs. For a model to include GPs as referrers, providers of medical perspectives in care plans and key members of primary care and multidisciplinary teams, there must be strong DGP leadership in the model design and implementation. This will require the PCPs and CHSs to negotiate an arrangement (including provision of funding) with the local DGP to increase their capacity to liaise with general practice around CDM. This could include:

- providing funding to the DGP to reimburse GP representatives to provide clinical input to the service model design
- funding a position within the DGP to conduct practice visits to targeted GPs to 'recruit' general practice engagement and provide systems development to enable GPs to participate
- providing funding to the DGP to enable work around targeted GP liaison, which includes establishing referral pathways from GPs (to maximise the proportion of general practices in the catchment areas that participate in the program) and communication mechanisms that will improve coordination of care.

Additional resource materials will be developed to provide information and examples of successful projects and programs.

DGPs, PCPs and CHSs, in conjunction with other PCP member agencies, should develop an agreed plan for building on existing capacity for liaison with general practice. Expanding DGP programs, such as GP representation, practice support/visiting and continuing professional development, should be considered.

The outcomes being sought include:

- GP representation and participation in planning and development
- DGP-based coordination of GP engagement
- support for systematic approaches to identification of eligible patients in general practice (for example, using agreed clinical and/or service usage eligibility criteria supported by information management systems in the practice)

- referral, feedback and care planning processes for general practice
- sustainable GP participation
- flexible arrangements (for example, delivery of services within general practice clinics, incorporating roles for nurses in general practice).

7.3.2 Client recruitment, referral pathways and disease specific care pathways

Experience from other projects and programs have shown that recruitment from health care providers is very successful; however, it takes effort and resources. As GPs will be a primary source of referral for the EliCD initiative, the DGP will be key to developing clear pathways and supporting general practice referrals. DGP should encourage the use of the Statewide Referral Tool for GP referrals.

Other key referrers should also be identified and targeted. These may include:

- hospital allied health staff
- HARP-CDM staff
- pharmacists (in particular medication review pharmacists)
- council-based home care staff
- ACCHOs

CHSs should also review current clients and identify those who meet the criteria (as per the target group) and register them for the new initiative.

Referral pathways should be underpinned by the Service Coordination strategy and include quality information sharing, feedback and agreed response times. Recruitment criteria should be clearly defined and become part of initial needs identification, which involves screening of client needs, determining access and priority, and assessing risk. Clear definitions will help to differentiate this initiative from others and avoid confusion for clients, GPs, HARP-CDM program and others.

CHSs should consider strategies to ensure that the 'right people' are recruited into the program, particularly those who have difficulty accessing services due to geographic location, ethnicity, language barriers, limited literacy levels or who lack the confidence to be good self-managers of their own health care.

Disease-specific care pathways should be discussed, developed and agreed upon with multiple agencies. It is acknowledged that this work may only focus on one or two diagnostic groups. Decisions for this targeted work should be based on local population health, burden of disease and other relevant data. Work on developing consistent disease care pathways will help to ensure that clients receive the same care regardless of where they enter the service system.

7.3.3 Key worker

All people registered for the EliCD initiative by the CHS will be assigned a key worker. The role of the key worker should be defined and delegated. The key worker should be an appropriately qualified health professional whose role includes:

- coordinating a comprehensive assessment (if required, see section 7.3.4)
- collecting clinical information at regular intervals
- ensuring that a care plan is in place and that it is monitored and reviewed (see section.7.3.8)
- identifying client and carer capacity for self-management
- communicating and liaising (including service outcome communication) with other health care providers (including GPs, AHPACC Partnership worker)
- coordinating a multidisciplinary case conference
- being a contact for the client should their condition deteriorate or circumstances change that may impact on the course of their condition
- supporting carers
- referring to community-based activities
- a flexible approach to ongoing follow up
- following up clients dropping out of the program.

For example:

A diabetes care pathway may include agreements about:

- who provides what services
- how clients are prioritised for service
- who, how and when clients are referred to diabetes education programs.

It is possible that once a care plan is in place, the key worker may have less frequent contact with the client, for example, every six months to ensure that the client's disease is stable and to provide ongoing support for self-management (for example, relapse prevention and/or support, appointment keeping with their GP and other health care providers). The frequency and type of contact (in person or over the phone) will be determined in consultation with the client and is likely to vary over time.

7.3.4 Assessment

Better Access to Services—a policy and operational framework describes three types of assessment; service specific, specialist and comprehensive assessment³¹.

Comprehensive assessment is described as:

‘an extensive process of inquiry that gathers information about medical, physical, social cultural and psychological dimensions of need and assesses restorative options and capacity for improvement’.

The level and type of assessment required will depend on the individual client's needs. It is important that assessment builds on information gathered through broad initial needs identification and includes a focus on self-management.

Many clients with chronic disease will benefit from a comprehensive assessment. It is expected that the key worker role within the CHS will include coordinating assessments from a range of different agencies to ensure a comprehensive approach, undertaking comprehensive assessment or nominating another health service provider to conduct a comprehensive assessment.

Some clients will only need service specific and/or specialist assessments. However, it will be important to coordinate assessments to avoid duplication and ‘over assessing’. As a minimum, all clients must have medical assessment and management (which necessitates a GP being identified), and coordination of medical and other assessment and care.

7.3.5 Direct service delivery and decision support tools

Direct service delivery from CHSs will include allied health, nursing, counselling and other services as needed. CHSs, in conjunction with PCPs, GPs through DGPs, and acute health services, should consider the profile of services available in the area and identify service gaps when deciding on the disciplines and skills mix required to support an integrated approach to CDM.

Flexible approaches to service delivery and addressing service gaps is encouraged, for example, using sessional staff or establishing partnerships with local agencies currently delivering community-based services for people with chronic disease.

People with chronic medical conditions and complex care needs are able to receive up to five allied health provider consultations per year as part of the allied health and dental care items under the MBS. To be eligible, GP patients must have both a GP Management Plan and a Team Care Arrangement service in place (form part of the new MBS items for CDM)³². PCPs and CHSs should work with their DGP and local allied health providers to ensure that eligible clients can access these services.

It is expected that clients registered for the EliCD initiative will need a diversity of services funded by a range of different programs and agencies. Referral options should be discussed with the client (and family/carers as appropriate). Services and programs could include:

- CHSs—for example, allied health, nursing, self-management programs
- local government—for example, Home and Community Care funded services
- medical services provided by GPs and specialists—for example, endocrinologists, respiratory specialists
- other specialist services—for example, mental health, drug and alcohol
- community-based activities—for example, neighbourhood houses, local gyms, swimming centres, walking groups.

31 Department of Human Services (2001) *Better Access to Services—a policy and operational framework*, Primary Care Partnerships Victoria <<http://www.health.vic.gov.au/pcps/publications/index>>

32 Commonwealth Department of Health and Ageing <<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease>>

Clients registered for the EliCD initiative must be able to access all appropriate services within the CHS based on clinical need. Communicating service outcomes to referrers and others involved in providing care should be a part of service delivery.

Decision support tools can support health care providers to provide good clinical care. Decision support tools may be existing clinical guidelines (for example, diabetes clinical guidelines available from Diabetes Australia), reminder systems, decision algorithms or tools which assist health care providers work through a standard process (such as the Flinders Tools).

7.3.6 Self-management interventions

Effective CDM includes evidence-based self-management interventions, delivered by trained health care providers and/or consumers. It is expected that all clients registered for the EliCD initiative by the CHS will have access to self-management support. Clients who have adopted self-management approaches are better equipped to maintain optimal health levels and remain in community-based services for a greater period of time. Self-management interventions aim to place the person in control of their life and assist them to be as independent as possible, rather than creating health system dependency.

Existing **evidence-based self-management interventions** include:

- Flinders Model³³
- Stanford Model³⁴
- Self-Management 5As (Kaiser Permanente)³⁵
- Telephone Coaching³⁶
- Motivational Interviewing for Behaviour Change (Prochaska & DeClemente Model),

33 Flinders University Model of Chronic Condition Self Management
<<http://som.flinders.edu.au/FUSA/CCTU/home.html>>

34 Stanford Chronic Disease Self-Management Program
<<http://patienteducation.stanford.edu/programs/cdsmp.html>>

35 <http://jeny.ipro.org/attachment.php?attachmentid=1322&d=1146597543>

36 Linder H, Menzies D, Kelly J, Taylor S, Shearer S, (2003) Coaching for behaviour change in chronic disease: A review of the literature and the implications for coaching as a self management intervention, La Trobe University, *Australian Journal of Primary Care*, Special Issues, The Management of Chronic Diseases in Primary Care Settings, Vol 9, Numbers 2 & 3 2003.

Self-management is:

The client working in partnership with their (and family/carers as appropriate) health care provider to:

- Know their condition and various treatment options,
- Negotiate a plan of care,
- Engage in activities that protect and promote health,
- Monitor and manage the symptoms and signs of the condition(s),
- Manage the impact of the condition on physical functioning, emotions and interpersonal relationships³¹.

Self-management is the ability of the client to deal with all that a chronic disease entails, including symptoms, treatment, physical and social consequences, and lifestyle changes.

Self-management support is the care and encouragement provided to people with chronic disease to help them understand their central role in managing their conditions, making informed decisions about care, and engaging in healthy behaviours. Self-management support goes beyond traditional knowledge-based client education to include processes that develop client problem-solving skills, improve self-efficacy, and support application of knowledge in real-life situations that matter to clients.

Good self-management support involves collaboration between client and health care provider, where the provider is coach as well as clinician and the client and family are managers of daily care. It also includes helping clients identify and achieve appropriate behavioural and lifestyle changes. This often means identifying the attitudes and beliefs clients hold about their health, and addressing the barriers to behaviour change.

Self-management support should include family and/or carers, if appropriate. Supporting behaviour change for individuals may include supporting changes being made within a family. For example, an individual who wants to make changes to their diet may need support from family members who do the food shopping or meal preparation.

Providing self-management support:

- requires a focus on building client self-efficacy as well as client knowledge
- includes assessment, goal setting, action planning and problem solving
- includes providing psychosocial support, motivating behaviour change and building confidence
- can be delivered using flexible approaches
- requires a system that describes who provides self-management support (for example, all allied health, designated and counselling staff), when, how and in what context (for example, as part of an allied health consultation, as a stand alone consultation)
- should be supported by tools that assist clients and health care providers in the process (for example, a standardised self-management care planning template, decision making support tools)
- requires staff training and ongoing support for skill development.

Self-management should be routinely encouraged through all health care encounters. This will require leaders to create systems that enable staff to promote and provide self-management support and to build their knowledge, skills and confidence to use self-management interventions.

CHSs should consider offering a range of self-management interventions, which cater to various client preferences and to different stages along a disease continuum.

Self-management interventions can be generic or disease specific and can be offered to individuals or groups.

Interventions that target clients from culturally and linguistically diverse backgrounds and significantly disadvantaged backgrounds should also be considered.

There is international and local evidence to support CHSs making adaptations to programs and approaches in order to make them more appropriate for their target audience.

CHSs may also consider supporting self-help groups. After receiving self-management support, clients may want to participate in self-help groups that provide peer support and motivation to meet self-management goals.

7.3.7 Psychosocial support

People with chronic medical diseases commonly experience depression and anxiety. Literature, the National Survey on Mental Health and Wellbeing (NSMHW, ABS, 1998) and the Victorian Burden of Disease data support this finding.

The NSMHW reports that in 1998 anxiety disorders affected just under one in 10 adults in Australia and mood disorders (including depression) affected 5.8 per cent of Australian adults. Around 40 per cent of people who experienced anxiety, depression or alcohol disorders in the NSMHW study also had chronic physical health issues, including cardiac and respiratory disorders and arthritis. These findings suggest there may be a connection between mental and physical health problems.

Depression can result from specific biological effects of chronic medical diseases. Examples of this relationship include central nervous system disorders (eg. Parkinson's disease, cerebrovascular disease, or multiple sclerosis) and endocrine disorders (eg. hypothyroidism). The association between depression and chronic medical conditions appears to be mediated by behavioural mechanisms; the limitations on activity imposed by the condition leads to gradual withdrawal from rewarding activities. Depression significantly increases the overall burden of disease. Studies have found that depression (for clients with chronic medical diseases) is associated with reduced quality of life, more days of restricted activity or missed work, 50%–80% increase in health services use and costs, and a poorer prognosis and more rapid progression of chronic disease³⁷.

Studies also show that undiagnosed depression will make it harder for people to self-manage, for example, take medications, eat properly, and keep health care appointments³⁸.

Effective CDM requires awareness of the association between depression and chronic medical conditions by all practitioners involved, particularly those in key worker roles.

37 Gregory E. Simon, *Treating depression in patients with chronic disease* <http://www.immunesupport.com/library/showarticle.cfm/ID/3203/T/CFIDS_FM/searchtext/>

38 University of Arkansas for Medical Sciences (UAMS), *Depression makes chronic diseases harder to handle* <<http://www.uams.edu/today/2003/021003/chronic.htm>>

Care planning conducted by the CHS should include psychosocial screening, which could be conducted using the psychosocial SCTT profile, and offering to refer the client to counselling if necessary. Most CHSs employ counsellors who provide effective interventions for common mental health problems, including depression. GPs also have the capacity to refer people to private counsellors at little or no cost under the MBS or other programs funded by the Australian Government. For further information, refer to *Future directions and standards for quality counselling in community health services*.³⁹

Because of the association between depression and chronic medical conditions, partnering approaches including information sharing about research and practice could lead to better outcomes for people affected by chronic conditions.

Clear eligibility criteria should be established around providing psychosocial support. Clients with a primary diagnosis of complex psychosocial needs are not appropriate for the EliCD initiative. As specialist clinical skills are required to manage these clients, they should be referred to more appropriate programs, such as HARP-CDM⁴⁰.

7.3.8 Care planning and care coordination

All people receiving services under the EliCD initiative will be assigned a CHS key worker who will liaise with their GP to assist with:

- developing a written care plan or revising and updating an existing care plan
- ensuring that the care plan is delivered, monitored, review dates are set, and that re-assessments are initiated where appropriate
- providing feedback, when necessary, to referring providers and others involved in the care of the client.

CDM service models will be expected to include arrangements that promote the participation of GPs in care planning and care coordination, and the alignment of community-based care coordination with planned multidisciplinary care for chronic disease. New items for CDM under the MBS were introduced in 2005 and these apply to people with chronic conditions and complex needs, in particular, asthma, cancer, arthritis, diabetes, heart disease and mental illness.

Three of the new MBS items include:

- preparation and review of a GP management plan
- coordination and review of team care arrangements
- contribution to a multidisciplinary care plan being prepared by another health or care provider.⁴¹

A shared plan of care is an essential element of effective CDM. It provides structure and coordination of services as the client negotiates the many care episodes characterised by long-term care and support. Care plans should be informed by established 'best practice' guidelines and recognised clinical pathways and include the following elements:

- issues/problems
- goals, actions, target dates, responsible agents
- regular review dates
- participants
- checklist—evidence of need
- method of planning.

Best practice guidelines for particular diagnoses can be accessed from peak bodies, such as Diabetes Australia, Arthritis Foundation, and Heart Foundation.

It is preferable to use the Service Coordination Plan form of the SCTT.⁴²

39 Department of Human Services (Victoria) 2006, unpublished draft *Future directions and standards for quality counselling in Community Health Services*, Primary Health Branch, Rural and Regional Health and Aged Care Services Division, Melbourne

40 <http://www.health.vic.gov.au/harp-cdm/#harp>

41 Commonwealth Department of Health and Ageing, <<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease>>

42 Department of Human Service (2006) *Service coordination tool templates*, Victoria <<http://www.health.vic.gov.au/pcps/coordination/tooltemp>>

The care planning process should be a dynamic, consultative process that includes the client (and family/carers as appropriate) and health care providers and is aimed at meeting the client's health needs in a holistic way. Treatment options should be provided so that clients can make informed decisions about their care. Goals and actions should be measurable and clearly articulate who is responsible, so that review and reflection is possible.

An example of a coordinated approach for a client with diabetes:

A GP management plan is developed by the GP. Given that ongoing multidisciplinary care from at least three providers is needed, and the client has complex needs, the GP initiates a 'Team Care Arrangement' (TCA) and makes a referral to the CHS EliCD program. The key worker receives the referral and with the GP and client, develops a multidisciplinary care plan involving collaboration with the participating providers. The care plan is based on best practice guidelines for diabetes and includes:

- involvement in a generic self-management program
- diabetes specific education
- dietary advice, planning and review
- foot care and treatment of foot problems or deformities
- involvement in a physical activity program - exercise classes/walking groups
- counselling
- involvement with peer-led support activities with people with the same condition.

7.3.9 Recall and reminder systems

CHSs should establish systems to enable service providers to be proactive in inviting or reminding clients to participate in their documented plan of care. This may be via current electronic software systems such as Microsoft Outlook, SWITCH. Agreements may be developed with the DGP and local GPs to ensure that recall and reminders are coordinated between service providers and that CHS systems do not duplicate existing recall and reminder systems within general practice.

For example:

Coordination between the GP and CHS needs to occur for a client with diabetes, so the reminder for an annual foot care assessment is not generated by two agencies.

7.3.10 Health promotion approaches

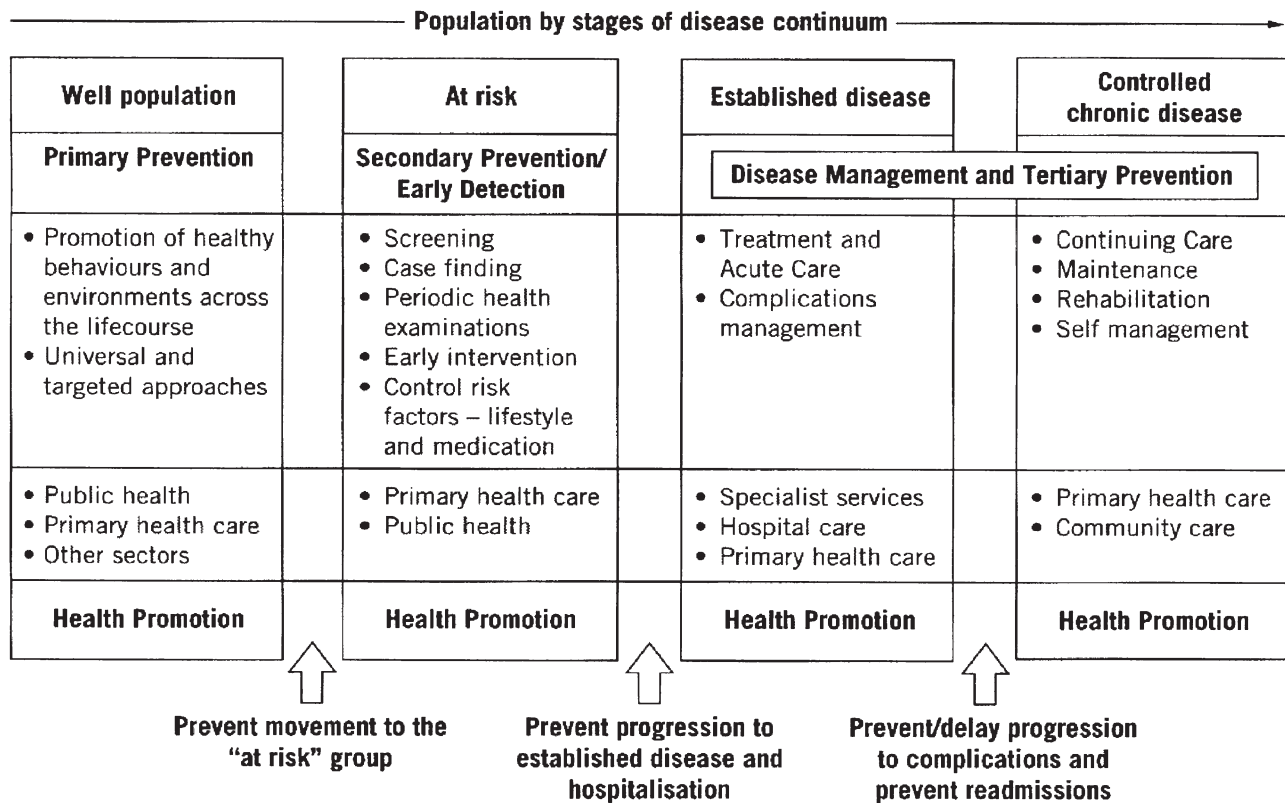
Diagram 3 illustrates a comprehensive model of chronic disease control across the continuum of care, and the role of prevention and health promotion at each stage. The model highlights the need for planning for chronic disease prevention and control across the health system. At each point on the spectrum of care, there are important opportunities for improving health literacy, client empowerment and supporting self-care.

The EliCD initiative should include health promotion approaches at the secondary and tertiary end of the continuum. This includes:

- Acknowledging that chronic disease is not just a result of individual risk factors but also broader social and environmental determinants of health. These are often the underlying causes of chronic disease.
- A focus on reducing barriers to services, often experienced by disadvantaged groups within the community. It is important that the EliCD initiative is available to these people, who often experience higher than average levels of chronic disease.
- Using health promotion approaches to develop appropriate programs that meet the needs of clients with chronic disease, particularly those from disadvantaged backgrounds, Neighbourhood Renewal areas, and from culturally and linguistically diverse backgrounds.

Diagram 3: Chronic Disease Prevention and Management Continuum

Comprehensive model of chronic disease prevention and control



(National Public Health Partnership (2001) *Preventing chronic disease: A strategic framework—Background paper*, p.6)

8. Deliverables

8.1 For PCPs

All PCPs have a role in ICDM to promote coordinated local approaches to improve the management of people with chronic disease, regardless of whether they are working with a CHS funded under the EliCD initiative in their catchment. However, PCPs without a CHS funded under the EliCD initiative will have fewer deliverables.

8.1.1 All PCPs—ICDM initiative

All PCPs are required to plan and progress work against seven ICDM goals (see Table 2, section 6). PCPs include a plan for ICDM in their Community Health Plan and report their progress through the CHPIA.

8.1.2 PCPs working with CHSs funded under the EliCD initiative

PCPs working with one or more CHSs funded under the EliCD initiative have additional goals (see Table 3, section 6). PCPs working with a CHS funded for the first time in 2006–07 are also required to work with the CHS to develop an implementation plan (see section 8.2). Information about the work of the PCP in the implementation plan should replicate information in the PCP’s Community Health Plan.

8.2 For CHSs funded under the EliCD initiative

8.2.1 Planning for CHSs funded for the first time in 2006–07

It is expected that CHSs funded for the first time in 2006–07, and their corresponding PCPs, will work together to undertake a planning (and preparation for implementation) process during 2006, and be ready for implementation in early 2007. (This includes PCPs that have an existing EliCD funded CHS and a new EliCD funded CHS.) CHSs also funded through the AHPACC Partnership should ensure coordination of effort in planning processes.

CHSs and PCPs should work together to achieve the following deliverables.

Table 4: Planning Requirements

Initial planning approach	Due 20 October
	In developing a CDM service model, CHSs and PCP member agencies are asked to use an initial planning approach. A guide (Appendix 3) has been provided to assist agencies work through this initial planning approach. The initial planning approach should be discussed with Department of Human Services regional office. CHSs and PCPs can negotiate the format of this planning approach with their regional contacts.
Implementation Plan	Due 1 December
	The implementation plan will outline: <ul style="list-style-type: none"> • a CDM service model including all components outlined in section 7.3 of this document • a planned approach to implementation that includes support for change management across the service system and within agencies. A template has been provided to assist in completing the implementation plan. The implementation plan should be documented on the template and forwarded to the Department’s regional and central offices.

8.2.2 Implementation for all CHSs funded under the EliCD initiative

Newly funded CHSs should plan to recruit staff in late 2006 in preparation for service delivery in 2007.

It is expected that the original nine funded sites have recruited staff and are implementing their CDM service models. However, it is recognised that implementation will include incremental systems changes and a process to embed new practices, over time. Therefore, it is expected that PCP planning subcommittees established for this initiative will continue to meet to monitor and review implementation and address issues as they arise. CHSs are encouraged to use these guidelines, along with additional resources and workforce development opportunities that will be provided to support their initiatives.

Data collection and reporting approaches will be developed and implemented throughout the life of the three-year agreement as described in the *Primary Health policy and funding guidelines 2006–09*.

The new approaches and systems developed by the 18 sites will inform further development and initiatives in all CHSs. Data indicates that a high proportion of clients of all CHSs have chronic disease and therefore improved CDM is important to all CHSs.

9. Planning

The following information relates specifically to PCPs and CHSs where there is new funding under the EliCD initiative. However, it can also be used by:

- all PCPs undertaking planning for their ICDM initiatives
- CHSs funded under the EliCD initiative last year, to support ongoing planning and development of their CDM service models
- CHSs that have not received EliCD funding but are keen to develop their systems to provide evidence-based care to clients with chronic disease.

As stated, it is expected that newly funded CHSs will develop an initial plan with their PCP and present this to their regional department contact (see Appendix 3 for further details).

9.1 The initial planning approach

CHSs and PCP member agencies will be engaged in planning to develop a CDM service model that will be described in an implementation plan. The implementation plan is due on 1 December. In developing this plan, agencies are asked to use the following initial planning approach, which identifies:

- the agencies to be involved and how they will work together (through the PCP)
- how the Wagner Chronic Care Model (described below) will be used to underpin the local CDM service model
- how assessment of organisational capacity will be conducted
- the resources that will be used for change management
- how the initiative will include community participation
- how Plan Do Study Act (PDSA) cycles will be used to monitor and review changes that are made during implementation.

CHSs and PCPs are asked to report on this planning approach to their Department of Human Services regional contact. The format of reporting should be negotiated with the regional contact and may be a process of discussions, a presentation, or a document with initial planning information in the form of dot points. It is important that agencies undertake this planning approach in developing their implementation plan.

The following sections provide some background information to the above dot points.

9.1.1 Partnerships

Care for people with chronic disease usually involves multiple health care providers in multiple settings. To provide this care within an integrated system, health care providers must work collaboratively through the local PCP (and AHPACC Partnership, where relevant) to coordinate and plan care and services. It requires a commitment to work together to achieve shared goals.

The PCP should be the governance structure adopted to have input into the EliCD initiative. The process used to coordinate planning for both the ICDM and EliCD initiatives may be through an existing or new PCP subcommittee. The PCP partners must agree on governance and accountability arrangements that encourage active participation and articulate shared aims and commitments. Representation from agencies should include people who can make decisions and have the capacity to implement the decisions within their own agencies. PCP executive officers/project managers would be expected to have a key role in the initiatives.

Key agencies involved in planning and implementing the initiatives should include:

- CHSs
- HARP
- DGP
- local government
- Department of Human Services regional advisor (as appropriate)
- others (for example, ACCHO, Royal District Nursing Service, neighbourhood houses, other areas of the hospital).

Regular meetings should be scheduled to discuss and make decisions, foster working relationships, develop communication pathways within agencies, and agree on common work practices.

9.1.2 The Wagner Chronic Care Model

Many articles explain the Chronic Care Model and provide examples of how it is used in health care agencies (references include quality improvement journals, medical journals, primary care journals).

Diagram 2 provides a model that contains the following elements:

1. **Community**—resources and activities that provide ongoing support for people with chronic disease/s.
2. **Health systems**—support prepared and proactive practice teams.
3. **Self-management support**—empowers and prepares clients to manage their health and health care.
4. **Delivery system design**—assists care teams to deliver systematic, effective, efficient clinical care and self-management support.
5. **Decision support**—including designs systems and tools to ensure clinical care is consistent with evidence-based guidelines.
6. **Clinical information systems**—including data systems that provide information about the client population, reminders for review and recall, and monitor the performance of care teams.

ICDM plans and CDM service models should be based on the Chronic Care Model, identify system changes that need to occur, and make reference to areas for improvement within each of the elements.

9.1.3 Organisational capacity

‘Tell me and I’ll forget, show me and I may remember, involve me and I’ll understand’

(Chinese Proverb)

Involving service providers and managers of agencies in the planning process will assist in building organisational capacity to implement and sustain the EliCD initiative.

Organisational capacity building includes:

- determining human resources, skills and knowledge,
- building organisational structures, systems and policies and
- a commitment to health improvements over time.

All elements are essential. The Victorian Integrated Disease Management Projects found that:

capacity building must focus on implementation issues for practitioners and support for organisational change. Practitioners attending training programs identified significant barriers to practice change from within their organisation⁴³.

PCPs and member agencies should consider using the following resources to plan for organisational capacity building:

Table 5: Capacity Building Resources

<p>The Assessment of Chronic Illness Care (ACIC)⁴⁴</p>	<p>CHSs may find the ACIC tool useful in surveying their organisational capacity to undertake quality integrated chronic disease management. The ACIC, based on the Chronic Illness Care Model, is designed to:</p> <ul style="list-style-type: none"> • identify areas for improvement in chronic illness care before beginning quality improvement work • identify systems gaps • measure the organisation’s capacity to implement new systems • periodically evaluate the impact of the changes being made to improve chronic illness care.
<p>Integrated health promotion resource kit</p>	<p>The partnership may consider using the IHP capacity building framework <i>Key action areas for capacity building</i>, which are appropriate for planning integrated disease management capacity building. The framework includes planning strategies under key action areas:</p> <ul style="list-style-type: none"> • partnerships • organisational development • leadership • workforce development • resources

PCPs and member agencies need to make a long term commitment to capacity building for CDM. Capacity building strategies should be aimed at staff, managers and leaders.

43 Department of Human Services (2005) *Improving chronic disease care: learnings from the Integrated Disease Management projects*, State Government, Victoria

44 A resource from the Institute for Healthcare Improvements <<http://www.ihl.org/IHI/Topics/ChronicConditions/AllConditions/Tools/ACICSurvey.htm>>

9.1.4 Change management

Implementing effective CDM strategies will require agencies to make changes to the way they practise and provide care. The ICDM initiative calls for realigned systems across agencies and the EliCD initiative calls for new and innovative approaches to providing care to people with chronic disease.

Agencies should understand and have the capacity to lead change. PCPs already have an established change management role, which will be required for their ICDM work, in particular, their support for the CHS.

Organisational change is a process that can be facilitated by perceptive planning, well-managed implementation and supportive monitoring⁴⁵.

PCPs and CHSs should consider having a plan to manage change, using a model and tools to support the change approach, and allocating resources to lead the change. Again, the integrated health promotion capacity building framework is a useful tool to support change management. (See Appendix 4 for resource links).

9.1.5 Consumer participation

Consumer, carer and community participation in the Victorian health care system is recognised as a key enabling strategy in working with and meeting the needs of a community. The *Doing it with us not for us* participation policy⁴⁶, launched in 2006, provides guidance for participation, which is described as:

Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment and the wellbeing of themselves and their community.

Building consumer, carer and community participation into the EliCD initiative will strengthen and support its implementation. Participation can occur across many levels:

- in treatment and care
- consumers employed by services as consultants and advocates
- in service delivery and evaluation,
- in policy and planning,
- in education and training,
- in staff recruitment.

Participation should be considered a priority and strategies to include participation should be planned. See Appendix 4 for useful links and resources that can show why and how participation can be supported.

9.1.6 Plan, Do Study, Act Cycles

In assessing organisational capacity, system gaps and areas for improvement will be identified. A common model used for making improvement is the PDSA cycle. This may be familiar to agencies as a quality improvement approach, used as part of their continuous quality improvement activity and preparation for accreditation (for example, EQUIP, QICSA).

PDSA cycles are used for testing a change by planning it, trying it, observing the results, and acting on what is learned. It is a scientific method used for action-oriented learning.

To begin a PDSA the following questions must first be answered:

- What are we trying to accomplish?
- How will we know that the change is an improvement?
- What changes can we make that will result in an improvement?

After changes are tested, PDSA cycles can then be used to implement or spread change. The key principle behind the PDSA cycle is to test on a small scale and test quickly. Traditional quality improvement has been anchored in laborious planning that attempts to account for all contingencies at the time of implementation; usually resulting in failed or partial implementation after months or

45 <http://www.sdo.lshhtm.ac.uk/managingchange.html>

46 http://www.health.vic.gov.au/consumer/downloads/do_it_with_us.pdf

even years of preparation. The PDSA philosophy is to design a small test with a limited impact that can be conducted quickly to work out unanticipated 'bugs'. Repeated rapid small tests and the learnings gleaned build a process ready for implementation that is far more likely to succeed.

Additional resource materials have been provided in Appendix 4 to assist PCPs and agencies use the PDSA cycle.

Reasons to test changes

- To increase your belief that the change will result in improvement.
- To decide which of several proposed changes will lead to the desired improvement.
- To evaluate how much improvement can be expected from the change.
- To decide whether the proposed change will work in the actual environment of interest.
- To decide which combinations of changes will have the desired effects on the important measures of quality.
- To evaluate costs, social impact, and side effects from a proposed change.
- To minimise resistance upon implementation.

9.2 The implementation plan

The implementation plan, also to be developed by the CHS and PCP member agencies, should be completed using an implementation template. The template is available from department regional contacts and will be due on 1 December. The implementation plan should be forwarded to the regional DHS contact and Adele Hamlyn (DHS central office). Feedback will be provided by the regional contact before Christmas. Gaps or issues identified through the feedback should be addressed prior to late January, so that implementation can begin in February.

To assist with completing the implementation plan, more information will be provided through resource materials and workforce development opportunities over the next several months.

10. Funding

10.1 For PCPs

Recurrent funding for ICDM will be provided to additional PCPs commencing in the 2006–07 financial year. This will mean that all PCPs will receive specific funding for work on ICDM, regardless of whether there is a CHS in their catchment with funding for the EliCD initiative.

The level of funding to PCPs will vary based on the number of CHSs in their catchment operating EliCD services; the complexity of their service coordination task (as indicated by the number of health services and GPs operating in their catchment); and the level of disadvantage and remoteness. To acquit this funding, PCPs will be required to undertake a number of tasks related to ICDM, including self-management.

PCPs that cover areas where there is no CHS funded for the EliCD initiative will receive a base amount of \$30,000 full year effect (FYE). PCPs that cover areas where a CHS receives funding for EliCD initiative will receive a base amount of \$50,000 (FYE). Those PCPs that cover areas where two or more CHSs receive funding for the EliCD initiative will receive a base amount of \$70,000 (FYE). A base amount of \$70,000 should be considered as one pool of funds to undertake ICDM activities.

In 2006–07, PCPs will receive 11 months of funding.

10.2 For CHSs

All 18 CHSs will receive \$400,000 per annum (FYE). However, in 2006–07 the nine new CHSs will receive 11 months of funding, that is, \$367,000. The funding includes a development and resource component and in the first year includes planning and establishment costs. The funding notionally equates to four full time positions, FYE.

10.2.1 Fees

Fees for services associated with the additional funding for CHSs should be as per the department of Human Services fees policy for the Community Health Program and the Home and Community Care Program. Fees are chargeable for services based on a person's income (low, medium or high) and their ability to pay.

10.2.2 Budget

CHSs will be required to prepare a budget for expenditure against their first year of funding. The first year includes funding for planning, set up and establishment (\$167,000) and funding for service delivery (\$200,000), all of which should include a development and resource component. The budget should be provided in the implementation plan and include:

- staff (including project manager)
- participation in evaluation (see section 13)
- GP involvement
- staff and management training
- resources
- minor capital and office set up costs (including IT requirements)
- translation (if required)
- vehicle purchase/leasing
- other.

11. Accountability and reporting

11.1 PCP reporting

Formal reporting on the PCP-ICDM initiative will be through completion of the ICDM element of the Community Health Plan and Community Health Plan Implementation Agreement (described in the *PCP reporting guidelines 2006–09*)⁴⁷.

Section 6.2 of these guidelines provided information about the work expected of PCPs over the next three years.

These are the major accountability requirements for PCPs. The department will also measure the impact of ICDM over time using the Service Coordination and Integrated Chronic Disease Management Snapshot Survey and the Self-Management Mapping Survey. All PCPs are asked to complete the survey twice during the reporting period 2006–09. PCPs are asked to conduct the self-management mapping in early 2007, using the web based survey produced by DHS.

11.2 CHS reporting

Items have been added to the CHS data reporting process so that clients registered as part of the EliCD initiative will be flagged through the Multipurpose Report. CHSs should refer to the *Community and women's health programs 2006–07, data reporting requirements*⁴⁸ for information about data reporting.

For CHSs funded in 2006–07, it is expected that there will be, at a minimum, an additional 2,555 service hours to support clients with chronic disease and complex needs. In subsequent years, this will rise to approximately 5,108 hours per annum per CHS.

For CHSs funded in 2005–06, it is expected that they will deliver 5,108 hours per annum.

⁴⁷ Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*

⁴⁸ http://www.health.vic.gov.au/communityhealth/data_reporting/reporting.htm

Table 6: Planning and reporting

	Planning				Reporting			
	1st year	Date	Ongoing	Date	1st year	Date	Ongoing	Date
CHS with new EliCD	Initial plan (presentation)	20th Oct 2006	N/A *	N/A *	Multipurpose Report Evaluation Tools	Every quarter	Multipurpose Report Evaluation Tools	Every quarter
	Implementation plan (documentation)	1st Dec 2006						
PCPs with new EliCD	Initial plan (presentation)	20th Oct 2006	Community Health Plan (CHP)	End Oct 2006	Community Health Planning and Implementation Agreement (CHPIA) Evaluation Tools	End July 2007	CHPIA Evaluation Tools	End July 2007
	Implementation plan (documentation)	1st Dec 2006						
CHS with existing EliCD							Multipurpose Report Evaluation Tools	Every quarter
All PCPs	CHP	End Oct 2006	CHP		CHPIA	End July 2007	CHPIA	

* Not applicable unless there are concerns expressed by region and central office about the initial plan and/or the implementation plan.

12. Evaluation

The Australian Institute of Primary Care has developed a statewide evaluation and reporting framework for the EliCD, in consultation with the existing nine EliCD initiatives funded in 2005–06. The final framework will be provided to agencies in November 2006 and training provided before the end of the calendar year. In addition, most CHSs funded in 2005–06 are undertaking more localised evaluations of their initiatives.

CHSs funded in 2006–07 will be required to participate in the statewide evaluation process. Out of their set up costs in the first year, newly funded CHSs are asked to contribute \$7,500 toward the development of the evaluation framework and preparation of individual agency reports summarising baseline, six-month and 12-month data. PCPs and CHSs may choose to conduct local level evaluation; however, this should be negotiated with the Department of Human Services regional contact and **must not** duplicate what is occurring at a statewide level. Local evaluation will only be supported if it is targeted towards investigating particular impacts not captured in the statewide evaluation. This would include evaluation of a specific client group, for example a culturally and linguistically diverse client group, or evaluation of a particular model component such as a GP engagement strategy.

CHSs funded in 2005–06 are not asked to contribute additional money towards evaluation, as many have already committed more than \$10,000 to local evaluation. The department will work with agencies to coordinate their local evaluation strategies with the statewide evaluation framework. Following commencement of evaluation through the statewide framework, CHSs will receive individual agency reports summarising baseline, six-month and 12-month data.

Further information

For information and advice about the development and implementation of the ELICD initiative and PCPs ICDM initiative, contact:

Adele Hamlyn
Project Manager
Integrated Chronic Disease Management
Ph 9096 6150
Mobile 0402 188177
email: adele.hamlyn@dhs.vic.gov.au

Abbreviations

ABHI	Australian Better Health Initiative
ACCHO	Aboriginal Community Controlled Health Organisation
ACIC	Assessment of Chronic Illness Care
AHPACC	Aboriginal Health Promotion and Chronic Care
BATS	Better Access to Services
CDM	Chronic Disease Management
CHPIA	Commonwealth Health Planning and Implementation Agreement
CHS	Community Health Service
DGP	Division of General Practice
DHS	Department of Human Services
EliCD	Early Intervention in Chronic Disease
GP	General practitioner
HARP	Hospital Admission Risk Program
ICDM	Integrated Chronic Disease Management
IHP	Integrated health promotion
LGA	Local government area
MBS	Medical Benefits Schedule
PCP	Primary Care Partnership
PDSA	Plan Do Study Act
PIP	Practice Incentives Program
SCTT	Service Coordination Tool Templates

Glossary

Burden of disease—the health and socioeconomic costs of a given medical condition on a society.

Chronic disease—usually characterised by complex causality, multiple risk factors, a long latency period, a prolonged course of illness, functional impairment or disability and, in most cases, the unlikelihood of cure.

Chronic disease management—is used in a generic sense in this document to refer to care for people with chronic disease and chronic conditions, which usually involves numerous health care providers in multiple settings. Care should be provided within an integrated system.

Complex needs—complexity as it related to chronic disease and chronic conditions typically involves co-morbidities and psychosocial factors. This could include older people who are becoming frailer, carer stress or a reduced ability to function independently.

Early Intervention in Chronic Disease (EliCD)—a specific funding initiative: Early Intervention in Chronic Disease for Community Health Services.

Integrated Chronic Disease Management (ICDM)—care for people with chronic disease and conditions is coordinated and connected across the continuum of services and amongst providers in all sectors and levels. This term is used in this document to describe the funded ICDM role of PCPs for 2006–09.

Appendix 1

The Australian Better Health Initiative (Commonwealth Government funding)

The Australian Better Health Initiative (ABHI) package will include the following priority areas:

a. Promoting healthy lifestyles

The program will encourage people to make informed lifestyle choices and reduce the risk of developing chronic disease. The details of these activities are under development.

b. Supporting early detection of risk factors and chronic disease

From November 2006, the Australian Government will introduce a new Medicare Benefits Schedule (MBS) item to support general practitioners, assisted by practice nurses, to provide a focused health check for patients aged around 45 years with identifiable risk factors such as weight, smoking or family history. This health check will identify patients at risk of developing chronic conditions and provide an opportunity to promote lifestyle changes, for example through Lifestyle Prescriptions (Life-scripts), or referrals to programs such as Quitline.

This new item will also help general practitioners and their staff in the early detection of chronic disease so that any required treatment can be commenced early and the risk of the disease progression reduced.

c. Supporting lifestyle and risk modification

The initiative will support people at high risk of developing a chronic condition to make lifestyle changes and reduce their risk. Individual and group lifestyle counselling and education services, including progress monitoring and follow up, will be made available to patients identified as having significant modifiable risk factors. The services will be given by approved providers such as registered nurses, Aboriginal health workers and allied health professionals.

d. Encouraging active patient self-management of chronic conditions

This measure will encourage active patient self-management of chronic conditions through targeted training for health professionals to assist people with chronic conditions to better manage their health. State and territory governments will provide leadership and support for a range of local and regional self-management activities for patients such as face-to-face group courses, telephone counselling and motivational counselling.

The Australian Government will work closely with health care professionals and state and territory health authorities to support the training of GPs and other health providers in self-management practice; assist the university and TAFE sectors in the provision of self-management education for new general practitioners, nurses, allied health professionals and Aboriginal health workers; and ensure quality control and accreditation processes relating to a range of self-management interventions; and innovative research on enhancing self-management practice.

e. Improving communication and coordination between care services

This measure will improve the coordination and continuity of care for people with chronic diseases, especially cancer. Governments will provide incentive funds to appropriate organisations to improve local connections between service providers, including private medical services, community health services and allied health services, so that patient's needs are better met.

From November 2006, a new MBS item for case conferencing will provide increased support for cancer specialists to bring together all experts working with an individual patient. State and territory health services will improve coordination of treatment and support for cancer patients, including the use of 'care coordinators'.

Appendix 2

Definitions of target populations

Hospital Admission Risk Program-Chronic Disease Management

HARP-CDM has two identified streams of care:

1. people with complex needs (including people with psychosocial needs)
2. people with chronic diseases (including people with chronic heart failure, chronic respiratory diseases, and diabetes Type 1 and Type 2 with complications. These complications may be related directly to the chronic disease; such as in the case of diabetes retinopathy, neuropathy, amputation; or may be other co-morbidities or psychosocial factors impacting on the clients ability to manage their chronic condition).

1. Complex care needs stream

This stream incorporates children and adults with a variety of interrelated health, functional and/or social issues, who are at risk of, or are experiencing, significant functional decline and/or imminent hospitalisation. The complexity is compounded by the presence of one or more of the following:

- an unstable or deteriorating condition
- increasing fragility and/or dependence
- development of complications
- co-morbidities
- significant change in social circumstances.

This stream also encompasses complex psychosocial issues related to drug and alcohol misuse and abuse, domestic violence, homelessness or at risk of homelessness, suicide ideation and self-harm, non-acute mental health issues and personality disorders. The focus is to provide:

- specialist assessment, care planning and care coordination to facilitate links to other specialist services, including drug and alcohol services and mental health services
- access to outreach services and/or case management
- specialist services as required
- medication management, self-management and self-efficacy approaches
- access to brokerage.

2. Chronic disease stream

People are supported by a care coordination model providing interdisciplinary and multidisciplinary care for the management of their chronic conditions. Chronic conditions include chronic heart failure, chronic respiratory disease (including chronic obstructive pulmonary disease, bronchiectasis, pulmonary fibrosis, chronic asthma), paediatric asthma and people with Type 1 and Type 2 diabetes with or without complications (including wound management, peripheral vascular disease, neuropathy, retinopathy). Optimal medical management between the specialist physician and GP is paramount to maintaining people with chronic disease in the community. In addition, management may consist of specialist assessment, care planning and care coordination, facilitation and links to existing services, exercise and education rehabilitation programs, management of complications and complex care needs as a result of the chronic condition, medication management, self-management and self-efficacy approaches, carer support and/or access to brokerage.

The level of service/interventions required by people in these streams is of high resource intensity. For example, in the management of chronic heart failure, clients often require co-management of their diabetes. Care may be provided through a number of services both internal and external to the health service and HARP-CDM program team.

Integrated Chronic Disease Management across the Continuum

Together, the HARP-CDM, the EliCD initiative and existing health promotion programs encompass the continuum of care from prevention through to treatment, management and maintenance of health in an effort to keep people in their community for as long as possible.

The tables below provide examples of the conditions and the level of client complexity managed by the EliCD and HARP-CDM services and differentiate between the models of care.

Table A1: Level of complexity

		HARP-CDM	EliCD
Chronic Diseases	Heart disease	Chronic heart failure	Cardiovascular disease
	Respiratory disease	Chronic obstructive pulmonary disease Clients regularly attending Emergency Department due to symptoms of asthma	Asthma Chronic obstructive pulmonary disease not requiring oxygen
	Diabetes	Complications such as wounds, PVD, amputations, neuropathy, retinopathy, renal impairment, issues around medication management	No significant complications related to diabetes
Complex Needs	Complex needs	Multiple co-morbidities Medication management issues Medically unstable and at risk of imminent hospitalisation Need for rapid access to specialist services People experiencing social and/or emotional stress Carer stress	Older people who are becoming frailer Reduced ability to function independently People experiencing social and/or emotional stress Carer stress
	Psychosocial issues	Drug and alcohol abuse Personality disorders Homelessness Suicide and self-harm	

Table A2: Summary of service models

HARP-CDM	EliCD
Responsive model	Proactive model
Short/immediate risk	Medium/longer term risk
Care coordinator	Key worker
High intensity and multiple service usage	Low intensity, but possibly multiple service usage
Specialised intervention	Recall and review, annual cycle of care

Please note that Department of Human Services HARP-CDM and Primary Health Branch staff are continuing to work together to clarify and provide advice on the respective client target groups for each program, including the links between HARP-CDM and the EliCD services.

Appendix 3

Guide to initial planning approach

Community Health Services (CHSs) and primary care Partnerships (PCPs) are asked to report on the initial planning approach to their Department of Human Services regional contact. The format of this reporting should be negotiated with the regional contact and may be a process of discussions, a presentation, or a document containing thoughts in the form of dot points.

In undertaking the initial planning approach to develop the implementation plan, CHSs and PCPs should work through the following questions. While these questions do not need to be answered in detail, regional contacts will expect that thought has been given to each question and agencies are on track in terms of planning and developing an implementation plan.

1. Partnerships

What are the key agencies?

Within the PCP governance structure, what forum (existing or new) will be used to coordinate planning for this initiative?

What documentation describes the functions and processes of this forum (for example, Terms of Reference)?

What are the accountability arrangements?

2. The Wagner Chronic Care Model

How will the Chronic Care Model inform local service model development?

What elements of the model will the CHS and the PCP focus on?

How will the model be used as a framework for quality improvement in chronic disease management?

3. Organisational capacity

What tool/s will be or have been used to assess organisational capacity within the CHS?

How will capacity building be planned and supported within the CHS, PCP and across member agencies?

What training and development opportunities will be planned for managers and for staff?

4. Change management

What resources and personnel will be used to lead change within the CHS, and across the PCP?

Who (which agencies, teams, staff) will be involved?

How will leaders be supported to manage change?

How will staff be supported through change?

5. Community participation

At what level will community participation occur?

How? Who will support participation?

6. Plan Do Study Act (PDSA) cycles

What is the capacity to undertake PDSA cycles (knowledge, understanding, leadership, time)?

How will they be used?

How will the learnings from PDSA cycles be disseminated?

Appendix 4

Resources and links to support planning

1. Partnerships

Primary Care Partnerships strategic directions 2004–2006—outlines the vision for partnerships within the primary care sector

http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_strat_2004_06.pdf

2. The Wagner Chronic Care Model

Information about the chronic care model can be sourced from the following websites:

<http://www.improvingchroniccare.org/>

<http://www.ihl.org/IHI/Topics/ChronicConditions/>

Becoming a member of the Institute for Healthcare Improvement is free (via the above website) and provides access to a range of resources that can assist agencies implement the model, including using PDSA cycles, setting up teams, and examples of the model in practice.

The Chronic Care Model is not a quick fix or a magic bullet; it is a multidimensional solution to a complex problem. It provides a road map for changing the system. There is now strong evidence that an integrated set of system changes can substantially improve client health and satisfaction. There are many examples, in literature and on the Web, of how the Chronic Care Model has been used to improve health care.

3. Change management

Developing change management skills:

<http://www.sdo.lshtm.ac.uk/managingchange.html>

This website contains three useful documents that can easily be downloaded:

1. Developing change management skills. A resource for health care professionals and managers

Valerie Iles and Steve Cranfield

This publication and web-based resource aims to help those leading change in health care settings.

2. Organisational change: a review for health care managers, professionals and researchers

Valerie Iles and Kim Sutherland

This publication is a review of models of change management to help managers, professionals and researchers in health care find their way around the literature and consider the evidence available about different approaches to change.

3. Making informed decisions on change: key points for health care managers and professionals

Marsaili Cameron, Steve Cranfield, Valerie Iles and Jud Stone

A booklet, drawing on the above review, which encourages managers and professionals to reflect on and share what helps and hinders successful change to improve the quality of services.

4. Assessing organisational capacity

The ACIC (Assessment for Chronic Illness Care) can be downloaded from the Institute for Healthcare Improvement at:

<http://www.improvingchroniccare.org/improvement/docs/acic35.pdf>

The *Integrated health promotion resource kit* can be downloaded from the following website:

http://www.health.vic.gov.au/healthpromotion/resources_links/integrated.htm

Section 5 provides advice on how to plan and implement capacity building strategies.

5. Community participation

The policy, *Doing it with us not for us*, developed by the Victorian Department of Human Services describes the strategic direction in consumer, carer and community participation across the Victorian health services system. A strategic directions paper is also available.

http://www.health.vic.gov.au/consumer/downloads/do_it_with_us.pdf

http://www.health.vic.gov.au/consumer/downloads/do_it_with_us_strategic.pdf

Supporting and promoting consumer participation is a main role for the Health Issues Centre. Their web page provides many links and resources.

http://www.healthissuescentre.org.au/consumer_participation/index.asp

Another helpful resource, developed by the Department of Human Services in 2000, is a guide that assists health practitioners to work with consumers to design written health information. The guide aims to ensure that information meets consumer's needs, is comprehensive and written in an unbiased way.

<http://www.health.vic.gov.au/consumer/pubs/written.htm>

6. Plan, Do, Study, Act (PDSA) cycles

PDSA cycles are very useful in testing small scale changes. Further information about PDSA cycles and examples of how they have been used to implement aspects of the Chronic Care Model are available on the Institute for Healthcare Improvement website at:

<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>

The NSW Government has produced a document, *Improving care for people with chronic disease: a practical toolkit for clinicians and managers*. It includes information, tools and a step by step process using PDSA cycles. It has been developed to facilitate implementation of improvements for people with chronic disease. The toolkit is based on outcomes from the NSW Chronic Care Collaborative and includes a CD of resources developed by the collaborative team. The document is available at:

http://www.health.nsw.gov.au/pubs/2005/chronic_toolkit.html

The Australian Primary Care Collaboratives Program is an initiative funded by the Australian Government that aims to help general practitioners (GPs) and primary health care providers work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex conditions and promote a culture of quality improvement in primary health care. The Collaboratives methodology, designed by the Institute for Healthcare Improvement in the USA, uses the PDSA approach to achieve incremental, rapid and locally relevant improvements across a broad range of clinical and practice business issues. The topics to be addressed in the first phases of the Australian Primary Care Collaboratives Program are Diabetes, the Secondary Prevention of Coronary Heart Disease, and Better Access to primary care. PDSA tools are available at:

http://www.npcc.com.au/sharing_resources.html

