

North Central Metropolitan Primary Care Partnership

CHRONIC ILLNESS CARE SYSTEMS DEVELOPMENT

A COMMUNITY HEALTH MODEL

FINAL REPORT

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Marie Gill & Jane Willcox

t 03 95335369
e marie@gillandwillcox.com.au
p PO BOX 9163 Brighton 3186

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Introduction

Background

Approximately 70% of the burden of disease and injury borne by the Australian population can be attributed to chronic conditions that require ongoing management over a period of years or decades.¹ Chronic diseases are amongst the most prevalent, costly and preventable of all health problems leading to an increasing burden both on our health care system and on individuals with chronic conditions.²

Studies strongly suggest that people with chronic disease have a better quality of life, experience fewer complications and reduce their overall use of health care resources if they participate in an integrated disease management program tailored to their needs.²

Integrated Disease Management (IDM) is a comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease or condition, aiming to reduce the burden of disease through a holistic approach. It encompasses the continuum of care from prevention through to treatment, management and maintenance.³

There is an increasing emphasis on delivery of chronic disease care through a more systematic and holistic approach with a number of State and Federal government initiatives such as the National Chronic Disease Strategy (NCDS)², the Victorian Ambulatory Care Framework (ACF)⁴, the Hospital at Risk Program (HARP) Chronic Disease Management Guidelines⁵ and Community Health Services—Creating a Healthier Victoria⁶.

Each of these initiatives identifies the important role of community health in supporting chronic disease care through:

- Prevention and early detection
- Early intervention
- Providing comprehensive intervention programs that support integration of care across health care sectors
- Promoting self management.

With these policy initiatives in mind the four community health services within the North Central Metropolitan Primary Care Partnership (NCMPCP) commissioned work to develop a Chronic Disease Care Model for community health that encompassed the continuum of care outlined above.

Purpose of consultancy

- Document a proposed model of good practice in chronic illness care suitable for adoption by four nominated Community Health Services: Plenty Valley Community Health, Darebin Community Health, North Yarra Community Health and North Richmond Community Health Centre.
- Propose a staged plan for implementation of the model in each of the four nominated Community Health Services based on an assessment of their current level of alignment with the proposed model.

Methodology

The following process was undertaken to ensure the development the model was based on current best practice and consistent with community health, care practices and policy initiatives.

1. Literature review

A literature review was undertaken to identify learnings related to the provision of care within community health for people with chronic health conditions and practical strategies that agencies could adapt to support system change within their organisations. This information was provided in July prior to the service workshops and further documentation reviewing updated HARP guidelines circulated prior to the August combined workshop.

2. Mapping of chronic disease related care activities across the community health centres

Needs Analysis Tool

An organisational Needs Analysis Tool was completed by key personnel in three of the community health services. The Needs Analysis Tool was adapted from the Department of Human Services (Public Health) Health Promotion Skill Assessment Tool for Organisations.⁷

The tool outlined a number of indicators for best practice in chronic disease prevention and management and stepped participants through a process that:

- a. Assisted agencies to reflect on the role they can play in promoting best practice within a community setting, and the corresponding skills and infrastructure required for best practice.

- b. Reviewed the agency's current skills and practices in chronic disease prevention and management.
- c. Established priorities for service and skill development.

Best practice pointers were identified from a number of chronic disease best practice guidelines and recommendations.^{2 8 9 10 11 12}

Workshops

Facilitated workshops were held in July with three of the community health services to complete the Needs Analysis Tool. Current activities related to chronic disease care were also mapped within the workshop.

The workshop results were collated and discussed in a combined workshop (17/8/2005) with representatives from each of the organisations. The combined workshop provided the opportunity for key personnel across the four organisations to develop a common understanding and collectively agree on:

- a. What is best practice in chronic disease care within a community health setting?
- b. What changes need to occur to improve chronic disease care within organisations?
- c. Strategies and priorities for implementing those changes.

A summary of the findings from the workshops is outlined in [Attachment 1](#).

3. Documentation of Chronic Diseases Care Model

The results from the literature review, mapping matrix, Needs Analysis Tool and the workshops were synthesised to develop key recommendations to inform documentation of the model and implementation plan.

The recommendations and a draft model were discussed and refined in a workshop (16/9/2005) with representatives of the four community health services.

Chronic Disease Care – A community health model

Chronic disease

Chronic disease occurs across of the whole community affecting both children and adults and results in both physical and or mental health problems. These problems can not be cured and often become progressively worse over time. Living with a chronic disease can be stressful both for the person with the condition and family members or carers. Unlike acute health conditions significant responsibility for managing the condition rests with the individual.

The Australian Institute of Health and Welfare (AIHW) defines chronic disease as those conditions that have the following key elements:

- Have complex and multiple causes
- Usually have a gradual onset, although they can have sudden onset and acute stages
- Occur across the life cycle, although they become more prevalent with older age
- Compromise quality of life through physical limitations and disability
- Are long term and persistent, leading to a gradual deterioration of health
- While usually not immediately life-threatening, they are the most common and leading cause of premature mortality.¹³

This definition was used in considering model development and a number of key chronic diseases were identified as being the focus for the model these included:

- Asthma and chronic obstructive pulmonary disease (COPD)
- Diabetes
- Cardiovascular disease including angina, hypertension, congestive heart failure and stroke
- Osteoarthritis, rheumatoid arthritis and osteoporosis.

A community health model

Community health has been providing care for people with chronic health conditions since its inception. The increasing prevalence of chronic health problems in the community, and increasing financial burden of providing care within hospitals has resulted in a greater demand for care within a community health setting.

Community health's holist approach to chronic disease care has gained greater attention as governments and health organisations recognise the need to place greater emphasis on prevention and early intervention.

Meeting the increasing demand for chronic disease care requires a review by community health services. Refinement and streamlining care practices to ensure they are consistent with best practice and effectively using available resources will be required.

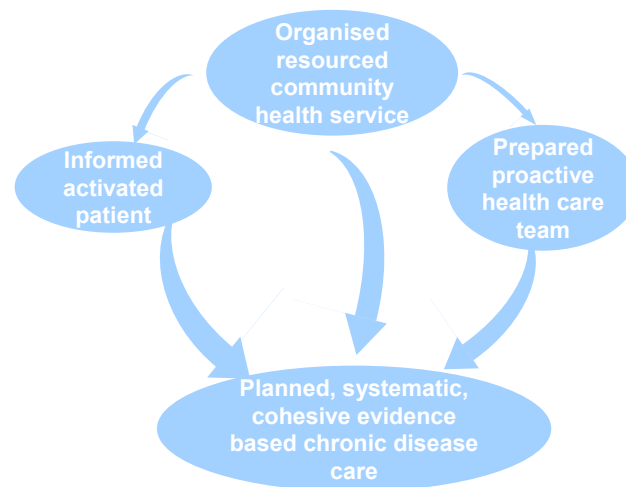
As a result of reviewing the way care is presently delivered, considering the literature and discussing the policy environment number of key areas where improvements could be made chronic disease care within identified.

Four key areas for improving chronic disease care identified were:

- An organised resourced service
- Informed and activated clients
- Prepared proactive health care team
- Systematic cohesive evidence based chronic disease.

Focussing on these key areas provides an overarching framework for improving chronic disease care. (Figure 1: Chronic disease care: a community health model)

Figure 1: Chronic disease care – A community health model



(Adapted from Wagner - Chronic Care Model¹⁴)

The model is applicable to both children and adults with a chronic disease.

Improving chronic disease care: what we aiming to achieve?

The first step in clarifying what was required to improve chronic diseases care was to consider what the service would look like if it was delivering best practice care as identified through the workshop phase. The key outcomes table (*Table 1*) highlights the desired outcomes of the implementation of the chronic disease community health model.

Table 1: Key outcomes of chronic disease community health model

Target group	Outcomes
Client	<ul style="list-style-type: none"> ▪ Clear point of entry/needs identified • Collaborative care plan • Multidisciplinary support to actively manage disease • Interventions to match their needs • Effective communication with other health services • Ongoing support
Health care team	<ul style="list-style-type: none"> • Systems and tools to support systematic planning and delivery of care • Appropriate training to deliver best practice care • Clear expectations of their role and other teams members
Other organisations	<ul style="list-style-type: none"> • Clear point of entry/ease of access • Articulates/compliments their service • Capacity to share information • Clear and consistent communication
The community health centre	<ul style="list-style-type: none"> • Systematic planning and delivery of care • Effective use of resources • Improved capacity to evaluate service, identify service gaps • Improved clinical governance through robust clinical practices and protocols • Improved capacity to be responsive to community need
The community	<ul style="list-style-type: none"> • Greater health knowledge • Improved access to services

Key areas for change

Delivering chronic disease care is core business for community health. Achieving best practice chronic disease care through the implementation of the chronic care model doesn't require community health to change the way they provide care but rather refine chronic disease care practices.

Changes to refine chronic disease care have been categorised under four organisational components of chronic disease care as identified by Improving Chronic Illness Care (ICIC), a national program of The Robert Wood Johnson Foundation.¹⁵

1. **Delivery system design**- organise care teams to deliver systematic, effective, efficient clinical care and self management support.
2. **Self-management support** - empower and prepare patients to manage their health and health care. (see below for definition of self management)
3. **Decision support** - promote clinical care that is consistent with scientific evidence and patient preferences.
4. **Clinical information system** - organise patient and population data to facilitate efficient and effective care.

Areas for change in these four organisational areas were discussed in the workshops and essential elements for change under each of these categories considered and prioritised to form the basis for the implementation plan. A summary of key changes are outlined in *table 2*.

Definition of self management

Involves the individual with the chronic condition working in partnership with their carers and health professionals so that they can:

- Know their condition and various treatment options
- Negotiate a plan of care i.e. care plan, and review/monitor the plan
- Engage in activities that protect and promote health
- Monitor and manage the symptoms and signs of the condition
- Manage the impact of the condition on physical functioning, emotions and interpersonal relationships.¹⁶

Table 2: Summary of key changes

Organisation component	Essential elements for change
Delivery system design	<ul style="list-style-type: none"> ▪ Clear point of access ▪ Assessment & care pathways ▪ Care plan /case management ▪ Follow up and review
Self-management support	<ul style="list-style-type: none"> ▪ Collaborative care planning ▪ Self management integrated into services ▪ Capacity building of health professionals
Decision support	<ul style="list-style-type: none"> ▪ Embed evidence-based guidelines into assessment and care plans ▪ Integrate specialist & care primary expertise
Clinical Information system	<ul style="list-style-type: none"> ▪ Share information with providers to coordinate care ▪ Facilitate individual patient care planning ▪ Monitor performance of practice team and care system ▪ Organise patient and population data

Implementation plan

Achieving sustainable change within community health requires a systematic long term approach. Changes need to be integrated with other initiatives influencing change within the sector such as PCP service coordination and health promotion programs, community health early intervention initiatives and HARP chronic disease care guidelines.

The implementation plan that follows outlines the key changes required under the four organisational areas and suggestions for a stepped three year approach to implementation. The plan is intended as a template for each service to discuss and refine according to own needs and priorities

Organisational Requirements

Changes identified in the implementation require support for change at all levels of the organisation.

Implementation of the proposed model requires:

- Designated personnel responsible for planning, implementing and evaluation the changes
- Management support for the changes
- Adequate resourcing for planning implementation and evaluation
- Training for staff as identified in the implementation plan.

The tables below indicate the key changes under the organisational components of the model and each of the identified essential areas for change.

1. Delivery system design
2. Self-management support
3. Decision support
4. Clinical information system.

Changes identified as high priority or areas for collaboration (as discussed in the workshops) along with links to other initiatives are indicated.

1.0 Delivery Design System

1.0 Delivery system design		Other considerations
1.1. Clear point of access		
Year 1	<ul style="list-style-type: none"> ▪ Establish one point of access for all referrals i.e. receptionist, intake worker. ▪ Establish minimum data to be collected at this point. ▪ Ensure that intake process provides: <ul style="list-style-type: none"> ○ Information on eligibility for the service and types of services available ○ Individuals not eligible for the service are referred to appropriate resources. ▪ Implement standard initial needs identification (INI) process including protocols to ensure: <ul style="list-style-type: none"> ○ Minimum data set agreed upon that supports identification of high risk clients ○ Those at high risk are referred and care prioritised appropriately within the service ○ Referrals from other agencies are acknowledged (receipt of referral) and informed of progress of referral. 	<p>High priority</p> <p>Align with:</p> <ul style="list-style-type: none"> ▪ PCP service coordination
Years 2 & 3	<ul style="list-style-type: none"> ▪ Integrate one point of access to be available via a number of methods i.e. online, phone, fax, e-referral web/email. ▪ Promote one point of access to other organisations i.e. GPs. 	

1.2. Assessment & care pathways	
Year 1	<ul style="list-style-type: none"> ▪ Develop a common assessment form, completed for all clients with a chronic condition. ▪ Common assessment collates minimum data for all chronic conditions, including identifying lifestyle risk factors, self management skills and depression. ▪ Ensure assessment builds on data collected at INI. ▪ Develop agreed upon care pathways (may begin with limited number of conditions). ▪ Ensure assessment is based on the participation of the individuals with chronic disease, their support systems(s) and interdisciplinary team members. ▪ Arrange allied health chronic care teams to support common assessment and identification of clients with complex. Attachment 2: Assessment examples ▪ Attachment 3: Care pathway example <p style="text-align: right;">High priority</p> <p>Align with:</p> <ul style="list-style-type: none"> ▪ PCP service coordination ▪ HARP CDM guidelines
Year 2 & 3	<ul style="list-style-type: none"> ▪ Continue to work on assessment forms to incorporate: <ul style="list-style-type: none"> ○ Discipline and disease specific profiles that can be added to common assessment form ○ Information about medical, physical, social and psychological needs, from a range of sources, to reflect a comprehensive picture of consumer/family/carer strengths, resources and problems. ○ Risk assessment for complications and other co-morbidities associated with their chronic disease. ▪ Organise care team to support above processes. ▪ Refine care pathways to incorporate: <ul style="list-style-type: none"> ○ Use of varied intervention options, general and disease specific i.e. group programs, telephone coaching ○ Integration with other chronic care services within the community. ▪ Consider staff training needs, cross training and expanding practitioner roles to provide flexibility in care delivery. ▪ Clinical pathways expanded to include other chronic conditions.

1.3. Care plan /case management	
Year 1	<ul style="list-style-type: none"> ▪ Develop key worker role. ▪ Key workers will be team members who take overall responsibility for coordinating the care of individual clients. ▪ Clients are allocated a key worker. ▪ All clients have a documented care plan that: <ul style="list-style-type: none"> ○ Is based on a comprehensive assessment ○ Is developed collaboratively with individuals(s) with chronic disease, their support systems(s) and interdisciplinary team members ○ Identifies issues/problems, risk profile and develops appropriate strategies to address these ○ Includes appropriate treatment regime and education interventions according to best practice guidelines ○ Encourages and supports self-care strategies ○ Identifies appropriate follow up and review. ○ Documents individual's progress, including goals and achievement of them ○ Privacy and confidentiality procedures are adhered to
Years 2 & 3	<ul style="list-style-type: none"> ▪ Develop disease specific care plans, protocols and care pathways across disciplines. ▪ Refine care plans and pathways to reflect complexity of condition based on agreed criteria. ▪ Upskill staff to promote capacity for key worker to provide comprehensive care. ▪ Develop planned visit protocols (aim to predict needs of clients rather than react to problems). ▪ Organise care teams to provide care according to complexity of condition. ▪ Upskill staff to provide case management role for complex clients. ▪ Involve consumers in consultative role - planning and evaluation of care.
	<p>High priority</p> <p>Align with:</p> <ul style="list-style-type: none"> ▪ PCP service coordination ▪ HARP CDM guidelines ▪ GP chronic disease initiatives <p>Potential for sharing</p>

1.4 Follow up and review	
Year 1	<ul style="list-style-type: none"> ▪ All care plans document planned follow up for clients. ▪ Referral to other providers is documented and appropriate information supplied. ▪ Develop process to support routine follow up.
Years 2 & 3	<ul style="list-style-type: none"> ▪ Recall mechanisms in place including protocols for early identification and treatment of complications. ▪ Develop process/protocols for identifying and managing missed follow ups.
	<p>High priority</p> <ul style="list-style-type: none"> ▪ Align with PCP service coordination ▪ HARP CDM guidelines ▪ GP chronic disease initiatives

2.0 Self Management Support

Self-management support		Other considerations
2.1. Collaborative care planning		
Year 1	<ul style="list-style-type: none"> ▪ Ensure client central role in managing their health emphasised. ▪ Use self management tools to assess self care capability. ▪ Care plan includes client goals. ▪ May consider stepped introduction with specific client groups. 	<p>High priority</p> <p>Align with:</p> <ul style="list-style-type: none"> ▪ GP chronic disease initiatives
Years 2 & 3	<ul style="list-style-type: none"> ▪ Evaluate year one strategies, refine and extend to broader client population. ▪ Consider strategies for coordination of collaborative care planning to support self management across organisations. ▪ Involve consumers in consultative role - planning and evaluation of care. 	
2.2. Self management support strategies		
Year 1	<ul style="list-style-type: none"> ▪ Identify effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up. ▪ Ensure clients are provided with information on their condition, their results and disease specific guidelines. ▪ Ensure client information is consistent with, and promotes, self management. 	<p>High priority</p>

2.2. Self management support strategies cont		Potential for sharing
Years 2 & 3	<ul style="list-style-type: none"> ▪ Continue to develop client information in particular information for “at risk groups” in catchments. ▪ Consider taking self management programs out into the community. ▪ Consider role of peer workers 	
2.3. Self management integrated into services		
Year 1	<ul style="list-style-type: none"> ▪ Self management strategies incorporated into all programs. ▪ Consider worker roles and responsibilities to carry out self management support and follow up. ▪ Provide a number of options including groups and individual counseling. 	High priority
Years 2 & 3	<ul style="list-style-type: none"> ▪ Consider whole of organisation approach to self management from first point of contact to ongoing follow and maintenance ▪ Consider role of peer support ▪ Look at working with other organisations in catchments. ▪ Identify community resources that could support clients achieve self management goals. ▪ Involve consumers in planning and evaluation of care 	Potential for sharing
2.4. Capacity building of health professionals		
Year 1	<ul style="list-style-type: none"> ▪ Train staff in key self management strategies <ul style="list-style-type: none"> ○ Goal setting/problem solving ○ Coaching/motivational interviewing. ▪ Documented self management programs to support systematic implementation. 	High priority
Years 2 & 3	<ul style="list-style-type: none"> ▪ Expand number of team members trained in self management strategies. ▪ Ongoing staff development to consider new or expand self management strategies. 	

3.0 Decision Support

3.0 Decision support		Other considerations
3.1. Embed evidence-based guidelines into assessment		
Year 1	<ul style="list-style-type: none"> Embed evidence based guidelines in care delivery system (could start with a number of key conditions). Provide workforce development to support comprehensive assessment incorporating guidelines. 	Align with <ul style="list-style-type: none"> HARP CDM guidelines GP chronic disease initiatives
Years 2 & 3	<ul style="list-style-type: none"> Expand work of year one to involve more conditions, early identification/screening. Use locally adapted evidence-based guidelines that include standardized severity assessment and intensification of care. 	
3.2. Embed evidence-based guidelines into care plans		
Year 1	<ul style="list-style-type: none"> Develop standardised care plans to prompt consistent evidence based care. Adapt guidelines to consumer friendly resource. Provide consumers with handouts outlining "Care Standards". Undertake workforce development to support incorporating guidelines into care plans. 	Potential for sharing Align with <ul style="list-style-type: none"> HARP CDM guidelines GP chronic disease initiatives
Years 2 & 3	<ul style="list-style-type: none"> Expand work of year one to involve more conditions, early identification/screening. Expand capacity of organisation to link clients to easily accessible, accurate information. 	
3.3. Integrate specialist & care primary expertise		
Year 1	<ul style="list-style-type: none"> Protocols /service agreements for communication/care planning, case conferencing and consultation. 	
Years 2 & 3	<ul style="list-style-type: none"> Create mutually agreed-on care plans that can be used in primary & specialist care. Look at strategies for sharing of expertise between specialist care and community health. 	

4.0 Clinical information systems

4.0 Clinical information systems

4.1. Share information with providers to coordinate care.

Other considerations

<p>Align with:</p> <ul style="list-style-type: none"> ▪ PCP Service coordination and e-referral initiatives ▪ GP chronic disease initiatives 	<ul style="list-style-type: none"> ▪ Ensure client information is documented and managed so that all team members have access to information at all points of care. ▪ Implement Service Coordination protocols for sharing information within and across services. ▪ Ensure client has copy of agreed care plan and has consented to sharing of information.
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<p>Year 1</p>	<ul style="list-style-type: none"> ▪ Build IT capacity to facilitate sharing of information and access to client information for all care providers.
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4.2. Facilitate individual patient care planning.

<p>Align with:</p> <ul style="list-style-type: none"> ▪ PCP Service coordination and e-referral initiatives ▪ GP chronic disease initiatives 	<ul style="list-style-type: none"> ▪ Ensure data base contains information to prompt guideline based care. ▪ Develop IT systems that populate client record. ▪ Establish client registry.
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<p>Year 1</p>	<ul style="list-style-type: none"> ▪ Develop processes for use of client registry including designating personnel for data entry, assuring data integrity and registry maintenance.
<p>Years 2 & 3</p>	<ul style="list-style-type: none"> ▪ Use registry to generate reminders and care planning tools.

4.3. Monitor performance of practice team and care system	
Year 1	<ul style="list-style-type: none"> Develop systems/process to utilise client registry, assessments and care plans to monitor delivery of best practice care and identify areas of care not meeting practice guidelines. (May start with a number of key conditions and expand in year two and three)
Years 2 & 3	<ul style="list-style-type: none"> Review practices and protocols for sub population groups. Build opportunity for consumers input regarding areas for improvement in care system and practice team into care delivery.
4.4. Organise patient and population data	
Year 1	<ul style="list-style-type: none"> Identify high risk groups, groups not presenting for care or groups not meeting best practice guideline care.
Years 2 & 3	<ul style="list-style-type: none"> Use IT system to organise client data to assess delivery of care for individuals, populations, identify at risk groups, groups not attending for care. Use client registry to plan interventions, new programs, screening, prevention activities and social marketing.
	<p>Align with:</p> <ul style="list-style-type: none"> PCP Service coordination and e-referral initiatives GP chronic disease initiatives
	<p>Align with PCP health promotion</p> <p>Potential for sharing</p>

Getting started and checking on progress

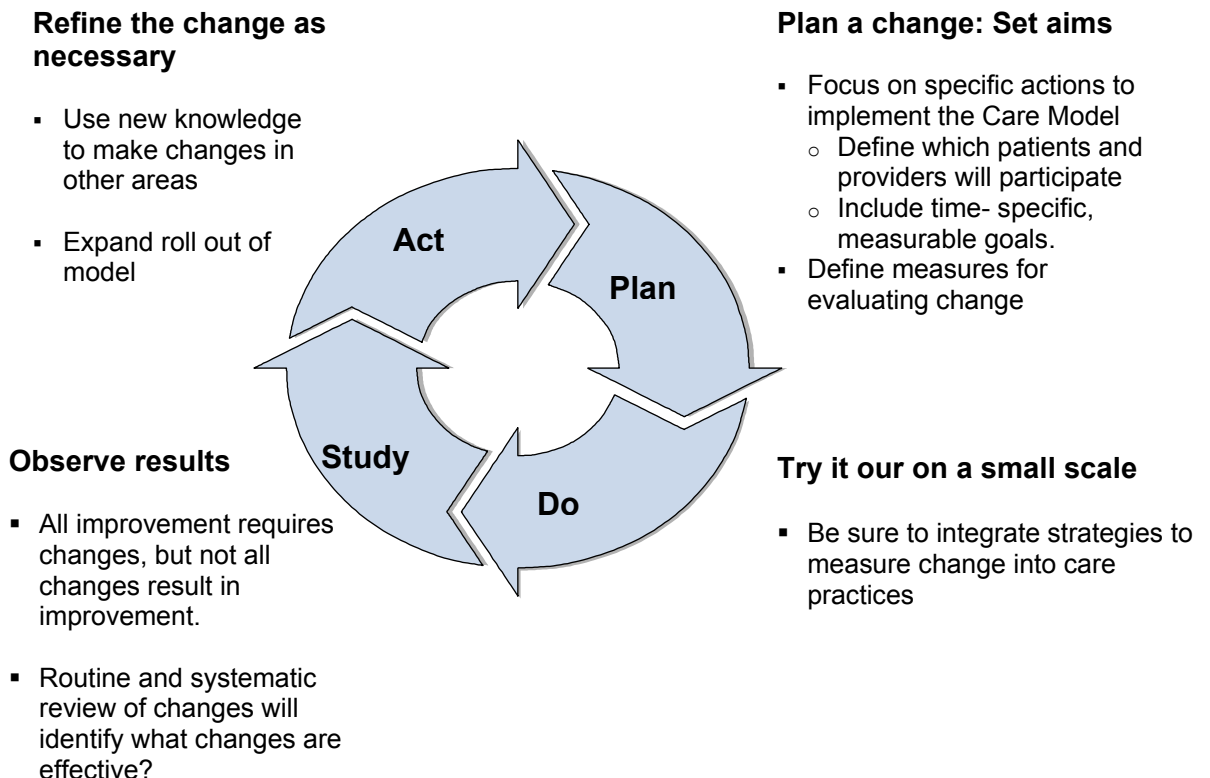
The collaborative approach taken in the review of organisational approaches to chronic diseases care and workshopping model development will provide a valuable start to the change process.

Continuing this collaborative, inclusive approach will provide ongoing support for change.

Getting started with change is often the most difficult part. Engaging service providers by asking them to consider their role in chronic disease care and what changes they could make to improve care under the four key component area could help to start the process. (See attachment 4 for example)

A continuous improvement model of plan, do, study, act is recommended to support implementation and evaluation of the changes.

Figure 2: Plan do study act cycle



Evaluation

Process and outcome measures of individual components of the model and global measures of organisational improvements should be integral components of the implementation process. The effectiveness of the model for improving chronic disease care will be reliant not only on the capacity of the model to effect change in care delivery but also the way the changes are planned and implemented. Suggestions for outcome and process measures are listed below.

A stepped approach to evaluation is recommended with a combination of process and outcome measures used to consider individual aspects of the program along with the overall outcomes for model implementation.

Process measures

The use of the *plan do study act* methodology:

- Defining standards to be achieved
- Defining time frames and measurable criteria for meeting the standards
- Embedding processes for measuring compliance with standards into care delivery
- Reviewing results and refining processes

Strategies could include:

- Case review meetings to review client care plans and assess care in relation to standards
 - case review processes can also identify cases where the standards may need to be adapted to meet the needs of different groups
- Audits of intake processes, client records, recall and reminder mechanisms to determine percentage of clients receiving care according standards
- Documenting client goals on care plans and assessment of goal attainment, and collating this information for the whole or sub groups of the client population.
- Quality of life and self management questionnaires for individual counselling and group programs

A book by Lorig and colleagues “Outcome Measures for Health Education and other Health Care Interventions”¹⁷ provides a number of tools that could be used to measure outcomes of care processes. This book can be purchased from Arthritis Victoria.

The Health Education Impact Questionnaire developed by Richard Osborne at Melbourne University is a self management evaluation tool that has been validated within Australia and is readily available from the Rheumatology Department, Melbourne University ph 9342 7634.

Outcome measures

Focussing on key outcomes of chronic disease community health model identified in Table 1 earlier in this document would provide the basis for planning outcome evaluation.

Strategies for measuring outcomes could include:

- Satisfaction surveys to clients and partner organisations
- Focus groups with clients/ community members
- Global collation of results utilising techniques and tools identified under process evaluation.
- Self assessment tool developed by authors of the ICIC model. This tool has a number of different subscales that measure each of the four organisational components of the model along with overall organisational and integration scales. These components can be used individually to assess progress in relation to implementation of components of the model or as one tool to provide an overall assessment of progress. A copy of the tool is included in [Attachment 5](#).

Attachment 1: Mapping and review of chronic disease care

The review of services was undertaken using the Chronic Illness Needs Analysis Tool by NYCH, DCH and PVCH and reviewed in a combined workshop. Within the combined workshop participants reflected on:

- How chronic care is delivered at the moment in and across organisations
- Identified areas they are doing well in and areas for improvement
- Identified key drivers and priorities for change.

The key findings of the mapping and discussion process are outlined below.

1. Summary of Chronic Illness Needs Analysis Tool findings

Agency capacity and resources	
1.1 There is agency support for best practice chronic disease prevention and management.	<ul style="list-style-type: none"> • Identified need for improvement • Needs to be high priority in order to support change
1.2 The suitably qualified. <u>Management</u> staff	<ul style="list-style-type: none"> • Identified need for improvement
1.3 Co-operative working relationships with other agencies.	<ul style="list-style-type: none"> • Doing well in this area
1.4 Suitably qualified staff who <u>provide</u> chronic disease prevention and management services are	<ul style="list-style-type: none"> • Identified need for improvement

Provision of planned care based on best practice guidelines	
2.1 Provision of <u>planned</u> care at initial contact	<ul style="list-style-type: none"> • Identified need for improvement • High priority for change
2.2 <u>Assess</u> the needs of individuals	<ul style="list-style-type: none"> • Identified need for improvement • High priority for change
2.3 <u>Care planning</u>	<ul style="list-style-type: none"> • Identified need for improvement • High priority for change
2.4 <u>Education</u>	<ul style="list-style-type: none"> • Doing well in this area

2.5 Tailor education to meet the special needs of clients?	<ul style="list-style-type: none"> • Doing well in this area • Recognised potential for sharing across the four organisations. i.e. collaborating in the development and sharing of resources
2.6 Self management and behaviour change	<ul style="list-style-type: none"> • Identified need for improvement • High priority for change
2.7 Evaluate the effectiveness	<ul style="list-style-type: none"> • Identified need for improvement • Medium priority for change

Planning and provision of chronic disease services including health promotion and early intervention programs

3.1 <u>Establish a relationship</u> and <u>consult</u> with key community members/groups?	<ul style="list-style-type: none"> • Identified need for improvement • Variability across organisations potential for sharing learnings/collaboration
3.2 <u>Assess the needs</u> of chronic disease community as whole?	<ul style="list-style-type: none"> • Identified need for improvement • Variability across organisations potential for sharing learnings/collaboration
3.3 <u>Plan social marketing</u> activities?	<ul style="list-style-type: none"> • Identified need for improvement • medium priority for change
3.4 <u>Undertake social marketing</u> ?	<ul style="list-style-type: none"> • Identified need for improvement • Medium priority for change
3.5 <u>Plan risk factor screening</u> activities for health promotion/early intervention?	<ul style="list-style-type: none"> • Identified need for improvement • Medium priority for change
3.6 <u>Implement</u> risk factor screening programs?	<ul style="list-style-type: none"> • Identified need for improvement • Medium priority for change

2. Service Mapping findings and reflections

- Consistency across all organisations relating to services provision for individual consultations
- Significant variability across organisations in relation to types of group programs
- Very few group programs for people with chronic disease except diabetes and heart disease.
- Variability has evolved from:
 - Meeting demand or from looking back at the community and providing services.
 - Historical – “hard to stop when you’ve started”
- Recognition that there are gaps between community statistics and known risk groups etc. for chronic disease and provision of group programs.
 - Therefore there is tension between disease specific and generic groups

- Can be dependant upon the way people identify themselves ie culture, disease
- Socialisation very important for cultural group identification
- Consideration of the different phases people go through and the need to have disease specific groups/programs.
 - But model needs to not lock people into programs/groups but help to move them along the continuum.

3. Considerations for model development

Client perspective

- Needs to accommodate all the needs ie help me – give me info – leave me alone and let me manage myself.
- Need to recognise that the focus is on the individual and their family – it important that the family are recognised and included.

Model

- Single entry point – a common process of intake and how people can apply it locally.
 - GP engagement – single entry point could encourage GP referrals.
 - GPs need to be engaged.
 - May need some consumer consultation
- Systematic approach
- Model applicable across region
- CH can't and doesn't want to replicate HARP but wants to incorporate some of the positive principles.
- Consider role of Practice Nurses and Nurse Practitioner – greater access to federal funding.

Attachment 2: Assessment Forms

Lifestyle assessment tools

Lifestyle assessment tools incorporating stages of change and goal setting have been developed by the Department of Health and Aging. Copies of these tools are included in the Attachment 6 (note these are a separate PDF file in the online version titled "Lifestyle Assessment tools")

These tools along with other resources including best practice and supporting evidence can be located at: www.health.gov.au/pubhlth/strateg/lifescrpts.

Chronic and complex care assessment tool

The interRAI tool is a validated tool for comprehensive assessment of clients with complex needs. The interRAI tool provides a consistent set of data on individuals that can be utilised by all providers across settings. There are various versions for different types of client groups: Residential / long term care, home care, acute care, post acute care, palliative care and mental health. (Gray, L. 2003); www.interrai.org or <http://www.interrai-au.org>.¹⁸

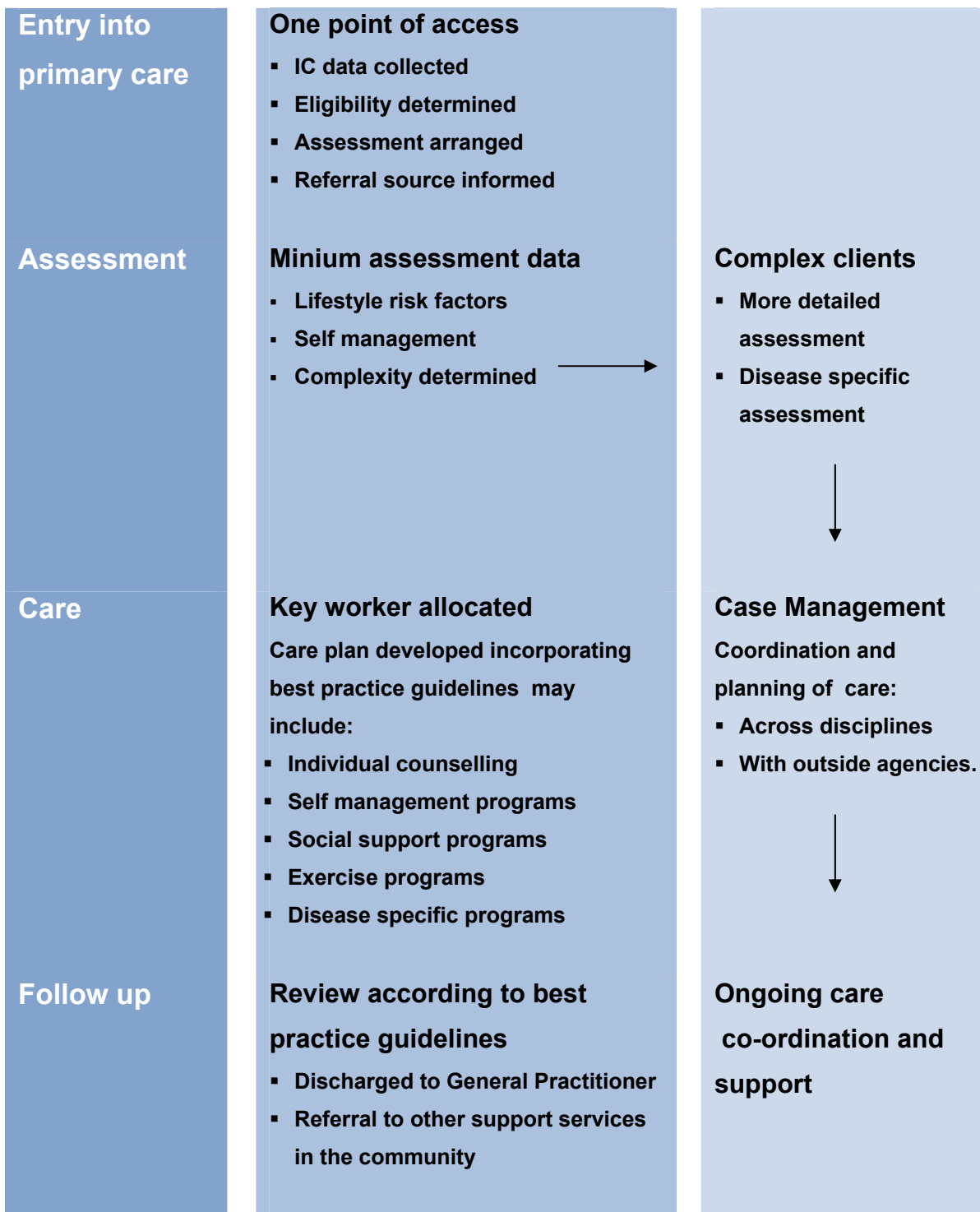
Depression

A depression tool kit including a number of validated assessment tools including brief 2 and 9 question item tools can be found at: www.depression-primarycare.org/.

Self Management

A partner in Health Scale (PIH), developed by Flinders University, is a twelve part questionnaire that is based on the six principles of self management. The client completes the questionnaire by scoring their response to each question on a nine point scale. Information on this scale can be found at: <http://som.flinders.edu.au/FUSA/CCTU/home.html>.

Attachment 3: Care pathway



Attachment 4: Getting Started

The following questionnaire could be used by different teams or individual practitioners to look at changes required within their areas to support implementation of the Chronic Disease model.

1. Your team

Who is in your team?

What is your own role on the team?

2. Aim

What is your team trying to accomplish?

3. Measures

What are the top three measures your team is tracking, and how does each of the measures help you know if the changes you make are helping you achieve your aim?

4. Changes

Identify key changes under model components for your team

Components of the Care Model	What key changes will you make?	How will you measure effectiveness of the change?
Delivery System Design		
Self-Management		
Decision Support		
Clinical Information System		

Attachment 5: Self Assessment

Assessment of Chronic Illness Care, Version 3.5¹⁹

Part 1: Organisation of the Healthcare Delivery System. Chronic illness management programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care.

Components	Level D	Level C	Level B	Level A
Overall Organizational Leadership in Chronic Illness Care Score	...does not exist or there is a little interest. 0 1 2	...is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work. 3 4 5	...is reflected by senior leadership and specific dedicated resources (dollars and personnel). 6 7 8	...is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable. 9 10 11
Organizational Goals for Chronic Care Score	...do not exist or are limited to one condition. 0 1 2	...exist but are not actively reviewed. 3 4 5	...are measurable and reviewed. 6 7 8	...are measurable, reviewed routinely, and are incorporated into plans for improvement. 9 10 11
Improvement Strategy for Chronic Illness Care Score	...is ad hoc and not organized or supported consistently. 0 1 2	...utilizes ad hoc approaches for targeted problems as they emerge. 3 4 5	...utilizes a proven improvement strategy for targeted problems. 6 7 8	...includes a proven improvement strategy and uses it proactively in meeting organizational goals. 9 10 11
Incentives and Regulations for Chronic Illness Care Score	...are not used to influence clinical performance goals. 0 1 2	...are used to influence utilization and costs of chronic illness care. 3 4 5	...are used to support patient care goals. 6 7 8	...are used to motivate and empower providers to support patient care goals. 9 10 11
Senior Leaders Score	...discourage enrolment of the chronically ill. 0 1 2	...do not make improvements to chronic illness care a priority. 3 4 5	...encourage improvement efforts in chronic care. 6 7 8	...visibly participate in improvement efforts in chronic care. 9 10 11
Benefits Score	...discourage patient self-management or system changes. 0 1 2	...neither encourage nor discourage patient self-management or system changes. 3 4 5	...encourage patient self-management or system changes. 6 7 8	...are specifically designed to promote better chronic illness care. 9 10 11

Total Health Care Organization Score _____ **Average Score (Health Care Org. Score / 6)** _____

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Part 2: Community Linkages. Linkages between the health delivery system (or provider practice) and community resources play important roles in the management of chronic illness.

Components	Level D	Level C	Level B	Level A
Linking Patients to Outside Resources Score	...is not done systematically. 0 1 2	...is limited to a list of identified community resources in an accessible format. 3 4 5	...is accomplished through a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources. 6 7 8	... is accomplished through active coordination between the health system, community service agencies and patients. 9 10 11
Partnerships with Community Organizations Score	...do not exist. 0 1 2	...are being considered but have not yet been implemented. 3 4 5	...are formed to develop supportive programs and policies. 6 7 8	...are actively sought to develop formal supportive programs and policies across the entire system. 9 10 11
Regional Health Plans Score	...do not coordinate chronic illness guidelines, measures or care resources at the practice level. 0 1 2	...would consider some degree of coordination of guidelines, measures or care resources at the practice level but have not yet implemented changes. 3 4 5	...currently coordinate guidelines, measures or two chronic illness areas. 6 7 8	...currently coordinate chronic illness guidelines, measures and resources at the practice level for most chronic illnesses. 9 10 11

Total Community Linkages Score _____ **Average Score (Community Linkages Score / 3)** _____

Part 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice (e.g. individual clinic) have been shown to improve chronic illness care. These characteristics fall into general areas of self-management support, delivery system design issues that directly affect the practice, decision support, and clinical information systems.

Part 3a: Self-Management Support. Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.

Components	Level D	Level C	Level B	Level A
Assessment and Documentation of Self-Management Needs and Activities	...are not done.	...are expected.	...are completed in a standardized manner.	...are regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Self-Management Support	...is limited to the distribution of information (pamphlets, booklets).	...is available by referral to self-management classes or educators.	...is provided by trained clinical educators who are designated to do self-management support, affiliated with each practice, and see patients on referral.	...is provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Addressing Concerns of Patients and Families	...is not consistently done.	...is provided for specific patients and families through referral.	...is encouraged, and peer support, groups, and mentoring programs are available.	...is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Effective Behaviour Change Interventions and Peer Support	...are not available.	...are limited to the distribution of pamphlets, booklets or other written information.	...are available only by referral to specialized centers staffed by trained personnel.	...are readily available and an integral part of routine care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Self-Management Score _____ **Average Score (Self Management Score / 4)** _____

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Part 3c: Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care. It may necessitate changes to the organization of practice that impact provision of care.

Components	Level D	Level C	Level B	Level A
Practice Team Functioning	...is not addressed.	...is addressed by assuring the availability of individuals with appropriate training in key elements of chronic illness care.	...is assured by regular team meetings to address guidelines, roles and accountability, and problems in chronic illness care.	...is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Practice Team Leadership	...is not recognized locally or by the system.	...is assumed by the organization to reside in specific organizational roles.	...is assured by the appointment of a team leader but the role in chronic illness is not defined.	...is guaranteed by the appointment of a team leader who assures that roles and responsibilities for chronic illness care are clearly defined.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Appointment System	...can be used to schedule acute care visits, follow-up and preventive visits.	...assures scheduled follow-up with chronically ill patients.	...are flexible and can accommodate innovations such as customized visit length or group visits.	...includes organization of care that facilitates the patient seeing multiple providers in a single visit.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Follow-up	...is scheduled by patients or providers in an ad hoc fashion.	...is scheduled by the practice in accordance with guidelines.	...is assured by the practice team by monitoring patient utilization.	...is customized to patient needs, varies in intensity and methodology (phone, in person, email) and assures guideline follow-up.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Planned Visits for Chronic Illness Care	...are not used.	...are occasionally used for complicated patients.	...are an option for interested patients.	...are used for all patients and include regular assessments, preventive interventions and attention to self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Continuity of Care	...is not a priority.	...depends on written communication between primary care providers and specialists, case managers or disease management companies.	...between primary care providers and specialists and other relevant providers is a priority but not implemented systematically.	...is a high priority and all chronic disease interventions include active coordination between primary care, specialists and other relevant groups.

Components	Level D	Level C	Level B	Level A
Score	0	1	2	3
	4	5	6	7
	8	9	10	11

Total Delivery System Design Score _____ Average Score (Delivery System Design Score / 6) _____

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Part 3d: Clinical Information Systems. Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.

Components	Level D	Level C	Level B	Level A
Registry (list of patients with specific conditions)	...is not available.	... includes name, diagnosis, contact information and date of last contact either on paper or in a computer database.	...allows queries to sort sub-populations by clinical priorities.	...is tied to guidelines which provide prompts and reminders about needed services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Reminders to Providers	...are not available.	... include general notification of the existence of a chronic illness, but does not describe needed services at time of encounter.	... includes indications of needed service for populations of patients through periodic reporting.	... includes specific information for the team about guideline adherence at the time of individual patient encounters.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Feedback	...is not available or is non-specific to the team.	...is provided at infrequent intervals and is delivered impersonally.	...occurs at frequent enough intervals to monitor performance and is specific to the team's population.	...is timely, specific to the team, routine and personally delivered by a respected opinion leader to improve team performance.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Information about Relevant Subgroups of Patients Needing Services	...is not available.	...can only be obtained with special efforts or additional programming.	...can be obtained upon request but is not routinely available.	...is provided routinely to providers to help them deliver planned care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Patient Treatment Plans	...are not expected.	...are achieved through a standardized approach.	...are established collaboratively and include self management as well as clinical goals.	...are established collaborative and include self management as well as clinical management. Follow-up occurs and guides care at every point of service.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Clinical Information System Score _____ **Average Score (Clinical Information System Score / 5)** _____

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4: Integration of Chronic Care Model Components. Effective systems of care integrate and combine all elements of the Chronic Care Model; e.g., linking patients' self-management goals to information systems/registries.

Components	Little support	Basic support	Good support	Full support
Informing Patients about Guidelines	...is not done.	...happens on request or through system publications.	...is done through specific patient education materials for each guideline.	...includes specific materials developed for patients which describe their role in achieving guideline adherence.
Score	0	3	6	9
Information Systems/Registries	...do not include patient self-management goals.	...include results of patient assessments (e.g., functional status rating; readiness to engage in self-management activities), but no goals.	...include results of patient assessments, as well as self-developed using input from the practice team/provider and patient.	...include results of patient assessments, as well as self-management goals that are developed using input from the practice team and patient; and prompt reminders to the patient and/or provider about follow-up and periodic re-evaluation of goals.
Score	0	3	6	9
Community Programs	...do not provide feedback to the health care system/clinic about patients' progress in their programs.	...provide sporadic feedback at joint meetings between the community and health care system about patients' progress in their programs.	...provide regular feedback to the health care system/clinic using formal mechanisms (e.g., Internet progress report) about patients' progress.	...provide regular feedback to the health care system about patients' progress that requires input from patients that is then used to modify programs to better meet the needs of patients.
Score	0	3	6	9
Organizational Planning for Chronic Illness Care	...does not involve a population-based approach.	...uses data from information systems to plan care.	...uses data from information systems to proactively plan population-based care, including the development of self-management programs and partnerships with community resources.	...uses systematic data and input from practice teams to proactively plan population-based care, including the development of self-management programs and community partnerships, that include a built-in evaluation plan to determine success over time.
Score	0	3	6	9
Routine follow-up for appointments, patient assessments and goal planning	...is not ensured.	is sporadically done, usually for appointments only.	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager).	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager) who uses the registry and other prompts to coordinate with patients and the entire practice team.
Score	0	3	6	9

Components	Little support	Basic support	Good support	Full support
	0	3	6	9
Guidelines for chronic illness care	2	4	7	10
Score	1	5	8	11
	0	3	6	9
	1	4	7	10
	2	5	8	11
	3	6	9	10
	4	7	10	11
	5	8	11	

Total Integration Score (SUM items): _____ **Average Score (Integration Score/6) =** _____

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Assessment of Chronic Illness Care Scoring Summary

(Bring forward scoring at end of each section to this page)

Section	Total Score
1. Health Care System	
2. Community Linkages	
3. Self-Management	
4. Decision Support	
5. Delivery System Design	
6. Clinical Information System	
7. Integration	
Total Program Score (Sum of all scores)	
Average Program Score (Total Program /7)	

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Analysing the Chronic Illness Care Score

What does it mean?

The ACIC is organized such that the highest “score” (an “11”) on any individual item, subscale, or the overall score (an average of the six ACIC subscale scores) indicates optimal support for chronic illness. The lowest possible score on any given item or subscale is a “0”, which corresponds to limited support for chronic illness care. The interpretation guidelines are as follows:

Score	Analysis
Between “0” and “2”	Limited support for chronic illness care
Between “3” and “5”	Basic support for chronic illness care
Between “6” and “8”	Reasonably good support for chronic illness care
Between “9” and “11”	Fully developed chronic illness care

It is fairly typical for teams to begin a collaborative with average scores below “5” on some (or all) areas the ACIC.

After all, if everyone was providing optimal care for chronic illness, there would be no need for a chronic illness collaborative or other quality improvement programs.

It is also common for teams to initially believe they are providing better care for chronic illness than they actually are.

As you progress in the collaborative, you will become more familiar with what an effective system of care involves.

You may even notice your ACIC scores “declining” even though you have made improvements; this is most likely the result of your better understanding of what a good system of care looks like.

Over time, as your understanding of good care increases and you continue to implement effective practice changes, you should see overall improvement on your ACIC scores.

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Attachment 6: Lifestyle Assessment Tools

See pages following references

References

- ¹ World Health Organisation. *Chronic Conditions: the global burden*. Geneva: 2005. Available from: http://www.who.int/chronic_conditions/burden/en/, accessed 12/8/05.
- ² National Public Health Partnerships. *Preventing chronic disease: a strategic framework background paper*. Melbourne: National Public Health Partnerships 2001.
- ³ The Institute for Public and Health Services Research, Monash Medical Centre, and Centre for Community Child Health, Royal Children's Hospital. *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector*. Melbourne: Victorian Government Publishing Service, 2000.
- ⁴ Victorian State Government. *Victorian Government Health Information Ambulatory care policy & planning framework*. Melbourne: Department of Human Services 2005. Available from: <http://www.health.vic.gov.au/ambulatorycare/>, accessed 18/10/05.
- ⁵ Victorian State Government. *Victorian Government Health Information: Hospital Admission Risk Program: Chronic Disease management*. Melbourne: Department of Human Services 2005. Available from <http://www.health.vic.gov.au/harp-cdm/>, accessed 18/10/05.
- ⁶ Primary and Community Health Branch, Victorian Department of Human Services. *Community Health Services—Creating a Healthier Victoria*. Melbourne: Department of Human Services, 2004.
- ⁷ Department of Human Services (Public Health). *Health Promotion Skill Assessment Tool for Organisations*. Victoria: Public Health. 2001.
- ⁸ Department of Human Services (Primary Care Partnerships). *Integrated Disease Management Interim Policy Directions and Guidelines*. Victoria: Aged, Community and Mental Health Division, Victorian Government Department of Human Services, 2001.
- ⁹ Department of Human Services - Public Health Diabetes Prevention and Management Initiative. *Diabetes Workforce: Needs Analysis Tool* Developed by gill + willcox, 2003.
- ¹⁰ Primary and Community Health Branch, Victorian Government Department of Human Services. *Implementation plan for the Primary Care Partnerships Strategy 2004–2006*. Victoria: Department of Human Services, 2004.
- ¹¹ World Health Organization Noncommunicable Diseases and Mental Health. *Innovative Care for Chronic Conditions Building Blocks for Action global report*. Geneva: WHO, 2002.
- ¹² Wagner H. et al. Quality improvement in chronic illness care; a collaborative approach. *JAMA* 2001; 27:63-80.
- ¹³ Australian Institute of Health and Welfare. *Chronic Diseases and Associated Risk Factors in Australia, 2001*. Canberra: AIHW, 2002.
- ¹⁴ Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1:2-4.
- ¹⁵ Robert Wood Johnson Foundation. *Improving Chronic Illness Care, a national program of The Robert Wood Johnson Foundation*. Online from the Improving Chronic Illness Care program. <http://www.improvingchroniccare.org/index.html>, accessed 18/10/05.
- ¹⁶ Flinders Human Behaviour & Health Research Unit *What is Self-Management?* Online accessed 9/9/05 <http://som.flinders.edu.au/FUSA/CCTU/Home.html>
- ¹⁷ Lorig K, Stewart A, Ritter R, Gonzalez V, Laurent D, Lynch J, Outcome measures for health Education and other Health Care Interventions. California: Sage Publications, 1996
- ¹⁸ Health and Aged Care Services Division, Department of Human Services. *HARP Chronic Disease Management Guidelines*. Victoria Department of Human Services, 2005. Available from: www.health.vic.gov.au/harp-cdm/harp_cdm_guidelines.pdf, accessed 20/10/05.
- ¹⁹ Improving Chronic Illness Care: ICIC is a national program supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's MacColl Institute for Healthcare Innovation". <http://www.improvingchroniccare.org/tools/acic.html>. accessed 22/10/05