Attachment 1 – ICDM Summary of Achievements

RAG Status:

* RED	*Implementation is immature, and limited in coverage*
*AMBER	*A strong foundation exists for implementation that is progressing, but is either not mature or widespread*
*GREEN	*Implementation is mature, and widespread*

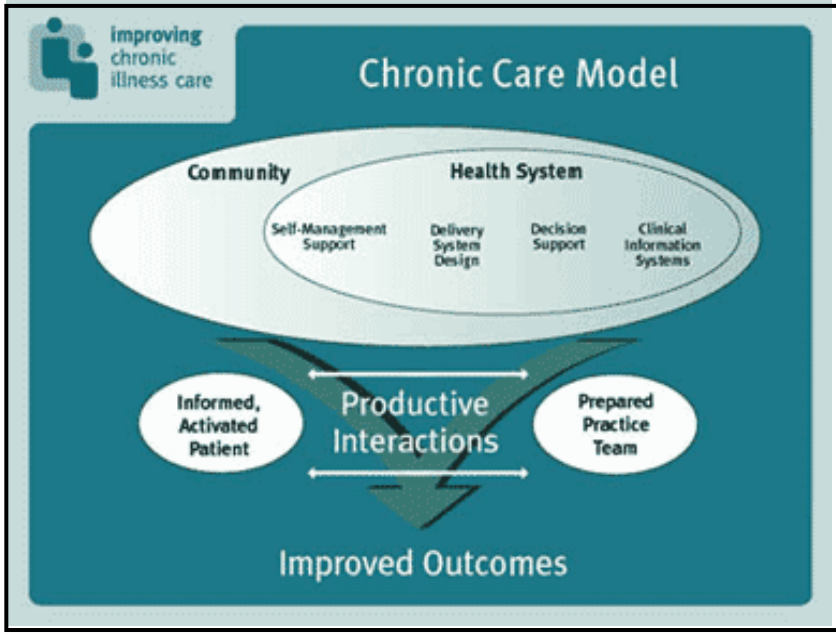
Objectives	Strategies	RAG	Outcomes and Outputs
Health Care Organisation			
Establish strong governance and leadership within and across organisations to spread and sustain improvements in ICDM	• Strengthen PCP governance arrangements to support improved shared responsibility and accountability across member organisations • Increase organisational focus on ICDM • Increase organisational skills to drive quality improvement • Increase role of private services in ICDM work • Increase consumer/carer engagement in service planning and provision	    	• PCPs implementing legally binding partnering agreements with clearer roles and responsibilities of partner organisations • Updated PCP program logic provides a clear 2009–2012 program of work for local partnerships to progress ICDM • Development of PCP strategic plans for 2009–2012 with identified local health and well being priorities aligned with state priorities and PCP program logic • Over 90% of PCPs have a hospital or health service and a division of general practice engaged in their ICDM activity. • Increased number of EIiCD funded organisations establishing change management teams • Increased number of EIiCD funded organisations undertaking restructures to develop multidisciplinary teams • Increased local workforce skills and confidence in progressing quality improvement initiatives using evidence based methodologies • Increased numbers of organisations with ICDM as a strategic priority, documented in their strategic plan • Strong engagement of general practice divisions in PCP activity, and increased numbers of private services (eg allied health and pharmacy) also involved
Delivery System Design			
Support organisations to deliver effective and efficient chronic care, supported by evidence based care pathways	• Develop and implement care pathways that improve access to community health services and services funded by the MBS • Support the use of standardised tools and processes to provide high quality care that addresses broad needs and initiates proactive referral • Increase access to and the number of chronic disease management services provided by community health service • Identify the models of MBS funded allied health care that can be implemented most effectively and efficiently within community health services • Provide tools and models of care to support state funded primary health service to make use of MBS and work more effectively with private providers	    	• In 2009, 137 agencies representing 434 programs/services reported progress against the requirements for ICDM as part of annual PCP reporting requirements • Feedback on the ICDM reports provides organisations with quantitative evidence of quality of care and for organisation accreditation requirements • Analysis of the ICDM reports indicate that the majority of these agencies are implementing: best practice clinical care; proactive ongoing support; and support for health behaviour change • 7,200 clients provided with 62,400 (additional) service hours funded by the EIiCD initiative • 1261 rural clients provided with diabetes care • Over a 4–month period, 271 community health service clients have received additional services funded through MBS • Client health improvements demonstrated at a local level

Objectives	Strategies	RAG	Outcomes and Outputs
			• Increased numbers of referrals between state funded and commonwealth/private services • Community health services demonstrate an enthusiasm for, and a better understanding of, the pathways to work with private providers
Self Management Support			
Improve access to services that provide clients with the skills, knowledge, and confidence to manage their health and health care needs	• Develop coordinated approaches across PCP catchments to upskill the health workforce in using self management approaches • Increase the delivery of self management approaches across community health services (and the wider health service sector) • Trial an alternate modality (telephone based) for the delivery of self management support, particularly to marginalised populations		• All community health services with EIiCD and DSM initiatives funding have implemented new self management interventions • Many community health services with EIiCD and DSM initiatives funding have led organisational change to embed self management approaches into existing service delivery • PCPs supporting coordination and access to training, mentoring, and secondary consultation as part of workforce development in self management across local catchments • NOC Health Coaching service established with state-wide client recruitment, service currently being evaluated • Increased numbers of clients with reduced lifestyle risks
Decision Support			
Increase the use of consistent tools and resources that support client access to evidence based care	• Support local implementation of decision supports to improve chronic disease management across CHSs and PCPs more broadly		• Increased numbers of clients receiving evidence based diabetes care and regular screening • Increased provision of standardised and quality client information with the use of the Service Coordination Tool Templates used by over 600 services across the state. • Improved privacy practice with the use of standardised consent forms and consumer information brochures in over 40 community languages. • Routine screening practice that identifies the broad range of needs including psychosocial issues (using common tools) implemented across service providers
Community Resource Mobilisation			
Improve client access to health promotion and community resources that support chronic disease management	• Strengthen partnership development with community organisations (though PCPs) to assist clients engage in community programs that support health behaviour change. • Strengthen health promotion activity across the continuum to improve access to health promotion for people with diagnosed disease.		• New health promotion measures being developed • Increased use of human service directory to support referral across the service system • Increased numbers of clients with improved emotional wellbeing who are involved in EIiCD and DSM initiatives

Clinical Information Systems			
Improve organisation of patient and population data to facilitate efficient and effective care	• Support the use of clinical information systems within agencies as a mechanism to drive practice change to ensure the delivery of best practice care • Support the use of electronic information sharing systems to improve inter-agency communication	 	• PCPs have facilitated improved sharing of health information (with client consent), using secure electronic referral systems • A single suite of service coordination tools used for screening, referral and coordinated care planning has replaced over 300 different tools used by the sector • Service coordination tools used by more than 600 health and human services across the state resulting in the reduction in the duplication of information collection about consumers and assessment of their needs • The service coordination tools are supported by electronic referral resulting in 130,000 referrals sent and received electronically in 2008–09. This represents about 540 services from a range of health and human services including several major hospitals • Work being progressed to develop secure electronic care planning systems and practice that build on existing electronic referral systems

Attachment 2 – Chronic Care (Wagner) Model

Edward 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. The Wagner Model provides a framework that helps to identify the systems changes (within the primary health care services and across the service system) that are necessary to improve the coordination of care for people with chronic disease. Taking a systems approach is important to ensure the delivery of proactive and integrated client centred care.



The model has six interdependent elements for improving chronic care. They are:

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 design, 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.

Attachment 3 - Service Model Characteristics

The following table outlines common service characteristics reported as part of the EIiCD scoping exercise, completed in 2009.

Disease cohort/s	***Eligibility criteria for chronic disease programs***	***Initial contact***	***Initial needs identification***	***Assessment***	***Care Planning***	***Service Provision***	***Recall/review and Transition/ exit***	***Feedback to other services (includes general practice)***
Common disease states being targeted through EIiCD: • type 2 diabetes • cardio-vascular disease • respiratory disease • depression and anxiety (as a comorbidity) • neuro-degenerative disorders • musculo-skeletal conditions • hepatitis C	Variable across organisations	Generally with a centralised intake	Generally completed by intake, sometimes by key worker	Most CHSs use a self management tool, often Flinders or modified Flinders tool	Related to self management support and client self management goals	Focus on self management support, various models applied	Review occurs, variable timeframes (3,6,12 months usually)	Routine feedback to general practice at specified, pre determined intervals
	Diagnosis of a chronic disease	(Some central intakes newly established, some previously established)	May be duplicated at times May also be a part of assessment	Some instances of comprehensive assessment	Care plan reviews established		Transition/exit not well described	Feedback to other providers
	Priority based on other co-morbidities such as depression and anxiety and other mental health issues and complex psychosocial issues	Need for additional support for self management was the overall focus	Processes in place to identify self management support needs	Psychosocial needs are an area of focus	Limited examples of case conferencing (area of interest for most organisations)	Formal processes to support team based care not the usual practice as yet due to organisational capacity and communication systems issues	Ongoing disease management not discussed	Some examples of case conferencing with GPs in place
	Suboptimal self management skills		Often feedback to referrer at this point	Clinical assessment using a standardised approach less common	Where clinical need identified, referral out to provider is instigated	Key worker role to coordinate care based on self management plan not necessarily disease management guidelines		
	Presence of risk factors			May be repeated a number of times across various clinicians	Some examples of multiple care plans in place	Generally remain ‘in program’ for 12 months		
	Consent for SMS			Few examples of processes in place to coordinate assessment	Few examples of processes in place to coordinate care planning			