

Status Report 2008-10

Chronic Disease Initiatives progressed through Partnerships and Primary Health

health

Foreword

In response to the increasing burden of chronic disease a range of initiatives have been funded in Victoria to prevent and manage chronic disease across the disease continuum. Some of these initiatives deliver service within primary health settings, while others aim to improve integration across the service system. This status report focuses on the following initiatives delivered in the primary care setting that focus on early intervention:

- the Early Intervention in Chronic Disease (EliCD) and Diabetes Self Management (DSM) service delivery initiatives
- the integrated chronic disease management initiatives of Primary Care Partnerships (PCPs)
- initiatives aimed at establishing private allied health services within Community Health Services (CHSs) utilising Medicare funding.

This report provides a summary for these initiatives of current activities, achievements and area for further work. The information is drawn from a variety of sources including:

- the Primary Health data set
- an EliCD scoping study of 16 agencies
- results from the annual PCP survey
- results from a Plan, Do, Study, Act workforce capacity building project
- reports from agencies engaged in specific initiatives.

Primary Care Partnerships

Improved service integration is being progressed through the PCP strategy. PCPs, now 10 years old, have provided a sound platform for agreed, robust and evidenced based practice across the state around:

- service coordination (SC)
- integrated chronic disease management (ICDM)
- integrated health promotion.

Service Delivery Initiatives

The service initiatives (EliCD and DSM) featured in this report are delivered by the statewide community health platform. The initiatives seek to enhance the existing capacity of CHSs to support people with chronic disease and have two broad objectives. The first objective is service improvement using the Chronic Care (Wagner) Model as a framework for change. The second is to provide the following additional services:

- multidisciplinary clinical care (allied health and nursing)
- psychosocial support
- care coordination
- self management support.

Increasingly, CHSs are working with private services including services funded through the Medicare Benefits Schedule (MBS) to provide team care to people with chronic and complex conditions. A number of CHSs have implemented models of care that include a mix of state funded and MBS funded allied health to increase access to service for people with chronic disease.

Executive Summary

The Victorian health care system is comprised of services funded by state government, commonwealth government, private services, volunteer-led and community-based organisations. Improving integration of this complex and often fragmented service system is important for people with chronic disease. These people will typically interact with multiple health care providers across multiple settings over extended periods of time. The initiatives identified within this report have been playing their part to:

- improve the coordination of care for clients
- address gaps in care
- provide additional services targeted to those more vulnerable within the community.

Key Integration Achievements

PCPs have been successful in supporting integration across organisations to improve the quality and coordination of care for people with chronic disease. In 2008–09 a total of 266 agencies across the state were engaged in ICDM as part of their participation in PCPs. Key achievements for the period have been:

- implementation of a robust evidenced based chronic disease model (Chronic Care Wagner Model) across the service system
- systematic partnership between organisations to progress service system reforms that improve access to and coordination of care for clients and their carers/families
- maximising use of the MBS and integrating MBS funded services with state government funded services to improve access to chronic disease care.

In CHSs work has been undertaken to improve the coordination of care with General Practice, in recognition of its central role in a person's care. Achievements have included:

- the development of referral & feedback protocols and agreed care pathways in order to improve communication and information sharing between service providers
- establishing systems to undertake coordinated care planning and case conferencing.

Key Service Delivery Achievements

The EliCD and DSM initiatives have established innovative models of care and delivered additional community based services targeting people from disadvantaged backgrounds, who don't traditionally access primary care services but are overrepresented in hospital use data. Approximately 70% of clients who accessed services in 2007–08 had a health care card.

The initiatives have achieved the following outcomes:

- *Service redesign*: CHSs are driving redesign more broadly to improve care for clients with chronic disease. There is extensive evidence to show that CHSs' continuous quality improvement work has a strong focus on chronic disease management. Improvements include:
 - restructuring siloed services into care teams
 - developing systems to coordinate assessment and care planning across providers
 - implementing review and recall systems.
- *Additional Services*: Clients across CHSs are accessing proactive, planned, managed care as a result of the service system redesign work. During 2008–09:

- the ELICD initiative provided 7,200 registered clients with 62,400 (additional) service hours, comprised of multiple types of service.
- the DSM initiative provided 1261 rural clients with diabetes care that included
 - diabetes education
 - group exercise programs
 - behaviour change support to address lifestyle risks
 - foot care
 - dietary management.
- *Improved health and wellbeing:* Statewide and local evaluation results indicate that clients involved in these initiatives have:
 - improved self reported health status and self management
 - reduced psychosocial distress
 - increased daily activity and function
 - improved clinical indicators.

Projects implemented by CHSs to establish models of team care that include MBS funded allied health, have faced challenges in terms of establishing models that are not only effective but are financially sustainable and viable. However despite the challenges, project findings are demonstrating that models are effective in increasing access to certain allied health services (such as podiatry, psychology/social work, dietetics and diabetes education), and over time models are viable providing the rights structures, processes and business systems are in place.

Introduction

This report provides information regarding achievements and areas for further work, mapped against the six elements of the Improving Chronic Care (Wagner) Model. Each section also includes specific examples and case studies. Achievements observed across the service system and within CHSs have also been summarised in attachment 1 with a Red, Amber, Green (RAG) status applied to each of the strategies that identifies their implementation status.

The Improving Chronic Care Model

The Improving Chronic Care (Wagner) Model has been used to structure this report because it well known and is the model of choice to drive change across the health system. It recognises the need to reorient health care away from a reactive approach towards one that is proactive and focused on keeping people as well as possible (see attachment 2 for more details). The model has a strong evidence base and has undergone rigorous independent evaluation showing demonstrated improvements to the service system. These improvements have resulted in efficiencies, cost savings, and client health improvements.

The model describes systems that improve the coordination of care for people with chronic disease. It identifies six interdependent elements that contribute to achieving the goal of informed, activated clients engaged with a prepared and proactive care team resulting in improved outcomes:

1. Health care organisation
2. Delivery System Design
3. Self Management Support
4. Decision Support
5. Community Resource Mobilisation
6. Clinical Information Systems.

The EliCD Scoping Study

Many of the CHS findings in this report have been drawn from an EliCD scoping study. The scoping study was undertaken in the 2009 calendar year with 16 agencies that had been funded in the earlier rollout of the initiative. It used semi-structured interviews and provided the interviewees with a set of questions in advance. The interviews were conducted by several departmental staff and then transcribed and analysed. Key themes were identified and categorised using the chronic care model and service coordination elements as a framework.

This methodology resulted in some limitations in reviewing and interpreting the data. The following limitations need to be considered when using the findings:

- interviews were conducted with sector staff from various levels in organisations
- the semi-structured interview methodology allowed questions to be presented differently by various departmental interviewers
- data fields developed for coding purposes were not addressed by all participants creating gaps in some information
- the changes identified are perceived changes and based on interviewee's experience.

The Six Model Elements

1. Health Care Organisation

This element relates to creation of culture, organisation and mechanisms that promote safe, high quality care. It includes leadership at all levels of organisations, effective quality improvement strategies, systematic handling of quality problems and agreements that facilitate care coordination within and across organisations.

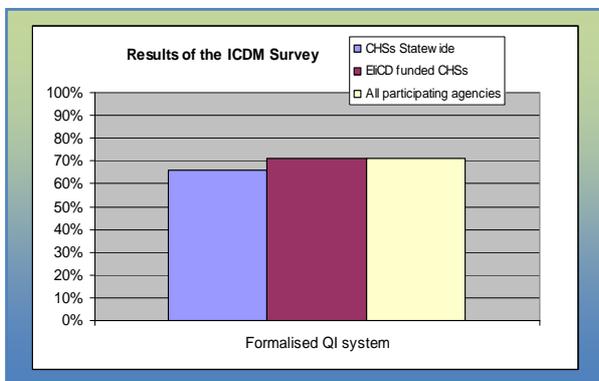
1.1 Achievements

Strategic Priority

The 2008–09 year highlighted the role of strong governance and leadership within and across organisations to spread and sustain improvements in ICDM. Prioritising chronic care has led to organisations making structural changes, such as creating teams with a focus on chronic care to drive improvements and establishing multidisciplinary teams (real and virtual) to provide more coordinated care to clients with chronic disease.

Darebin CHS has taken an organisational approach to improving chronic care through its governance and board reporting mechanisms. It used the Assessment of Chronic Illness Care (ACIC) and the Patient Assessment of Chronic Illness Care (PACIC) to assess strengths and weaknesses of the organisation and of individual programs. These were rated against key aspects of chronic disease care, from a patient and systems perspective. Findings are being used to inform service-planning activities across the organisation and improve the delivery of evidence based care.

Of the 139 organisations who participated in the 2009 SC/ICDM survey 71% had established a formalised quality improvement team that had chronic disease management as a priority focus.



CHS improvements included:

- restructures to establish multidisciplinary teams aligned to population groups and particular lifestages
- development of public/private models using the Medicare Benefits Schedule to augment service delivery
- work in partnership with other health and community service organisations to establish coordinated models of care.

Partnership arrangements

Organisations recognise that providing an integrated approach to client care means working in partnership. The 2010 PCP participation database shows that all PCPs include representation from CHSs, divisions of general practice, local governments and community-based agencies. Of the 30 PCPs across the state, 70% are chaired by agencies delivering CHSs.

In 2009, PCPs began work to strengthen governance arrangements and formalise partnership agreements. Now all PCPs have a formal governance arrangement in place that includes a legally binding partnering agreement and articulates members' accountability to each other.

1.2 Areas for further work

Putting all of the elements in place

The statewide SC/ICDM survey results showed that less than half of participating organisations had established a formalised quality improvement system to drive service improvements. Organisations missed one or more of the following elements, and feedback suggests that they were commonly the last two elements:

- intra- and inter-agency partnership
- representation from the full range of stakeholders, including consumers
- support from management and mechanisms to implement agreed improvement initiatives
- use of data to set priorities
- measurement of performance, evaluation of outcomes and regular reporting.

The scoping study also showed that although some organisations had made chronic disease management a strategic priority this did not necessarily flow through to their operational plans and quality improvement plans.

Implementing change requires a plan that outlines tangible activities and identifies how strategic priorities will be achieved.

Getting 'buy in' for shared work and progressing the work using common methodologies within PCPs is reported to be challenging work. Using Plan, Do, Study, Act (PDSA) cycles to make incremental changes over time is a common methodology used by many health services and sectors (particularly general practice through their experience in Primary Care Collaboratives). This could be an effective approach for PCPs to improve common issues such as access to care, transition between services, coordination of care and feedback to general practice. In 2011, the chronic disease incentives project will support capacity building among PCP staff to use of PDSA cycles, both with CHSs and more broadly.

Improving partnerships

Many state funded organisations are working collaboratively. However, PCP partnership reports indicate that PCPs and CHSs could do more to partner with private health providers such as private allied health and pharmacy. It is acknowledged that this is an area of 'stretch' for PCPs and CHSs, but these providers play an important role in the health care system and therefore should be a part of delivery systems.

2. Delivery System Design

This element relates to the delivery of effective, efficient clinical care and self management support, defined by care pathways. The need to examine the way services are currently delivered and coordinated has been cited as the most important element to improving chronic care.

2.1 Achievements

Leadership and Partnership

The Banyule Nillumbik Primary Care (Partnership) Alliance used a 'collaboratives' approach to improve access and integration of services for people with chronic disease. Recognising that general practice plays a crucial role for these clients the Division of General Practice was identified as key to successful implementation of new referral protocols and processes developed by the partnership. The work focused on increasing the quality and quantity of referrals and establishing a 'no wrong door' approach. An agency in receipt of a referral from a GP will identify the most appropriate service/s for the client, including on-referral to services from external providers. This is accompanied by agreements to provide consistent and quality feedback to GPs.

PCPs have progressed the development of care pathways across catchments. It is known from PCP reporting that 70% of PCPs have developed (or commenced) local systems and agreements to identify clients with chronic disease who require comprehensive assessment. As well, 83% of PCPs have developed or commenced agreements and systems to identify clients with chronic disease who require multi-agency care planning (including general practice). CHSs have recently also reported that HACC Active Service Model implementation has increased the impetus for inter-organisational systems improvement. One CHS working with its local council mapped their assessment practice and found a 30% duplication between HACC and allied health assessment questions for people with chronic disease. They have since embarked on work to reduce this duplication of effort.

Implementation within CHSs

During 2008–09 CHSs receiving initiatives funding undertook significant improvement activities against this element, both within and across organisations. Achievements at a local level include:

- development and implementation of disease specific pathways incorporating services funded through various sources (eg state funded programs and MBS items)
- use of standardised tools and processes to support comprehensive assessment, which identifies broad needs and prompts referral according to evidence based guidelines
- proactive review and follow-up of clients to support and monitor client care plans
- establishment of innovative models of care that include outreach to marginalised populations and telephone based support
- development of case conferencing processes to align client management goals and reduce gaps and duplication related to care provision
- definition of roles and distribution of tasks among health care providers, including the initiation of new roles such as key worker and health coach
- establishment of processes for staff to access expertise through secondary consultation, such as psychologists providing allied health staff with support regarding clients' psychosocial issues.

Models of Care

The scoping study elicited information about the models of care that EliCD funded CHSs have developed to support people with chronic disease. The service coordination framework has been used to show eligibility criteria and common characteristics of the models (see attachment 3).

Models usually commenced with identification of chronic disease at intake or during assessment and most CHSs identified a central intake process (some newly established). All CHSs commented that a centralised intake process was critical to implementing effective chronic disease models of care. Meeting eligibility criteria prompted referral to a key worker who undertook further assessment centred around self management capacity. Care planning followed and included the development of a self management plan and referral on to relevant clinical services. Feedback was provided to the referrer at prescribed time intervals. Clinicians involved in the client care provided feedback to the key worker, through progress notes in client files and in some instances via case conferences.

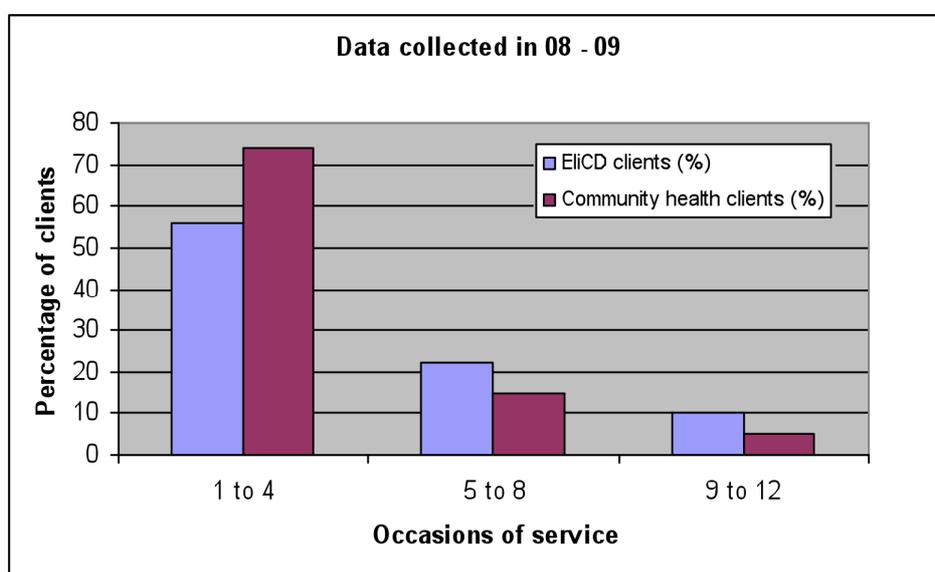
A centralised intake process is critical to effective ICDM implementation

CHSs noted that mapping care pathways has highlighted the importance of developing processes and protocols for comprehensive and coordinated assessment and care planning. Some organisations have embarked on this work. This is consistent with findings from the 2008 EliCD statewide evaluation report, which stated:

“Significant organisational change within agencies has occurred in response to the EliCD initiative and organisations have developed a variety of service models in line with best practice chronic disease management approaches.”

Additional Service Delivery

The EliCD and DSM initiatives have been successful in providing additional services to clients and enhancing the coordination of care. In 2008–09 an additional 62,400 hours of services were provided to 7,200 clients through EliCD and 1260 rural clients received additional diabetes care through DSM. (These figures are underreported due to organisations experiencing reporting issues related to the implementation of healthSMART.) On average the initiatives provide clients with 8 hours of care per annum from a range of service types. This reflects client access to a greater range and number of services through these initiatives.



Data for 2008–09, from the Primary Health data set identifies that:

- over 80% of clients who received an EliCD funded service received more than one occasion of service (compared with 65% of the broader community health population) and a greater range of services
- EliCD and DSM care was provided over an extended period of time.

This information supports the view that clients are accessing a broader range of services to meet their needs and using regular review and follow-up appointments.

These more recent findings regarding EliCD resonate with the 2008 EliCD statewide evaluation report that states:

“Service models are supported by a wide variety of allied health and other services and these services were funded from numerous sources including community health funding, home and community care funding, and in some case MBS funding (with services delivered by private providers).”

The range of chronic diseases targeted under the EliCD initiative include: diabetes, chronic obstructive pulmonary disease (including asthma), heart disease, musculoskeletal conditions (including pain management), depression and anxiety (both as a primary condition and as a co-morbidity), neurodegenerative disorders (including Parkinsons disease), and hepatitis C.

Local evaluation data collected across four agencies for 60 clients who had baseline and follow up (6 months) data in 2009

Improvements in:	% of clients experiencing improvement:
Emotional wellbeing	75%
Social engagement	58%
Social support	42%
Blood pressure	67%
Total cholesterol	67%
Weight	63%
Blood glucose	70%

Clients involved in the EliCD and DSM initiatives are reporting significant health, wellbeing and social improvements. Health improvements include increased engagement in physical activity, improved nutritional intake and improvements against limited clinical indicators. Wellbeing improvements include reduced emotional distress and improved self management. The table (left) shows improvements that were captured across four EliCD funded CHSs in 2009.

Eight CHSs were funded in 2009 to develop and implement models of allied health supported by MBS funding. These ongoing trials seek to identify service models most likely to achieve improved access to allied health services and coordination between services.

The trial sites are at various stages of implementation. The data collected over a six month period following implementation suggested that 444 clients had been provided with 1273 additional services funded by chronic disease MBS items. Of these clients, 61% were concession cardholders and most had a diagnosis of diabetes. The services were primarily podiatry and diabetes education. Supporting this work is a state-wide strategy (the MBS project) to raise agencies' capacity to make the most of the MBS and to work effectively with private providers as part of care teams for people with chronic disease and complex care needs.

2.2 Areas for further work

Buy-in and management skills

Delivery system design is an area that organisations have reported as difficult to progress. It requires buy in from multiple staff at clinician and manager levels, all working cooperatively to achieve a common goal. For example, work to improve the delivery system for a client cohort can impact on practice for the intake team as well as clinicians across other teams. This can challenge the status quo. Resistance to change was reported in the scoping study as a particular barrier to change.

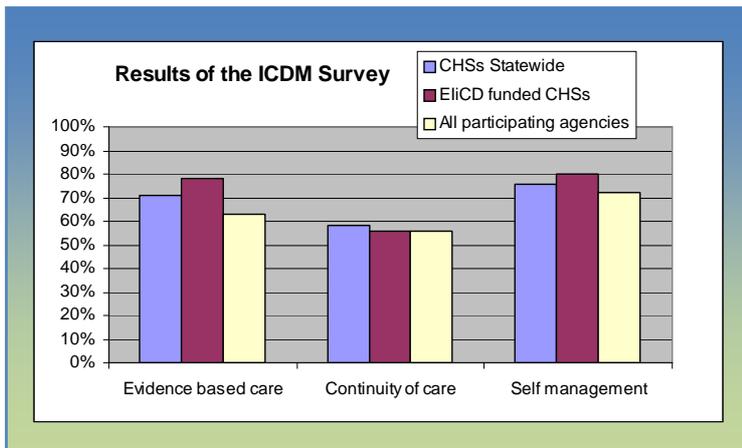
The work also requires planning and proactive management using evidence based approaches. Both senior managers and project leaders reported that the knowledge and skills required to plan and manage change needs to be supported through organisational workforce development and capacity building.

Given that this work is often the responsibility of those with previous clinical backgrounds, additional skill development is required in areas such as:

- theoretical frameworks for change management
- negotiation and facilitation skills (including managing resistance)
- project management
- continuous quality improvement using methods such as auditing and plan do study act cycles

- process mapping.

Best practice and continuity of care



The results of the 2009 SC/ICDM survey highlighted that the least progressed domains measured by the survey were the development of clinical care protocols and pathways that demonstrate:

- the delivery of evidence based practice clinical care (question 4)
- continuity of care (question 5).

Only 18% and 16% of organisations respectively had a system in place that included the full range of elements required for best practice.

The EliCD scoping study identified that care pathways were documented but were not based on referral to the range of services indicated by best practice guidelines. Rather, they were based on client identified needs and required clients to 'opt in' (particularly in regards to self management support).

The study also identified that transition and/or exit processes are not well established. Organisations documented eligibility criteria for entry into services and programs. However, there was little documented evidence of exit criteria and processes for transition, review and recall.

Referral should not only result from clinician judgement but also by following guidelines that include triggers for care.

Evaluation

While many PCPs and CHSs are measuring improvements to processes such as care planning and GP feedback, they have not implemented systems to measure client impacts and outcomes across their client population. Individual clinicians measure improvements against indicators relevant to specific interventions. However, these are recorded manually in progress notes so there is no way to generate population reports.

Although outcomes based monitoring and evaluation at a population level can be challenging, organisations are encouraged to determine the aims of their chronic disease program and identify a few outcomes measures (such as changes in lifestyle risks, goal attainment, general health) and standard clinical indicators that can provide quantitative information about changes occurring for the client cohort engaged in the program.

Evaluation at an inter-organisational level (for example across a PCP catchment) is also challenging, especially evaluating impacts of catchment wide work such as the impacts of implementing local agreements and care pathways. Engaging assistance and expertise to do this work may be appropriate, particularly where PCP led ICDM projects seek to make significant change, demonstrate client benefits and disseminate findings.

3. Self management Support

Self management support emphasises clients' central role in managing their health and aims to provide them with the skills, knowledge, and confidence to manage their health and health care needs.

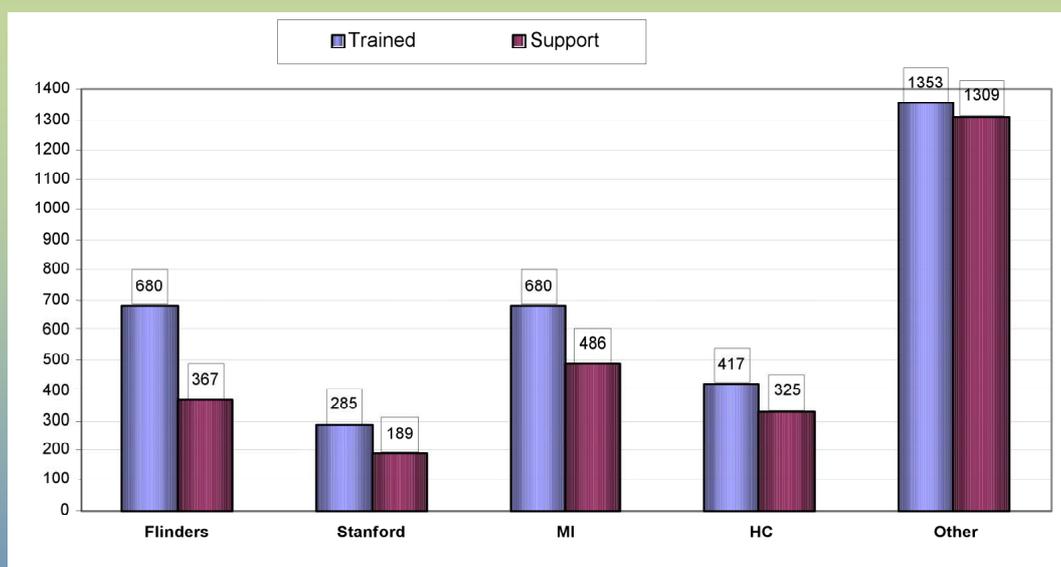
3.1 Achievements

Embedding Self Management Support Into Practice

In 2007 a statewide mapping of self management was undertaken to identify the uptake of self management training and the application of self management support principles into practice. It was the first collection of its type involving all 31 PCPs, and engaging 216 agencies in completing the survey. Results were encouraging and demonstrated significant PCP work in this area:

- 71% of the respondents stated that integrated chronic disease management was an identified organisational priority
- 63% of organisations reported that they were providing specific chronic disease management programs
- more than 1500 clinicians had undertaken self management training in the previous year in one or more self management approaches.

The results also suggest that organisations are implementing a range of self management support interventions, taking the view that no single approach is appropriate for all clients. This has required organisations to invest in a range of training, allowing clinicians to acquire a 'toolkit' of strategies in order to tailor their support according to individual client needs.



Explanation:

Flinders – Flinders University Self Management Model (used in service delivery to individuals)

Stanford – Stanford University Group Self Management Model

MI – Motivational interviewing

HC – Health coaching

Other – Approaches such as diabetes education, counselling training, exercise related training and health promotion training

Since the mapping, PCPs have developed plans to continue building skills and capacity in the sector to deliver effective care planning and self management support, and are implementing a range of evidence-based interventions. However, CHSs in receipt of initiatives funding have been more likely to implement new programs and lead organisational change to embed new approaches into existing service delivery.

These CHSs have invested in self management training, mentoring and providing access to secondary consultation to support practice change. They have also responded to the significant psychosocial self management barriers experienced by clients accessing CHSs. This has been achieved by establishing psychological support services within multidisciplinary teams and providing allied health staff with access to professional development and secondary support. CHSs have recruited psychologists and/or partnering with organisations such as primary mental health teams to provide training and secondary consultation.

The underpinning philosophy of self management support is increasingly being reflected in intake tools and assessment tools. It is also a core feature of care plans. Furthermore, organisations are now incorporating self management support principles into job descriptions and in selection and orientation processes. This reflects major organisational cultural change.

ISIS Primary Care has made significant organisational change to incorporate self management support into practice. This has included the development and implementation of a chronic condition self management framework across the organisation, an investment in ongoing training, the development of mentoring and support opportunities for clinicians to gain competence in practice, and the introduction of new roles focusing on the provision of self management support interventions.

Self Management Approaches

A new model of delivering self management support has been implemented through the Nurse On Call—Health Coaching Service. This demonstration project aims to explore dedicated telephone based health coaching as a modality in assisting clients with chronic disease make changes toward a healthier lifestyle. It also aims to improve patients' ability to manage chronic disease/s, enhance their capacity to self-care and reduce or delay deterioration and/or unplanned hospital admission. The project has recruited clients across the state and is currently in early implementation phase.

As part of the 2010 chronic disease innovations grants, five CHSs are currently implementing new models of care for people from disadvantaged backgrounds. The models have a focus on health literacy. There is growing interest in health literacy and understanding how health literacy impacts on self management. These CHSs will lead progressive work and showcase findings as part of the project.

3.2 Areas for further work

Self management is everyday business

Literature regarding Chronic Care emphasises the importance of redesigning all elements of the service delivery pathway when implementing self management interventions. In the scoping study some CHSs reported low referral numbers to self management programs. However, other CHSs progressing delivery system design work did not report this issue.

A key difference was the implementation of self management principles into initial needs identification, assessment, care planning processes and clinical care. This approach reflects organisational cultures which acknowledge that all clients self-manage to some extent, and all clients can be supported to improve their self management. Some chronic disease programs participating in the scoping study sought separate client consent as an entry criterion for participation in self management support interventions. These CHSs reported that where consent is not given the client is referred for 'usual' clinical service, suggesting that these clients miss out on self management approaches. This is not a practice supported by the literature. Rather, the literature suggests that every encounter a client has with a health practitioner in every setting offers opportunities to contribute to the client's capacity to self manage.

Every encounter with a health practitioner offers opportunities to contribute to the client's capacity to self-manage

For these reasons self management support should not be seen as the exclusive domain of self management support providers, and should be embedded within 'usual' clinical care. This does not exclude additional structured or planned self management support being built into service delivery pathways. For some clients additional support outside of the usual clinical consultation time is required to provide them with the support they require to enhance their health and self care. This is described in the ICDM Resource titled 'Incorporating Self Management Support into Primary Care', available on the Department's website at: <http://www.health.vic.gov.au/communityhealth/cdm/resources.htm>.

Health literacy

Health literacy is receiving increased attention due to evidence that suggests low health literacy is associated with increased mortality, hospitalisation, poor self management skills, poor adherence to prescribed medications and treatments, and difficulty communicating with health professionals. Health literacy has been defined as the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health (World Health Organisation definition). There is a need for clinicians across the service system to understand health literacy and gain the skills and tools required to help them engage with the cognitive, social and motivational situations of their clients.

4. Decision Support

Decision support involves ensuring clinical care is consistent with evidence, clinicians use proven education methods and care supports patient preferences. It also requires developing a consistent approach to sharing and using evidence based guidelines and information with clients as part of a self management approach.

4.1 Achievements

There have been demonstrated improvements in the uptake and implementation of decision support tools to improve chronic disease management across PCPs and within CHSs (particularly where there has been additional funding). Organisational improvements relating to decision support include:

- intake workers using common tools to identify risks and prioritise care
- development of standard (evidence based) chronic disease information for clients.

Two PCPs in the east of Melbourne began their ICDM work together in 2006, with a vision to improve the journey for people with type 2 diabetes. The member agencies have worked together to develop a vision, common principles for working together, common systems and tools, strategies for implementation and an evaluation plan. Implementation started with a pilot project that included three agencies implementing a standard package of care to people with diagnosed type 2 diabetes, supported by a range of common tools. They included:

- *a diabetes risk tool to determine level of risk and prioritisation for service*
- *a package of care that determined the range of services to be provided and agreed recall and reminder systems*
- *a client information pack that included evidence based information in easy to read language*
- *standard letters and templates for referral and GP communication*

Client outcomes included:

- *provision of standardised care and support for self management and behaviour change,*
- *improved continuity of care,*
- *early identification of risk factors at initial client contact and*
- *increased satisfaction with and use of client information*

In organisations and PCPs where work in this area has progressed, decision support tools and mechanisms have been tested for certain chronic diseases and are now being implemented more broadly to ensure access to high quality chronic disease management for a greater number of clients. These learnings will also be taken up at a statewide level in 2010 to improve the Service Coordination Tool Templates (SCTT). This will support improved initial needs identification of chronic disease and complex needs, facilitating access to appropriate services and supporting the coordination of care.

There have been demonstrated improvements in the uptake and implementation of decision support tools within CHSs. Key pieces of work that featured in discussions during the scoping study, in addition to the above strategies were:

- implementing the community health priority tools and including additional intake tools to identify chronic disease
- developing common assessment frameworks, tools and processes to identify and assess
 - broad needs
 - self management capacity
 - associated risks
- standardising care planning practice by developing a common care plan template and common tracking sheets to support the implementation of agreed care protocols
- developing standard communication letters and templates to support health practitioners sharing care plans and service outcomes information with general practice

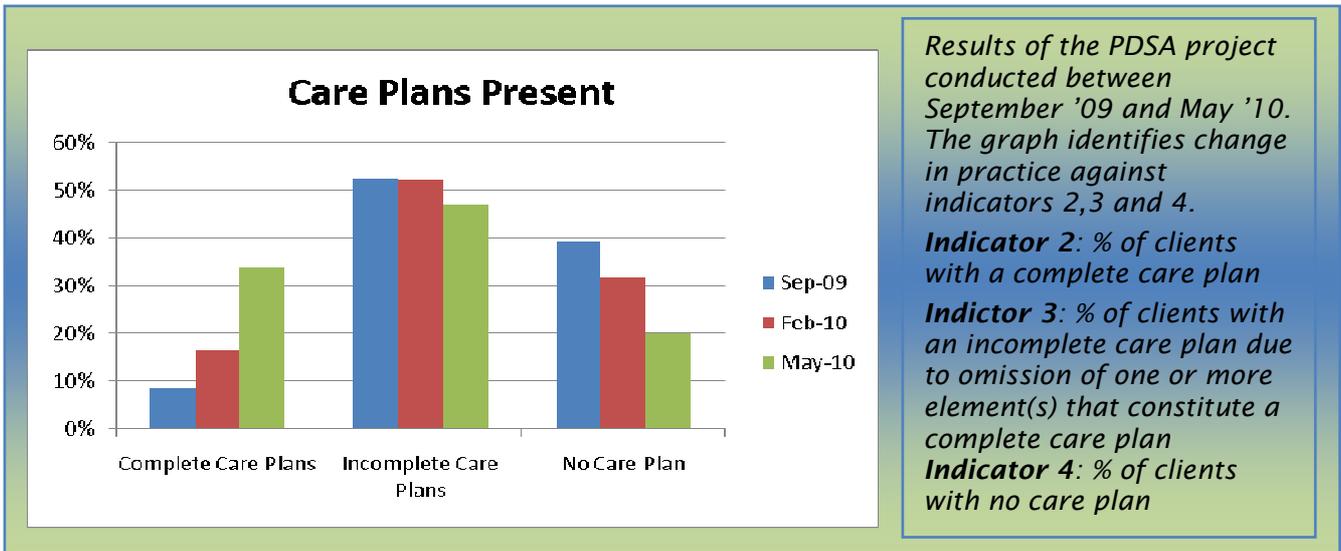
- developing manual systems and prompts to support review and recall.

Plan Do Study Act

The Plan Do Study Act (PDSA) workforce capacity building project was conducted over 2009–10. It involved 22 CHSs and assisted the implementation of decision supports, which in turn supported improved practice, particularly in the area of care planning. The project used seven of the ‘good practice indicators’ developed by the Victorian Health Association in consultation with the sector.

Indicator 1, Format of Care Plans, determines whether specified elements of a care plan are present in an agency’s standard care plan template. Initial baseline data indicated that care plan templates had on average 38% of the elements present. On final evaluation this had improved to 71%.

Indicators 2, 3 and 4 address the number of files with complete, incomplete or no care plans present. The final evaluation demonstrated that the number of complete care plans improved (9% baseline to 34% final) with a corresponding reduction in the number of incomplete care plans (52 % baseline to 47% final) or files with no care plan (39 % baseline to 20% final).



4.2 Areas for further work

Feedback from the scoping study suggested that evidence based practice could be delivered more consistently by embedding decision support into client management systems. CHSs do not currently have the capacity to do this but have shown interest in the work.

While most CHSs are using the service coordination tool templates (SCTT) and the community health priority tools to support initial needs identification, many have developed additional intake tools to identify chronic disease. This suggests that the SCTT could be strengthened to support common chronic disease screening practice at a statewide level.

Peak bodies have a key role in developing best practice guidelines for the management of specific chronic diseases and information and resources for patients with these conditions. During the scoping study, few CHSs identified that they were working with peak bodies or including the implementation of these guidelines into organisational care pathway and protocols. Some CHSs are using peak body patient resources but not in a systematic way. Organisations still tend to produce their own resources.

The PDSA project identified some confusion regarding care planning, particularly in relation to intra and inter-organisational care planning. Organisations understood that best practice indicates all clients should receive a service specific care plan as part of care (documented separately from progress notes so that they can receive a copy). However in relation to clients accessing multiple services, organisations did not have triggers/guidelines to determine those clients who require a coordinated care plan, nor did they have protocols and processes in place to clarify roles and responsibilities in relation to coordinating the care planning process and documenting an agreed plan. More work is required in the area of care planning that addresses the range of barriers that prevent effective coordinated care.

5. Community Resource Mobilisation

Identifying and mobilising community resources to meet the needs of clients is core to achieving a sustainable chronic disease management response. Access to community resources for these clients is facilitated by the role that primary health care services and PCPs play in health promotion and providing knowledge and understanding of the local service system.

5.1 Achievements

Typically, the client cohort accessing state funded primary health care services have a range of complex issues that can often benefit from support from community organisations. PCPs have a sound history of engaging with human services and community based agencies. The diversity of sectors involved in PCPs includes disability, drug and alcohol, education, housing, and justice.

The integrated health promotion work of PCPs is complementary to the work of ICDM. Many PCPs are establishing programs that address lifestyle risk factors and support the prevention of secondary complication through a coordinated effort including a focus on:

- promoting mental health and wellbeing
- promoting physical activity and active communities
- promoting accessible and nutritious food.

The Towards a Healthy Heart program is an example of a highly successful prevention and early intervention program in the Portland region.

The program addressed the risk factors for heart disease in 'hard to reach men' within the high-risk age group of 30–60 year old industry workers. Initiated by the Southern Grampians Glenelg Primary Care Partnership, the program involved 16 agencies that linked health, industry and sports (including eight local sporting facilities providing a range of physical activities to support participants to become regularly active).

By the end of the program the men's cholesterol, blood glucose, blood pressure, weight and waist measurements had all reduced, they were less depressed and anxious, and their eating was healthier. Alcohol consumption and cigarette smoking were also reduced or ceased. Best of all, the men (many of whom did not even have a GP, or hadn't seen one in years) established a much better connection with the health system.

The social model of health

The work of CHSs is underpinned by the social model of health, a theoretical framework for considering individual and population health and wellbeing. The framework operates on the premise that improved health and wellbeing is achieved by focusing on the social and environmental determinants of health as well as biological and medical factors. Typically, the client cohort accessing CHSs has a range of issues and their health is often influenced by social determinants outside their control. CHSs are recognised leaders in linking such clients with health promotion initiatives and referring them to community organisations.

CHSs are also developing formal links with community organisations that are assisting clients engage in healthy behaviours and address lifestyle risks. Examples include:

- establishing referral pathways and agreements between CHSs and local gyms, including subsidised memberships negotiated to improve client access to physical activity programs
- supporting neighbourhood houses to provide healthy eating/cooking programs
- referring and linking clients to services such as drug and alcohol, problem gambling, housing etc.

5.2 Areas for further work

CHSs are committed to community participation. However, strong community engagement in the planning, monitoring and review of integrated chronic disease management and organisational service improvement did not feature in the scoping study. Some CHSs had consumer and community engagement processes that were a part of their PCP's ICDM work. However, many CHSs acknowledged that this is an area for improvement.

The department's policy, called *Doing it with us and not for us* (DHS 2006) reports that consumer, carer and community participation is a key enabling strategy in working with and meeting the health needs of communities. It is valued as an aid to improve health outcomes and the quality of health care, a mechanism to ensure accountability, and an important democratic right. 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 the community.

6. Clinical Information Systems

This is critical component relates to the organisation of patient and population data to facilitate efficient and effective care.

6.1 Achievements

HealthSMART

The roll out of the HealthSMART applications has been a major focus for organisations over 2008–09. CHSs have identified that the implementation was more complex than anticipated. There is ongoing work within organisations to improve the use of the application as staff become more familiar with it. The HealthSMART program area is working with program areas and users to enhance the application to align with practice.

There is considerable interest in using clinical information systems as a mechanism to drive practice change, to ensure the delivery of best practice care and routinely identify client and population improvements. Organisations have reported that the HealthSMART applications are still limited in supporting effective chronic disease management practice. However, CHSs have opportunities to identify the key requirements and work through the HealthSMART governance arrangements to advocate for such improvements.

A number of CHSs have developed alternative systems to:

- audit practice
- map the client journey through the organisation
- record clinical measures.

These CHSs have reported that this process has provided benefits in that clinicians, managers and boards are able to track improvements over time. The data has provided opportunities for organisation wide discussions regarding improving chronic disease management and has been shown to lead to strong engagement in progressing the required work.

Merri Community Health Service used data to engage staff and managers in ongoing practice improvements, specifically targeting improved access to services for clients with chronic disease living in supported residential services. The data captured includes a mix of both process and client measures and includes baseline and 6-months measures. The findings from a client sample demonstrated:

- 94% of clients were provided with multidisciplinary care
- 61% of clients had a care plan in place
- 95% of clients' general practitioner was provided with feedback relating to progress
- 42% of clients showed improved cholesterol measures at 6-months
- 50% of clients lost weight during the 6-month period
- 94% of clients with diabetes, with recorded blood sugar measures, showed clinical improvements

The data also provided the organisation with identified areas for improvement. These included ensuring that all clients received a care plan, working with other programs to develop a consistent approach to care planning and case conferencing, and developing a single key worker model.

E-referral

PCP work in electronic referral has supported practitioners making referrals and sharing quality information within and across organisations using secure e-referral systems.

In 2009, about 130,000 e-referral transactions were reported. This represents about 540 services from a range of health and human services, including several major hospitals. E-referral work is now being expanded to support care planning. A consortium of eight PCPs have commenced a project to develop further their e-referral system. The aim is to allow registered users from multiple organisations who are participants in the care of a common client to view and add to a common care plan, and to share supporting

documentation and treatment plans. The project will include developing the infrastructure and protocols for use, and supporting implementation and practice change.

6.2 Areas for further work

Enhanced functionality

CHSs have suggested the following improvements in functionality of client information management systems to support effective chronic disease management practice:

- capacity for multiple service providers (regardless of funding stream) to document assessment information on one form and to contribute to one care plan
- functionality to provide reports about client populations (for example risk and disease registers) and outcomes of care
- recall and reminder systems that have the capacity to generate task lists and send SMS reminder messages to clients' mobile phones
- functionality that supports efficient client flow through an organisation
- clinical decision support, such as referral prompts based on risk profiles
- clinical quality audits such as SC survey and VHA indicator measures.

Advancing improvements in information management systems will require a coordinated effort between CHSs and the department and will take time to work through. Some work in this area has been identified in section below, next steps.

Practice and systems together

There is no doubt that 'high functioning' clinical information management systems can support the coordination of care. However, a focus on practice change is just as critical. Therefore work to improve coordinated care planning and service delivery requires an emphasis on changes to practice as much as to changes in systems.

Next Steps

Although this report focuses on the significant achievements of EliCD-funded CHSs, the department acknowledges that progress is also being made within CHSs where there has been no EliCD funding. This progress has been made possible by:

- PCPs supporting activity to progress service system improvements
- provision of a workforce capacity building strategy
- provision of one off chronic disease incentive grants to all CHSs not in receipt of EliCD funding, and provision of 15 innovation grants
- CHSs being supported to develop mixed models of care to maximise access to MBS funded allied health services.

The following table identifies areas for further work to be led by the department. The actions will support all Victorian PCPs and CHSs to engage in service improvement to deliver evidence based, proactive chronic care. It is envisaged that these actions will be progressed by the department in 2011 and beyond.

Areas that require further work	Actions proposed to be progressed from 2011 and beyond
<p>Improve client access to proactive chronic disease management across the state</p>	<ul style="list-style-type: none"> ○ As part of the SCTT revision process, refine the tools to support initial needs identification of chronic disease and complex needs, facilitating access to appropriate services and supporting the coordination of care. ○ Foster continued and more widespread uptake of mixed models of care in CHSs that improve access to services funded through MBS. ○ Support increased involvement of private allied health providers with PCPs in order to increase the inclusion of private providers in referral and care pathways. ○ Support the ICDM work of PCPs through the PCP - ICDM mentor project over 2011/12. ○ Identify actions to address chronic disease in the government's health plan.
<p>Support the provision of best practice care</p>	<ul style="list-style-type: none"> ○ Encourage agencies and PCPs to work with peak bodies to implement clinical guidelines into care pathways and practice. ○ Review and revise the chronic disease management guidelines. ○ Improve reporting and accountability mechanisms to improve understanding of chronic disease management practice across the sector, including the development of chronic disease management Key Performance Indicators. ○ Provide chronic disease management forums for CHSs that address particular areas of interest, and provide capacity building in key priority areas. ○ Support the building of primary health care evidence through funded projects in two regions that include CHSs working in partnership with universities to build the primary care evidence in particular priority areas (managing complexity and chronic disease, delivering multidisciplinary care).

	<ul style="list-style-type: none"> ○ Undertake a state-wide trial in the use & benchmarking of indicators for community health and develop a sustainable mechanism for community health to use benchmark data to report to stakeholders on the quality and safety of their services (e.g. Quality of Care Report, Accrediting Organisations).
<p>Develop innovative models to engage disadvantaged and high risk clients groups</p>	<ul style="list-style-type: none"> ○ Support the dissemination of learnings from the demonstration projects 'Improving Access to primary health care services for people with serious mental illness' funded from 2008–10 in two sites within the eastern and southern metropolitan regions, that includes a forum in June 2011 for community health and mental health sectors. ○ Support implementation of the 2010 funded chronic disease innovation projects that support the development of new models of chronic disease care for other disadvantaged subpopulations, and disseminate the learnings. ○ Support the dissemination of chronic disease management practice across the sector by supporting the ICDM clearing house and publishing ICDM PCP case studies. ○ Work in partnership with Deakin University and a number of HACC and Community Health funded agencies to progress research in the area of health literacy (particularly in relation to strategies for working with people with low health literacy).
<p>Continue to support the coordination of services with a focus on general practice</p>	<ul style="list-style-type: none"> ○ Continue to encourage divisions of general practice to be active participants in PCP ICDM work and encourage greater engagement by private allied health. ○ Progress work to enhance GP feedback. ○ Disseminate the learnings from the trial sites currently developing models of allied health supported by MBS funding to enhance the uptake of effective models across CHSs. ○ Continue to work with HACC to streamline the implementation of ASM and ICDM policy, particularly in relation to shared clients.
<p>Continue to advocate for further enhancements to clinical information systems and e-health platforms to improve capacity for quality referral, care planning and information sharing</p>	<ul style="list-style-type: none"> ○ Conduct a project to assist CHSs to monitor the effectiveness of their chronic disease management activity and establish agreed measurement processes. ○ Following the above project, work with HealthSMART and the sector to identify and implement improvements to client information management systems that will enable CHSs to monitor and measure effectiveness across the populations for which they serve. ○ Monitor implementation of the new electronic care planning project within two regional catchments and support broader take up of learnings across other regions. ○ Work with NEHTA to progress the e-health agenda nationally in a way that aligns with Victorian reforms.

<p>Continue supporting workforce and organisational capacity building that will build the skills of the sector to drive reform, integration and the most efficient and effective use of all existing investment within the system</p>	<ul style="list-style-type: none"> ○ Implement activities identified in the primary health workforce development strategy with a focus on leadership, change management, project management and quality improvement. ○ As part of the above, provide further project management training, to support agencies to plan and manage change, within a project management framework. ○ Convene provider forums open to all state funded primary health care providers that support organisational improvements in chronic disease management. ○ Provide PDSA training for PCPs and CHSs (not receiving ELiCD funding) and engage them in a project that provides a supportive environment for change using the improvement methodology. ○ Finalise the care planning training package and resources, and support access to the training more broadly delivered by the Vocational Education Sector, through phase 2 of the care planning project. ○ Consider longer term sustainable strategies to build the capacity of the sector to understand health literacy.
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