ISCHS Chronic Conditions Project

Year 1 Report

July 2009 - July 2010

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Executive Summary

Background

Chronic conditions account for more than 70% of Australia's burden of disease.[1] ISCHS clients report high levels of chronic conditions and associated risk factors.[2] Local, national and global leaders in health recommend health system redesign to prevent chronic conditions and better meets the needs of people living with chronic conditions[1],[3],[4].

ISCHS is committed to providing best practice chronic conditions care for the community. However, in the absence of specific funding, improvement of chronic conditions care at ISCHS has progressed primarily through the work of individual teams and programs, causing variation in the approach to systems, processes and care across the organisation.

In July 2009 ISCHS initiated an internally funded 12 month chronic conditions change management project with the aim of accelerating the development of an organisation wide coordinated and comprehensive approach to preventing and managing chronic conditions, in order to improve the overall health and well being of the community.

The project has been extended for a further 12 months, to July 2011. This report details the development, implementation process and outcomes of the ISCHS Chronic Conditions Project Year 1 (2009-10).

Methodology

ISCHS had identified the Chronic Care Model (Wagner) as the overarching model of care on which to base improvements. This is in line with Victorian Government policies and initiatives as well as international best practice[1,4,5] and describes six interdependent domains of care:

1. Organisation of the health system (i.e. ISCHS)
2. Community resource mobilisation
3. Delivery system design
4. Self-management support
5. Decision support
6. Clinical information system

The project developed a "Chronic Conditions Care Model" and planning objectives that expanded each of these domains specific to the ISCHS setting.

The project was driven by the Chronic Conditions Change Group (CCCG), project worker and Practice Reference Group (PRG). An audit of organisational skills in chronic care identified priority areas for improvement linked to the six domains of the Chronic Care Model. This informed the development of the key project activities which included client assessment and care planning, staff training, and service evaluation. Consultation with staff, consumers, other community health services and industry advisors guided the progression of the project. The project took a generalist approach to improving care rather than a condition specific approach.

Summary of Key Outcomes

A key outcome of the work was the organisational "paradigm shift" that resulted in the management team agreeing that the Chronic Care Model articulated the overall approach to care suitable for **all** ISCHS clients (not just those with chronic conditions). This strengthens the impact of the project by ensuring that all teams will be working towards improving the access of all ISCHS clients to best practice prevention and management of chronic conditions.

> At the time of writing ISCHS was in the process of renaming the "ISCHS Chronic Conditions Care Model" to better represent this paradigm shift. From August 2010 the ISCHS model of care will be called "**Partners for Better Health**".

The project developed and trialled a template for a common assessment form "front sheet" with the intention of decreasing duplication in assessment across the organisation and clarifying the minimum assessment data to collect from clients. The template requires a brief period of further refinement before implementation across the organisation. The template and supporting guidelines will continue to be developed during the next year of the project with the aim of implementing a more comprehensive assessment and decision support tools.

A common care plan template was developed to improve integrated client centred care planning. The template requires a brief period of further refinement before roll out to teams who currently use a care plan template. Further work to develop and trial guidelines and processes for integrated care planning needs to be completed to establish a consistent approach to care coordination across the organisation. This will allow broader roll out of the template and is a key project activity for 2010-11.

The project proposed a Chronic Conditions Care Evaluation Plan which is currently under review by the Chronic Conditions Change Group. The plan includes an evaluation framework that addresses system, process and client outcomes. The system and process strategies have been utilised during the project, however, the client outcomes evaluation activities have not and require a trial period during the next year of the project.

The capacity of the electronic records system at ISCHS (TrakCare) was identified as a barrier to developing effective and efficient processes for documenting and sharing common assessment information and care plans, as well as collecting and analysing client outcome evaluation data. Project work for 2010-11 will need to include significant consultation with the IT Team and other community health services to address this.

Initial work began on the development of a mandatory in-service training package re: chronic care at ISCHS but was deferred until year 2 of the project.

Summary of Key Recommendations

Recommendations for future work to improve chronic care are found throughout this report and are summarised here:

Project governance

- Expand the CCCG membership to include consumers, Organisational Support and Development Program and Mental Health Team.
- Expand the PRG membership to include Paediatrics Team and a Case Manager/Health Facilitator.
- Review the communication strategy including clarification of the roles and responsibilities of all management staff in consulting with their teams and feeding back to the CCCG.

Over-arching Model of Care

- Review the Chronic Conditions Care Model and Planning Objectives, and the ISCHS Assessment and Care Policy to represent the vision of care and overall approach to care for **all** ISCHS clients.
- Further develop the client pathway, including links to assessment and care planning.

Assessment front sheet and Care plan template

- Implement the assessment front sheet and documentation process in TrakCare, across the organisation.
- Continue the development of the assessment front sheet and supporting guidelines, including additional best practice recommendations for comprehensive assessment and decision support for staff.
- Implement the common care plan template, to replace existing templates, once the IT capacity has been upgraded.
- Continue the development of the common care plan template and supporting guidelines as a key project activity for 2010-11 including clear articulation of roles and responsibilities for care coordination.
- Progressively audit uptake of assessment and care planning processes.

Workforce development

- Complete a training needs analysis and consult with an industry advisor to develop team targeted in-service training re: chronic care at ISCHS - including self-management support specific to the ISCHS client group and environment.
- Work with individual teams to support them integrating the model of care into their current processes and practices.
- Promote systematic opportunities for staff to develop and sustain new skills and knowledge learnt in training.

Evaluation

- Trial the client outcomes evaluation strategy proposed by the ISCHS Chronic Conditions Care Evaluation Plan.
- Implement the system and process evaluation strategies proposed by the ISCHS Chronic Conditions Care Evaluation Plan.
- Develop a process to collate relevant results of Chronic Care, Health Promotion, Community Participation and Program activities to create a comprehensive report of chronic conditions care at ISCHS.

Terminology and Abbreviations

Naming the model of care

At the time of writing ISCHS was in the process of replacing "ISCHS Chronic Conditions Care Model" with "Partners for Better Health" to better represent the application of the model as the overall approach to care for ISCHS clients. This in turn means the name of the project and the change management group will change to incorporate Partners for Better Health. The language used in this report attempts to capture the new direction of the project, whilst accurately describing the results of the project over the past 12 months.

Strategy / Framework / Model of care

A key activity of the project was to develop a chronic conditions service "strategy" for ISCHS clients. When reviewing the literature to guide the development of the "strategy" it was evident that there is overlap between the terms "strategy", "framework" and "model". Initially the project developed the "ISCHS Chronic Conditions Care Framework", however, as the project progressed it became clear that the term "model of care" was the most commonly used and understood way of describing this work in the community health setting.

To ensure consistency in terminology moving forward, the term "model of care" is used throughout this document.

Chronic conditions/diseases

The term "chronic conditions" has been chosen to represent that the work applies to a range of long term illnesses, disabilities and diseases. ISCHS acknowledges that the term is somewhat interchangeable with "chronic disease" including in local and state forums that support and fund improvements in chronic conditions care e.g. Department of Health initiatives such as Early Intervention in Chronic Disease and Integrated Chronic Disease Management.

Abbreviations:

CCCG	Chronic Conditions Change Group
EHR	Electronic health record
EIiCD	Early Intervention in Chronic Disease
ISCHS	Inner South Community Health Service
IT	Information technology
OSAT	Organisational Skills Analysis – Chronic Disease Care
PACIC	Patient Assessment of Chronic Illness Care
PDSA	Plan, Do, Study, Act
PRG	Practice Reference Group
QOL	Quality of life
SCTT	Service Coordination Tool Template

1. Introduction

1.1 Purpose of this Report

This report details the development, implementation process and outcomes of the ISCHS Chronic Conditions Project Year 1 (2009-10) and includes recommendations for further development and broader roll out of the ISCHS Chronic Conditions Care Model.

It will inform the project plan for Year 2 (2010-11).

Additional note:

The improvement of chronic care at ISCHS is broader than just the activities of the chronic conditions project. There are other projects and quality improvement work within the organisation that also aim to improve our chronic care. This report describes the chronic conditions project work.

1.2 Background to the ISCHS Chronic Conditions Project

ISCHS is committed to providing best practice chronic conditions care for the community. The prioritisation of chronic conditions care is articulated in the ISCHS strategic plan and much work has already been done to enhance ISCHS chronic conditions care. In 2007 a Chronic Conditions Working Group was convened to develop an organisation wide model of chronic conditions care. The preliminary work identified the evidence based Chronic Care Model[5] as the basis for the ISHCS Chronic Condition Model.

ISCHS had hoped to attain Early Intervention in Chronic Disease (EIiCD) funding from the Department of Human Services (now Department of Health) to progress the work around chronic conditions care and implement the organisation wide model. Thus far the funding has not been awarded and improvement of chronic conditions care has progressed through the work of individual teams and programs, thus variation in the approach to systems, processes and care exists across the organisation.

In March 2009 ISCHS ran a “Chronic Disease Planning Day”, facilitated by an industry specialist, where the management team identified strategies to progress chronic conditions care at ISCHS in the absence of additional funding.

The ISCHS Board agreed to internally fund a Chronic Conditions Project Worker 0.8 EFT for 12 months and in May 2009 ISCHS convened the Chronic Conditions Change Group (CCCG) to accelerate the development of a coordinated and comprehensive approach, across the organisation, to preventing and managing chronic conditions, in order to improve the overall health and well being of the community.

In July 2009 a project worker was employed and the Chronic Conditions Project initiated.

1.3 Project Aim and Scope

The ISCHS Chronic Conditions Project was initiated to assist the CCCG to develop a coordinated and comprehensive approach across ISCHS, to

preventing and managing chronic conditions. It is an organisation-wide project, the focus of which is to address the high priority areas for improvement as identified by an internal audit of organisation skills and deficits in chronic conditions care.

1.4 Project Objectives

1. Develop a chronic conditions service model for ISCHS, based on best practice guidelines and the Chronic Care Model (Wagner).
2. Develop planning objectives for integrating the chronic conditions service model.
3. Trial priority aspects of the chronic conditions service model.
4. Identify and develop training and resources to support staff in implementing the chronic conditions service model.
5. Develop an evaluation plan that includes process evaluation, impact evaluation and outcome evaluation.

1.5 Project Deliverables

a) Audit of existing chronic conditions care at ISCHS

- Audit of ISCHS skills in chronic conditions care
- Audit Report
- Consumer feedback
- ISCHS Service Map and Gap Analysis

b) ISCHS Chronic Conditions Model based on the Wagner Chronic Care Model.

- Develop and articulate an overarching ISCHS model of care for chronic conditions
- Planning objectives to achieve the overarching model
- Client pathway/s
- Common assessment tool/process
- Common care plan template/process
- Implementation plan

c) Training and Resources

- In-service training package for ISCHS staff that describes key aspects of best practice chronic conditions care, including
  - prevention
  - screening
  - assessment
  - care planning
  - self management
  - self efficacy
  - client centred approach

d) Evaluation

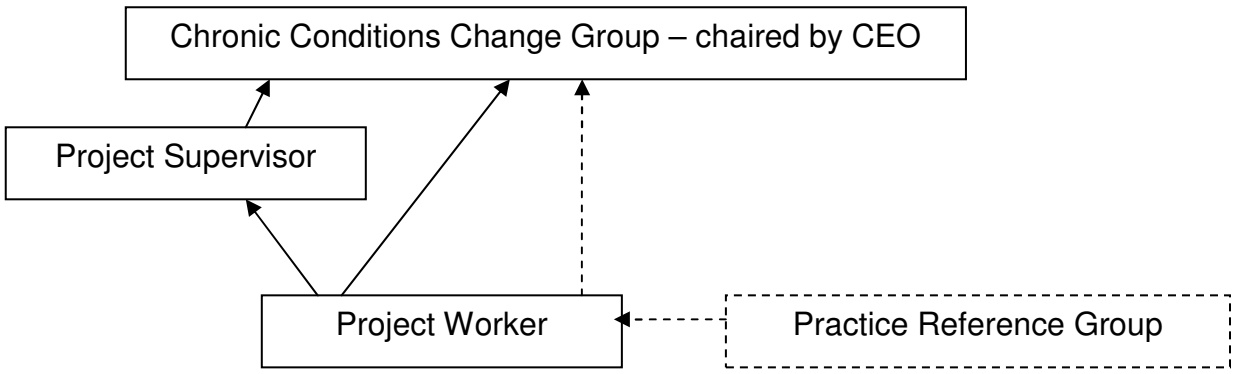
- ISCHS Chronic Conditions Care Evaluation Plan
- Chronic Conditions Project evaluation

1.6 Project Governance

The project governance structure consists of the project worker reporting to the project supervisor and governing body - CCCG. The CCCG includes representation from all direct care program areas and all levels of staff.

In March 2010 the Practice Reference Group (PRG) was initiated to trial priority aspects of the chronic care service strategy. The PRG includes representation from all direct care programs except Oral Health & GP*. It is responsible for providing representative practitioner level feedback to the project worker who then reports to the CCCG. The PRG is chaired by the project supervisor.

The CCCG is responsible for providing strategic direction to the project worker and PRG.



* Representation on the PRG is currently unfeasible for these teams due to the funding structure of the Oral Health service and the time demands on the small GP service. Consultation will be sought through other methods as required.

2. Project Methods and Process

The overarching method was to improve care in line with the Chronic Care Model which describes six components:

1. Organisation of the health system (i.e. ISCHS)
2. Community resource mobilisation
3. Delivery system design
4. Self-management support
5. Decision support
6. Clinical information system

The initial development work of the project included an internal audit of chronic conditions care at ISCHS, against the components of the Chronic Care Model. The results of this audit informed the priority tasks for the project work plan. Project methods were dependent on the task and included:

- Literature search and review
- Organisational skills audit
- Service and process mapping
- Client interviews and focus groups
- Practice reference group
- Utilisation of industry specialist – workshops for CCCG and ISCHS management, development of service evaluation plan
- 1:1 consultation with relevant agencies
- File and document audits

Plan Do Study Act (PDSA) cycles were applied to several project activities.

2.1 Establishment of priorities

Between June and October 2009 the CCCG endorsed an audit of ISCHS Chronic Conditions Care, using

- Organisation Skills Analysis – Chronic Disease Care (OSAT-CDC)[6]
- Patient Assessment of Chronic Illness Care (PACIC)[7]
- Map of ISCHS services against the Kaiser Permanente Pyramid*

These audit processes required active participation by every team across the organisation.

The results of the audit identified high priorities for improvement of chronic care at ISCHS and informed the development of the work plan.

2.2 Development of Work Plan

An industry specialist was engaged to facilitate a workshop with the CCCG to translate the audit results into key project tasks. These were endorsed in December 2009:

- Develop ISCHS Chronic Conditions Model based on the Chronic Care Model.

* The Kaiser Permanente Pyramid describes levels of chronic and complex care prevention and management

- Develop common approach to assessment of clients with chronic conditions.
- Develop common approach to care planning with clients with chronic conditions.
- Develop mandatory ISCHS in-service training re: chronic conditions.
- Develop ISCHS chronic conditions care evaluation plan.

2.3 Development of ISCHS Chronic Conditions Model based on the Chronic Care Model.

2.3.1 Literature review

An initial review of the literature focussed on models of chronic conditions care and change management in community health settings. Additional literature and resources specific to project tasks were sourced as the project progressed. The list of key literature and resources reviewed can be found in appendix 2.

2.3.2 External consultation

Over the course of the project an industry specialist was engaged to facilitate three workshops to assist the agency progress its vision and model for chronic conditions care.

In the initial months of the project consultations with community health services in receipt of EIiCD funding focussed on gathering information and resources to inform and support the ISCHS chronic care change management process. As the project progressed additional consultations and communications occurred around specific project activities as they arose.

Throughout the project consultation occurred with partner agencies through existing forums such as the Inner South East Partnership in Community Health. Strong links were maintained with local relevant projects such as the Health Matters Inner South Project and South East Bayside Diabetes Alliance Project.

2.3.3 Consumer consultation

Apart from the PACIC, consultation with consumers occurred through the following methods:

- Monthly consumer reference group (in collaboration with the Health Matters Project).
- Additional consumer focus groups for care planning and client outcomes evaluation.
- Community Participation Committee meetings.

2.3.4 Staff consultation and internal communication strategy

The PRG was established in March 2010 to be the main vehicle for trialling and refining practice changes to improve chronic care. The group evolved from an existing working group and was established later than planned, primarily due to the ISCHS organisational re-structure.* This delayed the trialling of key aspects of the model by approximately one month.

* The organisational restructure was implemented in November 2009.

Broader staff consultation was sought through involvement of all direct care staff in the OSAT-CDC, regular project updates in The Latest (workplace newsletter), at site meetings and at program meetings when requested. Additionally the CCCG terms of reference articulated that the chronic conditions project work was to be a standing agenda item at manager and coordinator meetings, and the project communication strategy articulated that the CCCG, coordinators and managers were responsible for communicating re chronic conditions project work at team meetings on a regular basis.

In April 2010 feedback to the project worker from a range of sources indicated that there was a breakdown in the communication strategy between the CCCG, management and staff resulting in a degree of anxiety about the implications of the project on program and performance planning. The communication strategy and communication responsibilities of the CCCG were reviewed and additional resources were directed to consulting with staff about the implications of the project on their work.

Strategies to address the communication breakdown included:

- Increase in visible senior management support of the project – including CEO.
- Addition of the project as a standing agenda item at management meetings
- A summary of key messages from CCCG meetings circulated to CCCG monthly, to be communicated at management, team and program forums.
- Project worker presentation and staff consultation at program planning meetings.
- Project worker consultation at program Manager and Coordinator meetings.
- Key representatives of the CCCG consulting with their teams in team meetings.
- Development of background and guidance documents to support managers and coordinators consulting with and supporting their teams re: chronic conditions care at ISCHS.
- An externally facilitated workshop for managers and coordinators to address the concerns and gain agreement on how to move forward.

2.3.5 Articulation of the "vision of care"

As a result of the consultations discussed above the project articulated a "vision of care" and underpinning processes that summarised and simplified the aims of the ISCHS Chronic Conditions Care Model.

> Vision of Care for ISCHS clients:
>
> All ISCHS clients have access to comprehensive and appropriate client centred care, that provides support to meet their goals, and that improves or maintains their health and wellbeing.
>
> ISCHS has systems and structures in place to support comprehensive and appropriate client centred care, provided in partnership with the individual and/or community, and that improves or maintains the health and wellbeing of individual clients and client groups.

Underpinning processes:

That all ISCHS clients will have access to:

- Support to be active partners in the management of their health
- Assessment consistent with the presenting issue that includes opportunities for assessment of other issues/risks
- An allocated key worker i.e. one person who is overall responsible for a person's care
- Specialist/discipline specific knowledge and care as required
- Collaborative care planning (client, carer/family, service providers)
- Care that is coordinated across the organisation including regular, systematic, planned review
- Linkage to appropriate community resources

That ISCHS will have systems in place to support:

- Initial Needs Identification at Intake and Referral so that clients are given appropriate information and directed in the appropriate direction as soon as possible.
- Consistent approach to assessment and risk screening
- Consistent approach to care planning
- Consistent approach to care coordination
- Evaluation of the service, including client outcomes
- Collection and analysis of population health data for planning services
- Consumer consultation in planning and delivery of services

2.4 Trialling of Key Aspects of the Model

The project work plan identified a common care plan template and a common assessment "front page" as the key aspects of the model to trial.

2.4.1 Development and trial of common assessment form "front sheet"

PDSA cycles were used to develop, trial and refine a common assessment form "front sheet" that decreases the duplication in assessment across the organisation and identifies the minimum assessment data to collect. The "front sheet" was developed through document and file audits, examination of common assessment forms developed by other health services and staff feedback.

Alongside the development of the "front sheet" the project investigated processes for efficiently and effectively documenting and sharing the assessment information in the client electronic health record (EHR), in a way that could also be used for population health analysis.

The Practice Reference Group reviewed the "front sheet" and trialled the documentation processes in the EHR to make refinements.

2.4.2 Development and trial of common Care Plan Template

PDSA cycles were used to develop, trial and refine a common care plan template that meets the best practice clinical indicators for care plans and suits ISCHS clients and staff. The template was developed through document

and file audits, and consumer and staff feedback. The PRG trialled the template with clients to make final refinements.

Alongside the development of the template the project investigated processes to support the implementation of integrated care planning, including documentation in the EHR.

2.5 Development of training and resources to support staff in implementing the chronic conditions service model.

The CCCG was aware of several external training options relevant to improving chronic conditions care. However, no one package met the needs of the generalist introduction to chronic care at ISCHS that the project deliverables described.

As the project progressed and the size of the tasks became clear, the CCCG agreed to defer the development of in-service training until the next phase of the project.

2.6 Development of the chronic conditions care evaluation plan

A literature search and consultation with industry experts identified system, process and client outcome objectives for improvement of chronic care at ISCHS.

Consultations with community health services and a review of chronic conditions care guidelines and toolkits were used to identify relevant evaluation tools. However, the project was unable to source an evaluation framework that would efficiently and effectively evaluate the key objectives of the ISCHS chronic conditions care model. An evaluation consultant was engaged periodically over a four month period to guide the development of an evaluation framework and plan specific to ISCHS needs.

3. Project Outcomes and Recommendations

This section of the report evaluates the success of the project in progressing and achieving the objectives and deliverables. The chronic conditions project 2009-10 had a large focus on analysis of current care and identification and early development of system, process and practice changes required to improve chronic conditions care at ISCHS. The work aimed to put ISCHS in a position to implement practice changes across the organisation. The objectives and deliverables were system changes and trials of process and practice changes, thus the evaluation is essentially the analysis of the results of recorded project activities.

3.1 Development of ISCHS Chronic Conditions Model and planning objectives based on best practice guidelines and the Chronic Care Model.

The ISCHS Chronic Conditions Care Model and planning objectives were agreed by the CCCG in November 2009. As the work progressed the project was fundamental in creating an organisation "paradigm shift" by gaining agreement from the management team that the model and vision of care articulated by the project, is applicable across all teams and with all client groups as the overall approach to care. This agreement came in May 2010 thus at the time of writing this report ISCHS was in the process of renaming the model, and all related work, to reflect the new direction and the diverse client groups and services at ISCHS.

To support the integration of an overall approach the project was successful in facilitating the addition of chronic conditions care items in all position description and performance planning templates[*].

Results

a) Audit of existing chronic conditions care at ISCHS

Organisational Skills Analysis – Chronic Disease Care:

The OSAT-CDC was completed in September 2009 with seven items identified as high priorities for action:

1. Agency support for best practice in chronic conditions care.
2. Suitable qualification of management team members responsible for the planning, implementation and evaluation of chronic conditions services.
3. Planned prevention and management when a person with chronic conditions contacts ISCHS.
4. Needs assessment of individuals with chronic conditions.
5. Care planning for people with chronic conditions.
6. Support for individuals to understand how their condition affects their body and the implications for healthy living.
7. Evaluation of chronic conditions services.

[*] Chronic conditions care was already articulated in the strategic plan and program plan templates.

The OSAT-CDC was an effective tool for auditing chronic conditions care at ISCHS and has been integrated into the ISCHS Chronic Conditions Care Evaluation Plan. It provided benefits including raising awareness of best practice in chronic conditions care, raising awareness of the CCCG and chronic conditions project, highlighting the relevance of chronic conditions care to all staff and demonstrating that ISCHS had already done a significant amount of work to improve chronic conditions care.

A limitation of the OSAT-CDC was in assessment of health promotion. The OSAT-CDC focuses on social marketing and failed to capture ISCHS health promotion activities such as health information and skill development.

The communication strategy for implementing the OSAT-CDC was an important factor in its success. Clear and timely communication was provided and the project worker was available to all staff for support. The involvement of project workers in facilitating completion of the OSAT-CDC in team meetings added value to the process by:

- Improving consistency of information and support provided to staff.
- Building rapport between staff and project workers.
- Enabling project workers to directly observe how staff think and feel about chronic conditions change management.
- Increasing project workers' understanding of services across the organisation.

The discussion generated by completing the OSAT-CDC in team meetings provided context specific detail about ISCHS chronic conditions care that informed CCCG decision making throughout this year of the project.

Patient Assessment of Chronic Illness Care

The PACIC was completed with 35 clients in October and November 2009 and was a useful tool for providing a client perspective of how well ISCHS meets key domains of the Chronic Care Model:

- Patient Activation
- Delivery System Design and Decision Support
- Goal Setting
- Problem solving/Contextual Counselling
- Follow-up/Coordination

In all domains the majority response was "some of the time" (or 3/5).

The results were also analysed in service specific groups. This highlighted that services specifically designed for best practice chronic conditions care, e.g. the Hospital Admission Risk Program Pulmonary Rehabilitation, rated higher ("most of the time") than services not yet exposed to chronic conditions change management.

Analysis of the PACIC results against the OSAT-CDC priorities confirmed that by addressing the OSAT-CDC priorities the PACIC domains would also be improved.

The PACIC has been integrated into the ISCHS Chronic Conditions Care Evaluation Plan.

Service mapping and gap analysis

The service mapping activity involved coordinators listing the services provided by their teams within the corresponding level of care on the Kaiser Permanente Pyramid. It was completed in January 2010 and produced two service maps:

1. All ISCHS services/activities mapped against Kaiser Permanente levels of care and prevention
2. Condition specific services/activities and lifestyle risk factor services mapped against Kaiser Permanente levels of care and prevention

The two service maps can be used as decision support tools for staff in terms of identifying what ISCHS services are available for their clients based on the intensity of care they require, including prevention. However, the service maps have had limited circulation and the usefulness to staff has not been evaluated.

The service mapping activity highlighted the broad range of ISCHS services and activities providing care and support for people at risk of and living with chronic conditions. These results and an extensive literature review informed the gap analysis of chronic condition services, risk factor services and self-management services at ISCHS and identified key service gaps:

- Smoking cessation support
- Diabetes education
- Self-management support
- Overweight and obesity support

As well as other considerations for condition specific service development:

- Cardiovascular disease and stroke
- Asthma and chronic obstructive pulmonary disease
- Musculoskeletal conditions and chronic pain

RECOMMENDATIONS:

- Re-audit chronic conditions care at ISCHS by repeating the OSAT and PACIC by July 2011 and include additional items to ensure it accurately captures health promotion activities at ISCHS.
- Promote the service maps consistently across the organisation and review biannually to ensure current.

b) ISCHS Chronic Conditions Model based on the Wagner Chronic Care Model.

Overarching model and planning objectives

The ISCHS Chronic Conditions Care Model and planning objectives were developed with assistance from an external industry consultant and informed by the results of the organisation skills audit. The model was articulated using the six components described in the Chronic Care Model.

The model and planning objectives were agreed by the CCCG in November 2009 (see appendix 3). As the project progressed it became apparent that some staff had concerns about the interpretation of the model on their clients and their work. A key area of concern was the language used in the chronic

conditions care documentation and communications. Some teams found the language neglected to acknowledge our diverse range of clients and variety of approaches to care that are required to meet their needs. There was also some dissatisfaction with the consultation process and indicated more consultation was required.

These concerns highlighted that there had been a breakdown in the communication strategy for the project and, as discussed above in item 2.3.4, additional strategies were implemented to address the communication breakdown and increase consultation with staff.

The conversations that evolved from implementing these strategies were successful in addressing staff concerns, clarifying language issues and enhancing the interpretation of the work across the organisation. This resulted in the agreement from management that the overall approach to care articulated by the model applies to all client groups - not just those with chronic conditions. This strengthens the integrity of the project by ensuring that all teams will be working towards improving the access of all ISCHS clients to best practice prevention and management of chronic conditions.

The complexities of the language issues also extend to how ISCHS communicates the work externally. The consultation with staff indicated they understand that this approach to care is referred to as chronic condition (or disease) management in external forums, such as those that provide funding, and that we will engage with that language when required.

Following the agreement from the management team that the chronic care model is applicable across all teams and with all client groups as the overall approach to care, the CCCG revised the aim of the project for moving into year 2:

> *Develop a coordinated and integrated approach to care across ISCHS, in order to improve the overall health and well being of individuals, families and the community.*

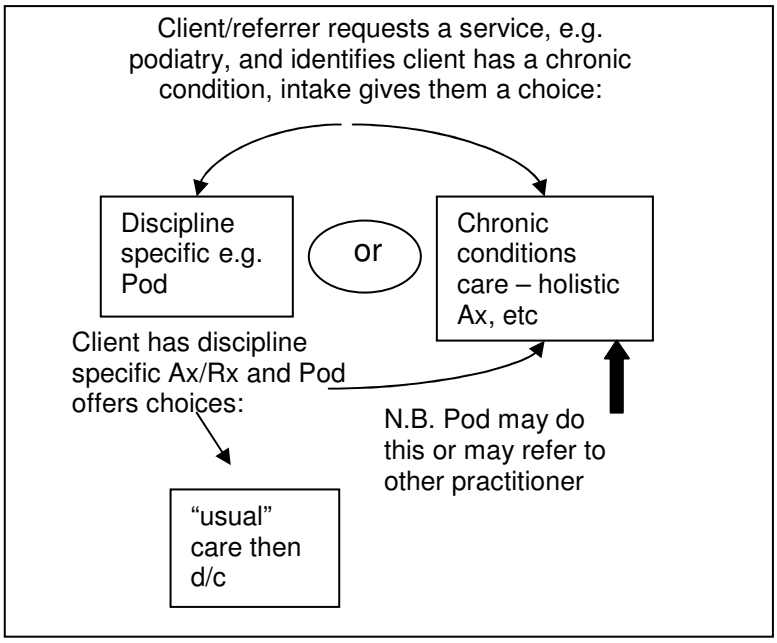
RECOMMENDATIONS:

- Review the Chronic Conditions Care Model and Planning Objectives developed during 2009-10 to better represent the vision of care and overall approach to care for **all** ISCHS clients.
- Review the ISCHS Assessment and Care Policy to align with the model of care.
- Ensure the management team understand that other improvements to conditions specific services and activities will primarily be the responsibility of program and team planning.*

* N.B. The project supervisor and project worker will continue to support the development of the ISCHS Diabetes Coordinated Care Model through the PRG which was formerly the Diabetes Working Group.

Client pathway

A simple client pathway was proposed within the CCCG during one of the workshops with the industry consultant:



Some further development of the pathway occurred, to capture some of the complexity of how clients access ISCHS. However, the CCCG agreed that for 2009-10 the client pathway should remain simple.

RECOMMENDATION:

- Further develop the client pathway, including links to assessment and care planning.

3.2 Trial priority aspects of the chronic conditions service model.

The CCCG identified a care plan template and a minimum assessment data "front sheet" as the priority aspects of the model to trial including supporting guidelines. Both of these aspects were developed and trialled by the PRG and significant progression made. The trials were delayed by the later than expected formation of the PRG and additional challenges were identified as the trials progressed including limitations of the EHR and varying levels of skill and support for integrated care planning.

Results

a) Development of Assessment 'front sheet' and process

Consultation with community health services in receipt of EIiCD funding identified several comprehensive assessment tools developed and used by chronic disease teams. The CCCG discussed that in the absence of a "chronic disease team" ISCHS was not ready to implement a common comprehensive assessment. Therefore the project focussed on decreasing duplication of assessment and improving consistency of assessment and risk screening by developing a common assessment form "front sheet" that contained the minimum assessment data to be collected for all clients.

The minimum assessment data "front sheet" was developed through analysis of document and file audits, assessment process mapping, consultation with IT and PRG feedback. Document audits identified 16 assessment form templates across the organisation. Whilst these forms all had discipline or service specific assessment items there was also significant overlap in generic assessment items such as client details, medical history, medications and social history. The audit also highlighted a gap in risk factor screening.

File audits identified that 88% of ISCHS see two or more health care workers at ISCHS and that 27% of clients have two or more "initial" assessments in a 12 month period.

Process mapping of initial client assessment identified the following significant findings:

- 11 teams use hardcopy assessment form templates with clients
- 3 teams don't have templates.
- The majority of teams handwrite assessment notes and transfer the information into the progress notes of the EHR. A significant number of teams do not transfer all assessment information into the EHR, instead summarising their assessment in the EHR progress notes then filing the hard copy form in the client hardcopy medical record.
- Many staff do not "call up" the hardcopy medical record and would therefore not see previous initial assessment forms.
- Some teams use the SCTT forms embedded in the EHR. However these are reported to be time consuming, episode specific and lack coding to allow for population health data analysis.
- Anecdotally there is a sense that accessing assessment information of other practitioners is difficult within the EHR and not routinely done.

This highlighted a gap in information sharing, the potential for duplication and the difficulties for staff in providing coordinated, collaborative care.

The CCCG and PRG agreed the importance of having efficient and effective processes for documenting the information in the EHR. Consultation with IT staff identified the "Clinical History" tab in the EHR as the most efficient and effective way to document and share the assessment "front sheet" information. The PRG trialled the documentation process and at the time of writing were trialling use of the hardcopy "front sheet" with clients and transferring that data into the EHR.

The feedback from these trials has informed the implementation plan. The "front sheet" and documentation processes require a brief period for further refinement before implementation across the organisation. Implementation will require training staff to use a section of the EHR not currently in use.

RECOMMENDATIONS:

- Implement the assessment front sheet and documentation process in TrakCare, across the organisation.
- Continue the development of the assessment front sheet and supporting guidelines as a key project activity for 2010-11 including additional best practice recommendations for comprehensive assessment and decision support for staff.

- Progressively audit uptake of assessment front sheet and documentation in the Clinical History tab of TrakCare.

b) Development of Care Plan template and process

The care plan template was developed through analysis of document and file audits, consumer consultation and PRG feedback. Document audits identified a variety of templates in use across the organisation, many of which did not meet best practice standards. File audits highlighted low utilisation of care plans. Where care plans were found they were essentially discipline specific and with no evidence of integration/collaboration with other service providers – internal or external.

Consumer consultation identified preferred template formats which were then presented to the PRG for trialling. The agreed template for trialling met the clinical indicators published by the Victorian Health Care Association. Significant effort was made to align the care plan template with the SCTT Care Coordination template that is embedded in EHR and advocated by the Department of Health. However, the development process identified that currently the SCTT Care Coordination template does not meet the needs of ISCHS clients and staff.

The trial of the care plan template proved more difficult than anticipated. During the first month of the trial only one PRG member was able to trial the template. The PRG reported the following barriers:

- One off appointments (i.e. client not needing return for review)
- Clients with cognitive issues
- Clients did not attend
- Staff on leave
- Acute problems needed addressing
- Didn't have "appropriate" clients
- Time – need longer appointments
- Clients already had GP Management Plans
- Introducing a care plan to longer term clients – "why now?"
- Concern re: capacity for follow-up.

Other barriers observed by the project worker include lack of clarity around responsibility for care planning, variety in understanding the purpose of a care plan and how to collaborate with clients in developing them, and lack of structure within the organisation to support integrated care planning.

The PRG problem-solved the barriers and extended the trial for one month, after which the majority of members had trialled the template and feedback was collected to refine the template and inform the recommendations for further implementation.

An additional barrier to developing and trialling a care plan template was that the care plan function in the EHR does not meet the needs of ISCHS due to its limited ability to allow expansive client information to be entered. Thus there is currently no process to efficiently and effectively document and share care plans across the agency. Consultation with IT staff identified that the best process would be to scan or save and attach a completed care plan to

the EHR. However, at the time of writing ISCHS did not have the IT capacity to support attaching documents to the EHR thus limiting the trial of the template. The PRG agreed in theory to documenting and sharing the care plan this way but the proposed process will need trialling after the ISCHS "WAN backbone" connection is upgraded. This is due for completion in July 2010.

The care plan template is ready for final formatting and before limited implementation to replace existing templates used across the organisation [*]. Implementation will require training staff to attach documents to the EHR. Further work to develop and trial guidelines and processes for integrated care planning needs to be completed to establish a consistent approach to care planning and care coordination across the organisation, and allow broader roll out of the template.

Significant work is required to improve care planning and care coordination processes across ISCHS. In 2010-11 development work should include:

- define ISCHS care coordination
- who is responsible (Key Worker)
- what care planning do we expect (including levels)
- case review/conference processes
- follow-up, reminders/recall
- staff training

RECOMMENDATIONS:

- Implement the common care plan template, to replace existing templates, once the IT capacity has been upgraded.
- Continue the development of the common care plan template and supporting guidelines as a key project activity for 2010-11 including clear articulation of roles and responsibilities for care coordination.
- Progressively audit uptake of care plan template and care coordination processes.

3.3 Identify and develop training and resources to support staff in implementing the chronic conditions service model.

Results

In-service training package for ISCHS staff that introduces key aspects of best practice chronic conditions care in the ISCHS context.

The CCCG identified the key aspects to be described by the training:

- prevention
- screening
- assessment
- care planning
- self management
- self efficacy
- client centred approach

[*] with exceptions for teams who use templates/processes mandated by DH/DHS

A literature search identified a Flinders University resource that the CCCG agreed covered most of the key elements required for the in-service training[8] and could be used as the foundation for developing the ISCHS specific training. As development of the package progressed it was identified that different programs and teams have different training needs that will not be met by one generic in-service session. The project did not have adequate resources to address such a large task and, as discussed above, completion of this objective was deferred until year 2 of the project.

RECOMMENDATIONS:

- Develop team targeted in-service training re: chronic care at ISCHS including self-management support specific to the ISCHS client group and environment.
    - Complete a skills audit and training needs analysis
    - Consult with industry advisor to assist the development of team targeted in-services re: chronic care at ISCHS.
- Work with individual teams to support them integrating the model of care into their current processes and practices.
- Promote systematic opportunities for staff to develop and sustain new skills and knowledge learnt in training.

3.4 Develop an evaluation plan that includes process evaluation, impact evaluation and outcome evaluation.

Results

ISCHS Chronic Conditions Care Evaluation Plan

An ISCHS Chronic Conditions Care Evaluation Plan has been proposed and is currently under review by the CCCG. The plan includes an evaluation framework that addresses the three levels of evaluation for chronic conditions care:

1. **System evaluation** – overall evaluation of the model of care.
2. **Process evaluation** – evaluation of specific processes used to achieve the model of care.
3. **Outcome evaluation** – evaluation of client outcomes.

The development of the ISCHS Chronic Conditions Model identified several system and process objectives to evaluate. The objectives are short, medium and long term. For a full description of the objectives see Appendix 3.

The CCCG discussed and identified the key client outcomes, relevant to all ISCHS programs, to be evaluated:

1. Satisfaction with service
2. Behaviour change that promotes health
3. Improved self-efficacy
4. Improved quality of life (QOL)
5. ISCHS chronic conditions care reaches [sub-populations within] the target group.

Evaluation of systems and processes to support chronic care involves activities and tools that have been utilised to collect baseline data for the project, and have shown to be suitable for use at ISCHS:

- OSAT-CDC
- PACIC
- Service and process mapping
- PDSA cycles
- Focus groups

Client outcomes from chronic conditions care are widely considered difficult to evaluate. A literature search identified existing, validated tools to measure these outcomes. However, the CCCG found that some of these tools are too detailed and complex for many ISCHS clients. External consultation was sought to assist the project in developing a client outcomes "evaluation hierarchy" that includes qualitative questions, evaluation of goals set in care planning and validated tools. Consumer consultation assisted the selection of suitable validated self-efficacy and QOL tools for the majority of our diverse clients. These client outcomes evaluation activities have not been utilised at ISCHS before and therefore require a trial period.

The process of developing the evaluation plan identified collection and storage of client outcomes data as a barrier to implementing the plan. Currently the electronic records system does not have the capacity to collate and analyse the client data to be collected. Consultation with IT identified issues with creating a separate a database including workload and confidentiality. Recent consultation with The Department of Health suggested other community health services have addressed the issue of confidentiality in relation to an evaluation database. Agency contacts were provided for follow-up. A method for collecting and analysing client outcomes data will need to be resolved before roll out of the evaluation plan.

RECOMMENDATIONS:

- Identify a secure way of collecting and analysing client outcomes data.
- Trial the client outcomes evaluation strategy proposed by the ISCHS Chronic Conditions Care Evaluation Plan.
- Implement the system and process evaluation strategies proposed by the ISCHS Chronic Conditions Care Evaluation Plan.

4. Other considerations and recommendations for year 2 of the project.

This section discusses some additional considerations and recommendations for year 2 of the project.

4.1 Project Governance 2010-11

The challenges faced during the first year of the project highlighted the importance of consistent communication and consultation across the organisation as well as the need for champions to inform and promote practice changes.

RECOMMENDATIONS:

- Expand the Membership of the CCCG to include representation from consumers, Organisational Support and Development Program and Mental Health Team.
- Expand the membership of the PRG to include representation from Paediatrics Team and Case Manager/Health Facilitator.
- Review the communication strategy including clarification of the roles and responsibilities of all management staff in consulting with their teams and feeding back to the CCCG.

4.2 Integration of the model of care across the organisation

ISCHS has a diverse range of programs and activities for diverse client groups with varying needs. ISCHS teams are structured in different ways in order to best meet the needs of these clients thus teams and services will have various capacities to integrate the new model of care and implement practice changes.

RECOMMENDATION:

- Encourage teams to choose one (or more) condition, client group or service aspect to focus on for initial roll out of changes directed by the project.

4.3 Organising and reporting chronic conditions prevention and care at ISCHS

As discussed above the improvement of chronic care at ISCHS is broader than just the activities of the chronic conditions project. The complexity is in capturing this, organising it and reporting on it to truly reflect the excellent work occurring across the organisation. In the current context of national health reform with a focus on prevention and early intervention approaches as well as integrated and coordinated primary health care service delivery, it would be useful for ISCHS to explore how this can be best achieved.

RECOMMENDATION:

- Develop a process to collate relevant results of Chronic Care, Health Promotion, Community Participation and Program activities to create a comprehensive report of chronic conditions care at ISCHS.

5. Implementation Plan 2010-12

Achieving sustainable change within community health requires a systematic long term approach[9]. Enhancement of services to better address the ongoing health needs of the ISCHS community is a large body of work that requires a significant investment of time and is larger than the chronic conditions project alone. The proposed implementation plan outlines key areas of work for the next two years, based on the components of the Chronic Care Model and the outcomes of the 2009 organisational skills audit.

The implementation plan acknowledges previous work in addressing the components of the model. The language used in the plan reflects ISCHS's decision to use the Chronic Care Model as the overarching approach to care for **all** ISCHS clients and services. However, as ISCHS has not yet re-named their model of care, and related work, the term "chronic care" is used for clarity.

The improvement of chronic care at ISCHS is broader than just the activities of the chronic conditions project, however this implementation plan focuses on the generalist aspects of improving care as articulated by the ISCHS model of care. The implementation plan for 2010-11 is primarily within the scope of the project. The CCCG will need to ensure the implementation continues through 2011-12.

(see next page for implementation plan)

ISCHS CHRONIC CARE MODEL IMPLEMENTATION PLAN 2010-12		
1.0 Organisational Support		
1.1 Prevention and management of chronic conditions is part of organisation/long term planning and specific people are held accountable		**Other considerations**
Current status	• ISCHS has model and planning objectives for improving prevention and management of chronic conditions. • Prevention and management of chronic conditions is integrated into strategic planning, program planning and performance planning. • Commitment to prevention and management of chronic conditions is articulated in position description templates and is the responsibility of all staff. • The Chronic Conditions Change Group and project worker are responsible for driving improvements in prevention and management of chronic conditions.	
2010-11	• Clarify roles and responsibilities of ISCHS management team in progressing system, process and practice changes resulting from the project. • Support the management team in providing change management support to their staff.	• Training.
2011-12	• Assess the need for further development of roles and responsibilities re: prevention and management of chronic conditions e.g. key workers. • Develop a process to collate relevant results of Chronic Care, Health Promotion, Community Participation and Program activities to create a comprehensive report of chronic care at ISCHS.	• Team roles, responsibilities and skill mix.
1.2 Chronic care receives necessary resources		
Current status	• ISCHS has project workers, a steering group and a practice reference group dedicated to the improvement of prevention and management of chronic conditions. • ISCHS programs have dedicated resources to relevant externally provided training such as self-management support and behaviour change techniques. • ISCHS has a large health promotion budget including a Health Promotion Coordinator. • ISCHS has a Community Participation Officer and strong commitment to community participation.	

2010-11	• Dedicate training resources specific to the practice changes rolled out during the change management process. • Dedicate resources to training project workers and management staff in organisational change management processes. • Dedicate resources to evaluation of the service	• Training.
2011-12	Dedicate resources to key gaps identified by service mapping and organisational skills audit – smoking cessation, diabetes education, self-management support activities, overweight/obesity activities.	• Training. • Community links.
1.3 Care delivery is specifically designed to improve health outcomes for people living with or at risk of chronic conditions		
Current status	• ISCHS has had a multidisciplinary team structure for several years. • ISCHS has a vision of care the meets best practice guidelines re: chronic care that includes: o Regular assessment o Documented care plans o Care coordination o Preventative interventions o Self-management support o Health promotion o Evaluation	
2010-11	• Review the Chronic Conditions Care Model and Planning Objectives developed during 2009-10 to better represent the vision of care and overall approach to care for **all** ISCHS clients. • Review the ISCHS Assessment and Care Policy to align with the model of care.	
2011-12	• Review the progress towards achieving the planning objectives and assess the need for further development.	
2.0 Community Linkages		
2.1 Active partnerships with local health and community services and clients		**Other considerations**

Current status	• ISCHS has strong linkages with the community at organisational, program and team levels. • ISCHS actively seeks partnerships and linkages between local health and community services and clients to develop formal, supportive programs and policies across the entire system. • Consumers are consulted regularly throughout chronic care improvement activities.	
2010-11	• Formalise consumer involvement in chronic care project. • Formalise partnership with GP for the chronic care project. • Report progress quarterly to the Inner South East Partnership in Community Health Service Coordination and Integrated Chronic Disease Management sub-group.	
2011-12	• Develop further links that address gaps identified as the work progresses	
3.0 Delivery System Design		
3.1 Clear point of access		**Other considerations**
Current status	• ISCHS has an effective information and referral system that provides consistency of access to services via a variety of methods – phone, online, fax. • ISCHS has innovative assertive outreach processes	
2010-11	• Implement the demand priority tools mandated by the Department of Health.	• Training. • Clinical information system.
2011-12	• Ensure the intake processes and initial needs assessment (INI) supports the common assessment and care plan process. • Consider establishment of one point of access for all referrals.	As above
3.2 Regular Assessment		
Current status	• ISCHS management team agreement that common assessment “front sheets” can be developed and implemented across the organisation. • Minimum assessment data “front sheet” developed and trialled. • Consistent approach to documenting minimum assessment data developed and trialled	
2010-11	• Implement minimum assessment data “front sheet” and procedures across organisation.	• Training.

	• Continue development of minimum assessment data "front sheet" to progress to a more comprehensive assessment including self-management skills, depression and additional lifestyle risk factors. • Ensure assessment is based on the participation of the client and their supports. • Ensure assessment is linked to care planning and care pathways.	• Team roles, responsibilities and skill mix.
2011-12	• Continue to develop assessment forms to align minimum assessment data front sheet with condition specific and discipline specific assessments. • Explore the development of risk assessments for complications and co-morbidities associated with specific conditions.	As above
3.3 Care planning		
Current status	• Common care plan template developed and trialled. • ISCHS management agreement that key worker role can be developed.	
2010-11	• Implement the common care plan template to replace existing templates. • Clarify roles and responsibilities for care planning and care coordination. • Develop and trial key worker role – team members who will take overall responsibility for coordinating care of individual clients. • Develop and trial a process for allocating a key worker to clients. • Develop and trial consistent care planning processes that support the development of documented care plans for all clients: • Develop and trial consistent case review and case conferencing processes, including across disciplines/teams. • Develop and trial processes to include GPs in collaborative care planning.	• Training. • Team roles, responsibilities and skill mix. • Self-management support. • Clinical information system.
2011-12	• Implement recommendations from 2010-11 work. • Up-skill staff and consider expanding practitioner roles to promote increased capacity for key worker to provide coordinated/integrated care. • Explore inter-agency care planning with key partners.	As above
3.4 Follow-up and review		
Current	• Consultation with IT to define current capacity for systematic reminders/recall for follow-up	

status	and review.	
2010-11	• Develop and trial consistent processes for review of care plans and regular follow-up. • Develop and trial consistent processes for documentation of referral to other providers. • Develop and trial consistent processes for identifying and managing missed follow-ups.	• IT capacity. • Clinical information system. • Training.
2011-12	• Implement recommendations from 2010-11 trials. • Assess need for further development of follow-up and review processes and practice to support broader implementation across the organisation.	As above.
4.0 Self-management Support		
4.1 Integrate self-management support strategies into all services		**Other considerations**
Current status	• ISCHS are cognisant of a variety of self-management models.	
2010-11	• Integrate assessment of self-management into regular assessment procedures (see 3.2 above). • Develop collaborative care planning (detail discussed above item 3.3). • Clarify worker roles and responsibilities to carry out self-management support and follow-up. • Clarify current options for self-management support, group and individual, and update the service map.	• Training.
2011-12	• Develop processes to ensure clients are provided with information on their risk factors and conditions, including condition specific guidelines. • Develop processes to ensure information for clients is consistent with and promotes self-management. • Consider whole of organisation approach to self-management from first point of contact to ongoing maintenance. • Identify community resources that could support clients achieve self-management goals.	• Training. • Decision support resources. • Team structure/skill mix. • Community links.
4.2 Capacity building of health professionals		
Current	• ISCHS teams have undertaken significant training in self-management support and	

status	behaviour change techniques including motivational interviewing, health coaching, Flinders Model and other condition specific and discipline specific training.	
2010-11	• Skills audit and training needs analysis. • Use results of skills audit and training needs analysis to develop team targeted mandatory in-service training re: chronic care at ISCHS, including self-management support specific to the ISCHS client group and environment. • Ensure systematic opportunities for staff to develop and sustain new skills learnt in training (both external an internal trainings).	• External consultation. • Training. • Time to follow-up training.
2011-12	• Continue with team targeted in-service as required. • Develop generic chronic care in-service for new staff.	• Training. • Time to follow-up training
5.0 Decision Support		
5.1 Embed evidence-based guidelines into assessment and care planning		**Other considerations**
Current status	• The minimum assessment data "front sheet" developed during 2009-10 incorporates some of the best practice recommendations for chronic care assessment – key lifestyle risk factors, medical history, medications and psychosocial history.	
2010-11	• Provide evidence based resources to support staff take appropriate action on assessment findings, including progressing to care planning. • Ensure the development of assessment forms incorporates further best practice guidelines e.g. depression screening.	• Training. • Existing decision support tools.
2011-12	• Assess need for further provision and development of decision support resources to assist staff take appropriate action on assessment findings.	
5.2 Integrate specialist and primary care expertise		
Current status	• ISCHS services include secondary consultation within the agency. • The ISCHS Assessment and Care Policy describes Secondary Consultation and Internal Cross referral principles.	
2010-2011	• Develop and trial protocols for intra-agency care planning, case review/case conferencing (see 3.3), that integrates the specialist and primary care members of the ISCHS care	• Team roles, responsibilities, skill

	team. • Develop and trial protocols for care planning and case conferencing with GP (see 3.3).	mix. • Collaboration with GP
2011-12	• Implement recommendations from the 2010-11 work.	
6.0 Clinical Information Systems		
6.1 Share information with providers to coordinate care		**Other considerations**
Current status	• ISCHS has an electronic medical records system, "TrakCare", that allows access to client information at all sites, for all staff except Oral Health & GP and Post Acute Care.	
2010-11	• Implement a process to support relevant access to "TrakCare" for all ISHCS staff. • Implement common protocols for documenting the minimum assessment data and care plans. • Work with other agencies who use TrakCare to develop common protocols for documenting assessment data and care plans. • Trial IT options to support practitioners to more efficiently and effectively communicate about client care coordination.	• IT capacity. • Training. • Collaboration with other agencies.
2011-12	• Implement recommendations from the 2010-11 work • Trial IT options for generating follow-up reminders and prompts for guideline based care.	• IT capacity. • Collaboration with other agencies.
6.2 Monitor performance of practice team and care system		
Current status	• ISCHS has drafted an evaluation framework for system, process and client outcomes. • ISCHS has spreadsheets for collecting and analysing the OSAT-CDC and PACIC.	
2010-11	• Develop IT process for collecting and analysing client outcomes information.	• Training. • IT capacity. • Privacy and confidentiality policy.
2011-12	• Use results of evaluation to identify good practice as well as areas of care not meeting best practice guidelines.	• IT capacity. • Evaluation resources

6.3 Organise patient and population data		
Current status	• ISCHS has an electronic medical records system, “TrakCare”, which has some capacity to collect and organise patient and population data.	
2010-2011	• Ensure client data entry protocols allow for maximum collection and analysis of priority population health data including diagnoses, risk factors and client demographics. • Work with other agencies to develop the capacity of TrakCare to collect and organise patient and population health data.	• Training. • TrakCare capacity. • Collaboration with other agencies.
2011-12	• Analyse ISCHS population health data to guide strategic and program planning to meet priority needs of the ISCHS community. • Continue to work with other agencies to develop the capacity of TrakCare to collect and organise patient and population health data.	• TrakCare capacity. • Collaboration with other agencies.

6. Appendices

Appendix 1: List of recommendations from body of report

Project governance

- Expand the Membership of the CCCG to include representation from consumers, Organisational Support and Development Program and Mental Health Team.
- Expand the membership of the PRG to include representation from Paediatrics Team and Case Manager/Health Facilitator.
- Review the communication strategy including clarification of the roles and responsibilities of all management staff in consulting with their teams and feeding back to the CCCG.
- Encourage teams to choose one (or more) condition, client group or service aspect to focus on for initial roll out of changes directed by the project.

Over-arching Model of Care

- Review the Chronic Conditions Care Model and Planning Objectives developed during 2009-10 to better represent the vision of care and overall approach to care for **all** ISCHS clients.
- Review the ISCHS Assessment and Care Policy to align with the model of care.
- Further develop the client pathway, including links to assessment and care planning.

Assessment front sheet and Care plan template

- Implement the assessment front sheet and documentation process in TrakCare, across the organisation.
- Continue the development of the assessment front sheet and supporting guidelines as a key project activity for 2010-11 including additional best practice recommendations for comprehensive assessment and decision support for staff.
- Implement the common care plan template, to replace existing templates, once the IT capacity has been upgraded.
- Continue the development of the common care plan template and supporting guidelines as a key project activity for 2010-11 including clear articulation of roles and responsibilities for care coordination.

Workforce development

- Develop team targeted in-service training re: chronic care at ISCHS including self-management support specific to the ISCHS client group and environment.
    - Complete a skills audit and training needs analysis

- Consult with industry advisor to assist the development of team targeted in-services re: chronic care at ISCHS.

- Work with individual teams to support them integrating the model of care into their current processes and practices.
- Promote systematic opportunities for staff to develop and sustain new skills and knowledge learnt in training.

Evaluation

- Identify a secure way of collecting and analysing client outcomes data.
- Trial the client outcomes evaluation strategy proposed by the ISCHS Chronic Conditions Care Evaluation Plan.
- Implement the system and process evaluation strategies proposed by the ISCHS Chronic Conditions Care Evaluation Plan.
- Develop a process to collate relevant results of Chronic Care, Health Promotion, Community Participation and Program activities to create a comprehensive report of chronic conditions care at ISCHS.

Appendix 2: Literature and Resource List

ISCHS resources:

1. Inner South Community Health Service (2009) Client Survey 2009.
2. Inner South Community Health Service (2009) ISCHS Databook.
3. Inner South Community Health Service (2008) ISCHS Community Needs Assessment 2008-2011.
4. Inner South Community Health Service (2007) Health Promotion Policy and Procedure.
5. Inner South Community Health Service (2006) Assessment and Care Policy.
6. Inner South Community Health Service (2005) Prevention, Early Identification and Intervention Policy.
7. Inner South Community Health Service (2003), Diabetes Project Report.

Victorian resources:

1. Better Healthcare in Gippsland (2007) Chronic Disease Management Resource Kit.
2. Gill, M. & Willcox, J (2005) Chronic Illness Care Systems Development: A community health model – Final Report. North Central Metropolitan Primary Care Partnership, Victoria
3. Hagger, V. & Keleher, H. (2008) Practice Change: Learnings from the integrated chronic disease programs. Monash University, Peninsula Campus.
4. Hawke, K. & Wright, L. (2007) Client journey through the primary health service system. South East Health Communities Partnership, Victoria.
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6. Knox Community Health Service (2008) Key Worker Role – Care Coordination – DRAFT.
7. Primary Care Partnerships Victoria (2009) Victorian Service Coordination practice manual 2009). State Government of Victoria.
8. Organisational Skills Analysis Tool, Gill + Willcox.
9. Victorian Department of Human Services (2009) Primary health care in Victoria: A discussion paper. State Government of Victoria.
10. Victorian Department of Human Services (2008) Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services. State Government of Victoria.

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12. Victorian Department of Human Services (2006) Care in your community: A planning framework for integrated ambulatory care. State Government of Victoria.
13. Victorian Department of Human Services (2006) Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services. State Government of Victoria.
14. Victorian Department of Human Services (2004) Community health services: Creating a healthier Victoria. State Government of Victoria.
15. Victorian Department of Human Services - Public Health Division Australia-Victoria (2001) *The Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses,* Melbourne.
16. Victorian Healthcare Association (2009) Clinical indicators in community health. Victorian Healthcare Association.

National resources:

1. Australian Government Department of Health and Ageing, Primary Healthcare Reform in Australia: Report to Support Australia's First National Primary Healthcare Strategy, Australian Government 2009.
2. Australian Institute of Health and Welfare (2006) Chronic diseases and associated risk factors in Australia 2006. AIHW, Canberra.
3. Flinders Human Behaviour and Research Unit (2005) The 'Flinders Model' of Chronic Condition Self-Management: Information paper. Flinders University, Adelaide.
4. Kubina, N & Kelly, J. (2007) Navigating self-management: A practical approach to implementation for Australian health care agencies. Whitehorse Division of General Practice, Victoria.
5. National Public Health Partnership (2001) Preventing Chronic Disease: A strategic framework. National Public Health Partnership, Melbourne.
6. Royal District Nursing Service (2005) Transition in chronic illness: Self care. RDNS, South Australia.
7. South Australian Community Health Research Unit The Australian Health Ministers' Conference (2005) National Chronic Disease Strategy and supporting National Service Improvement Frameworks. Australian Government.
8. Zwar, N., Harris, M., Griffiths, R., Roland, M., Dennis, S., Davies, G.P. & Hasan, I. (2006) A systematic review of chronic disease management. Research Centre for Primary Healthcare and Equity, University of New South Wales.

International resources:

1. Barr, V.J., Robinson, S., Marin_Link, B., Underhill, L., Dotts, A., Ravensdale, D. & Salivaris, S. (2003) The Expanded Chronic Care

Model: An integration of concepts and strategies from population health promotion and the Chronic Care Model. *Hospital Quarterly,* vol. 7 no. 1 pp73-82.

2. Battersby, M. & Lawn, S (2009) Capabilities for supporting prevention and chronic condition self-management: A resource for educators of primary health care professionals. Flinders Human behaviour and health Research Unit, Adelaide.
3. Buckworth, J (2002) Characteristics related to meeting CDC/ACSM physical activity guidelines in adults, *American Journal of Health Studies.*
4. MacColl Institute for Healthcare Innovation, RAND & The California Health Care Safety Net Institute (2008) Integrating chronic care and business strategies in the safety net. Rockville, MD.
5. National Health Service (2005) Promoting optimal self care: Consultation techniques that improve quality of life for patients and clinicians. UK.
6. Patient Assessment of Chronic Illness Care, MacColl Institute for Healthcare Innovation 2004.
7. Singh, D. & Ham, C. (2006) Improving care for people with long term conditions: A review of UK and international frameworks. NHS Institute for Innovation and Improvement & University of Birmingham, UK.
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10. World Health Organisation (2002) Innovative Care for Chronic Conditions: Building Blocks for Action.

Condition specific resources:

1. Clinical Oncological Society of Australia (2003) Optimising Cancer Care in Australia.
2. Diabetes Australia (2007) Outcomes and Indicators for Diabetes Education – a national consensus position.
3. National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (2006) Guidelines for the prevention, detection and management of chronic heart failure in Australia.
4. National Pain Summit Initiative (2009) Draft National Pain Strategy.
5. National Stroke Foundation (2005) Clinical Guidelines for Stroke Rehabilitation and Recovery.
6. The Australian Lung Foundation and the Thoracic Society of Australia and New Zealand (2009) The COPDX Plan: Australian and New

Zealand guidelines for the management of chronic obstructive pulmonary disease.

Appendix 3

ISCHS Chronic Conditions Care Framework & Planning Objectives

Framework Component	Planning Objectives
Organisational Support • Chronic conditions care is part of Inner South Community Health Service's long term planning strategy. • Chronic conditions care receives necessary resources. • Specific people are held accountable for chronic conditions care. • Care delivery is specifically designed to improve health outcomes for people with chronic conditions through evidence-based practice.	• ISCHS has a long term chronic conditions care vision. • ISCHS has organisational goals for chronic conditions care. • Chronic conditions care is integrated into ISCHS business and health promotion plans. • Specific dedicated resources for chronic conditions care are identified. • ISCHS has a comprehensive Chronic Conditions Program that includes: ▪ regular assessment, ▪ documented care plans, ▪ preventative interventions, ▪ self-management support, ▪ health promotion, ▪ evaluation.
Community Linkages Inner South Community Health Service develops active partnerships with local health care agencies, community services and clients to support/accomplish coordinated, holistic and integrated care for people with chronic conditions.	• ISCHS supports active coordination between the health system, community services and clients • ISCHS actively seeks partnerships and linkages between local health care agencies, community services and clients to develop formal, supportive programs and policies across the entire system
Self-Management Support Clients, their families and carers are effectively supported to develop strategies that: • help them cope with the challenges of living with and managing a chronic condition. • reduce complications and symptoms.	• Effective self-management support, that fosters self efficacy, is integrated into assessment and care delivery processes for all people with chronic conditions. • ISCHS staff have the appropriate skills and resources to provide effective self-management support.
Decision Support Inner South Community Health Service has systems and processes in place to ensure practitioners have access to and integrate evidence-based information necessary to care for clients with chronic conditions. This includes: • evidence-based practice guidelines and protocols. • specialty consultation. • systematic provider education. • resources for clients	• Evidence-Based Guidelines are available, supported by provider education and integrated into care through care plans and reminders. • Protocols and service agreements for communication, care planning and case conferencing are developed with specialty services/practitioners both within and outside of ISCHS. • Specific and appropriate client materials and programs are developed that describe the client's role in achieving guideline adherence.
Delivery System Design Care teams across Inner South Community Health Service are organised to deliver systematic, effective, efficient and client centred clinical care, self management support and preventative interventions for people with chronic conditions.	• A comprehensive chronic care program is used for all chronic conditions clients including: ▪ regular assessment ▪ documented care plans ▪ risk factor screening and preventive interventions ▪ attention to self-management support. • Chronic conditions care is driven by senior management who assures that roles and responsibilities for chronic conditions care are clearly defined. • Systems are in place to support the development of one care plan for complex clients with clear articulation of responsibility for care coordination. • An evaluation framework is used to evaluate system and client changes.
Clinical Information System Inner South Community Health Service's clinical information system: • allows staff to access and contribute appropriate client information at point of care. • provides useful information about populations of clients with chronic conditions.	• Information about individual clients and populations of clients with chronic conditions is available to support program planning. • Assessment and care planning tools are integrated into clinical information systems to support sharing of information and joint care planning. • Systems are in place to support recall and reminder and are tied to guidelines which provide prompts and reminders about needed services.

6. References

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[5] Wagner, E.H. (1998) Chronic disease management: what will it take to improve care for chronic illness? *Effective Clinical Practice,* vol. 1 no. 1 p 2-4.
[6] Organisational Skills Analysis Tool, Gill + Willcox.
[7] Patient Assessment of Chronic Illness Care, MacColl Institute for Healthcare Innovation 2004.
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