gill+willcox

Organisational Skills Analysis Tool

Chronic Disease Care

Table of contents

This tool has been adapted from the Department of Human Services (Public Health) Health Promotion Skill Assessment Tool for Organisations by gill + willcox.

gill + willcox would welcome feedback on your experiences of using the tool or suggestion for improvements to the tool. Please forward comments to:

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Introduction

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

The Australian Institute of Health and Welfare (AIHW) provides the following list of elements to define chronic diseases.

Chronic diseases:

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

Living with a chronic disease can be stressful both for the person with the condition and family members or carers. Unlike acute health conditions significant responsibility for managing the condition rests with the individual.

Both federal and state Australian governments have recognised that, in order to improve care for people with chronic disease, there must be:

+ a change and move away from episodic, disease based approaches to a "life course' approach to health care that recognises the interactive and cumulative impact of social and biological influences on health
+ collaboration with sectors outside of health to develop strategies to address chronic disease risk factors
+ greater emphasis on integration and continuity of care across the continuum from prevention to management.[3]

Community Health has always played a significant role in helping people manage chronic health problems. The increasing demand for chronic disease care requires community health services to consider how they can refine and streamline the way they deliver care to ensure care practices are consistent with best practice and effectively using available resources.

The Organisational Skills Analysis Tool is designed to assist agencies recognise the skills they have in chronic disease care and identify opportunities and scope for further system and workforce development. The tool is not a stand alone improvement strategy, organisation commitment and resourcing is required to plan and implement changes to address issues identified by the tool.

The tool is designed for use in a multidisciplinary or cross sectorial group facilitated by an experienced practitioner. The tool aims to assess the workforce as a whole, not just skill or practice deficits of individual practitioners or teams.

1. World Health Organisation, Chronic Conditions: the global burden (online) http://www.who.int/chronic_conditions/economics/en/print/.html
2. National Public Health Partnerships 2001, Preventing chronic disease: a strategic framework background paper. October 2001
3. ibid

Organisational Needs Analysis Tool - An Overview

Aim

This Organisational Needs Analysis Tool outlines a number of indicators for best practice in chronic disease care and steps through a process that will:

1. Assist the agency to reflect on the role it can play in promoting best practice within a community setting, and the corresponding skills and infrastructure required for best practice.
2. Review the agency's current skills and practices in chronic disease care.
3. Establish priorities for service and skill development.

The tool has been designed to reflect on the collective chronic disease prevention and management services of the participating team members not to review the skills of individuals within the service.

Content

The Tool has three sections:

1. **Agency capacity and resources**

   Considers agency capacity and resources to; provide chronic disease care, in accordance with best practice recommendations.

2. **Provision of planned care based on best practice guidelines**

   Considers the process of care delivery and how it is planned, delivered and evaluated according to best practice guidelines.

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

   Considers the capacity of the agency to assess, plan and implement chronic disease services, health promotion and early intervention programs for people with, or at risk of developing a chronic disease.

The format of the tool has been adapted from the Department of Human Services (Public Health) Health Promotion Skill Assessment Tool for Organisations.[4]

Best practice pointers have been identified from a number of chronic disease best practice guidelines and recommendations.[5 6 7 8 9 10]

4. Department of Human Services (Public Health). "Health Promotion Skill Assessment Tool for Organisations. Victoria 2001
5. Department of Human Services (Primary Care Partnerships). "Integrated Disease Management Interim Policy Directions and Guidelines". Victoria 2001
6. Department of Human Services, Public Health Diabetes Prevention and Management Initiative. "Diabetes Workforce: Needs Analysis Tool". Developed by gill + willcox.
7. Primary and Community Health Branch, Victorian Government Department of Human Services "Implementation plan for the Primary Care Partnerships Strategy 2004–2006" 2004
8. National Public Health Partnerships 2001, "Preventing chronic disease: a strategic framework background paper." October 2001
9. World Health Organization Noncommunicable Diseases and Mental Health "Innovative Care for Chronic Conditions Building Blocks for Action global report" 2002
10. Wagner H. et al "Quality improvement in chronic illness care; a collaborative approach" JAMA 2001 27 (2) 63-80.

The process

1. Individual practitioners across the service who are involved in planning or delivery of chronic disease care complete the Tool.
2. Individual results are discussed and collated within disciplines or teams.
3. Representatives from teams/ discipline meet to discuss responses and agree on overall ratings across the organisation. Ideally this process would be facilitated by an experienced chronic disease practitioner.
4. Results are collated and summarised. Priorities for systems change and skill development are identified.

Ratings and priorities can be used to inform development of an implementation plan for improving chronic disease care within the organisation.

Note: The role of the facilitator is to clarify/ interpret aspects of the skill components that participants may not be clear about and provide in depth understanding of chronic disease care practice and theory.

Completing the tool

1. Complete the tool individually by considering each of the questions and their best practice pointers related to your team. Use the rating score below for each question.
2. Discuss the results with your team or discipline aiming to reach census with a collective rating score for each question (see rating system below). Highlight the boxes next to the best practice pointers that need particular attention for your team or discipline.

Rating System

Rating	Definition
A	The Agency meets the criteria of best practice, and has leading edge expertise that others could learn from.
B	The Agency's approach has been considered; some best practice indicators are being met but there is room for further improvement.
C	The Agency's approach has been considered; there is some intention to improve the performance of the agency in relation to this skill.
D	The Agency has yet to consider this approach
E	Not applicable to our Agency

1. Agency capacity and resources

+ Note for each of the questions below there may be disease specific activities that occur rather than generic chronic disease activities. Indicate this in the comments section identifying the diseases.

Key Question Section 1

Agency capacity and resources	Grading/comment
1.1 There is agency support for best practice chronic disease care.	
Best practice would mean: + An overall agency vision has been developed via a collaborative effort within the organisation. The vision is explicitly supported in agency policies and plans.	
+ Work plans are developed and implemented collaboratively with clear objectives, agreed timeframes and specified team member roles (Note this may include disease specific work plans).	
+ Appropriate resources and time are allocated to the provision of chronic disease care and prevention.	
+ There is support for team members involved in chronic disease services to participate in chronic disease related committees, working parties and professional activities.	
1.2 The management team members responsible for the planning, implementation, and evaluation of chronic disease services is suitably qualified.	
Best practice would mean: + Chronic disease services have a project coordinator with academic and/or experiential preparation in program management.	
+ The agency ensures that the skill level of health professionals involved in managing chronic disease services is appropriate.	
+ Managers involved in chronic disease services work to co-ordinate their roles with others in the team to ensure quality of practice is maintained.	
+ Team member job roles are defined and performance expectations clearly articulated.	
+ Quality improvement processes are planned, implemented and used to review and refine services.	

A - Meets the criteria of best practice.

B - some best practice indicators being met but further improvement needed.

C - The agency has considered this approach and identified areas for improvement.

D - The agency has yet to consider this approach.

E - Not applicable to our agency.

Key Question Section 1 (continued)

Agency capacity and resources	Grading/comment
1.3 The agency develops co-operative working relationships with other agencies.	
Best practice would mean:	
+ The agency involves key partners in the development of new services and/ or products.	
+ The agency explores options for problem solving and works towards reaching an agreement with partner agencies to solve problems.	
+ The agency supports the formation of joint planning working parties involving interdisciplinary representation of health professionals and consumers to develop implementation agreements.	
1.4 Chronic disease care services are provided by suitably qualified team members.	
Best practice would mean:	
+ Core chronic disease care is provided by a multidisciplinary team.	
+ Team members have appropriate qualifications and recent experience and knowledge in chronic disease conditions they are providing services for. They would be competent to educate clients in the following areas:	
- Describing the disease process and treatment options	
- Incorporating appropriate lifestyle information and skills such as *nutritional management & physical activity*	
- Utilising *medications* (if applicable) for therapeutic effectiveness	
- *Appropriate monitoring* of their condition (when appropriate) and using the results to improve control	
- Preventing, detecting, and treating *acute complications*	
- Preventing (through *risk reduction* behaviour), detecting, and treating chronic complications	
- *Goal setting* to promote health, and *problem solving* for daily living	
- Integrating psychosocial adjustment to daily life.	
+ Team members are encouraged and supported to widen and expand their individual skills.	
+ Opportunities are provided to team members to access relevant professional development activities/resources.	

A - Meets the criteria of best practice.

B - some best practice indicators being met but further improvement needed.

C - The agency has considered this approach and identified areas for improvement.

D - The agency has yet to consider this approach.

E - Not applicable to our agency.

2. Provision of planned care based on best practice guidelines

Key Question Section 2	
Provision of planned care based on best practice guidelines.	**Grading/comment**
2.1 How well does your agency provide planned chronic disease care when a person with chronic disease contacts your agency?	
Best practice would mean: The agency has clear protocols for **Initial Contact/Initial Needs Identification**. That is when people with a chronic disease contact your agency team members collect appropriate information to: + determine eligibility for the service	
+ identify individuals at high risk	
+ ensure those at high risk are referred and care prioritised appropriately within the service	
+ individuals not eligible for the service are referred to appropriate resources	
+ referrals from other agencies are acknowledged (receipt of referral) and informed of progress of referral.	
2.2 How well do health professionals in your service, assess the needs of individuals with chronic disease?	
Best practice would mean the agency has a clear and documented process for **comprehensive assessment** of all individuals with a chronic disease attending the agency including: + Information about medical, physical, social and psychological needs, from a range of sources, to reflect a comprehensive picture of consumer/family/carer strengths, resources and problems.	
+ Assessment is based on the participation of the individuals with chronic disease, their support systems(s) and interdisciplinary team members.	
+ The assessment incorporates appropriate risk assessment for complications and other co-morbidities associated with their chronic disease.	

A - Meets the criteria of best practice.
B - some best practice indicators being met but further improvement needed.
C - The agency has considered this approach and identified areas for improvement.
D - The agency has yet to consider this approach.
E - Not applicable to our agency.

Key Question Section 2 (continued)

Provision of planned care based on best practice guidelines.	Grading/comment
2.3 How well do health professionals plan care for people with chronic disease?	
Best practice would mean:	
+ Chronic disease care is provided according to best practice standards incorporating current knowledge and research findings.	
+ Following a comprehensive assessment, individuals with a chronic disease have a documented **care plan** that:	
- is developed collaboratively with individuals(s) with chronic disease, their support systems(s) and interdisciplinary team members	
- identifies issues/problems, risk profile and develops appropriate strategies to address these	
- includes appropriate treatment regime and education interventions according to best practice guidelines	
- encourages and supports self-care strategies	
- identifies appropriate follow up and review	
- has recall mechanisms in place including protocols for early identification and treatment of complications	
- documents progress, including goals and achievements	
- referral to other providers is documented and appropriate information supplied	
- privacy and confidentiality procedures are adhered to.	
2.4 How well do health professionals support individuals to understand how chronic disease affects their body and the implications of healthy living?	
Best practice would mean the agency consistently provides comprehensive information/education for all people with a chronic disease including information on:	
+ Factors involved in the development of their chronic disease.	
+ Basic components of the treatment appropriate to the type of chronic disease.	
+ How to prevent, recognise and treat short and long term complications.	
+ The interrelationship between nutrition, exercise, stress, smoking, medications, and healthy living with their chronic disease.	
+ Information about other disease specific services such as Diabetes Australia, Asthma Victoria, Arthritis Victoria, and National Stoke Foundation.	

A - Meets the criteria of best practice.

B - some best practice indicators being met but further improvement needed.

C - The agency has considered this approach and identified areas for improvement.

D - The agency has yet to consider this approach.

E - Not applicable to our agency.

Key Question Section 2 (continued)

Provision of planned care based on best practice guidelines.	Grading/comment
2.5 How well do health professionals tailor education to meet the special needs of clients?	
Best practice would mean:	
+ Team members are sensitive to cultural beliefs and the social and economic circumstances of individuals.	
+ Education is provided in a variety of formats and structured to suit different learning styles.	
+ Information is provided in appropriate languages.	
+ Individuals are provided with consumer friendly versions of best practice guidelines.	
2.6 How well do health professionals support individuals to be actively involved in their own care and change behaviour?	
Best practice would mean:	
+ Team members understand and apply the principles underlying effective behaviour change including:	
- assessing readiness to change	
- teaching goal setting and problem solving skills.	
+ Appropriate group facilitation strategies are applied to enhance skill development, self management skills and peer support.	
+ Referral pathways exist and team members refer clients to other programs to support maintenance of lifestyle changes.	

A - Meets the criteria of best practice.
B - some best practice indicators being met but further improvement needed.
C - The agency has considered this approach and identified areas for improvement.
D - The agency has yet to consider this approach.
E - Not applicable to our agency.

Key Question Section 2 (continued)

Provision of planned care based on best practice guidelines.	Grading/comment
2.7 How well does your agency evaluate the effectiveness of its chronic disease service?	
Best practice would mean the agency **collects and documents appropriate client data** and is able to demonstrate that:	
+ Individuals with chronic disease attending the service report or demonstrate increased ability to accomplish goals for healthy living with chronic disease that are important or meaningful to them and consistent with their desired quality of life.	
+ Individuals with chronic disease report or demonstrate increased confidence in managing their chronic disease.	
+ There is improved physiological control of their chronic disease as demonstrated by relevant biochemical markers and appropriate behaviour change.	
+ Referral and follow-up records indicate that:	
- early detection of risk factors for chronic disease complications occurs	
- individuals with chronic disease use resources to prevent complications	
- emergency and other hospital admissions related to preventable complications are minimised	
- length of hospital stays related to chronic disease complications is minimised.	
+ That the services and care provided are appropriately matched to the client base of the service.	
+ The needs of "at risk" groups have been identified and addressed.	
+ Care planning and service coordination protocols are being adhered to.	

A - Meets the criteria of best practice.

B - some best practice indicators being met but further improvement needed.

C - The agency has considered this approach and identified areas for improvement.

D - The agency has yet to consider this approach.

E - Not applicable to our agency.

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

Key Question Section 3

Planning and provision of chronic disease services including health promotion and early intervention programs	Grading/comment
3.1 How well does your agency establish a relationship and consult with key community members/groups?	
Best practice would mean:	
+ Client stakeholders and/or client groups have been defined and team members are familiar with local community networks and leaders.	
+ The needs of specific cultural and other minority groups are valued and participation by these groups is actively promoted.	
+ Mechanism and systems are in place to ensure community participation and input into chronic disease program planning.	
+ The appropriateness of specifically targeted programs is checked with consumers.	
(Note this may include disease specific activities)	
3.2 How well do people in your agency assess the needs of chronic disease community as whole?	
Best practice would mean:	
+ Available data about health needs/status of individuals/communities and populations is identified and sourced for planning.	
+ Team members have the skills to interpret and critically evaluate the available data.	
+ A holistic approach to collating a profile is used and information is sought about physical, socio- economic environment and existing services to identify needs and set priories.	
+ Communities of client groups are involved in identifying needs and setting priorities.	
(Note this may include disease specific activities)	

A - Meets the criteria of best practice.

B - some best practice indicators being met but further improvement needed.

C - The agency has considered this approach and identified areas for improvement.

D - The agency has yet to consider this approach.

E - Not applicable to our agency.

Key Question Section 3 (continued)

Planning and provision of chronic disease services including health promotion and early intervention programs	Grading/comment
3.3 How well do people in your agency plan social marketing activities?	
Best practice would mean:	
+ Target audience attributes are identified and segmented to create messages specifically for each segment.	
+ The appropriate locations and channels are selected to position the health message for effective audience reach.	
+ An established health behaviour model is used as the basis of the program.	
+ All the products, promotion materials and services developed for the program are pre-tested with the target audience.	
(Note this may include disease specific activities)	
3.4 How well do people in your agency undertake social marketing?	
Best practice would mean:	
+ Connections are established with key people, and networks built with community, media and other relevant stakeholders who may be able to complement the program.	
+ A variety of mass media or limited reach approaches are used and creatively executed.	
+ The effectiveness of the social marketing strategies are recorded and monitored and activity is adjusted accordingly.	
(Note this may include disease specific activities)	

A - Meets the criteria of best practice.

B - some best practice indicators being met but further improvement needed.

C - The agency has considered this approach and identified areas for improvement.

D - The agency has yet to consider this approach.

E - Not applicable to our agency.

Key Question Section 3 (continued)

Planning and provision of chronic disease services including health promotion and early intervention programs	Grading/comment
3.5 How well do people in your agency plan risk factor screening activities for health promotion/early intervention?	
Best practice would mean:	
+ Screening programs take into account community sensitivities and issues such as cultural factors, access to transport and follow-up medical attention.	
+ The screening programs are supported by complimentary health promotion interventions aimed at creating agency and social changes to support individual access to resources.	
+ Specific high-risk populations are reached via planned strategies to access these groups.	
+ Key referral pathways exist to local GPs and other relevant agencies for diagnosis and on going counselling, support and management.	
(note this may include disease specific activities)	
3.6 How well do people in your agency implement risk factor screening programs?	
Best practice would mean:	
+ Team members ensure individuals are screened with privacy and sensitivity.	
+ Best practice use of screening tools and quality control is maintained and monitored to ensure the accuracy and validity of risk factor measurements.	
+ Pre-screening information and post-screening counselling/discussion is provided to all individuals screened.	
+ Clients are assisted to identify their own needs and rights to determine appropriate action.	

A - Meets the criteria of best practice.
B - some best practice indicators being met but further improvement needed.
C - The agency has considered this approach and identified areas for improvement.
D - The agency has yet to consider this approach.
E - Not applicable to our agency.

Establishing priorities for skill development/practice change

Following discussion of team responses in relation to tool components and best practice indicators for each, ask the participants to indicate those areas that were rated B, C or D by their team. Collate these results on the table on the next page by including the number of B,C and D's. Ask to group to indicate what they feel the overall rating for the whole organisation for each component should be. See Table1.

Ask participants to assign a priority rating to each of the components.

Guide to priority rating

High - Skills critical to improving chronic disease care within the organisation that must be addressed in the next 6 - 12 months

Medium - Skills critical to improving chronic disease care within the organisation that must be addressed in the next 12 - 18 months

Low - Skills important to improving chronic disease care within the organisation that could be addressed over the next 1 - 5yrs

Ratings and priorities can be used to inform development of an implementation plan, for improving chronic disease care within the organisation.

Table 1. Workforce skills analysis summary

Component Title	Number B, C or D's	Overall Rating A, B,C, D or E	Priority (H/M/L)
1.1 Is there agency support for best practice chronic disease care?			
1.2 The management team members responsible for the planning, implementation, and evaluation of chronic disease services is suitably qualified?			
1.3 The agency develops co-operative working relationships with other agencies			
1.4 Chronic disease care services are provided by suitably qualified team members?			
2.1 How well does the service provide planned prevention and management when a person with a chronic disease contacts your agency?			
2.2 How well do health professional in the service, assess the needs of individuals with a chronic disease?			
2.3 How well do health professional plan care for people with a chronic disease?			
2.4 How well do health professionals involved in the service support individuals to understand how their condition affects their body and the implications of healthy living?			
2.5 How well do health professionals tailor education to meet the special needs of clients?			
2.6 How well do health professional in the service support individuals to be actively involved in their own care and change behaviour?			
2.7 How well does the agency evaluate the effectiveness of its chronic disease services?			
3.1 How well does the agency establish a relationship and consult with key community members/groups?			
3.2 How well does the agency assess the needs of the community as whole?			
3.3 How well does the agency plan and implement social marketing activities?			
3.4 How well does the agency undertake social marketing?			
3.5 How well do people in the agency plan risk factor screening activities for health promotion/early intervention?			
3.6 How well do people in the agency implement risk factor screening programs?			