Integrated chronic disease management (ICDM) resource

Checklist for monitoring ICDM progress

Background

Primary Care Partnerships (PCPs) are funded in Victoria to deliver improvements through partnerships across the health and broader human services system in four areas, one of which is integrated chronic disease management (ICDM). The outputs and focus of this work are detailed in the *Revised PCP program logic, July 2009,* available at <www.health.vic.gov.au/pcps/about/prr.htm>.

This checklist provides a set of indicators for assessing the likelihood that a given ICDM initiative will result in improved outcomes for people with chronic disease. Please note that there will be valid and appropriate activities and strategies that are not included in the checklist. Those included are what is indicated through the available evidence as being minimum standards for successful ICDM initiatives. The six sections into which the checklist is structured are intended to support progressive implementation of an ICDM PCP project or initiative from establishment of the partnership through to its planning and implementation.

The checklist has been developed using the following frameworks as its evidence base:

A. *Improving chronic disease care: Learnings from the integrated disease management projects* (Victorian Department of Human Services, 2005).

B. *It takes a region: Creating a framework to improve chronic disease care* (Wagner, E., Austin, B., Coleman, C., 2006).

C. *Integrating chronic care and business strategies in the safety net* (Wagner et al, 2008)

D. Model for improvement (Langley GL et al, The improvement guide, 2nd edition, 2009).

These frameworks are also the basis of the Department of Health's expectations of PCP ICDM activity as outlined in the *Revised PCP program logic, July 2009*. A column has been included in the checklist (labelled Ref), to indicate the framework(s) from which each of the points have been drawn, which correspond to the four references provided above. These can be used to source further information and resources about a particular point or indicator.

The checklist has been designed using Stufflebeam's methodology outlined in the *Guidelines for developing evaluation checklists.* See <www.wmich.edu/evalctr/checklists>.

Uses of the checklist

The primary users of the checklist are anticipated to be Department of Health regional office staff and PCP staff.

It is intended that this checklist will be useful for several purposes, which may include:

- guiding ICDM planning by PCPs
- identifying barriers to the progress and success of ICDM activity
- monitoring the progress of PCP ICDM activity over time
- generating discussion prompts in meetings between departmental staff and PCP chairs and/or staff
- guiding review (by departmental staff) of annual reports and written plans submitted by PCPs.

The checklist can be applied to individual projects (in which case it could be repeated for each project), to the whole ICDM work plan of a PCP or to regional projects and initiatives. Two approaches to responding to the checkpoints are suggested (see checklist, p.1). Either the four-point or two-point rating scale can be used. It is not intended that scores are summed.

A Victorian Government initiative

Victoria The Place To Be

Integrated chronic disease management checklist

Suggested scale for response column:

? = Unknown; 0 = Not met; 1 = Planned; 2 = Partially met; 3 = Met

Alternatively, ✔ = met and ✘ = not met

PCP: **Project** (if relevant): **Date:**

1. Effective partnerships	Ref	Response
1.1 A formalised governance structure exists to guide ICDM activity	B,C	
1.2 Each of the following are engaged as active partners:		
a) local government (HACC)		
b) community health		
c) division(s) of general practice		
d) Hospital Admission Risk Program (HARP)		
e) sub-acute care services (SACS)		
f) Aboriginal community-controlled health organisations (ACCHOs)		
g) mental health (primary mental health teams, mental health alliances, PDRSS, mental health area services, as appropriate for your focus)		
h) consumers, carers and community		
i) private providers		
1.3 Active partners are engaged in the PCP's quality improvement approach to partnership development Note: ALL PCPs are required, as detailed in the *Revised PCP program logic, July 2009,* to use a partnership evaluation tool to assess partnership strengths and weaknesses.	B	
1.4 A vision or charter for integrated chronic disease management has been endorsed by senior leaders in key partner organisations (such as PCP executive)	B,D	

Notes:

2. Workforce capacity building	Ref	Response
2.1 **All relevant staff of partner agencies, including senior leaders, have been oriented to the Wagner chronic care model**	B,C	
2.2 **There are skills within the partnership to lead continuous quality improvement activities** (such as the improvement model and breakthrough collaboratives)	C	
2.3 **There are skills within the partnership to implement rapid cycle change methods** *(for example, PDSA)*	C	
2.4 **Individuals facilitating ICDM activity** (such as PCP staff, chairs of PCP working groups and others) **have received training (or have extensive experience) in project management**	C	
2.5 **Most clinical staff have received training (or have extensive experience) in providing chronic disease self-management support, as it relates to their clinical role**	C	
2.6 **Most clinical staff have access to support for practice change and implementation of chronic disease self-management support**	C	
2.7 **Most agency staff have received orientation to the *Victorian service coordination practice standards***	C	
2.8 **If consumer representatives are the chosen consumer engagement model in ICDM planning and implementation, consumers involved have received sufficient training and/ or support to contribute effectively**	C	

Notes:

3. Strategic priorities	Ref	Response
3.1 Publicly available localised population health and service utilisation data has been collated and presented	C	
3.2 Consumer health care satisfaction and experience information has been collected and presented	A,B,C	
3.3 Active partners have shared information relating to each of their system and improvement priorities (may include the *Service coordination and ICDM survey* results, organisational assessments of chronic care, such as ACIC/ABCD tools, and strategic plans)	B	
3.4 An outline of the key local issues revealed by available data (see 3.1, 3.2 and 3.2) **has been presented to the active partners**	B,C	
3.5 Improvement priorities that reflect all of the above information (priority chronic disease(s) or population subgroups, and areas of improvement) **have been agreed, documented and endorsed by senior leaders of all active partners** (for example, through PCP executive or board) (Note: All PCPs are required to select one or more health and wellbeing priorities that focus on chronic disease, as per the *PCP planning and reporting guidelines 2009–2012)*	B	

Notes:

4. Effective planning and monitoring	Ref	Response
4.1 Planning has involved senior leaders, clinical champions and managerial leaders from partner organisations	B,C	
4.2 Ideas/learnings from other initiatives (such as successful work from other PCPs) **have been used to inform the development of the work plan**	B	
4.3 The systems or reasons for existing practice, in the areas where change and improvement is being implemented, have been identified, analysed and used to inform the work plan	D	
4.4 A work plan has been developed, documented and endorsed by senior leaders of all active partner agencies, identifying: a) key tasks—incorporating implementation strategies for all planned changes b) achievement indicators *(impacts and outcomes)* c) roles and responsibilities of each partner agency d) key stakeholders and how they will be involved in implementation e) resources and funding arrangements f) timelines for achieving/completing tasks	B,D	
4.5 A strategy for monitoring and reporting progress against achievement indicators specified in the work plan has been developed and documented, incorporating both process measures and outcome or impact measures	B,D	
4.6 A communications strategy has been developed and documented, identifying mechanisms for communicating plans, progress and outcomes to all effected by the changes, including: a) partner agencies (senior leaders, management staff, and clinical staff) b) consumer, carers and community	D	

Notes:

5. Effective implementation and sustainability	Ref	Response
5.1 **Evidence-based rapid cycle change methods** (such as PDSA) **are being used to test changes and interventions**	D	
5.2 **Changes tested successfully are *refined* and *implemented* as a routine part of health care delivery**	D	
5.3 **Changes implemented have been *spread* and implemented in other parts of the organisation or other organisations**	D	
5.4 **Implementation has involved senior leaders, clinical champions and non-clinical or managerial leaders within organisations**	C,D	
5.5 **The impact of interventions on achievement indicators** (predetermined, as in 4.5) **has been assessed and presented**	B,D	
5.6 **New partnerships have been established where services or processes cannot be delivered with existing partners**	B	
5.7 **Future opportunities for improvement are systematically identified during improvement activities, and fed into subsequent rounds of PCP planning**	D	

Notes:

6. Outcomes—as per departmental expectations 2009–12 in *PCP revised program logic*

6.1 Documented and endorsed local agreements between partner agencies have been developed that define the following.

In relation to each of the following stages of the consumer pathway (as per *Victorian service coordination practice manual*) and workforce capacity building:	**Roles and responsibilities** ✔	**Communication and information sharing** ✔	***Guiding documents*** *(such as policies, protocols, pathways)* ***developed and endorsed*** ✔
a) initial contact			
b) initial needs identification			
c) assessment			
d) care planning			
e) service delivery			
f) information provision			
g) consent			
h) referral			
i) feedback			
j) exiting			
k) follow-up			
l) workforce capacity building – clinical skills			
m) – self-management support skills			
n) – planning, implementing and measuring improvements			

6.2 Generally these agreements have involved the following partner types:	✔
a) local government (HACC)	
b) community health	
c) division(s) of general practice	
d) Hospital Admission Risk Program (HARP)	
e) sub-acute care services (SACS)	
f) Aboriginal community-controlled health organisations (ACCHOs)	
g) mental health (primary mental health teams, mental health alliances, PDRSS, mental health area services, as appropriate)	
h) community groups	
i) private providers	

(Local agreements involving: (a) more care continuum components; (b) more partners; and/or (c) partners that have been more difficult to engage may indicate greater ICDM progress, where these agreements have been effectively implemented)

Notes:

6.3 Organisational structures and/or services have been redesigned or enhanced to address gaps/inefficiencies

Year *e.g. 2007*	**Target group** *e.g. All clients*	**Organisational structures** *e.g. Single point of access established*

Notes:

Further information and resources

Below are key resources to support ICDM, grouped in the same structure as the checklist.

Hold down *Ctrl* plus click the links to go directly to each resource. They are also available, unless otherwise stated, at <www.health.vic.gov.au/communityhealth/cdm/resources.htm>.

1. Effective partnerships

Fact sheets:

- General practice engagement in ICDM
- Getting started on ICDM

Case studies:

- Member agency engagement Wimmera PCP
- General practice PCP partnership in Banyule and Nillumbik
- Working with general practice

2. Workforce capacity building

Fact sheets:

- Chronic disease self-management
- Common models of chronic disease self-management support

3. Strategic priorities

Fact sheets:

- Population health data sources for ICDM planning
- ICDM audit tools
- Consumer consultation and participation in CDM

Case study:

- Consumer consultation, Inner East PCP

4. Effective planning and monitoring

Fact sheets:

- Population health data sources for ICDM planning
- Evidence-based guidelines and clinical pathways for ICDM planning

Resources:

- Service coordination and ICDM survey—available at <www.health.vic.gov.au/pcps/publications/survey_sc_icdm09.htm>
- PCP planning and reporting guidelines 2009–12—available at <www.health.vic.gov.au/pcps/about/prr.htm>

5. Effective implementation and sustainability

The IHI improvement map is an online tool that builds on the IHI model for improvement. Available at <www.ihi.org/IHI/Programs/ImprovementMap>.

Another key resource which has informed this checklist is *The 'how to' guide—Turning knowledge into practice in the care of older people,* September 2008, available at <www.health.vic.gov.au/acute-agedcare>.

For further information about this checklist, please contact the industry advisors—ICDM, Integrated Care Branch, Victorian Government Department of Health:

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