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1. Introduction

1.1 Background

The Better Healthcare in Gippsland (BHCiG) project commenced in 2004 with a regional approach to improve service coordination for patients, with a particular focus on people at risk of or experiencing chronic disease.

Three project components were identified:

- **Partnerships** – Establishment of a cross-sector partnership encompassing acute, community health, general practice and local government HACC services, to govern and implement the project.
- **Service Coordination** – Implementation of a regional service coordination model in accordance with the *Better Access to Services* policy framework.
- **Chronic Disease Management** – Piloting of a chronic disease management care pathway protocol, with a focus on diabetes.

This resource kit documents the key learnings from the third BHCiG project component – Chronic Disease Management.

It is important to acknowledge that the success of the BHCiG initiatives were the result of successful partnerships and collaboration between the project partners and staff from the various agencies that participated in the project.

1.2 Piloting a new model

1.2.1 Pilot sites

As part of working towards new solutions for managing chronic disease, the BHCiG project enabled healthcare providers in the region to work collaboratively to pilot a new approach and model.

Three pilot projects were established to develop a type 2 diabetes management pathway (stage 1 only), in mid 2005. The management pathway, based on the established Diabetes Annual Cycle of Care, utilised the principles of the Chronic Illness Care Model as developed by the MacColl Institute for Healthcare Innovation.

The three pilot projects were conducted by a range of primary healthcare providers located in the following towns:

- **Traralgon**
- **Foster**
- **Heyfield**

The selection of these towns provided insights into how communities with different population sizes would respond to the implementation of a chronic care model.

The pilot projects were conducted over a 9 month period ending in June 2006. Reference groups for each of the three sites guided and informed the implementation of the pilot projects.

1.2.2 Keeping the momentum going

This resource kit has been developed as a direct result of the work carried out during the three pilot projects.

It has been designed to help general practices and healthcare teams implement similar approaches to chronic disease management.

1.3 Vision

1.3.1 Meeting the challenge of managing chronic disease

- Managing chronic disease represents one of the greatest challenges to Australian healthcare providers. New models are needed in order to provide adequate care for an aging population with long-term healthcare needs. The implications of this challenge include taking into account that:
- Chronic disease management requires a healthcare system that is focussed on regular and longer term contact rather than episodes of illness.
- Effective management of chronic disease involves changed behaviours and lifestyle. Effective partnerships between patients and healthcare professionals will therefore lead to better outcomes.
- Management of chronic disease is not limited to hospitals, clinics and GP practices – it extends into the community and all parts of the patient's life.
- Most chronic diseases can be prevented if action is taken early enough.
- Many of the risk factors for different chronic diseases are the same, so one intervention can have an impact on different conditions.¹

Did you know that in Australia...

- Chronic diseases account for up to 90% of deaths.
- At least 80% of premature heart disease, stroke and type 2 diabetes could be prevented through healthy diet, regular physical activity and avoidance of tobacco products.

World Health Organisation www.who.int/chp

Did you know that in Victoria...²

- Ischaemic heart disease and cancer are the leading cause of avoidable deaths.
- Other significant causes of avoidable deaths are diabetes, suicide, traffic accidents and Chronic Obstructive Pulmonary Disease (COPD).
- Rates for avoidable deaths are higher in rural than metropolitan areas.
- The largest cause of avoidable hospital admissions (ambulatory care sensitive conditions) is diabetes complications.

¹ Adapted from OATSIH Healthy for Life Toolkit

² Your Health: A report on the health of Victorians, 2005, DHS p.36, 37, 42

1.3.2 A person-centred system of care

Increasingly, health practitioners around Australia recognise the importance of a more person-centred approach to healthcare. This is echoed by government policies.

For example, the Department of Human Services (DHS)³ has outlined that:

“The guiding vision is for a responsive, person-centred, effective system of care for people with a chronic disease. A chronic disease management approach should be adopted and aim to: demonstrate improved health outcomes and quality of life for people with chronic disease.”

Objectives include to:

- Slow the rate of disease progression whilst maximising their health and wellbeing within the community.
- Improve access to quality integrated multidisciplinary care across the continuum.
- Facilitate patient and carer empowerment through self-management programs and approaches.
- Promote and encourage protective behaviours.
- Actively engage GPs as part of a multidisciplinary coordinated approach, including the development of written care plans.
- Reduce inappropriate demands on the acute healthcare system.

1.4 Policy context

1.4.1 The importance of partnerships

The implementation of an integrated chronic care model fits well within the current context of health policy in Victoria. Most importantly, these policy directions acknowledge the importance of effective partnerships:

“Care for people with chronic diseases usually involves multiple healthcare providers in multiple settings. To provide this care within an integrated system, healthcare providers must work collaboratively to coordinate and plan care and services. It requires a commitment to working together to achieve shared goals. In particular people with chronic disease need a responsive, person-centred and effective system of care.”⁴

1.4.2 The Primary Care Partnership (PCP) Strategy

The Primary Care Partnership Strategy is funded by the Victorian government to improve the health and wellbeing of community members by strengthening relationships between primary care providers across a catchment area so they are able to implement improved service coordination, integrated health promotion and planning and joint programs.

³ Reference: DHS 2006, Planning, Implementation & Program Guidelines for Integrated Chronic Disease Initiative p.8

⁴ DHS 2006, Planning, Implementation & Program Guidelines for Integrated Chronic Disease Initiative p.3

Aims of the strategy include to:

- Improve the experience and outcomes for people who use primary healthcare services.
- Reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs, early intervention and chronic disease management.
- Develop service coordination links between primary care providers to enable early needs identification and service planning, and effective and efficient referral and care coordination between GP's and other healthcare agencies.
- Plan and deliver more effective health promotion programs and services underpinned by a social model of health.
- Increase community participation in needs identification, service development and implementation.

1.4.3 Role of PCPs

In 2006 – 2009, PCPs will be responsible for the strategic areas of:

- Partnership development
- Integrated health promotion
- Service coordination and improving access to services for all people
- Developing an integrated community-based approach to the prevention and management of chronic disease.
- Integrated Chronic Disease Management (ICDM) activity for all PCPs will be focused on facilitating service system integration and change management.

Activities include to:

- Map the provision of self-management interventions and facilitate planning processes to respond to identified gaps.
- Facilitate a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions.
- Implement the Better Access to Services service coordination framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.
- Work with member agencies, particularly GPs, to develop and define local agreements and systems to identify patients with chronic disease who require comprehensive assessment and coordinated cross-disciplinary/multi-agency care planning.
- Strengthen approaches to address disadvantage and health equality in integrated health promotion, including barriers to participation such as chronic disease.

1.5 Structure of resource kit

When using the resource kit, it is important to remember that it is a multi-purpose resource to help you develop an approach to managing chronic disease that suits your local context.

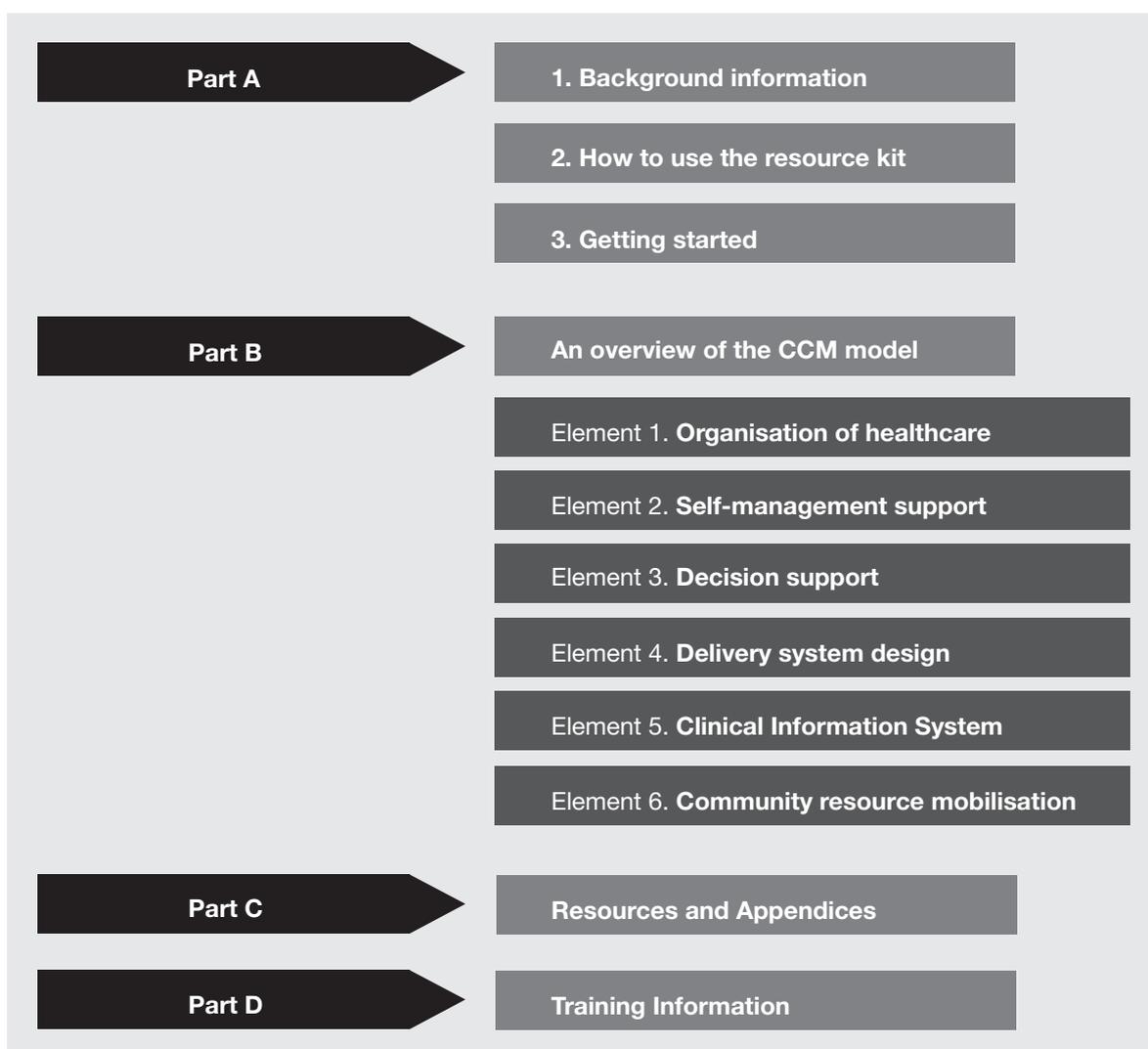
The resource kit is divided into four parts, each of which contains a range of materials designed to assist you in implementing an integrated approach to chronic care.

This section, **Part A** provides background material and information about how to use the kit.

Part B provides a detailed description of each of the six elements of the chronic care model (CCM). It includes worksheets so that you can plan for your local CCM approach.

Part C provides a list of resources, web links and other useful tools as well as the appendices.

Part D provides training information such as PowerPoint slides that you can use to train others in development of a CCM and the use of this resource kit.



2. How to use the resource kit

2.1 The who, what, when and why of the resource kit

Who should use the resource kit?

The resource kit is designed to help practitioners, practice managers and other members of the healthcare team implement a chronic disease management model in their own setting. While specifically designed for the Gippsland region, many of the sections can be applied in other parts of Victoria.

What's in the resource kit?

The resource kit contains a detailed description of all the key elements of a chronic care model and provides tools and resources to help you implement the model in your organisation. Helpful hints and other materials from the pilot projects have been included to show how agencies have worked to establish an integrated CCM model. The resource kit incorporates both theoretical and practical examples.

Why should I use this resource kit?

Implementing a comprehensive CCM model includes managing a range of issues and it is important to have an understanding of the key action points and challenges. The resource kit includes information about each part of the chronic care model so that you can use the kit as a starting point for each part of your implementation plan. The resource kit can help you ensure that all aspects of the change process are covered.

How should I use the resource kit?

The resource kit can be used in sections or as a whole. However, we recommend that you spend some time familiarising yourself with the contents of the resource kit and then use sections as you need them. You will probably find it most useful if you use the sections as you need them rather than reading the resource kit from beginning to end!

You may wish to use the resource kit in a range of settings, including community health centres, GP clinics, PCPs and primary health teams. The resources are designed to be used on a day-to-day basis to support implementing a CCM model in your local setting.

How do I ensure that this material suits my local situation?

Your local setting, the needs of your patients and your community and the organisation of healthcare systems in your area will all determine how the principles described in the resource kit will be applied. Although a range of approaches have been suggested and guidelines for implementation have been provided, there is no single way of implementing a CCM model.

You can customise the resource kit to suit your own needs. For example, you may want to insert your own materials into the relevant sections. There is space in many of the sections of the resource kit for you to make your own notes and map your own action plan. The resource kit is a starting point for collecting information that you can keep adding to over the next few years.

How can the model be applied to different chronic diseases?

Although the Gippsland pilot project was designed to create management pathways for diabetes, the CCM model has been designed to help healthcare providers implement management systems for any chronic condition. Whilst many of the examples in the resource kit are based on diabetes management, the principles can be applied more broadly. The section with tools and resources also includes references to information about the full range of chronic conditions.

How do I make sure implementation is successful?

Obviously there are many factors that will ensure success of your program of change. However, if you undertake careful planning, work in partnership and monitor your performance, you will be well placed to achieve improved outcomes. This resource kit will be particularly helpful in the planning of your program.

How does this resource kit relate to the Service Coordination project?

The Practices, Processes, Protocols and Systems (PPPS) designed as part of the Better Healthcare in Gippsland project, are compatible with the processes recommended in this resource kit. However, the tools and protocols provided in this resource kit are mostly designed for the assessment and care planning functions of service coordination. They do not replace the need to implement the regional or statewide Service Coordination requirements.

2.2 Notes and terminology

The material compiled in this resource kit has been designed to assist you in implementing a chronic disease management model in your organisation or region. While it will provide useful information, ideas and tools, it cannot take the place of expert advice of members of your healthcare team.

The materials are also not intended to constitute professional advice on clinical pathways, or any other decision making processes. At the same time, the tools and suggestions contained in the resource kit may assist professionals in finding the information that will assist them in making decisions.

The information from pilot projects conducted as part of the Better Healthcare in Gippsland (BHCiG) project has been included as a means of sharing practical experiences in your local settings. However, it was not within the scope of these projects to formally evaluate the methods that were applied. Likewise, the suggestions in the text boxes throughout the kit are based on the experience of the BHCiG pilot projects and should be taken as suggestions only.

Throughout this document the term “patient” has been used to describe consumers or clients. In doing so, it is recognised the terms “consumers” or “clients” may be the preferred terminology for many users of this resource kit. The use of “patient” does not suggest that this term is preferred or should be applied in all settings.

3. Getting started

3.1 Planning

3.1.1 Introduction

There are no set formulas for establishing an integrated approach to chronic disease management. There is also no ideal or “correct” approach. However, based on the experience of the Better Healthcare in Gippsland pilot projects and international experience in implementing similar models, you might like to try following some of the suggestions outlined below.

- *Determine which order will work best in your local situation.* In part, the order in which you proceed will be depend on whether the decision to implement an integrated approach is initiated by one organisation or by a group of organisations in an existing partnership. The gap analysis will also determine which areas are prioritised.
- *Use the resources provided throughout the kit,* together with the experience and knowledge you already have, to implement each component.
- *Allow plenty of time for each part of your implementation plan.* The experience provided by the pilot projects shows that establishing a comprehensive, integrated system for managing chronic illness takes time - especially as you will be managing a great deal of change. You may need to allow three years or more for full implementation of all six elements in the chronic care model.

3.1.2 Six steps to getting started

Step 1: Establish why you want to develop an integrated approach

Use these prompting questions for practitioners, staff, community stakeholders and patients:

- How might an integrated approach help us to manage chronic disease more effectively?
- How can we use our current resources more effectively?
- How might government policy and funding initiatives provide opportunities to address current and future needs?

Action Point

Discuss the answers to these prompting questions in planning or staff meetings and carefully note what your organisation might gain from a different approach. These points can then be turned into aims for your implementation program.

Step 2: Identify the areas of strength or weakness in your current approach

Your organisation will already be doing many of the things that will be required to implement a chronic care model. For example, you may already have excellent patient education programs and good links to schools and community organisations. On the other hand, there will be areas that will be less developed and need more effort. For example, you may not have a register or the clinical information systems you require.

The gap analysis should be done at the individual service provider level. However, you should share the results with other project partners to see what that can do to help you address some of the gaps you have identified.

Action Point

Use the ACIC tool to assess current performance (appendix 7) or the gap analysis tool developed as part of the pilot project (appendix 6). Map the areas of strength and weakness and discuss the findings with members of the healthcare team.

Step 3: Identify key partners and establish effective partnerships

Working in partnerships with other health and community organisations is fundamental to a successful, integrated approach to chronic disease management. Partnerships will help you address the gaps in your own service and will ensure that your patients receive seamless integrated care for all their needs.

Identify any existing partnerships that could be utilised or developed to form the basis of your partnerships. Working with the Division of General Practice, your local Primary Care Partnership (PCP), National Primary Care Collaboratives or local community health centre are examples of ideal starting points.

Action Points

- Use the information from the gap analysis conducted by individual organisations to identify the impact that each organisation has on the project partners and how partners already work together effectively.
- Build a stronger and more lasting relationship with partners by using the Partnership Analysis Tool developed by VicHealth (appendix 13).
- Establish a reference group to steer and manage the implementation of key initiatives across the agencies.
- Develop a Memorandum of Understanding to clarify roles and responsibilities of project partners. Keep it simple so that it does not become a barrier to progress.

Step 4: Develop an implementation plan with clear priorities for project partners

Use the information about areas needing improvement to establish an action plan. Your plan should answer questions such as:

- What are we trying to do? (Aims)
- How will we try to do it? (Strategies)
- How will we know how we are going? (Measures)
- How long will it take? (Timeframe)
- What is the estimated cost? (Financial resources)

Action Point

Use the tools and guidelines in Section 6 of the Healthy For Life Toolkit to develop your action plan using the questions listed above. You can access the information on the web: Go to www.health.gov.au then search “OATSIH programs”, go to “Healthy for Life” and you will find a link to the Healthy for Life website embedded in the text.

Step 5: Develop a cycle for monitoring progress (ongoing)

Use reference group meetings, staff meetings and other forums to measure the outcomes of each part of your implementation plan to monitor progress and define new areas requiring improvement. Make sure you identify areas for training.

In addition to monitoring your progress against the action plan, consider things like:

- patient satisfaction surveys
- staff surveys
- community focus groups
- web-based surveys
- analysis of patient data (clinical information systems)
- any other systems for measuring performance that are applicable to your situation.

Action Point

Create a checklist or simple monitoring framework for the activities you will undertake to monitor progress.

Step 6: Celebrate successes

Use the information from your monitoring processes to identify areas where you have been successful. For example, pilot project participants found that the program resulted in improved relationships between members of the healthcare team. Communicating good news will also motivate project partners, community members and staff to continue supporting the implementation of the program.

Action Point

Be creative in finding ways of celebrating success. Don't be afraid to try new ways of recognising individuals and organisations. For example:

- Discuss positive outcomes at reference group meetings and staff meetings.
- Tell community members and external organisations about positive developments by posting small snippets on your website, in newsletters or email bulletins.
- Feature a good news story in your local paper.
- Publish testimonials from patients and their carers (with their permission).

3.1.3 Learn from others

The experience of the pilot projects involved in the Better Healthcare in Gippsland initiative provides a wealth of information that will assist others in implementing a chronic care model. Overall, participants in the pilot projects found that implementation of an integrated chronic care model resulted in very positive outcomes and involvement in the project was considered worthwhile.

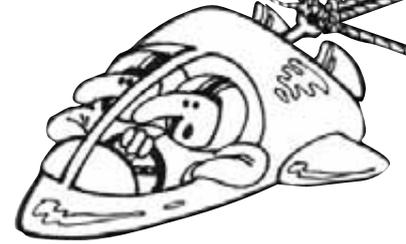
Listed below are a selection of key learnings, including things that worked in the experience of the pilot projects.

Things that worked

- Introducing incremental changes and building on them slowly. Make sure you communicate and engage with project partners and the reference group regularly. Discuss the impact of changes before forging ahead.
- Using the data you collect to illustrate the need for change as well as monitoring outcomes. In the pilot projects, the data proved essential to optimising patient outcomes.
- Enhancing the role of the practice nurse to assist with triaging patients may improve efficiency.
- Communicating changes with those outside the reference group enables discussion and results in more successful outcomes.
- Build commitment in your reference group (or equivalent) to avoid high turnover and to monitor progress effectively.
- Use existing communication channels between health service providers in your region to discuss patient-related issues with a view to implementing positive change.

Your approach

Remember that the approach you choose is likely to be more successful if you work in partnership and keep the overall aim of your project in mind – keep your eye on the goal post!



1. Overview of the Chronic Care Model

1.1 Concept and selection of a model

The health system has traditionally been designed to deal with sickness rather than health and most resources have been focused on making sick people better.

The chronic care model turns this approach on its head and takes a proactive approach to the management of chronic disease. Instead of managing ill health, the model attempts to keep people well for as long as possible. As a result, it moves health providers from focusing on those who are sick to a proactive approach that works towards keeping a person well for as long as possible.

The Better Healthcare in Gippsland project utilised the principles of the Chronic Illness Care model as developed by the MacColl Institute for Healthcare Innovation.

In developing the model, the MacColl Institute for Healthcare Innovation team found that all members of the healthcare team came up against challenges such as:

- Lack of time to provide the kind of care recommended in established guidelines.
- Poor coordination of care between service providers.
- Lack of appropriate follow up.
- Working with patients with poor self-management skills and knowledge.

These challenges are common amongst healthcare providers in the Gippsland region. The strategies suggested in the chronic care model were found to be very useful during the CCM pilot.

1.2 Why use this approach?

1.2.1 The need for new approaches

The approach used in the resource kit may at first appear complex. Many people may prefer a single intervention approach as it would be easier and quicker to implement, but chronic disease is complex, with most patients requiring a range of strategies to deal with the multiple issues caused by their disease.

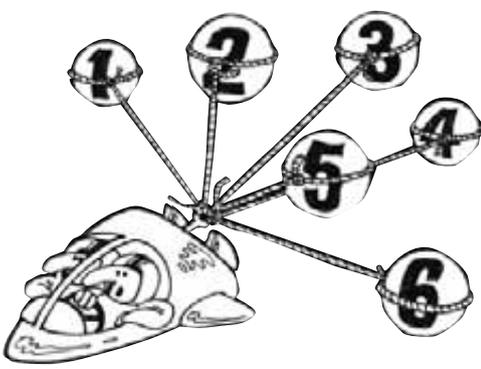
In addition, there is significant evidence that chronic disease can be effectively prevented and managed by mobilising the resources in the community as well as asking the patient to be involved in the management of their disease.

A Strategy to achieve rapid results⁵...

Population-wide approaches seek to reduce the risks of developing chronic disease throughout the entire population. They address the causes rather than the consequences of chronic diseases and are central to attempts to prevent the emergence of future epidemics. Small reductions in the exposure of the population to risk factors such as tobacco use, unhealthy diet and physical inactivity lead to population-level reductions in cholesterol, blood pressure, blood glucose and body weight. More fundamentally, interventions are also required to address the underlying determinants of chronic disease.

Interventions for individuals focus on people who are at high risk and those with established chronic disease. These interventions reduce the risk of developing chronic disease, reduce complications, and improve quality of life.

⁵World Health Organisation Report 2006: Preventing Chronic diseases: a vital investment, Chapter 3



1.2.2 Building on existing approaches

Although it is recognised that new approaches need to be developed, there are many things that you will already be doing in your organisation that will not need to be changed as they are fully compatible with the models described in this resource kit. Similarly, there may be existing networks or structures that can be used to develop an integrated approach.

1.2.3 Benefits experienced during the pilot projects

The experience of the three pilot sites in Gippsland suggests there are significant benefits in working to implement the chronic care model described in the resource kit. Those who participated in the pilot project provided the following assessment of the benefits:

- Improved patient outcomes as a result of looking at process from various perspectives by using a team approach.
- Bringing together of representatives and expertise from various sectors including GP practices, community health, acute and private allied health providers on the reference groups.
- Increased communication and knowledge of services provided by different healthcare providers.
- The opportunity to develop internal systems to achieve a better fit with other agencies.
- Development of a team approach to management of chronic disease.
- Increased patient access to services.
- Progress towards a more consistent use of IT systems and better management of information.

The key to the success of the model is based on:

- Creating a culture of collaboration and cooperation between healthcare providers.
- Developing productive interactions between patients and the healthcare team which support them in taking an active part in the management of their health.



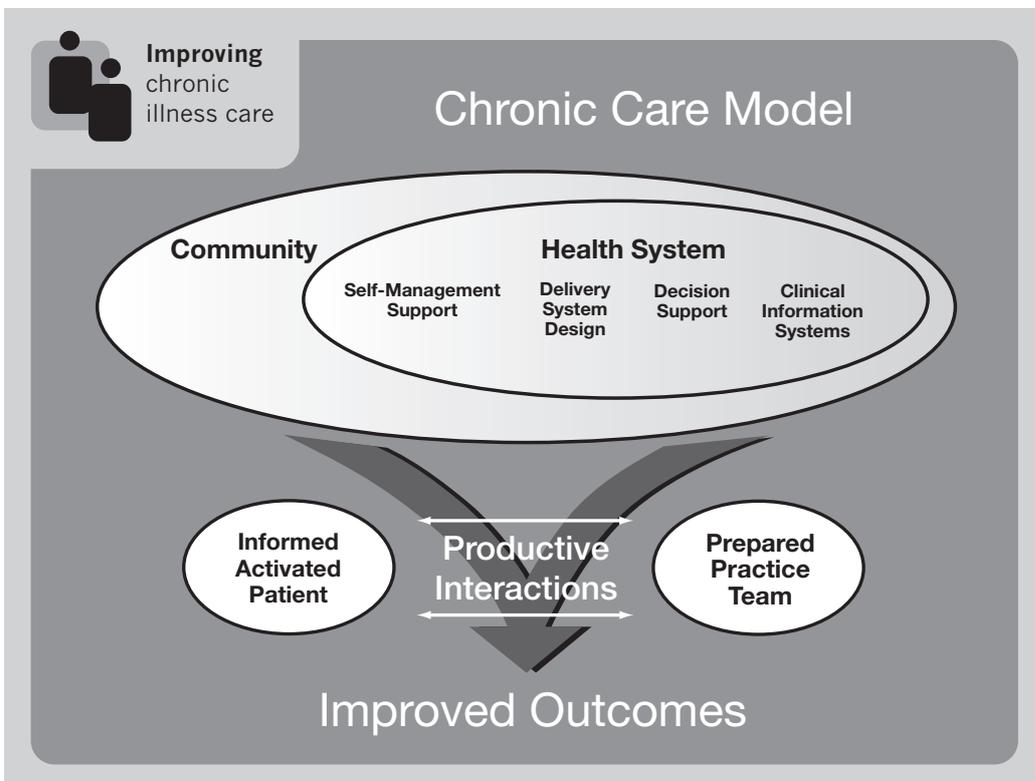
1.3 Overview of the chronic care model

The chronic care model, illustrated in Figure 1, has six essential elements. These elements are not intended to be sequential, but rather should be implemented simultaneously. However, for the purposes of structuring and navigating the resource kit, the elements have been numbered from one to six.

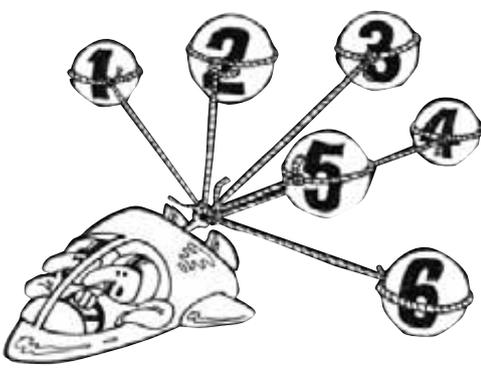
- Element 1: **Organisation of healthcare**
- Element 2: **Self-management support**
- Element 3: **Decision support**
- Element 4: **Delivery system design**
- Element 5: **Clinical information system**
- Element 6: **Community resource mobilisation**

A brief description of each element and examples of how this element was applied in the Gippsland pilot sites are included. Part B of the resource kit describes each individual element in detail.

Figure 1: Overview of the MacColl Chronic Care Model



Source: Institute for Healthcare Improvement website, www.IHI.org



Element 1 Organisation of healthcare

Principle

Underpinning the model is the component known as organisation of healthcare. This relates to creating a culture and mechanisms to promote high quality healthcare.

Efforts to improve healthcare for those with chronic disease need to have input from a variety of health-care providers from both the public and private health sector.

Senior management and health professional champions need to be visible and their commitment to the improvement of chronic disease management needs to be adequately resourced and supported.

Example

One pilot project used a community development model whereby reference groups consisting of members of the healthcare team involved with managing patients with chronic disease (in our case type 2 diabetes), came together and discussed how to build on existing processes and programs to improve service delivery.



Element 2 Self-management support

Principle

In order to best meet the needs of their condition/s, patients need basic information about their disease, support to develop self-management skills and ongoing support from the healthcare team.

Example

At some sites this element included the development of a patient-held record which was to be used by providers and by the patient. This allowed all involved to be aware of patient goals and progress. A couple of the sites included the patient care plan in the record.



Element 3 Decision support

Principle

Evidence based guidelines that are accessible to all involved are essential to the management of patients with chronic conditions.

Example

The CDM task group developed a clinical pathway which identified referral pathways and a risk screening tool. As a result, all providers and intake staff are aware of and have agreed to what high, medium and low risk states are, and what the time frames should be for seeing these patients. The times frames are in line with those set out in the PPPS manual.



Element 4 Delivery system design

Principle

Clarifying roles and responsibilities of healthcare team members is vital to ensuring optimal care is delivered to the patient in the most effective and efficient manner. As a result, service providers have a clear understanding of each others role and knowledge of what services are available and how to access them.

Example

One site increased the role of the practice nurse to incorporate a basic assessment, followed by a basic education session. More detailed education was then provided by the community health service through a group information session with more targeted sessions with individual providers as required. The patient held record was used to keep all providers and the patient up to date.



Element 5 Clinical information system

Principle

A register needs to be able to track patients individually as well as populations of patients to enable monitoring and modification of processes. Good information technology and information management systems are essential to the successful integration of all elements of the chronic care model.

Example

In Gippsland, work in this area was limited to GP practices due to time constraints. This included working on IT issues and data cleansing of the diabetes register and developing recall and reminder systems. This proved to be very resource intensive and while it is an example of developing clinical support systems, the trial showed that other methods may need to be applied.



Element 6 Community resource mobilisation

Principle

If community resources are tapped into effectively, they will serve to markedly improve population health and support patients in the management of their disease. Service providers can also help to build capacity for the community to develop its own support structures.

Example

One of our sites established a link with a community resource centre and now has an increased awareness of what services are offered and how to access them. Various options are discussed with the patient by various members of the team including the GP, the Diabetes Nurse Educator and the Practice Nurse.

Element 1: Organisation of healthcare



Element 1 Organisation of healthcare

1.1 Introduction⁶

Create a culture and mechanisms that promote safe, high quality care in the organisation

Effective organisations try to prevent errors and care problems by reporting and studying adverse events and making appropriate changes to the system. Breakdowns in communication and care coordination can be prevented through agreements that facilitate communication and data sharing as patients navigate across settings and providers.

Aims

To visibly support quality improvement at all levels of the organisation, beginning with the senior practitioner.

- To promote effective improvement strategies aimed at comprehensive system improvement.
- To encourage open and systematic handling of errors and quality problems to improve care.
- To develop agreements that facilitate care coordination within and across organisations.
- To ensure that high quality service is provided to achieve accreditation.
- To utilise the 'Plan, Do, Study, Act' (PDSA) cycle to ensure a common and comprehensive approach to quality improvement.

Agency responsibilities

- Train staff in the 'Plan, Do, Study, Act' model.
- Provide resources to undertake quality improvement projects.
- Ensure access by staff to computers.
- Ensure that senior leaders support and are involved in the program.
- Recognise and promote the achievements of the team.
- Be available to attend local events and promotional campaigns.

⁶The materials in this chapter have been adapted from the Institute for Healthcare Improvement website (www.IHI.org) and the MacColl Institute for Healthcare Innovation website (www.improvingchroniccare.org)

1.2 Essential Process Steps

Step 1: Make improving chronic healthcare a part of the planning processes within the organisation.

Step 2: Make sure senior staff openly support and promote the efforts to improve chronic care.

Step 3: Assign day-to-day leadership for continuing clinical improvement.

Step 4: Integrate quality improvement into all organisational processes.

Step 1: Make improving chronic healthcare part of the planning process within the organisation

Process Steps		Key Action Points	✓ Checklist
1.1	Link measurable outcomes to the strategic business plan	<ul style="list-style-type: none"> • In collaboration with the healthcare team, identify the impact that improved outcomes can have on the organisation. (This may include accreditation, increased productivity, improved outcomes for the patients, improved community linkages, business planning) 	<ul style="list-style-type: none"> <input type="checkbox"/> A register of improvement and supporting data is kept <input type="checkbox"/> Accreditation is achieved <input type="checkbox"/> Community is well informed and actively participates
1.2	Provide comprehensive reports to senior staff/management	<ul style="list-style-type: none"> • Organise monthly briefing meetings with the senior management or staff • Develop reports that demonstrate key measurable outcomes are being achieved • Ensure that all reports are readily accessible for clinic staff • Highlight issues and include strategies to address them • Utilise the Clinical Information System to inform the reports and provide statistical evidence • Develop standard report for the Board/regional health service (include patient case studies, evidence based data, graphical information, PowerPoint presentations, barriers and solutions) 	<ul style="list-style-type: none"> <input type="checkbox"/> Regular meetings are scheduled <input type="checkbox"/> Reports are developed for senior management and Board <input type="checkbox"/> All reports are posted in a communal place for both staff and patients <input type="checkbox"/> Barriers and strategies are documented <input type="checkbox"/> Clinical Information Systems and registry provide statistical evidence
1.3	Promote the achievements	<ul style="list-style-type: none"> • Develop presentations to regional, state and national forums • Develop 'story boards' with patient case studies and place in the clinic and use for promotion at local events provided that the identity of the patient can be protected. Alternatively gain appropriate consent for use of the patient's information. 	<ul style="list-style-type: none"> <input type="checkbox"/> Presentations are available <input type="checkbox"/> Story boards are available and used for local events

Step 2: Make sure that the senior practitioner visibly supports and promotes the efforts to improve chronic care

Process Steps		Key Action Points	✓ Checklist
2.1	Keep senior practitioners informed	<ul style="list-style-type: none"> • Involve senior practitioners in staff meetings wherever possible • Invite the senior practitioner to provide presentations/updates on broader issues • Invite the senior practitioner to be a public speaker at local events 	<ul style="list-style-type: none"> <input type="checkbox"/> Attendance is demonstrated by minutes <input type="checkbox"/> Attendance of the senior leader is evident <input type="checkbox"/> Invitation is extended to the senior practitioner to attend local events
2.2	Seek out data that makes the case for change	<ul style="list-style-type: none"> • Utilise data to demonstrate the need for change and to develop strategies to continue to improve service delivery • Provide reports using the clinical and registry information systems to demonstrate outcomes 	<ul style="list-style-type: none"> <input type="checkbox"/> Collect and analyse data on ACSCs and burden of disease <input type="checkbox"/> Collate information on patients outcomes and organisational achievements
2.3	Develop mechanisms to keep the community informed	<ul style="list-style-type: none"> • Develop a Community Newsletter • Use the data provided by the clinical information system to inform the newsletter • Request 'air time' on the local radio and present patients 'stories' • Involve the Health Care team to provide input/suggestions 	<ul style="list-style-type: none"> <input type="checkbox"/> Newsletter is circulated quarterly <input type="checkbox"/> Time on the local radio has been achieved

Step 3: Assign day to day leadership for continuing clinical improvement

Process Steps		Key Action Points	✓ Checklist
3.1	Identify a clinical improvement leader	<ul style="list-style-type: none"> • Nominate a dedicated person to be responsible for clinical improvement • Secure a medical champion who is committed to improving the system • Ensure that clinical practice improvement is a standing agenda item at team meetings • Encourage all staff to participate and take ownership of quality projects • Utilise the clinical information systems and registry information to inform projects and demonstrate outcomes 	<ul style="list-style-type: none"> <input type="checkbox"/> One person is nominated to be responsible for the day to day leadership for clinical improvement <input type="checkbox"/> Quality improvement is a standing agenda item <input type="checkbox"/> All staff are involved in QI projects and this is part of their performance appraisal

Step 4: Integrate quality improvement into all organisational processes

Process Steps		Key Action Points	✓ Checklist
4.1	Participate in the strategic quality program	<ul style="list-style-type: none"> • Involve the day-to-day clinic quality person in the strategic plan • Involve the quality person in the development of the aims and measures • Involve the quality person in the regional quality meeting • Encourage staff to problem-solve 'barriers' 	<input type="checkbox"/> Clinic is involved in strategic planning at a broader level
4.2	Integrate collaborative models	<ul style="list-style-type: none"> • Involve the multidisciplinary team in developing models for improvement • Employ the 'Plan, Do, Study, Act' cycle for all CQI projects • Implement a quality improvement committee • Identify ways to share experiences with other centres 	<input type="checkbox"/> Quality committee is a multi disciplinary team <input type="checkbox"/> PDSA cycle is used and documented in the evaluation of CQI projects

1.3 Practical application



Case Study: Organisation of Healthcare

East Bentleigh Medical Group used PDSA principles to set up a mini-clinic for the management of diabetes. A brief overview of the project is provided below.

Method

- Discussion of concept at practice meeting
- Clarification of roles
- Development of protocols
- Clinical content development
- Communication with other staff
- Conduct a practice run

Typical mini-clinic

- Nurse conducts clinical review using cycle of care items and lifestyle issues
- GP reviews information
- Nurse completes notes, prints pathology forms and patient information
- Appointment recommended for regular GP

What worked well

- Process allowed for a thorough review of patient's clinical status
- Allowed time for lifestyle counselling
- Allowed tracking of diabetes SIP requirement
- Patients were satisfied

For further information: www.npcc.com.au click on "Events" then "wave 2" then "Learning Workshop 1" then "Setting up a diabetes mini-clinic".



1.4 Tools and Resources: Organisation of Healthcare

Topic	Details	References
Organisational self-assessment of current performance	<ul style="list-style-type: none"> Assessment tool: <i>Assessment of Chronic Illness Care (ACIC)</i> developed by IHI to assess your current organisation's performance against the elements of the integrated chronic care model 	See appendix 7
Introduction to Quality Principles	<ul style="list-style-type: none"> Consider presenting basic quality concepts to staff using this presentation 	See appendix 9
Ideas and Resources for Quality Improvement	<ul style="list-style-type: none"> Tool: The Medicare Quality Improvement Community provides a national knowledge forum for healthcare and quality improvement professionals. It includes interventions and examples Tool: The American Health Quality Association tool to share information about best practices with physicians, hospitals, and nursing homes. 	http://www.medqic.org/ http://www.ahqa.org/
Gap analysis tool	<ul style="list-style-type: none"> A modified version of the ACIC tool developed as part of the Gippsland pilot programs 	See appendix 6
A practical approach to implementing PDSA	<ul style="list-style-type: none"> Slide show: Outlines a simple, but practical approach to implementing the Plan-Do-Study-Act Cycle (PDSA) of quality improvement 	www.npcc.com.au click on "events" then "Wave 1" then "Learning Workshop 1" then "Model for Improvement"
Case study: Implementing PDSA in a GP clinic	<ul style="list-style-type: none"> Case study: East Bentleigh, Victoria, outlines how one practice worked with a multi-disciplinary team to implement PDSA 	www.npcc.com.au click on "events" then "Wave 1" then "Learning Workshop 1" then "Setting up a diabetes Mini-clinics"



1.4 Tools and Resources: Organisation of Healthcare, Cont.

Topic	Details	References
The Improvement Model	<ul style="list-style-type: none">• Diagram: Outlines how PDSA principles might be applied to managing various aspects of chronic disease	See Appendix 10 or www.npcc.com.au click on “shared resources” then “collaborative information”
Improvement Stories	<ul style="list-style-type: none">• Case studies: This resource provides a wealth of case studies related to organisations working to improve patient care. Covers major topic areas including patient flow, leadership and and many others	http://www.ihl.org/IHI/Results/ImprovementStories/#Perinatal
Systems assessment tool	<ul style="list-style-type: none">• Tool: An Australian adaptation of the ACIC tool	See appendix 11 Menzies School of Health Research

How we will improve our organisation of healthcare?					
Action Area	What do we aim to do?	How will we do it? (strategies)	Who will do it?	When will we start?	When will we finish?

Table adapted from the Healthy for Life Toolkit (OATSIH)



Element 2: Self-management support



Element 2 Self-management support

2.1 Introduction⁷

Empower and prepare patients to manage their health and healthcare

Self-management is the element that focuses on ensuring patients have the opportunity to participate in the management of their disease and empowering them to do so.

Aims

- To facilitate patients' central role in managing their own health by using an individualised self-management care plan.
- To provide basic information on the patient's disease.
- To use effective self-management support strategies that include assessment, goal setting, action planning, problem solving and follow up.
- To organise internal and community resources to provide ongoing self-management support to patients.

Agency responsibilities

In order to implement this element, healthcare providers will need to:

- Acknowledge patients' central role in their care.
- Recognise that the role of healthcare providers is to foster a sense of responsibility for the patient's own health and provide support to enable them to make decisions.
- Encourage patients to engage in behaviours that affect their own health.
- Implement evidence based programs that provide basic information, emotional support, and strategies for living with chronic illness.
- Work collaboratively with patients to help them define problems, set goals and priorities and to learn together how to problem-solve.

Each agency has the responsibility to ensure that their staff will:

- Have access to training on how to support the principles of self-management.
- Develop and introduce evidence based self-management programs.
- Ensure that the team is empowered to institute the necessary changes required to facilitate self-management.

⁷The materials in this chapter have been adapted from the Institute for Healthcare Improvement website (www.IHI.org) and the MacColl Institute for Healthcare Innovation website (www.improvingchroniccare.org)



2.2 Essential Process Steps

Step 1: Identify self-management tools that are evidence based

Step 2: Establish and document self-management goals collaboratively with patients

Step 3: Train providers and other key staff on how to help patients with self-management goals

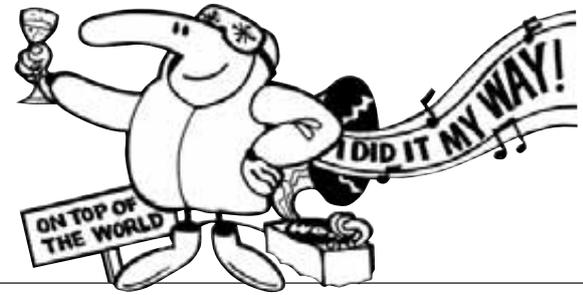
Step 4: Follow up and monitor self-management goals and action plans

Step 5: Use group visits to support self-management

Step 6: Build community resources to support self-management goals

Step 1: Identify self-management tools that are based on evidence

Process Steps		Key Action Points	✓ Checklist
1.1	Research and identify self-management programs that can be adapted to suit the local environment	<ul style="list-style-type: none"> • Provide and discuss the research findings with the healthcare team • Highlight the different options with the healthcare team 	<ul style="list-style-type: none"> <input type="checkbox"/> The options agreed with the patient will be used to develop the action plan/ care plan for the patient
1.2	Develop an action plan/care plan for self-management	<ul style="list-style-type: none"> • Consider different levels of literacy and need for larger print • Identify a tool to assess the suitability of the patient to participate in self-management • Remove all outdated education material from the practice • Clarify the team roles • Identify what languages are required 	<ul style="list-style-type: none"> <input type="checkbox"/> All patients are assessed for suitability for self-management <input type="checkbox"/> Documentation of the assessment of the patient for self-management is in the patient record
1.3	Patient feedback	<ul style="list-style-type: none"> • Give the draft action plan/care plan to patients, families and carers and get feedback • Test action plan/care plan with patients and revise as necessary • Distribute draft plan to pharmacies, community groups and Division of GPs 	<ul style="list-style-type: none"> <input type="checkbox"/> Patient feedback is incorporated into the plan <input type="checkbox"/> Pharmacy, community groups and Division of GPs have provided feedback which has been considered



Step 1: Identify self-management tools that are based on evidence, Cont.

Process Steps		Key Action Points	✓ Checklist
1.4	Pilot the action plan/care plan	<ul style="list-style-type: none"> • Evaluate the pilot • Discuss the findings with the healthcare team • Modify the plan as required 	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluation is written up <input type="checkbox"/> Action plan/care plan format is agreed by the healthcare team <input type="checkbox"/> Plan has been modified if necessary
1.5	Develop guidelines on using care plan	<ul style="list-style-type: none"> • Ensure that the guideline written is in the standard format • Ensure that all guidelines/policies are referenced 	<ul style="list-style-type: none"> <input type="checkbox"/> Guideline/policy is written <input type="checkbox"/> Guideline/policy is based on evidence and is referenced

Step 2: Establish and document self-management goals collaboratively with patients

Process Steps		Key Action Points	✓ Checklist
2.1	Identify the appropriate self-management tool for the patient	<ul style="list-style-type: none"> • Identify patients who are willing and able to use self-management care plan • Complete a self-management care plan with patients that include goals and describes behaviours • Problem-solve with the patient including any barriers they may have, eg forgetting medication • Assess the patient conveys confidence to self-manage • Care plan includes the goals of the patient • Develop follow up plan with the patient 	<ul style="list-style-type: none"> <input type="checkbox"/> A self-management plan is completed with all patients that want to participate
2.2	Implement goal setting	<ul style="list-style-type: none"> • Ensure that the team works with the patient to define goals • Allow the patient to prescribe the goals • Ensure that checklists are used 	<ul style="list-style-type: none"> <input type="checkbox"/> All goals are patient centric and reflect what the patient has stated
2.3	Multi-disciplinary patient reviews are undertaken	<ul style="list-style-type: none"> • Ensure that the healthcare team reviews the patient plan • Ensure that staff are trained in behavioural techniques to support the patient 	<ul style="list-style-type: none"> <input type="checkbox"/> Healthcare team have signed the plan and agree with the action
2.4	Establish and/or review goals with patients as part of the planned visit and follow up	<ul style="list-style-type: none"> • Ask the patient and/or carer about their goals • Ensure that the goals are realistic • Review the goals with the patient and/or carer • Provide the patient with a copy of the goals 	<ul style="list-style-type: none"> <input type="checkbox"/> The patient has signed of with the practitioner on the agreed goals <input type="checkbox"/> The goals are entered into the patient registry

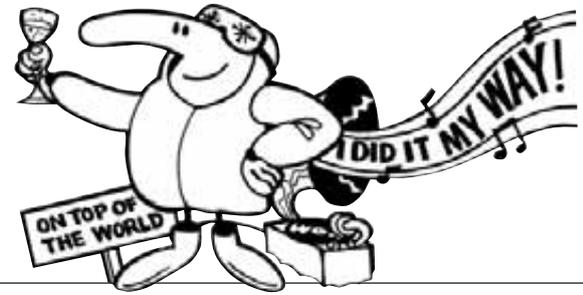


Step 3: Train providers and other key staff on how to help patients with self-management goals

Process Steps		Key Action Points	✓ Checklist
3.1	Select an appropriate self-management curriculum	<ul style="list-style-type: none"> • Participate fully in education of self-management principles • Once the course has been completed, share information with others • Schedule healthcare team to attend a self-management course 	<ul style="list-style-type: none"> <input type="checkbox"/> The selected self-management curriculum is one that has been tested and been found effective <input type="checkbox"/> Certificate of attendance is documented within the staff members performance appraisal
3.2	Define the tasks for team members	<ul style="list-style-type: none"> • Ensure that all members of healthcare team are aware of their role and the tasks that they are to undertake, eg who will set the action/care plan, follow up and assessments 	<ul style="list-style-type: none"> <input type="checkbox"/> All staff are clear on their role and tasks
3.3	Test the self-management care plan	<ul style="list-style-type: none"> • Provide the opportunity for the tool to be tested with the team, patient and a carer • Ensure that patient concerns lead the discussion 	<ul style="list-style-type: none"> <input type="checkbox"/> Self-management tool has been tested and modified as required
3.4	Provide follow up education	<ul style="list-style-type: none"> • Ask healthcare team to review the self-management care plan • As staff gradually become familiar with the care plan, add layers of competence and complexity 	<ul style="list-style-type: none"> <input type="checkbox"/> Self-management care plan is fully implemented <input type="checkbox"/> Staff are all competent in its use

Suggestion

Busy practitioners need an opportunity to look at how they can better support the role of the patient as the central person in setting and maintaining their self-management goals. What has been shown to be helpful is additional training for practitioners in Motivational Interviewing followed for some by specific advanced training in self-management education.



Step 4: Follow up and monitor self-management goals and action plans

Process Steps		Key Action Points	✓ Checklist
4.1	Train staff for follow-up	<ul style="list-style-type: none"> • Introduce a system for follow up that ensures it is not overlooked • Educate the staff of the importance of follow up 	<input type="checkbox"/> Follow up system is developed
4.2	Test having different staff do the follow up	<ul style="list-style-type: none"> • Train different staff on how to do follow up • Consider non-clinical staff to assist with the follow up 	<input type="checkbox"/> There are designated people that are competent to undertake follow up
4.3	Schedule follow up	<ul style="list-style-type: none"> • Ensure that patients choose the follow-up date and method, i.e. fax, email, phone, and that this is noted 	<input type="checkbox"/> There are performance targets for follow up appointments
4.4	Review and update action plan	<ul style="list-style-type: none"> • Review and update action plan every 3 to 6 months 	<input type="checkbox"/> All action plans are reviewed and updated
4.5	Test follow up mechanisms	<ul style="list-style-type: none"> • Put mechanisms for follow up and prescriptions in place, eg calendar, registry • Develop an audit to assess the effectiveness of the follow up mechanisms 	<input type="checkbox"/> There is an audit for follow up mechanisms



Step 5: Use group sessions to support self-management

Process Steps		Key Action Points	✓ Checklist
5.1	Identify the type of group sessions	<ul style="list-style-type: none"> Schedule the different types of group visits, i.e. support groups, educational groups, chronic disease self-management groups 	<input type="checkbox"/> Planner is available with all the different groups scheduled
5.2	Identify the appropriate educational resource materials	<ul style="list-style-type: none"> Develop systems to monitor the sessions to ensure that vital content is still covered. Identify the most appropriate facilitator for the group session 	<input type="checkbox"/> All educational material is evidenced based <input type="checkbox"/> All educational material is 'user friendly' <input type="checkbox"/> Facilitator is identified on the planner
5.3	Organise the logistics of the session	<ul style="list-style-type: none"> Organise a forum that allows the patients to determine the content of the session Ensure that the venue, etc is organised Develop an Evaluation/feedback form 	<input type="checkbox"/> Evaluation/feedback form is evaluated and sessions modified accordingly
5.4	Advertise the pending group session	<ul style="list-style-type: none"> Make reminder calls Consider providing snacks and soft drinks Consider child care arrangements 	<input type="checkbox"/> Attendance record is documented and noted in the patient registry

Step 6: Build community resources to support self-management goals

Process Steps		Key Action Points	✓ Checklist
6.1	Identify community resources	<ul style="list-style-type: none"> Consider the community network, e.g. senior citizen clubs, schools, universities etc and involve them in meeting the self-management goals 	<input type="checkbox"/> Participation by community organisation is documented
6.2	Facilitate community capacity building	<ul style="list-style-type: none"> Work with community organisations and institutions to help them develop their own capacity to support self-management principles as well as prevention strategies 	<input type="checkbox"/> Partnerships with community organisations build capacity for those organisations to provide support



2.3 Practical applications

The journal article summarised below provides an example of a self-management program based on a 7-week, small-group intervention attended by people with different chronic conditions.



Lorig KR, Sobel DS, Ritter PL, Laurent D, Hobbs M. *Effect of a self-management program on patients with chronic disease*. Stanford University School of Medicine, Calif, USA.

Context: For patients with chronic disease, there is growing interest in “self-management” programs that emphasise the patients’ central role in managing their illness. A recent randomised clinical trial demonstrated the potential of self-management to improve health status and reduce healthcare utilisation in patients with chronic diseases.

Objective: To evaluate outcomes of a chronic disease self-management program in a “real-world” setting.

Patients And Setting: Of the 613 patients from various Kaiser Permanente hospitals and clinics recruited for the study, 489 had complete baseline and follow-up data.

Intervention: The Chronic Disease Self-management Program is a 7-week, small-group intervention attended by people with different chronic conditions. It is taught largely by peer instructors from a highly structured manual. The program is based on self-efficacy theory and emphasises problem solving, decision making, and confidence building.

Main outcome measures: Health behavior, self-efficacy (confidence in ability to deal with health problems), health status, and healthcare utilisation, assessed at baseline and at 12 months by self-administered questionnaires.

Results: At 1 year, participants in the program experienced statistically significant improvements in health behaviors (exercise, cognitive symptom management, and communication with physicians), self-efficacy, and health status (fatigue, shortness of breath, pain, role function, depression, and health distress) and had fewer visits to the emergency department (ED) (0.4 visits in the 6 months prior to baseline, compared with 0.3 in the 6 months prior to follow-up; $P = 0.05$). There were slightly fewer outpatient visits to physicians and fewer days in hospital, but the differences were not statistically significant. Results were of about the same magnitude as those observed in a previous randomised, controlled trial. Program costs were estimated to be about \$200 per participant.

Conclusions: We replicated the results of our previous clinical trial of a chronic disease self-management program in a “real-world” setting. One year after exposure to the program, most patients experienced statistically significant improvements in a variety of health outcomes and had fewer ED visits.



The journal article summarised below provides an example of a self-management program based on a self-management asthma education program.



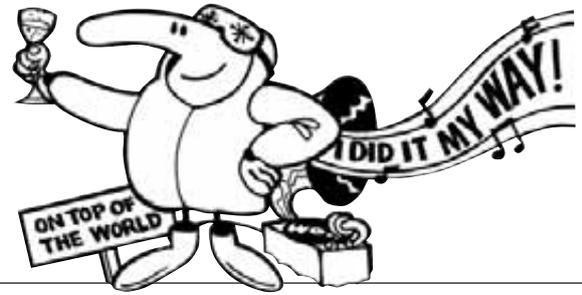
Wilson SR, Scamagas P, German DF, Hughes GW, Lulla S, Coss S, Chardon L, Thomas RG, Starr-Schneidkraut N, Stancavage FB, et al. *A controlled trial of two forms of self-management education for adults with asthma*. Institute for Healthcare Research, American Institutes for Research, Palo Alto, CA.

Purpose: Excess morbidity and mortality due to asthma, aggravated by demonstrably poor patient self-management practices, suggest the need for formal patient education programs. Individual and group asthma education programs were developed and evaluated to determine their cognitive, behavioral, and clinical effects.

Methods: We compared changes in asthma symptoms, utilisation of medical services, knowledge about asthma, metered-dose inhaler (MDI) technique, and self-management behaviors for 323 adult Kaiser Permanente patients with moderate to severe asthma who were randomly assigned to small-group education, individual teaching, or 1 of 2 control conditions—an information (workbook) control or usual control (no formal asthma education). Data were collected from patients by questionnaire, diary, and physical examination at enrollment and at 5 months and 1 year after intervention. Medical record data on these patients were abstracted for a total 3-year period, from 1 year before to 2 years after enrollment.

Results: Compared with the usual control, the self-management education programs were associated with significant improvements in control of asthma symptoms (reduced “bother” due to asthma and increased symptom-free days), MDI technique, and environmental control practices. Small-group education also was associated with significant improvements in physician evaluation of the patients’ asthma status and in patients’ level of physical activity. For both group and individual education recipients, improvement in MDI technique was positively correlated with improved control of symptoms; however, the degree of improvement in symptoms was greater than that which could be accounted for on the basis of improvement in MDI technique alone. The time course over which changes occurred in the various outcome measures suggests the mechanism by which education resulted in improvement in the patient’s status. Significant improvements in MDI technique and environmental control practices were manifest immediately following education (5-month follow-up) and at the 1-year follow-up. Significant improvements in symptom measures were not apparent until the 1-year follow-up. The rate of utilisation of medical care for acute exacerbations decreased between baseline and the 2-year follow-up period, but this decrease did not differ significantly among treatment conditions. However, there was a trend toward greater reduction in patients receiving small-group education. An ad hoc finding of a significant difference favoring small-group education between the baseline and the second follow-up year acute visit rates was observed. This result must be regarded as tentative, since it is not clear that unambiguous statistical significance is attained in the light of multiplicity issues. However, this trend is consistent with the antecedent benefits of the small-group education, and appears to warrant further investigation.

Conclusions: Carefully designed asthma education programs for adults can improve patients’ understanding of their condition and its treatment and increase their motivation and confidence that the condition can be controlled, thereby increasing their adherence to the treatment regimen and management of symptoms, and, in turn, improving control of symptoms. Both small-group education and individual education were associated with significant benefits, but the group program was simpler to administer, better received by patients and educators, and more cost-effective. The results show promise for improving clinical outcomes, through well-designed educational programs, for patients with asthma and other chronic health problems.



The journal article summarised below provides an example of a patient education program for people with arthritis.



Barlow JH, Williams B, Wright CC. *Patient education for people with arthritis in rural communities: the UK experience*. Psychosocial Research Centre: Chronic Conditions & Disability, School of Health & Social Sciences, Coventry University, Priory St., CV1 5FB, Coventry, UK.

Research literature, based largely on studies conducted in the USA and Australia, suggests that rural and urban residents differ on health status variables. This assumption was examined in an exploratory study conducted in the UK. The experience of arthritis in rural communities was explored through interviews and comparisons were made between rural and urban participants attending an educational intervention designed to improve self-management ability. Results showed that rural residents valued their independence and the sense of community spirit. Contrary to expectations, urban rather than rural residents showed greater psychological distress. However, the effectiveness of the educational intervention was found to be independent of location; both urban and rural dwellers appeared to derive similar benefits.

The information summarised below provides an example of a nurse-led service in Portsmouth supporting practice staff to deliver group education programs for newly-diagnosed type 2 diabetes patients and those about to start insulin treatment.

Consultant Nurse in Diabetes Sue Cradock – part of Portsmouth NHS Trust Diabetes Centre and Portsmouth City PCT – has been one of the driving forces behind a series of structured self-education programs for patients with diabetes⁸.

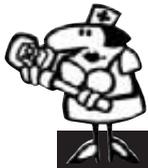
Building on their success, she is now working with a specialist diabetes nurse and a small development team in the PCT to deliver structured group education for those newly-diagnosed with type 2 diabetes and those about to start insulin treatment. The key difference is that the team are now training and supporting practice nurses and a GP to deliver group education sessions in surgery settings.

“There is good evidence that following up patients with structured group-based education slows or reverses deterioration in the patient’s condition,” says Sue. “What we are trying to do is reap some of those benefits by using existing primary care resources to better effect.”

According to Sue, it is more difficult for patients to learn in one-to-one consultations because there is a limit to what they can take in a 20-minute slot. At the group sessions, the nurse or GP can spend a couple of hours with six or more patients without using any more resources or professional time.

Take-up for the group sessions is high with between six and 12 patients attending the practice-based programs which are run three or four times a month. As a result of the sessions, hospital doctors are reporting that the patients are more confident about adjusting their insulin and keeping their blood sugars under control. GPs and nurses say it is easier to work with newly-diagnosed patients who have participated in the program.

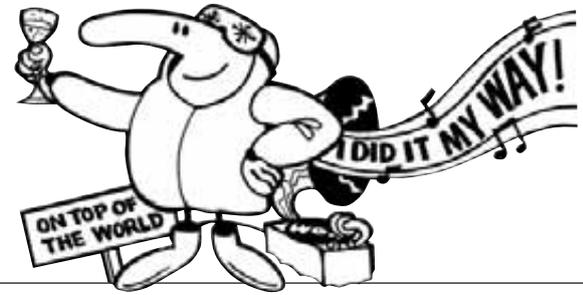
⁸ NHS: Supporting people with long term conditions. www.doh.gov.uk



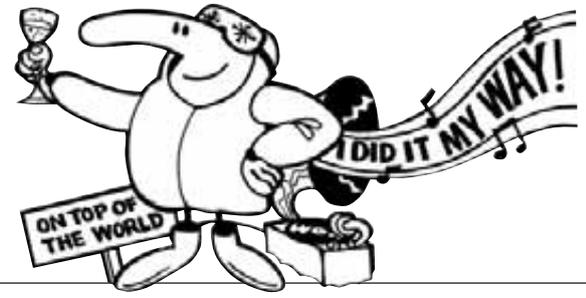
2.4 Tools and resources: Self-management support

See also resources for Community Resource Mobilisation

Topic	Details	References
Patient Education	<ul style="list-style-type: none"> The NHS has developed the Expert Patients Program (EPP) for partnerships with patients 	www.doh.gov.uk search "self care" http://www.expertpatients.nhs.uk/
Developing local strategies	<ul style="list-style-type: none"> NHS Publication: <i>Supporting people with long-term conditions to...</i> 	www.doh.gov.uk search "publications"
Case studies for management of lung disease	<ul style="list-style-type: none"> <i>Informed Partnership for Effective Self-management of Chronic and Complex Lung Diseases</i> published by the Flinders Human Behaviour & Health Research Unit describes outcomes from a number of informed partnerships 	http://som.flinders.edu.au/FUSA/CCTU click on "what is self-management" and go to references at the end of the section
Assessing patients using principles of self-management	<ul style="list-style-type: none"> As part of the development of the Flinders Model, the Partners in Health Scale (PIH) and Cue and Response Interview (C& R) have been developed 	http://som.flinders.edu.au/FUSA/CCTU/ click on "what is self-management"
Case Study: Applying the Partners in Health principles in an aboriginal community	<ul style="list-style-type: none"> <i>Eyre Peninsula Chronic Disease Self-management Project for Aboriginal Communities</i> is the final report for the project and contains specific case studies and the adapted social and clinical measurement tools that were used for this project 	http://som.flinders.edu.au/FUSA/CCTU search document or phone 08 8276 8350
Partnerships with Patients	<ul style="list-style-type: none"> A presentation which outlines key success factors for working in partnership with patients developed by Dr Malcolm Battersby & Mignon Markwick of Flinders University 	www.npcc.com.au click on "events" then "Learning Workshop 1" then "Chronic Condition Self-management, Partnerships with Patients"
RACGP Self-management guidelines	<ul style="list-style-type: none"> <i>Sharing Healthcare Guidelines - Chronic Condition Self Management Guidelines for GPs</i>. Summaries and Desktop guides for GPs, Nurses and Allied Health Professionals 	http://www.racgp.org.au/guidelines/sharinghealthcare



Topic	Details	References
Case Study: Self-management in General Practice	<ul style="list-style-type: none"> A case study from the Whitehorse Division of General Practice 	<p>www.npcc.com.au click on “events” then “Wave 3” then “Learning Workshop 1” then “Self-management in General Practice”</p>
10 Steps for coping with a chronic condition	<ul style="list-style-type: none"> Article: Help for patients who want to manage their own chronic disease 	<p>See Appendix 14 http://www.health.harvard.edu/heart</p>
Patient Held Record	<ul style="list-style-type: none"> A patient held record was developed during the pilot project, but had not been widely used by other practices at time of printing. Further development work is in progress 	<p>See Appendix 15 Central West Gippsland Division of GP and BHCiG (Pilot Project)</p>
Chronic Disease Self-Efficacy Scales	<ul style="list-style-type: none"> Tool: Assessment of patients management of their own health 	<p>See Appendix 16 Stanford Patient Education Research Centre http://patienteducation.stanford.edu/research/</p>
Lay led self-management programs	<ul style="list-style-type: none"> This extensive bibliography provides an extensive listing of journal articles regarding the implementation of self-management principles 	<p>http://patienteducation.stanford.edu/bibliog.html</p>
Patient Education – “how to” of self-management	<ul style="list-style-type: none"> The short and simple booklet is designed to be distributed to patients to assist them in managing their own healthcare proactively. 	<p>www.health.vic.gov.au/consumer then search for “10 tips for safer healthcare”</p>
Information for Patients	<ul style="list-style-type: none"> References to patient information on key chronic conditions 	<p>See Appendix 17 for compilation of patient information</p>



How we will improve our self-management systems?					
Action Area	What do we aim to do?	How will we do it? (strategies)	Who will do it?	When will we start?	When will we finish?

Table adapted from the Healthy for Life Toolkit (OATSIH)

Element 3: Decision support



Element 3 Decision support

3.1 Introduction⁹

Promote clinical care that is consistent with scientific evidence and patient preferences

In order to successfully manage chronic disease, clinical decisions need to be based on sound evidence that is supported by research. This information can then be passed on to patients so that they can understand the principles behind their own care and make the appropriate decisions.

Aims

- To embed evidence based guidelines into the care delivery system.
- To include the use of a structured assessment to diagnose and determine severity of illness for all patients.
- To establish linkages with key specialists to ensure that primary care providers have access to expert support.
- To ensure that care is provided by the multidisciplinary team, particularly for more complex patients.
- To provide skill-focused training programs for all staff in support of chronic illness improvement.
- To educate patients about guidelines and best practice as part of their own decision support (See Self-management).

Agency responsibilities

In order to implement this element, healthcare providers will need to:

- Ensure that all staff members are well trained in the current approaches to evidence based care.
- Ensure that computers with internet access available.
- Educate staff on how to undertake a literature search and write a guideline.
- Provide financial support for staff to attend conferences and training programs.
- Implement guidelines through timely reminders, feedback, standing orders and other methods that increase their impact on clinical decision making.

⁹The materials in this chapter have been adapted from the Institute for Healthcare Improvement website (www.IHI.org) and the MacColl Institute for Healthcare Innovation website (www.improvingchroniccare.org)



3.2 Essential Process Steps

Step 1: Embed evidence based guidelines into daily practice

Step 2: Establish linkages with key specialists to ensure that primary care givers have access to expert support

Step 3: Provide skill orientated interactive training programs for all staff

Step 4: Educate patients about guidelines

Step 1: Embed evidence based guidelines into daily practice

Process Steps		Key Action Points	✓ Checklist
1.1	Identify existing evidence based guidelines	<ul style="list-style-type: none"> • Ensure that there is consensus by the clinical team regarding the guidelines • Engage a medical professional who is enthusiastic about the proposed changes to participate in the development of clinical guidelines • Contact other service providers and ask for copies of evidence-based guidelines • Develop a standardised assessment tool to assess the severity of all patients' illnesses • Utilise the assessment tool to guide management of the patient with a complex chronic disease 	<ul style="list-style-type: none"> <input type="checkbox"/> Guidelines are documented and referenced to recent literature <input type="checkbox"/> Guidelines are multidisciplinary <input type="checkbox"/> A standard format is used for each guideline <input type="checkbox"/> Guidelines are part of the care plan
1.2	Review existing guidelines	<ul style="list-style-type: none"> • Review all guidelines and ensure that they are referenced with the most recent literature/research • Identify generic guidelines that can (see Appendix 8) • Contact other primary care providers in your region or network to see whether they have already developed guidelines that can be adapted • Delegate review of guidelines to all members of the care team and ensure that timeframes and expectations are clearly articulated • Organise meetings to review the draft guidelines and discuss/debate • Ensure that the Medical Practitioners are part of the development process 	<ul style="list-style-type: none"> <input type="checkbox"/> All guidelines have been reviewed and are dated <input type="checkbox"/> Guidelines are part of the standing agenda at staff meetings



Step 1: Embed evidence based guidelines into daily practice, Cont.

Process Steps		Key Action Points	✓ Checklist
1.3	Develop a standard format for guidelines	<ul style="list-style-type: none"> • In collaboration with the care team, review and identify guidelines to be written • Each the care team the basics and importance of evidence based guidelines 	<ul style="list-style-type: none"> <input type="checkbox"/> Guidelines are relevant to the disease and documented <input type="checkbox"/> Education has been provided to the staff and this is documented
1.4	Identify an audit process to benchmark current practice against evidence	<ul style="list-style-type: none"> • Develop an audit process • Conduct a baseline audit to benchmark current practice against agreed evidence based guidelines • Agree with the care team which patients will be included in the audit • Feedback the audit results to the care team and discuss what may need modification 	<ul style="list-style-type: none"> <input type="checkbox"/> Audit tool is implemented <input type="checkbox"/> Results from audit are part of a report and are documented <input type="checkbox"/> There is evidence that guidelines have been changed following the audit <input type="checkbox"/> The audit has focussed on a specific group of patients
1.5	Develop flow charts, clinical pathways	<ul style="list-style-type: none"> • Develop a flow chart that outlines the steps to be followed • Ensure that the flow chart is in all key areas • Remove any barriers created with previous guidelines and ensure that the new guidelines provide for a seamless service 	<ul style="list-style-type: none"> <input type="checkbox"/> A flow chart is available in all key areas of the clinic
1.6	Review guidelines annually	<ul style="list-style-type: none"> • Ensure that all guidelines are dated and an annual review is undertaken 	<ul style="list-style-type: none"> <input type="checkbox"/> Guidelines are dated and the date for review is part of the guideline
1.7	Implement guidelines	<ul style="list-style-type: none"> • Ensure that all guidelines are fully implemented • Ensure that guidelines are a standing agenda item at staff meetings • Encourage debate on guidelines 	<ul style="list-style-type: none"> <input type="checkbox"/> A master file of guidelines is available <input type="checkbox"/> Changes to guidelines are clearly documented

Suggestion

Organisations that introduced evidence based multidisciplinary care pathways during the pilot, found them to be both efficient and effective clinically.



Step 2: Establish linkages with key practitioners to ensure that primary care givers have access to expert support

Process Steps		Key Action Points	✓ Checklist
2.1	Identify specialists that will support the care of patients	<ul style="list-style-type: none"> • Seek out other healthcare providers who support the chronic care model and engage them in assisting with providing care as appropriate (this may include involvement in Reference Groups) • Identify any opportunities for GP registrars to rotate through the clinic • Request assistance from other specialists in the development of guidelines 	<ul style="list-style-type: none"> <input type="checkbox"/> External specialists participate in the care delivery of patients with a chronic disease <input type="checkbox"/> Practitioners from other organisations attend the clinic <input type="checkbox"/> External specialists are involved in the development of guidelines
2.2	Define appropriate processes for referral	<ul style="list-style-type: none"> • Include mode of referral as part of the guidelines • Streamline the process for communication, i.e. fax, email, phone 	<ul style="list-style-type: none"> <input type="checkbox"/> Referral process is documented as part of the guidelines
2.3	Establish a follow up process	<ul style="list-style-type: none"> • Ascertain from the specialists how they would like patients to be followed up • Develop a process for referral and feedback as per PPPS guidelines • Use the register to document follow up and referrals to specialists • Undertake random audits to check the process is working 	<ul style="list-style-type: none"> <input type="checkbox"/> Follow up process is documented as part of the guideline <input type="checkbox"/> A tracking process is clearly defined as part of a policy <input type="checkbox"/> Processes are in keeping with PPPSs <input type="checkbox"/> Random audits are undertaken and evaluated



Step 3: Provide skill orientated training programs for all staff

Process Steps		Key Action Points	✓ Checklist
3.1	Evaluate educational needs of staff	<ul style="list-style-type: none"> • Undertake an educational needs analysis for all members of the healthcare team to assist in identifying what additional training is required 	<input type="checkbox"/> Needs analysis is undertaken and evaluated
3.2	Develop an annual education planner	<ul style="list-style-type: none"> • Schedule regular in-service planning based on the evaluation of the needs analysis • Include skill training as part of the regular education plan, ie use of peak flow • Establish credentialing systems for specific skills and provide a certificate of attainment 	<input type="checkbox"/> Education sessions reflect the results of the needs analysis <input type="checkbox"/> Staff are assessed and deemed competent in specific clinical skills <input type="checkbox"/> Credentialing certificates are part of the staff performance appraisal
3.3	Identify educational opportunities	<ul style="list-style-type: none"> • Contact specialists to gain their support in providing education to clinic staff • Ensure that staff are given the opportunity to attend conferences • Following attendance at a conference, staff share information with others 	<input type="checkbox"/> Specialists are involved in delivering staff education <input type="checkbox"/> Staff attend conferences <input type="checkbox"/> Reports from conferences are available
3.4	Implement a multi disciplinary case management review	<ul style="list-style-type: none"> • Develop a case management review mechanism • Determine the frequency of the reviews • Decide how the case review information will be used to make changes in care delivery and to educate patients and providers 	<input type="checkbox"/> Case management process is a documented part of a policy

Step 4: Educate patients about guidelines (refer to self-management)

Process Steps		Key Action Points	✓ Checklist
4.1	Develop patient friendly guideline handouts or wallet cards	<ul style="list-style-type: none"> • Survey patients about their knowledge of the disease processes and their expectations • Design a patient friendly guideline handout 	<input type="checkbox"/> Patient survey is completed and evaluated <input type="checkbox"/> Patient friendly handout is available and distributed to patients
4.2	Ensure that patients use the information	<ul style="list-style-type: none"> • Distribute guidelines to patients • Ensure that staff reinforce patient expectations and encourage patients to participate in following the guidelines • Include patient information as part of all support groups, public presentations and health fairs 	<input type="checkbox"/> Guidelines are distributed to patients <input type="checkbox"/> Information on chronic disease is included at public forums



3.3 Tools and resources: Decision support

Topic	Details	References
Evaluating the Evidence Base	<ul style="list-style-type: none"> • <i>A Schema for Evaluating Evidence on Public Health Interventions</i> published by National Public Health Partnerships 	www.nphp.gov.au then search “publications”
Finding good evidence	<ul style="list-style-type: none"> • A special training course developed by the Cochrane Collaboration includes a section called “finding the evidence” which outlines how you can conduct your own literature search 	www.vichealth.vic.gov.au/cochrane/training/index.htm click on “systematic review 2-day course workbook” and select “Unit Six”
Developing clinical guidelines	<ul style="list-style-type: none"> • In developing your own guidelines, you may want to consider using generic guidelines available through key research or peak bodies. Alternatively, other primary care providers in your region may be willing to share 	See Appendix 8 A list of generic guidelines that can be downloaded from various websites has been developed.
Conducting a clinical audit	<ul style="list-style-type: none"> • As part of the Healthy for Life Toolkit, a number of clinical audit tools and protocols have been developed using the Audit and Best Practice for Chronic Disease Approach (ABCD) 	www.health.gov.au then search “OATSIH programs” then go to “Healthy for Life” and you will find a link to the website embedded in the text
Accessing information about specific diseases	<ul style="list-style-type: none"> • The American Centers for Disease Control and Prevention (CDC) present a wealth of information about various chronic diseases. The online database allows you to search for articles and other materials 	http://www.cdc.gov/cdp/he.htm for an online health promotion and education database
Clinical auditing	<ul style="list-style-type: none"> • This section of the Healthy for Life Toolkit contains clinical audit tools and protocols for diabetes and asthma as well as prevention 	www.health.gov.au then search “OATSIH programs” then go to “Healthy for Life” and you will find a link to the Healthy for Life website embedded in the text. Select “toolkit” and go to section 3.2
National Quality Measures Clearinghouse	A range of tools and resources to assist in developing clinical guidelines developed by US government agencies	http://www.ahrq.gov/



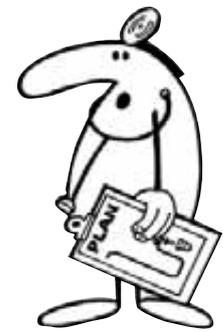
3.3 Tools and resources: Decision support, Cont.

Topic	Details	References
Effective Models and Evidence	<ul style="list-style-type: none">The <i>Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector</i> has been developed by DHS and provides an overview of models for the full range of chronic diseases	www.health.vic.gov.au/pcps/publications/chronic.htm
Information to assist patient decision making	A range of resources that can be used to assist in providing information to patients	See Appendix 17
Guidelines for treatment of chronic conditions	Reference List: Range of generic clinical protocols and guidelines that can be downloaded from the web	See Appendix 8



How we will improve our decision support?					
Action Area	What do we aim to do?	How will we do it? (strategies)	Who will do it?	When will we start?	When will we finish?

Table adapted from the Healthy for Life Toolkit (OATSIH)



Element 4: Delivery system design



Element 4 Delivery system design

4.1 Introduction¹⁰

Assure the delivery of effective, efficient clinical care and self-management support

Improving the healthcare of people with chronic disease requires transforming a system that is often rigid and not designed to support the chronically ill person. It is normally a system that responds well to an acute illness but is generally less capable of providing support for chronic disease.

Delivery system design occurs primarily through clarifying roles and responsibilities of healthcare team members. In addition, service providers have a clear understanding of each other's role and a thorough knowledge of what services are available and how to access them.

Aims

- To develop or strengthen the multidisciplinary and/or multi-agency approach to the management of patients with a chronic disease.
- To define the roles, tasks and responsibilities of each team member involved in the care of a patient with a chronic disease.
- To work collaboratively to provide a streamlined approach to patient care in the most effective and efficient manner.
- To develop standardised care plans and assessment tools.
- To ensure timely, planned follow up to review care plans and for check ups, e.g., foot clinic.
- To ensure planned visits in the group and individual settings.

Suggestion

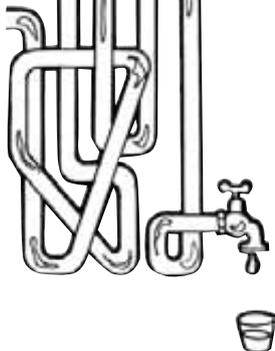
Taking time to establish the roles of each member of the multidisciplinary team is important. This may include some team member's role being expanded. Clear definitions of the roles can help to prevent team conflict in the future.

Agency responsibilities

In order to implement this element, healthcare providers will need to:

- Understand the roles and responsibilities of each team member.
- Know who is the leader of the team, this needs to be a strong person who is credible within the group.
- Use planned interactions to support evidence based care.
- Ensure that all staff are fully familiar with and utilise the Interagency Referral Protocol and committed to collaborative, cooperative and coordinated working arrangements between service providers.
- Maintain comprehensive knowledge of the service system within the relevant parts of the region.
- Be fully familiar with the relevant guidelines for completing the Service Coordination Tools and understand the importance of accuracy, detail and legibility when completing referral documentation.

¹⁰ The materials in this chapter have been adapted from the Institute for Healthcare Improvement website (www.IHI.org) and the MacColl Institute for Healthcare Innovation website (www.improvingchroniccare.org)



4.2 Essential Process Steps

Step 1: Use the Patient Registry to proactively review care and plan follow up

Step 2: Assign roles, duties and tasks for planned visits for the multidisciplinary team

Step 3: Use planned visits in individual and group settings

Step 4: Make designated staff responsible for follow up by various methods, including outreach, telephone calls and home visits

Step 5: Ensure that appointment systems support the needs of patients for urgent visits

Step 6: To ensure that service providers can efficiently and effectively make and receive referrals and to reduce inappropriate referrals

Step 1: Use the Patient Registry to proactively review care and plan follow up

Process Steps		Key Action Points	✓ Checklist
1.1	Develop a proactive system to organise scheduled visits	<ul style="list-style-type: none"> Use the Patient Registry to schedule planned, regular follow up 	<ul style="list-style-type: none"> <input type="checkbox"/> Review the Registry monthly and collect statistics to measure population based data <input type="checkbox"/> Each patient has a action plan that has clearly defined goals
1.2	Use scheduled visits	<ul style="list-style-type: none"> Plan the visits and note who will be undertaking which tasks for the patient, ie any referrals, assessments or self-management goals Communicate the information about the visit with the care team to ensure all are aware of their roles 	<ul style="list-style-type: none"> <input type="checkbox"/> Specific needs are documented on the Action Plan <input type="checkbox"/> All referrals, assessments or self-management goals are documented on the Action Plan <input type="checkbox"/> A time is scheduled to meet with the care team to review their roles and tasks
1.3	Use care plans, action plans, assessment tools to guide care and follow up	<ul style="list-style-type: none"> Review the care plan/action plan Identify which assessments are required for this visit Use the statistical data to identify areas for improvement, ie use of anti inflammatory medications 	<ul style="list-style-type: none"> <input type="checkbox"/> All changes are clearly documented and completed actions are dated with stated outcomes <input type="checkbox"/> Relevant assessments are documented and organised

Suggestion

Creating a process map that identifies barriers within the current system and then applying a team approach to developing solutions is worth the time invested. This activity provides the team with the opportunity to have some ownership of the changes made to the system and to identify their role and responsibility within the changed systems.

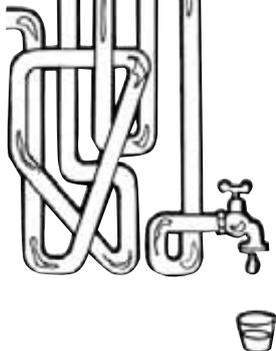


Step 2: Assign roles, duties and tasks for scheduled visits for the multidisciplinary team

Process Steps		Key Action Points	✓ Checklist
2.1	Determine who has responsibility for each step of the planned visit and follow up	<ul style="list-style-type: none"> Identify who has responsibility for the patient 	<input type="checkbox"/> The follow up visit is documented on the care plan and action plan and entered into the patient registry
2.2	Undertake training and education of staff in their new roles	<ul style="list-style-type: none"> Identify the training needs of staff and ensure attendance at relevant workshops 	<input type="checkbox"/> Training needs are scheduled and staff rostered to attend
2.3	Identify training resources and tools	<ul style="list-style-type: none"> Source the relevant standardised tools used in the Gippsland Region Ensure that staff know how and when to use the relevant tools Introduce a 'train the trainer' education program and allocate staff time to observe/learn the new skill 	<input type="checkbox"/> Resource kit is available at the clinic for all staff <input type="checkbox"/> All staff are credentialed in the use of the various tools and this is documented on their performance appraisal
2.4	Determine what standing orders for medication are to be prescribed	<ul style="list-style-type: none"> Identify the standing orders that are required Ensure that policies are in place to guide the nursing staff when to issue a standing order Ensure that delegation of standing orders is to an appropriate staff member 	<input type="checkbox"/> Ensure staff have been assessed as being able to prescribe standing orders

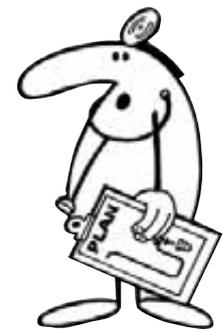
Step 3: Use planned visits in individual and group settings

Process Steps		Key Action Points	✓ Checklist
3.1	Introduce a calendar of group information sessions	<ul style="list-style-type: none"> Develop and publish an annual planner for group information session 	<input type="checkbox"/> An annual planner is published
3.2	Review all patient education material and update as required based on evidence.	<ul style="list-style-type: none"> All patient education material is up to date and clearly referenced to demonstrate evidence based care. 	<input type="checkbox"/> Patient education material is updated and reviewed annually and is evidence based



Step 3: Use planned visits in individual and group settings, Cont.

Process Steps		Key Action Points	✓ Checklist
3.3	Develop a group education schedule and provide to the Division of GP	<ul style="list-style-type: none"> • A annual patient education schedule is published and provided to the Division of GP 	<input type="checkbox"/> Education schedule is published annually
3.4	Ensure patients are screened for suitability for group or individual education sessions	<ul style="list-style-type: none"> • A screening tool is used to assess suitability of patients to attend the group or individual education sessions 	<input type="checkbox"/> Each patient has a screening tool completed
3.5	Train the front desk staff in the use of the referral pathway	<ul style="list-style-type: none"> • Criteria are developed for front desk staff to triage patients for individual or group education sessions. • Front desk staff are given time to learn how to triage patients for group or individual education sessions 	<input type="checkbox"/> Criteria is used for triaging patients
3.6	Use the patient registry to identify patients in need of visits	<ul style="list-style-type: none"> • Planned visits are scheduled using the patient registry 	<input type="checkbox"/> All relevant patients receive planned visits
3.7	Ensure staff are trained	<ul style="list-style-type: none"> • Ensure that all staff have received education in what is required at a planned visit and what benefits it brings 	<input type="checkbox"/> All staff managing planned visits are supported
3.8	Identify what key criteria will be used in planned visits	<ul style="list-style-type: none"> • Develop key criteria for planned visits that guide practice regarding assessment and review of self-management goals 	<input type="checkbox"/> Criteria are established for planned visits
3.9	Staff document the outcomes of the planned visit	<ul style="list-style-type: none"> • Ensure that all staff document the outcome of the planned visit 	<input type="checkbox"/> Outcomes are clearly documented in the patient care plan

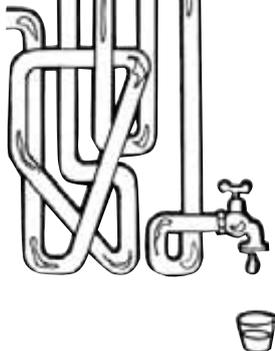


Step 4: Make designated staff responsible for follow up by various methods, including outreach, telephone calls and home visits

Process Steps		Key Action Points	✓ Checklist
4.1	Identify follow up needs, eg medication refills	<ul style="list-style-type: none"> Develop a follow up approach, including who will contact patients, how and when 	<input type="checkbox"/> Patients are followed up when stated
4.2	Develop follow up methods	<ul style="list-style-type: none"> Identify the methods for follow up, eg phone or mail outs 	<input type="checkbox"/> Patients are notified of follow up

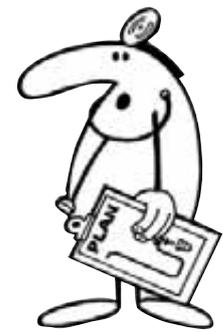
Step 5: Ensure that appointment systems support the needs of patients for urgent visits

Process Steps		Key Action Points	✓ Checklist
5.1	Mechanism is developed to manage urgent appointments	<ul style="list-style-type: none"> Identify trends in the number of urgent appointments required by disease group Make agreements with the team on how urgent visits should be managed, ie double booking 	<input type="checkbox"/> Urgent appointments are noted on the registry
5.2	Develop education tool for patients on when to book an urgent appointment	<ul style="list-style-type: none"> Ensure patients are educated on when to book an urgent appointment 	<input type="checkbox"/> When to book an urgent appointment is listed as part of the patient education training



Step 6: To ensure that service providers can efficiently and effectively make and receive referrals and to reduce or eliminate inappropriate referrals

Process Steps		Key Action Points	✓ Checklist
6.1	Implement staff education on how to use the Interagency Referral Protocols outlined in the PPPS manual	<ul style="list-style-type: none"> • Ensure that all staff are skilled in the use of the Interagency Referral Protocol • Ensure that all staff have a knowledge of the privacy and consent practices and legislative standards 	<input type="checkbox"/> All staff are trained in the use of the Interagency Referral Protocol
6.2	Implement the Risk Assessment and priority/urgency rating in accordance with the PPPS Manual for referrals	<ul style="list-style-type: none"> • Ensure that all staff are able to understand risk assessment and priority/urgency rating as it relates to referrals • Ensure that all staff are using the PPPS Manual and Service Coordination documentation 	<input type="checkbox"/> All staff are trained in the use of the risk assessment and priority/urgency rating
6.3	Identify the need for referral and appropriate referral pathways	<ul style="list-style-type: none"> • Organise an interpreter if necessary • Consider issues of patient competence i.e. legal capacity, guardianship/ power of attorney 	<input type="checkbox"/> All staff understand how to access interpreter services <input type="checkbox"/> Have access to accurate information on appropriate services
6.4	Ensure patient involvement in the referral process	<ul style="list-style-type: none"> • Explain the need for referral • Explain referral options, processes, timelines and information required • Provide the patient with appropriate written information regarding the referral • Assist and support the patient to make an informed choice 	<input type="checkbox"/> Patients are able to understand referral options and processes <input type="checkbox"/> Can make an informed choice regarding referral options <input type="checkbox"/> Receive appropriate written information regarding the referral



4.3 Practical applications

4.3.1 Case Study: Delivery System Design and patient education

Background

The reference groups involved in the Better Healthcare in Gippsland pilot project worked together to improve the delivery of patient education in order to:

- Improve access to diabetes educator and dietitian at the community health service
- Develop and implement an agreed process for patients to receive appropriate information within BHCiG documentation (PPPS manual and BHCiG type 2 diabetes management pathway).



Strategies

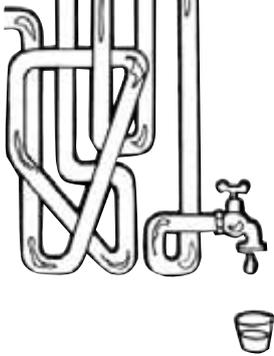
The community health service involved had extensive waiting times to access both the diabetes educator and the dietitian. Adding to this was the misconception by GPs involved in the reference group that the community health service was without a dietitian. This resulted in GP not referring patients to the community health service for education.

It was agreed by the reference members to develop a calendar of group information sessions. These were promoted through the Division of General Practice to facilitate patient education with a targeted individual appointment for patient. These requiring further interventions were referred to a team care arrangement, assessed by the GP practice or referred to allied health providers.

This was a multi-agency approach to the change in practice which was created by an understanding by all involved of the 'bigger picture issues' and thus the project partners were able to work together to build the program and the pathway to implement the changes.

Process undertaken

- Development of a calendar of group information session.
- Content update for existing programs.
- A five-session program developed by the allied health team to cover various aspects of managing diabetes (e.g label reading, supermarket tours, exercise etc).
- An attendance fee was introduced to avoid the high dropout rates.
- Programs provided through the Division of General Practice.
- Systems established to encourage GPs to refer to group sessions.
- Front office staff were trained in screening using a risk assessment tool and 'triage' patients.



4.3.1 Case Study: Delivery System Design and patient education, Cont.

Key findings

The key findings were:

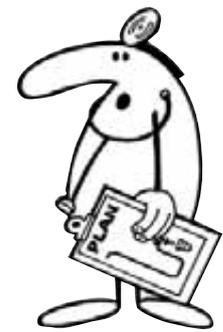
- Working together across health sectors and working with the Division of General Practice helped overcome misconceptions.
- The use of a multi-agency approach led to innovative solutions for problems.
- The process used enabled the change in delivery system design to be promoted across health sectors resulting in increased awareness of the services offered.
- The new program resulted in a significant reduction in waiting time to access the diabetes educator and dietitian.
- Diabetes educator and dietitian now seeing patients who have a level of knowledge regarding diabetes and therefore providing more targeted interventions.
- The standardised pathway and agreed documentation provided to those with type 2 diabetes leads to a reduction in 'mixed messages' being provided to patients.

Challenges

A multi-agency approach was a new way of working for those involved in the project. Initially there was a high level of resistance to addressing what was viewed as agency based issues. The development of trust between the stakeholders over the time of the project led to benefits being seen and more open communication evolved.

Summary

The project provided an opportunity for agencies from a variety of sectors to discuss delivery system design. The stakeholders were able to look at services available, monitor referral patterns and work in a collaborative manner to utilise the available resources in a more efficient and effective manner.



4.3.2 Case Study: Delivery System Design and patient education

Basic Survival Kit: Developing the role of members of the healthcare team

Background



As part of the Better Healthcare in Gippsland project, the reference group worked to develop a resource kit to assist practice nurses in the delivery of basic education and in meeting best practice guidelines.

The basic survival kit is not intended to replace or duplicate the education provided by the diabetes educator and/or dietitian. It is to provide a basic level of understanding about type 2 diabetes and knowledge of the clinical management and annual cycle of care involved in the management of type 2 diabetes.

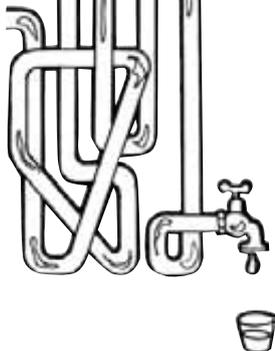
The kit was also designed to provide patients with information that would encourage them to attend future formal education sessions. By involving other members of the healthcare team, it was envisaged that in the longer term, the diabetes educator and dietitian would be able to provide more targeted interventions to meet individual patient needs.

Key findings

- Need for someone to drive the change process is essential, particularly early on. Once the value of the change can be demonstrated, the resistance to change reduces.
- Communication is vital to ensure that the various health professionals can work together effectively.
- Working together across health sectors and working with the Division of General Practice enabled many misconceptions of health sector operations to be overcome.
- The use of a multi-agency approach led to innovative solutions to problems as all stakeholders involved in the management of the patients were able to address the patient needs and arrange the most appropriate use of resources.
- Links to the Division of General Practice proved very useful

Challenges

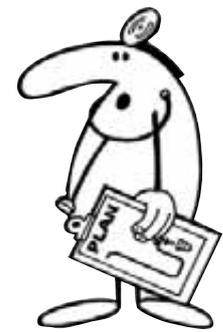
This case study illustrates the challenges involved in refining roles and responsibilities of those involved in the management of type 2 diabetes. In this instance it was necessary to commence undertaking the task prior to all stakeholders agreeing with the change. The development of a draft document including the aims of the tool provided a means to progress as the reference group members understood the intention of the tool and began to take ownership.



Sample table of contents

The Foster Medical Clinic developed a folder as a “basic survival kit” that has been utilised by the practice nurse and others. The table of contents outlines the materials in their kit and can be used as content guide for developing similar kits.

- Section 1** Type 2 Diabetes Management Pathway
- Section 2** A Guide to Diabetes Education of Health Professionals
Chronic Disease Self-management for People with Diabetes
- Section 3** FMC Diabetic Management Framework
GP Coordination of Team Care Arrangements
Patient Kept Record
Physically Active Lifestyle
PALS Program
- Section 4** National Standards of Practice for Diabetes Educators
The Role of the Diabetes Nurse Educator
FMC Diabetes Services
Enhanced Primary Care (EPC) Referral Form
NDSS Registration Form
Flinders Model – Chronic Condition Self-management
- Partners In Health Scale (guidelines)
 - Partners In Health Scale
 - Cue and Response Interview
 - Cue and Response Summary Sheet
 - Problem and Goals Assessment
 - Problem Definition/Goals
 - Problem and Goals Monitoring Record
 - Symptom Action Plan and Diary
 - Patient Checklist
- Section 5** Foot Assessment
FMC Basic Foot Screening Checklist
Action Plan (following basic foot screening)
Doppler Ultrasound
Ankle-Brachial pressure Index
- Section 6** Community Sharps Disposal Program
- Section 7** Diabetes Management and Resource Kit Materials Fax Form
Patient Information
- Diabetes Fact Sheet
 - Diabetes Zones for Management



- Section 8** Gippsland Foot Clinic Request Form
 - Your Podiatrist Talks About Diabetes
 - Podiatry Caring for Your Feet
- Section 9** Brochure – Optometrists Association Australia
- Section 10** Contact List and Web sites
South Gippsland Resources for Diabetes – by location
Facilities and Programs in Foster
- Section 11** Data collected from FMC MD Data Base Compact Disc
 - FMC Power Point Presentation
 - Diabetes Project
 - Chronic Disease Self-management

4.3.3 Case Study – Implementation of the Chronic Care Model

Organisation of Healthcare and Reference Group Development

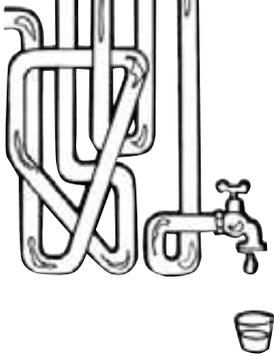


This case study details the development of a reference group consisting of various stakeholders involved in the management of patients with type 2 diabetes undertaken as part of the BHCiG CCM. The partnership worked collaboratively to identify areas to build on.

Aims

The aim was to:

- Develop or strengthen the multidisciplinary and/or multi-agency approach to the management of type 2 diabetes.
- Work collaboratively to provide streamlined patient care in the most effective and efficient manner.
- Define the roles and responsibilities from those involved in the care of patients with type 2 diabetes.
- Provide on going support for a multidisciplinary/multi-agency approach to chronic disease management.



4.3.3 Case Study – Implementation of the Chronic Care Model, Cont.

Strategies

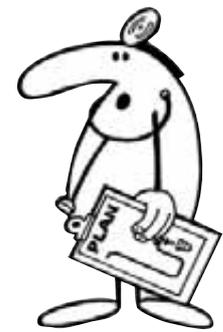
The primary strategy was to use the chronic care model as the basis for multi-agency discussion around how to best utilise available resources to manage type 2 diabetes using best practice guidelines.

Stage 1: Engaging GP practices

1. In consultation with the Divisions of General Practice selection criteria was developed.
2. Information regarding the chronic care model and the benefits of involvement in the project was compiled.
3. Liaison with the relevant Division of General Practice for expression of interest from GP practices.
4. Project coordinator met with interested practices meeting the criteria to further discuss what the 1. project may offer them and what they were looking to achieve.
5. The above information was collated and the GP practice was selected.
6. The successful practice was notified and it confirmed desire to participate. The unsuccessful practices were contacted and debriefed.

Stage 2: Establishing the reference group

1. Project coordinator met with GP practice representatives to determine referral pathway for patients with type 2 diabetes and key stakeholders involved.
2. Project coordinator approached representatives of agencies identified above regarding participating in the reference group.
3. Interested parties accepted invitation to participate. The reference group members consisted of a GP and the practice nurse coordinator from the GP practice, the programs officer from the Division of General Practice, diabetes educators and dietitians from the community health service, a private podiatrist and a private optometrist.
4. Project coordinator called a meeting of the above stakeholders and discussion about the project, timelines and expectations took place.
5. The memorandum of understanding and funding agreements were agreed to and signed by the stakeholders.



Stage 3: Gap analysis

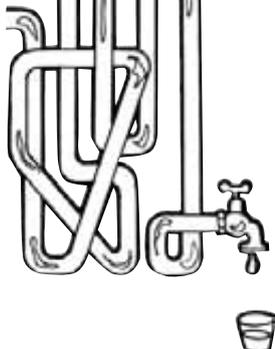
1. Gap analysis was undertaken, exploring current chronic disease management activities against the chronic care model. This identified intra-agency activities in each agency.
2. The analysis above identified a number of 'gaps'. This included identification of training needs.
3. As a group, priority areas were identified as urgent, high, medium or low.
4. Work plan identifying responsibilities, tasks, budget and timelines was agreed to.

Stage 4: Implementation

1. Work plan activities were undertaken.
2. Reference groups meetings were held approximately bi-monthly for 1-2hours.
3. Activities reported against and work plan/activities modified accordingly.
4. A second work plan and budget was developed to roll out post project coordinator engagement.

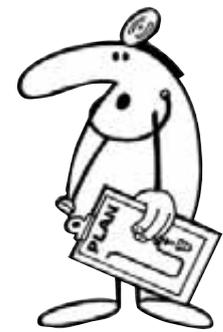
Key Findings

- Trust needs to be developed by those involved in the reference groups but this takes time to build.
- Need to find common issue to focus on initially and built from that base.
- Solutions need to be driven by the reference group.
- Communication is vital to ensure that the various sectors of health are able to work together.
- Working together across health sectors and working with the Division of General Practice enabled many misconceptions of health sector operations to be overcome.
- The use of a multi-agency approach led to innovative solutions to problems as all stakeholders involved in the management of the patients were able to address the patient needs and the most appropriate use of resources.

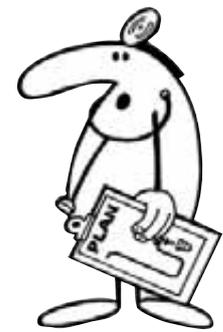


4.4 Tools and resources: Delivery System Design

Topic	Details	References
Establishing a local partnership between health services	<ul style="list-style-type: none"> NHS Publication <i>Creating Healthier Communities: a resource pack for local partnerships</i> 	www.doh.gov.uk then “publications” then search title
Principles of setting up a partnership	<ul style="list-style-type: none"> This website contains a wealth of information on partnerships. The section “Partnership Lifecycle” provides practical insights and suggestions for practical steps to establishing and closing partnerships 	www.ourpartnership.org.uk click on “Partnership Lifecycle”
Approaches to case management for chronic diseases	<ul style="list-style-type: none"> <i>Case management competences framework</i> published by the NHS outlines approaches using case managers and community matrons 	www.doh.gov.uk and search “publications and statistics”
Regional Service Coordination Practice and Protocol Manual	<ul style="list-style-type: none"> A manual describing practices, processes, protocols and systems for the Gippsland Health Services Partnership with a view to facilitating service coordination 	Copies of the manual have been distributed to agencies in the Gippsland region
National Primary Care Collaborative	<ul style="list-style-type: none"> A very useful website that reports on the learnings from various primary care collaboratives around Australia that have focussed on approaches to chronic disease management 	www.npcc.com.au click on “events” for a range of practical presentations on implementing chronic care models around Australia
Diabetes screening intake procedure	<ul style="list-style-type: none"> Tool: for screening during intake 	Latrobe CHS (Pilot Project)
Diabetes nurse educator (DNE) referral outcome	<ul style="list-style-type: none"> Tool: Referral outcome for referral from DNE to GP 	Central West Gippsland Division of GPs (Pilot Project)



Topic	Details	References
Diabetes referral and resource tool for practice nurses	<ul style="list-style-type: none"> • Tool: Screening and assessment of urgency for diabetes patients 	www.ihi.org
Diabetes intake screening tool	<ul style="list-style-type: none"> • Tool: Risk screening for diabetes patients 	See Appendix 1 Latrobe CHS (Pilot Project)
Gap analysis tool	<ul style="list-style-type: none"> • Tool: Assessment of current organisational performance on chronic disease management 	See Appendix 6 BHCiG (Pilot Project)
Assessment of Chronic Illness Care (ACIC)	<ul style="list-style-type: none"> • Tool: Assessment of current organisational performance on chronic disease management 	See Appendix 7 MacColl Institute for Healthcare Innovation (www.improvingchroniccare.org)
Partnerships Building and Analysis	<ul style="list-style-type: none"> • Tool: VicHealth has developed this analysis tool for partners in health promotion 	See Appendix 13



How we will improve our delivery systems design?					
Action Area	What do we aim to do?	How will we do it? (strategies)	Who will do it?	When will we start?	When will we finish?

Table adapted from the Healthy for Life Toolkit (OATSIH)



Element 5: Clinical Information System



Element 5 Clinical Information System (CIS)

5.1 Introduction¹¹

Organise patient and population data to facilitate and monitor efficient and effective care

The clinical information system is an integral part of ensuring all the other elements are linked and coordinated. Practitioners need timely and relevant access to clinical data and population health data. This may include key outcome measures, patient history, reminders, how often they have been seen, and attendance at self-management groups.

Aims

- To develop a registry that will capture data that can be used for planning for population health and for individual care plans.
- To identify relevant sub populations for proactive care.
- To monitor performance of practice teams and care system.
- To collect data collection tools to ensure standardisation of data.

Agency responsibilities

Each agency or organisation should ensure:

- Service providers have access to the Medical Director software (or similar).
- Organisations and health service providers have computers accessible for staff.
- Staff are trained in the use of Medical Director or other software program.
- Population data that is to be included in the data collection is communicated to the clinic.
- Data definitions to ensure standardisation across the region.

Suggestion

Experience during the pilot phase found that it is more effective if a designated person from the clinic takes on the responsibility of entering the retrospective data.

¹¹ The materials in this chapter have been adapted from the Institute for Healthcare Improvement website (www.IHI.org) and the MacColl Institute for Healthcare Innovation website (www.improvingchroniccare.org)



5.2 Essential Process Steps

Step 1: Establish a registry

Step 2: Develop processes for use of the registry, including designating personnel to enter and maintain data

Step 3: Use the registry to generate reminders and care planning tools for individual patients

Step 4: Use the registry to provide feedback to healthcare providers and clinic team

Step 1: Establish a registry

Process Steps		Key Action Points	✓ Checklist
1.1	Develop a registry	<ul style="list-style-type: none"> • Delegate responsibility of entering retrospective data to a member of the healthcare team • Arrange training for the nominated team member in the specified software • Plan for the nominated team member to teach all other team members how to use the clinical information system. 	<ul style="list-style-type: none"> <input type="checkbox"/> All clinic staff are informed and aware of who the nominated data person is <input type="checkbox"/> Training is provided to the nominated data person <input type="checkbox"/> A 'Train the Trainer' session is included in the clinic's education planner
1.2	Identify the data that will be entered	<ul style="list-style-type: none"> • Agree on a data set after consultation with the healthcare team • Identify any national data sets on chronic disease that should be included • Identify any population data sets that will be included • Consider data to be included in reports (e.g. quality improvement projects, patient/carer feedback, and financial management) • Plan for all information to be electronic and keep manual data to a minimum • Include patients that are 'active' and 'inactive.' 	<ul style="list-style-type: none"> <input type="checkbox"/> A data set is available that includes: <ul style="list-style-type: none"> -Clinical patient data sets -National chronic disease data sets -Population data <input type="checkbox"/> Data is used to produce standard reports: <ul style="list-style-type: none"> -Quality improvement projects -Patient/carer feedback -Budget reports <input type="checkbox"/> Manual data is minimal <input type="checkbox"/> Patients are identified as 'active' and 'inactive'



Step 1: Establish a registry, Cont.

Process Steps		Key Action Points	✓ Checklist
1.3	Identify data definitions	<ul style="list-style-type: none"> • Develop key definitions and clinical indicators to facilitate benchmarking • Ensure that measurable outcomes are defined • Ensure that additional data fields can be added at a later date 	<ul style="list-style-type: none"> <input type="checkbox"/> Key definitions are documented <input type="checkbox"/> Clinical indicators are established and are benchmarked against other service providers <input type="checkbox"/> Outcome criteria are established
1.4	Develop a policy on data definitions	<ul style="list-style-type: none"> • Ensure that data definitions are documented in a policy to enable new staff members to familiarise themselves with them • Include the key measurement criteria 	<ul style="list-style-type: none"> <input type="checkbox"/> Policy is documented that clearly states the definitions and outcome measures
1.5	Pilot the registry	<ul style="list-style-type: none"> • Provide training to all staff in using the registry • Conduct a pilot over a designated period • Evaluate the pilot and modify as necessary 	<ul style="list-style-type: none"> <input type="checkbox"/> Team registry training is part of the clinic education planner <input type="checkbox"/> Pilot has been conducted and evaluated <input type="checkbox"/> Evidence of modification/changes is available

Suggestion

Remember a registry is a repository of information - not an electronic medical record



Step 2: Develop a process for use of the registry

Process Steps		Key Action Points	✓ Checklist
2.1	Identify data flows	<ul style="list-style-type: none"> • Ask the nominated data person to examine the current data flows • Present the data flows to the healthcare team • Eliminate any unnecessary steps in the flow • Present final data flow to the healthcare team for ratification 	<ul style="list-style-type: none"> <input type="checkbox"/> Existing data flows are mapped. <input type="checkbox"/> Final data flow approved by the healthcare team
2.2	Develop tools for collecting data	<ul style="list-style-type: none"> • Make sure a hard copy of the data to be collected is available for all staff to complete • Ensure that all data fields are included on this form 	<ul style="list-style-type: none"> <input type="checkbox"/> Policy is developed that clearly articulates the data to be collected
2.3	Develop a verification process	<ul style="list-style-type: none"> • Develop an audit to periodically check the integrity of the data collected 	<ul style="list-style-type: none"> <input type="checkbox"/> Audit tool is developed and is part of the policy <input type="checkbox"/> Three monthly audits are undertaken and documented
2.4	Develop a standard process for the entering of data	<ul style="list-style-type: none"> • Create a standard process that facilitates collection of data at point of entry without manual records as an interim step • Ensure that policy clearly articulates the standard process 	<ul style="list-style-type: none"> <input type="checkbox"/> Standard process is developed and is part of the data policy
2.5	Schedule and produce reports	<ul style="list-style-type: none"> • Identify required reports for specific personnel, i.e. clinic staff, board, executive management 	<ul style="list-style-type: none"> <input type="checkbox"/> Template of all reports that are required is documented
2.6	Ensure system integrity	<ul style="list-style-type: none"> • Determine levels of access (read only, full, partial) • Ensure that terminals in public places do not violate patient confidentiality • Develop a process and policy for back up 	<ul style="list-style-type: none"> <input type="checkbox"/> Security systems are developed and documented <input type="checkbox"/> Terminals are situated in places that protect patient confidentiality <input type="checkbox"/> Policy is written for data back up
2.7	Develop training for staff	<ul style="list-style-type: none"> • Provide training for all staff in the software system • Ensure that all staff are aware of the back up and security procedures required to maintain patient confidentiality • Include all aspects of the above in an orientation manual for new staff 	<ul style="list-style-type: none"> <input type="checkbox"/> Staff are credentialed in the software system, back up and security measures <input type="checkbox"/> Data policy is part of the orientation manual for staff

Suggestion

The registry can act as a flag for services due, provide up to date care plans and produce performance data for both the team and the provider. This means that all practitioners have current information on which to base clinical decisions or to allow patients to make decisions about managing their own condition.



Step 3: Use the registry to generate reminders and to develop care planning tools

Process Steps		Key Action Points	✓ Checklist
3.1	Identify patient record at time of visit	<ul style="list-style-type: none"> • Ensure that at the time of visit, the patient record is ready and outlines information required at that visit • Use these lists as a reminder for patients and send letters or make reminder telephone calls 	<ul style="list-style-type: none"> <input type="checkbox"/> All patient records are available at the time of the patient's appointment <input type="checkbox"/> A record of patients who have missed or have an overdue visit is documented
3.2	Identify patients that are overdue	<ul style="list-style-type: none"> • Develop a 'flag' system' for patients that are overdue or missing a visit • Produce a summary sheet of patients that are overdue or missing and record those that have been sent reminder notices/telephone calls 	<ul style="list-style-type: none"> <input type="checkbox"/> A policy is written for a 'flag' system <input type="checkbox"/> A summary sheet is filed of all overdue and patients who have missed a visit and includes the follow up action
3.3	Identify a high risk registry	<ul style="list-style-type: none"> • Create a high risk register • Develop a written protocol for follow up of high risk patients 	<ul style="list-style-type: none"> <input type="checkbox"/> High risk register is up to date <input type="checkbox"/> Protocol is documented <input type="checkbox"/> All high risk patients are followed up and documented in the registry
3.4	Develop a process for 'Did Not Arrive' (DNA)	<ul style="list-style-type: none"> • Identify a process to manage patients that did not arrive for a planned appointment • Develop a routine whereby the clinical team can review those patients who did not arrive 	<ul style="list-style-type: none"> <input type="checkbox"/> DNA and follow up procedures are documented

Suggestion

Investment of time and effort in developing the registry will, in the long term, streamline service delivery. Analysis of the data can help to eradicate any unnecessary work and assist in the development of the most efficient data management system.



Step 4: Use the Registry to provide feedback to clinical team and leaders

Process Steps		Key Action Points	✓ Checklist
4.1	Identify what elements in the system require daily discussion	<ul style="list-style-type: none"> • Discuss with the healthcare team what is important for daily reporting 	<input type="checkbox"/> Feedback is documented with data and any action undertaken
4.2	Identify elements that provide information for formal reports	<ul style="list-style-type: none"> • Discuss with the healthcare team what should form the foundation of any formal reports, including trend analysis and evaluation to generate discussion • Develop a format for reporting • Identify who should receive report and how frequently 	<input type="checkbox"/> Format is developed <input type="checkbox"/> Who receives reports and how often is documented <input type="checkbox"/> Reports are included as part of the regular communication meetings within the clinic

Suggestion

It is vital that management supports the person entering and being responsible for the data integrity by allocating dedicated time for this task



5.3 Practical application

Better Healthcare in Gippsland case study: Clinical Information Systems – Data Cleansing

Background

As part of the Better Healthcare in Gippsland, a number of pilot projects relating to clinical information systems were implemented in GP practices, including the development of a diabetes register, appropriate coding and tracking systems, and a recall system.



This case study details the approach to data cleansing in order to:

- Establish an accurate register of all patients with diabetes attending for regular follow up
- Develop and implement a system for coding aspects of diabetes management

Process

The development process for the diabetes register using *Medical Director* involved the following steps:

1. Print out of existing diabetes register
2. Cross referencing the register with HbA1c results for previous two years
3. Manually updating the patient records (adding diabetes to past history diagnosis if required)
4. Removing those deceased and those deemed *inactive (patients not seen by GP practice for any reason for greater than 12 months) on both PracSoft and Medical Director databases
5. Development and agreement of a coding system by practice staff and GPs
6. Manually updating record to reflect coding system

The following coding system for diabetes diagnosis was proposed and agreed to by all GPs within the practice:

1. Diabetes Mellitus – type 1
2. Diabetes Mellitus – type 2
3. Gestational Diabetes
4. Impaired Glucose Tolerance
5. Impaired Fasting Glucose

To assist with claiming, Medicare Item numbers and the timing of such the following codes have been developed. These are also recorded in the past history and are marked not active and not for summary.

1. Completion of annual cycle of care – Diabetes Assessment
1. Development of Care Plan (GPMP/TCA) – Care Plan preparation 720
1. Review of above – Care Plan review 724

The latest HbA1c, Lipid, height, weight, blood pressure and creatinine results were transcribed into the diabetes assessment record in *Medical Director*. The purpose of this was to facilitate the use of the National Primary Care Collaboratives (NPCC) data extraction tool. This tool will enable tracking of diabetes & cardiovascular disease management, using best practice clinical indicators along with access to GPs. The tool will then provide access to patient management data for each provider and for the practice as a whole for use as a benchmarking tool.



Results

Initially (20/10/2005) there were 418 patients registered as having diabetes. After completing steps 1 & 2 of the process to develop a diabetes register 420 were identified. At the conclusion of the entire data cleansing process (29/3/2006), the number of patients on the diabetes register was 383. The table below represents a baseline data collection as at 29/3/2006 looking at diabetes management as coded in the history and seen by any doctor between the 1/1/2005 and 1/1/2006.

Indicator	No. of patients recorded (29/3/2006) (n=383)
Patients with diabetes mellitus – type 2	342
Patients with diabetes mellitus – type 1	21
Patients with Gestational diabetes	19
Patients with impaired glucose tolerance	76
Patients with impaired fasting glucose	68
Patients having a completed annual cycle of care (coded as diabetes assessment)	195
Patients with diabetes mellitus & a care plan completed	270
Patients with diabetes mellitus & a care plan review completed	77

The table below lists the clinical indicators based on the Commonwealth Department of Health and Ageing criteria[^] for the management of diabetes (annual cycle of care). Unlike the NPCC, it does not demonstrate the proportion of patients that reach the evidence based best-practice guidelines; it only shows the proportion of clinical indicators measured.

Item	Criteria [^]	% meet criteria pre data cleansing	% meet criteria post data cleansing
HbA1c	12 monthly	5.3	59.5
Eye exam	2 years	1.9	2.9
Height	6 months	55.2	59.5
Weight	6 months	71.7	76.5
Smoker	NIL	6.3	9.6
BP	6 months	90.1	95.5
Foot exam	6 months	2.6	4.8
Cholesterol	12 months	4.6	50.7
Triglycerides	12 months	4.6	50.7
HDL	12 months	4.6	50.7
Microalbumin	12 months	2.9	3.7



A snapshot audit of patients (n = 21) with diabetes was undertaken. To ensure validity of the audit, Ön + 1 was used to determine the sample size. The audit looked at documentation recorded in the patient record and married claimable items with the *PracSoft* claims.

Key Findings

Key findings of the audit were:

- 12/21 (57%) patients had care plans documented and claimed.
- 7/21 (33%) had annual cycle of care 'completed' and claimed. Several of these were incomplete. Two were completed and documented but not claimed.
- 6/21 (29%) patients didn't have a care plan created.
- 4/21 (19%) had progress notes that indicated care plan completed but there was no documentation found. Three of these were claimed through Medicare.
- 2/21 patients were visiting from other areas. These patients remain on the register as they have visited in the practice in the past 12 months. There are no LMO details or correspondence between the two practices noted.
- Evidence of annual cycle of care components difficult to locate in progress notes.
- Limited documentation from allied health providers. 4 reports from optometrists found. No feedback from diabetes educator or dietitian recorded – even when patient has a TCA. Documentation of self-management was located.

Challenges

Limitations of the data cleansing process included:

- Business structure of GP practices that doesn't provide for a practice-wide approach.
- Limitations of the Medical Director software package to self populate data for easier data manipulation.
- Due to time constraints, the Medical Director notes were not always cross referenced with PracSoft to determine if and when Medicare claims were or were not submitted and if any were rejected.
- The lack of feedback identified during the data cleansing process may relate in part to the loss of scanned information due to a computer problem.
- It was a difficult and lengthy process due the variation in reporting, documentation and inconsistent use of *Medical Director*.

Overall findings/trends included

- Statistics generated highlight the importance of complete documentation and accurate data collection.
- Annual cycle of care is the criterion most often missed or incomplete.
- There are cases of completed care plans and annual cycles that are not claimed, resulting in missed income for the practice.
- Inconsistent documentation of annual cycle of care being claimed, creating potential rejection of claims.
- Evidence of poor communication and follow-up systems between medical and allied health providers.
- Pathology required as part of the annual cycle of care often not evident, particularly lipids and microalbumin.
- Recall system is slowly being implemented, initiated in the first instance by the care coordinator.

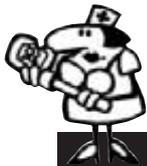


Sustainability

The process of establishing an accurate register and standardised coding system for the management of diabetes is very time and resources demanding. Key personnel involved in this project took steps to ensure that stakeholders were engaged in the process and had agreed to make the necessary changes. This strategy was used as a method to promote a sustainable new system and to embed the changed practices.

Summary

The outcomes above highlighted to the GPs that the management of diabetes was not meeting the best practice goals. It became evident to the practitioners that a level of consistency regarding the management of data was beneficial to the practice as a whole as it helped ensure 100% claims for services. It also helps to ensure that patient care meets best practice target. The practice has agreed to use the National Primary Care Collaborative data extraction tool to increase their capacity to monitor patient outcomes.



5.4 Tools and resources: Clinical Information Systems

Topic	Details	References
Creating a patient register	<ul style="list-style-type: none"> This presentation outlines how to use <i>Medical Director</i> to develop a patient registry. It provides a step-by-step outline complete with “screen dumps” and lots of cartoons. Developed by Dr Don Angus 	www.npcc.com.au click on “events” then “Wave 1” then “Learning Workshop 1” then “How to build and maintain a CHD register “
Case Study: Developing a Diabetes Register	<ul style="list-style-type: none"> A case study of a rural GP practice that tried to develop a simple approach to setting up a diabetes register 	www.npcc.com.au click on “events” then “Wave 3” then “Learning Workshop 1” then “Developing your Diabetes Register”
Using Computerised Registries for CCM	<ul style="list-style-type: none"> An overview of functions of computerised disease registries and issues to consider. Includes information to assist practitioners to conduct assessments of available tools. Developed in the USA 	www.chcf.org/topics/chronicdisease/index Search for Item ID 21718 or “Using computerised registries in chronic disease care”



How we will improve our clinical information system?					
Action Area	What do we aim to do?	How will we do it? (strategies)	Who will do it?	When will we start?	When will we finish?

Table adapted from the Healthy for Life Toolkit (OATSIH)



Element 6: Community resource mobilisation



Element 6 Community resource mobilisation

6.1 Introduction¹²

Mobilise community resources to meet needs of patients

The chronic care model relies on the community playing a pivotal role in supporting chronically ill patients. This element is focussed on considering how the community can support and/or enhance the care support systems.

Aims

- To encourage patients to participate in effective community programs by providing them with information on the support services available.
- To form partnerships with community organisations to support and develop interventions that fill gaps in needed services.
- To advocate for policies to improve patient care.
- To involve external agencies, for example the Emergency Department or local universities, to provide clinical and demographic data to help inform quality improvement.
- To keep the general community aware of the management of chronic disease by attending community events.

Agency Responsibilities

- Be supportive and proactive in securing support from community organisations.
- Seek opportunities for support from other organisations.
- Develop collaborative relationships with community representatives.
- Provide funding for the interpreter service.
- Provide information on grants that are available.

¹² The materials in this chapter have been adapted from the Institute for Healthcare Improvement website (www.IHI.org) and the MacColl Institute for Healthcare Innovation website (www.improvingchroniccare.org)



6.2 Essential Process Steps

Step 1: Establish linkages with organisations to develop support programs and policies

Step 2: Link to community to assist with costs of medication, education resources and materials

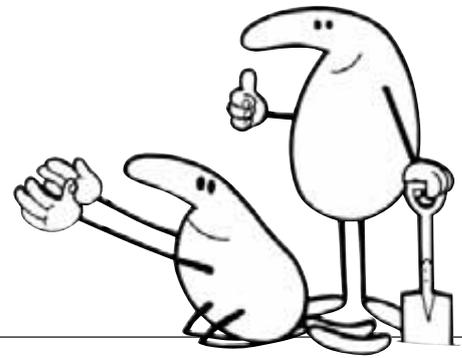
Step 3: Encourage participation in community education classes and support groups

Step 4: Raise community awareness through networking, outreach and education

Step 5: Provide a list of community resources to patients, families and staff

Step 1: Establish links with communities to develop support programs and policies

Process Steps		Key Action Points	✓ Checklist
1.1	Identify opportunities for receiving and providing community support	<ul style="list-style-type: none"> • Discuss with the healthcare team what their needs are in relation to support from community organisations • Identify community organisations that could provide support in the community • Identify community organisations that you could assist in running programs of their own • Identify organisations that match areas of need 	<input type="checkbox"/> Community organisation involvement is part of the standing agenda item for the clinic
1.2	Identify key community organisations	<ul style="list-style-type: none"> • Invite the community organisations to discuss how you can work together to support care for the chronically ill • Develop Memorandum of Understanding (MOU) • Prepare a brief presentation outlining what the goals of the chronic care model are and the benefits to the community • Ask the community organisations to be part of advisory groups for specific diseases and offer to have staff involved in helping to promote their initiatives 	<input type="checkbox"/> MOU is developed and signed by both parties <input type="checkbox"/> Brief is prepared and goals are clearly stated <input type="checkbox"/> Community groups are part of the membership of advisory committees
1.3	Identify key interest groups	<ul style="list-style-type: none"> • Develop Memorandum of Understanding (MOU) • Prepare a brief presentation outlining the goals of the chronic care model and benefits to the community • Develop a partnership with these groups and request involvement in strategic initiatives • Discuss opportunities for data sharing 	<input type="checkbox"/> MOU is developed and signed by both parties <input type="checkbox"/> Team member from the clinic is part of the membership of key state and national interest groups, or, the clinic is part of the circulation group to receive minutes from relevant committees <input type="checkbox"/> Partnerships with key groups are established and clearly documented



Step 1: Establish links with communities to develop support programs and policies, Cont.

Process Steps		Key Action Points	✓ Checklist
1.4	Establish connections with the local Emergency Department	<ul style="list-style-type: none"> • Provide a brief presentation to the ED staff on the chronic care model • Presentation to ED is part of the education planner • Request automatic information if a patient with a chronic disease has an ED attendance or admission 	<ul style="list-style-type: none"> <input type="checkbox"/> Dates for presentations are clearly stated on the annual education planner <input type="checkbox"/> Automatic patient information flow is established and information is kept as part of the clinical information system
1.5	Involve local education providers	<ul style="list-style-type: none"> • Develop contacts with the local educational facilities at the primary, secondary and tertiary level • Seek opportunities to work with local University campuses, rural clinical schools etc to conduct research or to assist with pilot programs • Consider school-based programs (see Section 6.3) to manage chronic disease in children 	<ul style="list-style-type: none"> <input type="checkbox"/> Contacts are established and details kept in the clinical information system <input type="checkbox"/> In-service from the local educational facilities is part of the annual education planner
1.6	Identify a member of the clinic to serve on community boards	<ul style="list-style-type: none"> • An interested member of the healthcare team is given time to serve on a community board • The identified member of the healthcare team is the contact person for this group 	<ul style="list-style-type: none"> <input type="checkbox"/> Participation by the clinic on community boards is evident by clinic minutes and is posted in the clinic on the notice board
1.7	Form partnerships with the local pharmacies	<ul style="list-style-type: none"> • Meet with the local pharmacists and provide information on what the clinics trying to achieve • Request that any patients requiring frequent chronic disease medication are referred to the clinic for follow up 	<ul style="list-style-type: none"> <input type="checkbox"/> Information from the pharmacist is part of the patient registry <input type="checkbox"/> All patients notified to the clinic from the pharmacy are followed up and noted in the patient registry

Suggestion
Community linkages were found to be very beneficial as service providers learned more about community organisations and synergies were possible. It was also found that this collaboration enhanced the service delivery for service providers.

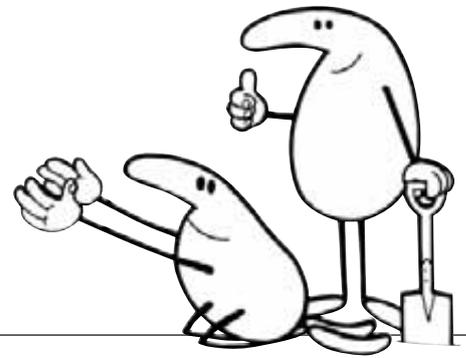


Step 2: Link to community to assist with medical costs, education and materials

Process Steps		Key Action Points	✓ Checklist
2.1	Identify opportunities for funding support	<ul style="list-style-type: none"> • Work with the Division of General Practice and others to identify opportunities for sponsorship from commercial sponsors. Develop relationships with pharmaceutical companies to get free samples • Discuss with the healthcare team how “in kind” support can be used 	<ul style="list-style-type: none"> <input type="checkbox"/> Sponsors are part of the Education Planner for both staff and self-management groups <input type="checkbox"/> Criteria are developed to allocate “in kind” sponsorship
2.2	Identify education providers	<ul style="list-style-type: none"> • Identify local educational institutions to provide in-service to the self-management support groups • Negotiate for ‘in kind’ services. 	<ul style="list-style-type: none"> <input type="checkbox"/> Education costs are minimised and within budget allocation
2.3	Involve pharmacies in supporting patients on medication	<ul style="list-style-type: none"> • Discuss with pharmacies what programs are available and ensure that the healthcare team and patients are aware 	<ul style="list-style-type: none"> <input type="checkbox"/> Programs are advertised within the clinic <input type="checkbox"/> Criteria for access for programs are posted within the clinic
2.4	Identify any government grants	<ul style="list-style-type: none"> • Discuss with the state and national groups what grants may be available for specific chronic diseases 	<ul style="list-style-type: none"> <input type="checkbox"/> Applications for any government grants are copied and available

Suggestion

Participants in the Gippsland pilot project found that by involving organisations like the emergency department at the nearby hospital and local pharmacies, fragmentation of services was reduced.



Step 3: Encourage participation in education classes, events and support groups organised by community or corporate organisations

Process Steps		Key Action Points	✓ Checklist
3.1	Identify community organisations to provide education classes	<ul style="list-style-type: none"> • Check the content of the class to ensure it is appropriate and matches your organisation's goals • Ensure that the nominated clinic representative organises the education to be provided 	<input type="checkbox"/> Evaluation supports that the course content is appropriate
3.2	Consider conducting lay-led self-management management	<ul style="list-style-type: none"> • Consider training community members with a chronic disease in conducting courses similar to the Chronic Disease Self-management program (see section 6.3) 	<input type="checkbox"/> A lay-led training program has been considered and implemented where possible
3.3	Keep patients and community members informed of programs offered	<ul style="list-style-type: none"> • Notify patients of programs organised by community or corporate organisations (e.g information sessions, community fun runs, support groups) by using the patient registry • Develop a template for educational flyers • Notify the patient/carer preferred method, i.e. fax, email, SMS 	<input type="checkbox"/> The registry includes when patients have been invited and attended any education session <input type="checkbox"/> Template is developed and documented
3.4	Develop an evaluation form for education sessions	<ul style="list-style-type: none"> • Implement evaluation system for each education session • Review the evaluations and present results to the healthcare team members 	<input type="checkbox"/> Evaluations are fully reported <input type="checkbox"/> Evaluation report is documented as part of the clinic's agenda.



Step 4: Raise community awareness through networking, outreach and education

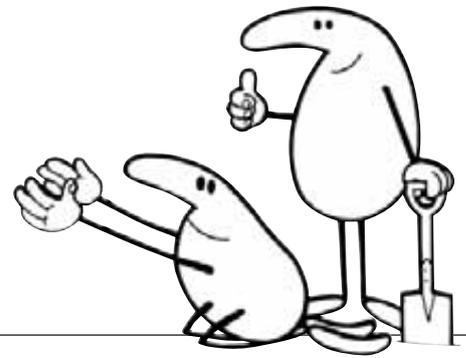
Process Steps		Key Action Points	✓ Checklist
4.1	External promotion for management of chronic disease	<ul style="list-style-type: none"> • Identify any local events which the organisation can use as a promotional venue • Develop partnerships with local groups to ensure that they notify the organisation of any upcoming events • Provide information to churches, charity organisations, etc. about what the clinic is aiming to achieve • Develop strong relationships with local schools to provide awareness and education to students on chronic diseases affecting young people 	<ul style="list-style-type: none"> <input type="checkbox"/> Documented evidence of attendance at local events <input type="checkbox"/> Evidence of all types of communication from and with charity groups <input type="checkbox"/> School education sessions are part of the annual planner
4.2	Recruit volunteers from the community	<ul style="list-style-type: none"> • Identify where the community could assist in supporting the program, for example, transport of patients to education sessions • Identify patients who could provide testimonials at local events, support groups, etc. 	<ul style="list-style-type: none"> <input type="checkbox"/> Patients are part of providing education

Suggestion

A team member should be nominated to be responsible for marketing programs externally.

Step 5: Provide a list of community services to patients, families and staff

Process Steps		Key Action Points	✓ Checklist
5.1	Create a list or website of existing services	<ul style="list-style-type: none"> • Ensure that all community services listed are still available • Provide all patients and families with a list of available services • Ensure that all staff are aware of what services are available • Ensure that all community services being promoted are in line with organisational goals 	<ul style="list-style-type: none"> <input type="checkbox"/> List of available services are documented
5.2	Develop a mechanism to keep community service information up to date	<ul style="list-style-type: none"> • Nominate a team member to be responsible for ensuring the information is current • Utilise the library, phone directory to provide information 	<ul style="list-style-type: none"> <input type="checkbox"/> All information on community services is up to date



6.3 Practical application



The World Health Organisation (WHO) suggests there are three steps in community resource mobilisation

Step 1 Core: Networks of community members and organisations, health professionals and policy-makers are established for information sharing, consultation, and collaboration.

Step 2 Expanded: Community-based programs for chronic disease prevention are formed, and then implemented and evaluated. School health programs for chronic disease prevention are systematically implemented.

Step 3 Desirable: Communities assume responsibility for ongoing implementation and monitoring of chronic disease prevention programs. Employers implement chronic disease prevention and self-management activities in the workplace.

Some international examples of using schools to promote healthy diets and physical activity

- Large-scale school-based projects are being implemented in developing countries to reduce obesity, improve nutrition and increase physical activity.
- Brazil has recently required that 70% of the food offered through its national school meals program should be minimally processed. Chile has included more fruits and vegetables in the national school meals program.
- The Ministries of Health and Education in China have been fostering the health-promoting school concept
- Malaysia, Mexico, the Republic of Korea, South Africa and Thailand have initiated similar programs.
- In the Republic of Korea, a healthy traditional diet was preserved through the joint efforts of dietitians and the government

The most promising programs use culturally appropriate methods and messages.

World Health Organisation: http://www.who.int/chp/chronic_disease_report



“Expert patients” are those with experience of self-management of long-term conditions and the program centres on developing a model of peer support for patients with similar conditions. The EPP team has built on work at Stanford University in the USA where patients and their carers provide peer advice and support – an initiative termed “lay-led self-management”.

The EPP team developed a six-week course facilitated by trained lay people based on the Stanford “Chronic Disease Self-management Course” (CDSMC). This course was incorporated in a pilot study which ended in 2004 and in which the NHS collaborated with accredited voluntary organisations. A total of 98 per cent of Primary Care Centres in the UK took part.

Findings – Evaluation by questionnaire confirms data from other countries showing improvement in patients’ conditions and a decrease in their use of health services. Access to the EPP program is to be widened and will be available throughout the NHS by 2008.

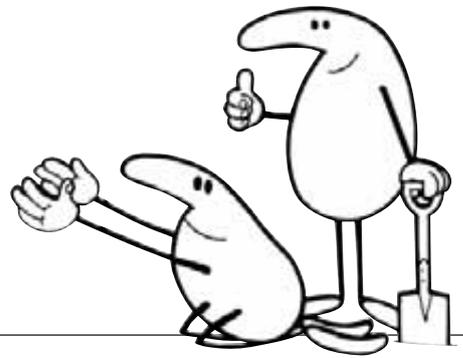
Further information www.emeraldinsight.com

A typical Chronic Disease Self-management would include the following:

- 7 x 2.5 hour sessions
- 2 leaders (usually at least one is a community member who is suffering from chronic disease)
- About 10 participants

The program is based on self-efficacy theory and emphasizes problem solving, decision making, and confidence. Topics covered are presented in a highly structured manual and include:

- Overview of self-management and chronic health conditions
- Making an action plan
- Relaxation/cognitive symptom management
- Feedback/problem solving
- Anger/fear/frustration
- Fitness/exercise
- Fatigue management
- Healthy eating
- Advance directives
- Communication
- Medications
- Making treatment decisions
- Depression
- Informing the healthcare team
- Working with healthcare professionals



Asthma Friendly® Schools

The Asthma Friendly Schools Program is a national initiative aimed at improving quality of life, health outcomes and well being for school children with asthma.

85% of schools across Victoria are currently involved in the Program with 58% of these being recognised as Asthma Friendly. All Victorian schools, both primary and secondary, can become Asthma Friendly.

To be recognised as Asthma Friendly, schools must address and fulfil eight criteria.

- Asthma education is provided for all school staff
- Action Plans / Student Asthma Records for each student with asthma are actively encouraged and kept in a central location
- Asthma First Aid posters are on display
- Students with asthma are encouraged to have their medications readily available and safely stored at all times
- A blue reliever puffer and spacer device(s) are available for emergency use
- A plan is in place for managing asthma during school sporting activities, excursions and camps
- Asthma related information is provided through the school to parents/carers that contributes to the quality of life, health outcomes and well being for their children
- Asthma Friendly Schools Program teaching resources are used as part of the school's health curriculum

www.asthma.org.au or for more information email schools@asthma.org.au



6.4 Tools and resources: Community Resource Mobilisation

Topic	Details	References
<p>Working with the community to address health inequities</p>	<p>Consider a campaign similar to the <i>Take a Loved One for a Checkup Day</i>, a national campaign conducted in the US</p>	<p>The toolkit for the campaign is available at: http://www.omhrc.gov/healthgap/toolkit2006.aspx#kit or via www.qualitytools.ahrq.gov</p>
<p>Patient, Carer and Community Participation</p>	<p>Case Studies: Victorian examples from PCPs showing the benefits of involving patients and community</p>	<p>Appendix 4: DHS: 2002 Consumer, Carer and Community Participation: <i>A Supplementary Report on Primary Care Partnership</i></p>
<p>Community or lay-led self-management support programs</p>	<p>The article <i>Effect of a Self-management Program on Patients with Chronic Disease</i> summarises the outcomes of a “real life” study on the impact of a Chronic Disease Self-management Program. The study was conducted by Kate Lorig et al and provides an evidence base for using lay-led programs as an example of good use of community resources</p>	<p>http://www.acponline.org/journals/ecp/novdec01/lorig.htm</p>
<p>Lay-led self-management programs to support arthritis sufferers</p>	<p>These articles provide an evaluation of lay-led self-management courses for arthritis in the UK</p>	<p>www.expertpatients.nhs.uk click on “publications” then scroll to articles “Looking after me” and “Taking Control”</p>
<p>A lay-led program outline</p>	<p>This resource explains the basic steps to establishing a lay-led program</p>	<p>http://www.expertpatients.nhs.uk/ then click on “Stepping Stones to Success”</p>
<p>Community participation guidelines</p>	<p>This policy document outlines the rationale for community and patient participation and provides simple guidelines on how to work with your community</p>	<p>www.health.vic.gov.au/consumer then search for “Doing it with us not for us”.</p>



How we will improve our community resource mobilisation?					
Action Area	What do we aim to do?	How will we do it? (strategies)	Who will do it?	When will we start?	When will we finish?

Table adapted from the *Healthy for Life Toolkit (OATSIH)*



1. References and resources

Topic	Description	References
General resources about chronic disease management	A useful portal for information about a range of NHS initiatives	www.doh.gov.uk
	A rich source of information about management of chronic disease, including descriptions of MacColl model	http://www.improvingchroniccare.org
	A wealth of information and resources for the improvement of chronic disease management	www.ihl.org
	The World Health Organisation provides a range of useful examples of chronic disease management and related issues. While most examples are international, there are Australian sections	http://www.who.int/en/
	A literature review of models and interventions for chronic disease in primary care settings in Victoria	http://www.health.vic.gov.au/pcps/publications/chronic.htm
	Links to various sources of information about various chronic disease management strategies	http://patienteducation.stanford.edu/research/
Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services	CDM guidelines from the Department of Human Services, Victoria. Appendix 4 includes links to information, tools and resources to support implementation	http://www.health.vic.gov.au/communityhealth/publications/
Regional Service Coordination Practice and Protocol Manual	A manual describing practices, processes, protocols and systems for the Gippsland Health Services Partnership with a view to facilitating service coordination	Available from PCP offices in the Gippsland region
Practical implementation of a chronic care model	This program developed by the Department of Health and Ageing is designed to assist in the implementation of chronic disease management in indigenous communities	www.health.gov.au then search "OATSIH programs" then go to "Healthy for Life" and you will find a link to the Healthy for Life website embedded in the text.



Topic	Description	References
Overview of the Flinders Model	A good summary of the CCM developed by Flinders University	http://som.flinders.edu.au/FUSA/CCTU/ click on “what is self-management”
National Quality Measures Clearinghouse	A range of tools and resources to assist in developing clinical guidelines developed by US government agencies	http://www.ahrq.gov/
National Primary Care Collaboratives	A very useful website that reports on the learnings from various primary care collaboratives around Australia that have focussed on approaches to chronic disease management	www.npcc.com.au click on “events” for a range of practical presentations on implementing chronic care models



2. Appendices: Index of additional tools and resources

Appendix Number	Title	Description	Source	Cross reference to element
1	Diabetes screening intake procedure	Tool: for screening during intake	Latrobe CHS (Pilot Project)	Delivery System Design
2	Diabetes nurse educator (DNE) referral outcome	Tool: Referral outcome for referral from DNE to GP	Central West Gippsland Division of GP (Pilot Project)	Delivery System Design
3	Diabetes referral and resource tool for practice nurses	Tool: Screening and assessment of urgency for diabetes patients	BHIG (Pilot Project)	Delivery System Design
4	Patient, Carer and Community Participation	Case Studies: Victorian examples from PCPS showing the benefits of involving patients and community	DHS: 2002 <i>Consumer, Carer and Community Participation: A Supplementary Report on Primary Care Partnership</i>	Community/ Self-management
5	Diabetes referral outcome sheets	Tools: assessment outcomes for dietitian, optometrist, podiatrist, DNE)	BHCiG (Pilot Project)	Delivery System Design
6	Gap analysis tool	Tool: Assessment of current organisational performance on CCM management	BHCiG (Pilot Project)	Delivery System Design
7	Assessment of Chronic Illness Care (ACIC)	Tool: Assessment of current organisational performance on CCM management	MacColl Institute for Healthcare Innovation (www.improvingchroniccare.org)	Delivery System Design
8	Guidelines for treatment of chronic conditions	Reference List: Range of generic clinical protocols and guidelines that can be downloaded from the web	Compilation of references to clinical guidelines	Decision Support



Appendix Number	Title	Description	Source	Cross reference to element
9	An introduction to quality improvement	Slideshow: Practical introduction to PDSA principles	Healthy for Life Service Toolkit (OATSIH) www.health.gov.au then search "OATSIH programs" then go to "Healthy for Life" and you will find a link to the Healthy for Life website embedded in the text.	Organisation of Healthcare
10	The Improvement Model	Diagram: Outlines how PDSA principles might be applied to managing various aspects of managing chronic disease.	National Primary Care Collaboratives (www.npcc.com.au)	Organisation of Healthcare
11	Systems assessment tool	Tool: An Australian adaptation of the ACIC tool	Menzies School of Health Research www.menzies.edu.au	Organisation of Healthcare
12	Chronic Conditions Collaborative Overview	Table: Overview of key action steps in implementing the chronic care model	ICIC Collaborative (improvingchroniccare.org)	Getting Started
13	Partnerships Analysis Tool	Tool: VicHealth has developed this analysis tool for partners in health promotion.	VicHealth www.vichealth.vic.gov.au	Delivery System Design
14	10 Steps for coping with a chronic condition	Article: Help for patients who want to manage their own chronic disease	http://www.health.harvard.edu/heart	Self-management, Community



Appendix Number	Title	Description	Source	Cross reference to element
15	Patient-Held Record	A patient-held record was developed during the pilot projects, but had not been widely used by other practices at the time of printing. Further development work is in progress	Central West Gippsland Division of GP, and BHCiG (Pilot project)	Self-management
16	Chronic Disease Self-Efficacy Scales	Tool: Assessment of patients' management of their own health	Stanford Patient Education Research Centre http://patienteducation.stanford.edu/research/	Self-management
17	Information to assist patient decision making	Reference List: A range of resources that can be used to assist in providing information to patients	Compilation of references to information to assist in self-management	Decision Support, Self-management



3. Glossary of key terms and concepts

The following definitions of terms and concepts are not designed to be definitive or prescriptive. They have been compiled to assist service providers in using this resource kit.

Ambulatory care sensitive conditions (ACSCs)

Conditions for which hospitalisation is thought to be avoidable with the application of Public Health interventions and early disease management, usually delivered in ambulatory settings such as primary care.

Assessment of Chronic Illness Care (ACIC)

Evaluates the utilisation of elements of the chronic care model against current practice in an organisation. This can be used as part of the development of a gap analysis to assist with planning.

Better Access to Services (BATS)

The Better Access to Services framework (DHS) provides a foundation for common approaches across the State and supports agencies to work together so that, from the consumer's perspective, services appear integrated and are easier to access.

Better Healthcare in Gippsland (BHCiG)

A range of collaborative approaches to managing chronic disease used by service providers in the Gippsland region of Victoria.

Chronic disease

Chronic diseases are those that “..occur across the whole spectrum of illness, mental health problems and injuries. Chronic diseases tend to be complex conditions in how they are caused, are often long-lasting and persistent in their effects and can produce a range of complications” (AIHW 2002).

Evidenced-based practice

Evidence based practice can be defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about treatment and care. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Integrated Chronic Disease Management (ICDM)

A model or a system of care that addresses the fragmentation between the primary, secondary and tertiary health systems for improved outcomes and management of chronic disease.

MacColl Institute/model

The Institute was created in the US in 1992. Its goal is to develop, evaluate, and disseminate innovations in healthcare delivery. The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care.



National Primary Care Collaboratives (NPCC)

This Australian Government initiative focuses on illness prevention strategies. The aim of the programs is to spread and sustain agreed changes related to improving prevention, management, and underpinning clinical and business systems relating to diabetes, cardiovascular disease, and patient waiting times.

Clinical information system (CIS)

Clinical information systems consist of information technology that is applied at the point of clinical care. They include electronic medical records, clinical data repositories, decision support programs (such as clinical guidelines and drug interaction checking), handheld devices for collecting data and viewing reference material, imaging modalities and communication tools such as electronic messaging systems.

Motivational interviewing

Motivational interviewing is a directive, client-centred counselling style characterised by a style and approach that is essentially collaborative, respectful and guiding as opposed to confrontational, authoritative and instructional.

Person-centred care

The practice whereby the patient is empowered to direct their own care in collaboration and partnership with health professionals.

Primary Care Partnerships (PCP)

This Victorian State Government package of reforms aims to improve access to services, facilitate health promotion and reduce the preventable use of hospital, medical and residential services. Over 800 services have come together in 31 Primary Care Partnerships across all parts of Victoria.

Service Coordination Practices, processes, protocols and systems (PPPS)

The BHCiG Service Coordination PPPS Manual (2005) and the statewide Victorian Service Coordination Practice Manual, Good Practice Guide for Practitioners and Continuous Improvement Framework (2006).

1. Your training resources

This section is left blank for you to insert training materials at a later date.

You may wish to insert both training materials developed by the BHCiG CDM project in conjunction with this resource kit as well as those developed by your organisation.