

Banyule Nillumbik Primary Care Alliance

INTEGRATED CHRONIC DISEASE MANAGEMENT

BACKGROUND BREIFING PAPER

PREPARED FOR THE

STRATEGIC PARTNERSHIP GROUP

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PURPOSE OF BACKGROUND BRIEFING DOCUMENT

To assist the BNPCA Strategic Partnership Group (SPG) to make strategic decisions in relation to activities to be undertaken by the Integrated Chronic Disease Management (ICDM) Portfolio over the next 18 months.

The paper will be discussed at the October SPG meeting and focus key activities for the ICDM work for the next 6-12 months decided upon.

The process undertaken in preparing this discussion paper included:

- Review of the outcomes of the CDM project previously undertaken in the catchment and how the learnings can be built on
- Consultation with relevant agency representatives
- Review of the ICDM literature, particularly the Wagner Chronic Care Model, and specific evidence based interventions such as the Flinders Model, the Stanford Model, Self-Management 5As (Kaiser Permanente), Telephone Coaching and Motivational Interviewing for Behaviour Change.

Key learning from the “Take the Pressure Down” Project

In 2001 five Integrated Disease Management (IDM) pilot projects were funded for a period of three years, at three metropolitan and two rural PCP locations. The BNPCA “Take the Pressure Down” Hypertension IDM program was one of the five programs. IDM programs aimed to implement a comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease or condition, aiming to reduce the burden of disease through a holistic approach. They encompassed the continuum of care from prevention through to treatment, management and maintenance.

Summarised below are the key learnings of the “Take the Pressure Down” project and the other IDM projects as highlighted in the summary of key learnings report for the IDM projects¹.

Partnering stakeholders

¹ Willcox J, Gill M. *Improving Chronic Disease Care: Learnings from the Integrated Disease Management Projects*
Department of Human Services Victoria, 2004.

Partnering key stakeholders and creating partnerships across the service sector were identified as crucial to the implementation and success of IDM.

Most projects had limited success engaging with GPs. Key strategies identified as supporting GP engagement were:

- Programs delivered through a Division of General Practice or individual GP practices
- Providing coordinated and planned care to GPs in ready made form with clear benefits for GPs and links to reimbursement incentives and other initiatives
- Programs targeted towards a “priority” disease such as diabetes
- Building on local achievement and systems already in place with an emphasis on agency wide engagement
- Building feedback from health professionals to GPs into the service coordination models.

Coordinated Care

A cooperative approach to planning was identified as imperative to improving CDM. Projects identified that cooperative planning resulted in more clearly identified gaps in services, agencies working cooperatively on strategies to address the gaps including resource sharing, realignment of resources and collaboratively seeking other funding sources.

A greater commitment from management within organisations, clearer definition of roles and responsibilities of stakeholders, clear leadership and funding incentives were identified as the key factors needed to fully operationalise system change.

Consumer engagement/ participation

Projects reported a range of benefits from consumer participation, ranging from positive health and connectivity benefits for consumers to programs and services being more responsive to the needs of consumers.

Broadening entry points and recruitment into a program increased access for consumers, reduced selection bias and reduced the risk of reliance on one source for recruitment. Building on local referral patterns and professional relationships and utilising local champions and project staff with knowledge of the local area were seen as clear advantages to successful recruitment.

Self management

Barriers identified by the projects to implementing comprehensive self management were:

- Knowledge and misunderstanding of self management concepts by health care providers
- Skills of health care providers to support behavior change

- Access to services
- Implementation of care plans
- Health care providers lacking the skills and processes to promote self management programs.

Awareness raising, capacity building, incorporating the essential elements of self management interventions into program development and adopting a number of different approaches to meet the needs of consumers was important for promoting self management.

The learnings highlighted that change was needed on a number of different levels including policy, organisational, practitioner and consumer to improve coordination of care and imbed effective promotion of self management.

A full report of the BNPCA "Take the Pressure Down" Hypertension IDM program can be accessed at: <http://www.bnPCA.org.au/publications/items/2004/03/68385-upload-00001.pdf>

The report highlighting the overall learnings from the IDM projects can be accessed at: <http://www.health.vic.gov.au/communityhealth/publications/icdc.htm>

Consultations with key stakeholders

Consultations with key stakeholders were conducted to identify clinical, practical and service issues in relation to current chronic disease programs that could inform considerations for improving integration of chronic disease care across the catchment.

Organisations represented and individuals interviewed along with a full overview of the information gathered in the interviews are included in Appendix 1. Key areas explored in the interviews were:

- What Chronic Disease programs were being offered?
- Model of care used?
- Referral pathways
- Barriers to integrated chronic disease care across the region
- What would be the priorities for change to improve integration of chronic disease care in the region?

The key themes emerging from the interviews are summarised below.

Chronic Disease programs being offered and models and referral pathways

Programs being offered varied across setting. The HARP programs and both of the community health services are offering generic chronic disease management programs incorporating standardised assessments, care planning, and support for self management.

All organisations are offering disease specific programs incorporating assessment, care planning, and to a varying degree support for self management.

In general for most organisations there is consistency within chronic disease programs in the areas of assessment and care planning but consistent approaches to assessment and care planning across organisations was not evident.

A number of different models of care are being offered across the catchment including programs focussing on treatment, information, education, social support and preventative lifestyle programs. Interventions ranges from intensive case management/care coordination to a focus on supporting self care skills and behaviour change incorporating health coaching and the Flinders assessment process.

Some programs have clear referral pathways with agreed protocols with key service providers and clear entry criteria but for most programs entry criteria were not identified and referral pathways not documented or articulated with other relevant services.

Barriers to integrated chronic disease care across the region

Three key areas were the most commonly identified barriers to integrated chronic disease care in the catchment:

- Lack of coordination of programs and referral pathways – uncertainty of what programs were being offered, entry criteria and referral pathways and lack of coordination to make sure programs linked effectively.
- Health professional's skills – skill development needed for health professionals to support practice change and client centred approach e.g. motivational interviewing, coaching.
- Funding models – current funding models do not support collaborative planning or care delivery, a lack of out of hrs services was also seen as a key barrier, inadequate funding was seen as influencing this.

Priorities for change to improve integration of chronic disease care in the region

Priorities for change could also be categorised under four key themes:

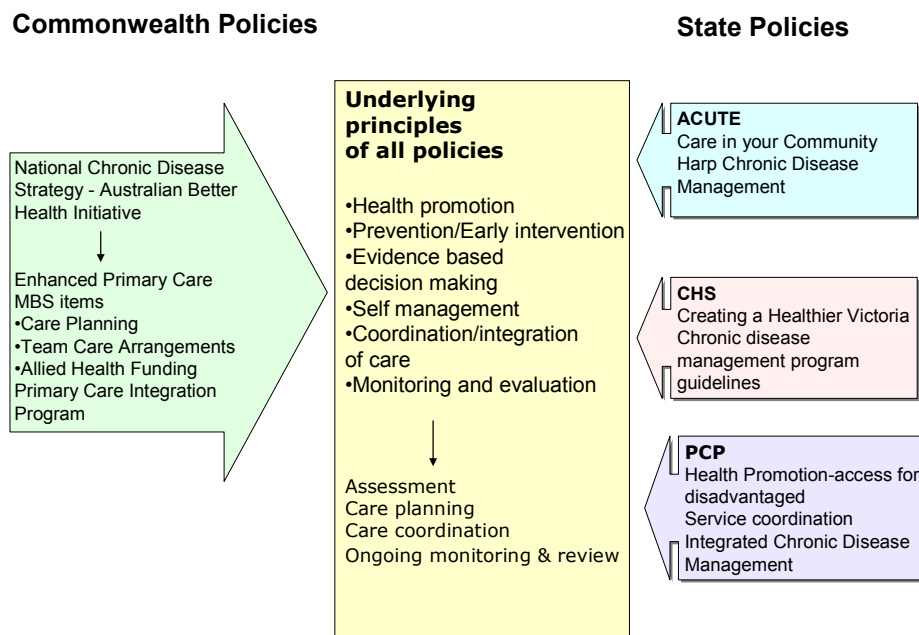
- A more cooperative approach to planning- collecting catchment wide data on chronic disease and gaps in service and planning to address gaps across services collectively. Identifying clear referral pathways, clarity of eligibility criteria, better coordination between services, reducing duplication of services and ensuring access for all.

- Engaging with GPs and developing ways to collaborate more effectively with care planning.
- Consolidating paperwork across catchment
- Skill development of health professions e.g. Health coaching, motivational interviewing, person centred assessments and sharing information and learnings across services.

Review of Policies and Chronic Care Models

A review of the ICDM literature and specific evidence based interventions along with a summary of key polices informing chronic disease care in Australia is outlined in Appendix 2. Figure 1 below summarizes the key chronic care polices and highlights commonalties across policies.

Figure 1: Summary of key chronic disease care policies.



The chronic care literature highlight key elements in the care delivery process for chronic disease care needed to support consistent comprehensive approaches to care and organisational changes needed to support delivery of planned systematic proactive chronic disease care.

Key components of care identified were

- Assessment
- Care plans

- Regular review
- Self-management support.

Assessment

Accurate diagnosis and assessment according to best practice is fundamental to initiating appropriate treatment and optimising ongoing care.²

Common assessment forms should collate minimum data for all chronic conditions, including identifying lifestyle risk factors, self management skills and depression.

The Chronic Care Model also highlights the importance of exploring patient's perceptions of; their health problem, fears and priorities for care as fundamental to the assessment process.

Care plans

All clients with chronic conditions should have a documented care plan that:

- Is based on a comprehensive assessment
- Is developed collaboratively with individuals(s) with chronic disease, their support systems(s) and interdisciplinary team members
- Identifies issues/problems, risk profile and develops appropriate strategies to address these
- Includes appropriate treatment regime and education interventions according to best practice guidelines
- Encourages and supports self-care strategies
- Identifies appropriate follow up and review.
- Documents individual's progress, including goals and achievement of them.

Regular review

Systematic monitoring and review has been identified as a key component to improving outcomes for chronic disease. Recall mechanisms should be in place including protocols for early identification and treatment of complications.

Self-management support

Self-management involves the patient with the chronic condition working in partnership with their carers and health professionals so that they can:

- Know their condition and various treatment options
- Negotiate a plan of care (i.e. care plan) and review/monitor the plan

² National Health Priority Action Council (NHPAC). *National Chronic Disease Strategy*. Canberra: Department of Health and Ageing, 2006.

- Engage in activities that protect and promote health
- Monitor and manage the symptoms and signs of the condition
- Manage the impact of the condition on physical functioning, emotions and interpersonal relationships.³

Health care services provide support for self-management by:

- Emphasizing the patient's central role in managing their health
- Using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organizing internal and community resources to provide ongoing self-management support to patients.⁴

Strategies for organising and delivering care

Equally as important is consideration of strategies for organising and delivering care to ensure the identified key elements are systematically integrated into care delivery processes. This involves attention to care delivery practices and systems within individual organisations practices and cooperative planning across organisations.

A number of key drivers for integrating the identified key elements into care delivery processes have been identified. These include:

Proactive systematic care: identification and implementation of strategies to support more systemised, coordinated, proactive care and embedding self-management support into the delivery system as well as specific strategies for engaging with the priority groups.

Appropriately trained health professionals: delivery of care incorporating the identified key elements requires health professionals with specialised skills that are not routinely included in medical or allied health undergraduate training.

Increased community awareness: a lack of awareness among health professionals and the general public of effectiveness of self-management have been identified as a key barrier to accessing self-management.

³ Flinders Human Behaviour & Health Research Unit. *What is Self-Management?* Adelaide: Flinders University, 2005. Accessed online May 2007 at: <http://som.flinders.edu.au/FUSA/CCTU/What%20is%20Self%20Management.pdf>

⁴ Bodenheimer T, Wagner EH, Grumbach K. *Improving primary care for patients with chronic illness.* The Chronic Care Model, Part 2. *JAMA* 2002; 288: 1909–14.

Readily accessible accurate information and support: the importance of linking with community organisations in chronic disease care, particularly in relation to providing access to information and peer support is emphasised in the literature.

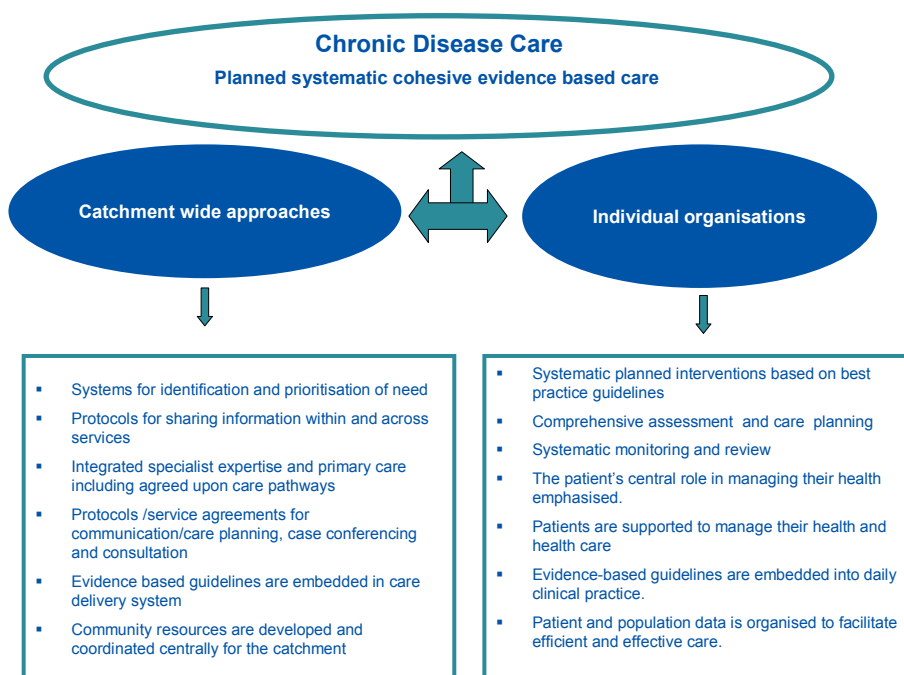
Person-centred health care: The promotion of more ‘person-centred’ care is a central aim of the improvement in health service delivery outlined in the National Chronic Disease Strategy; a more person centred approach is a key principle of self management support.

Chronic Disease Care in BNPCA catchment what is needed?

The key elements discussed above suggest that chronic disease care needs to be planned, systematic and proactive within and across organisations. Care also needs to be responsive to the needs of the individual and aim to build confidence and skills to manage the condition and its impact on their lives. Health professionals need to appropriately trained and delivery systems designed appropriately to provide best practice care, facilitate coordination of care and promote self management.

A vision for planned systematic cohesive chronic disease care for the BNPCA catchment along with strategies and processes for achieving this outlined in figure 2 below.

Figure 2: Strategies for improving chronic disease care



Issues for consideration when planning for improved chronic disease care

Stakeholder priorities

The priorities for change identified by stakeholders in the catchment were:

- A more cooperative approach to planning
- Better coordination of care between services
- Engaging with GPs
- Consolidating paperwork across catchment
- Skill development of health professions

Building on existing initiatives/programs

The literature and learnings from past projects highlights the need for a catchment wide approach involving all stakeholders involved in chronic disease care and consideration of what initiatives/programs are already in place and how these can be supported. Initiatives and programs already operating that have clear links with ICDM objectives include:

- HARP CDM programs which aim to provide integrated seamless care within and across hospital and community sectors, their focus is on people with complex care needs. Coordination of care pathways and eligibility criteria between HARP and other programs to ensure care is matched to need and equitable access to care across the catchment could be considered.
- Both community health services have undertaken service restructuring to integrate components of the Chronic Care Model, strategies for supporting further implementation of the models could be considered.
- NEVDGP has been working general practice to improve information management systems so that practices can identify patients with chronic disease and develop systems to systematically deliver and evaluate chronic disease care. This has potential to support greater coordination of care between general practice and community health and increase appropriate referrals to community programs.
- The PCP GP liaison worker has had success promoting the Banyule Health for Life program to general practice. Strategies for continuing this work and support for Nillumbik CH to promote their chronic care program could be considered.
- PCP/NEVDGP Lifescripts project which aimed to develop the capacity of GP's to implement the Lifescripts program and encourage links to primary care services, using referral and feedback processes, the project has been successful in promoting Lifescripts particularly to practice nurses and building links with community health, strategies to provide ongoing support for this work could be considered.

Note: Consideration for how the expected funding to Divisions of General Practice for the Primary Care Integration Program could build on the above three initiatives should also be considered.

- PCP service coordination work has clear links with ICDM particular in the areas of common assessment and care planning tools/processes and referral and care coordination tool/protocols, strategies for how ICDM could progress this work for people with chronic disease could be considered.
- PCP health promotion work also has clear links with ICDM catchment wide approaches to risk factor screening and referral pathways and targeted programs for those with risk, with a focus on hard to reach groups could be considered.

Suggested strategies and or activities linked to each of the programs/initiatives listed above are outlined in Table 1 below are.

A column for priority for change has been included on the table so that, these areas can be discussed within organisations and a rating for priority for change considered before the meeting. Each organisation's priorities will be discussed at the meeting to facilitate identification of and agreement on catchment wide priorities.

When considering priorities, rate each of the activities within the three areas.

Guide to priority rating

High – Critical to improving chronic disease care within the organisation that must be addressed in the next 6-12 months.

Medium – Critical to improving chronic disease care within the organisation that must be addressed in the next 12- 18 months.

Low – Critical to improving chronic disease care within the organisation that could be addressed over the next 1-5yrs.

Table 1: Strategies and or activities for change linked to existing programs/initiatives

Local initiatives/programs	Strategies/activities for improving chronic disease care planning, coordination and delivery	Priority for change
<p>Health Promotion GP Liaison and GP information management work.</p>	<p>Health promotion activities focussing on increased physical activity and healthy eating. Specific culturally appropriate programs/information targeting high risk groups. Clear referral pathways to lifestyle programs. Catchment wide awareness raising of risk factors and symptoms for certain chronic conditions and identification and targeting of high risk groups. Collaboration (esp. general practice) to develop local system wide approach to risk identification, screening and interventions.</p>	
<p>Support to community health for implementation of chronic care programs Service coordination GP Liaison and GP information management work.</p>	<p>Promotion of use of Lifescripts across services and links with GPs and the 45 Year old Health Check. Patient and population data organised to facilitate efficient and effective care, identify gaps in services and identify specific population groups. Identification and agreed upon clinical guidelines across services and systems for monitoring implementation of guidelines. Consistent approaches to assessment and care plans across services. Explore opportunities to arrange care across services to meet best practice guidelines i.e. clarification of responsibilities for areas of care/review and sharing of information to avoid duplication of services. Explore opportunities to link with private allied health services to meet demand/expand range of services. Local agreements on identification of need and care pathways. Clear/central entry points for referral to programs.</p>	

	<p>Catchment wide planning and delivery of group self management/education programs.</p> <p>Explore opportunity to ensure client education information is consistent across services e.g. agreed upon education material, central point of access to material collaborative process for updating or identifying new material.</p> <p>Capacity building across organisations to develop systems and skills for assessment and collaborative care planning in particular processes and skills to support promotion of self-care strategies.</p> <p>Systematic involvement of consumers in planning and delivery of care.</p> <p>Clear pathways for referral of people to support programs</p> <p>Local system wide development and support for peer led educators/support workers and support programs.</p> <p>Consider catchment wide workforce development activities to support best practice.</p> <p>Protocols and processes for sharing of information and care across services.</p>
<p>Service coordination</p>	<p>Develop catchment wide criteria for determining level of need, appropriate programs to match level of need and clear and agreed upon referral and care pathways.</p> <p>Develop systems for coordination of care across multiple services.</p> <p>Protocols for key points of contact for client and responsibility for coordination of care both within and across services.</p> <p>Systematic and agreed upon approaches to identification of “high risk” patients.</p> <p>Explore opportunities to share expert knowledge and integrate specialist services</p> <ul style="list-style-type: none"> ▪ Consider strategies to provide secondary consultations for general practice with specialist services ▪ Consider pooling of specialist resources/equipment. <p>Share expertise and resources to develop and maintain registries, data bases and IT decision support systems.</p>

