



**MONASH** University  
Medicine, Nursing and Health Sciences

Department of Health Science

**PRACTICE CHANGE:  
LEARNINGS FROM THE INTEGRATED  
CHRONIC DISEASE PROGRAMS**

**FINAL REPORT JULY 2008**



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## Executive summary

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Health policy initiatives in Victoria have been implemented to improve chronic disease care in order to respond to the increasing burden of chronic disease. People with chronic disease need a responsive person-centred and effective system of care. To provide this care within an integrated system, health care providers must work collaboratively to coordinate and plan care and services.

Early Intervention in Chronic Disease (EliCD) is a Victorian Department of Human Services program that provides funding to Community Health Services and Primary Care Partnerships to provide early intervention services to people with chronic diseases. The EliCD program requires change to the way Community Health Services have been delivered, so the Department of Human Services has adopted the Wagner Chronic Care Model as a guide to transform systems for chronic disease care in community health. The Wagner model describes six essential elements of chronic illness care at the community, organisation and health care system level.

This is the report of a research project that was a collaboration between three Melbourne-based Community Health Services: Knox, MonashLink and Darebin Community Health Services with the Department of Health Science at Monash University. Staff from the Department of Health Science undertook the research which was funded by a grant from the Helen Macpherson Smith Trust. The study aimed to identify changes to management and care practices within and across organisations, and how individual health workers can further develop the necessary skills that support improvements in care for people with chronic medical conditions within Victorian Community Health Services. The qualitative research methods used included a review of relevant published literature, focus groups and interviews with key informants, document review and a consultation workshop.

The Wagner model was used as a benchmark to assess the kinds of changes that were the centre of interest to this study. The report then, is about internal processes in those three CHS organisations that were developed through the establishment of their EliCD programs as well as the broader system change that was needed to develop integrated and multidisciplinary care. The project found that change necessarily occurred at three levels:

- The practitioner,
- The organisation, and
- The broader service system.

All levels of change are essential for effectiveness and sustainability of the EliCD.

As the project progressed, it became clear that the Wagner model alone was not a sufficient driver of these three levels of change. Informed by the literature and the project itself, a further outcome of this study was the development of an Early Intervention Framework for Change that demonstrates the attributes, resources and processes that support and sustain practice change in the community health context. The key elements of the Early Intervention Framework for Change are:

- The drivers of change;
- The internal and external environment;
- Leadership and strategy;
- People;
- Skills & learning; and
- Systems and structures.

The details of the Framework are provided in the report and have informed the recommendations.

Health workers need to develop the necessary skills that support self management for people with chronic disease. The cornerstone of success is the systems and structures that support individual and organisational practice change. This report describes the activities that have supported individual and organisational change to implement ELiCD in the three community health services. It also highlights key processes that were successful in supporting implementation of the Chronic Care Model and detailing critical drivers and barriers for change. Based on the Framework and the findings from the qualitative research, recommendations for organisational and practice change to improve chronic illness care are proposed. The recommendations will have relevance for other community health services which are going through similar change processes.

## **Recommendations for organisational and practice change**

The following recommendations are based on synthesis of the findings and the literature that considers how to promote the kind of organisational and practitioner capacity that is essential in the process of improving early intervention for chronic disease programs in community health settings. In turn, the recommendations are intended to be a guide for other organisations intending to move to integrated, multidisciplinary early intervention programs for chronic disease.

The recommendations are grouped into themes derived from the Chronic Care Model:

1. Health care organisation
2. Delivery system design
3. Decision support
4. Self-management support
5. Community linkages
6. Clinical information systems

### **1 Health care organisation**

When planning change for the development of early intervention programs, the following recommendations are made at the level of the organisation's strategic thinking and planning. Recommendations are that:

- The whole organisation needs to be engaged in the change effort
- The vision for change is compatible with the organisation's mission and goals and is clearly articulated to staff. The strategic plan, operational plans, policies and procedures reflect the organisation's commitment to preventive, client-centred care.
- Change champions are accessible and help the organisation to implement chronic care systems.
- Formal and informal processes for communication, consultation and learning for staff are planned for all stages of the change process. Structured learning and regular communication should be ongoing and supported by peers at team meetings and mentors/supervisors.
- Services assess the need to reorient priorities to reduce waiting times for clients in ELiCD, to enable integrity of the early intervention goals and care planning for each client.

## **2 Delivery system design**

- The organisational structure supports chronic disease care:
  - Services are organised around client needs through multidisciplinary care teams.
  - Integrated, multidisciplinary care is guided by a shared, client-centred care plan. There are opportunities for case conferencing and interdisciplinary care planning.
  - Team leaders are utilised for communicating and supporting practice change across the organisation.
  - Clinical supervision and mentoring to promote self management is available to all staff involved in chronic care. 'Secondary consultation' by psychologists or counsellors supports individual practice change.
- Clients' problems, risk factors and health care needs are explored by way of a generic assessment to inform a care plan.
- A plan of care, based on the client's goals, is documented and shared with the health care team. A copy, in language understood by the client, is provided to the client. The care plan and client goals, guide future visits and referrals to other providers.
- Care is coordinated and routine follow-up is planned. Responsibility is designated to a particular person or role, for example the key worker or primary contact in the organisation.
- The key worker role and the scope of practice within professional disciplines are defined. A job description and guidelines are available.
- The appointment structure is flexible to allow extended consultation when required.

## **3 Decision support**

- A process for organisational self assessment is undertaken to identify gaps and determine priorities for improving chronic care and monitoring progress of change, for example the Organisational Skills Analysis Tool.
- Common assessment and care planning tools are implemented across the organisation. A standard set of tools ensures consistent practice.
- Evidence-based guidelines are developed to guide decision-making and support practice change, and include:
  - Referral criteria and treatment pathways are based on appropriate target groups and health risk category to help prioritise demand for services.
  - Clinical guidelines for management of chronic diseases.
  - Criteria for follow up and ongoing review of care and outcomes or discharge/referral to other services.
- Staff are trained in self management and use tools such as the Flinders or Health Coaching tools to support behaviour change. Training needs to be ongoing due to workforce turnover. Programs organised centrally through DHS or regionally through PCPs may be more sustainable.

#### **4 Self-management support**

To ensure effective development of self-management skills in clients, recommendations are that:

- Clients are supported to improve self management skills through collaborative problem solving, goal setting, information about their condition and treatment plans, self management courses and support groups.
- Health professionals have access to informal learning such as peer support networks and counselling support/consultation.

#### **5 Community linkages**

To ensure that community linkages function effectively to support referrals into early intervention programs, recommendations are that:

- GP engagement is established early by employing a GP liaison role, and relationships built with divisions, practice nurses, and GPs to promote referrals and communicate client information .
- Professional networks are formed at a local, regional and state level to develop a common communication strategy about self management for consumers and GPs and to provide self management training.
- Information resources about community-based services, recreation centres, industry, clubs and churches are available to refer clients for social and self management support.

#### **6 Clinical information system**

To ensure that clinical information systems operate effectively to support early intervention programs, recommendations are that:

- A system is used to register and track clients for follow-up and to monitor care processes and outcomes.
- A shared client record is available to all members of the healthcare team to promote interdisciplinary communication and coordinated care.
- Electronic information systems support client care delivery, eg. e-referral, HealthSMART, Switch.

# Contents

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<b>1. Background and introduction</b> .....	8
1.1 The Victorian early intervention context .....	8
1.2 The project .....	9
1.3 Aims and objectives.....	9
1.4 The project partners.....	10
Knox Community Health service.....	10
Darebin Community Health Service.....	10
MonashLink Community Health Services .....	10
<b>2. Methods</b> .....	11
Data analysis.....	13
<b>3. Literature review</b> .....	14
3.1 Summary of key themes – Six dimensions of change .....	18
<b>4. Results</b> .....	19
4.1 Drivers of change .....	19
4.2 External & internal environment.....	20
4.3 Leadership and Strategy.....	22
4.4 People .....	23
4.5 Skills and Learning .....	25
4.6 Systems and Structures.....	27
4.7 Outcomes of EliCD.....	28
<b>5. Discussion</b> .....	29
<b>6. Early Intervention Framework for Change</b> .....	33
Figure 1: Early Intervention Framework for Change .....	34
<b>7. Recommendations for organisational and practice change</b> .....	36
Appendix 1 – Focus group topic questions.....	39
Appendix 2 – Questions for Manager’s interview.....	40

# 1. Background and introduction

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This section introduces the context for early intervention in chronic disease in Victoria, the project and its aims and objectives, and the three Community Health Services whose programs were the basis of the project. The report is about internal processes in those three CHS organisations that developed through the establishment of their EliCD programs as well as the broader system change that was needed to develop integrated and multidisciplinary care.

## 1.1 The Victorian early intervention context

The Victorian Department of Human Services Chronic Disease Management Program (CDMP) Guidelines identify that people with chronic disease need a responsive person-centred and effective system of care. To provide this care within an integrated system, health care providers must work collaboratively to coordinate and plan care and services. This requires a commitment to working together to achieve shared goals. The guidelines identify a Chronic Care Model endorsed by the World Health Organisation as the care model that should inform and guide practice change in the implementation of CDMPs.

Early Intervention in Chronic Disease (EliCD) provides funding to Community Health Services and Primary Care Partnerships for early intervention services to people with chronic diseases who may require future hospitalisation<sup>1</sup>. EliCD is underpinned by the guiding principles of 'person-centred care'.

The Department of Human Services has adopted the Wagner Chronic Care Model as a guide to transform systems for chronic disease care in health services<sup>2</sup>. The Chronic Care Model was developed by an advisory panel at Group Health Cooperative in Washington, USA, based on a review of the literature, with the aim of redesigning systems to optimise standards of care for chronic disease<sup>3 4</sup>. The model describes six essential elements of chronic illness care at the community, organisation and health care system level<sup>3</sup>.

Policy initiatives across both acute and community health services in Victoria have been implemented to improve chronic disease care in order to respond to the increasing burden of chronic disease. Initiatives are focused on system performance in relation to early intervention and integrated care, particularly in Community Health Services (CHS). The broad aim of early intervention policy initiatives is to build the capacity of the Victorian health care system to deliver person-centred health care in community settings, reducing the need for in-patient care, and improving the health outcomes of individuals and populations.

Specific purpose funding was provided from 2006 to nine CHS for Early Intervention in Chronic Disease (EliCD). This funding was to develop systems and practices to improve care for people with chronic conditions, and to assist the process of implementing internal changes to deliver

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<sup>1</sup> DHS. *Early Intervention in Chronic Disease in Community Health*. In. Melbourne: State Government of Victoria, Australia, Department of Human Services; 2008.

<sup>2</sup> DHS. *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services*. Victorian Government Department of Human Services; 2006.

<sup>3</sup> Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. *JAMA* 2002a;288(14):1775-79.

<sup>4</sup> Wagner EH. Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness? *Effective Clinical Practice* 1998;1:2-4.

integrated chronic disease care, consistent with the Chronic Care Model. The funding was provided to the CHS and also to the PCP to support the broader reform agenda. Three of those nine CHS, Knox, Darebin and MonashLink, identified the need for an evaluation process that examined barriers and enablers for practice change involved in the implementation of the Chronic Care Model.

The findings will have relevance for other CHS which are going through similar changes to implement integrated care consistent with the Chronic Care Model.

## **1.2 The project**

This was a collaborative project between three Melbourne-based Community Health Services: Knox, MonashLink and Darebin Community Health Services and Monash University, Department of Health Science which undertook the research. A funding submission was prepared for the Helen Macpherson Smith Trust. The submission was successful, and the project ran from August 07-August 08. Knox CHS was the lead agency, providing administrative support and a coordination role for the project.

Key to the project was the value placed on identifying and communicating not just the learnings from the implementation of the Chronic Care Model, but also on developing a framework for best practice in change management.

This report will highlight key practice change processes and organisational changes that were successful in supporting implementation of the Chronic Care Model and detailing critical drivers and barriers for change that informed the framework.

## **1.3 Aims and objectives**

The study aimed to identify sustainable changes to organisational and individual practices within and across community health services that support improvements in chronic care, and document how individual health workers developed the necessary skills to support integrated care that leads to client self management.

### **Objectives**

The process evaluation sought to:

- measure the activities and quality of the model of implementation, change in practice as a result of training provided, practitioner experiences and their satisfaction with the program (practitioner change);
- measure the activities and quality of the model of implementation, what management, system and care practices have been implemented and how are they working (organisational change).

The impact evaluation sought to:

- measure whether the objectives of the program for practice change have been achieved
- Assess system reorientation

## **1.4 The project partners**

### ***Knox Community Health service***

Knox Community Health Service (KCHS) operates as an independent community health service located within the City of Knox. KCHS provides a wide range of community based services primarily to people who live, work or study within the City of Knox.

With a team of over 100 staff, KCHS operates from two sites, providing centre and home based services including group programs. Services include counselling, occupational therapy, community nursing, physiotherapy, podiatry, oral health, dietetics, diabetes education, speech pathology, psychology, family services, service coordination, volunteer coordination, health promotion and community development.

Further information on KCHS can be obtained by accessing the website: [www.kchs.org.au](http://www.kchs.org.au)

### ***Darebin Community Health Service***

Darebin Community Health Service (DCHS) operates as an independent community health centre from four sites the City of Darebin, located in the Northern metropolitan region of Melbourne. DCHS employs 180 staff and serves a community of 129,000 people, 40% of whom can speak a language other than English. DCHS provides a wide range of community-based programs including general medical practice, dental, dietetics, diabetes education, occupational therapy, physiotherapy, podiatry and speech pathology plus child and family and aged care counseling, service coordination, youth services, HARP, planned activity groups, pharmacotherapy, community liaison, health education and treatment groups and health promotion.

Further information on DCHS can be obtained by accessing the website: [www.dch.org.au](http://www.dch.org.au)

### ***MonashLink Community Health Services***

MonashLink Community Health Service (MLCHS) operates as an independent community health centre located within the City of Monash. It provides a wide range of community based services to a population in excess of 165,000 people who live, work or study within the City of Monash.

With a team of 112 staff, MLCHS operates from four sites providing centre, home based and group programs. Services include counselling, occupational therapy, community nursing, physiotherapy, podiatry, oral health, dietetics, diabetes education, speech pathology, psychology, family services, service coordination, volunteer coordination, health promotion and community development.

Further information on MLCHS can be obtained by accessing the website: [www.monashlink.org.au](http://www.monashlink.org.au)

## 2. Methods

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The project was designed to gather data that would enable reasoned judgments about the extent to which each of the individual CHS met their EliCD program objectives and to document the model of program delivery that was being developed. In keeping with best practice in qualitative research, a variety of methods were used to collect data. This created a form of triangulation which serves to increase the validity of the research. The qualitative research methods used included focus groups and interviews with key informants, document review and a consultation workshop.

### Data collection

Method	Participant / source
Literature search	Electronic databases for relevant publications from 1999.
Focus groups	EliCD Key workers
	Staff trained in self management
	Non-self management trained staff
Interviews	Program managers
	Project managers
Document review	EliCD project plans
	Evaluation report on Health Coaching professional development
Self Management Organisational Assessment	Workshop with MonashLink staff Report of Chronic Disease Care or Self Management Organisational Self-Assessment.
Consultation workshop	Managers and health professionals from MonashLink, Darebin, Knox CHS, other CHS in the regions, representatives from local Primary Care Partnerships and the Department of Human Services.

### Ethics

An application for ethics approval was sought and granted through the Monash University Human Research Ethics Committee (SCERH 2007001967: Identification of Practice Change Models for Improving Chronic Disease Care) in September 2007. The application identified the methods for the project and outlined the ethical considerations for the project.

### Steering group

A steering group was formed with representatives from the three community health services, the Primary Health Care Branch, Department of Human Services, Primary Care Partnership, expert consultant in chronic disease management and researchers from Monash University. The group met five times during the 12 month project, to facilitate organisational input and feedback to the research team and monitor progress of the study.

### Literature search

A search for relevant publications was undertaken to better understand change management in the primary health care context and the scope of research undertaken in this area. CINAHL, EMBASE and MEDLINE databases were searched for publications describing (i) practice changes that lead to improved care and better health outcomes for people with chronic medical conditions, (ii) the conditions that contribute to individual practice change to implement integrated chronic disease care, and (iii) the features and processes associated with successful organisational change in community health services.

Search terms used:

Organisational change or innovation; systems or practice change; change management or measurement; work redesign; health care reform; organisational culture; multi-skilled health practitioners; learning methods; institutional management teams or models.

AND

Community health services or centers; community health nursing; multidisciplinary care; continuity of patient care; integrated; primary health care; nursing practice; professional practice; institutional practice or practice management; program development; chronic disease management.

Twenty-three publications about individual practice change and organisational change in community health services were included. Studies and review articles that provided insight into the conditions that contribute to individual practice change and the features and processes associated with successful organisational change were analysed for common themes.

### **Focus groups**

Focus group interviews were conducted with staff at each community health service. Participants were twelve 'key workers' in the EliCD program from Darebin and MonashLink CHS, 22 self-management trained staff not directly involved in the EliCD program, and 17 staff who had not yet attended self-management training. Interviews were semi-structured, with pre-defined questions used to guide the discussion. Participants were asked to describe their current role, self-management and Health Coaching training they had attended and how they had used this training in their current roles. Implementation of the EliCD program was discussed, including communication systems, learning models, role changes and potential barriers and facilitators to implementing the chronic care model into the organisation. The focus group schedule is provided in Appendix 1.

### **Manager Interviews**

Semi-structured interviews were conducted with managers responsible for the EliCD program in each CHS. Managers were asked to describe the EliCD program model at their health service, the structure for governance, learning, implementation and resources and expectations for patient and organisational outcomes. Barriers and facilitators of good practice for chronic disease care were explored. At Knox CHS, the interview questions were completed by the managers as a written questionnaire. The interview questions are provided in Appendix 2.

### **Document review**

During the initial planning phase of the project in 2006, Darebin and Knox CHs engaged a consultant to conduct a workshop with staff. The focus of the workshop was to investigate the current capacity and practice in chronic illness care and self-management and set priorities within the agency for implementing best practice in chronic disease prevention and management. An additional priority from the workshop was the integration of self-management into care processes across the organisation. Reports from these early self-assessment workshops were reviewed.

The Self Management Organisational Assessment Tool (SMOAT) developed by Gill & Willcox<sup>5</sup> was completed by 15 staff from across MonashLink CHS and the findings discussed at a workshop facilitated by Monash University in December 2007. A summary of the workshop discussion was included in the research.

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<sup>5</sup> Gill M. *Self Management Assessment Tool for Community Health Organisations*. Melbourne: Gill and Willcox Consulting; 2007.

### **Consultation workshop**

A workshop was held in April 2008, to provide an opportunity for the partner agencies to showcase their achievements and learnings from the implementation of EliCD to stakeholders from the sector. The fifty participants included executive and clinical staff from MonashLink, Darebin, Knox and other local CHS, representatives from Primary Care Partnerships and the regional and central offices of the Department of Human Services.

Working in groups, participants discussed the facilitators, barriers and lessons learned about integrating chronic disease initiatives across the organisation. They also were asked to identify the elements of system change that supports EliCD and gaps in the current model. Responses from the workshop were collated and included in the analysis.

### **Case studies**

The transcriptions from the focus groups and manager interviews were analysed thematically and documented as a case study for each community health service. A feedback meeting was then held with each organisation to clarify the information presented in their case study and to discuss the issues that had been identified during the consultations reported in the case studies. These meetings provided an opportunity to test ideas that would contribute to the report.

The case studies are not provided with this report as they were intended for the information of each organisation to assist them in assessing their progress towards integrated, multidisciplinary care pathways. However, a discussion of overall findings is presented with some examples from the case studies to demonstrate facilitators or barriers to implementation of integrated chronic disease care and the change process.

### **Data analysis**

Key themes were identified from the literature, and were used to structure the presentation of the findings from the case studies and consultation workshop. Drawing on the concepts discussed in the literature and several key change management publications, a Framework for Change was created. This was further developed and elaborated from the findings in the case studies and consultations.

### 3. Literature review

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A background review of the literature was conducted to identify publications that would inform the study about individual practice changes and organisational change relevant to the implementation of integrated chronic disease care in community health services. The purpose of the literature review was to inform the methods and possible approaches to analysis of practice and organisational change in this context.

The search was selective and not intended to be systematic. The search identified studies and review articles and selected change models that provide insight into the conditions that contribute to individual practice change and the features and processes associated with successful organisational change. A brief overview of relevant literature is provided here. Readers are encouraged to follow up the references for further detail.

The change management literature is extensive and contains diverse approaches, theoretical perspectives and models with which to navigate change, however there is limited empirical evidence for the efficacy of the various models<sup>6</sup>.

Traditional approaches to change management characterise change as planned, sequential and imposed from the top down<sup>7</sup>. In contrast, emergent change models portray a continuous process of adaptation and adjustment, through learning and experimentation, which is led by a workforce engaged in development and continuous improvement (ibid). Iles and Sutherland<sup>6</sup> (p. 16) assert that organisational change is, in reality, 'uncontrolled and disorderly with often unexpected events and consequences, and changing goals'.

Lewin's 'Forcefield' model proposes that organisational change occurs when the forces that drive change overcome restraining forces that serve to maintain the status quo. Lewin describes this as 'unfreezing' the current position, 'changing' and 'refreezing', and is best achieved by lessening the restraining forces<sup>8</sup> (p. 59).

Approaches based on systems thinking recognise the complexity and interconnection between elements within the organisation and between the organisation and the external environment<sup>6, 9</sup>. Burke and Litwin<sup>10</sup> highlight the limitations of models that fail to adequately consider the external environment, which they assert has the strongest impact on organisational change. Environmental factors are the context in which change occurs and have an influence on the priorities for what and how change will occur<sup>11</sup>. Burke and Litwin<sup>10</sup> (pp. 531-532) propose a model that distinguishes between the 'transformational' factors that lead organisational change, and 'transactional' factors – 'management practices' associated with the structure and systems that facilitate change. 'Reorientation' of the organisation requires change to occur at both levels<sup>12</sup> (p. 76).

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<sup>6</sup> Iles V, Sutherland K. *Managing Change in the NHS. Organisational Change: A review for health care managers, professionals and researchers*. London: National Coordinating Centre for NHS Service Delivery and Organisation R&D.; 2001.

<sup>7</sup> Telford K, Maddock A, Isam C, Kralik D. Managing change in the context of a community health organisation. *Australian Journal of Primary Health* 2006;12(2):156-166.

<sup>8</sup> Lewin 1947, in Garside P. Organisational context for quality: lessons from the fields of organisational development and change management. *Quality in Health Care* 1998;7 (Suppl):S8-S15.

<sup>9</sup> Leischow, S. and Milstein, B. (2006) Systems Thinking and Modeling for Public Health Practice. *Am J Public Health*, 96, 403–405.

<sup>10</sup> Burke W, Litwin G. A Causal Model of Organizational Performance and Change. *Journal of Management* 1992;18(3):523-545.

<sup>11</sup> Pettigrew et al. 1992, in Garside P. Organisational context for quality: lessons from the fields of organisational development and change management. *Quality in Health Care* 1998;7 (Suppl):S8-S15.

<sup>12</sup> Johnson A, Paton K. *Health Promotion and Health Services: Management for change*. Sth Melbourne: Oxford University Press; 2007

Improvement in the delivery of chronic disease care, health outcomes and service use have been reported following implementation of the Chronic Care Model<sup>13, 14</sup>. However, successful implementation of organisational change is not easily sustained<sup>12, 14</sup>. Gustafson et al,<sup>15</sup> (p. 758) report that many conceptual models for organisational change have been put forward including theories about strategic planning, adaptive learning, decision making, management applications, diffusion of innovations, and social–psychological processes of organisations while others have examined how organisational structures, environments, and relationships affect how people in organisations manage and achieve change (p 753). However Gustafson et al also report that there are very few actual models for change, and those that have been developed, including their own model to predict outcomes in organisational change, are quite complex and multifaceted. They define success as ‘a process improvement that persisted six months after implementation and still had the support of management and staff’ (p.758). Sustainability is an indicator of the effectiveness of the processes that support change and is dependent on the continuity of resources, structures and systems that support new behaviours<sup>12</sup>.

### **Readiness to change**

Sustained change may be easier for organisations that proactively seek change<sup>16</sup>. As change is constant, organisations should work to enhance receptiveness to change rather than try to overcome resistance<sup>6, 17</sup>. Conditions for change are created through reflection, debate, relationship building and learning<sup>7, 18</sup>. Tension or dissatisfaction with the current status<sup>15</sup> and insight into existing problems<sup>19</sup> provide impetus for change. However, workers must perceive there are benefits and that proposed changes are realistic<sup>15</sup>.

### **Adoption of change**

Individuals vary in their response to change and are influenced by the way they perceive change will affect them<sup>6</sup> and whether their needs will be met<sup>15</sup>. Resistance is a normal reaction and managers should be sensitive to differing perspectives and responses<sup>7</sup>. Berwick<sup>20</sup> (p. 1970) correlates the rate of ‘diffusion’ of change with three factors: ‘(1) perceptions of the innovation; (2) characteristics of the people who adopt the innovation, or fail to do so; and (3) contextual factors’. ‘Innovators’ should be supported to identify new ideas and ‘early adopters’ allowed the resources to trial and demonstrate innovations (ibid).

Change management in the health care environment is complicated by perceptions of professional autonomy<sup>7, 17</sup>, role boundaries<sup>21</sup> and resistance to changing long-standing practice<sup>22</sup>. Conversely,

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<sup>13</sup> Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. *JAMA* 2002a;288(14):1775-79.

<sup>14</sup> Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. The Chronic Care Model Part 2. *JAMA* 2002b;288(15):1909-14.

<sup>15</sup> Gustafson D, Sainfort F, Eichler M, Adams L, Bosognano M, Steudel H. Developing and Testing a Model to Predict Outcomes of Organizational Change. *Health Services Research* 2003;38(2):751-776.

<sup>16</sup> Ruhe MC, Weyer SM, Zronek S, Wilkinson A, Wilkinson PS, Stange KC. Facilitating practice change: Lessons from the STEP-UP clinical trial. *Preventive Medicine* 2005;40(6):729-734.

<sup>17</sup> Callaly T, Arya D. Organizational change management in mental health. *Australasian Psychiatry* 2005;13(2):120-123.

<sup>18</sup> Rowe A, Hogarth A. Use of complex adaptive systems metaphor to achieve professional and organizational change. *Journal of Advanced Nursing* 2005;51(4):396-405.

<sup>19</sup> Boshoff K. Towards facilitating change in service delivery: An illustrative example. *Australian Occupational Therapy Journal* 2005;52(2):149-159.

<sup>20</sup> Berwick D. Disseminating Innovations in Health Care. *JAMA* 2003;289(15):1969-1975.

<sup>21</sup> Every B. Better for Ourselves and Better for Our Patients: Chronic Disease Management in Primary Care Networks. *Healthcare Quarterly* 2007;10(3).

<sup>22</sup> Keleher H, Round R, Marshall B, Murphy B. Impact evaluation of a five-day Short Course in Health Promotion: workforce development in action. *Health Promotion Journal of Australia* 2005;16(2):110-5.

challenging change may help to balance new practices with continuity, question aspects that may be unsuitable, encourage innovation and consideration of alternative options<sup>7</sup>.

### **Leadership**

Leadership for organisational change should be facilitative rather than directive<sup>6,7</sup> and promote participation and consultation with stakeholders<sup>7,16, 17,18,19,20</sup> as well as a shared vision that is consistent with organisational values and mission<sup>6,7, 12</sup>. Goals are clearly articulated and communicated<sup>7, 12</sup> and benefits versus risks made clear<sup>20</sup>. Champions for change may be managers or clinicians,<sup>16, 23, 24</sup> and leaders should model the desired new behaviors<sup>7, 16</sup>. Sustaining change initiatives requires commitment and support from those with power and influence<sup>12,16,17,19</sup>.

### **Communication**

Effective communication is critical to successful implementation. Open conversation raises awareness and interest and helps to build alliances and provide opportunities for participation and debate<sup>6, 7, 12, 17, 18, 24</sup>. Early opportunities to share learning promote dissemination and adoption of change<sup>20</sup>.

### **Learning**

For practice change to occur managers and staff need insight into current deficiencies and the capacity to critically reflect and internalise learning<sup>16, 18, 19</sup>. The opportunity to adapt, experiment and demonstrate innovations in the local environment fosters uptake of change<sup>6, 18, 19, 20</sup>. Staff must have the required skills and be recognised and rewarded for new behaviours<sup>7, 16, 22, 24</sup>. Learning and skill development can be supported by formal education and mentoring<sup>22, 24</sup>, multidisciplinary learning collaboratives<sup>12, 24</sup> and recognition programs to gain individual or organisational accreditation<sup>24</sup>. Lessons from successes and failures of the change process should be recorded and shared<sup>12</sup>.

### **Resources**

Improving chronic disease management requires additional resources and funding<sup>14, 25, 26</sup> for training and skill development<sup>7</sup> and system support, such as information management systems<sup>16, 21, 26</sup>. Dedicated time is needed for staff to manage their current workload and change processes<sup>7, 20, 22, 26, 27, 28</sup>. Successful implementation is impeded by inappropriate funding models to support preventive care, inadequate clinical information systems<sup>14, 26</sup>, loss of individual change champions, workforce turnover<sup>14</sup>, and excessive workload<sup>26</sup>.

Although action learning and continuous improvement may be forces for change, the literature also reinforces the role of leadership in the change process. Effective leadership is necessary to create and maintain a vision, supply resources and communicate feedback, and ensure that structures

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<sup>23</sup> de Jong I, Jackson C. An evaluation approach for a new paradigm--health care integration. *Journal of Evaluation in Clinical Practice*. 7(1):71-9, 2001 Feb. 2001.

<sup>24</sup> Wigan K, Caren B, McKenzie T. A structured approach to changing practice. *Journal of Community Nursing* 2007;21(1):23-5.

<sup>25</sup> Robinson K, Farmer T, Riley B, Elliott SJ, Eyles J, Chhdp Investigative Team S, et al. Realistic expectations: investing in organizational capacity building for chronic disease prevention. *American Journal of Health Promotion*. 21(5):430-8, 2007 May-Jun. 2007.

<sup>26</sup> Rundall T, Shortell S, Wang M, Casalino L, Bodenheimer T, Gillies R, et al. As good as it gets? Chronic care management in nine leading US physician organisations. *BMJ* 2002;325:958-961.

<sup>27</sup> Allen C, Stevens S. Health service integration: a case study in change management. *Australian Health Review*. 31(2):267-75, 2007 May. 2007.

<sup>28</sup> Peres EM, Andrade AM, Dal Poz MR, Grande NR. The practice of physicians and nurses in the Brazilian Family Health Programme - Evidences of change in the delivery health care model. *Human Resources for Health* [Electronic Resource] 2006;4(25).

are in place to support change. Creating a culture of reflection and open communication and attraction to change, that encourages investigation and experimentation, will enhance adoption and diffusion of change.

Dissemination is one method in broader capacity building strategies to support the transfer and uptake of innovations, the science of which is called the diffusion of innovation. Diffusion of innovation has four stages:

- Passive diffusion;
- Active dissemination involves 'active and planned efforts to persuade target groups to adopt an innovation'<sup>29</sup>;
- Implementation involves 'active and planned efforts to mainstream an innovation within an organization'<sup>29</sup>;
- Sustainability is about whether an innovation is used routinely until it reaches obsolescence.

One of the key issues for sustainability of the EliCD in Community Health will be effective dissemination of knowledge, especially the interface between new knowledge about chronic disease management as well as development of new practice knowledge and its documentation and dissemination.

### **The Chronic Care Model**

Chronic care models are both an organising framework and a tool for improvements to care pathways and individual client care<sup>30</sup>.

The Wagner Chronic Care Model (CCM) promotes a systems approach to managing chronic illness and is based on evidence that supports comprehensive, multifaceted interventions that include provider and patient-oriented strategies, and changes to the way care is organised and delivered<sup>31, 32</sup>. Implementation of the model has resulted in improvements to care processes and some patient outcome measures<sup>32</sup>. Results from the Coordinated Care trials in South Australia, showed improved health and well-being for some patients through patient-centred care. Service coordination, use of a multidisciplinary care plan, and behaviour-change strategies contributed to successful outcomes in the trial<sup>33</sup>. Evidence to date for the CCM comes from patients in general practice, specialist medical care, managed care settings, or the Hospital Admission Risk Program (HARP) in patients with chronic and complex needs at risk of rehospitalisation.

The CCM has six elements<sup>34</sup>:

#### **Health care organisation**

- Improved care should be institutionalised and aligned with a quality improvement system.
- Leadership and organisational goals to improve chronic and preventive care are reflected in policies, procedures, business and financial plans.
- Senior leaders and clinician champions are visible and committed members of the team, and give personnel the resources and support they need.

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<sup>29</sup> Pawson, R., Greenhalgh, T., Harvey, G. and Walshe, K. (2004). Methods of synthesis: making it useful for evidence-based management and policy making. *Journal of Health Serv Res Policy*, 10(Suppl 1):21-34.

<sup>30</sup> Flandt K. The chronic care model: description and application for practice. *Topics in Advanced Practice Nursing eJournal*, 2006; 6(4).

<sup>31</sup> Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. *JAMA* 2002a;288(14):1775-79.

<sup>32</sup> Wagner EH, Austin B, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving Chronic Illness Care: Translating Evidence Into Action. *Health Affairs* 2001;20(6):64-78.

<sup>33</sup> Battersby M, Harvey P, Mills PD, Kalucy P, Pols RG, Frith P, et al. SA HealthPlus: A Controlled Trial of a Statewide Application of a Generic Model of Chronic Illness Care. *The Millbank Quarterly* 2007;85(1):37-67.

<sup>34</sup> IHI. *Changing Practice Changing Lives. Training Manual*. In: Institute for Healthcare Improvement.

### **Delivery system design**

- What care is needed and roles and tasks to provide it are established.
- Clinicians have centralised, up-to-date information about the patient's status.
- Planned visits are based on the patient's needs and self-management goals.
- Routine follow-up is planned.
- Non-physician staff are cross-trained to provide care via standing orders.

### **Decision support**

- Evidence based guidelines.
- Ongoing education.
- Communication between providers.

### **Self-management support**

- Collaborative problem solving, priority and goal setting, treatment plans

### **Community linkages**

- Health centres form alliances and partnerships with state programs, local agencies, schools, faith organisations, businesses, and clubs
- Community awareness raised.
- Community resources available to support self management.

### **Clinical information system**

- A registry or information system to track individuals and populations of patients.
- The entire care team uses the registry to guide the course of treatment, anticipate problems, and track progress.

## **3.1 Summary of key themes – Six dimensions of change**

The themes identified in the literature have been used to guide interpretation of the study findings and to develop a framework for practice change, which is described later in the report.

Six dimensions of change have been identified and are defined below.

### **1. Drivers of change**

These are the drivers that lead to change and overcome resisting forces. For example:

- A problem or need identified in the community or the organisation;
- The expected benefits and rewards from a proposed change;
- Policy initiatives or funding models from government or a strategic review.
- New evidence for health risks or effective treatment.

### **2. The internal and external environment**

Environmental factors are the context in which change will occur and the features that will be affected by, or will need to be influenced to effect change.

The external environment includes :

- Stakeholders – consumers, population groups, other organisations, providers, funders.
- Economic factors – funding models, socio-economic factors
- Political factors – eg. national and local health priorities, private and public providers, acute and chronic care

- Socio-cultural factors – eg. characteristics of the local community, expectations of healthcare.

Features of the internal environment are :

- Organisational culture
- Norms, practices - 'the way things are done around here'<sup>35</sup>
- Organisational capacity – eg. adequate staff resources, time and skills

### **3. Leadership & strategy**

Leadership refers to the people and vision that will provide the direction for change, including change champions, goals and strategies. Management is the process of operationalising strategies and establishing new systems and practices.

### **4. People**

The attitudes, personal / professional attributes and roles occupied by staff in relation to change processes are discussed in this theme. Included here are the values and needs of staff and readiness to adopt change or degree of resistance encountered and how this is managed.

### **5. Skills & learning**

Included in skills and learning are the processes for learning, adapting and integrating new skills into practice and the strategies that reinforce new behaviours.

### **6. Systems & structures**

Key features of the Chronic Care Model are decision support tools and systems such as recall systems, disease management guidelines, and information management systems to coordinate care and share information. Systems also include performance monitoring and feedback for maintaining momentum and sustaining improvement.

## **4. Results**

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In this section, the results of the focus groups, workshop and interviews have been documented. It includes examples of change management processes carried out by the community health services involved in this study. The themes or 'dimensions of change' described above, have been used to frame the findings from the focus groups and stakeholder consultations.

### **4.1 Drivers of change**

Although the Early Intervention in Chronic Disease initiative was an important driver of change in the EliCD funded community health services, plans for change had been initiated in response to a perceived need to improve the delivery and coordination of chronic illness care.

Over a period of 12 to 18 months prior to receiving EliCD funding, Knox and Darebin Community Health Services undertook various consultations and workshops for planning, formative

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<sup>35</sup> Deal & Kennedy 1982, in Burke & Litwin. A Causal Model of Organizational Performance and Change. *Journal of Management* 1992;18(3):523-545, p. 532.

assessment, staff development and communication. Using the Organisational Needs Analysis Tool<sup>36</sup>, Darebin and Knox CHS assessed chronic care processes within the organisation, identifying self management support and systems change as organisational priorities to improve chronic illness care. Knox undertook an internal review to investigate and make recommendations for implementing service coordination and care planning systems and processes. MonashLink CHS worked collaboratively with the Inner East Primary Care Partnership and identified the need for regional and internal systems change to support the improvement of chronic disease care.

DHS specified the Wagner Chronic Care Model to guide the focus of change efforts. However, individual community health services made decisions about what and how change would occur based on their assessment of current and future needs and organisational practice, not relying just on the CCM to guide or drive change.

## **4.2 External & internal environment**

The Primary Care Partnership strategy is a key strategy in Victoria to assist in service system reform. Through PCPs, other agencies have been engaged to participate in steering groups, to disseminate information and share resources and training. Referral and service coordination processes that have been established within agencies and across PCPs are integral to ELiCD, and are important for sharing clinical information and community linkage. These are important components of the Chronic Care Model.

### **Funding**

Funding models determine how a service delivers care. Funding to community health is complex, provided from multiple streams and departments, with different components and activities, potentially limiting the integration of chronic disease initiatives across the organisation in a consistent manner. Targets are set for clinician activity and throughput, rather than for systems, care processes or patient outcomes.

Funding for ELiCD has provided time for planning and consultation, and systems development, though this has been limited initially to developing the ELiCD program and processes in some agencies. Learning and systems developed for ELiCD can be integrated across the organisation to promote client-centred care and support self management.

For services without additional funding for ELiCD, service priorities may need to be reoriented. Establishing criteria to identify those clients at highest risk and eligibility for services may help to prioritise client demand. For example, the podiatrists at Knox CHS identified clients with high risk foot conditions, such as diabetes, as high priority, enabling them to discharge those attending for routine care unrelated to a medical condition. This helped to manage demand and waiting time for services.

### **Waiting lists and demand**

Demand for services and long waiting lists may delay the uptake of self management approaches and integrated multidisciplinary care in the wider organisation, outside of the ELiCD funded teams. Health professionals reported that self management strategies, such as goal setting and care planning, cannot be completed in the usual appointment time. Lengthening appointment times would impact on waiting lists, which for some services can be as long as six months. Interdisciplinary communication about clients and case conferencing is also hampered by long and varied waiting times for services.

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<sup>36</sup> Gill M. *Self Management Assessment Tool for Community Health Organisations*. Melbourne: Gill and Willcox Consulting; 2007.

Staff saw these as barriers to changing their practice, though these issues may reflect entrenched ways of working and thinking as much as structural barriers to change. Managers recognised the need for flexibility and had allowed staff to modify appointments to meet client needs.

### ***Stakeholder engagement***

Engagement of GPs and referral of clients into the EliCD program is a challenge and is constrained by time factors and lack of awareness of the available programs by GPs. Using practice nurses to identify suitable participants and facilitate referral processes appears to be successful, so establishing relationships with practices is essential. MonashLink CHS engaged a GP liaison officer from the local Division of General Practice (Div GP). Knox has access to and partially funds GP Liaison and GP Consultant positions that are employed through the Knox Division of General Practice.

It was generally recommended to engage a position for GP Liaison early in the project, rather than waiting for the program and processes to be fully established.

Relationships with other stakeholders have been strengthened through EliCD, including Primary Care Partnerships (PCPs), Royal District Nursing Service (RDNS), consumers, Neighbourhood Renewal Programs and DHS, for example through participation of these organisations on EliCD steering committees. Steering groups and working parties for EliCD were integrated with local Primary Care Partnerships, other chronic disease programs, such as HARP, self management networks and interdisciplinary work groups in the organisations to ensure that EliCD interfaced with related programs in the region to enhance referral processes and access for target population groups.

### ***Recruitment***

Recruiting into a self management program is difficult, particularly as the strategies and outcomes are hard to quantify and explain. Clients want their clinical problem managed, and may not be interested in referrals to unrelated practitioners. Finding the language to explain the concept of self management and the key worker role to GPs and clients was a challenge for marketing the intervention. Education for GPs and clients about self management is needed, and suitable resources will need to be developed. Having a consistent program name and marketing approach led by DHS would help to reduce confusion, particularly when services cross Div GP and local government boundaries.

### ***Target groups***

Many community health service clients speak English as a second language. Over 35% of the residents of the cities of Darebin and Monash were born outside Australia, coming predominantly from Italy, Greece, South East and South Asia. Sixteen percent of Knox residents speak a language other than English as their first language. Interpreters were used for non-English speaking clients, and self management tools will be translated and adapted for non-English speaking clients. Darebin CHS initially piloted processes with English-speaking clients to establish protocols and allow staff to practice new self management skills.

Clients from culturally and linguistically diverse (CALD) groups, in particular older, non-English speaking clients, were perceived by some health professionals to be less willing to participate in self management as this is not compatible with their expectations of health care, and prefer a more directive approach. The Flinders assessment tools and care plans are seen as very time-consuming to use, particularly with an interpreter and the meaning can be 'lost in translation'.

Although referral pathways were documented and disseminated, some clinicians were unclear about which clients could most benefit from the EliCD self management program. Having clearly defined target groups helps to determine eligibility, however, these were not helpful to some staff for identifying those who may benefit from self management support. Eligibility criteria were based on medical conditions, rather than risk factors which are amenable to change.

### **4.3 Leadership and Strategy**

#### **Program goals and objectives**

Knox CHS identified the following priorities for chronic disease care: more streamlined, consistent internal referral system; enhanced continuity between dental and other services; to embed self-management and; support evidence-based care through assessment and care planning tools.

The overall goal for the EliCD program at Darebin is for better outcomes for clients with chronic disease, through client centred care and care planning.

The MonashLink program is a multi-disciplinary model, aiming to integrate care coordination and self-management across programs in the organisation. Building capacity for chronic disease management, improving referral pathways and service coordination, and better communication and engagement with GPs and the Divisions of GP are also an aim of the program.

#### **Organisational structure**

Although each CHS had similar goals and objectives, the approach to implementation of EliCD has differed. Knox CHS undertook an organisation-wide approach, training staff involved in chronic disease care in self management and health coaching, with most having roles as the 'primary contact' to coordinate referrals and be the contact point in the organisation for clients. Staff worked in multidisciplinary teams and there was an established chronic disease program. Service coordination processes have been redesigned and coordinated intake, assessment and referral pathways established.

Darebin CHS commenced a planned restructuring of programs and services into multidisciplinary teams during 2007. The EliCD program and key worker role was integrated into the new chronic and complex care team. Seven key workers from different professional disciplines provide holistic assessment, health coaching and self management support to clients meeting specific criteria and are referred into the 'Healthwise' (EliCD) program.

MonashLink CHS also created a multidisciplinary key worker team to provide care planning and self management support for clients with chronic medical conditions. Health professionals work in three care teams for Healthy Ageing, Children and Community and Counselling and Drug and Alcohol. A range of support programs augmented the EliCD intervention and complemented existing services for clients with chronic conditions.

Implementation of the key worker role and strategies for chronic disease care were adapted to the existing service structure in each CHS. Knox had restructured their clinical teams prior to implementing EliCD. Darebin were undertaking an organisational restructure concurrently with EliCD, and Monashlink have plans to reorganise their clinical groups into multidisciplinary teams. Each CHS took a different approach initially, though they are all working towards integrated systems for chronic care and self management support across the organisation.

### **Vision and goals**

Workshop participants identified the importance of leadership and commitment at all levels of the organisation and a clear vision for EliCD that is consistent with organisational goals. Participation of staff at all stages along the way was advised, through consultation, opportunities for feedback, and regular communication of information. Change took longer than expected to achieve so expectations and timelines should be realistic.

### **Change champions**

External consultants, self management trainers and peer support networks have strengthened the uptake of self management at the community level in the northern metropolitan, and Inner and Outer East PCP regions. These networks have been a vehicle for sharing information and maximising resources for staff development and local self management program delivery.

Key workers have become change champions as they have been able to demonstrate positive client outcomes and personal development in the role. Staff also appreciated the value of, and were able to identify, role models from within each discipline and in key-worker and non-key worker roles to promote adoption of self management at the clinical practice level.

Project managers, who need to be engaged early on, lead and initiate change. However, this role has changed and managers/team leaders have assumed a greater role in operationalising activities as the program has evolved.

## **4.4 People**

To be successful, the whole organisation needs to be engaged in the change effort. There are three main categories of people in the organisation affected by change: managers and leaders; those coordinating implementation; and those who are the recipients of change<sup>37</sup>.

Several roles have been significant in the EliCD change process. External experts in chronic disease management were consulted to facilitate a self assessment and priority setting process. They have continued to act as a resource at the organisational and PCP level.

During the establishment phase of the program the agencies employed project managers to lead the change process. This position has transitioned into the team leader role. This is consistent with the transformational and transactional features of change in Burke and Litwin's model<sup>38</sup>. Project managers were leaders and drivers of change, however, team leaders are instrumental in the management and implementation of change. Team leaders have an important role in the dissemination of change across the organisation, through communication, role modelling and modifying work practices. They can also monitor behaviour change and provide feedback to team members.

### **Key workers**

A central feature of the EliCD program was the key worker who became the primary contact in the organisation and coordinator of care for each client. This role involves the following activities:

- self-management assessment / generic assessment using the Flinders tools,
- collaborative goal setting for personal change,

<sup>37</sup> Garside P. Organisational context for quality: lessons from the fields of organisational development and change management. *Quality in Health Care* 1998;7((Suppl)):S8-S15.

<sup>38</sup> Burke W, Litwin G. A Causal Model of Organisational Performance and Change. *Journal of Management* 1992;18(3):523-545.

- coordinating referrals to other disciplines and services,
- monitoring management of the client's condition,
- following up the clients' progress with personal goals.

Becoming a key worker was a new way of practicing for those who were appointed to the role, and requires certain skills and attributes. Professional disciplines experienced with case management and self management adopted the role more readily, whereas those whose usual role is to provide clinical treatment or advice were reported to have more difficulty in adapting to the role. Being able to hand over control to the client was challenging for some health professionals.

The role also created a number of dilemmas that were resolved as confidence grew and processes became established. Several clinicians were uncertain about how to resolve their duty of care and client autonomy, if clients made choices that potentially compromised their safety. Some described themselves wearing 'two hats', and wanted to separate their clinical role when they give advice or information, from the key worker role, where the client identified the problem and potential solutions. Knowing when to discharge clients from the program was also unclear. Key workers had not yet sufficient experience to determine when to cease the intervention or how this would occur.

Staff identified the need for a process to clarify clinical and operational supervision of the multidisciplinary key worker team. Scope of practice, role boundaries and criteria for interdisciplinary referral also needed to be defined.

MonashLink developed a comprehensive orientation manual and job description for key workers to help prepare them for the role. At Darebin CHS supervision and line management of key workers occurred through the restructured work teams which made accountability clearer and helped to facilitate change. Clinical supervision, referred to as 'secondary consultation' with a staff psychologist or counselor, was provided to key workers on a regular, formal basis for debriefing, and to support learning and practice change.

### ***Readiness to change***

The key workers appeared to be early adopters who trialled and adapted the EliCD intervention within their organisation. Staff who had not attended Flinders self-management or Health Coaching courses may be those who are less ready to change or to recognise the need for change. Responses from the focus groups indicated a difference between the perceptions of key workers and other staff regarding the degree of personal change required to adopt self management strategies and integrate them into their own practice.

Ongoing training and providing the opportunity for key workers to demonstrate strategies and client outcomes to others was important for them to see the benefits and advantages first hand. This may help to avoid the late adopters from lagging behind and include them in the change effort. Nevertheless, it takes time for staff to change, for processes to be trialled and implemented and difficulties to be ironed out and this needs to be recognised at all levels.

### ***Communication***

Staff were invited to participate in a range of consultation and feedback forums conducted by their organisations. These were a forum for staff to hear about the EliCD program, to voice concerns or contribute ideas.

A number of organisational features appeared to limit communication and networking. This included having more than one service site, part-time workers and staff employed across a number of program areas. Although email and other mass communication are efficient, this sometimes

failed to reach all staff. Informal, personal communication in teams, shared work areas and offices was reported by staff to be the most effective method to hear news and keep updated.

### **Staff satisfaction**

The opportunity to take on new roles and learn new skills was valued by staff. The positive benefits of the EliCD program and self management approaches were reported by staff and from clients. As EliCD clients made significant lifestyle improvements staff felt professionally rewarded. These beneficial results increased client referrals into the program.

## **4.5 Skills and Learning**

### **Skill development**

Clinical staff in each organisation participated in training to facilitate client self management. The two-day 'Health Coaching' course was delivered by a health psychologist and an exercise physiologist from Health Coaching Australia. This course focussed on skills to improve lifestyle risk factors and adherence to medical treatment regimens for chronic illness self-management. The two-day Flinders Self Management Course was delivered by an accredited trainer. The course content was based on the Flinders tools, and included assessment and care planning and building confidence and skills when working with clients. To successfully complete the Flinders Certificate of Competency, participants submit three completed care plans for assessment.

Learning and practice change was supported during the course with the opportunity to practice and gain confidence using the self management tools. It was recommended that incorporating the tools into clinical practice as soon as possible would reinforce learning. This needed to be planned ahead and suitable clients scheduled. Although recognition for training can be an incentive for learning, few staff had achieved the Flinders Certificate of Competency, as they had not had the opportunity to use the tools with clients or did not feel they needed to use them in their current role.

Informal support for learning was highly valued by staff. They preferred to learn through peer support from key workers, other team members, secondary consultations and by clinical supervision. Other methods of building confidence included the sharing of experiences in team meetings as well as a buddy system where staff would pair up to model and observe self management skills. Key workers were mentored by the EliCD psychologist or counselor. Job descriptions, an orientation manual, clinical guidelines and structured self management tools, such as Flinders tools, also helped key workers to understand their new role and their scope of practice.

### **Self management tools**

Staff found the Health Coaching tools helpful and could be used with a range of clients. Some thought that the Flinders tools were too time consuming and prescriptive, preferring to remain flexible in their approach to client care, while others found the structured assessment tools and care plans, such as the Flinders tools, were helpful for learning.

The EliCD program teams in each CHS used a combination of the Flinders tools, Health Coaching or DHS service coordination tools (SCTT) when assessing clients and care planning for self management. It is anticipated that in time, these tools would be implemented across the organisations.

### **Practice change**

An aim of EliCD is to have a workforce and system of care that can respond to the needs of people with chronic disease. This includes having the appropriate skills to support clients with self management. Training in the Flinders Model of Self Management and the Health Coaching course

were important for practice change. The Flinders tools assist health professionals to modify their own behavior with clients. To be effective, learning needed to be put into practice as soon as possible and staff needed to feel enabled to change the way they interact with clients and to spend more time during consultations. Ways to manage waiting lists and appointment times need to be planned. Clinical supervision, informal support from peers and time for practice to develop new skills and confidence was also important. Health professionals who had observed positive lifestyle changes in their clients were enthusiastic about the new approach and skills.

Flinders promotes person-centred care, in which the client's needs and problems are explored and their priorities and goals form the basis of the care plan. The attributes of the self management practitioner include the skills to assess risk factors, to support clients to cope with their emotions and living with a chronic condition, and to be flexible and allow the client to find their own solutions. Attitudes to mental health problems and lack of confidence to explore emotions were barriers to practice change for some staff. Being able to relinquish control and the role of expert was also hard for some. Self management challenges the traditional clinical model.

### ***Integrating new skills into practice***

Practice changes adopted by key workers will need to be disseminated across the organisation. A number of issues were observed which indicated some of the gaps and changes that may be needed to integrate self management strategies organisation-wide. These included:

- A consistent understanding by all staff of the features of the chronic care model in the context of their organisation and professional practice, including self management.
- There is a difference between knowing and understanding self management and incorporating it into the clinical role. Confidence and experience using the Flinders tools takes time and practice and is a significant change to the way many health professionals work.
- A holistic approach includes both the physical, emotional and social issues affecting client self management. Some staff expressed a strong reluctance to explore emotional issues and lacked confidence and knowledge about how to deal with mental health problems. With the exception of key workers and counsellors, most clinicians do not routinely screen for anxiety and depression.
- A lack of consistent processes and documentation for screening and care planning and shared access to information in some clinical teams. Screening for biomedical, lifestyle, emotional and social issues that may impact on self management should be consistent and common tools used throughout the organisation to identify issues and facilitate appropriate referrals. Care plans should be documented and a written copy provided to clients.

### ***Workforce development***

Provision of training courses needs to be ongoing to account for workforce turnover and to maintain skills. Current training courses are expensive, so ongoing funding and coordination of training, perhaps at the Primary Care Partnership (PCP) or state level would be advantageous. This is happening at the PCP level in several regions, with shared provision of training courses and regional, self management peer support networks.

## **4.6 Systems and Structures**

Attention to the systems and infrastructure that support practice change is essential to embed innovation in the organisation. Processes need to be standardised, communicated to, and understood by all staff and uniformly implemented to trial and demonstrate their effectiveness. Decision support tools, including policies and procedures, referral pathways, clinical guidelines and assessment and care planning tools create a standard way of providing care, and support clinician behaviour change.

### ***Decision support tools***

Screening to assess lifestyle and psychosocial risk factors related to chronic disease self management is an important component of care. The DHS service coordination tools (SCTT) are a generic screening tool to identify needs that require further investigation. Some clinicians used them only when referring to other providers. Currently generic screening is not conducted routinely by all clinicians, however, the organisations were working towards developing common screening and self management tools.

Responses from staff during focus group sessions indicated conflicting views on the acceptability of the tools and resistance to changing individual ways of working. Lack of confidence using the tools and moving outside of their discipline-specific clinical role were barriers to using generic tools. Staff also found it hard to identify which clients could benefit. The outcomes of self management are not explicit, and though some individuals change lifestyle behaviours and gain mastery, these events are hard to generalise for clients. Some staff will resist change, however, this is to be expected and decision support tools can be used to underpin change efforts and identify where compliance is slipping and guide feedback on performance.

### ***Service coordination and internal referral systems***

Service coordination systems were well established and supported intake and referral within the organisations. New processes and practices have been trialled with a group of staff or key workers then implemented across the organisation.

Knox CHS undertook a review of service coordination which resulted in a comprehensive implementation plan for referral, assessment, care planning and coordination of care. They have also developed clinical pathways and guidelines for common chronic conditions, including diabetes, chronic obstructive lung disease and osteoarthritis to guide practice and disease management.

### ***Communication/participation***

Communication for input, feedback, information and motivation needs to be planned and provided at all stages of the change process. Personal interaction during team meetings, office and tea room settings may be more effective for dissemination of change. Involving team leaders and peers for example buddy systems, may improve communication, particularly to part-time staff or those who work outside the office or main sites.

### ***Clinical information systems***

Electronic referral systems have been initiated and a patient data management system will be installed in agencies via the DHS HealthSMART initiative. This will facilitate sharing of information between providers and sites, care planning, client recall and review, which are key elements of the chronic care model.

### ***Time***

Time and funding arose repeatedly during the consultation, as vital resources for facilitating change. Planning meetings, consultation, staff training, developing processes, roles and decision

support tools take time, and the EliCD funding provided for additional staff to undertake these activities. Extra time needs to be allowed during consultations for using self management strategies, therefore the appointment structure needs to be flexible to include longer consultations and regular follow-up. Clients' time and cost to participate also needs to be considered and may be a barrier to recruitment if the benefits are not clear.

### ***Monitoring change***

Change management should be integrated with quality systems to monitor performance and adjust goals. Auditing the uptake of new processes will help to identify barriers to change and areas for further development. The community health services have conducted audits and repeated the organisational self assessment used in the planning stages, to review the implementation of systems for chronic illness care.

## ***4.7 Outcomes of EliCD***

The evaluation also sought to assess the model of implementation and whether the objectives for practice change and system reorientation have been achieved. The consultation workshop attended by representatives from community health services across the region, regional DHS staff, managers and clinical staff of the three CHS provided the opportunity to demonstrate the outcomes of EliCD and system reorientation for integrated chronic care.

The main achievements from EliCD have been the development of processes for assessment and care coordination and strengthening of relationships within services and with external stakeholders.

Key achievements reported by the three organisations were:

- Relationship building with PCP, Divisions of General Practice and the acute sector;
- Increased self management awareness and capacity in the organisations;
- Increased service capacity for multidisciplinary care;
- More flexible and coordinated approach to chronic disease management;
- Improved care and responses to people with chronic diseases;
- Common screening tool to identify risk factors that may prompt referral to other clinicians;
- Evidence-based treatment options;
- Linking with, and enhancing, other internal self management programs, eg smoking cessation, support groups;
- Involving consumers and a broad range of staff in planning and development.

## 5. Discussion

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The three case studies provided the opportunity to explore how the chronic care model was being implemented and the conditions that facilitated change at the practitioner, organisational and service system level. At the time, each organisation was simultaneously dealing with other transitions including the introduction of new information management systems, staff turnover, and restructuring, all or any of which can induce 'change fatigue' for staff dealing with constant change.

### 5.1 Facilitators and barriers to individual change

At the individual practitioner level, a number of activities were reported to facilitate practice change:

- Structured learning programs to develop self management skills. The Health Coaching program and accompanying worksheets were well regarded by staff. Responses to the Flinders course varied. Some found it rather prescriptive whereas for others it helped them learn the required skills for supporting self management.
- Ongoing support for learning. Key workers were practicing outside their usual scope of clinical practice and valued the support from mentoring, peer support, clinical supervision or secondary support from counsellors. Provision of training needs to be ongoing to accommodate workforce turnover.
- Practice new skills and build confidence as soon as possible after training occurs. Consultations with longer appointment times need to be scheduled to practice using the Flinders tools. This would increase completion of the case studies for the Certificate of Competency. Although recognition for training can be an incentive for learning, few staff had achieved the Certificate of Competency, as they had not had the opportunity to use the tools with clients or did not feel they needed to use them in their current role. Practice with using the tools and self management skills soon after training helped to reinforce learning and confidence, so the importance of completing the required case studies could be emphasised more strongly.
- Clinical roles are specified through a job description and orientation manual to clarify roles and role boundaries and accountability.
- Clinical tools are used to support and reinforce new behaviours. Referral pathways, and intake criteria can help to identify those clients who are at greatest risk to prioritise service demand, and which clients may benefit most from self management support. Criteria to determine the appropriate time for discharge may also be helpful to clinicians and to use services most efficiently. Common assessment tools and care plans (SCTT and Flinders tools) promote consistent practice and encourage use of the tools, particularly for staff who may be less confident with exploring areas outside their usual clinical role.
- The clinician has experienced the benefits of practicing in a different way to support client self management and observed the lifestyle changes their clients had made.
- Being consulted and having the opportunity to participate and feedback suggestions increased awareness and interest in EliCD.

A number of barriers to individual practice change were observed, which may impact on the capacity to offer effective self management support to clients.

- People with chronic diseases have high rates of co-morbid depression and anxiety<sup>39</sup>, which may impact on self care and adherence to treatment<sup>40</sup>. The common screening tools (SCTT) include an anxiety and depression screening score (K10), however, some staff lacked the skills and confidence to explore mental health problems with clients, and believed stigma often prevented clients from accepting treatment or referral to mental health professionals.

Results from the SA HealthPlus Coordinated Care Trial showed that the clients who benefited most from care planning and coordination had social and lifestyle risk factors, were depressed, had low motivation and poor knowledge and control of their condition<sup>41</sup>. Screening and assessment tools that include emotional and behavioural components can support clinical decision-making and identify potential areas for change, and prompt referral to a key worker or counsellor. Raising awareness of the association between depression, anxiety and poor self management of chronic conditions should be considered. Staff will need to develop skills in assessment and referral and dealing with emotions. These skills ought to be incorporated into self management training.

- Older clients, in particular those from non-English speaking backgrounds, were perceived to be less amenable to self management and the assessment and care planning tools less effective with interpreters. Although different cultural and age groups have different views of health and expectations of health care, results from self management programs with CALD and Aboriginal groups have not supported this view. However, outcomes may not be consistent across all cultural groups, requiring some program aspects to be modified to suit particular groups<sup>42, 43, 44</sup>. The statewide evaluation only included English speaking clients, so further evaluation with Non-English speaking clients is required.

## 5.2 Service level change

- Flexibility to extend the duration of consultations is needed to allow adequate time for self management assessment and goal setting. However, demand for services and appointments that are booked long in advance, prevented some staff from being able to modify their practice. Self management consultations could be scheduled into the appointment system.
- Dedicated time is required for developing pathways and tools and processes for incorporating these changes into clinical practice. The EliCD funding provided the extra resources for staff to be available to complete these projects.

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<sup>39</sup> Golden S., Lazo M., Carnethon M., et. al. Examining a Bidirectional Association Between Depressive Symptoms and Diabetes. *JAMA*, 2008; 299(23): 2751-2759.

<sup>40</sup> Reddy, P & Dunbar, J. (2007). Type 2 diabetes and depression: Assessing the prevalence in Victoria and identifying effective public health interventions. Greater Green Triangle University Department of Rural Health.

<sup>41</sup> Battersby M, Harvey P, Mills PD, Kalucy P, Pols RG, Frith P, et al. SA HealthPlus: A Controlled Trial of a Statewide Application of a Generic Model of Chronic Illness Care. *The Milbank Quarterly* 2007;85(1):37-67.

<sup>42</sup> Swerisson H, Belfrage, J., Weeks, A., Jordan, L., Walker, C., Furler, J., McAvoy, B., Carter, M., Peterson, C. A randomised control trial of a self-management program for people with a chronic illness from Vietnamese, Chinese, Italian and Greek backgrounds. *Patient Education & Counseling* 2006.

<sup>43</sup> Wade V, Jackson D, Daly J. Coronary heart disease in Aboriginal communities: towards a model for self-management. *Contemporary Nurse* 2003;15(3):300-9.

<sup>44</sup> Rowley KG, Daniel M, Skinner K, Skinner M, White GA, O'Dea K. Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian aboriginal community. *Australian and New Zealand journal of public health* 2000;24(2):136-44.

- In the initial stages, project managers were important for leading change. However, team leaders have a key role in disseminating information and uptake of new practices, and for monitoring and managing the response to change. They will be important for promoting the uptake of change across the organisation.

### **5.3 Change at the organisation level**

- A process for self-assessment to identify the need and priorities for change to chronic care delivery created an impetus and direction for organisational change.
- Leadership and commitment from managers was evident and ELiCD complemented organisational goals and other programs and initiatives being established within the local communities. Leadership for change needs to be at the organisation and program level to integrate and communicate change.
- Working in multidisciplinary teams supported integrated chronic disease care. Observing other ways of working and thinking, for example through case conferencing, exposes individuals to multidisciplinary options for managing client issues and promotes interdisciplinary communication and referral.
- New protocols, procedures and self management tools were developed and trialled in a team or program area so they could be adapted for the service and implementation issues ironed out before extending to the broader organisation.
- The Chronic Care Model is a systems-based approach to care. Elements of the model are interrelated, as are the elements of the change process. Standardised approaches help to ensure that care is appropriate, effective, efficient, safe and timely, which are the basic criteria for healthcare quality. Systems also support the sustainability of change.

Systems that support implementation of ELiCD are:

- Documented systems for organisation-wide intake, service coordination and referral processes support decisions about which clients are referred and where and how to prioritise health resources. People with chronic disease are regularly reviewed and follow-up is planned.
- Standard assessment and care planning tools and evidence-based treatment guidelines improve the consistency of care.
- Information systems designate how staff are consulted and kept informed and how client information is recorded and shared between providers and outcomes are monitored. Informal communication may be effective for disseminating change, for example through work teams and peers.
- Learning is supported by training, practise with the self management tools and mentoring. Training is ongoing for new staff. Reward or recognition systems could be used to promote learning, such as accreditation or career pathways.

#### ***5.4 Change at the Primary Care Partnership level***

One of the benefits from EliCD has been the building of relationships with stakeholders in the PCP. Sharing learnings and resources, secondment and mentoring could facilitate uptake of EliCD in the region and local partnerships could share training and marketing.

Regional networks can offer support, mentoring, sharing of resources and coordination of training. A greater role could also be played by DHS to disseminate consistent messages about self management and early intervention for GPs and consumers, and to support ongoing provision of training.

## 6. Early Intervention Framework for Change

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In order to integrate the learnings from this study, a framework for practice change has been created. The *Early Intervention Framework for Change* identifies the features associated with successful individual and organisational change in community health services. Based on the six dimensions identified from the literature, and the qualitative data collected from the focus groups and workshops conducted during this project, the framework demonstrates the interrelated attributes, resources and processes that should be considered when planning change. *The Early Intervention Framework for Change* is presented in Figure 1.

Two key publications have strongly influenced the development of this framework. Burke and Litwin developed the 'Model for Organisational Performance and Change', to demonstrate the main variables that they believed will have an effect on change and should be considered when planning organisational change<sup>45</sup> (p. 529). Their model was based on open systems theory<sup>46</sup> where each element interacts bi-directionally. The variables were derived from practice and supported by empirical evidence from the change management literature. Their 12 variables incorporating the 'transformational' and 'transactional' factors associated with leadership and management of change have been integrated within the components of our framework.

Gustafson et. al.<sup>47</sup> engaged an expert panel to create an 18 factor model to predict the outcomes of organisational change efforts. They included a three level scale of performance criteria to rate the predicted likelihood of successful implementation of change. Gustafson's model and performance criteria have also contributed to the elements within our framework, and inclusion of the 'organisational conditions / personal attributes' component. This component of the framework may be used for planning change strategies or further developed as indicators for monitoring the implementation of change.

The objective of the *Early Intervention Framework for Change* is to guide other community health services involved in similar change processes to support improved chronic disease care. The framework prompts consideration of the elements within the organisation that will be affected by change and may influence outcomes. It also describes the organisational and personal attributes that facilitate change and outlines the resources and strategies that support change within each dimension.

This framework may not be applicable to other types of organisations, as it has been developed for community health services, which has a largely female, health professional workforce. This could influence the most appropriate attributes and strategies for change.

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<sup>45</sup> Burke W, Litwin G. A Causal Model of Organisational Performance and Change. *Journal of Management* 1992;18(3):523-545.

<sup>46</sup> Katz and Kahn (1978) in Burke and Litwin. A Causal Model of Organisational Performance and Change. *Journal of Management* 1992;18(3):523-545.

<sup>47</sup> Gustafson D, Sainfort F, Eichler M, Adams L, Bosognano M, Steudel H. Developing and Testing a Model to Predict Outcomes of Organizational Change. *Health Services Research* 2003;38(2):751-776.

## 6.1 Figure 1: Early Intervention Framework for Change

Change dimension	Organisational conditions/ Personal attributes	Resources	Strategies / Processes
<b>Drivers of change</b> <ul style="list-style-type: none"> <li>○ <i>Problem or needs</i></li> <li>○ <i>Benefits &amp; rewards</i></li> <li>○ <i>Policy</i></li> <li>○ <i>Programs &amp; funding</i></li> </ul>	<ul style="list-style-type: none"> <li>• Problems or needs identified</li> <li>• Dissatisfaction with current conditions</li> <li>• Reflects on practice</li> <li>• Driving forces overcome resistance</li> </ul>	<ul style="list-style-type: none"> <li>• Change champions</li> <li>• Funding</li> <li>• Evidence / information</li> </ul>	<ul style="list-style-type: none"> <li>• Explore problem and needs</li> <li>• Seek new ideas</li> <li>• Review evidence-base</li> <li>• Self assessment</li> <li>• Critical reflection</li> </ul>
<b>Environment</b> <p><b>External</b></p> <ul style="list-style-type: none"> <li>○ <i>Stakeholders</i></li> <li>○ <i>Economic</i></li> <li>○ <i>Political</i></li> <li>○ <i>Socio-cultural</i></li> </ul> <p><b>Internal</b></p> <ul style="list-style-type: none"> <li>○ <i>Culture</i></li> <li>○ <i>Norms, practices</i></li> <li>○ <i>Capacity</i></li> </ul>	<ul style="list-style-type: none"> <li>• Organisational culture open to innovation and communication</li> <li>• Structure supports implementation</li> <li>• Funding models appropriate</li> <li>• Appropriate target groups identified</li> <li>• Equity and access optimal</li> <li>• Stakeholders engaged</li> </ul>	<ul style="list-style-type: none"> <li>• Community</li> <li>• Needs assessment</li> <li>• Incentives / rewards</li> <li>• Funding</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholder consultation</li> <li>• Seek staff input</li> <li>• Staff development / education</li> </ul>
<b>Leadership &amp; strategy</b> <ul style="list-style-type: none"> <li>○ <i>Mission &amp; vision</i></li> <li>○ <i>Goals</i></li> <li>○ <i>Plans</i></li> </ul>	<ul style="list-style-type: none"> <li>• Leaders and staff motivated</li> <li>• Managers committed</li> <li>• Proposed changes compatible with mission &amp; values</li> <li>• High expectations for performance</li> </ul>	<ul style="list-style-type: none"> <li>• Change champions</li> <li>• Time for planning and/or redesign work</li> <li>• Funding</li> <li>• Evidence of effectiveness</li> <li>• Model - CCM</li> </ul>	<ul style="list-style-type: none"> <li>• Set goals &amp; vision</li> <li>• Proposed solution tailored to the organisation</li> <li>• Plan tasks</li> <li>• Communicate vision and plans</li> <li>• Monitor performance and seek feedback</li> </ul>

Change dimension	Organisational conditions/ Personal attributes	Resources	Strategies / Processes
<b>People</b> <ul style="list-style-type: none"> <li>○ Values &amp; needs</li> <li>○ Attitudes</li> <li>○ Roles</li> <li>○ Skills</li> <li>○ Adoption of change</li> </ul>	<ul style="list-style-type: none"> <li>• Culture supports innovators &amp; early adopters</li> <li>• Readiness to change / resistance</li> <li>• Staff support change</li> <li>• Perceived advantages outweigh disadvantages</li> <li>• Roles and professional boundaries clear</li> <li>• Job satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• Adequate staff time for planning and developing resources to support change</li> <li>• Training programs</li> <li>• Funding</li> <li>• Rewards and feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Innovators seek new ideas</li> <li>• Early adopters trial and adapt innovations</li> <li>• Opportunities are provided for debate &amp; feedback</li> <li>• Communicate progress</li> <li>• Roles specified</li> </ul>
<b>Skills &amp; learning</b> <ul style="list-style-type: none"> <li>○ Skills</li> <li>○ Knowledge</li> <li>○ Job roles</li> </ul>	<ul style="list-style-type: none"> <li>• Staff have the required skills &amp; knowledge</li> <li>• Clinicians have the confidence to implement new skills</li> <li>• Job role fit</li> <li>• Feedback is used to improve processes.</li> </ul>	<ul style="list-style-type: none"> <li>• Policies, procedures, protocols documented</li> <li>• Training materials and programs</li> <li>• Mentors</li> <li>• Job descriptions</li> <li>• Evidence for effectiveness</li> <li>• Funding supports ongoing provision of training</li> <li>• Recognition/accreditation</li> </ul>	<ul style="list-style-type: none"> <li>• Self-assessment</li> <li>• Generate solutions</li> <li>• Formal learning, coaching</li> <li>• Informal learning / support /</li> <li>• Secondary consultation / support</li> <li>• Recognition / accreditation</li> <li>• Define roles / job descriptions</li> <li>• PDSA</li> <li>• Share learning</li> </ul>
<b>Systems &amp; structures</b> <ul style="list-style-type: none"> <li>○ IM systems</li> <li>○ Decision-support tools</li> <li>○ Individual and organisational performance</li> </ul>	<ul style="list-style-type: none"> <li>• Consistent processes across the organisation</li> <li>• New behaviours are supported</li> <li>• Technology supports systems</li> </ul>	<ul style="list-style-type: none"> <li>• Referral pathways</li> <li>• Tools to support consistent assessment, care planning and documentation</li> <li>• Information management systems</li> <li>• Communication systems</li> <li>• Infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>• Implement protocols</li> <li>• Develop tools to support new behaviours and skills</li> <li>• Develop methods for customer and staff feedback</li> <li>• Implement IM systems</li> <li>• Monitor performance</li> </ul>

## 7. Recommendations for organisational and practice change

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*“A key factor in closing the gap between **best practice** and **common practice** is the ability of health care providers and their organizations to rapidly spread innovations and new ideas. Pockets of excellence exist in our health care systems, but knowledge of these better ideas and practices often remains isolated and unknown to others”.*<sup>48</sup>

Our study identified the changes that occurred in both management and care practices required for the successful implementation of the chronic care model. Health workers need to develop the necessary skills that support self management for people with chronic disease. However, the cornerstone of success is the systems and structures that support individual and organisational practice change.

Based on the findings from the qualitative research, recommendations for organisational and practice change to improve chronic illness care are proposed. The recommendations will have relevance for other community health services which are going through similar change processes and can be used to support implementation of the Chronic Care Model.

The recommendations are grouped into themes derived from the Chronic Care Model:

1. Health care organisation
2. Delivery system design
3. Decision support
4. Self-management support
5. Community linkages
6. Clinical information systems

### **1 Health care organisation**

When planning change for the development of early intervention programs, the following recommendations are made at the level of the organisation’s strategic thinking and planning. Recommendations are that:

- The whole organisation needs to be engaged in the change effort.
- The vision for change is compatible with the organisation’s mission and goals and is clearly articulated to staff. The strategic plan, operational plans, policies and procedures reflect the organisation’s commitment to preventive, client-centred care.
- Change champions are accessible and help the organisation to implement chronic care systems.
- Formal and informal processes for communication, consultation and learning for staff are planned for all stages of the change process. Structured learning and regular communication should be ongoing and supported by peers at team meetings and mentors/supervisors.
- Services assess the need to reorient service priorities to reduce waiting times for clients in EliCD, to enable integrity of the early intervention goals and care planning for each client.

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<sup>48</sup> Massoud MR, Nielsen GA, Nolan K, Nolan T, Schall MW, Sevin C. *A Framework for Spread: From Local Improvements to System-Wide Change*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006. (Available on [www.IHI.org](http://www.IHI.org))

## **2 Delivery system design**

- The organisational structure supports chronic disease care:
  - Services are organised around client needs through multidisciplinary care teams.
  - Integrated, multidisciplinary care is guided by a shared, client-centred care plan. There are opportunities for case conferencing and interdisciplinary care planning.
  - Team leaders are utilised for communicating and supporting practice change across the organisation.
  - Clinical supervision and mentoring to promote self management is available to all staff involved in chronic care. 'Secondary consultation' by psychologists or counsellors supports individual practice change.
- Clients' problems, risk factors and health care needs are explored by way of a generic assessment to inform a care plan.
- A plan of care, based on the client's goals, is documented and shared with the health care team. A copy, in language understood by the client, is provided to the client. The care plan and client goals, guide future visits and referrals to other providers.
- Care is coordinated and routine follow-up is planned. Responsibility is designated to a particular person or role, for example the key worker or primary contact in the organisation.
- The key worker role and the scope of practice within professional disciplines are defined. A job description and guidelines are available.
- The appointment structure is flexible to allow extended consultation when required.

## **3 Decision support**

- A process for organisational self assessment is undertaken to identify gaps and determine priorities for improving chronic care and monitoring progress of change, for example the Organisational Skills Analysis Tool.
- Common assessment and care planning tools are implemented across the organisation. A standard set of tools ensures consistent practice.
- Evidence-based guidelines are developed to guide decision-making and support practice change, and include:
  - Referral criteria and treatment pathways are based on appropriate target groups and health risk category to help prioritise demand for services.
  - Clinical guidelines for management of chronic diseases.
  - Criteria for follow up and ongoing review of care and outcomes or discharge/referral to other services.
- Staff are trained in self management and use tools such as the Flinders or Health Coaching tools to support behaviour change. Training needs to be ongoing due to workforce turnover. Programs organised centrally through DHS or regionally through PCPs may be more sustainable.

#### **4 Self-management support**

To ensure effective development of self-management skills in clients, recommendations are that:

- Clients are supported to improve self management skills through collaborative problem solving, goal setting, information about their condition and treatment plans, self management courses and support groups.
- Health professionals have access to informal learning such as peer support networks and counselling support/consultation.

#### **5 Community linkages**

To ensure that community linkages function effectively to support referrals into early intervention programs, recommendations are that:

- GP engagement is established early by employing a GP liaison role, and relationships built with divisions, practice nurses, and GPs to promote referrals, communicate client information .
- Professional networks are formed at a local, regional and state level to develop a common communication strategy about self management for consumers and GPs and to provide self management training.
- Information resources about community-based services, recreation centres, industry, clubs and churches are available to refer clients for social and self management support.

#### **6 Clinical information system**

To ensure that clinical information systems operate effectively to support early intervention programs, recommendations are that:

- A system is used to register and track clients for follow-up and to monitor care processes and outcomes.
- A shared client record is available to all members of the healthcare team to promote interdisciplinary communication and coordinated care.
- Electronic information systems support client care delivery, eg. e-referral, HealthSMART, Switch.

## **Appendix 1 – Focus group topic questions**

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1. Introduction to project, researchers and study.
2. Tell me about your current role and your experience working with integrated chronic disease management / self management.
3. What do you understand are the elements of the early intervention in CD / chronic care model?
4. What changes have you made to your own practice as a result of the self management training you have participated in?
5. How would you describe good practice in chronic disease management?
6. What are the facilitators of good practice in the EICD program?
7. How do you think the EICD model will change the way you work?
8. Do you experience issues regarding role boundaries? How are these sorted out?
9. What are the barriers and / or weaknesses in the model?
10. How might the barriers be overcome?

## Appendix 2 – Questions for Manager’s interview

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1. How would you describe the program model?
2. What new positions have been created or restructuring has occurred?
3. What management structure governs the project?
4. What is the learning model for the program?
5. What do you hope the project achieves?
6. What does EICD mean in terms of organisational change?
7. What individual practice change do you want to see?
8. What can clients expect to achieve from EICD?
9. What you see as the hurdles to achieving the program aims?
10. What are the facilitators of good practice in chronic disease care?
11. What are the successes to date of the EICD program?
12. What might you do differently if starting again?