

DHS Primary Health Branch

Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services

October 2008

These revised Guidelines are based upon the '*Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services*' published in October 2006.

Changes reflect more current and accurate information with some reorganisation of the material.

A more comprehensive review of the guidelines is planned in 2009.

Published by the Victorian Government Department of Human Services, Melbourne, Victoria

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Foreword

The burden of chronic disease is increasing rapidly. In Victoria, approximately 70% of the total burden of disease is attributable to six groups: cardiovascular disease, cancers, injuries, mental health conditions, diabetes and asthma. Risk factors including lifestyle factors (such as tobacco smoking, physical inactivity, alcohol consumption, diet, unsafe sex and intimate partner violence) and physiological states (such as obesity, high blood pressure and high cholesterol) are responsible for a sizeable proportion of the burden of disease in Victoria.

Victoria's primary health care system must be able to respond in an appropriate and cost effective way to this challenge. This includes prevention, early detection and proactive management of chronic disease.

The funding initiatives for Primary Care Partnerships and primary health care services, described in this document, are just two Victorian government strategies aimed at reducing the burden of chronic disease in Victoria. In particular these initiatives are aimed at providing planned, managed and proactive care for people with chronic disease by providing more community based health services and providing services within an integrated health care system.

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1. Introduction

Care for people with chronic diseases usually involves multiple health care providers across multiple settings. To provide this care within an integrated system, health care providers must work collaboratively to coordinate and plan services and care. This requires a commitment to work together to achieve a shared vision.

People with chronic disease need a responsive person-centred and effective system of care. These planning, implementation and program guidelines have been developed to support Primacy Care Partnerships (PCPs) and their member agencies, including primary health care services in the development of integrated chronic disease management (ICDM) across the service system. In particular, these guidelines support the planning and implementation for the Early Intervention in Chronic Disease (EIiCD) initiative, a key component in the broader work being undertaken in health service system reform.

1.1 Rationale

Chronic diseases currently contribute to more than 70 per cent of Australia's overall disease burden due to death, disability and diminished quality of life. This is expected to increase to 80 per cent by 2020¹. Evidence indicates that people who participate in chronic disease management programs have a better quality of life, experience fewer complications and reduce their overall use of health care resources.²

Strengthening the role of primary health care services and utilising the PCP platform to facilitate service system reform to provide ICDM responds to the following issues:

- An increasing prevalence of preventable chronic disease.
- Community health care services across the State already see many people with chronic and complex conditions (approximately 60 per cent of all registered clients).
- Demand pressures on primary health care services challenge their capacity to support multidisciplinary care in a coordinated manner with integrated service provision for people with chronic disease and complex needs.
- Major public hospital costs in Victoria (2003–04) for four chronic conditions alone - diabetes, chronic obstructive pulmonary disease, chronic heart failure and asthma - is estimated at \$200 million.
- Significant evidence in Australia and internationally demonstrates the value of partnerships in improving the delivery of primary health care services and programs.³
- The vision for PCPs supports more integrated responses to clients with chronic disease and complex needs.⁴

1.2 Audiences

1.2.1 Primary health care services funded under the Early Intervention in Chronic Disease (EIiCD) initiative

The EIiCD initiative builds on the work already being done by primary health care services to support people in the community who have chronic disease. It provides additional funding to increase service delivery and build in new components that are consistent with evidence-based chronic care. In addition, the EIiCD funding is to support work on system changes to deliver the ICDM model of care developed with the PCP and other key agencies.

These guidelines provide information to primary health care services newly funded and already funded under the EIiCD initiative. For newly funded primary health care services, the guidelines provide details about planning an ICDM service model in the context of partnerships and implementing the ICDM service

¹ Australian Institute of Health and Welfare (AIHW) 2002, *Chronic diseases and associated risk factors in Australia*, 2001, Canberra.

² Institute for Public Health Services Research, Monash Medical Centre, and Centre for Community Child Health, Royal Children's Hospital (2000). *Literature review of effective models and interventions for chronic disease management in the primary care sector*. Victorian Government Publishing Service.

³ Gillam, Abbott, Banks-Smith (2001) Can primary care groups and trusts improve health?, *BMJ* 323 14 July 2001. Evans D, Killoran A (2000) Tackling health inequalities through partnership working: learning from realistic evaluation, *Critical Public Health* 10(2) 2000. Rae Walker, *Collaborations and alliances: a review for VicHealth*, Victoria <<http://www.vichealth.vic.gov.au>>.

⁴ Department of Human Services (2004) *Primary Care Partnerships strategic directions 2004-2006*, Victoria, <http://www.health.vic.gov.au/pcps/about/index.htm#strategy>

model within a primary health care service. For primary health care services already funded, the information supports ongoing planning and development of their ICDM service models.

1.2.2 Other agencies with a focus on integrated chronic disease management

These guidelines can assist other agencies, such as PCP member agencies, to develop a more integrated approach to the care of people with chronic disease.

Improved ICDM is important to all primary health care services as data indicates that a high proportion of their clients have a chronic disease. While specific EIiCD funding has been allocated in some local government areas (LGAs) across the state, all primary health care services see significant numbers of people who have one or more chronic diseases. In addition, many metropolitan, rural and regional primary health care services are also involved in delivering services under a number of other chronic disease initiatives eg the Hospital Admission Risk Program-Chronic Disease Management (HARP-CDM) program and the Aboriginal Health Promotion and Chronic Care (AHPACC) partnership.

1.2.3 Primary Care Partnerships – Integrated chronic disease management (ICDM)

Implementing effective ICDM strategies requires agencies to make changes to the way they practise and provide care and calls for realigned systems across agencies. The EIiCD initiative complements this work with a focus upon new and innovative approaches to providing care to people with chronic disease. It is recognised that this work, like service coordination, is incremental and builds on the partnership, service coordination and integrated health promotion foundations that have been embedded over the past 8 years.

Since 2006–07, all PCPs receive recurrent funding for ICDM, a key deliverable for all PCPs⁵. The funding acknowledges that all PCPs play an important role in bringing agencies together to develop systems that support a coordinated approach to the planning and delivery of services for clients with chronic disease.

The focus on ICDM builds on the established PCP role in facilitating service system integration and change management across member agencies. PCPs have broadened their scope over recent years, collaborating with the acute sector around HARP-CDM and participating in a range of chronic disease initiatives, including EIiCD and the Life!⁶ program. ICDM funding builds on this work. PCPs are increasingly engaging sectors / agencies outside of the traditional 'health service' arena, such as ethno-specific groups, which strengthen the role of the PCP in facilitating planning and service system reform.

These guidelines provide all PCPs (staff and member agencies) with a focus for activities that facilitate service system integration and change management. PCPs are expected to work with the broader service system (including primary health care services) to develop integrated systems across agencies to care for people with chronic disease. Work with member agencies relevant to ICDM should include general practice and build on existing PCP activities, service coordination, integrated health promotion (IHP) and partnerships.

A greater breadth of activity is expected from PCPs working with one or more primary health care service funded under the EIiCD initiative. PCPs working with primary health care services receiving EIiCD funding for the first time will be expected to be involved in a planning process with the service along with other PCP member agencies, to develop an ICDM service model.

These guidelines should be read by PCP staff and member agencies, including Divisions of General Practice (DGP), that are working with a service funded under the EIiCD initiative and involved in the PCP service system redevelopment and change management work.

⁵ Refer: http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_guidelines.pdf

⁶ Go for your life: http://www.goforyourlife.vic.gov.au/hav/articles.nsf/pages/Life_Taking_Action_on_Diabetes_Program?Open

2. Policy context

2.1 State level

2.1.1 Care in your community

Aligned with the Government's *Growing Victoria Together* agenda and *A Fairer Victoria* policy, *Care in your community*⁷, launched in April 2006, builds on existing policy directions to provide a coherent whole-of-health framework for the delivery of integrated, community-based health care. It provides a ten-year vision for a modern, integrated and patient-centred health system.

Care in your community (CiYC) builds on established and successful elements of the current health system. The guiding principles aim to maximise access, quality and continuity of care, service flexibility, opportunities for service substitution and diversion as well as optimal use of scarce resources.

To enable area-based planning to make a substantial contribution to achieving the vision and principles underpinning the CiYC framework, a strategic planning approach is required.

The Victorian CiYC area-based planning trials demonstrated strong engagement of senior level representatives from health services who were able to agree on **local health priority areas for action**. The area-based planning trials provided an opportunity to implement the tangible elements of the CiYC framework with the majority of participants valuing the process and moving forward with the initiative even though the trials have been completed. Some services that were not part of the trials have developed their own area-based planning partnerships.

Further implementation of area based planning is currently under consideration.

2.1.2 Primary Health

2.1.2.1 Primary Care Partnerships (PCPs)

In response to the *Better Access To Services* (BATS) policy, released in 2001, and the introduction of PCPs, PCP member agencies—including primary health care services, local governments, Divisions of General Practice, women's health, aged care assessment services, district nursing, ethno specific services, and metropolitan and rural health services—have worked together to develop a stronger, more integrated community-based health and community service sector. Services have work together to look at: reducing duplicated practices; increasing understanding of referral pathways; improving service coordination; and delivering integrated health promotion (IHP) practice. This has included a focus on ICDM consistent with the PCP objective of reducing the number of preventable hospital admissions.

The vision for PCPs includes⁸ includes:

- an integrated health care system based on partnerships, where providers see planning and working together to better meet the needs of their communities as core business
- people with chronic diseases being active partners in their own care, with the system structured around consumers, not agencies or programs
- prevention and management of chronic diseases coordinated across the health sectors
- consumers' needs identified early and appropriate services delivered promptly
- improved service coordination practice enhanced and embedded in agency practice, streamlining assessment and access to services
- consumers' record built upon and shared with other practitioners involved in their care with consumer consent.

2.1.2.2 Community Health Program

The Community Health Program funds services located in every LGA that provide a range of health services to many Victorians, as well as participating in and contributing to their local communities. This strong connection to communities enables the program to provide clinical care within the social model of health to maximise outcomes for clients.

⁷ Department of Human Services (2006), *Care in your community- a planning framework for integrated ambulatory care*, Melbourne, Victoria <<http://www.health.vic.gov.au/ambulatorycare/careinyourcommunity>>

⁸ Department of Human Services (2004), *Primary Care Partnerships strategic directions 2004-2006*, Melbourne, Victoria <http://www.health.vic.gov.au/pcps/about/index.htm#strategy>

*Community Health Services – creating a healthier Victoria*⁹ outlines the benefits of strong Community Health Services (CHSs). It states the role of CHSs in improving health and diverting patients from acute care through integrated primary health care and disease management programs.

It sets out five strategic directions for CHSs:

- provide a platform for delivery of primary health care
- coordinated community-based disease management and ambulatory care
- focus on child and family health
- expanded primary medical care
- leadership in health promotion

In response to these strategic directions, the Government has invested funding for EIiCD in primary health care services and extended funding under the PCP strategy for ICDM. The EIiCD initiative now provides funding to 36 local government areas and since 2006/07 all PCPs receive funding for ICDM to enhance their capacity for facilitating system integration and change management to support people with chronic disease.

2.1.3 Hospital Admission Risk Program

In the late 1990s, Victoria experienced unprecedented growth in demand for public health services. Hospitals faced pressure from the growing number of people presenting to emergency departments.

As a response, the Victorian Government initiated the *Hospital Demand Management Strategy (2001–2005)*¹⁰ to address:

- emergency demand
- elective surgical waiting lists
- strategies to prevent avoidable hospital use by providing more appropriate care.

As part of this strategy, funding was allocated to develop new approaches to patient management, providing more appropriate care for individuals known to have a high risk of health deterioration; thus preventing avoidable hospital use in the future. These initiatives were mainstreamed under the Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM) service.

The objectives of HARP-CDM include:

- To improve patient outcomes
- To provide integrated seamless care within and across the hospital and community sectors
- To reduce avoidable hospital admissions and Emergency Department presentation
- To ensure equitable access to health care

Evaluation of the initiative from 2001–04 demonstrated that it successfully reduced the growth rate in demand for acute services for the target client groups. Achievements have included:

- improved identification and proactive management of patients frequently presenting to hospital or at imminent risk of hospitalisation
- increased health system capacity
- greater collaboration between acute and community services.

For clients, the benefits of participating in HARP-CDM have included:

- improved health outcomes.
- empowerment through education and self-management strategies
- individually tailored care
- the opportunity to stay at home longer.

Currently, 23 HARP-CDM services exist in Victoria, with 11 metropolitan, 11 rural and 1 state-wide service. Additionally, in 2007, the program was expanded into 14 rural hospitals through the HARP Better

⁹ Department of Human Services (2004), *Community Health Services – creating a healthier Victoria*, Melbourne, Victoria. <<http://www.health.vic.gov.au/communityhealth>>.

¹⁰ Additional information about Hospital Demand Management can be found at <<http://www.health.vic.gov.au/hdms/>>.

Care for Older People (HARP BCOP) Commonwealth Long Stay Older Patient (LSOP) initiative. The HARP BCOP programs are Commonwealth funded and focus on people aged 65 years and older (or 45 years and older for Aboriginal and Torres Strait Islanders people) with chronic and complex conditions, who frequently present, or are at risk of presenting, to hospital.

2.1.4 Go for your life strategy

As part of its commitment to improving the health and wellbeing of all Victorians, the Victorian Government launched its Go for your life¹¹ strategy in 2005 to promote opportunities for Victorians to be healthy, active and involved in their community.

The Life! initiative is an important part of the Victorian Government's 'Go for your life' strategy and has been developed to support Victorians aged 50 years and over and Aboriginal and Torres Strait Islander people of all ages who are at risk of developing type 2 diabetes.

2.2 National initiatives

2.2.1 National Chronic Disease Strategy

The Australian Health Ministers' Advisory Council endorsed a national strategic approach to chronic disease prevention and management in Australia. The *National Chronic Disease Strategy*, released in 2005¹², is a high level generic policy guide that focuses on nationally agreed directions to be taken by the health system at a national level. The strategy recognises that the health sector cannot work in isolation from other sectors and services. It must achieve significant and sustainable change to meet the chronic disease challenge and take a leadership role in advocating, engaging and partnering with other sectors to influence the social and environmental factors that determine the burden of chronic disease. This includes developing more consistent, integrated, evidence-based practice and effective consumer-focused approaches to improve the prevention, detection and management of chronic disease. The strategy focuses on improved outcomes along the whole continuum – health promotion, prevention, detection, management, self-management, rehabilitation and end of life care.

2.2.2 Australian Better Health Initiative¹³

In response to the trends for chronic diseases in Australia¹⁴, the Australian Government, in partnership with the states and territories, is strengthening the focus of the health system on prevention and health promotion, and management of chronic disease. From 1 July 2006, the Australian Government and the state and territory governments began implementing a five-year, \$500 million national package called the Australian Better Health Initiative (ABHI) to reduce the impacts of chronic disease with a focus on the needs of Indigenous Australians.

The ABHI package includes the following priority areas:

- promoting healthy lifestyles
- supporting early detection of risk factors and chronic disease
- supporting lifestyle and risk modification
- encouraging active patient self-management of chronic disease
- improving the communication and coordination between care services.

Governments will provide incentive funds to appropriate organisations to improve local connections between service providers, including private medical services, primary health care services and allied health services, so that patient needs are better met.

¹¹ Refer: <http://www.goforyourlife.vic.gov.au/>

¹² *National Chronic Disease Strategy*, 2005, Australian Government Department of Health and Ageing. <http://www.health.gov.au/internet/main/publishing.nsf/Content/pg-ncds>

¹³ Further information:

[www.health.gov.au/internet/healthyactive/publishing.nsf/content/a962641b529d56c9ca2571b0001126de/\\$file/healthy-living-initiatives.pdf](http://www.health.gov.au/internet/healthyactive/publishing.nsf/content/a962641b529d56c9ca2571b0001126de/$file/healthy-living-initiatives.pdf)

¹⁴ Chronic diseases - such as diabetes, heart disease, cancer and arthritis - are estimated to be responsible for nearly 80 per cent of the total burden of disease and injury in Australia, and more than two thirds of all health expenditure. Diabetes and heart disease alone cost the health system more than \$6 billion per annum. These chronic diseases also have a disproportionate impact on some population groups, particularly Indigenous Australians.

3. Vision for integrated chronic disease management

Vision

The guiding vision is for a responsive, person-centred, effective system of care for people with chronic disease.

Aim

A chronic disease management approach¹⁵ should aim to demonstrate improved health outcomes and quality of life for people with chronic disease.

Objectives

- Slow the rate of disease progression (in the context of the person's clinical condition) while maximising their health and wellbeing within the community.
- Improve access to quality integrated multidisciplinary care across the care continuum.
- Facilitate client and carer empowerment through self-management programs and approaches.
- Promote and encourage protective behaviours (such as healthy eating and physical activity).
- Actively engage GPs as part of a multidisciplinary coordinated approach, including the development of written care plans.
- Reduce inappropriate demands on the acute health care system.
- Demonstrate the contribution primary health care services and PCP strategy can make to the care and management of people with chronic disease.

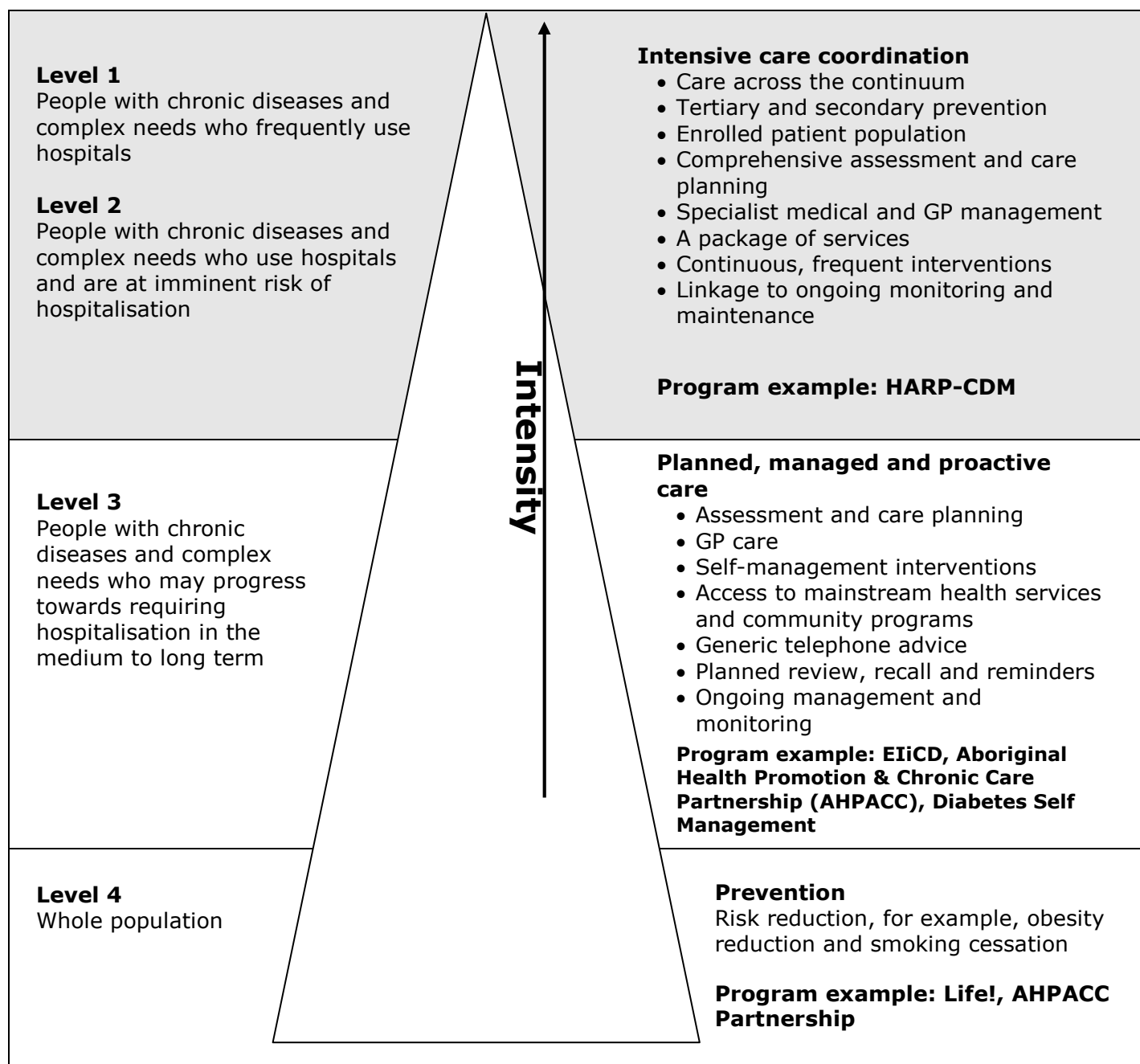
Integrated chronic disease management is the provision of person-centred care in which health services work with each other and with the client (and/or their carer) with a chronic illness to ensure coordination, consistency and continuity of care for clients over time and through the different stages of their condition.

¹⁵ Department of Human Services (2005) *Improving chronic disease care: learnings from the Integrated Disease Management projects*, Melbourne, Victoria.

4. Levels of chronic and complex care prevention and management

Chronic disease management (CDM) encompasses the continuum of care from prevention through to treatment and care management for people with chronic disease. Diagram 1 provides a visual representation of a schema for CDM, which describes four levels of service intensity for people with or at risk of chronic and complex needs and the target populations for each level.

Diagram 1: Levels of chronic and complex care prevention and management



Adapted from Kaiser Permanente¹⁶

¹⁶ Refer: <https://www.kaiserpermanente.org/>

4.1 Explanation of levels

Levels 1 and 2: Intensive care coordination

Target population:

- Frequent hospital attendees or clients identified as being at imminent risk of hospitalisation who are most likely to benefit from integrated care and have the potential to reduce avoidable hospital use.

Service intensity:

- Model responds to acute exacerbations or significant decline in clients' conditions.
- Includes comprehensive assessment, specialist assessment, care planning, specialist intervention, identification of community-based services, access to brokerage and tertiary prevention.

The HARP-CDM is the main funded program within this level. It has two identified streams of care:

- People with complex needs (including people with psychosocial needs).
- People with chronic diseases (including people with chronic heart failure, chronic respiratory diseases, and diabetes Type 1 and Type 2 with complications. These complications may be related directly to the chronic disease, such as in the case of diabetes retinopathy, neuropathy, amputation, or may be other co-morbidities or psychosocial factors impacting on the client's ability to manage their chronic disease).

Level 3: Planned, managed and proactive care

Target population:

- People diagnosed with a chronic disease/s (especially, but not limited to, diabetes, cardiovascular disease, early stages of respiratory disease, and asthma).
- People with complex needs, particularly in the elderly, **prior to** complications or significant decline in function.
- People who could potentially require hospitalisation in the medium to long term and require a managed and planned approach to reduce risks.

Service intensity:

- Model responds proactively to clients with a chronic disease **prior to** significant complications or significant decline.
- Includes secondary and tertiary prevention, regular reviews, self-management interventions and care planning.

The EIICD and Diabetes Self Management (DSM) initiatives are the main state funded programs within this level. Further details about the target population for this initiative are described later. The chronic disease management component of the AHPACC¹⁷ Partnership is an example of a program that fits in this level.

Level 4: Prevention

Target population:

- People with high risk factors for developing a chronic disease.
- A focus on the social determinants of health and the underlying factors that make population groups at greater risk of ill health.

Service intensity:

- Model aims to improve the health and wellbeing of people prior to the onset of a chronic disease.

¹⁷ Refer: www.health.vic.gov.au/communityhealth/aboriginal_health

- Includes primary prevention, integrated health promotion, risk reduction and whole of population approaches.

The Life! Program is an example of a funded program within this level. It has two major components: detection and intervention. The program aims to identify people with pre-diabetes (impaired glucose tolerance and impaired fasting glucose) and to provide an intervention (Healthy Living Course) to support lifestyle changes to reduce the risk of progression to diabetes. The Life! program is a component of the Go for you Life initiative, which has a range of prevention focused interventions.

The AHPACC Partnership is an initiative that has a focus on both the prevention (level 4) and management (level 3) of chronic disease within a high risk target population group.

This level also includes health promotion activities involving agencies and organisations from a range of sectors and communities using a mix of population-based health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

4.2 Integrating chronic disease management across and between levels

Through the course of a chronic disease, it is likely that a person will move between the levels of chronic and complex care management described in Diagram 1, and require collaboration and cooperation between service providers.

Together, the HARP-CDM, the EIiCD initiative and existing health promotion programs encompass the continuum of care from prevention through to treatment, management and maintenance of health in an effort to keep people in their community for as long as possible.

Particularly where HARP-CDM, AHPACC Partnerships and EIiCD services co-exist, programs are to work together to ensure a seamless and integrated model for access to services and movement between services (based on client need). This is important for clients and/or carers and also for health professionals (including GPs), particularly those making referrals into the programs. The following strategies help in achieving integration:

- Joint planning across programs.
- Joint governance or steering committee arrangements.
- Workforce development or training opportunities available across programs including cultural respect training.
- Consistency in evaluation indicators and methodologies where relevant.
- Marketing undertaken as a joint activity.
- Rotation of staff through EIiCD and HARP-CDM or AHPACC Partnership to promote care across the continuum and increase the understanding of the services by health professionals.
- Systems by which intake/service coordination staff for each program can easily cross-refer without duplication of initial need identification.

5. The Wagner Model for Improving Chronic Care¹⁸

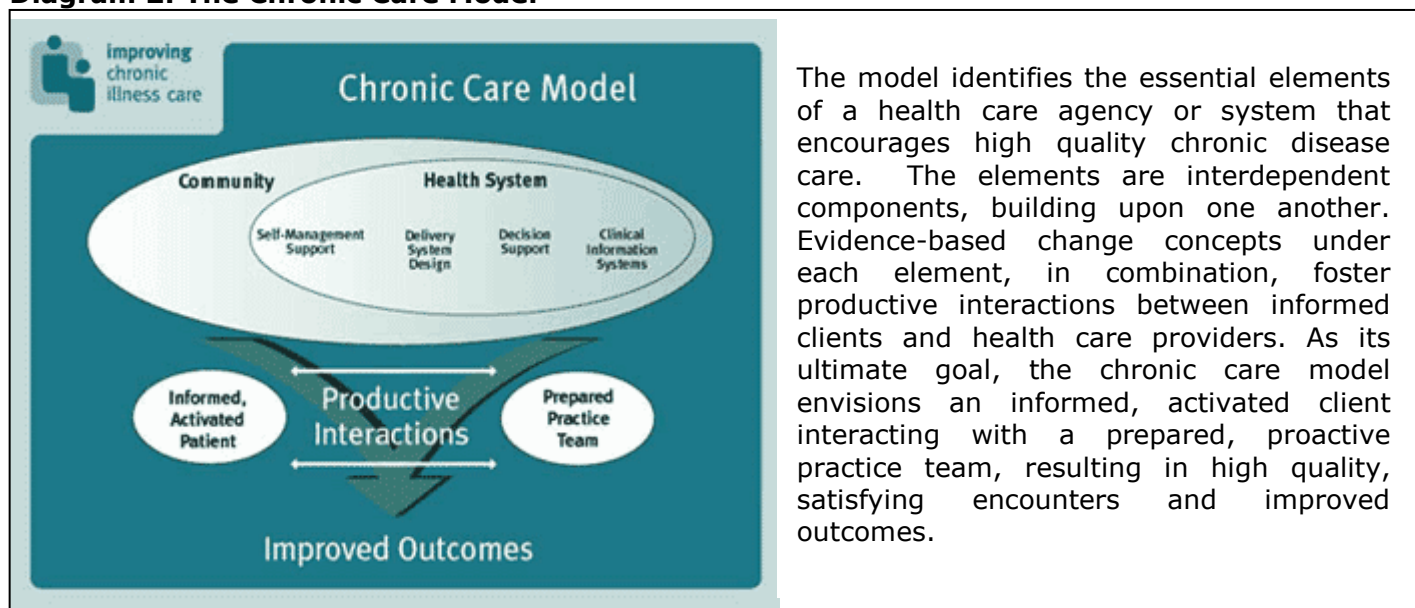
The Primary Health Branch has endorsed the Wagner Model for Improving Chronic Care as the model to inform and guide the service system redesign required to support people with chronic disease.

Edward Wagner proposes that managing chronic disease requires nothing less than a transformation of health care, from a system that is essentially reactive – responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible. The Wagner Model provides a framework that helps to identify the systems changes (within the primary health care services and across the service system) that are necessary to improve the coordination of care for people with chronic disease. Taking a systems approach is important to ensure the delivery of proactive and integrated client centered care.

The model has six interdependent elements for improving chronic care. They are:

1. **Community** – resources and activities that provide ongoing support for people with chronic disease/s.
2. **Health systems** – support prepared and proactive practice teams.
3. **Self-management support** – empowers and prepares clients to manage their health and health care.
4. **Delivery system design** – assists care teams to deliver systematic, effective, efficient clinical care and self-management support.
5. **Decision support** – including design, systems and tools to ensure clinical care is consistent with evidence-based guidelines.
6. **Clinical information systems** – including data systems that provide information about the client population, reminders for review and recall, and monitor the performance of care teams.

Diagram 2: The Chronic Care Model



Many articles explain the Wagner Model for Improving Chronic Care and provide examples of how it is used in health care agencies (references include quality improvement journals, medical journals, primary care journals). For further information refer to Section 8.3 for examples of the Chronic Care Model in action and Appendix 1 for website information.

¹⁸ Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. Health Aff (Millwood). 2001;20:64-78

The Chronic Care Model, endorsed by the World Health Organisation, was developed by Wagner and his team at The Robert Johnson Foundation based at the MacColl Institute for Healthcare Innovation (Seattle, USA).

6. The EIiCD initiative

6.1 EIiCD and the ICDM framework

Refer also Section 7.1

The EIiCD initiative is a key component of broader work across the health service system to improve capacity to respond to the needs of people with chronic disease. Implementing effective ICDM strategies requires agencies to make changes to the way they practise and provide care. The ICDM initiative calls for realigned systems across agencies and the EIiCD initiative complements this work with a focus upon new and innovative approaches to providing care to people with chronic disease.

The combination of ICDM funding for PCPs and EIiCD funding for primary health care services therefore provides agencies with an increased capacity to work towards achieving the ICDM vision. The EIiCD initiative provides additional funding to enhance services and build in new components of care that are consistent with evidence-based chronic care.

6.2 Target population for the EIiCD initiative

Example:

A primary health care service may target people with diabetes and cardiovascular disease as evidenced by local population health data and other relevant information. In subsequent years it is expected that generic ICDM capacity is developed so that all people with chronic disease can receive improved management.

The EIiCD initiative should be targeted towards clients at level 3 of the chronic and complex care continuum (Diagram 1). Clients will include:

- people diagnosed with one or more chronic diseases (especially, but not limited to, diabetes, cardiovascular disease, respiratory disease, asthma, arthritis)
- people diagnosed with one or more chronic diseases without complications or significant decline in function
- people who could require hospitalisation in the medium to long term and require a managed and planned approach to reduce risks.

Primary health care services should focus their EIiCD activity on the primary catchment area - the designated¹⁹ local government area for which they received funding. The targeting of client groups should be consistent with the needs of the local community. This may include delivering outreach services, if appropriate, to marginalized groups within the primary catchment. In particular, consideration for Indigenous Victorians should be given in recognition that this population is significantly at risk of poorer health outcomes.

To assist in identifying a target group, the following fact sheets are available to download from: www.health.vic.gov.au/communityhealth/cdm/resources.htm:

- 'Population Health Data Sources for ICDM Planning'
- 'Evidence-based Guidelines and Clinical Pathways for ICDM planning'.

6.3 The role of primary health care services in the EIiCD initiative

Each agency has an important but unique role to play in achieving the ICDM vision. A major focus in the implementation of the EIiCD initiative concerns broad systems change management and building the capacity of services to provide evidence based chronic care.

Organisational change is a process that can be facilitated by perceptive planning, well-managed implementation and supportive monitoring ²⁰.

¹⁹ Refer to the Primary Health Branch Policy & Funding Guidelines 2006-07 to 2008-09 (2008-09 update) at http://www.dhs.vic.gov.au/rrhacs/businessunits/primaryhealth/phb_guidelines.

²⁰ <http://www.sdo.lshtm.ac.uk/managingchange.html>

Primary health care services already provide services to people with a chronic disease. The EIiCD initiative should build on the work already being done by primary health care providers to support people in the community who have chronic disease. It is not intended that the initiative establishes separate teams and programs of service delivery working in isolation from existing services.

Agencies should understand and have the capacity to lead change. The components of the Wagner Model for Improving Chronic Care directly related to service provision are the responsibility of the EIiCD funded primary health care services to plan and implement.

EIiCD funded agencies are also expected to meet service delivery targets.

6.4 EIiCD Deliverables

Refer also to Section 7.6 PCP Deliverables and Section 8 Planning considerations

Along with additional services for people with a chronic disease, a key expectation for primary health care services in receipt of EIiCD funds is that they develop and implement planned, broad systemic changes across their agencies in line with the framework of the Wagner Model for Improving Chronic Care.

6.4.1 Primary health care services in receipt of EIiCD funding for the first time

- **Initial planning approach:**

It is expected that primary health care services funded for the first time, and their corresponding PCPs (staff and member agencies), will work together to plan (and implement) the EIiCD initiative. EIiCD plans are to be informed by the Wagner Model for Improving Chronic Care. Therefore agencies are to undertake a self assessment of their current chronic disease care using an acknowledged tool. The assessment should identify the key areas for improvement including system changes and partner agencies to include in the EIiCD implementation plan.

Various assessment tools²¹ are available to assist in this process and agencies are encouraged to discuss their selection with their PCP to ensure consistency.

The planning approach should reflect an iterative process that has engaged key partners including other primary health care services, Divisions of General Practice (DGP), Aboriginal Community Controlled Health Organisations (ACCHOs), other agencies/programs (for example, HARP-CDM, AHPACC Partnerships) and consumer groups. Working with partner agencies through the PCP platform will ensure that the approach meets the needs of the broader community and aligns with broader service system reform to support integrated chronic disease management. Involving key partners in the planning process will not only help to identify service gaps and service duplication, but will promote organisational capacity building to implement and sustain the EIiCD initiative.

- **Implementation Plan:**

The EIiCD implementation plan is to be completed using the implementation template available from regional DHS contact. It should address the key areas for improvement as identified through the self assessment process. The service model should include core elements of the Wagner Model.

The plan to implement the EIiCD initiative should articulate:

- Target population
- Objectives, Strategies and Key Activities to address key areas for improvement identified by the self assessment of chronic disease care
- Partners and Roles -both existing and new partners and their agreed roles and responsibilities
- Project management and governance arrangements

Primary health care services also funded through the AHPACC Partnership and / or HARP should ensure coordination of effort in planning processes.

The implementation plan should be forwarded to the regional DHS contact for discussion and feedback.

The plan will provide a structure for directing required change at a systems, organisation and practice level. In doing so, the document should support activities of the steering committee, or group involved in

²¹ For a discussion on the selection of an appropriate tool refer to www.health.vic.gov.au/communityhealth/cdm/resources.htm for the fact sheet "Chronic Disease Management Audit Tools".

the overview of the project and on going program management. As implementation of the plan evolves it is anticipated that it will be reviewed and refined as required.

To assist with completing the implementation plan, more information and resources are available on the ICDM webpage www.health.vic.gov.au/communityhealth/cdm/index

6.4.2 All primary health care services funded under the EIiCD initiative

The rate of development, change and implementation across programs within a catchment may vary, however, service system change is a process that extends into the work of subsequent years through an ongoing process of continuous improvement. It is recognised that implementation includes incremental systems changes and a process to embed new practices over time. It is expected therefore, that EIiCD funded agencies together with PCP planning subcommittees established for this initiative will continue to meet to monitor and review implementation and address issues as they arise.

Therefore, all primary health care services funded under the EIiCD initiative are encouraged to use these guidelines, along with additional resources and workforce development opportunities provided to support the implementation of their initiatives.

Possible activities include a focus on:

- systems change both across and within agencies
- organisational change
- partnership development with key agencies in chronic disease prevention and management
- integrated approaches across agencies where they share EIiCD funding
- delivering a range of additional services- allied health, nursing, self-management support, care coordination consistent with evidence-based practice in chronic care

Data collection and reporting requirements are described in the *Primary Health policy and funding guidelines 2006–09*.

The new approaches and systems developed by the existing EIiCD sites will inform further development and initiatives in all primary health care services.

6.4.3 Service Delivery

All previously funded EIiCD services are expected to deliver the service delivery targets articulated in the DHS Funding and Service Agreement.

Newly funded EIiCD agencies are also expected to meet service delivery targets as specified in the letter of confirmation. This will specify a reduced, minimum number of service delivery hours (dependent upon level of funding) to support clients with chronic disease and complex needs over the initial two year implementation and establishment period.

6.5 Funding for primary health care services

For agencies in receipt of EIiCD funding for the first time, regional offices will allocate funds to agencies once a plan has been approved and endorsed. In the first two years, funding includes planning and establishment costs to allow for implementation of the initiative.

6.5.1 Fees

Fees for services associated with EIiCD funding for primary health care services should be as per the Department of Human Services fees policy for the Community Health Program and the Home and Community Care Program.²²

6.5.2 Budget for primary health care services in receipt of EIiCD funding for the first time

Primary health care services will be required to prepare a budget for expenditure against their first year of funding. The budget for the first two years allows for planning, set up and establishment costs as part of the development and resource component and funding for service delivery. The budget is to be provided as part of the implementation plan and include:

- staff (including project manager)

²² Refer: http://www.health.vic.gov.au/communityhealth/service_provider/ch_fees.htm#download

- evaluation
- GP engagement
- staff and management training
- resources
- minor capital and office set up costs (including IT requirements)
- translation (if required)
- vehicle purchase/leasing
- other.

6.6 Accountability and reporting for primary health care services

6.6.1 Service delivery reporting: Primary health care services in receipt of Community and Women's Health funding should refer to the *Community and women's health programs 2006-07, data reporting requirements*²³ for information about data reporting.

Clients registered as part of the EIiCD initiative are to be flagged through the Multipurpose Report.

6.6.2 Additional reporting requirement for primary health care services in receipt of EIiCD funding for the first time

- **Verbal and narrative progress reports:** Progress reports based on the 'approved' implementation plan are required at 6 months and 12 months after commencement of the initiative using the template provided. To monitor establishment, the funded agency is to prepare for discussion with the regional office narrative reports on the achievement of the identified objectives and activities in the plan.
- **A two year plan:** At the 12 month discussion, agencies will be required to submit to the regional office a two year plan for the initiative, based upon the 12 month report.

Period	Requirement	Other Requirement
Quarterly	C&WH reporting	
6 months	Progress report	
12 months	Progress report	2 year plan

²³ Refer: http://www.health.vic.gov.au/communityhealth/data_reporting/reporting.htm

7. The ICDM initiative

7.1 ICDM framework

The ICDM work of the PCP should be underpinned by the following principles and evidence-based systems model.

7.1.1 Guiding principles

Guiding principles that should underpin local ICDM work include:

- providing person-centred care, including support for carers and/or families of people with chronic disease
- recognising that consumers are active partners in the management of their chronic disease
- increasing choice and control
- providing the right care in the right place at the right time
- proactively promoting health
- targeting population subgroups
- building a whole of service system response.

In summary, the above principles are about providing integrated care. Integrated care means health services working with each other and their clients to provide person-centred care that is connected and consistent with their care needs. Fragmentation of the service system exists. Agencies working together can help reduce this fragmentation so that a person receives coordinated and integrated services in a timely, efficient and seamless manner. The challenge for the service system is to improve integration and continuity of care for clients over time, through different stages of disease progression and life span.

7.1.2 The Wagner Model for Improving Chronic Care

Refer also Sections 5 and 8.3

For PCPs, this model is appropriate in guiding their work at the health system level and working with agencies to facilitate changes at the organisation and practice levels.

7.2 Focus for the PCP ICDM initiative

Improved ICDM is important to all (primary) health care services as data indicates that a high proportion of their clients will have a chronic disease. In supporting service system integration, PCPs need to work with member agencies that provide services to people with chronic disease. As GPs are at the centre of primary health care, priority should be given to working with the local DGP. (Refer Section 7.5)

For PCPs with an LGA funded under the EIiCD initiative, an initial focus of their work will be with the primary health care service(s) and other agencies operating across the funded LGA. However, overtime, it is expected that PCP resources are directed to support activity across the whole PCP catchment. How this occurs in practice will be directed by the PCP ICDM work plan. Work across the catchment may be targeted, for example where the PCP is working with member agencies to develop disease specific care pathways, or the PCP is working with member agencies to facilitate access to services for people from culturally and linguistically diverse backgrounds.

Table 1 provides a summary of the information detailed in this section.

Table 1: Target populations

	Primary Care Partnership
Primary target	<ul style="list-style-type: none"> • Agencies that provide services to people with chronic disease in the identified LGA, particularly the Division of General Practice (DGP).
Secondary target	<ul style="list-style-type: none"> • Agencies that provide services to people with chronic disease in other LGAs of the PCP catchment, • Targeted approach for disease specific care pathways

7.3 The role of all PCPs in ICDM²⁴.

For example:

- Agreement around priority of access to services for particular diagnostic groups as a result of initial needs identification.
- Agreement and definition around which clients will receive a multi-agency care plan and have a key worker.
- Systems to support nomination of a key worker and development/review of a care plan.
- Agreement around levels of written service outcome communication required by agencies.

Clients with chronic disease will generally require services from multiple providers over time. While the EIiCD service may be able to provide some of the required services, there is an expectation that additional services will be required.

PCPs provide the ideal platform to facilitate this work in an integrated and consistent manner. All PCPs have a role in ICDM to promote coordinated local approaches to improve the management of people with chronic disease, regardless of whether they are working with a primary health care service funded under the EIiCD initiative in their catchment. All PCPs receive core ICDM funding, and are required to plan and progress work against seven ICDM goals (refer Table 2, page 28). This work builds on existing PCP service coordination work. PCPs include a plan for ICDM in their Community Health Plan and report their progress through the Community Health Plan Implementation Agreement (CHPIA).

PCPs, as a voluntary alliance of agencies, are focused on facilitating service system integration between primary health care services and other agencies in delivering services to clients with chronic disease and on improving the client experience and outcomes. This includes supporting practice change that will lead to improved communication, referral and care planning. The PCP staff play a key role in supporting agencies in this work, particularly in facilitating partnership development, articulation of roles and responsibilities, planning and pathway development

Service coordination is an essential platform for ICDM with its focus on consistent approaches to initial contact, initial needs identification, assessment, care planning and referral. Common service coordination practice provides the foundation from which agencies can coordinate service delivery for the benefit of their clients.

Ongoing work to support a consistent approach to service coordination is occurring. The *Victorian Statewide Practice Manual*, has been developed to assist multi-catchment agencies in engaging with PCPs and implementing service coordination and to define statewide service coordination protocols and practices. The *Victorian Statewide Practice Manual* assists in achieving a consistent framework for referral practices between:

- acute services and community and primary health services
- metropolitan and rural services
- GPs and community/primary health services.

²⁴ Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*: http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_guidelines.pdf

PCPs' member agencies are required to implement and embed these statewide service coordination practices and protocols at a local level to support ICDM.

7.4 The role of PCPs working with EIiCD funded primary health care services

Refer Section 8 Planning considerations

PCPs working with one or more primary health care services funded under the EIiCD initiative have additional work in 2006–09. The activities in Table 3 on page 29 lists the activities for these PCPs and is consistent with the information provided in the *PCP reporting guidelines 2006–09*

PCPs working with a primary health care service funded for the first time in 2008–09 are also required to work with the primary health care service in the planning and implementation of an EIiCD plan (refer Section 6.4). The PCP, including +through its member agencies, is to provide support for the new EIiCD initiative through additional key activities in line with those outlined in Table 3, page 26.

7.5 Engaging DGP and GPs in the ICDM initiative

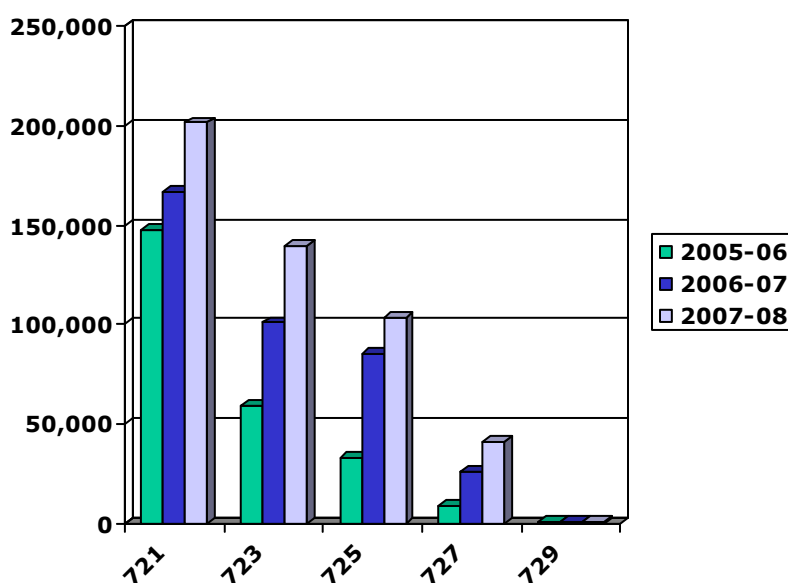
7.5.1 National initiatives

The Australian Government has encouraged GPs to take a multidisciplinary proactive approach to chronic disease through the provision of reimbursement arrangements within the MBS and the Practice Incentives Program (PIP).²⁵ Latest data shows that approximately:

- 75²⁶ percent of GPs in Victoria have claimed a GP Management Plan (MBS Item 721 – care plan for patient with a chronic disease developed by the GP)
- 72 per cent of GPs in Victoria have claimed a Team Care Arrangement (MBS Item 723 – coordinated care plan with at least two other care providers for patient with a chronic disease and complex care needs)
- 3.6 per cent of GPs in Victoria have claimed a Contribution to a Care Plan (MBS Item 729 – contribution to a multidisciplinary care plan coordinated by another provider for patient with a chronic disease and complex care needs)

Note: that this data is approximate and from a variety of data sources. Appropriate care may be provided but not claimed through specific MBS item numbers and PIPs/SIPs.

The claiming of GP care plans in Victoria has progressively increased over the last three years.



²⁵ The MBS includes new MBS items for ICDM. The Practice Incentive Program (PIP) includes incentives for mental health, diabetes and asthma planned approaches. See <http://www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease>

²⁶ See the GPV website for data sources and updated statistics in the GPV Statistics Package: <http://www.gpv.org.au/resources.asp?type=34>

The implications from this data are that PCPs and non-general primary health care services need to consider the local MBS uptake patterns of general practice: how local Division CDM programs [such as the Australia Better Health Initiative – Primary Care Integration Program²⁷ (ABHI-PCIP) work]; and how these might inform the development of the ICDM service model, in particular, care planning components.

As part of their core funding grant through the Commonwealth, DGPs report against 11 compulsory national performance indicators from four focus areas. These are access, prevention, chronic disease management and uptake of national indicators. Divisions may choose to invest resources in particular objectives under these priority areas.

Since early 2008, DGPs have also received funding through the ABHI-PCIP, an initiative of COAG. The aim of the initiative is to enhance integration between general practice and other local health care providers to assist in the delivery of more 'seamless' patient care, particularly in the context of assisting people with chronic and/or complex conditions and co-morbidities. \$6 million is being shared by the 29 DGPs in Victoria over three years.

A particular focus of the initial work in the PCIP initiative is the establishment or refinement of local care pathways and service coordination principles in partnership with PCP member agencies. DGPs will build on the work of the EIiCD initiatives and the PCP service coordination and ICDM activity. Another PCIP focus is the interrogation of GP client data to identify patients with a diagnosed chronic illness who may not be receiving the range of services they need to help them manage their condition. It is recommended that consideration be given to the particular foci of individual Victorian DGPs in the context of their core Commonwealth contract and the ABHI-PCIP when seeking to engage general practice, through DGPs, in ICDM work.

7.5.2 Work at the PCP level

The Centre for General Practice Integration Studies²⁸ identified four essential components of general practice capacity for better management of chronic disease:

- effective team work
- information management/information technology (IT/IM) maturity
- appropriate business systems
- effective linkages with external services.

GPs have a central role in providing well coordinated care for people with chronic disease and have primary responsibility for the medical management of people with chronic disease. For many people with chronic disease, multidisciplinary interventions are required to complement medical management.

All PCPs have a role in working closely with their local DGP to improve the coordination of care (through effective communication, referral and collaborative care planning) for people with chronic disease. For a model to include GPs as referrers, providers of medical perspectives in care plans and key members of primary care and multidisciplinary teams, there must be strong DGP leadership in the model design and implementation.

All 29 Victorian DGPs are members of PCPs and have been working with other PCP member agencies and some individual GPs to develop and implement consistent statewide practice to support client referral and communication pathways, including the sharing of client information. DGPs have facilitated improved understanding and relationships between GPs and other health care providers at the local level. With their PCIP funding, they will continue to play a central role in building upon the development and implementation of ICDM approaches (including the EIiCD initiative).

DGPs, PCPs and primary health care services, in conjunction with other PCP member agencies, should develop an agreed plan for building on existing capacity for liaison with general practice. Expanding DGP programs, such as GP representation, practice support/visiting and continuing professional development, should be considered. The PCP and funded primary health care services should work with GP representatives and key DGP staff to design an ICDM service model that ensures:

- processes for GP referral and participation in care planning are realistic and aligned with Medical Benefits Scheme (MBS) guidelines
- targets for reach to GPs (how many GPs/general practices to work with) are agreed and realistic
- strategies for informing GPs and their staff about the initiative are appropriate and effective

²⁷ Refer: <http://www.gpv.org.au/content.asp?cid=12,26&wid=675&t=Primary%20Care%20Integration>

²⁸ Centre for General Practice Integration Studies <<http://www.cgpis.unsw.edu.au>>

- strategies for developing general practice capacity needed to participate, for example, to identify eligible patients, share information such as GP management plans or information arising from a relevant service improvement payment (SIP) service, and liaise effectively with primary health care service providers.

The outcomes being sought include:

- GP representation and participation in planning and development
- DGP-based coordination of GP engagement
- support for systematic approaches to identification of eligible patients in general practice (for example, using agreed clinical and/or service usage eligibility criteria supported by information management systems in the practice)
- referral, feedback and care planning processes for general practice
- sustainable GP participation
- flexible arrangements (for example, delivery of services within general practice clinics, incorporating roles for nurses in general practice).

It is expected that this will require the PCPs and primary health care services to negotiate an arrangement (including provision of funding) with the local DGP to increase their capacity to liaise with general practice around ICDM. This could include:

- providing funding to the DGP to reimburse GP representatives to provide clinical input to the service model design
- funding a position within the DGP to conduct practice visits to targeted GPs to 'recruit' general practice engagement and provide systems development to enable GPs to participate
- providing funding to the DGP to enable work around targeted GP engagement, which includes establishing referral pathways from GPs (to maximise the proportion of general practices in the catchment areas that participate in the program) and communication mechanisms that will improve coordination of care.

Other resources have been and are being produced by DHS Primary Health Branch that will inform GP engagement strategies. These include:

- Fact Sheet: GP Engagement in Integrated Chronic Disease Management, produced through the PCP Industry Advisor Project²⁹
- *DHS Working With General Practice Position Statement and Resource Guide*, and the MBS Project Website and MBS item number flipchart, produced through the General Practice Partnerships Team³⁰
- GPV programs - Primary care integration (including the ABHI _ PCIP program) and the primary care liaison program³¹

7.6 Deliverables for PCPs

Refer also to Section 6.4 EIiCD Deliverables and Section 8 Planning considerations

7.6.1 All PCPs - Summary of ICDM work

All PCPs are required to plan and progress work against seven ICDM goals (Table 2). PCPs include a plan for ICDM in their Community Health Plan. The ICDM activity for all PCPs has a focus on facilitating service system integration and change management.

Table 2 provides a summary of the activities for all PCPs and is consistent with the information provided in the *PCP reporting guidelines 2006–09*³².

²⁹ Refer: <http://www.health.vic.gov.au/communityhealth/cdm/resources.htm>

³⁰ Refer: www.health.vic.gov.au/communityhealth/gps/index

³¹ Refer: <http://www.gpv.org.au/content.asp?cid=12,26&t=Primary%20Care%20Co-ordination>

³² Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*: http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_guidelines.pdf

NB. The PCP reporting guidelines will be updated for 2009–12.

Table 2: Activities for all PCPs

All PCPs are expected to:
<ul style="list-style-type: none"> • Build on the mapping of self-management interventions provided by agencies within the catchment, facilitate planning processes to further develop self-management interventions within member agencies that respond to identified gaps. • Facilitate a process for agencies to define their roles and responsibilities, especially acute and primary health care services, in relation to providing self-management interventions for people with chronic disease. • Implement the BATS framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease. • Work with PCP member agencies, particularly GPs, to develop and define local agreements and systems to identify clients with chronic disease who require comprehensive assessment. • Work with PCP member agencies, particularly GPs, to develop and define local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning. • Work with PCP member agencies, particularly GPs, to develop and define local agreements and systems around initiating and coordinating care planning for people with chronic disease. • Strengthen approaches to address disadvantage and health equality, in integrated health promotion, including barriers to participation such as chronic disease including for Indigenous Victorians.

The activities in Table 2 provide PCPs with direction for their work. Rather than embark on all the above systems at once, PCPs may initially chose to develop areas incrementally over time. However, PCPs should prioritise some components of work, such as the development of an action plan based on the findings from the self-management mapping.

Formal reporting on the PCP ICDM activities (Table 2) will be through the CHPIA. PCPs are also encouraged to report on this work to their members as part of their commitment to develop and maintain trust and strong collaborative partnerships.

7.6.2 PCPs working with primary health care services funded under the EIiCD initiative - Summary of work

Table 3: Activities for PCPs working with the EIiCD initiative

PCPs working with one or more primary health care services funded under the EIiCD initiative will be expected to:
<ul style="list-style-type: none"> • Undertake and support planning activities to identify local needs and support project establishment and on going program development. • Support change management within agencies, particularly primary health care services, that are implementing new systems or strengthening existing systems to provide proactive care rather than reactive care, for clients with chronic disease. • Support workforce development around approaches to self-management for agencies, particularly primary health care services and GPs. • Support communication and marketing strategies (developed in conjunction with the DGP) that promote the benefits and availability of local self-management interventions to GPs. • Work closely with the DGP to improve communication and collaborative care planning between GPs and primary health care services. • Support the adoption of disease-specific care pathways to ensure that clients get the right care in the right place, regardless of where they enter the service system. • Facilitate a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM. • Disseminate transferable change management lessons in relation to ICDM.

PCPs working with one or more primary health care services funded under the EIiCD initiative have additional work in 2006–09. Table 3 lists the activities for these PCPs and is consistent with the information provided in the *PCP reporting guidelines 2006–09*³³.

The activities in Table 3 provide those PCPs working with the EIiCD initiative with further direction for their work. Again, rather than embarking on all the above activities at once, PCPs may initially choose to prioritise and develop areas incrementally over time.

As stated previously, formal reporting on the PCP ICDM activities (Table 3) will be through the CHPIA. However, PCPs are also encouraged to report on this work to their member agencies as part of their commitment to develop and maintain trust and strong collaborative partnerships.

PCPs working with a primary health care service funded for EIiCD in previous years, will be involved in supporting the ongoing development of the ICDM service model.

7.6.3 PCPs working with primary health care services funded under the EIiCD initiative for the first time - Summary of work

In addition to the activities described in the above section, PCPs working with a primary health care service funded for the first time in 2008–09 are also required to work with the primary health care service in the planning and implementation of an EIiCD plan (Refer Section 6.4).

The PCP is to provide a letter of support to the relevant primary health care service to be attached to the application for the EIiCD initiative. The letter should outline additional key activities (including a budget) that the PCP, both staff and member agencies, will undertake to support the new EIiCD initiative. For example:

- How the PCPs as a voluntary alliance of agencies, will work on facilitating service system integration between primary health care services and other agencies in delivering services to clients with chronic disease and on improving client outcomes and experience.
- The role PCP staff are to play in supporting agencies in practice change that will lead to improved communication, referral and care planning eg by facilitating partnership development; articulation of roles and responsibilities; planning; and pathway development.

PCPs are required to provide a Community Health Plan for the period 2006–09 with annual updates as required and report annually with a final CHPIA due July 2009. Information about the work of the PCP in the implementation plan should be reflected in the PCP's updated Community Health Plan.

7.7 Funding for PCPs

Recurrent funding for ICDM is provided to all PCPs for ICDM work, regardless of whether there is a primary health care service in their catchment with funding for the EIiCD initiative.

The level of funding to PCPs will vary based on the number of primary health care services in their catchment operating EIiCD services; the complexity of their service coordination task (as indicated by the number of health services and GPs operating in their catchment); and the level of disadvantage and remoteness.

PCPs that cover areas where there is no primary health care service funded for the EIiCD initiative receive a base amount of \$30,000 full year effect (FYE).

Where PCPs cover areas where a primary health care service receives funding for an EIiCD initiative, an additional amount of \$20,000 (FYE) is provided. These funds should be considered as one pool of funds to undertake ICDM activities.

³³ Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*: http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_guidelines.pdf

NB. The PCP reporting guidelines will be updated for 2009–12.

7.8 PCP reporting

Over the next three years to June 2009, formal reporting on the PCP-ICDM initiative will be through completion of the ICDM element of the Community Health Plan and CHPIA (described in the *PCP reporting guidelines 2006–09*)³⁴.

These are the major accountability requirements for PCPs. The Department will also measure the impact of ICDM over time using the Service Coordination and Integrated Chronic Disease Management Snapshot Survey and the Self-Management Mapping Survey. All PCPs are asked to complete the survey twice during the reporting period 2006–09.

³⁴ Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*: http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_guidelines.pdf

8. Planning Considerations

The following information relates specifically to PCPs and primary health care services where there is new funding under the EIiCD initiative. It is expected that newly EIiCD funded primary health care services will develop an initial plan with their PCP and key partners and present this to their regional department contact

However, the information can also be used by:

- all PCPs undertaking planning for their ICDM initiatives
- primary health care services funded under the EIiCD initiative in previous years, to support ongoing planning and development of their ICDM service models
- primary health care services that have not received EIiCD funding but are keen to develop their systems to provide evidence-based care to clients with chronic disease.

8.1 The approach

EIiCD plans are to be informed by the Wagner Model for Improving Chronic Care. Agencies are to undertake an assessment of their current chronic disease care using an acknowledged tool³⁵ to identify system changes, partner agencies and the areas for improvement to include in planning their services. The plan is to address the key areas for improvement highlighted by the assessment.

The planning process should reflect an iterative process that has engaged key partners eg. primary health care services, DGP, other agencies/programs (for example, HARP-ICDM, AHPACC Partnerships) and consumer groups. Working with partner agencies will ensure that the approach meets the needs of the broader community and aligns with broader service system reform to support integrated chronic disease management.

In developing this plan, agencies should consider:

- how assessment of organisational capacity will be conducted
- the agencies to be involved and how they will work together (through the PCP)
- how the Wagner Chronic Care Model (described below and in Section 5) will be used to underpin the local ICDM service model
- the resources required to support change management activities articulated in the plan
- how the initiative will include community participation
- how Plan Do Study Act (PDSA) cycles will be used to test changes for broader implementation

The PCP is the platform of choice in facilitating this work to ensure local needs are met in the context of the local service system. PCP staff are able to provide an expert resource to assist in the process.

The following sections provide some background information to the above dot points.

8.2 Partnerships

Care for people with chronic disease usually involves multiple health care providers in multiple settings. To provide this care within an integrated system, health care providers must work collaboratively through the local PCP to coordinate and plan care and services. It requires a commitment to work together to achieve shared goals and benefits. For example, involving key service providers and managers of agencies will not only help to ensure service gaps are minimised and service duplication does not occur, but will also facilitate organisational capacity building to implement and sustain the EIiCD initiative.

Key agencies to be considered in planning and implementing the initiatives should include:

- Health Services

³⁵ Various assessment tools are available to assist in this process with nine commonly used in primary health care organisations. Agencies are encouraged to discuss their selection with their PCP to ensure consistency. For a discussion on the selection of an appropriate tool refer to the fact sheet "Chronic Disease Management Audit Tools" available at www.health.vic.gov.au/communityhealth/cdm/resources.htm for

- Division of GPs
- RDNS
- HARP program
- local government
- local consumer groups
- and /or the local health promotion network.
- Department of Human Services regional advisor (as appropriate)
- other partners may be appropriate (for example, ACCHO, Bush Nursing Service, neighbourhood houses, other areas of the hospital)

Regular meetings should be scheduled to discuss and make decisions, foster working relationships, develop communication and referral pathways within and across agencies, and agree on common work practices.

The PCP is well placed to provide the governance structure required for broad ICDM change management. Consideration should be given to coordinating planning for ICDM including the EIiCD initiative, through an existing or new PCP subcommittee. The PCP partners should agree on governance and accountability arrangements that encourage active participation and articulate shared aims and commitments. Representation from agencies should include people who can make decisions and have the capacity to implement the decisions within their own agencies. PCP executive officers/project managers would be expected to have a key role in coordinating ICDM activities that include the EIiCD initiative.

8.3 The Wagner Chronic Care Model and ICDM Service Model components

Refer to Section 5

ICDM service models aim to deliver responsive, person centered and effective system of care for people with chronic disease. A systems approach is important to achieve these aims and the Wagner Model for Improving Chronic Care is a framework that helps to identify the systems changes necessary to improve the coordination of care for people with chronic disease. ICDM plans and service models, including EIiCD, are to use the Chronic Care Model to identify the system changes that need to occur. Diagram 2 on page 16 provides a model that contains and briefly describes the following six interdependent elements:

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

The following section provides some examples of each of the six elements of Wagner's model. The list is not exhaustive but may provide a starting point to inform the planning and development of the EIiCD initiative. It is important to remember that the interdependency of the elements means that they overlap and therefore the examples provided eg health promotion, may be relevant when considering more than one element in Wagner's model.

8.3.1 Community – community resources and activities that provide ongoing support for people with chronic disease/s.

- **Health promotion approaches**

Opportunities for health promotion interventions are linked strongly with the Health System and Delivery System Design elements of the chronic care model.

Diagram 3 on page 33, illustrates a comprehensive model of chronic disease control across the continuum of care, and the role of prevention and health promotion at each stage.

The EIiCD initiative should facilitate access to and identification of relevant health promotion approaches to meet the needs of clients with chronic disease, particularly those from disadvantaged backgrounds,

Neighbourhood Renewal areas, and from culturally and linguistically diverse backgrounds including Indigenous Victorians.

- **Use of local resources**

It is expected that clients registered for the EIiCD initiative will need a diversity of services from a range of different programs and agencies. The EIiCD steering group may engage with the local community to identify support structures for clients to access. This may include working with or finding out more about local services and / or support groups.

The rationale for this is to provide additional support to clients and link them into other activities to reduce the impact of the chronic condition.

Examples include:

- collaboration with ethno-specific groups
- local government – for example, Home and Community Care funded services
- local community-based clubs and activities – for example, neighbourhood houses, swimming centres, walking groups, local gyms, - the primary health care services may be able to collaborate with the local gym to provide lower cost memberships.
- Self-help groups: As part of self-management support, clients may want to participate in self-help groups that provide peer support and motivation to meet self- management goals. Primary health care services may consider supporting self-help groups.
- peer support groups
- volunteer groups and other social groups
- web based resources

- **Consumer participation**

Consumer, carer and community participation in the Victorian health care system is recognised as a key enabling strategy in working with and meeting the needs of a community. The *Doing it with us not for us* participation policy³⁶, launched in 2006, provides guidance for participation, which is described as:

Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment and the wellbeing of themselves and their community.

Building consumer, carer and community participation into the EIiCD initiative will strengthen and support its implementation. Participation can occur across many levels:

- in treatment and care
- consumers employed by services as consultants and advocates
- in service delivery and evaluation
- in policy and planning
- in education and training
- in staff recruitment

Participation should be considered a priority and strategies to include participation should be planned. Refer to Appendix 1 for useful links and resources that show why and how participation can be supported.

8.3.2 Health systems – support prepared and proactive practice teams.

This element looks at the development of a shared vision and plan to effectively meet the needs of people with chronic disease and provide high quality care.

The element has both a catchment level focus and an internal agency focus.

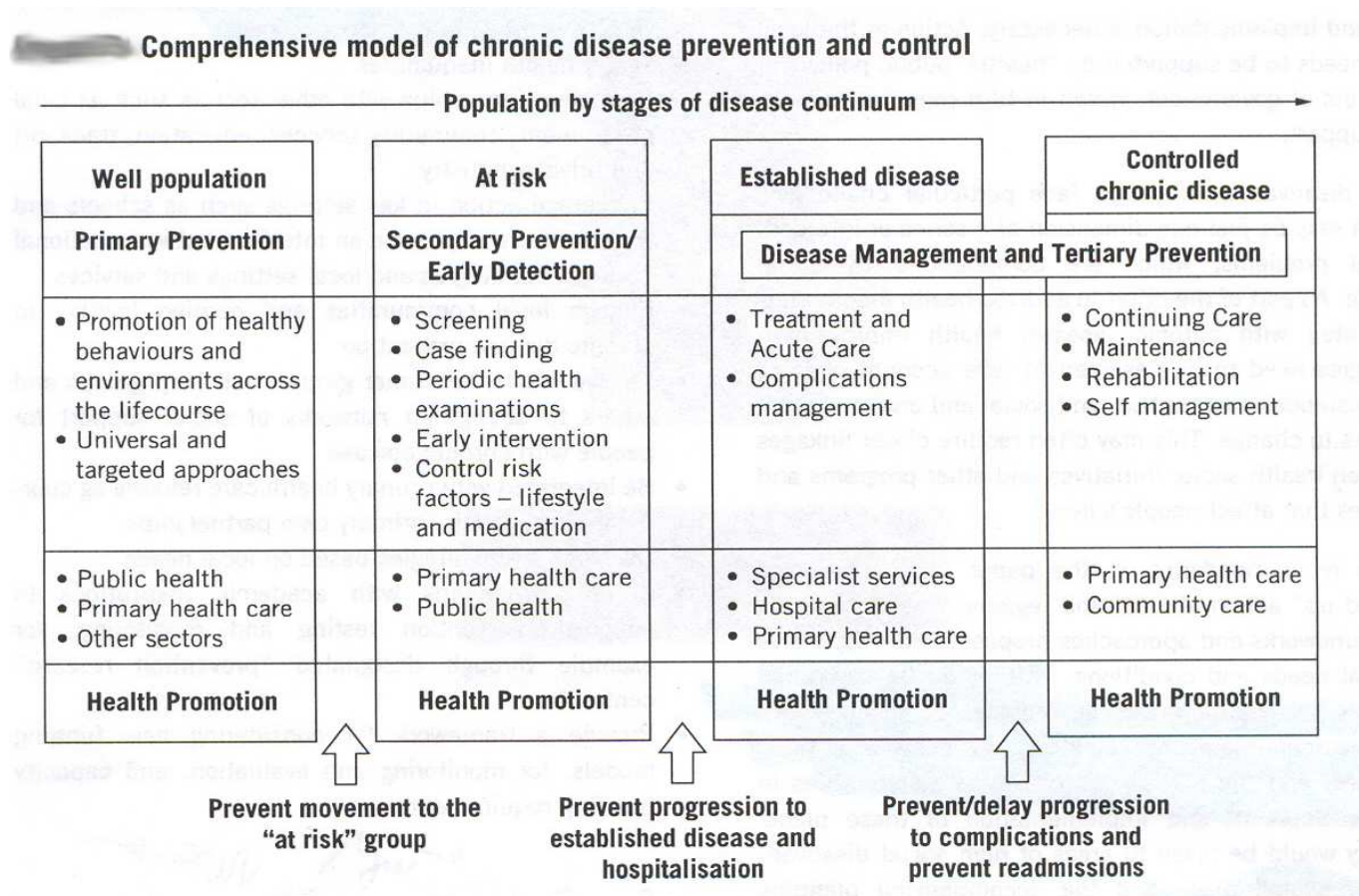
- **Health promotion approaches**

Diagram 3 illustrates a comprehensive model of chronic disease control across the continuum of care, and the role of prevention and health promotion at each stage. The model highlights the need for planning for chronic disease prevention and control across the health system. At each point on the spectrum of care,

³⁶ http://www.health.vic.gov.au/consumer/downloads/do_it_with_us.pdf

there are important opportunities for improving health literacy, client empowerment and supporting self-care.

Diagram 3: Chronic Disease Prevention and Management Continuum



(National Public Health Partnership (2001) *Preventing chronic disease: A strategic framework – Background paper*, p.6)

The EIiCD initiative should facilitate access to relevant health promotion approaches at the secondary and tertiary end of the continuum. This acknowledges:

- that chronic disease is not just a result of individual risk factors but also broader social and environmental determinants of health. These are often the underlying causes of chronic disease.
- a focus on reducing barriers to services often experienced by disadvantaged groups within the community. It is important that the EIiCD initiative is available to these people who often experience higher than average levels of chronic disease.

An IHP approach³⁷ involves agencies and organisations from a range of sectors and communities in a catchment, working in a collaborative manner and using a mix of population-based and evidenced based health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

PCPs and CHSs have a strong role in leading IHP planning, implementation and evaluation and both PCPs and CHSs receive funding that is targeted towards population-based health promotion. A proportion of this funding is to be used to address catchment-wide priorities identified by the PCP IHP catchment plans. These plans will address one to three of the following statewide health promotion health and wellbeing issues for 2007–12:

- physical activities and active communities
- accessible and nutritious food
- promoting mental health and wellbeing

³⁷ Department of Human Services (2003) *Integrated health promotion resource kit*, Victoria
 <http://www.health.vic.gov.au/healthpromotion/resources_links/integrated.htm>

- reducing tobacco related harm
- reducing and minimising harm from alcohol and other drugs
- safe environments to prevent un-intentional injury
- sexual and reproductive health.

The *PCP reporting guidelines*³⁸ asks PCPs to apply an integrated disease management lens to their IHP planning. **This is not** about focusing on chronic disease interventions but rather approaches to primary and secondary prevention to improve participation and access. PCPs are asked to reflect on how issues related to chronic disease have been incorporated within their IHP catchment planning and how, where applicable, existing IHP activities can be used to support people with chronic disease.

The following questions provide a 'lens' or a checklist for discussion:

- How are the IHP approaches and interventions in your IHP catchment being used to prevent and/or delay chronic disease within your catchment? Are specific chronic conditions and underlying social determinants being addressed within priority approaches?
- How are the barriers to participation, inclusion and 'whole of person' optimal wellbeing created by chronic conditions being addressed within IHP planning and implementation?
- What are the broader impacts of chronic disease on your catchment communities and services and how have they been considered in the planning process?
- What strategies are being used to encourage organisations with a 'downstream' focus on chronic disease to include a more 'upstream' approach, where relevant?

- **Organisational capacity building**

The Victorian Integrated Disease Management Projects found that:

capacity building must focus on implementation issues for practitioners and support for organisational change. Practitioners attending training programs identified significant barriers to practice change from within their organisation³⁹.

PCPs and member agencies need to make a long term commitment to capacity building for ICDM. Capacity building strategies should be aimed at staff, managers and leaders. The involvement of service providers and managers of agencies in the planning process assists in building organisational capacity to implement and sustain the EIiCD initiative.

Organisational capacity building includes:

- Determining human resources, skills and knowledge
- Building organisational structure, systems and policies
- A commitment to health improvements over time

Consideration needs to be given to the above across the local services to ensure service gaps are minimised and service duplication does not occur.

- **Working with GPs**

Refer Section 7.5.

Working with GPs as part of the care team requires the development of robust relationships and effective communication and involves:

- broad planning around ICDM and EIiCD
- referral, care planning and medical management at the practice level

The DGP is key to developing clear pathways and supporting general practice engagement. The ABHI-PCIP funding further enhances integration between general practice and other local health care providers to assist in the delivery of more 'seamless' patient care. DGP should encourage the use of the Victorian Statewide Referral Form (VSRF) for GP referrals.

³⁸Department of Human Services (2006) *Primary Care Partnerships, Guidelines for completing the community health plan and community health plan implementation agreement*: http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_guidelines.pdf

³⁹ Department of Human Services (2005) *Improving chronic disease care: Learnings from the Integrated Disease Management projects*, State Government, Victoria

8.3.3 Self-management support – empowers and prepares clients to manage their health and health care.

Effective ICDM includes evidence-based self-management interventions, delivered by trained health care providers and/or consumers. Based upon their identified self-management support needs, it is expected that all clients registered for the EIiCD initiative will have access to self-management support.

Self-management is the ability of the client to deal with all that a chronic disease entails, including symptoms, treatment, physical and social consequences, and lifestyle changes. Self-management interventions aim to place the person in control of their life and assist them to be as independent as possible, rather than creating health system dependency. Self-management principles aim to optimize people's capacity to manage the risk or impact of chronic illness over the lifespan and along the care continuum. Clients who are engaged in effective self-management interventions are better equipped to maintain optimal health levels and remain in community-based services for a greater period of time.

Agencies should work toward self-management support being routinely encouraged through all health care encounters. This will require leaders to create systems that enable staff to promote and provide self-management support and to build their knowledge, skills and confidence to use self-management interventions.

Primary health care services should consider offering a range of self-management interventions, to cater for various client preferences and the different stages along the disease continuum. Self-management interventions can be generic or disease specific and can be offered to individuals or groups. Interventions that target clients from culturally and linguistically diverse backgrounds and significantly disadvantaged backgrounds should also be considered. There is international and local evidence to support primary health care services making adaptations to programs and approaches in order to make them more appropriate for their target audience.

Self-management support:

- requires a focus on building self-efficacy as well as client knowledge
- includes assessment, goal setting, action planning and problem solving
- includes providing psychosocial support, motivating behaviour change and building confidence
- can be delivered using flexible approaches
- requires a system that describes who provides self-management support (for example, all allied health, designated and counselling staff), when, how and in what context (for example, as part of an allied health consultation, as a stand alone consultation). This includes clarification of scope of practice.
- should be supported by tools that assist clients and health care providers in the process (for example, a standardised self-management care planning template, decision making support tools)
- requires staff training and ongoing support, such as mentoring, budding systems and access to secondary consultation for skill development and support.

PCPs are asked to work with agencies to improve their understanding of self-management, map the provision of self-management interventions, and undertake planning to address the identified gaps in self-management interventions. In addressing the gaps, PCPs may need to facilitate a process for agencies to understand and define:

- How are people who need self-management support identified (screening for self-management capacity)?
- Who provides self-management interventions?
- How are good self-managers supported?
- Who provides ongoing management and review? If issues are identified as part of the review, how are people linked back into the system?

The above questions suggest that both health and community services have a role to play. The questions also suggest that health services may have different roles. It will be useful to discuss these roles, such as:

- What is the acute sector's role in self-management?
- What is the GP's role in self-management?
- What is the primary health care services' role in self-management?

8.3.4 Delivery system design – assists care teams to deliver systematic, effective, efficient clinical care and self-management support.

- **Communication between agencies**

Improved communication between agencies, such as referral acknowledgement, service outcome, and communication about coordinating care for clients, is key to building an effective service system for ICDM. PCPs have been supporting agencies to develop internal feedback and communication systems as part of implementing and embedding service coordination. This is also an important part of PCP ICDM work.

Refer to Victorian Service Coordination Practice Manual (including Good Practice Guide for Practitioners and Continuous Improvement Framework)

- **Client recruitment, referral pathways and care pathways**

Example:

A diabetes care pathway may include agreements about:

- who provides what interventions, including individual and group based interventions
- how clients are prioritised for service or referred to a more appropriate service
- who, how and when clients are referred interventions / services eg diabetes education programs.
- Such agreements may be broader than the Primary Health Care Services

Primary health care services should consider strategies to ensure that the 'right people' are recruited into the right program, particularly those who have difficulty accessing services due to geographic location, ethnicity, language barriers, limited literacy levels or who lack the confidence to be good self-managers of their own health care. Primary health care services should also review existing clients and identify those who meet the criteria (as per the target group) and may benefit from the program as a recruitment strategy.

Experience from other projects and programs has shown that recruitment takes effort and resources. Engaging with GPs as part of the care team is essential. (refer Section 7.5)

Other key referrers include:

- hospital allied health staff
- HARP-CDM staff
- pharmacists (in particular medication review pharmacists)
- council-based home care staff
- Aboriginal Community Controlled Health Organisations (ACCHOs)

Referral pathways should be underpinned by Service Coordination principles and include quality information sharing, feedback and agreed response times. Recruitment criteria should be clearly defined and become part of initial needs identification, which involves screening of client needs, determining access and priority, and assessing risk.

Disease specific care pathways should be discussed, developed and agreed upon with multiple agencies. It is acknowledged that this work may only focus on one or two diagnostic groups. Decisions for this targeted work should be based on local population health, burden of disease and other relevant data.

Work on developing consistent disease care pathways will help to ensure that clients receive the same care regardless of where they enter the service system. Pathways should articulate alternate programs or services. A mechanism for referring on should be in place to ensure access to appropriate services.

- **Key worker role**

All people registered for the EIICD initiative by the primary health care services are assigned a key worker. The role of the key worker should be defined and delegated and understood by all partner agencies. The key worker should be an appropriately qualified health professional whose role includes:

- coordinating a comprehensive assessment
- collecting clinical information at regular intervals
- ensuring that a care plan is in place and that it is monitored and reviewed
- identifying client and carer capacity for self-management and needs
- communicating and liaising (including service outcome communication) with other health care providers (including GPs, AHPACC Partnership worker)

- coordinating a multidisciplinary case conference
- being a contact for the client should their condition deteriorate or circumstances change that may impact on the course of their condition
- supporting carers
- referring to community-based activities
- a flexible approach to ongoing follow up
- following up those clients who drop out of the program.

The frequency and type of contact (in person or over the phone) will be determined in consultation with the client and is likely to vary over time. It is possible that once a care plan is in place, the key worker may have less frequent contact with the client. For example, the key worker may contact the client every six months to ensure that the client's disease is stable and to provide ongoing support for self-management (eg, relapse prevention and/or support, appointment keeping with their GP and other health care providers).

• **Assessment**

Primary health care services with EIiCD funding are required to coordinate comprehensive assessments for their clients who are part of the EIiCD initiative.

Better Access to Services – a policy and operational framework describes three types of assessment: service specific, specialist and comprehensive assessment⁴⁰. Comprehensive assessment is described as:

'an extensive process of inquiry that gathers information about medical, physical, social cultural and psychological dimensions of need and assesses restorative options and capacity for improvement'.

Many clients with chronic disease will benefit from a comprehensive assessment however the level and type of assessment required will depend on the individual client's needs. It is important that assessment builds on information gathered through broad initial needs identification and includes a focus on self-management.

As a minimum, all clients must have medical assessment and management (which necessitates a GP being identified) and coordination of medical and other assessment and care.

It is expected that the key worker role within the primary health care service will ensure a comprehensive approach by coordinating assessments from a range of different agencies; undertaking comprehensive assessments; or nominating another health service provider to conduct a comprehensive assessment.

It is important to avoid duplication and 'over assessing'. PCPs should lead a process to discuss and define which clients require a comprehensive assessment and which agencies are involved in coordinating comprehensive assessments.

The ICDM work for people with chronic disease should be integrated with the PCP's service coordination work⁴¹ to develop local agreements around assessment more broadly.

• **Direct service delivery**

Clients with chronic disease will generally require services from multiple providers over time. Depending on the needs of the client, direct service delivery from primary health care services will include a range of services and programs which could include:

- CHSs – for example, allied health, nursing, self-management programs
- local government – for example, Home and Community Care funded services
- medical services provided by GPs and specialists – for example, endocrinologists, respiratory specialists
- other specialist services – for example, mental health, drug and alcohol
- community-based activities

⁴⁰ Department of Human Services (2001) *Better Access to Services- a policy and operational framework*, Primary Care Partnerships Victoria. <http://www.health.vic.gov.au/pcps/publications/access.htm>

⁴¹ Refer: Victorian Service Coordination Practice Manual: www.health.vic.gov.au/pcps/publications/sc_pracmanual

Flexible approaches to service delivery and addressing service gaps is encouraged, for example, using sessional staff or establishing partnerships with local agencies currently delivering community-based services for people with chronic disease.

Primary health care services, in conjunction with PCPs, GPs through DGPs, and acute health services, should consider the profile of services available in the area and identify service gaps when deciding on the disciplines and skills mix required to support an integrated approach to ICDM.

People with chronic medical conditions and complex care needs may be able to receive up to five allied health provider consultations per year as part of the allied health items under the MBS. To be eligible, GP patients must have both a GP Management Plan and a Team Care Arrangement⁴² in place. PCPs and primary health care services should work with their DGP and local allied health providers to ensure that eligible clients can access these services.

Clients registered for the EIiCD initiative should be able to access all appropriate services within the primary health care service based on clinical need. Communicating service outcomes to referrers and others involved in providing care should be a part of service delivery.

- **Psychosocial support**

Effective ICDM requires awareness of the association between a range of social factors, depression and anxiety related to diagnosis and chronic medical conditions by all practitioners involved, particularly those in key worker roles.

Psychosocial screening, which could be conducted using the psychosocial SCTT profile, needs to be considered as a component of service delivery and may lead to offering to refer the client to counselling and other services if necessary. Most community health services employ counsellors who provide effective interventions for common mental health problems, including depression. GPs also have the capacity to refer people to private counsellors at little or no cost under the MBS or other programs funded by the Australian Government. For further information, refer to *Counselling in Community Health Services: Future directions and standards for quality counselling*.⁴³

People with chronic medical diseases commonly experience depression and anxiety. Literature, the National Survey on Mental Health and Wellbeing (NSMHW, ABS, 1998) and the Victorian Burden of Disease data support this finding.

The NSMHW reports that in 1998 anxiety disorders affected just under one in 10 adults in Australia and mood disorders (including depression) affected 5.8 per cent of Australian adults. Around 40 per cent of people who experienced anxiety, depression or alcohol disorders in the NSMHW study also had chronic physical health issues, including cardiac and respiratory disorders and arthritis. These findings suggest there may be a connection between mental and physical health problems.

Studies also show that undiagnosed depression will make it harder for people to self-manage, for example, take medications, eat properly, and keep health care appointments⁴⁴.

Whilst partnering approaches could lead to better outcomes for people affected by chronic conditions, clear eligibility criteria should be established around providing psychosocial support. The needs of clients with a primary diagnosis of complex psychosocial needs, depending upon the level of acuity, may be better met through referral to programs such as HARP-CDM⁴⁵ or other community based services where specialist clinical skills are available to more appropriately manage these clients.

- **Care planning and care coordination**

Example of a coordinated approach for a client with diabetes:

A GP management plan is developed by the GP. Given that ongoing multidisciplinary care from at least three providers is needed, and the client has complex needs, the GP initiates a 'Team Care Arrangement' (TCA) and makes a referral to the EIiCD program. The key worker receives the referral and with the GP and client, develops a multidisciplinary care plan involving collaboration with the participating providers. The care plan is based on best practice guidelines for diabetes and may include:

- involvement in a generic self-management program
- diabetes specific education
- dietary advice, planning and review
- foot care and treatment of foot problems or deformities
- involvement in a physical activity program - exercise classes/walking groups
- counselling
- involvement with peer-led support activities with people with the same condition.

Care planning is described as a process that:

ensures the needs of consumers are discussed with them, their carers and other relevant parties in the context of possible options, and subsequently worked through to an agreed strategy⁴⁶

Care plans developed and used within an agency may also be described as clinical plans, service plans or individual treatment plans. The definition of care planning also includes a process of drawing together existing care plans and building in aspects of coordination and communication to develop a cross-disciplinary/multi-agency care plan.

The level and type of care planning required for people with chronic disease will depend on their individual needs. However, at a minimum, clients will require care planning at an agency level and consideration given to cross-disciplinary/multi-agency care planning where multiple agencies are providing services. Cross agency communication and partnership is important to support this process.

The key worker role ensures that a care plan is in place and that it is monitored and reviewed.

A shared plan of care is an essential element of effective ICDM. It provides structure and coordination of services as the client negotiates the many care episodes characterised by long-term care and support. Care plans should be informed by established 'best practice' guidelines and recognised clinical pathways and include the following elements:

- issues/problems
- goals, actions, target dates, responsible agents
- regular review dates
- participants
- checklist – evidence of need
- method of planning

The care planning process should be a dynamic, consultative process that includes the client (and family/carers as appropriate) and health care providers and is aimed at meeting the client's health needs in a holistic way. Treatment options should be provided so that clients can make informed decisions about their care. Goals and actions should be measurable and clearly articulate who is responsible, so that review and reflection is possible.

Within this initiative, PCPs are asked to progress the development of local protocols to identify:

- clients who require cross-disciplinary/multi-agency care planning
- systems around initiating and coordinating care planning for people with chronic disease

This should focus on working with GPs. GPs are an important service provider for people with chronic disease. New items under the Medical Benefits Schedule⁴⁷ (MBS) for ICDM were introduced in 2005 and apply to people with chronic conditions and complex needs, in particular, asthma, cancer, arthritis, diabetes, heart disease and mental illness.

Three of the MBS items include:

- preparation and review of a GP management plan
- coordination and review of team care arrangements
- contribution to a multidisciplinary care plan being prepared by another health or care provider⁴⁸

PCPs should work with local DGPs (refer Section 7.5) and GPs to develop local arrangements that promote the participation of GPs in care planning and care coordination and the alignment of community-based care coordination with planned multidisciplinary care for chronic disease.

Where cross-disciplinary/multi-agency care planning occurs, it is preferable that the Service Coordination Plan template (part of the Service Coordination Tool Template, SCTT) is used.⁴⁹ The DHS is currently

⁴⁶ Department of Human Services (2001) *Better Access to Services- a policy and operational framework*, Primary Care Partnerships Victoria <http://www.health.vic.gov.au/pcps/publications/access.htm>

⁴⁷ Further information about MBS resources is available from: www.health.vic.gov.au/communityhealth/gps/mbs

⁴⁸ Commonwealth Department of Health and Ageing, <http://www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease>

⁴⁹ Department of Human Service (2006) *Service coordination tool templates*, Victoria. <http://www.health.vic.gov.au/pcps/coordination/sctt2006.htm>

reviewing the tool and supporting resources as part of the SCTT 2009 revision process, to be released in June 2009.

8.3.5 Decision support – includes design, systems and tools to ensure clinical care is consistent with evidence-based guidelines.

Decision support tools can support health care providers to provide good clinical care. Decision support tools may be existing clinical guidelines, reminder systems, decision algorithms or tools which assist health care providers work through a standard process (such as the Flinders Tools). Examples include:

- clinician flow charts
- intake decision support tools

Best practice guidelines for particular diagnoses can be accessed from peak bodies, such as:

- Diabetes Australia
- Arthritis Foundation
- The Heart Foundation.

8.3.6 Clinical information systems – includes data systems that provide information about the client population, reminders for review and recall, and monitor the performance of care teams. This component is important at both a planning level and also in ensuring clients are receiving best practice care.

Recall and reminder systems: Primary Health Care services should ensure systems enable service providers to be proactive in inviting or reminding clients to participate in their documented plan of care. This may be via current electronic software systems such as Microsoft Outlook, SWITCH or Healthsmart applications. Agreements may be developed with the DGP and local GPs to ensure that recall and reminders are coordinated between service providers and that primary health care service' systems do not duplicate existing recall and reminder systems within general practice.

Note: Coordination between the GP and primary health care services needs to occur for a client with diabetes, so the reminder for an annual foot care assessment is not generated by two agencies.

9. Evaluation

As part of the change management or project planning processes, mechanisms are required to identify if changes are having the intended impact or outcomes. Planning and implementing monitoring and evaluation activities provides a mechanism to ensure continuous quality improvement and informs ongoing implementation of the initiative.

Evaluation and monitoring activities will be discussed in greater detail with the central program via the community of practice and other opportunities, to be advised.

9.1 Plan-Do-Study-Act Cycles

Plan-Do-Study-Act (PDSA) cycles can be used to implement or spread change and is an approach documented as part of the chronic care model. The approach is also familiar to general practice as it has been successfully applied in the National Primary Care Collaboratives.

In assessing organisational capacity, system gaps and areas for improvement will be identified. A common model used for making improvement is the PDSA cycle, a scientific method which provides a relatively simple way to test a change by planning it, trying it, observing the results, and acting on what is learned and implementing changes more broadly.

The use of PDSA cycles is used for action-oriented learning, the key principle being to test on a small scale and to test quickly. The PDSA philosophy is to design a small test with a limited impact that can be conducted quickly to work out unanticipated 'bugs'. Repeated rapid small tests and the learnings gleaned build a process ready for implementation that is far more likely to succeed.

PDSA cycles may already be familiar to agencies as a quality improvement approach used as part of their continuous quality improvement activity and preparation for accreditation (for example, EQUIP, QICSA).

To begin a PDSA the following questions must first be answered:

- What are we trying to accomplish?
- How will we know that the change is an improvement?

- What changes can we make that will result in an improvement?

This approach differs from that of traditional quality improvement, which has been anchored in laborious planning that attempts to account for all contingencies at the time of implementation - usually resulting in failed or partial implementation after months or even years of preparation.

Additional resource materials have been provided in Appendix 1 to assist PCPs and agencies use the PDSA cycle.

Reasons to test changes

- To increase your belief that the change will result in improvement.
- To decide which of several proposed changes will lead to the desired improvement.
- To evaluate how much improvement can be expected from the change.
- To decide whether the proposed change will work in the actual environment of interest.
- To decide which combinations of changes will have the desired effects on the important measures of quality.
- To evaluate costs, social impact, and side effects from a proposed change.
- To minimise resistance upon implementation.

9.2 Potential evaluation and monitoring considerations and measures

The following section has been incorporated to facilitate discussion regarding how, at both an agency level and a partnership level, progress will be monitored and tracked. The purpose of monitoring and evaluation includes (and is not limited to):

- Tracking progress against objectives
- Ensuring intended impacts and / or outcomes are being achieved
- Modifying aspects of programs and services to better reflect current needs
- Identification of areas that may need addressing
- Highlighting areas where positive progress and changes have occurred

Previously funded EIiCD programs have found benefit in focusing efforts on areas as described below⁵⁰. Please note this list is not exhaustive nor does it necessarily reflect where measures are required for local needs as determined using the ACIC (or similar) tool. The list, however, does provide some suggestions to consider.

- Program, agency and PCP catchment level:
 - Number of partnerships
 - Organisational capacity as an example ACIC, continuous improvement framework (service coordination)
 - Demographics – age, ethnicity, gender
 - Referral source
 - Referrals out
 - GP communication
 - Quality of GP referrals
 - Clinician/key worker satisfaction or narrative feedback
 - Link with other service quality improvement activities /reporting

⁵⁰ For experience of past programs and their evaluation methodologies, please consult:

- Early Learnings from the State-wide Evaluation of the Early Intervention in Chronic Disease (EICD) initiative, February 2008
- Challenges of evaluating integrated chronic disease management innovations and practical learnings from the Victorian primary health sector – presentation to DMA conference, Sydney, 2008
- Improving Chronic Disease Care: Learnings from the Integrated Disease Management Projects

Download these resources at: www.health.vic.gov.au/communityhealth/cdm/

- Health Impact Evaluation Questionnaire ⁵¹ (heiQ)
- Number and type of care plan used
- Transition between services
- Hospital admission frequency
- Client-level – health and well being:
 - Mental health such as Kessler-10 depression score, hospital anxiety & depression scale
 - Health and well-being as an example National health survey questions, weight, blood pressure
 - Disease-specific indicators e.g. Hba1c, spirometry, blood pressure
 - Telephone surveys of discontinuing clients
 - Analysis of care plans against goal attainment scores
 - Patient assessment of chronic illness care for example PCIC – Wagner Chronic Care Model
- Client level – behavioural (self-efficacy):
 - Documented Self-management goals
 - Client self-efficacy for managing chronic disease such as Lorig scales (change in)

⁵¹ The heiQ™ is an Australian-developed health education impact evaluation system consisting of a set of eight scales to measure effectiveness of health education programs. Together they provide a comprehensive profile of the intended outcomes of health education / self-management programs.

Further information

For information and advice about the development and implementation of the EIiCD initiative and PCPs ICDM initiative, contact:

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Abbreviations

ABHI	Australian Better Health Initiative
ACCHO	Aboriginal Community Controlled Health Organisation
ACIC	Assessment of Chronic Illness Care
AHPACC	Aboriginal Health Promotion and Chronic Care
BATS	Better Access to Services
CDM	Chronic Disease Management
CHPIA	Commonwealth Health Planning and Implementation Agreement
CHS	Community Health Service
DGP	Division of General Practice
DHS	Department of Human Services
EIiCD	Early Intervention in Chronic Disease
GP	General practitioner
HARP	Hospital Admission Risk Program
ICDM	Integrated Chronic Disease Management
IHP	Integrated health promotion
LGA	Local government area
MBS	Medical Benefits Schedule
PCP	Primary Care Partnership
PDSA	Plan Do Study Act
PIP	Practice Incentives Program
SCTT	Service Coordination Tool Templates
SIP	Service incentives Payment

Glossary

Burden of disease – the health and socioeconomic costs of a given medical condition on a society.

Chronic disease – usually characterised by complex causality, multiple risk factors, a long latency period, a prolonged course of illness, functional impairment or disability and, in most cases, the unlikelihood of cure.

Chronic disease management – is used in a generic sense in this document to refer to care for people with chronic disease and chronic conditions, which usually involves numerous health care providers in multiple settings. Care should be provided within an integrated system.

Complex needs – complexity as it related to chronic disease and chronic conditions typically involves comorbidities and psychosocial factors. This could include older people who are becoming frailer, carer stress or a reduced ability to function independently.

Early Intervention in Chronic Disease (EIiCD) – a specific funding initiative: Early Intervention in Chronic Disease for Community Health Services.

Integrated Chronic Disease Management (ICDM) – care for people with chronic disease and conditions is coordinated and connected across the continuum of services and amongst providers in all sectors and levels. This term is used in this document to describe the funded ICDM role of PCPs for 2006–09.

Self-management⁵² – the client working in partnership with their (and family/carers as appropriate) health care provider to:

- Know their condition and various treatment options,
- Negotiate a plan of care,
- Engage in activities that protect and promote health,
- Monitor and manage the symptoms and signs of the condition(s),
- Manage the impact of the condition on physical functioning, emotions and interpersonal relationships³¹.

⁵² Flinders University Model of Chronic Condition Self Management: http://som.flinders.edu.au/FUSA/CCTU/self_management.htm

Appendix 1 Resources and links to support planning

1. Partnerships

- *Primary Care Partnerships strategic directions 2004–2006* – outlines the vision for partnerships within the primary care sector

http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_strat_2004_06.pdf

- The Industry Advisor project: Over the course of 12-months, two Industry Advisors are working with PCPs to develop strategies and approaches to further progress ICDM work across their catchments.

<http://www.health.vic.gov.au/communityhealth/cdm/ia.htm>

2. The Wagner Model for Improving Chronic Care

Many articles explain the Wagner Model for Improving Chronic Care and provide examples of how it is used in health care agencies (references include quality improvement journals, medical journals, primary care journals).

Information can be sourced from the following websites:

<http://www.improvingchroniccare.org/>

<http://www.ihl.org/IHI/Topics/ChronicConditions/>

Becoming a member of the Institute for Healthcare Improvement is free (via the above website) and provides access to a range of resources that can assist agencies implement the model, including using PDSA cycles, setting up teams, and examples of the model in practice.

The Wagner Model is not a quick fix or a magic bullet; it is a multidimensional solution to a complex problem. It provides a road map for changing the system. There is now strong evidence that an integrated set of system changes can substantially improve client health and satisfaction. There are many examples, in literature and on the Web, of how the Chronic Care Model has been used to improve health care.

3. Change management

- The integrated health promotion capacity building framework is a useful tool to support change management. can be downloaded from the following website:

http://www.health.vic.gov.au/healthpromotion/resources_links/integrated.htm

- Developing change management skills: <http://www.sdo.lshtm.ac.uk/managingchange.html>

This website contains three useful documents that can be downloaded:

- ***Developing change management skills. A resource for health care professionals and managers***
Valerie Iles and Steve Cranfield
This publication and web-based resource aims to help those leading change in health care settings.
- ***Organisational change: a review for health care managers, professionals and researchers***
Valerie Iles and Kim Sutherland
This publication is a review of models of change management to help managers, professionals and researchers in health care find their way around the literature and consider the evidence available about different approaches to change.
- ***Making informed decisions on change: key points for health care managers and professionals***
Marsaili Cameron, Steve Cranfield, Valerie Iles and Jud Stone
A booklet, drawing on the above review, which encourages managers and professionals to reflect on and share what helps and hinders successful change to improve the quality of services.

4. Assessing organisational capacity

- Primary health care services will find the ACIC tool useful in surveying their organisational capacity to undertake quality integrated chronic disease management. The ACIC, based on the Chronic Illness Care Model, is designed to:
 - identify areas for improvement in chronic illness care before beginning quality improvement work
 - identify systems gaps
 - measure the organisation's capacity to implement new systems
 - periodically evaluate the impact of the changes being made to improve chronic illness care.

The ACIC (Assessment for Chronic Illness Care) can be downloaded from the Institute for Healthcare Improvement at: http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35

- The *Integrated health promotion resource kit* can be downloaded from the following website:

http://www.health.vic.gov.au/healthpromotion/resources_links/integrated.htm

- For a discussion on the selection of an appropriate tool refer to the fact sheet "Chronic Disease Management Audit Tools" available at: <http://www.health.vic.gov.au/communityhealth/cdm/resources.htm>

5. Organisational capacity building

The partnership may consider using the IHP capacity building framework *Key action areas for capacity building*, which appropriate for planning integrated disease management capacity building. The framework includes planning strategies under key action areas:

- a. partnerships
- b. organisational development
- c. leadership
- d. workforce development
- e. resources

6. Self-management support

Existing **evidence-based self-management interventions** include:

- **Flinders Model:**

Flinders University Model of Chronic Condition Self Management

http://som.flinders.edu.au/FUSA/CCTU/self_management.htm

- **Stanford Model:**

Stanford Chronic Disease Self-Management Program

<http://patienteducation.stanford.edu/programs/cdsmp.html>

- **Self-Management 5As** (Kaiser Permanente):

<http://jeny.ipro.org/attachment.php?attachmentid=1322&d=1146597543>

- **Telephone Coaching:**

Linder H, Menzies D, Kelly J, Taylor S, Shearer S, (2003) Coaching for behaviour change in chronic disease: A review of the literature and the implications for coaching as a self management intervention, La Trobe University, *Australian Journal of Primary Care*, Special Issues, The Management of Chronic Diseases in Primary Care Settings, Vol 9, Numbers 2 & 3 2003.

- **Motivational Interviewing for Behaviour Change** (Prochaska & Declemente Model):

Miller WR & Pollnick S, (1991) *Motivational Interviewing: Preparing people to change behaviour*. London: The Guilford Press

7. Community participation

- The policy, *Doing it with us not for us*, developed by the Victorian Department of Human Services describes the strategic direction in consumer, carer and community participation across the Victorian health services system.

http://www.health.vic.gov.au/consumer/downloads/do_it_with_us.pdf

A strategic directions paper is also available.

http://www.health.vic.gov.au/consumer/downloads/do_it_with_us_strategic.pdf

- Supporting and promoting consumer participation is a main role for the Health Issues Centre. Their web page provides many links and resources.

<http://www.healthissuescentre.org.au/>

- Another helpful resource, developed by the Department of Human Services in 2000, is a guide that assists health practitioners to work with consumers to design written health information. The guide aims to ensure that information meets consumer's needs, is comprehensive and written in an unbiased way.

<http://www.health.vic.gov.au/consumer/pubs/written.htm>

8. Plan, Do, Study, Act (PDSA) cycles

- PDSA cycles are very useful in testing small scale changes. Further information about PDSA cycles and examples of how they have been used to implement aspects of the Chronic Care Model are available on the Institute for Healthcare Improvement website at:

<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>

- The NSW Government has produced a document, *Improving care for people with chronic disease: a practical toolkit for clinicians and managers*. It includes information, tools and a step by step process using PDSA cycles. It has been developed to facilitate implementation of improvements for people with chronic disease. The toolkit is based on outcomes from the NSW Chronic Care Collaborative and includes a CD of resources developed by the collaborative team. The document is available at:

http://www.health.nsw.gov.au/pubs/2005/chronic_toolkit.html

- The Australian Primary Care Collaboratives Program is an initiative funded by the Australian Government that aims to help general practitioners (GPs) and primary health care providers work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex conditions and promote a culture of quality improvement in primary health care. The Collaboratives methodology, designed by the Institute for Healthcare Improvement in the USA, uses the PDSA approach to achieve incremental, rapid and locally relevant improvements across a broad range of clinical and practice business issues. The topics to be addressed in the first phases of the Australian Primary Care Collaboratives Program are Diabetes, the Secondary Prevention of Coronary Heart Disease, and Better Access to primary care. PDSA tools are available at: <http://www.apcc.org.au/>

9. Other Websites:

Additional resource materials are available at:

- **Aboriginal Health:** http://www.health.vic.gov.au/communityhealth/aboriginal_health.htm
- **Care planning:** http://www.health.vic.gov.au/pcps/coordination/care_planning.htm
- **Chronic Disease Management:** <http://www.health.vic.gov.au/communityhealth/cdm/index.htm>
- **Early Intervention in Chronic Disease:**
http://www.health.vic.gov.au/communityhealth/cdm/early_intervention.htm
- **General practice partnerships:** <http://www.health.vic.gov.au/communityhealth/gps/index.htm>
- **Go for your life:**
http://www.goforyourlife.vic.gov.au/hav/articles.nsf/pages/Life_Taking_Action_on_Diabetes_Program?OpenDocument
- **GPV programs** - Primary care integration (including the ABHI _ PCIP program) and the primary care liaison program <http://www.gpv.org.au/content.asp?cid=12,26&t=Primary%20Care%20Co-ordination>

- **Hospital Admission Risk Program-Chronic Disease Management:**
<http://www.health.vic.gov.au/harp-cdm/>
- **Primary care partnerships:** www.health.vic.gov.au/pcps