cohealth case study
Team care for people with chronic conditions

The Chronic Care Model element highlighted in this case study is delivery system design.
Providing effective chronic conditions care requires a multidisciplinary team based approach.

Background
In 2012 when cohealth reviewed its care of people with multiple or complex chronic health conditions, they found that the care people received was fragmented, incomplete, inefficient and ineffective.

cohealth decided it needed to improve its delivery system design to reduce fragmentation of care and provide more person-centred care.

What they did
Setting up interdisciplinary site-based care
cohealth has a number of different sites across Melbourne, so it decided to set up interdisciplinary site-based care to support practitioners to provide person-centred, coordinated and integrated care.

Setting up the interdisciplinary teams required restructuring the allied health teams, defining their target audience and changing their care delivery processes and protocols.

Key activities in each of these three areas are described below.

Restructuring the allied health teams
- Allied health teams were restructured from discipline-specific teams to site-based interdisciplinary collaborative care teams that included the addition of counselling, social work and allied health assistants.
- Care coordination roles and key liaison roles were introduced and protocols developed to define for whom and when care coordination was required.
- A sense of team was built through critical reflection, development of a team charter, building trust and respect and understanding each discipline's role and what they bring to the client experience.
- Interprofessional clinical practice supervision and cross-discipline education were provided to the teams.
- Staff were trained in chronic disease self-management, motivational interviewing, health coaching and goal-directed care planning.

Defined the target audience
People with chronic and complex health conditions are identified at intake or internally by other practitioners and these individuals are offered a care coordinator to support them manage their condition.

Screening tools are used by intake and eligibility is determined based on the presence of a chronic condition and one or more of the following:
- the need for care coordination is due to a poorly managed chronic condition or because multiple services are involved
- the person is interested in self-management support
- the person is interested in support with behaviour or lifestyle change for issues relating to chronic condition risk factors.
Changing care delivery processes and developing protocols to support practitioners to provide person-centred care

People identified as eligible for care coordination were offered a meeting with a care coordinator or a key liaison officer who explains their role, works with the person to identify their needs/goals and organises a plan of care to meet these needs/goals.

The care coordinator role is a central link to coordinating access to the whole range of assessments and intervention services needed by the person, with the aim of enhancing the client’s independence and improved quality of life.

This includes:

- conducting comprehensive assessments
- undertaking person-centred care planning
- provision of self-management support
- provision of care coordination for people who choose to access this service.

The care coordinator role is essentially for people with complex needs. Allied health staff can also take on a key liaison role, which is a scaled-back version of the care coordinator role.

This is determined in consultation with the team as to whether the client would be managed by a care coordinator or a nominated key liaison worker.

Figure 1 provides a summary of the care delivery process for people with chronic or complex conditions. Figure 2 provides an overall summary of how care looks for a person with chronic or complex health conditions now compared to cohealth’s old care delivery processes.

The model is supported by tools and processes such as a common assessment and risk screening tools, a common care plan, regular team meetings and access to a range of self management support programs.

Outcomes

The findings of an independent evaluation conducted between 2011 and 2015, shows that cohealth’s model:

- is person centred, with people experiencing coordinated appointments, joint assessments, goal-driven care planning, increased capacity for self-management, and coordinated care. Importantly, the evaluation found that clients reported a high level of satisfaction
- has enabled the organisation to streamline and enhance many of its structures, policies, procedures and systems
- contributes to improved staff morale, competency and confidence.

How the changes made by cohealth have improved care for people with chronic conditions are highlighted in the client stories on pages 4 and 5.
The two client stories on the following pages highlight how the changes made by cohealth have improved care for people with chronic conditions.
**Tim’s story**

Tim, a 71-year-old man living alone in public housing on a Disability Support Pension and socially isolated, was being seen by a physiotherapist at cohealth.

Tim indicated that he wanted to do something about his health and lifestyle issues.

The physiotherapist felt that she was providing Tim with ‘reactive care’ and suggested that he would benefit from more planned, coordinated care to help him with his health and lifestyle issues.

The physiotherapist invited a care coordinator in for a joint session, they were able to identify that Tim’s recent fall had occurred while he was under the influence of alcohol and codeine but he was reluctant to discuss his alcohol issues.

After a further joint care planning session with the physiotherapist and care coordinator, Tim agreed to a referral to an alcohol and other drug (AOD) counsellor.

The care coordinator, in consultation with the other members of the care team, worked to engage and build trust with Tim, while completing an assessment of his complex health and lifestyle needs, using the organisation’s comprehensive screening tool.

The screening tool identified that Tim had: borderline diabetes, high blood pressure, chronic pain, obesity, sleep apnoea, alcohol dependence (10–13 glasses of wine per night), codeine dependence, anxiety and depression, and hoarding issues.

The care coordinator identified that Tim needed support from a number of team members including a physiotherapist, an occupational therapist and a podiatrist, as well as service providers from outside the organisation, including his general practitioner, a de-cluttering support worker, an AOD counsellor and the local pain clinic.

Tim agreed to work with the care coordinator and other clinicians to develop a shared care plan.

At the shared care planning meeting, Tim identified two goals:

- reduce and manage pain
- reduce intake of alcohol.

Tim began working with the care coordinator and other team members to realise his goals.

Tim undertook a number of programs and activities (walking, hydrotherapy and cycling) to help him reach his goals. He experienced a number of personal crises that saw his mood drop and lose confidence in achieving his goals but over time and with ongoing support from his care team, he made great progress.

At his review of his care plan session, Tim reported being proud of his achievements of being alcohol free, with increased energy, improved sleep, improved memory and a new routine that included walking every day.

He also reported that he had rediscovered his lifelong hobby of reading, his blood sugar levels had decreased and he felt confidence in managing his health issues.

After seven months in the program, Tim attended a discharge planning session. This involved planning a transition from the AOD counsellor to a general counsellor, so that Tim could begin addressing living with pain, hoarding, social isolation and mood issues.

It was determined that his general practitioner would take over the care coordination role (feedback to this effect was sent to his general practitioner).

Working together with Tim, supported by the suite of assessment and care planning tools, the care team were able to empower Tim with the skills and confidence he needed to take control of, and self-manage, his ongoing pain, alcohol and mental health issues.
Mary’s story

Mary, a 67-year-old woman, contacted the cohealth Central Intake Service seeking assistance for her asthma, type 2 diabetes, anxiety, chronic pain and arthritis.

After completing an initial needs identification process with the intake worker, it was determined that Mary fitted the criteria for coordinated care and she was offered the service.

Mary’s first visit involved a number of coordinated appointments.

She had an appointment with the physiotherapist for her chronic pain issues, the podiatrist for foot care related to her diabetes, the counsellor to discuss her anxiety and relationship issues, and the care coordinator to talk-over Mary’s concerns and goals and how her appointments and care would be coordinated.

Information gathered by each of the practitioners was documented in a common assessment. It was also identified that Mary needed a referral to the diabetes nurse educator and the dental service.

The clinicians who treated Mary held a client review meeting the next day to discuss her assessments, her goals and to develop a plan for how they would work together to coordinate her treatment and help her achieve her goals.

Mary’s goals, treatment plans and the agreed strategies for coordinating her care were documented in a care plan which was finalised with Mary by the care coordinator and a copy of the care plan was given to Mary.

The care coordinator organised Mary’s referrals to the diabetes nurse educator and dentist, and coordinated the timing of her follow-up appointments.

In mid-June Mary attended appointments with the physiotherapist for ongoing treatment, the diabetes nurse educator to check her HbA1c and explore self-management skills, the counsellor for therapeutic counselling, the podiatrist for follow-up care, and the dentist.

After these appointments, the care team held a client review meeting to review services and treatment, and it was agreed that the care coordinator would continue to coordinate her care.

Mary’s third and final set of coordinated appointments occurred in July, when she attended appointments with the physiotherapist, podiatrist, counsellor and diabetes nurse educator.

At the following client review meeting, the physiotherapist and counsellor reported that Mary was improving, but needed a couple more appointments. The podiatrist and diabetes nurse educator reported that her treatment was complete; Mary had her diabetes under control and was confident she had the knowledge and skills to manage her diabetes moving forward.

It was agreed that the care coordinator would organise to meet with Mary in September for follow up and undertake a final review.

The care coordinator met with Mary in September to complete a formal review of her goals, to develop a discharge plan and obtain feedback from Mary about her care experience.

Mary told the care coordinator that she was ‘feeling a lot better than when she started coming to the centre’. This improvement was reflected in the psychometric tools (DASS-21 and analogue rating) and other indicators (HbA1c) used by the clinicians to measure change.

Importantly, Mary’s feedback via the client feedback form indicated that she appreciated the coordinated care approach that enabled her to address all her health conditions:

‘I would like to thank everyone for the excellent service that has been provided to me since my first appointment. My care coordinator and counsellor made sure I was sent to the appropriate services for all my conditions – dental, physio, podiatry and counselling. Everyone made sure I was given due care and attention. They did not rush and made me feel special. I wish other places (mainly private) can adopt the same attitude.’
Working together with Mary and using the client review meeting to coordinate her care, the care team was able to assist Mary to ‘get back on track’.

In particular, Mary was empowered with information, education and practical strategies, to better manage her complex health needs.