FLINDERS CLOSING THE GAP PROGRAM™ OF CHRONIC CONDITION MANAGEMENT

IMPLEMENTATION INTO PRACTICE – A PRACTICAL GUIDE FOR MANAGERS OF CHANGE

August 2012

Flinders Closing the Gap Program™

Flinders Human Behaviour & Health Research Unit (FHBHRU)

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EXECUTIVE SUMMARY

This guide draws on examples of how health services have integrated chronic condition management into clinical practice (note: we use 'condition' and 'disease' interchangeably to include mental health) Prior to implementing the Flinders Closing the Gap Program™ of chronic condition management into a health service, it is important for the health service to assess what chronic condition management will require. Capacity includes the resources and ability to incorporate chronic condition management into daily practice. The Flinders Human Behaviour and Health Research Unit (FHBHRU) can provide support to organisations wishing to implement the program.

A **Twelve Step Implementation Process** (Figure 2) has been developed to assist organisations to implement the Flinders Closing the Gap Program™ into practice. An initial audit that considers the organisation's capacity to operationalize chronic condition management is important. The audit can inform an Action Plan that sets out the steps required to implement the program. FHBHRU can assist in this process and provide staff training. Ideally, one or two staff members within an organisation will have further training and become accredited trainers, trainers who can train new staff within the health service in chronic condition management. This will enable the sustainability of the program.

Does chronic condition management have a positive outcome for patients and for the health service (e.g. reduction in acute presentations)? This question is frequently asked. Health services want to know if they implement chronic condition management that it is worth doing. Evaluation is an important part of the process and FBHHRU will assist in designing data capture appropriate to organisation's e-health platform. The business case would indicate if a health service provides chronic condition management to patients that there will also be patient outcomes and outcomes to assist in the evaluation process.

In summary, this guide is designed to assist organisations to implement the Flinders Closing the Gap Program™ into practice. It is acknowledged that each organisation is unique and therefore implementation will be different in each organisation. We encourage you to consider how this guide relates to the circumstances of your organisation

A GUIDE FOR MANAGERS

This guide is for managers and drivers of change in Aboriginal Medical Services, state health services, Medicare Locals, GP practices and other relevant health settings. It is designed to help managers and drivers of change identify a process for implementation of the Flinders Closing the Gap Program™ of chronic condition management, and important considerations that parallel this process. .

It complements the *Flinders Closing the Gap Program™ Implementation into practice – a guide for practitioners* which is designed to help practitioners use the Flinders Tools in practice, on an organisational wide scale.

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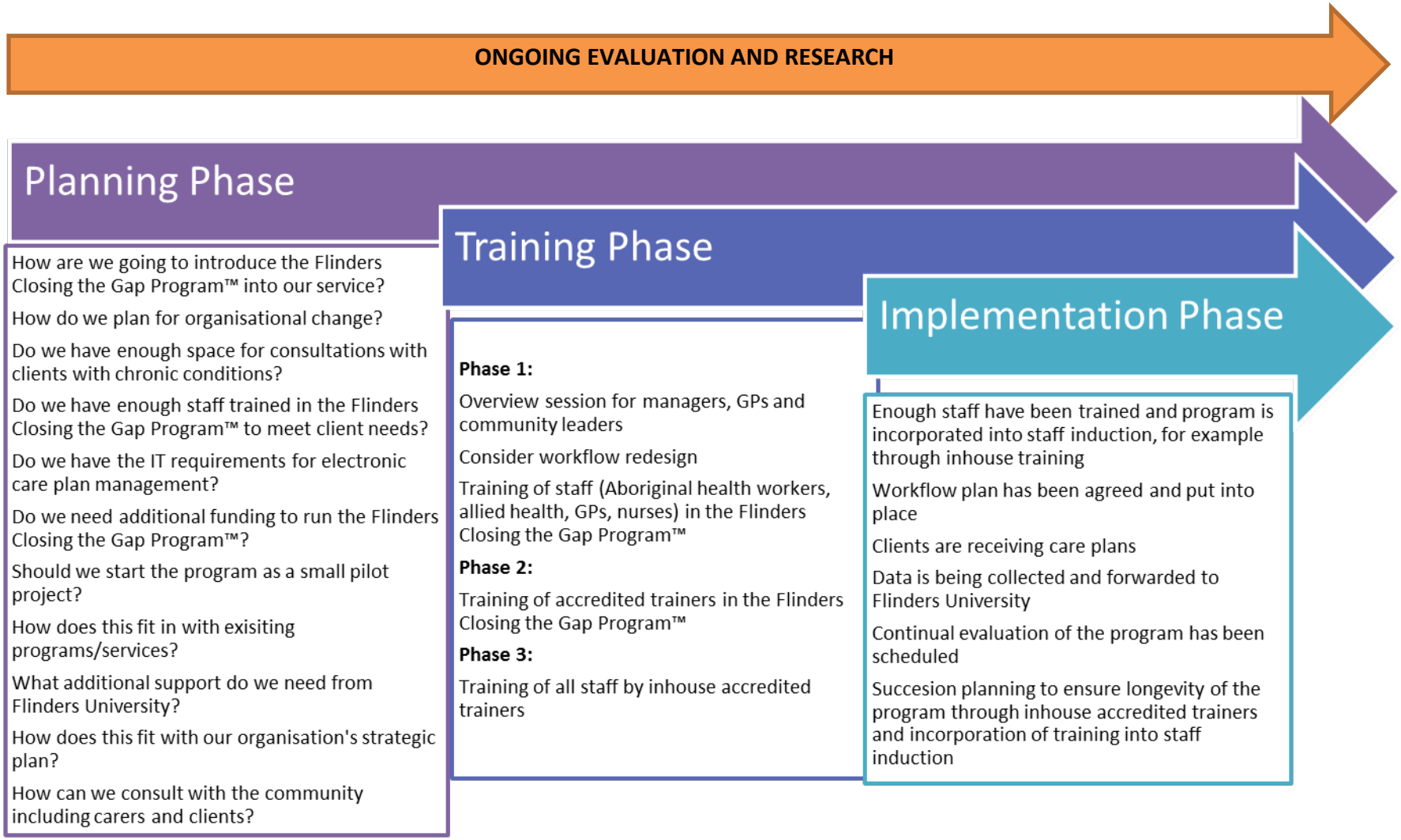
IMPLEMENTATION

Figure 1: Phases involved in implementing the Flinders Closing the Gap Program™ into health services and key questions to be considered



WHAT IS THE FLINDERS PROGRAM™?

The Flinders Program™ is a clinical program of chronic disease or condition management for a service or practice. It includes use of the Flinders Program™ care planning tools which are based on the concept of self-management support. The Program includes self-management and medical assessment which leads to a 12 month integrated disease and self-management care plan. Following the development of the care plan, the Flinders Program™ includes coaching and coordination. These three components 1) care planning 2) coaching and 3) coordination form the basis of chronic disease or condition management for any client or patient group in with any diseases in any setting.

BACKGROUND

Administered through the Flinders Human Behaviour & Health Research Unit the Flinders Closing the Gap Program™ of Chronic Condition Management (refer Appendix 1: Background to the Flinders Closing the Gap Program™) is funded through the Commonwealth 'Closing the Gap: Helping Indigenous Australians Self-Manage their Chronic Disease' Program as a measure within the Council of Australian Governments' (COAG) National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

The Department of Health and Ageing (DoHA) has a clear expectation that health services implementing the Flinders Program™ will embed the Flinders Program™ into clinical practice as reflected by an agreement between FHBHRU and the Health Service.

FLINDERS PROGRAM™ - DELIVERY RECOMMENDATIONS

We recommend that implementation within your organisation involves the following activities with Aboriginal clients:

Initial Care Plan conducted using *Flinders Program*™ Tools

Further 5-10 sessions (face to face, phone, email) within 12 months of the initial Care Plan. These can be:

- **Reviews of Goals**
- **Reviews of Care Plans**
- **Occasions of care**
- **Relapse Planning**

The health profile of the patient is to be checked 6 monthly or at least once within the 12-month period and health indicators recorded. Health indicators may include (but are not limited to) blood pressure, cholesterol, body mass index and

FLINDERS PROGRAM™ - EVALUATION RECOMMENDATIONS

The collection of data that summarises how many patients and how often they have an occasion of service can be used for annual reporting and key performance indicators. If a partnership with Flinders is established then the data can contribute to national patterns and trends on chronic condition management. Data that organisations are asked to collect include:

1. **Care Plan chronology (Appendix 2: Care Plan chronology):**
   - **Number of Care Plans and reviews**
   - **Dates of occasions of service**
   - **Type of review**

2. **Process data including (Appendix 3: Process Data):**
   - **Implementation process (steps)**
   - **Details of in-house training sessions**

3. **Client data including relevant health indicator data (Appendix 3: Process Data)**

ORGANISATIONAL ASSESSMENT

Organisations should conduct an realistic assessment regarding their readiness, capacity and commitment to implement the Flinders Program™. Considerations include:

Strategic Considerations (Vision and Goals)

- Model of Care – commitment to explore what a Chronic condition Model of Care incorporating the Flinders Program™ will look like[1] (Vision)
- Community and Client engagement – consulting and taking into account needs of clients and workers for community commitment and leadership in prevention and management of chronic conditions.
- Agreement to implement- Management supports implementation and is prepared to sign an Agreement outlining commitments by both parties ie Flinders and the organisation.
- Policy and Practice changes to policy and/or guidelines to accommodate Flinders Program™ into practice (both clinical and administrative processes)
- Organisational Culture there is a readiness and willingness to adapt to new process that is driven from Head of Practice/CEO.
- Organisational Change – commitment to both implementing and managing change. What changes will occur and how will they be managed and evaluated?
- Client Centred Care Planning – commitment to support training and optimum delivery of the Flinders Program™ to clients (commitment by health service reflected in positive culture and commitment by staff)
- Staff roles and skills – consider redefining individual and team roles
- Professional Development – Support refresher training/additional CCM related training. Support progression of staff to Accredited Trainer status to train all of workforce (if needs assessment /viability supports).
- Business Model – ongoing financial commitment to implementation (adequate financial and human resources allocated). Business Plan should factor in additional income through Medical Benefit Schedule Indigenous Chronic Disease Package: these are in addition to usual PIP and MBS, eg medication support and MBS items for care planning and chronic condition care.
- Human resources – sufficient staffing allocated to embedding the Flinders Program™ into practice[2]. ; include training in *Flinders Program*™ Care Planning into staff induction/orientation and access follow up and refresher training and support.

Operational Considerations (Day to Day Processes)

- Systems – incorporation of Flinders tools into ie clinical software, clinical systems to optimise attendance and facilitate linkages with health sector.
- Logistics/Capacity – room for health worker/professional to meet with client, capacity to follow-up, capacity to allow sufficient time for client liaison.
- Data – open to sharing information with FHBHRU about session delivery and client outcomes (within an ethical framework utilising de-identified information) to be used for evaluation and research purposes.

[1] Assistance may be available to develop a tailored Model of Care (dependent on location and resources available)

[2] Remote or on the ground resources may be able to assist with tailoring a Model of Care and embedding into practice contingent on location (dependent on location and resources available)

FLINDERS UNIVERSITY RESOURCES TO ASSIST IN IMPLEMENTATION

Information Technology (IT) systems

Electronic Flinders Program™ Care Planning templates (tools) that integrate with existing clinical information systems (as at July 2012 MMeX but anticipate integration into other clinical software such as Communicare and Best Practice).

- Template provision – to source templates please contact (08) 8404 2607.
- IT Integration Issues – (08) 8404 2607.

Research

FHBHRU can provide up to date evidence summaries and literature reviews about chronic condition management in Aboriginal communities. This information is available through the Closing the Gap website www.flindersclosingthegapprogram.com

- Evidence Summaries & Literature review – for further information contact (08) 8404 2607

Implementation support

Models of Care - advice on incorporating the Flinders Program™ Care Planning into existing GP Management Plans or Models of Care

- For further information please contact (08) 8404 2607

Managing change

Your organisation may benefit from doing a baseline system audit of preparedness for delivering chronic condition management, with annual repeat audits, to inform and monitor change. Your organisation may wish to consider other Continuous Quality Improvement (CQI) processes, eg using plan-do-study-act cycles.

- For further information please contact (08) 8404 2607

Roles and responsibilities of FHBHRU staff and contracted staff are outlined in Appendix 5: FHBHRU Staff and contracted staff - Roles and responsibilities.

Embedding into Practice

Research exists about embedding the Flinders Program™ into organisational practice, including the Chronic Care Model, top tips for embedding into practice Lawn (2010) and embedding into an Aboriginal Health Service Kowanko et al. (2012). Please see Appendix 6: Embedding into Practice – an evidence based approach. Appendix 7: Case Studies provide context for implementation in different settings, including Aboriginal Medical Services, state health services and Medicare Locals.

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TWELVE STEP IMPLEMENTATION PROCESS

What is the process for implementation of the Flinders Closing the Gap Program™ within an organisation? This document provides guidance, but the process will be specific to your organisation because it will reflect your organisation's needs. There is a broad range of organisations that will use the Flinders Closing the Gap Program™, for example Aboriginal Medical Services, State Health Services, Medicare Locals and GP private practices.

Implementation is presented as a cyclical process because it is recognised that all organisations will start at different points in the cycle. If it works for your organisation, the recommended place to start is the bright pink circle – 'consider developing a chronic care model for your organisation'.

We suggest reading the next section of the guide in conjunction with Figure 2 which outlines the Twelve Step Process.

Examples of organisational workflow, demonstrating how the Flinders Tools have been incorporated into the practice of two state health services, one in regional Victoria and the other in metropolitan Queensland, are provided in Appendix 8: Examples of organisational workflow for chronic condition management.

Figure 2: Implementing the Flinders Closing the Gap Program™ into organisational practice: Twelve Step Implementation Process

1. CONSIDER DEVELOPING A CHRONIC CARE MODEL FOR YOUR ORGANISATION

The starting point is understanding the difference between an acute care model of delivery and chronic condition management and the need to explicitly address chronic condition prevention and management in your organisation. The next step is in recognising the benefits of the Flinders Program™ to your health setting and establishing organisational intent to implement the Flinders Program™ as a strategy for chronic condition management.

Importantly, the Flinders Closing the Gap Program™ should be implemented as part of a wider chronic condition management strategy or chronic care model within your organisation. This involves assessing where your organisation is currently at and what needs to be done before the Flinders Closing the Gap Program™ is implemented. Consider combining behavioural change care planning with Point of Care testing ie instant blood results will reinforce or motivate behaviour change. Consider the other components of disease specific self-management, lifestyle risk factors, group and community activities that can support chronic condition prevention and management (see Kowanko et al)

2. INTENT TO IMPLEMENT THE FLINDERS PROGRAM™ AS A STRATEGY FOR CHRONIC CONDITION MANAGEMENT

In developing a chronic care model for your organisation, you have identified that the Flinders Closing the Gap Program™ is the strategy for chronic condition management that you wish to implement. The **Twelve Step Implementation Process** will assist you to do this.

3. OBTAIN MANAGEMENT SUPPORT

Management support has been identified as a crucial step to implementing chronic condition management services into an organisation (Lawn 2010). Managers may wish to attend part of a Flinders Closing the Gap Program™ workshop to get some background to the project. This can be arranged by contacting FHBHRU.

4. CONDUCT AUDIT/S

There are a number of audits that will assist your organisation to collect all of the information needed to successfully implement the Flinders Program™. These include an Agency Health Systems Audit, a Skills Audit, Process Mapping and a Clinical Audit. You will determine which audits are most relevant for your organisation. Refer to Appendix 9: Audit tools for further information. It is also important to identify who will take responsibility for actions arising from the audit/s.

5. DEVELOP AN ORGANISATIONAL ACTION PLAN

Developing an Action Plan requires your organisation to respond to the findings of the audit/s and to prioritise which changes are most important to your organisation.

Kubina and Kelly (2007, p. 39) suggest asking five key questions to stay on track when developing an Action Plan:

- What are you trying to improve?
- What needs to change?
- Who needs to be involved?
- How long will it take
- How will we keep on track?

When writing the aims of your Action Plan, ensure that your aims are SMART (specific, measurable, achievable, realistic, and timely) and plan for **sustainability**. Strategies for sustainability could include training of accredited trainers and incorporating training into induction for all new staff.

6. TEST THE PLAN

Once you have developed your Action Plan, it is important to test it. While testing the plan, take note of what works well and what doesn't work well. The Action Plan can then be refined based on what was learnt in the testing phase.

This represents the Plan, Do, Study, Act (PDSA) cycle. More information about this can be found in Kubina and Kelly 2007, pages 46-49. This cycle was originally developed by the Institute for Healthcare Improvement.

7. TRAINING FROM FLINDERS UNIVERSITY

Plan training of staff by FHBHRU as part of the implementation process: contact fctgp@flinders.edu.au. A minimum number of ten participants are required to organise training.

8. TRAIN KEY STAFF

It is a good idea to identify which staff to train first in your organisation; this might be might be Chronic Condition Coordinators/ Practice Nurses/ Aboriginal Health Workers but will vary from organisation to organisation.

9. STAFF OBTAIN A CERTIFICATE OF COMPLETION/ COMPETENCE

Obtaining a Certificate of Completion and preferably a Certificate of Competence is the process by which health professionals and Aboriginal Health Practitioners become accredited to use the Flinders Program™. This is achieved by participating in a Flinders Program™ workshop and completing two or three Care Plans with clients. Two Care Plans are completed with volunteer clients at the workshop, the other one or two with clients following the workshop.

10. SELECT STAFF BECOME ACCREDITED TRAINERS (SUCCESSION PLANNING)

It is recommended that after completing Flinders Closing the Gap Program™ training, health workers undertake further training to become accredited trainers. This allows chronic condition management training to be provided to other staff within your organisation. This is particularly important to consider where a high staff turnover occurs and forms part of succession planning for implementation of the program within your organisation.

It is recommended that health services include training in Chronic Condition Care Planning as a part of new staff orientation.

11. USE FLINDERS TOOLS WITH CLIENTS

In implementing the Flinders Program™ into your health service, it is suggested that you aim for the following outcomes. These expected outcomes are based on the agreement between FHBHRU and the Commonwealth Department of Health and Ageing

- Each Aboriginal client should have an initial Care Plan conducted using the Flinders Tools as the starting point in the Flinders Chronic Condition Care Plan process. Following this initial consultation between Health Worker and client a Care Plan is established including health goals or actions agreed to by the client
- The Health Worker the organisation and the client are responsible for achieving these goals. Follow up, review and support are essential components of the Care Planning process.
- Following this agreement a further 5-10 (face to face, phone, email, text) sessions are to be provided to the client within the 12-monthfrom the date of the initial Care Plan. These sessions may or may not require extensive formal consultations although some will require consultations. They may be just occasions of service which require finding out if the client is satisfied with their goals or whether there is a need to renegotiate the goals. This may be in the form of a relapse planning session.

The health profile of the client initially recorded at or prior to the first consultation will be checked 6 monthly or at least once within the 12-month period.

12. EVALUATION AND ONGOING REVIEW

Evaluation and review is a critical part of implementation. The PDSA cycle may be used by organisations to assess what they are doing and try new ways of approaching chronic condition care planning.

FHBHRU ask that your organisation provides basic, deidentified data about your organisation's implementation of the Flinders Program™. This information will contribute towards evidence about the effectiveness of implementation of the Flinders Program™ on the health and wellbeing of clients and can be used in the Continuous Improvement Processes around implementation. Any information that is collected as part of this evaluation will be fed back to you as overall evaluation information. The information required for evaluation purposes includes:

1. Care Plan Chronology (Appendix 2: Care Plan chronology), including:
   - Number of Care Plans and reviews with clients (occasions of service)
   - Dates of occasions of service
   - Type of review
2. Process data (Appendix 3: Process Data), including:
   - Implementation process (steps) including meetings, decisions
   - In-house training session, delivered by Accredited Trainers, requires number of people attending, occupation and Aboriginal/ Torres Strait Islander status, Care Plans submission date, Certificate of Competence receipt dates (information collected through two separate Training Logs)
3. Client data (Appendix 4: Client data), including:
   - Relevant health indicator data at all dates of service, including baseline and follow-ups

Your organisation may like to use the continuum provided (Appendix 10: Evaluating how your organisation is going) to assess progress with implementation.

FHBHRU also has a responsibility when it comes to research and evaluation. Responsibilities of FHBHRU include:

- Submission of ethics applications for research
- Collation of information provided by organisations
- Analysis and publication of data

FHBHRU welcome discussions with organisation interested in partnering to conduct, analyse and publish research. Contact (08) 8404 2607.

REFERENCES

Grumbach K, Bainbridge E & Bodenheimer T (2012) Facilitating improvement in primary care: the promise of practice coaching. The Commonwealth Fund. 15, pp. 1-13.

Kowanko I, Helps Y, Harvey P, Battersby M, McCurry B, Carbine R, Boyd J and Abdulla O (2012) Chronic condition Management Strategies in Aboriginal Communities: Final Report 2011. Flinders University and the Aboriginal Health Council of South Australia, Adelaide. Click here for a link to additional Reports and resources produced through this project.

Kubina N & Kelly J (2007) Navigating Self-Management: A practical approach to implementation for Australian health care agencies. Melbourne, Whitehorse Division of General Practice.

Lawn S & Battersby M (2009) Capabilities for Supporting Prevention and Chronic Condition Self-Management: A Resource for Educators of Primary Health Care Professionals. Flinders University, Adelaide: Australian Government Department of Health and Ageing.

Lawn SJ, (2010) Top Tips for Embedding Chronic Condition Self-Management (CCSM) Support into Practice. *Australian Journal of Primary Health*. 16 (4), pp. 334-343.

Wagner E H, Glasgow R E, Davis C, Bonomi A E, Provost L, McCulloch D K, Carver P & Sixta C (2001) Quality improvement in chronic illness care: A collaborative approach. *Journal of Quality Improvement*, 27, pp. 63 - 80.

APPENDIX 1: BACKGROUND TO THE FLINDERS CLOSING THE GAP PROGRAM™

The Flinders Closing the Gap Program™ of Chronic Condition Management is funded through the Commonwealth 'Closing the Gap: Helping Indigenous Australians Self-Manage their Chronic Disease' Program as a measure within the Council of Australian Governments' National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

This Program is available to Aboriginal Health Workers, General Practitioners, Registered Nurses and allied health professionals who deliver health services to Aboriginal and Torres Strait Islander clients. The Flinders Closing the Gap Program™ provides between 2–3 days of training that includes learning the principles of chronic disease support and practicing the Flinders tools of chronic condition management, in particular skills in Care Planning. The aim of the program is to enable Indigenous Australian clients' greater self-management of their chronic health conditions. Nested in this program is a shorter 1.5 day program for General Practitioners and practice nurses.

This funded training is facilitated by the Flinders Human Behaviour and Health Research Unit (FHBHRU) and is available to health professionals in urban and regional locations across Australia.

Follow up after the workshop includes mentoring (face to face, telephone and email) to support health workers to apply the Flinders tools to client Care Planning and to integrate this into the health service practice. Follow up training has included smaller group sessions; one to one support with individual 'shadowing' sessions of client contact; general Certificate of Competency follow up for Care Plans; and telephone mentoring. This follow up is provided at the participant's workplaces or at FHBHRU.

Goals of training in the Flinders Program™:

- support healthcare providers to offer a greater range of client-centred solutions to meet the health needs of the Indigenous population;
- assist health services to better manage specific Indigenous health needs, and barriers to self-management at the local level;
- increase collaboration between Indigenous people and communities, with local general practices, hospitals and allied health providers;
- assist Indigenous Australians to develop realistic health goals to help manage their health conditions and address their psychosocial issues;
- assist Indigenous Australians to identify and understand their health problems and improve their quality of life;
- raise awareness of chronic diseases and conditions generally within Indigenous communities;
- increase collaboration between Indigenous health services, local general practices, hospitals and allied health providers; and
- help 'Close the Gap' in life expectancy between Indigenous and non-Indigenous Australians.

APPENDIX 2: CARE PLAN CHRONOLOGY

Client name/ code	Date of service	Type of service (eg initial assessment, review)	Activity (i.e. PIH, C&R, P&G, CP, Review)

APPENDIX 3: PROCESS DATA

These tables are suggested ways to keep track of the implementation process and what happens at training. Organisations may create their own ways of recording this information.

Implementation log

Date	Activity	Comments	Outcome	Next steps

Training Log 1

Date	Trainers	Number of participants	Type of training (2 or 3 day)	Comments

Training Log 2

Participant name/ code	Occupation	Identify as Aboriginal and/ or Torres Strait Islander?*	Date CP 1 submitted	Date CP 1 returned	Date CP 2 submitted	Date CP 2 returned	Date CP 3 submitted	Date CP 3 returned	Date receive COC

*1=Aboriginal, 2=Torres Strait Islander, 3=Aboriginal and Torres Strait Islander, 4=Neither Aboriginal nor Torres Strait Islander, 5=not provided

APPENDIX 4: CLIENT DATA

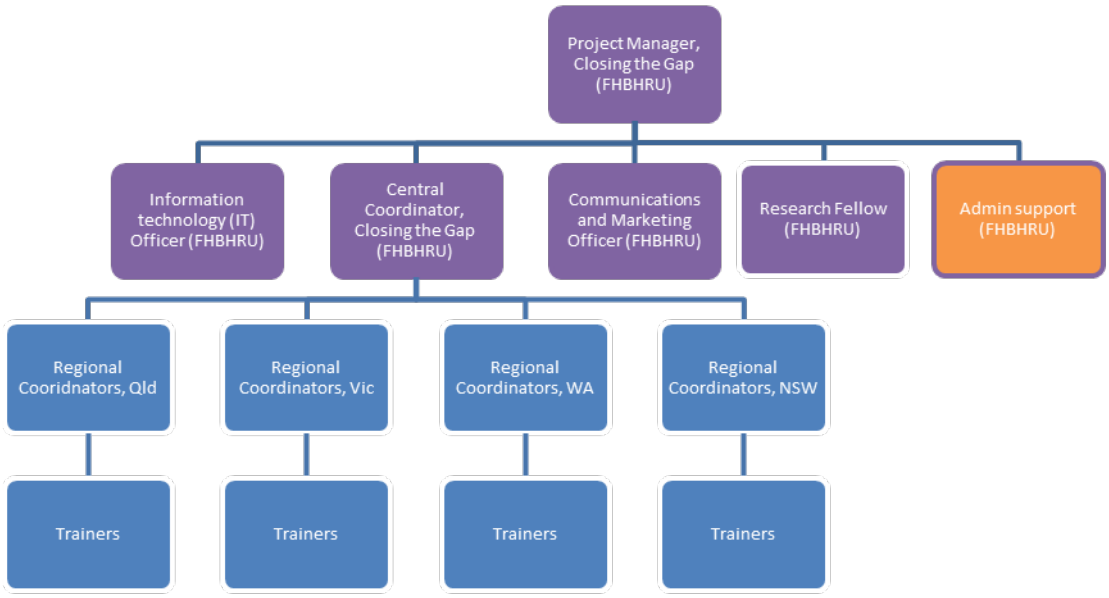
Client name/ code: ……. ……

Clinical indicator	Visit 1 (initial visit)	Review 1	Review 2	Review 3	Review 4	Review 5
	Date:	Date:	Date:	Date:	Date:	Date:
Blood pressure						
Total cholesterol						
LDL cholesterol						
HDL cholesterol						
Weight						
Body mass index (BMI)						

APPENDIX 5: FHBHRU STAFF AND CONTRACTED STAFF - ROLES AND RESPONSIBILITIES (RELATED TO IMPLEMENTATION)

FHBHRU Closing the Gap staff, based in Adelaide, include – Project Manager, Communications & Public Relations Officer, Research Fellow, IT Officer, Implementation Coordinator & Administrative staff (Figure 13). Other staff involved in the program, but not based in Adelaide, include trainers and regional coordinators.

Figure 3: Organisational structure of coordinators and staff involved in national roll-out of Flinders Closing the Gap Program™

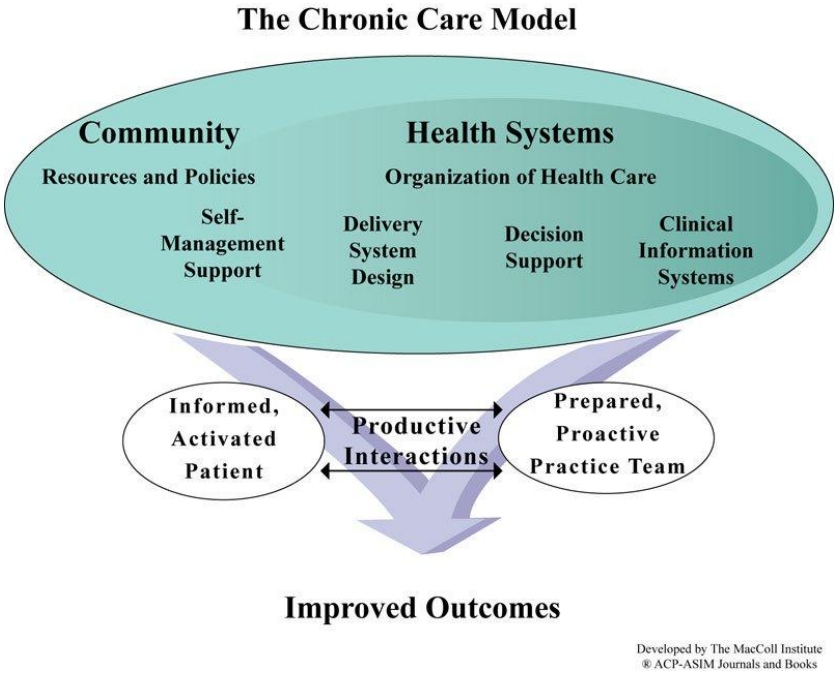


APPENDIX 6: EMBEDDING INTO PRACTICE – AN EVIDENCE BASED APPROACH

Key evidence exists about embedding chronic condition management, including the Flinders Program, into practice. This evidence may provide some guidance for organisations.

The Wagner Chronic Care Model is an internationally recognised evidence-based guide to delivering best practice chronic condition care. The Model identifies six core elements which are critical to delivering best practice chronic disease care and definitions of self-management have been informed by the Chronic Care Model (Wagner 2001) (Figure 2).

Figure 4: The Chronic Care (Wagner) Model



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There is an imperative to meet the growing demands of chronic conditions on health systems. Embedding the Flinders Program™ into clinical practice involves knowledge, skills and attitudinal change at the individual, team and system levels within an organisation (Lawn & Battersby 2009). Lawn (2010) identified ten themes that assist to embed chronic condition self-management into organisational practice. These are:

1. Clear leadership
2. The important role of workplace change champions
3. Understanding and addressing values of and skills strengths and gaps in the organisation and staff
4. Creating teamwork in the community and across services
5. Demystifying the process of change for staff
6. Adequately resource the process
7. Actively involving consumers
8. Having a toolkit of strategies for sustaining the distance
9. Effectively use evidence and training
10. Understanding interdependent relationships between each component. (Lawn:2010:p338)

Kowanko et al. (2012) identified key elements that need to be in place (or to be developed) by Aboriginal health services in order to implement chronic condition management systems:

1. An accessible, culturally appropriate and free health service that meets clients' needs
2. A model of chronic condition management based on principles of self-management support eg the Flinders Program™
3. Systematic and coordinated service delivery, with clear clinical protocols and pathways of care
4. Sufficient staff to work with and motivate clients
5. Staff with clinical expertise, teamwork skills, and trained in chronic condition self-management support
6. An effective clinical information system
7. Peer support and outreach programs
8. Organisational support for staff to implement structured client-centred care.

(Kowanko et al.:2012:p9)

Through interviews with clients and staff in Aboriginal Health Services, Kowanko et al. (2012, p. 8) also identified factors that enable implementation of chronic condition management strategies in Aboriginal health services. These include:

Health system/service related themes:

- Access to appropriate and affordable health services
- Effective clinical information management system (electronic client record system eg Communicare)
- Coordination and team care arrangements
- Facilitation of peer support

Staff related themes:

- Staff capacity and training in chronic condition management support
- Engagement with clients and community

Client-related themes:

- Client knowledge of chronic conditions and their management
- Commitment to lifestyle change
- Family and peer support

APPENDIX 7: CASE STUDIES

These case studies highlight some of the issues that may be relevant for implementation of chronic condition management programs within different types of health services such as state health services, acute settings, Aboriginal Medical Service, GP private practices and Medicare Locals. These case studies are hypothetical but based on 'real world' examples provided through feedback from Flinders Program™ health workers and trainers.

It is important to acknowledge that many of the issues apply to multiple services, however some will be unique.

These issues were identified by reading key papers in the area and reviewing student[3] assignments from postgraduate CCM courses. These assignments addressed the question "what do you need to do in your organisation to make CCM sustainable?"

The case studies are organised under the following headings:

- Issues – challenges with implementing CCM in the particular setting
- Key staff – staff identified as important to implementing CCM in the particular setting
- Enablers – things that helped implement CCM in the particular setting
- Barriers – things that made implementation difficult in the particular setting
- Benefits of the Flinders Program™ – what has been good about using the Flinders Program in this setting?
- Required (optimum) – what is required for optimum implementation of CCM in this setting?

Note: These case studies are a work in progress. This is the starting point based on available information and anecdotal feedback at this time. We plan to add to this through consultation with trainers and key health professionals involved with delivery of the Flinders Closing the Gap Program™.

[3] All students are practicing health professionals

Case Study 1 – Primary Health Setting (State Government funded)
Regional Hub Hospital

Issues:

- Outdated Model - 'Health care is organized around an acute, episodic model of care that no longer meets the needs of many clients, especially those with chronic conditions.' (WHO:2002:p4).
- Culture – acute system has little coordination with other services – specialty care is a referral process (changing from a provider focus to a client focus is a challenge). Referral culture does not encourage holistic approach. Further education/pathways should be offered to clients.
- Commitment - erratic and personality dependent – not fully embedded into practice
- Government focus on CCM (priority area) – goal of reducing burden on health system through reducing hospital admissions. Government funding to assist in implementation of CCSM
- Leadership (dearth of leadership – rather autocratic management style)
- Private Specialists - private versus public system access to services
- Bureaucracy – difficult to 'cut through' bureaucracy
- Management - need to be informed, educated and convinced of benefits (evidence based)

Key staff:

- Case Manager
- Discharge planner
- Diabetes educators
- Dietitians

Enablers:

- Influence – time dedicated to educating decision makers (directors and managers) to ensure buy in and support
- 'Champions' - resourcing more than one change champion within the hospital setting to provide systematic mentoring and coaching for staff. Passionate relationship with process by 'champions' assists in promotion and elicits support.
- Assessment of Chronic Illness Care (ACIC) tool– ACIC is responsive to changes to systems and correlates well into other measures of productivity and system change.
- Acute Setting - need to be aware that these health services 'have a powerful impact on people's confidence and ability to self-manage, often seeing people at a time when they are most vulnerable and open to change.' (National Chronic Disease Strategy 2005:p38)
- Systems - hospital systems supporting improved discharge and referral procedures
- Information management systems and infrastructure- supports integration and continuity of care across the 'patient journey'

Barriers:

- Acute care focus

Benefits of Flinders Program™:

- Greater understanding of their condition allows clients to make informed decisions
- Personalised Care Plan provides a goal and encouragement to achieve better health.
- Flinders Program™ can be easily individualised to each client's needs

Required (optimum):

- CCSM Staff dedicated to referrals (similar to the diabetes educator role)
- Encourage primary health care and self-management
- Provide education to all clients on a more personal level (rather than just standard care)
- Professional development for staff incorporating Flinders Program™ training

Case Study 2 – Primary Health Setting (Community Controlled) Aboriginal Medical Service

Issues:

- Continuity of Care (workforce issues)
- Different workplace culture from state health service
- CCM is not a stand-alone service or incorporated practice
- Resources – human resources allocated to implementing into practice (insufficient to meet high demand)

Key staff:

- General Practitioners
- Aboriginal Outreach workers
- Indigenous Project Officer
- Care Coordinator

Enablers:

- Evidence – Kowanko et al state that their research focussing on Aboriginal health service settings '…provides strong qualitative and quantitative evidence that people involved in structured chronic condition management strategies (eg Care Plans) improve their health and wellbeing over time.(Kowanko et al.:2012:p9)
- Benefits: - Benefits for clients included:
  - New knowledge about chronic conditions and how to manage them
  - Empowerment and taking control of their own health
  - Setting and achieving personal goals
  - Reassurance and keeping track of progress
  - Feeling better and avoiding complications of chronic conditions.' (Kowanko et al: 2012:p7)
- Funding – '…such evidence of clinical effectiveness would strengthen bids for further funds and support for these strategies' (Kowanko et al:2012:p9)
- Strategic vision – incorporation into policy and procedures ensures embedding into practice and systematic approach
- Clarity - clearly defined competencies (matched with training)
- Resources - adequate initial and ongoing resources
- Team Based Approach - health workers operating in effective primary health care networks are best placed to provide a team based approach to chronic condition self-management.
- Integrated care – health services working collaboratively together and with clients and their families/carers – health needs are better met and results in a more positive 'patient journey'
- Medicare rebates – financial incentive
- Client participation - policies, procedure and resources that enable client participation - support to ensure clients have capacity to engage (self-management is part of clinical practice through its inclusion in multidisciplinary planning)
- Successful pilot – paved way for full integration and implementation into practice

- Cultural safety – male and female Aboriginal health workers and community support workers. Resources available in local language (where relevant).

Barriers:

- Self-management support – not a discipline specific role (not just ie diabetes educators)

Benefits of Flinders Program™:

- Improved health and wellbeing - client can experience and improved quality of life and wellbeing which impacts on broader family unit and community (goal is increasing life expectancy and 'Closing the Gap' between Indigenous and Non-Indigenous Australians).
- Critical mass – case studies have shown once the host community supports the Flinders Program™ then community buy-in provides momentum (and achieving a critical mass of reach into the community).

Required (optimum):

- Professional Development - Flinders Program™ Accredited Trainer on staff- staff training to be mandatory training for all GPs, Aboriginal Outreach workers and Care Coordinators
- Integrated Service - practice is part of 'holistic' regional approach to Aboriginal Health Care Delivery including strong working relationships with hospitals, allied health professionals and other health agencies.

Case Study 3 – Primary Health Setting (Private Practice)
Medicare Local – GP Practice

Issues:
Resources – human and financial resources allocated to implementing into practice (insufficient)

Service Delivery - CCM is not a stand-alone service or incorporated practice

Key staff:
- General Practitioners
- Practice Nurses
- Practice Manager
- Care Coordinators
- Outreach workers

Issues:

Enablers:
- Strategic vision – incorporation into policy and procedures ensures embedding into practice and systematic approach
- Integrated care – health services working collaboratively together and with clients and their families/carers – health needs are better met and results in a more positive 'patient journey'
- Medicare rebates – financial incentive
- Client participation - policies, procedure and resources that enable client participation - support to ensure clients have capacity to engaged (self-management is part of clinical practice through its inclusion in multidisciplinary planning)
- Successful pilot – paved way for full integration and implementation into practice
- Clearly defined competencies (matched with training)
- Resources (both initial and ongoing)
- Continuity of care is underpinned by effective communication systems such as client registries and electronic health records.

Barriers:
- Cultural Safety – this may be an issue for Aboriginal clients ie absence of Aboriginal staff
- Bulk billing – practice may not support bulk billing practices
- Community outreach – practice may not have a community outreach program or support networks

Benefits of Flinders Program™:
- Improved health and wellbeing - client can experience and improved quality of life and wellbeing which impacts on broader family unit and community (goal is increasing life expectancy and 'Closing the Gap' between Indigenous and Non-Indigenous Australians).

Required (optimum):
- Professional Development - Flinders Program™ Accredited Trainer on staff and training to be mandatory training for all GPs and Care Coordinators

- Integrated Service - practice is part of ‘holistic’ approach to meet the need of all client groups including strong working relationships with hospitals, allied health professionals and other health agencies.

APPENDIX 8: EXAMPLES OF ORGANISATIONAL WORKFLOW FOR CHRONIC CONDITION MANAGEMENT

The following examples have been taken from real organisations currently using the Flinders Closing the Gap Program™ in practice. These examples demonstrate how specific organisations have incorporated the Flinders Program™ into their organisational practice.

Figure 5: Workflow for use of the Flinders Closing the Gap Program™ within one state health service in metropolitan Queensland

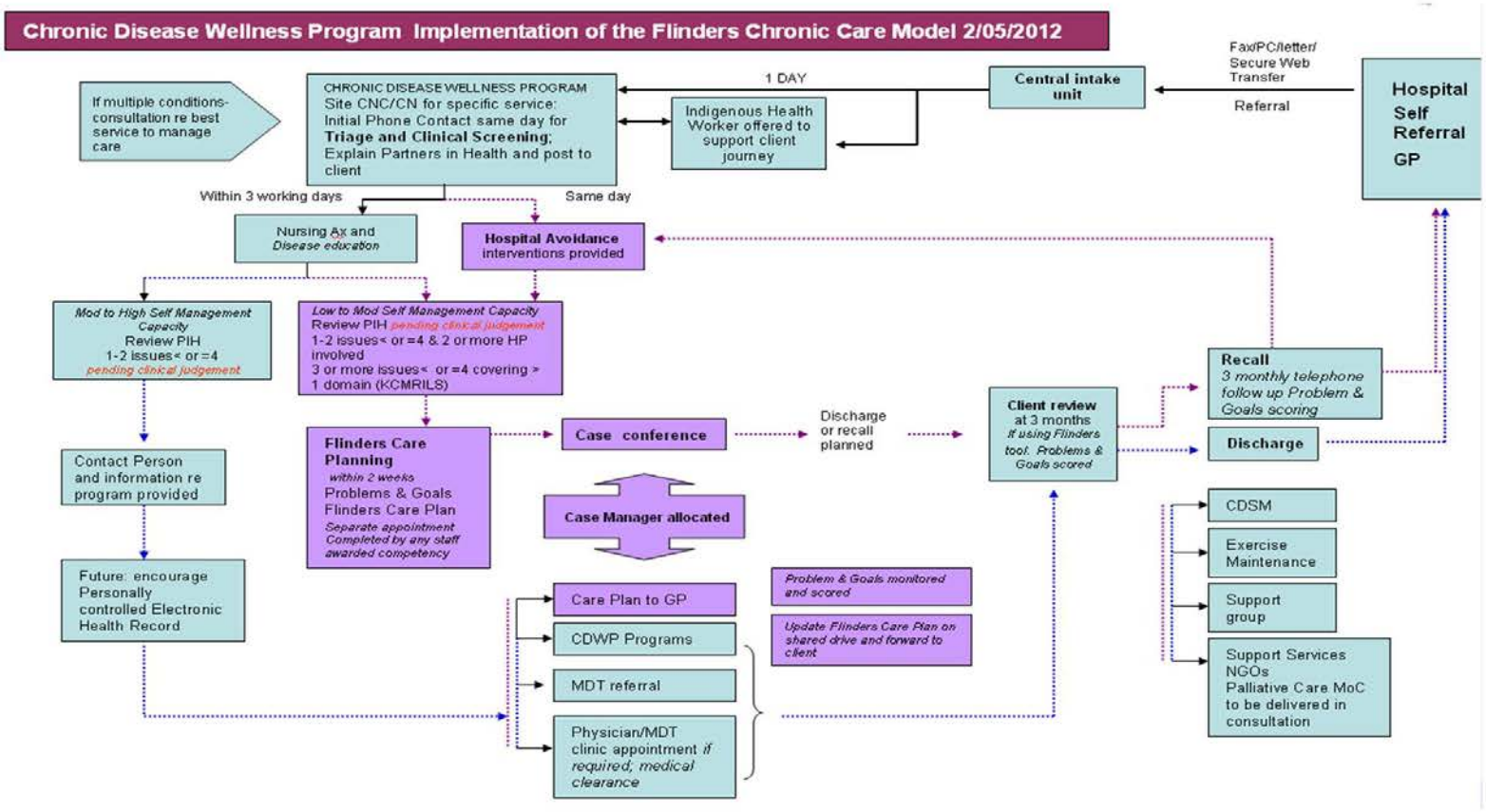
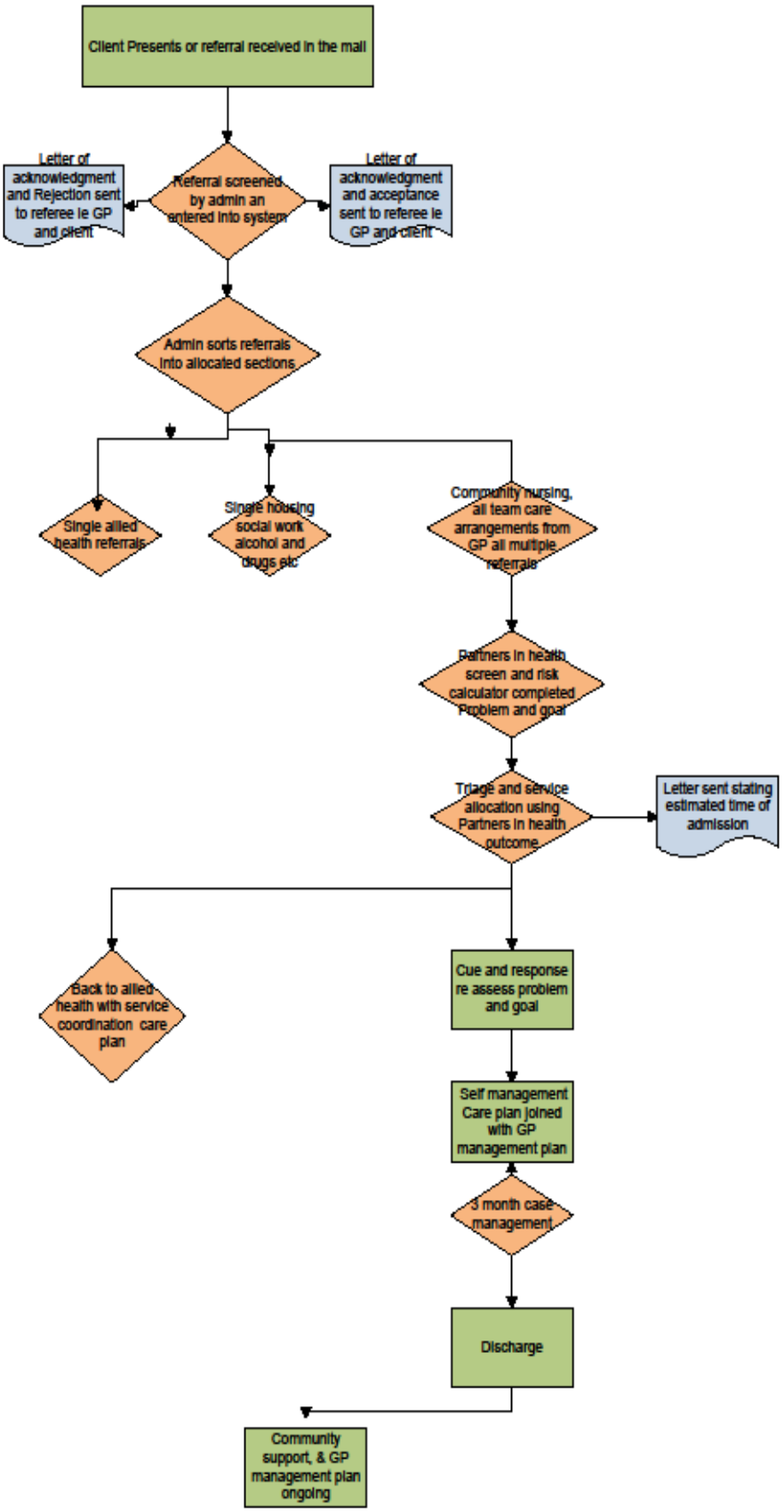


Figure 6: Workflow for use of the Flinders Closing the Gap Program™ within one state health service in regional Victoria



APPENDIX 9: AUDIT TOOLS

There are four types of audits that can help your organisation to identify strengths and weaknesses and tasks that need to be actioned to implement chronic condition management:

1. Agency Health Systems Assessment
2. Skills Audit
3. Process Mapping
4. Clinical Audit.

1. Agency Health Systems Assessment

Your organisation should conduct an 'agency health systems assessment' (Kubina & Kelly 2007). This process assesses how care is currently provided by your organisation and what areas need to be improved in order to support chronic condition management. It is important that you choose a tool that suits your organisation. Some examples of tools that can be used to conduct an agency health systems audit are provided below. More information about choosing a tool that suits your organisation can be found in Kubina and Kelly 2007, page 26. Information about interpreting the results from an audit and the next steps can be found in Kubina and Kelly 2007, pages 27-28.

One21seventy

One21seventy is a not-for-profit organisation that delivers a **Continuous Quality Improvement** (CQI) model that helps health centers and providers:

- Improve their overall systems for high quality care
- See how they're performing on prevention and management of major chronic diseases (diabetes, heart disease, renal disease)
- Set goals and measure progress
- Improve staff morale and motivation

Assessment of Chronic Illness Care (ACIC) Tool

A detailed description of ACIC can be found in Kubina and Kelly 2007, page 25. This tool was developed in the USA and measures the elements of a health service that have previously been identified as important for effective chronic disease care.

More information about this tool can be found on the Chronic Care website.

Organisational Needs Analysis Tool

A detailed description can be found in Kubina and Kelly 2007, page 25. This tool addresses three key areas of chronic disease care (agency capacity and resources, best practice and planning, and delivery of service). It is designed for organisations to identify the skills that they have and recognise opportunities and scope for further development of their workforce and systems in the future (Kubina & Kelly 2007). Further information is available from the Victorian Government.

2. Skills audit

A skills audit involves identifying the current skill level of your team, in particular around chronic condition management. This will enable you to identify what further training and support may be required (Kubina & Kelly 2007).

3. Process mapping

The purpose of process mapping is to identify the systems and processes that occur in your organisation that impact on how care is delivered.
'Ten easy steps to process map' Kubina and Kelly (2007, p. 31) will guide you through this process.

4. Clinical audit

The purpose of a clinical audit is to identify the health profile of the population that your organisation works with. This will enable you to create an approach to chronic disease management that is relevant to the needs of the population that your organisation primarily works with.

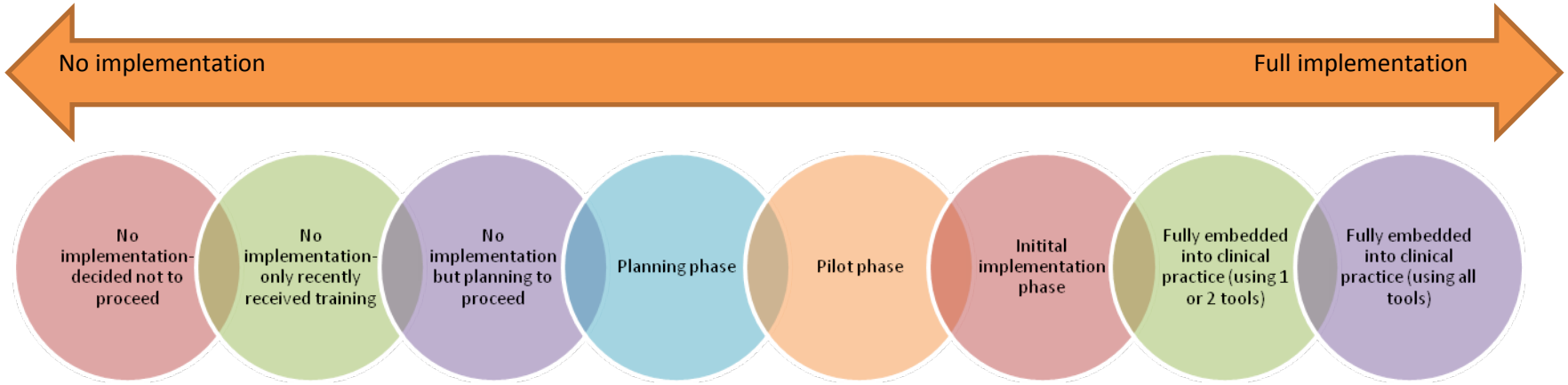
A clinical audit is also concerned with identifying how the care that your organisation is currently providing compares with best practice or evidence-based guidelines.

See pages 35-37 of Kubina and Kelly (2007) for more detail about clinical audits.

APPENDIX 10: EVALUATING HOW YOUR ORGANISATION IS GOING

It is important that your organisation assesses how it is going implementing the Flinders Program™. This continuum will help you to identify where your organisation is at, and consider how you might progress implementation.

Figure 7: Phases of implementation



APPENDIX 11: TERMINOLOGY

Aboriginal	For the purpose of this training the term 'Aboriginal' is used to encompass people of both Aboriginal and Torres Strait Islander origin.
Client	The document uses the term client but it is recognised that in some contexts the term patient is also applicable.
Health Worker	The document uses the term 'health worker' but is inclusive of all health professionals including Aboriginal health workers, General Practitioners, nurses and other clinicians.
Chronic Condition	This is written in the singular but is intended to include multiple chronic conditions.

APPENDIX 12: ACRONYMS

CCM	Chronic Condition Management
CCSM	Chronic Condition Self-Management
CTG or CtG	Closing the Gap
C & R	Cue and Response Interview
DoHA	Department of Health and Ageing
FHBHRU	Flinders Human Behaviour & Health Research Unit
FP	*Flinders Program*™
HP	Health Professional (as used in the Cue & Response Tool)
ICT	Information & Communication Technology
PHC	Primary Health Care
PIH	Partners in Health Scale
Pt	Patient abbreviation (as used in the Cue & Response Tool)
P & G	Problems and Goals Assessment
KICMRILS	**K**nowledge, **I**nvolvement, **Care Plan**, **M**onitor & **R**espond, **I**mpact, **L**ifestyle & **S**upport Services
MBS	Medicare Benefits Schedule
SMART	**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**imely (goals)
WHO	World Health Organization

Link here for a comprehensive list of definitions of Chronic Condition Self-Management and Related Terms (Lawn & Battersby 2009 page 7-8).

APPENDIX 13: GLOSSARY

Care Plan	This is a structured, comprehensive plan developed by the client and their significant others, carers and health professional(s). It defines problems, goals, actions, time frames and accountability of all involved, to prevent complications and deterioration of chronic conditions (Battersby et al. 2007). GP Management Plans are Care Plans with a medical focus.
Care Plan *Flinders Program*™	The *Flinders Program*™ Care Plan was developed after feedback from over 3,000 GPs in the Coordinated Care Trials (Battersby et al. 2007) and is a self-management support tool which has been modified for Aboriginal contexts. The client is actively involved in developing the content (client-centred approach). The Care Plan includes agreed interventions or strategies based on the client's own self-management abilities, Problems and Goals.
Chronic Disease and Chronic Condition	The term chronic condition encompasses disability and disease conditions that people may 'live with' over extended periods of time (ie more than 6 months). Chronic conditions are amenable to generic approaches based on the understanding that there are generic self-management tasks regardless of diagnosis. Chronic disease is a subset of chronic conditions and refers to a specific medical diagnosis. It may be more likely to have a progressively deteriorating path than other chronic conditions. (WHO 2002 as referenced in Lawn &Battersby 2009)
Chronic Condition Self-Management	Chronic condition self-management is a process that includes a broad set of attitudes, behaviours and skills. It is directed toward managing the impact of the disease or condition on all aspects of living by the client with a chronic condition. It includes, but is not limited to, self-care and it may also encompass prevention. The following are believed to contribute to the process: · Having knowledge of the condition and/or its management · Adopting a self-management Care Plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters · Actively sharing in decision-making with health professionals, significant others and/or carers and other supporters · Monitoring and managing signs and symptoms of the condition · Managing the impact of the condition on physical, emotional, occupational and social functioning · Adopting lifestyles that address risk factors and promote

	health by focusing on prevention and early intervention · Having access to, and confidence in, the ability to use support services (National Health Priority Action Council (NHPAC) 2006 as referenced in Battersby 2009 p 7)
Co-morbidity	Two or more diseases or conditions existing together in an individual. They may be related causally, with the primary condition involving complications which have led to or influenced the onset of the second and further co-morbid health conditions. They may also be unrelated and merely co-exist in the one individual, and can include other disorders and disabilities such as mental illness, drug addiction, developmental and congenital conditions. Lawn & Battersby 2009
Cue & Response (C&R) *Flinders Program*™	The *Flinders Program*™ Cue & Response tool uses a 'non-medical' format to help to explore the client's understanding/knowledge, what the client is doing to self-manage and their perceived strengths and barriers.
Flinders Program™	A proactive and client-centred program that uses a suite of tools (forms) to assist in providing a consistent, reproducible approach to assessing and supporting self-management of clients with chronic condition/s. The program assists in improving the health status of individuals by encouraging, empowering and enabling them to become active partners, with their health care providers, in the management of their health.
KICMRILS	A mnemonic acronym used to reference the seven principles of self-management Battersby et al. 2002
Partner in Health (PIH) *Flinders Program*™	This is a client-rated scale assessing the client's perception of their self-management (and can be used to benchmark and record change over time)
Psychosocial support	Based on the principles of holistic care this support addresses the psychological (emotions, relationships) and social (ie financial, housing) concerns and needs of people living with chronic condition/s.
Prevention	Primary: The promotion of health and the prevention of illness Secondary:

	The early detection and prompt intervention to correct departures from good health or to treat the early signs of disease Tertiary: Reducing impairment and disabilities, minimising suffering caused by existing departures from good health or illness (RACGP, 2006, p1 as referenced in Lawn & Battersby 2009)
Primary Health Care (PHC) Workforce Core Skills	Lawn & Battersby 2009 outlines 19 core skills essential for primary health care workforce involved in chronic condition management.
Problems & Goals Assessment *Flinders Program*™	This tool is used to identify the client's main problem and goal. Having the client identify their own problem helps them to know what their priority is and also what motivates them and is often the first step in acknowledging that a client is 'more than their disease'.
Wagner Model	The Wagner Model includes six elements required to improve health care in health systems (community, organisation, practice and client levels) – focussing on a proactive (rather than reactive) approach.
WHO Core Competencies	The World Health Organization has identified five core competencies for caring for clients with chronic conditions (refer also Pruitt & Epping-Jordon)

APPENDIX 14: SUGGESTED READING AND RESOURCES

The Chronic Care Model

The Chronic Care Model

Improving Chronic Illness Care has produced a number of resources on clinical practice change that will assist you to implement elements of the Chronic Care Model.

The Health Disparities Collaboratives has produced a useful resource on changing and improving diabetes care using the ICIC Chronic Care Model and the Model for Improvement. This document can be found on their web site:
Click on library, then collaborative processes. It is the diabetes training manual from April 2002.

Better Health Care in Gippsland has developed a resource kit on how to embed the elements of the ICIC Chronic Care Model. This manual can be located on the Victorian Department of Human Services website at :

Implementation

Kubina N. & Kelly J. (2007) Navigating Self-Management: A practical approach to implementation for Australian health care agencies. Melbourne, Whitehorse Division of General Practice.

This practical manual assists agencies to 'reorientate services' implementing self-management into routine practice (allowing provision of additional time and resources).

Johnson A, Paton K (2007) 'Health promotion and health services: management for change' (Oxford University Press: Melbourne).

New South Wales Health Clinical Services Redesign Program (2008) Chronic Disease Self-Management Support.

One21seventy (provides tools and processes especially tailored for Aboriginal chronic condition prevention & management)

Queensland Health (1999) Tools and Processes for Implementing Organisational Change: 'How to Guide'.

Web Links

Australian Government Department of Health and Ageing - MBS Primary Care Items

Australian Government Department of Health and Ageing - Chronic Disease Management (CDM) Medicare Items

Australian Indigenous Health Infonet

Australian Health Ministers' Conference (2005) National Chronic Disease Strategy

Department of Health and Ageing - Health topic quickview: Chronic disease

Department of Health and Ageing - Closing the Gap Tackling Indigenous Chronic Disease

Eyre Peninsula Division of General Practice and the Spencer Gulf Rural Health School Supporting Chronic Disease Self-Management: Experience from South Australia's Eyre Peninsula

Flinders Human Behaviour & Health Research Unit - Flinders Program™ Flinders Human Behaviour & Health Research Unit - Closing the Gap Program™

Flinders Human Behaviour & Health Research Unit - Publications

Improving Chronic Illness Care (A US based website on improving care for those with chronic conditions)

Living Improvement for Everyone Program (LIFE)

The Lowitja Institute

SA Health Chronic Disease Action Plan for South Australia 2009-2018

The Royal Australian College of General Practitioners (2002) Chronic Condition Self-management Guidelines for Nurses and Allied Health Professionals

The Royal Australian College of General Practitioners (2002) Chronic Condition Self-management Guidelines for GPs

The Stanford School of Medicine - Chronic Disease Self Management Program

World Health Organization - Chronic Diseases and Health Promotion

Evidence

Battersby M, Ah Kit WJ, Prideaux C, Harvey PW, Collins JP & Mills PD (2008), 'Implementing the Flinders Model of self-management support with Aboriginal people who have diabetes: findings from a pilot study', Australian Journal of Primary Health 14 (1): 66-74.

Kowanko I, Helps Y, Harvey P, Battersby M, McCurry B, Carbine R, Boyd J and Abdulla O (2012) . Chronic condition Management Strategies in Aboriginal communities: final Report 2011. Flinders University and the Aboriginal Health Council of South Australia, Adelaide. Click here for a link to additional Reports and resources produced through this project.

This is the final report of a project called 'Chronic Condition Management Strategies in Aboriginal Communities' conducted during 2008-2011. The goal was to evaluate, and where possible develop and demonstrate effective and transferable chronic condition management strategies, and to generate research evidence about their processes, impact and health outcomes.

This project provides strong qualitative and quantitative evidence that people involved in structured chronic condition management strategies (eg Care Plans) improve their health and wellbeing over time.

The report was created through a partnership of Flinders University and the Aboriginal Health Council, in collaboration with Port Lincoln Aboriginal Health Council, Nunkuwarrin Yunti of South Australia Inc., and the Riverland Community Health Service.

Kubina N. & Kelly J. (2007) Navigating Self-Management: A practical approach to implementation for Australian health care agencies. Melbourne, Whitehorse Division of General Practice.

This practical manual assists agencies to 'reorientate services' implementing self-management into routine practice (allowing provision of additional time and resources).

Lawn, S.J., 2010. Top Tips for Embedding Chronic Condition Self-Management (CCSM) Support into Practice. Australian Journal of Primary Health. 16 (4) pp. 334-343.

This paper identifies effective communication and connection between organisation leaders and work as one of the most important elements for progress in embedding CCSM support into practice.

Lawn S & Battersby M (2009) Capabilities for Supporting Prevention and Chronic Condition Self-Management: A Resource for Educators of Primary Health Care Professionals. Flinders University, Adelaide: Australian Government Department of Health and Ageing.

This document includes agreed definitions of CCSM related terms, a framework of delivery of self-management education, self-management support skills in the context of the Wagner Chronic Care Model and identification and definition of the knowledge, attitudes and skills required by the PHC workforce for prevention and CCSM support.

Lawn, S., Battersby, M., Lindner, H., Mathews, R., Morris, S., Wells, L., et al. (2009). 'What skills do primary health care professionals need to provide effective self-management support?: A consumer perspective.' *Australian Journal of Primary Health,* **15:** 37-44.

This reading includes recommendations for creating an increased understanding, competence and practice of chronic condition prevention and self-management support among PHC professionals (so they are better able to meet the growing burden of chronic conditions on the health system).

Pruitt, SD, & Epping-Jordan, JE (2005), 'Preparing the 21st Century Global Healthcare Workforce. ' *British Medical Journal* **330:** 637-639.

This document explores the five core competencies for delivering effective health care for clients with chronic conditions identified by the World Health Organization .

Wagner E (1998) Chronic Disease Management: What will it take to improve Care for Chronic Illness? American College of Physicians – American Society of Internal Medicine, 2-4.

This foundation resource is a touchstone of the Wagner Chronic Care Model and why clinical practice needs to incorporate a systems approach to chronic condition care.

Warren K, Lorig K & Coulthard F (2006), 'LIFE: living improvements for everyone - a course in chronic condition for Aboriginal people', Spencer Gulf Rural Health School & Pika Wiya Health Service: Whyalla.