



Early Intervention in Chronic Disease in Community Health Services Initiative

Statewide Evaluation

Final Report

Executive Summary



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Executive summary

The Early Intervention in Chronic Disease (EiCD) initiative forms an integral part of the Victorian Government Department of Human Services' (DHS) integrated chronic disease management strategy. EiCD follows the broad direction, articulated in the 2003 *Creating a Healthier Victoria* policy, of strengthening the role of community health in the management of people with chronic and complex conditions. The Australian Institute for Primary Care (AIPC) at La Trobe University conducted a statewide evaluation of the EiCD initiative, commencing in late 2006. This report provides an overview of the evaluation's key findings, and discusses the overall EiCD client profile and the initiative's impact on the systems, services and clients involved.

Client profile

The EiCD client profile was primarily established using a client survey, administered to EiCD clients on enrolment. These data were supplemented by other data from agencies and the DHS Community and Women's Health dataset. Major findings relating to the overall EiCD client profile were:

- As of February 2008, 1933 clients were enrolled in EiCD programs throughout Victoria. An additional 644 clients were described as being in a recall/review phase of EiCD programs.
- The demographic data for clients responding to the client survey indicated that these EiCD clients were, on average, 60 years of age; 65% were female and 86.9% listed English as their preferred language. In addition, 52.4% of these clients were born in Australia, 63.0% received some form of government benefit and 71.8% were Health Care Card holders.
- The majority of clients (58.8%) were diagnosed with diabetes; 18.1% reported having cardiovascular disease, 12.6% asthma and 7.5% COPD. Approximately one in five clients reported more than one chronic disease.
- On enrolment to programs, the majority (55.7%) of EiCD clients reported that their overall health status was either "fair" or "poor".
- Approximately two-thirds of EiCD clients had a Kessler-10 score of 16 or more, indicating at least a moderate degree of psychological distress. Approximately 20% of the client group were in the "very high" category of psychological distress.
- Over half (56.1%) of EiCD clients had an obese body mass index (BMI), and a further 26.1% were overweight. While 15.2% of clients reported that they were current smokers, more than half of all EiCD clients were previous smokers.
- Where data were available, it appeared that only half of EiCD clients had clinical indicators in the acceptable range. For example, 51.2% of clients under the age of 65 had acceptable blood pressure readings (less than 130/85 mmHg) and 53.4% of diabetics had an acceptable HbA_{1c} level of less than 7%. The small size of the clinical indicator dataset (for example, $n = 144$ for blood pressure data) limits the generalisability of this information across the EiCD client population.

Data from the client survey were supplemented by anecdotal information provided by EiCD key workers relating to their experience of working with EiCD clients. Key workers indicated that many EiCD clients have highly complex psychosocial needs. The major psychosocial issues for EiCD identified by key workers included social isolation, financial difficulties, family and relationship problems, as well as general self-esteem issues. In conjunction with the quantitative aspects of the client profile, the data suggest that the EiCD initiative engaged with a highly complex population of clients in need of considerable health and social support.

System impact

For many EiCD programs, system-related aspects of program implementation, such as liaison and communication arrangements with GPs and HARP-CDM, have lagged behind other aspects. Primary

Care Partnerships (PCPs) supported EiCD programs with governance and other systems-related functions, and, in some cases, joint arrangements (in terms of governance and client entry pathways) were developed with HARP-CDM programs. EiCD programs have developed links to other programs relating to specific social disadvantage and health inequalities (e.g. Aboriginal Health Promotion and Chronic Care (AHPACC) programs and local Neighbourhood Renewal programs); in many instances these links have been facilitated via the PCP platform.

Divisions of General Practice (DGPs) were also integral to governance models and the coordination of GP engagement activities, in partnership with agencies and PCPs. Agency programs were specifically supported by PCPs and their DGP members' efforts relating to workforce development; in several instances the PCP/DGP partnership provided specific education and training assistance to GPs and practice nurses regarding chronic disease self-management.

System- (and service-) level changes were described across the various domains of the Wagner Chronic Care Model (CCM); however, the clinical information systems element remains comparatively underdeveloped.

Service impact

In comparison to the slower response at the system level, EiCD has been a successful driver of *internal* change within individual agencies. These internal aspects of program implementation have mostly reached the level of sustained routine activities over the 12-month period of the evaluation. A number of difficulties were reported by agencies in the establishment phase of their programs; most notably in the recruitment to the program manager or leadership role. Delays in recruitment in this position commonly resulted in delays in planning, program deployment and (ultimately) client recruitment into programs. Similar recruitment difficulties were also observed in later stages of program development, as key workers were recruited in preparation for program deployment.

Significant organisational change within agencies occurred in response to the EiCD initiative. EiCD further developed the role of GP liaison officers, which in some instances were pre-existing positions. Developing the key worker role was the most significant form of change in this respect, with a variety of different models emerging (e.g. dedicated key workers or combined key worker/clinician roles). Communication strategies, particularly marketing activities to GPs, also form a substantial area of program activity.

EiCD programs developed a variety of different service models in line with best practice in chronic disease management. Key workers were involved in virtually all aspects of client care under these service models. The overall service models were supported by a wide variety of allied health and other services. The information provided by agencies indicated that these program-related services were supported by numerous funding sources, including the EiCD initiative itself, general community health funding as well as HACC funding, and (in some cases) privately funded services through the Medicare Chronic Disease Management items.

Client impact

The evaluation's ability to assess the impact of the EiCD initiative on clients was limited by the data available. From follow-up survey data, it appeared that positive changes had occurred in clients' ratings of their own health status; increases and decreases in confidence in self-management capacity were also observed. Clinical outcome data were extremely limited; improvements in HbA_{1c} levels were noted, but in an extremely small dataset. Shifts towards lower levels of psychological distress were also seen for some clients at six months. Body mass index (BMI) changes were not observed; however, this was not unexpected given the complexity of the clients involved and the timeframe of the evaluation.

Summary

The EiICD initiative successfully demonstrated the capacity of the community health sector to engage with a client population requiring a more integrated approach to chronic disease management. The initiative itself has also succeeded in providing the impetus for agencies to develop and deliver services in accord with the Wagner CCM. In addition, EiICD programs were becoming increasingly linked with specific local programs designed to address social disadvantage and inequalities (e.g. with AHPACC, Neighbourhood Renewal and local programs to alleviate transport disadvantage); in many instances these links have been facilitated via the PCP platform. In these respects, EiICD has moved towards realising the overall vision for integrated chronic disease management in Victoria.

The EiICD initiative engaged with a highly complex client population, with chronic disease/s, who face many psychosocial issues. The EiICD initiative is targeted to clients with chronic disease *with or without* complex needs; it is arguable that the vast majority of clients are, in at least some respect, those “with” complex needs. While this represents the successful engagement of a population in need of such services, future planning must account for the effect this has on demand for services and the coordination of those services.

Processes allied with the deployment of the EiICD initiative reflected activity associated with all six elements of the Wagner CCM. However, the evaluation has shown that the CCM element of clinical information systems was underdeveloped, and substantial improvements are required in order to support best practice in chronic disease management. The availability and communication of clinical data is essential to good chronic disease management; the evaluation has highlighted the need for this to be addressed.

At a policy level, the separation of Victoria’s chronic disease management programs—namely EiICD and HARP-CDM—should be reconsidered. Considerable transaction costs are associated with the need for EiICD programs to interface with HARP-CDM programs. In addition, the various program streams may be contributing to “program fatigue”, particularly among GPs. Ultimately, the Victorian strategy should be in a position to offer streamlined referral and service provision to clients; those with complex needs may or may not fit the existing EiICD/HARP-CDM “boxes”.

Recommendations

The following general recommendations have been made to DHS as part of this report:

1. That DHS create a greater awareness of its chronic disease management strategy and the explicit links between programs, the existing departmental GP policy and Commonwealth chronic disease initiatives. Harmonisation of chronic disease management programs should also be considered.
2. That DHS further explore and develop the role of consumers, carers and community representatives in EiICD programs.
3. That DHS develop case studies from existing EiICD programs. These would be useful as tools to assist understanding of the challenges in a chronic disease service model and approaches to addressing them.
4. That, in establishing future EiICD programs, DHS should, as much as possible, follow a staged roll-out to facilitate the planning and implementation phases and manage workforce availability and capacity challenges.
5. That DHS examine the scope and requirements of the key worker role, to ensure that the professional competencies, skills, functions and duties are properly characterised and supported.
6. That DHS encourage a strengthened focus on building on current activities and identifying gaps in realising the CCM, particularly in relation to clinical information systems.
7. That DHS consider ongoing monitoring of the progress of EiICD programs at policy and program levels, and take account of other chronic disease management programs, existing data tools and data sources.

