Summary of Draft

INTEGRATED CHRONIC DISEASE MANAGEMENT WORKFORCE CAPACITY BUILDING STRATEGY 2008/09-2012/13

Developed March 09

The ICDM team of the Primary Health Branch has developed a program of workforce development opportunities to be rolled out over the next few years to support the implementation of primary health led Integrated Chronic Disease Management. This document provides a summary of the draft Strategy and some background to the workforce development activities to be offered in 2009. The 2009 Schedule of Activities is contained in Appendix 1.

OVERVIEW

- Care for people with chronic diseases usually involves multiple health care providers across multiple settings. **Integrated chronic disease management (ICDM)** 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.
- **ICDM calls for reform:** realigned systems across agencies to deliver integrated chronic disease care. Effective ICDM strategies require agencies to make systemic changes to the way they practice and provide care. To achieve a shared vision, health care providers must work collaboratively to coordinate and plan services and care.
- **The EIiCD initiative is a component of the ICDM work** with a focus upon new and innovative approaches to providing care to people with chronic disease within primary health care. It plays a key role in the broader change management ICDM reforms.
- **The roles and responsibilities of people involved in ICDM within primary health sector reform vary both across and within agencies**, with each having a particular role to play in the complexity of providing proactive and integrated care to people with chronic disease.
- **These roles are interdependent** which means that success in achieving the desired reforms depends upon the achievement of other outcomes in other parts of the system. Strategically, therefore, **some workforce needs should be prioritised over others**.
- **Workforce issues are currently the focus of considerable attention from a number of program areas and jurisdictions**. This provides potential opportunities to capitalise on these other endeavours to meet the needs of the ICDM workforce. In addition, the inter connectedness of the workforce also presents opportunities to explore other training activities with partnering programs or agencies.
- **The draft ICDM Workforce Development Strategy 08/09-12/13 has been developed by the Primary Health Branch to strengthen current workforce capacity** to implement ICDM, particularly within community health services and across PCPs. With a comprehensive program of activities, the Strategy endeavours to foster sustainable mechanisms to support an ongoing culture of learning and continuous quality improvement.
- **To expedite the transfer of newly acquired knowledge and skills into changed practice** eg new/ redefined roles and responsibilities, restructured work

environments, priorities include the facilitation of authorised environments to support organisational and catchment wide change management as well as opportunities to support reflective practice.

- **A feature of the program of activities is the link between learning opportunities and support mechanisms** to facilitate the embedding of changed practice. It is expected that participation in learning opportunities will not be isolated events but link participants to support mechanisms such as peer learning circles along with concomitant organisational responses eg supervision, opportunities for reflective practice, support.

PROGRESSING HEALTH SYSTEM REFORM

The **WAGNER MODEL FOR IMPROVING CHRONIC CARE** has been endorsed by the Primary Health Branch as the model to inform and guide the service system redesign required to support people with chronic disease. The Wagner Chronic Care Model 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 six interdependent elements of the Wagner Model provide a framework that helps to identify the systems changes (within primary health care services and across the service system) that are necessary to improve the coordination of care for people with chronic disease. The six elements of Wagner's model 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.

CHANGE MANAGEMENT FOR QUALITY IMPROVEMENT: Using the Wagner Chronic Care Model as a framework for quality improvement can drive the development of innovative models of care that improve the consumer journey through the service system. This includes coordinated approaches:

- Across the continuum of care (access & initial contact, INI, assessment, care planning, care delivery, liaison & referral, monitoring & review, transition & exit, and proactive recall & ongoing support);
- That consider continuity of care and the provision of proactive and ongoing support (particularly General Practice);
- That clearly articulate intra- and inter-agency roles and responsibilities (particularly General Practice and relevant private providers);
- That clearly articulate intra- and inter-agency linkages and pathways (including with General Practice and relevant private providers);
- That are informed by consumer consultation and/or involvement

- That identify mixed models of care that utilise MBS services and other public and privately funded services and
- That clearly articulates communication within and between agencies and information sharing arrangements (including feedback and communication with General Practice and relevant private providers).

The ICDM and EICD initiatives are two key initiatives that invest in progressing health system reform. Both the ICDM initiative and EIiCD initiatives are essentially change management initiatives which aim to reorientate practice to facilitate a more coordinated, proactive and client centred approach to support the needs of people with chronic disease. Implementing effective ICDM strategies requires all agencies who provide care to people with chronic disease to make changes to the way they practice and provide care. The combination of ICDM funding for PCPs, EIiCD funding for primary health care services and existing funds already servicing people with chronic disease, provides agencies with an imperative to work towards achieving the ICDM vision.

THE INTEGRATED CHRONIC DISEASE MANAGEMENT AND THE EARLY INTERVENTION IN CHRONIC DISEASE INITIATIVES

The **INTEGRATED CHRONIC DISEASE MANAGEMENT (ICDM)** initiative is a key component of broader reform work across the health service system to improve capacity to respond to the needs of people with chronic disease. It provides PCPs with additional funding to facilitate the implementation of effective systemic strategies across catchments that support health care providers to work collaboratively in coordinating and planning services and care.

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

Aim: A chronic disease management approach[1] 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.

The **EARLY INTERVENTION IN CHRONIC DISEASE (EIiCD)** initiative complements the ICDM initiative as a key component of the work within primary care agencies to improve capacity to respond to the needs of people with chronic disease. The EIiCD initiative

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

provides additional funding to primary health care agencies to enhance their services and lead systems change to build new components into routine care that are consistent with evidence-based chronic care.

WORKFORCE CAPACITY BUILDING

This transformational work is a major undertaking that has considerable workforce implications both within agencies and across catchments. The nature of ICDM change management is a complex process and experience and capacity to manage the change process varies across the sector. Common to all stakeholders however, is a need for a better understanding of:

- Integrated chronic disease management
- Using the elements of the Wagner Chronic Care model to support broad organisational and systems improvements
- Implementation of improvements at a local level, including self-management support models
- Using evidence based improvement approaches to drive change

The desired health sector reforms also require different and complimentary actions from across the service sector from the various interdependent stakeholders. Briefly,

- The Department of Human Services has a role in working at a systems level to create the enablers for change.
- At senior agency levels, CEOs and senior managers play a pivotal role in mandating and leading change within their organisations and in the creation of an authorised environment for change both internally and as partners within the wider catchment.
- At the project leader level, project management skills are required for the change management process to be embedded within practice in a sustained and timely fashion.
- At the clinician level, the right skill mix and attitudes are needed to provide clients with evidence based practice for proactive planned coordinated person-centred care over time

ICDM WORKFORCE DEVELOPMENT PRIORITIES: To improve outcomes for clients with chronic disease, the ICDM workforce development activities endeavour to:

- Support planned, coordinated, person-centred service delivery as quickly as possible
- Strategically maximise momentum in translating new skills and knowledge into practice and service delivery
- Address training through flexible and sustainable learning programs
- Facilitate professional learning as an integral part of building and maintaining a quality workforce
- Support workplaces to be learning communities of practice that share and value knowledge, skills, diversity and innovation
- Support integrated, sustainable, multidisciplinary partnership approaches across sectors

ICDM DEVELOPMENT STRATEGY OBJECTIVES:

1. To further enhance the establishment of authorised environments to support organisational and catchment wide practice change and service system reforms.
2. To facilitate the establishment of support mechanisms to increase and support sector capacity to deliver EIiCD/ICDM services to people with chronic disease.
3. To increase the competencies of clinicians, ICDM workers and project leaders to effect evidence based EIiCD/ICDM services for people with chronic disease.

ICDM DEVELOPMENT STRATEGY DELIVERABLES:

For a range of key ICDM stakeholders provide access to:

1. Learning opportunities and training
2. Support for the implementation of newly acquired skills and knowledge into evidence based practice and service delivery.
3. Information and online resources

COMPONENTS of the ICDM WORKFORCE DEVELOPMENT STRATEGY: Some of the components of the draft Strategy are described below. Refer also to the diagram on page 6.

1. **Targeted groups -** the following have been prioritised according to the accompanying brief rationale.
   - Agency CEOs, chairs of PCPs and program managers: to establish the authorising environment and drive the strategic agenda
   - Project managers: to facilitate the systems change and manage project implementation
   - ICDM workers and PCP executive officers: to influence, guide, support and commence targeted elements of the integration work and to manage project implementation
   - Clinicians: to deliver best practice service delivery supported by the organisational culture and an authorised environment.
2. **Training modes -** A range of modalities are proposed to deliver learning opportunities to enable broad access by the sector according to individual needs and in recognition of particular needs of organisations and people living in rural regions.
3. **Learning content -** The nature of ICDM change management is a complex process with interdependencies. Experience in ICDM change management and capacity varies within and between organisations, staff and regions. Feedback strongly identified the need to strategically ensure that learning opportunities were coordinated in terms of timing and content. This would facilitate greater regional capacity to guide the design stage of new projects; sectorial leadership in establishing the authorised environment and organisational culture for reform; the establishment of support structures to sustain ongoing practice change by clinicians and finally training in the delivery of evidence based practice.
4. **Learning support mechanisms -** arising from both feedback and previous work was a need for opportunities to make links with, support and be supported by peers in the application of new skills and knowledge. It is therefore recommended, that participation in learning circles be a requirement of participation in any learning opportunity and that where possible training providers facilitate this approach so as to better embed learned skills into practice.

   Other supports including peer networks, supervision, mentoring and coaching opportunities are to be explored further in subsequent years.

WORKFORCE DEVELOPMENT ACTIVITY PLAN FOR YEAR 1:

Not all components of the Strategy will be activated in year 1. Implementation is to be phased so as to allow for work to begin on establishing stronger authorising environments and organisational structures. To maximise the interest of the newly funded sites, facilitate quick wins with the uptake of new practice components of the Strategy will particularly prioritised to primary care agencies with EliCD funding.

Diagram of the components of the draft ICDM Workforce Development Strategy.

Year 1 activities are included inside the orange dashed box.