

Service Coordination and Integrated Chronic Disease Management 2009 Survey

Statewide Survey Summary Report

Background

Since 2001, Primary Care Partnerships (PCP) have been working toward improving the way health and human services are coordinated. Service coordination is a key element of the PCP Strategy, which ensures that people have access to the services they need, opportunities for health promotion, early intervention, coordinated care and improved outcomes. The practice of service coordination particularly supports more effective ways of working with people with complex and multiple needs. For example, it provides a good foundation for the practice of integrated chronic disease management.

The Statewide Service Coordination and Integrated Chronic Disease Management (ICDM) survey is part of the PCP annual reporting requirements for the Department of Health. This survey provides quantitative evidence of coordinated care for people with multiple or complex needs and provides evidence for agency accreditation and program quality assurance requirements. This is the second year that the Service Coordination survey (Part A) component has been implemented and the first year ICDM questions (Part B) have been included.

Method

The Service Coordination component of the survey is from the *Continuous Improvement Framework* (www.health.vic.gov.au/pcps/publications/continuous.htm) that supports the *Victorian Service Coordination Practice Manual* (www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm). The *Continuous Improvement Framework* is a tool developed by PCP member agencies to monitor Service Coordination implementation for quality improvement, planning and reporting purposes.

The ICDM survey (part B) component measures the implementation of ICDM as defined by the *Primary Care Partnerships revised program logic* (www.health.vic.gov.au/pcps/downloads/programlogic.pdf) and further described in the *Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services* (www.health.vic.gov.au/communityhealth/downloads/cdm_program_guidelines.pdf). The ICDM questions were sourced from evidence based resources being used by Primary Care Partnerships and partner agencies to plan, implement and monitor Integrated Chronic Disease Management. The questions were adapted from the following sources: *Assessment of Chronic Illness Care*, (MacColl Institute for HealthCare Innovation, 2000), *Integrating Chronic Care and Business Strategies in the Safety Net*, (Wagner et al. 2008) and the *PCP Self-management mapping template* (Department of Human Services 2007).

Agencies were given some flexibility in how to gather the information to complete the survey. They were given a choice of a snapshot recording of their practice over one week for a maximum of 30 consecutive admissions to the agency. Or agencies could use a retrospective approach and audit 30 files of consecutive admissions within a one week period. Responses to the survey questions were submitted to the Department of Health via a web based survey. The data represented in graph 1 and graph 2 were analysed by program/services.

Response to Survey

Of the PCP member agencies that have implemented Service Coordination, 55% of agencies responded to Part A: Service Coordination survey. Of the PCP member agencies that have implemented ICDM, 44% of agencies responded to the ICDM component of the survey (Part B).

Table 1. Service Coordination & ICDM Survey participation

Total No of Participating	SC_Survey 2008	SC_Survey 2009	SC_Survey Increase	ICDM_Survey 2009
*Agencies	202	230	14%	137
Programs	635	773	21%	434

*PCP member agencies and non-PCP member agencies

The majority of the respondents represent core PCP members such as local government, metropolitan and rural health services, district nursing and community health. In addition a broader range of programs participated in the survey this year, including several new programs. There was greater than 30% increase in program participation from 2008 to 2009 for dental services, admitted patients, palliative care, HARP, sub-acute care and homelessness assistance. Disability services had the greatest overall increase in participation rate (43%). This indicates a broadening of the types of organisations and services participating in PCPs for the benefit of shared clients.

Community Health and Home & Community Care (HACC) are highly represented given these program areas have mandated the implementation of improved service coordination practice through engagement with Primary Care Partnerships (table 2).

The majority of respondents to Part B of the survey (ICDM) are health services such as metropolitan and rural acute health services, and state funded primary health services. Increasingly, Home and Community Care (HACC) services, often provided by local government and Aged Care Assessment Services (ACAS) are understanding their role in ICDM, and this was demonstrated in their high participation rates in the survey. Other services also involved in the survey (at smaller rates) include mental health services, disability services and child and family services.

Table 2. Program response to Service Coordination & ICDM Survey

Programs	SC_2008	SC_2009	ICDM_2009
Admitted Patients	16	25	15
Aged Care Assessments	40	22	15
Allied Health	34	35	29
Ambulance Services	1	1	2
Child Protection & Family Services	20	16	7
Community Health	83	84	66
Dental services	11	16	9
Disability Services	51	90	21
Drugs Services	17	15	6
Early Years Services	14	14	4
Emergency Services	10	12	11
HACC	189	185	88
HARP	26	38	33
Healthy Mothers, Health Babies	-	9	6
Homelessness Assistance	12	18	7
Kids Life	-	2	1
Long-term Housing Assistance	4	4	3
Maternal Child Health	-	18	5
Mental Health	32	33	14
Outpatients	13	15	15
Palliative Care	14	23	18
Post Acute	24	29	20
Problem Gambling	-	21	3
Refugee Health	-	11	9
Sub Acute	14	24	18
Youth Justice & Services	11	2	1
Other		8	8
TOTAL	636	773	434

*Programs/services are provided by an agency across one or more locations/sites, and in association with one or more PCPs.

Survey Results

Part A: Service Coordination

The Statewide Service Coordination component of the survey results (attached) indicate well developed areas of good practice and areas that continue to require more development. Statewide comparisons between the 2008 & 2009 survey are influenced by the changing profile of respondents. Approximately only 65% of the agencies participated in the survey both years, with some representing different programs/services between each year.

Stronger links and emphasis on integrating the Service Coordination & ICDM 2009 survey into internal quality assurance processes has resulted in a more robust methodology to collect the data. This enables individual agencies to create more meaningful representation of their current practice and provides a benchmark of their progress.

Part A of the 2009 survey results demonstrates a similar trend from the 2008 survey. Particular areas of consistent practice include obtaining client consent for disclosure of information and acknowledgement of urgent and routine referrals. These areas are vital to achieve efficient sharing of client health and care information, effective coordination of services and preventing clients from 'slipping between the gaps'.

The use of a coordinated care plan and sharing this care planning information with General Practice continue to be identified as areas requiring significant improvement. The Integrated Care Branch together with General Practice Victoria are implementing workforce development and further resources to specifically address this issue. This includes competence based training for care planning, through the Vocational Education and Training sector and supporting staff to implement Plan Do Study Act model to accelerate improvement of care planning and GP feedback practice at a local level. This work is ongoing and it is recognised that it takes time to change practice and produce impact that is measurable.

Part B: Integrated Chronic Disease Management

The Statewide ICDM survey results (attached) indicate areas of reasonable practice and areas that require more development. This is to be expected since the questions ask about evidence for best practice care rather than standard practice. National and international evidence suggest that ICDM best practice care is not often achieved. For example, evidence suggests that only 65% people who smoke are identified and less than half are referred for cessation counselling.

The highest survey result was achieved in assessment practice where 42% of programs/services respondents meet all elements of practice for more than 90% of consumers. This means their assessment practice includes gathering information about consumer needs beyond the presenting issue(s); gathering key medical, functional, lifestyle, social and psychological information; and assessing consumer capability and willingness to change significant health risk behaviour(s).

Health behaviour change support as an element of self-management support, is provided by most agencies (72%), however does not include all best practice elements such as: concordance with local agreements; individualised to meet the needs, circumstances, and capabilities of individual consumers; aims to strengthen consumer knowledge, skills, self-efficacy, motivation, and resources; and provided by appropriately trained clinicians.

Most agencies/programs have established a formalised quality improvement system with chronic disease management as a priority focus, however the system does not necessarily include all aspects of best practice such as including intra and inter agency elements; supported by leadership; using relevant data to set priorities; measuring performance; and evaluating outcomes.

Further work is required to develop clinical care pathways and decision supports to ensure consumers get access to the right care. This work is being progressed by PCPs and is included within ICDM core expectations 09-12 for PCPs. It is acknowledged that this work takes time to develop, implement and to achieve consistent practice across a catchment.

As this is the first year ICDM practice has been measured, these results indicate base line data. It is understood that quality improvement activities are being undertaken to address the gaps in care and future survey results should demonstrate the changes and improvements to care over time. Activities should focus on improvements across the areas of work and improving the quality of practice against all elements.

A guide to interpreting and formulating wording to explain the Service Coordination & ICDM survey graphs is attached.

Using the Survey Results

Feedback Reports

Tailored feedback reports will be provided to government program areas, government regional offices, PCP Executives and PCP member agencies.

PCPs

This quantitative analysis provides an opportunity for PCPs to identify specific areas for further resources and development, to be addressed through strategic and operational three year plans. PCPs can use these results to identify the agencies which require further support and those that have well developed service coordination and ICDM to lead or model practice. In addition, the survey provides support for PCPs as a platform to deliver service system reform and creates a benchmark for PCPs to measure the effectiveness of future strategies and interventions to further strengthen service coordination and ICDM.

Discussion of survey results at PCP/agency service coordination and ICDM networks may also include how to further integrate the Service Coordination & ICDM 2010 survey into existing quality improvement and reporting processes to reduce duplication. This is an opportunity to follow-up PCP member agencies that did not complete the 2009 survey and explore what support is required to ensure that they are able to participate in the next survey. This support may include identifying key contacts within an organisation, providing an authorising environment to participate in the process or workforce development in relation to methodology of data collection and the interpretation and use of data. This support can also extend to agencies that participated in the survey but are not currently PCP members.

Agencies

At an agency level the service coordination & ICDM survey supports internal quality assurance systems by providing a vehicle to review their current practice and identify the areas that need improving. The survey is not limited to assessing practice within an agency but also measures the effectiveness and efficiency of their communication with partnering PCP members. Therefore, this survey provides evidence of accreditation standards of providing quality services and programs and sustaining quality external relationships. In addition, the survey results may contribute to government funded services reporting and monitoring frameworks e.g. Quality of Care Reports for Integrated Care Branch funded agencies.

Agencies can now benchmark their service coordination practice against their previous year's results and other agencies within their PCPs. In 2009, the ICDM questions were included in the survey for the first time. This provides baseline data to measure the effectiveness of future strategies and interventions to further strengthen ICDM.

Agencies are encouraged to provide feedback to their individual service providers through their internal communication/quality networks or systems.

Government Departments

The survey provides government departments with quantitative evidence that PCPs have a mature service coordination platform to deliver future service reforms. The results are disseminated to relevant government departments to support implementation of service coordination within program areas. Analysis of the results assists in targeting effort to areas of need.

General Practice and Integrated Chronic Disease Management

Divisions of General Practice are key members of the PCPs. General Practice Victoria in conjunction with the Victorian Department of Health have developed General Practice Profiles to support the Service Coordination & ICDM 2009 survey. The General Practice Profiles provide data on MBS items that specifically relate to ICDM. It is intended to inform and support PCP's local planning and monitoring, especially around ICDM. The General Practice Profiles for your local area can be accessed at www.gpv.org.au. The General Practice Profiles' data has been drawn from a number of different sources that are publically available. Contact your local General Practice Division if you require further information.

Service Coordination and Integrated Chronic Disease 2010 Survey

The survey content and process will be reviewed and evaluated in consultation with government program areas, PCP members and accreditation organisations to build on the efficiency and accuracy of successive surveys.

MORE INFORMATION

Further information is available on the Victorian Government Health Information Web site (www.health.vic.gov.au/pcps/coordination). Alternatively contact your regional office or Shelly Lavery from Integrated Care Branch (email shelly.lavery@health.vic.gov.au or tel. 9096 1322).

Service Coordination and Integrated Chronic Disease Management Survey 2009

Statewide Report - Service Coordination (Part A)

773 programs/services* (from 230 agencies) across Victoria responded to the Service Coordination and Integrated Chronic Disease Management Survey

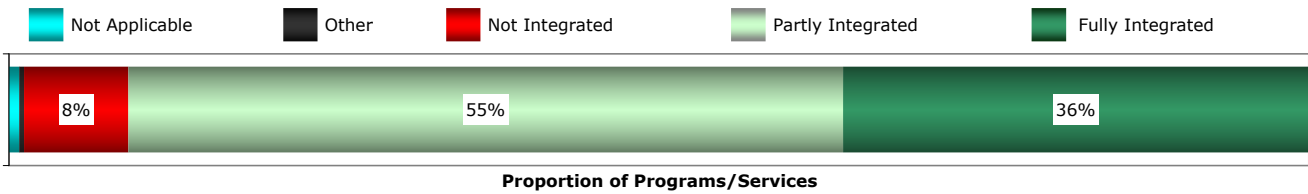
Programs	Total number of Programs/Services:
Acute Health Services	
Admitted patients	25
HARP	38
Emergency Services	12
Post Acute	29
Sub Acute	24
Palliative Care	23
Outpatients	15
Allied Health	35
Ambulance Services	1
Aged and Home Care	
Aged Care Assessment Services (ACAS)	22
HACC Assessment Services	81
Other HACC Organisations	104
Child and Family Services	
Child Protection and Family Services	16
Youth Justice and Services	2
Maternal and Child Health Services	18
Early Years Services	14
Disability Services	
Accommodation Services	8
Day Placement	14
Individual Support Package Providers	21
Planning and Case Management Services	19
Respite	28
Drugs Services	
Drugs Services	15
Housing Assistance	
Homelessness assistance	18
Long-term housing assistance	4
Mental Health	
Acute Inpatient Services	1
Clinical Residential Services	2
Community Mental Health Teams	10
Crisis Assessment and Treatment Services	1
Psychiatric Disability Rehabilitation and Support Services	19
Problem Gambling	
Problem Gambling	21
Primary and Dental Health	
Dental Services	16
Community Health	84
Healthy Mothers, Healthy Babies	9
Kids Life	2
Refugee Health	11
Other	
Other	11
Total	773

* Programs/services are provided by an agency across one or more locations/sites, and in association with one or more Primary Care Partnership.

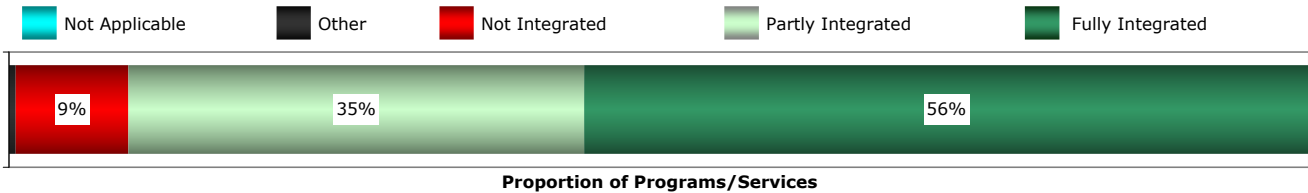
Prepared By: Integrated Care Branch
Wellbeing, Integrated Care and Aged Division
Department of Health

For more information email: pcp@health.vic.gov.au Website: www.health.vic.gov.au/pcps

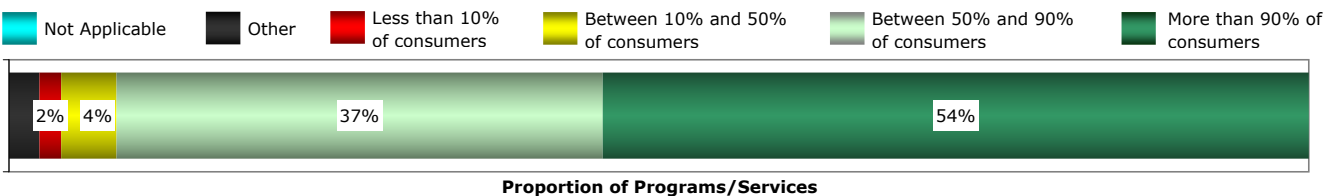
Question 1: Service coordination practice standards and program requirements are integrated into policy, work plans and position descriptions where applicable. (CIF^ Criteria 2.2/2.3)



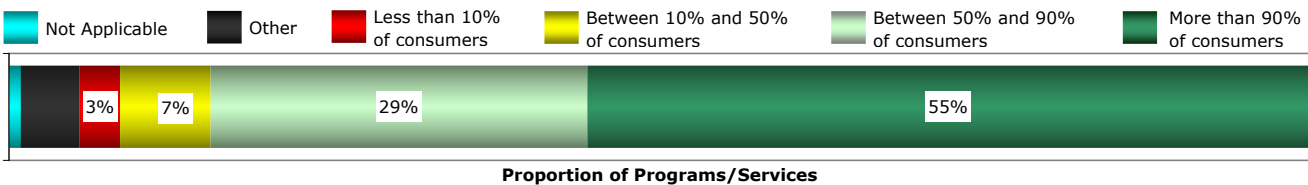
Question 2: Service coordination principles are integrated into consumer feedback systems, for example, consumer satisfaction surveys, complaints procedures or informal mechanisms. (CIF^ Criteria 2.11)



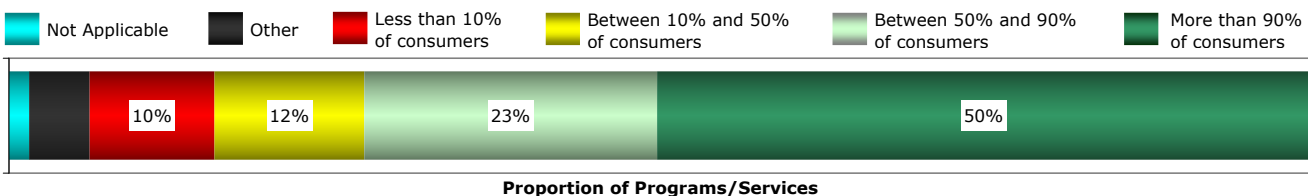
Question 3: Consumers have been provided with information about services available in response to their inquiry or as part of an outreach approach (such as: when & where the service is provided, eligibility or access criteria & how to get an appointment) within 1 working day of making contact. (CIF^ Criteria 3.1)



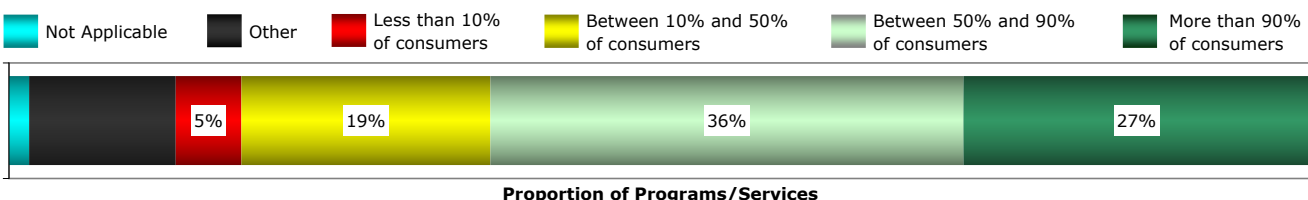
Question 4: Initial Needs Identification is conducted within no more than 7 working days of Initial Contact. (CIF^ Criteria 4.2)



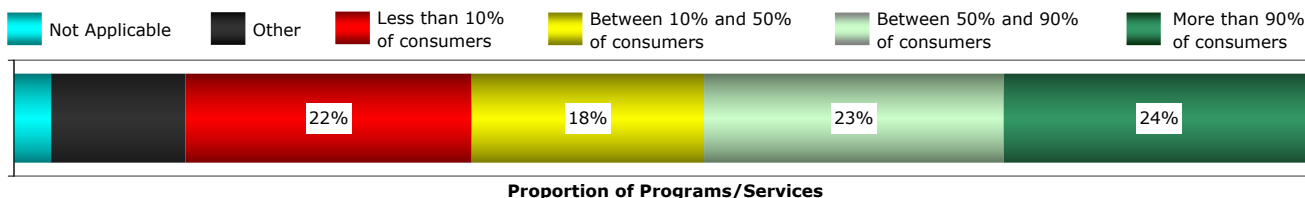
Question 5: Service Coordination Tool Templates (SCTT) have been used for referral in accordance with policy (for example, DHS program or agency policy) and the SCTT 2009 user guide. (CIF^ Criteria 7.4)



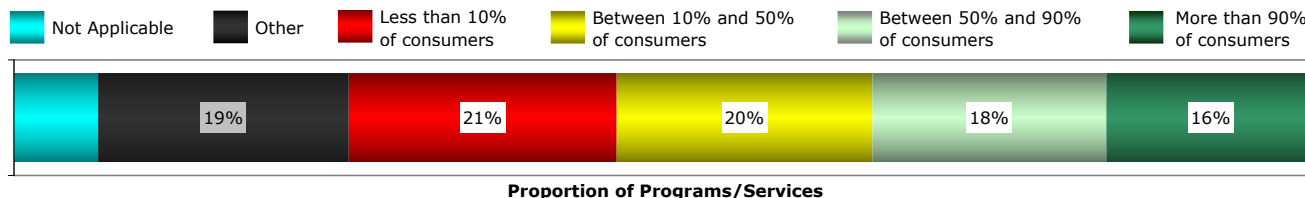
Question 6: Planned reviews for care planning have occurred within one month of the date listed for review (or within a time frame stipulated in your service provider procedures). Note: this refers to all types of care plans e.g. service specific, inter and intra-agency care plans. (CIF^ Criteria 6:12)



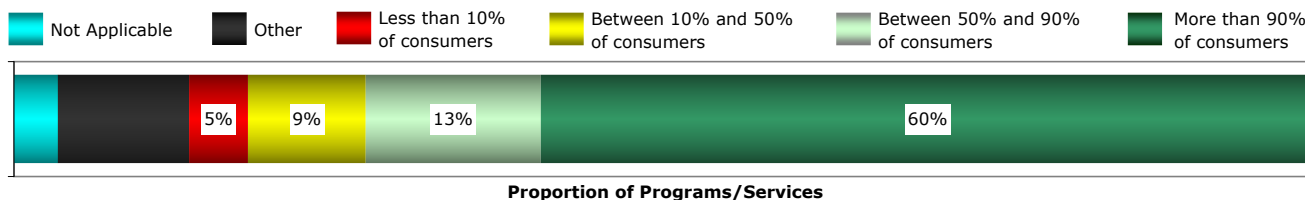
Question 7: Care Coordination Plans have been documented for consumers with multiple or complex needs who are receiving services from more than one organisation. (CIF^ Criteria 6.21)



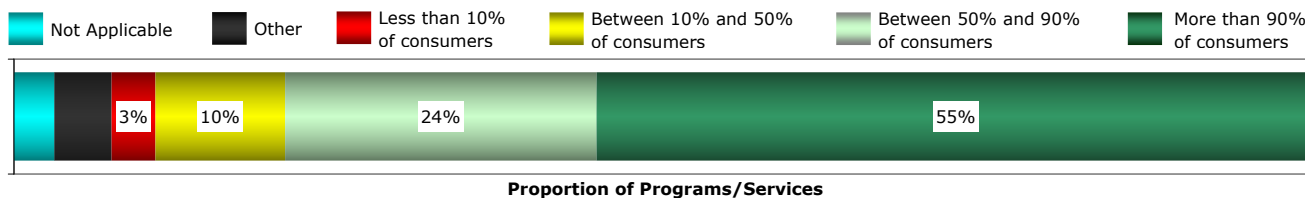
Question 8: When there is a Care Coordination Plan, the consumer's GP has been provided with a copy of it. (CIF^ Criteria 6.22)



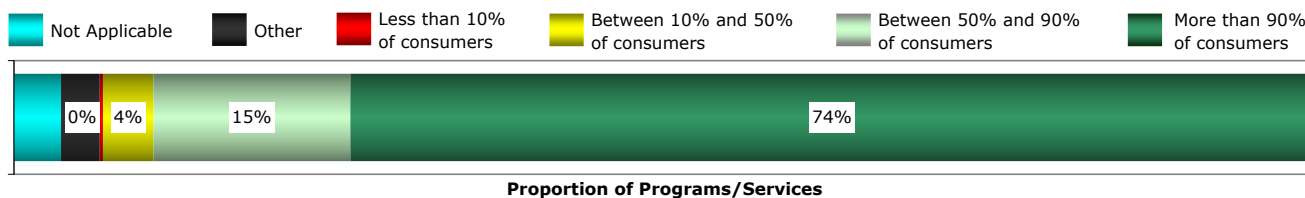
Question 9: When 'urgent referrals' are received, a referral acknowledgement has been sent within 2 working days of receipt. (CIF^ Criteria 7.7)



Question 10: When 'low' or 'routine' referrals are received, a referral acknowledgement has been sent within 7 working days of receipt. (CIF^ Criteria 7.8)



Question 11: When a referral is sent, the consent form has been completed for all referrals requiring the disclosure of personal information. (CIF^ Criteria 8.1)



^ Continuous Improvement Framework 2009: A resource of the Victorian Service Coordination Practice Manual

Service Coordination and Integrated Chronic Disease Management Survey 2009

Statewide Report - Integrated Chronic Disease Management (Part B)

434 programs/services* (from 137 agencies) across Victoria responded to the Service Coordination and Integrated Chronic Disease Management Survey

Programs/Services:	Total number of Programs/Services:
Acute Health Services	
Admitted patients	15
HARP	33
Emergency Services	11
Post Acute	20
Sub Acute	18
Palliative Care	18
Outpatients	15
Allied Health	29
Ambulance Services	2
Aged and Home Care	
Aged Care Assessment Services (ACAS)	15
HACC Assessment Services	41
Other HACC Organisations	47
Child and Family Services	
Child Protection and Family Services	7
Youth Justice and Services	1
Maternal and Child Health Services	5
Early Years Services	4
Disability Services	
Accommodation Services	0
Day Placement	4
Individual Support Package Providers	4
Planning and Case Management Services	7
Respite	6
Drugs Services	
Drugs Services	6
Housing Assistance	
Homelessness assistance	7
Long-term housing assistance	3
Mental Health	
Acute Inpatient Services	0
Clinical Residential Services	1
Community Mental Health Teams	6
Crisis Assessment and Treatment Services	0
Psychiatric Disability Rehabilitation and Support Services	7
Problem Gambling	
Problem Gambling	3
Primary and Dental Health	
Dental Services	9
Community Health	66
Healthy Mothers, Healthy Babies	6
Kids Life	1
Refugee Health	9
Other	
Other	8
Total	434

* Programs/services are provided by an agency across one or more locations/sites, and in association with one or more Primary Care Partnership.

Prepared By: Integrated Care Branch
Wellbeing, Integrated Care and Aged Division
Department of Health

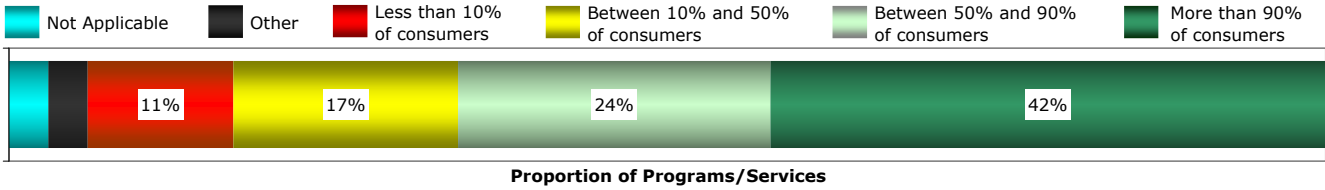
For more information email: pcp@health.vic.gov.au Website: www.health.vic.gov.au/pcps

Question 1: Assessments (meeting the criteria listed below, in full) have been documented for consumers.

Criteria: Assessments are documented in a standardised, common format and identify:

- a) consumer needs beyond the presenting issue(s);
- b) key medical, functional, lifestyle, social and psychological information;
- c) consumer stated issues; and
- d) consumer capability and willingness to change significant health related behaviour(s).

Note: Assessments may be contributed to by multiple service providers and added to or amended over time.

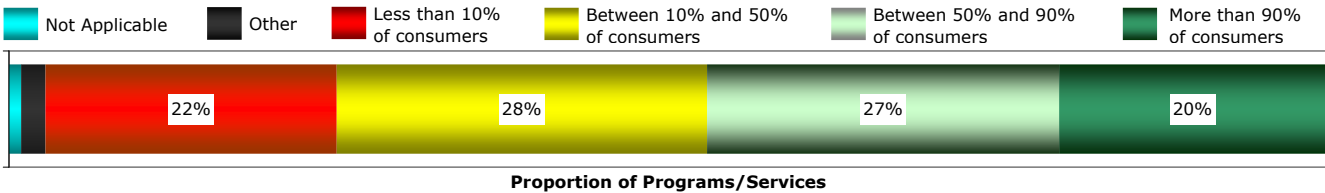


Question 2: Intra-agency care plans (meeting the VHA criteria listed below, in full) have been documented for consumers.

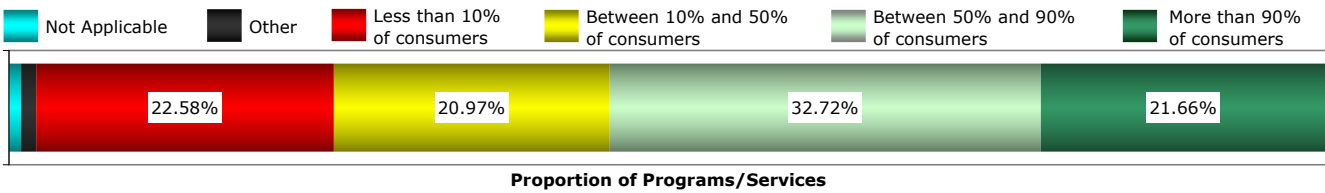
Criteria: A care plan is any documented plan of care that has all of the following 10 elements:

- a) consumer stated or agreed issues/problems; objectives/goals; and strategies/action;
- b) review date of care plan;
- c) timeframe for attainment of objectives/goals;
- d) responsibilities for implementing strategies/action;
- e) participants in development of care plan;
- f) consumer acknowledgement (signed or verbal acknowledgement recorded);
- g) date care plan developed; and
- h) goal/objective attainment. (Victorian Healthcare Association, November 2008.)

Note: Service specific care plans are sufficient where a consumer is receiving care from only one care provider within the organisation.



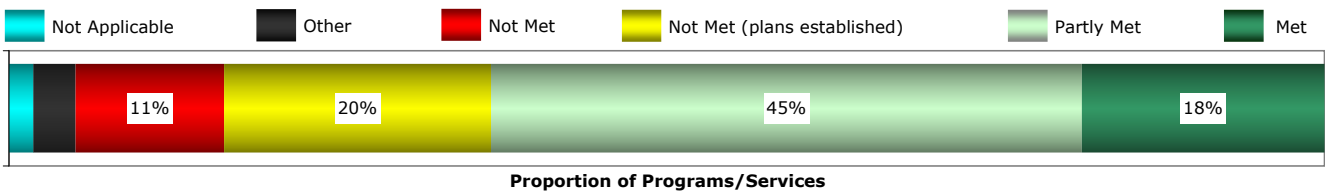
Question 3: Feedback to General Practice has been documented for consumers, in accordance with local agreements developed with input from General Practice.



Question 4: Clinical care protocols, pathways and decision support tools that demonstrate delivery of best practice clinical care (meeting the criteria listed below, in full) have been developed (or endorsed).

Criteria: These care protocols, pathways and decision support tools demonstrate:

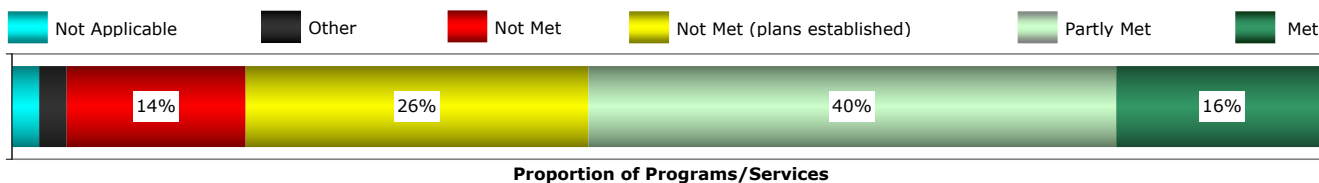
- a) concordance with local agreements developed within and across agencies; and
- b) concordance with evidencebased clinical guidelines.



Question 5: Clinical care protocols, pathways, and decision support tools that demonstrate continuity of care and the provision of proactive and ongoing support (meeting the criteria listed below, in full) have been developed (or endorsed).

Criteria: These care protocols, pathways and decision support tools demonstrate:

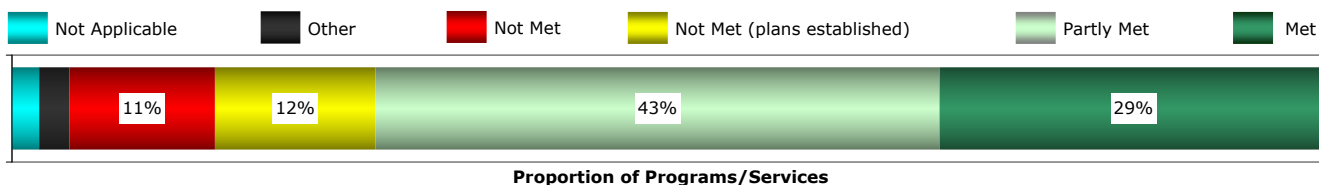
- a) concordance with local agreements developed within and across agencies;
- b) systems for routine monitoring of progress and review of goals;
- c) systems for proactive recall of consumers not currently receiving active care; and
- d) simple systems for consumer re-entry and crisis support.



Question 6: Health behaviour change support (meeting the criteria listed below, in full) is provided, as an element of self-management support.

Criteria: This health behaviour change support:

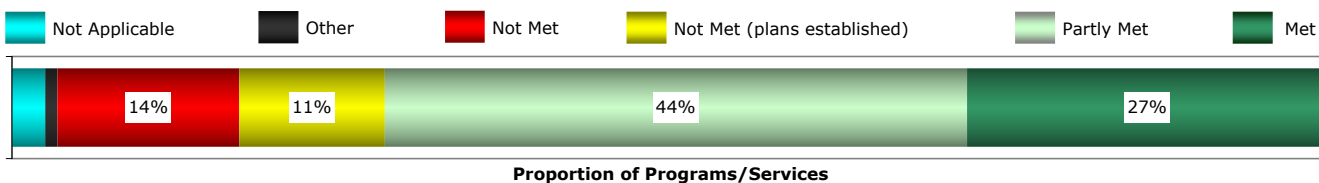
- a) demonstrates concordance with local agreements developed within and across agencies;
- b) is individualised to meet the needs, circumstances, and capabilities of individual consumers;
- c) aims to strengthen consumer knowledge, skills, self-efficacy, motivation, and resources; and
- d) is provided by appropriately trained clinicians.



Question 7: A formalised quality improvement system (meeting the criteria listed below, in full) is in place.

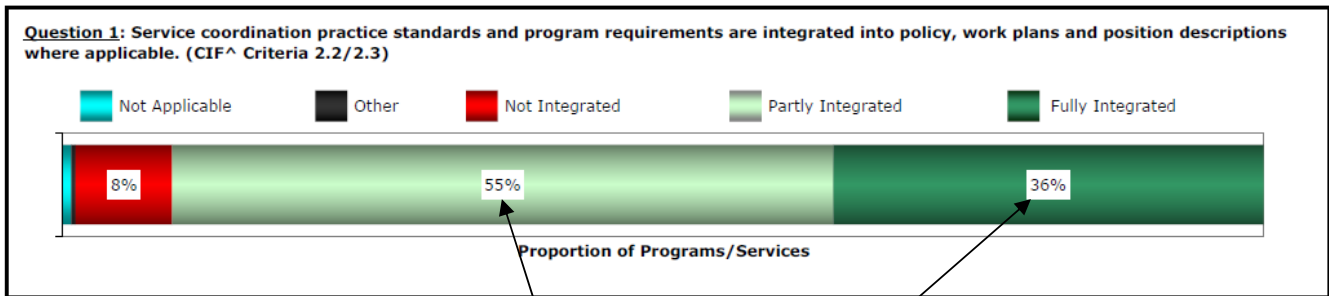
Criteria: This quality improvement system:

- a) has chronic disease management as a priority focus;
- b) includes intra- and inter-agency elements;
- c) represents the full range of stakeholders (including consumers);
- d) is supported by leadership and mechanisms within the organisation to effectively implement agreed improvement initiatives;
- e) uses relevant data to set priorities;
- f) measures performance; and
- g) evaluates outcomes.



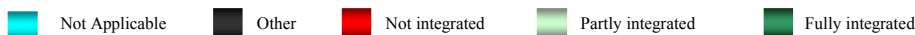
A Guide to Interpreting the Statewide Service Coordination & Integrated Chronic Disease Management Survey 2009

Interpretation Guide Sample (Part A)



The **numbers** represent the proportion of programs/services

The **colours** represent the level of integration



Suggested wording for interpretation

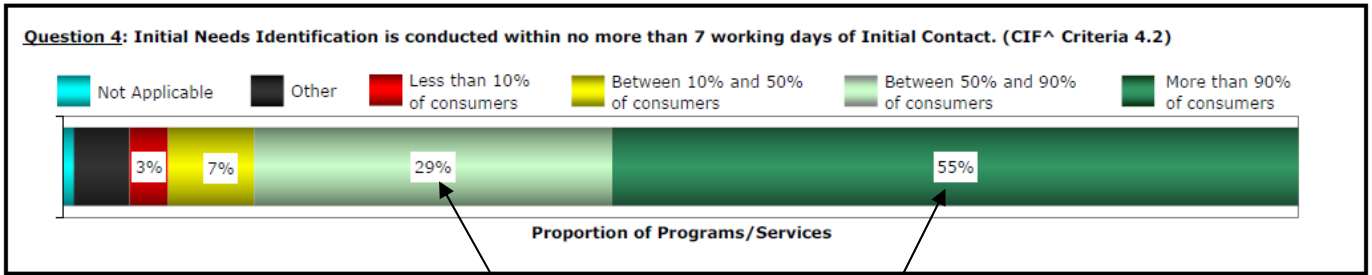
PCP member agencies participated in a Statewide Service Coordination and Integrated Chronic Disease Management (ICDM) Survey as part of the Primary Care Partnership (PCP) annual reporting requirements for the Department of Health. Agencies collected the data by auditing up to 30 consumer files, a week snapshot to record practice or a combination of methods.

230 agencies across Victoria responded to the Service Coordination and ICDM Survey (Part A) which included 773 programs/services (provided by agencies, across one or more locations and in association with one or more PCPs).

Suggested wording for interpretation:

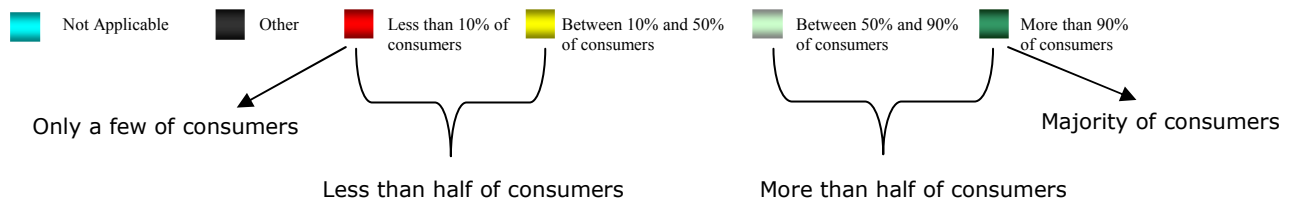
- In 36% of services, service coordination practice standards and program requirements are *fully* integrated into policy, work plans and position descriptions where applicable.
- In 55% of services, service coordination practice standards and program requirements are *partly* integrated into policy, work plans and position descriptions where applicable.
- In 8% of services, service coordination practice standards and program requirements are *not* integrated into policy, work plans and position descriptions where applicable.

Interpretation Guide Sample (Part A)



The **numbers** represent the proportion of programs/services

The **colours** represent the proportion of consumer files audited / recorded during a weeks snapshot



Suggested wording for interpretation

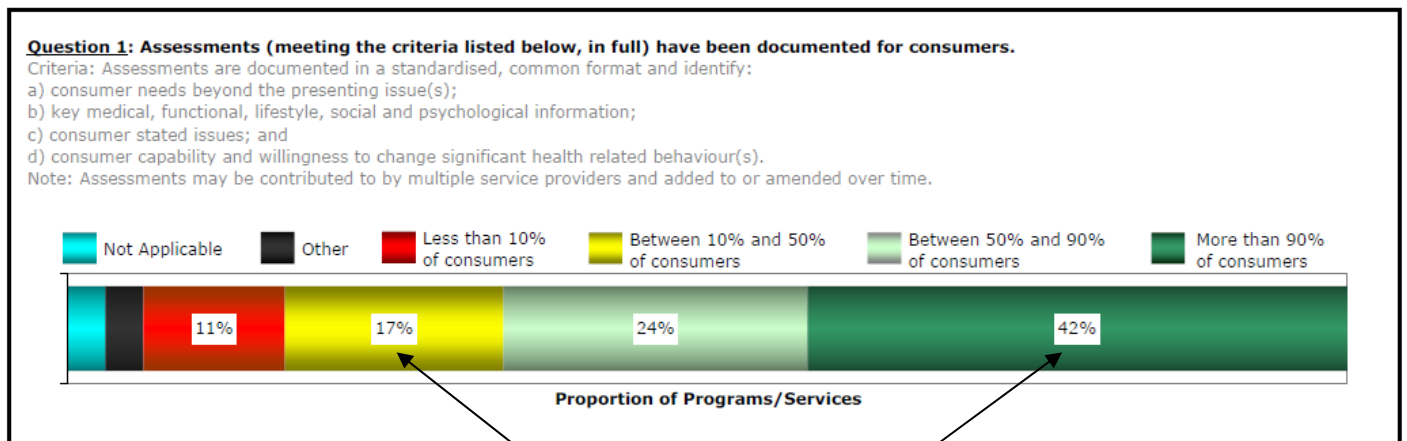
PCP member agencies participated in a Statewide Service Coordination and Integrated Chronic Disease Management (ICDM) Survey as part of the Primary Care Partnership (PCP) annual reporting requirements for the Department of Health. Agencies collected the data by auditing up to 30 consumer files, a week snapshot to record practice or a combination of methods.

230 agencies across Victoria responded to the Service Coordination Survey and ICDM (Part A) which included 773 programs/services (provided by agencies, across one or more locations and in association with one or more PCPs).

Consistent use of the same sentence structure will assist in communicating the survey results. Example of a structure is starting with the % of services, proportion of consumers (eg resulting from audits/snapshots) and then the question being answered. Please see below for examples:

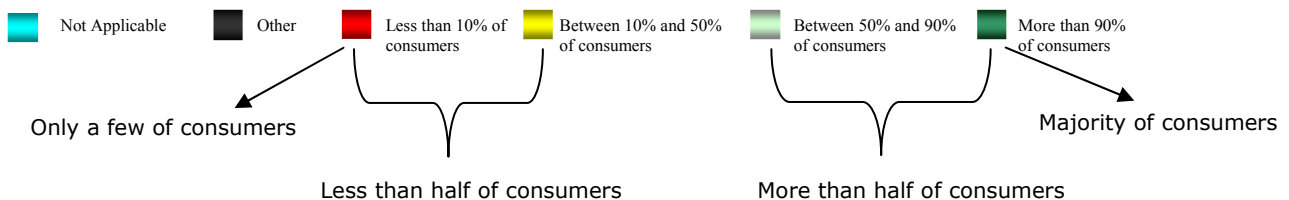
- In 55% of services the majority of the consumers (>90%) had an *Initial Needs Identification* conducted within no more than 7 working days of Initial Contact.
- In 84% of services more than half of the consumers had an *Initial Needs Identification* conducted within no more than 7 working days of Initial Contact.
(29% + 55% = 84%)
- In 10% of services less than half of the consumers had an *Initial Needs Identification* conducted within no more than 7 working days of Initial Contact.
(3% and 7% = 10%).
- In 3% of services only a few consumers (<10%) had an *Initial Needs Identification* conducted within no more than 7 working days of Initial Contact.

Interpretation Guide Sample (Part B)



The **numbers** represent the proportion of programs/services

The **colours** represent the proportion of consumer files audited / recorded during a weeks snapshot



Suggested wording for interpretation

PCP member agencies participated in a Statewide Service Coordination & Integrated Chronic Disease Management (ICDM) Survey as part of the Primary Care Partnership (PCP) annual reporting requirements for the Department of Health. Agencies collected the data by auditing up to 30 consumer files, a week snapshot to record practice or a combination of methods.

137 agencies across Victoria responded to the Service Coordination and ICDM (Part B) which included 436 programs/services (provided by agencies, across one or more locations and in association with one or more PCPs).

Consistent use of the same sentence structure will assist in communicating the survey results. Example of a structure is starting with the % of services, proportion of consumers (eg resulting from audits/snapshots) and then the question being answered. Please see below for examples:

- In 42% of services the majority of the consumers (>90%) had an assessment documented that met the listed criteria.
- In 68% of services more than half of the consumers had an assessment documented that met the listed criteria.
(24% + 42% = 66%).
- In 28% of services less than half of the consumers had an assessment documented that met the listed criteria.
(11% + 17% = 28%).
- In 11% of services only a few consumers (< 10%) had an assessment documented that met the listed criteria.