Assessment of Chronic Illness Care

Summary report

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Background

The Southern Grampians Glenelg Primary Care Partnership 2013-2017 strategic plan highlights a commitment to a responsive service system, focussing on enhancing care coordination within the region and ensuring consumers are at the centre of service delivery. We have a responsibility to ensure that consumers with chronic and complex needs have a streamlined and coordinated approach to their care, and undertaking the Assessment of Chronic Illness Care with our member agencies is a comprehensive way of assessing our current performance and planning for improvement activities. The Assessment of Chronic Illness Care is a survey strongly aligned with the Wagner Improving Chronic Care Model and assesses the six essential elements of high quality chronic disease care:

- Community
- The health system
- Self-management support
- Delivery service system design
- Decision support
- Clinical information systems

The ACIC survey addresses these elements for improving chronic illness care at the consumer, community and organisation level.

Participating in the ACIC survey gives organisations the opportunity to:

- Measure how chronic illness care is practiced or progressed by their agency using evidence-based standards
- Benchmark their own performance for future years and with similar organisations
- Identify areas of improvement for chronic illness care within their organisation and across the Southern Grampians Glenelg Catchment
- Provide evidence towards meeting accreditation standards (in particular NS&QHS, QIC Standard (6th Edition) and Community Care Common Standards)
- Educate and involve staff in Chronic Illness Care principles
- And ultimately, improve the consumer experience and outcomes.

ACIC Overview

Objective:
To undertake an evidence-based continuous improvement approach to enhancing chronic illness care in our Southern Grampians and Glenelg communities.

Consultation/Engagement Process:
Southern Grampians Glenelg Primary Care partnership invited 10 primary health organisations in our region to participate in the Assessment of Chronic Illness Care survey for 2014. Following the initial invitation letter to participate from our Executive Officer, organisations were asked to contact the project officer responsible for completing the ACIC to discuss their preferred method of completion. During this initial contact with each agency, the project officer highlighted the key aspects of the survey, and offered to facilitate the completion of the survey with them and their teams. SGGPCP felt that completion of the surveys with the project officer present would allow for better consistency in interpretation of questions and give the PCP greater insight into each individual organisation's status and needs. 8 organisations within the catchment agreed to participate. A copy of the ACIC version 3.5 was provided to all agencies in advance and individual 1.5 hour meeting times were arranged with each organisation.

Issues Management & Risk Analysis:
Prior to undertaking this project, SGGPCP recognised that although very comprehensive, the length and complexity of the ACIC survey may be confronting for some organisations and participation rates may be adversely affected. As such, SGGPCP chose the approach of formal invitation to participate from EO to primary care managers, followed by providing the time and resources of the project officer to facilitate each organisation's participation. SGGPCP decided against sending the survey out alone without explanation for fear of creating barriers for completion.

Given the ACIC is a self-evaluation, the questions are open to interpretation and can be difficult to quantify responses at times. Having facilitated sessions enabled organisations the opportunity to discuss examples of their work and rationales for their scoring, opening up conversations and dialogue that perhaps would go unsaid if organisations were simply completing the surveys alone.

The project officer regularly consulted the PCP guidelines for completing the ACIC, referred to the 'tips' sheet provided by South Coast PCP and was supported by the ICDM statewide group.

Methodology

All organisations received a copy of the ACIC survey prior to the facilitated session, were encouraged to familiarise themselves with the content and collaborate with their teams to gather the relevant information. Each organisation participated in a 1.5 hour session with the PCP project officer where the survey was completed. Some organisations had the manager representing and responding on behalf of the team, others were combined manager/clinician meetings where each survey question was answered collaboratively. Upon completion of the formal ACIC survey questions, the project officer asked for some further information including:

- What is currently working well in chronic illness care for your organisation?
- What is currently not working so well in chronic illness care for your organisation?
- Do you have any ideas or suggestions for improving chronic illness care at your organisation?

These questions gave each organisation the opportunity to summarise their strengths and areas for improvement, whilst also enabling the project officer to identify common themes or elements between organisations.

The PCP project officer completed the scoring for each organisation and will communicate these results individually as part of each organisation's report and the PCP catchment improvement plan.

Results

The ACIC interpretation guide is as follows:

Between 0-2 = limited support for chronic illness care
Between 3-5 = basic support for chronic illness care
Between 6-8 = reasonably good support for chronic illness care
Between 9-11 = fully developed support for chronic illness care

Southern Grampians Glenelg Primary Care Partnership catchment scored an overall score of 8.71, indicating reasonably good support for chronic illness care across the region. Areas of strength for our region include delivery system design and integration, both scoring in the fully developed support range. The areas of organisation of healthcare, community linkages, self-management, decision support and clinical information systems were scored slightly lower with reasonably good support for chronic illness care. These high scores are reflective of the comprehensive work undertaken by organisations in our region around improving systems of care, care planning, team work and collaborating with our partners. Upcoming changes to clinical information systems across the region will help continue to improve our systems scoring, while greater effective engagement with consumers and their self-management is a high priority for many organisations moving forward.

ACIC Domain	Southern Grampians Glenelg Average
Organisation of healthcare system	7.33
Community Linkages	8.54
Self-management support	8.75
Decision support	8.56
Delivery system design	9.95
Clinical information systems	8.74
Integration	9.09
TOTAL	8.71 Reasonably good support

Analysis

Along with completing the ACIC, participating organisations were also provided the opportunity to provide a qualitative response considering what was currently working well for chronic illness care in their organisation, the challenges of chronic illness care for their organisation and any ideas/suggestions for improvement of chronic illness care for their organisation or the region. These responses are aggregated and summarised below:

Strengths of chronic illness care for your organisation	Challenges of chronic illness care for your organisation	Ideas/suggestions for improvement of chronic illness care
Being a smaller community, people know where to come for help Committed and passionate clinicians Integrated model of care coordination Colocation with other services Recent changes in structure and alignment with improved complex care practice Service coordination through electronic care planning Excellent communication between staff Increase in participation of chronic illness programs Having a formalised plan for clients and evaluation after each program Teamwork Good systems in place, established feedback loops	Access to specialty services in remote areas Maintaining consistency with visiting services Reaching 'at risk' groups for chronic illness care Care models to reflect the amount of time spent with really complex clients Sharing care plans with external organisations IT systems not linking up between sectors Reform in the aged care sector Maintaining the cycle of care with changing clinicians Engaging the ageing community into programs Engaging GPs into the cycle of care Staff consistency of adhering to policies and procedures	Subregional networks with key clinicians for professional development and sharing ideas Improving relationships with GP services, marketing of services Engaging other community members, e.g. those not engaged with the service Improving partnerships in the region IT support for transition to TRAK community Need more focus on health promotion and prevention of chronic illness Recognising staff efforts with the complex clients more readily Health promotion training for staff Patient empowerment training Transport options for participating in programs Ongoing evaluation/auditing of systems to improve outcomes

Southern Grampians Glenelg Chronic Illness Improvement Action Plan 2014

Improvement Area	**Description of problem**	**Steps/ideas for improvement** *How will you do it?*	**Resources** *Who is needed to help implement the strategy/project*	**Timeframe** *When will you do it?*	**Outcome** *How will you know you met your goals?*	**Progress/comments**
Health organisation	The weakest of the domains in ACIC scoring for SGG, the organisation of healthcare systems could improve with greater consistency in leadership and accountability for excellence in chronic illness care. The existence of a 'regional' health plan focussing on chronic disease was not consistent.	Support organisations to participate in the BSW Enhancing Care coordination project, encouraging leadership and collaboration for system integration at the regional level. Encourage organisations to collect key performance indicators relating to best practice chronic illness care	PCP Project officer, BSW ECC project team, participating organisations, Community Health Indicators Project	2014-2016	Good participation rate of SGGPCP member agencies in BSW Enhancing Care Coordination project. Greater leadership support for Chronic illness care. Adherence to the regional KPIs for Enhancing Care Coordination, contributing to a 'regional' health plan	
Community Linkages	Reaching 'at risk' groups was	Invite Bank of Ideas presenter Peter	SGGPCP	November 2014	The conversation among member	

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	a challenge cited by most organisations in the region	Kenyon to speak at SGGPCP AGM and other community events to discuss ideas around community development and active community participation models			agencies around building ideas for engaging groups 'at risk' of chronic illness will have begun	
	Service Coordination for Chronic Mental Illness Care in Southern Grampians shire has been raised in several forums during this year (ACIC, Local Voices Shaping Local Services, Mental Health forum)	Establish a partnership with local service providers in the region to improve the journey for clients with chronic mental illness	SGGPCP project officer, WDHS, SWH, MIF, consumers, private providers	2015	Established working group with goals towards identifying and addressing issues of concern around MH service coordination for Southern Grampians Shire	
Self-management support	Varying levels of self-management support across	Investigate patient empowerment training programs, target audience	PCP project officer	2016 *(*note this is a lower priority action for SGGPCP at*	Patient empowerment workshop completed with	

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	the region, some organisations have trained and credentialed educators while others are using more ad hoc approaches	and potential funding options		*present with resources focussed on health organisation and community linkages for 2015)*	minimum of 10 participants across the catchment	
Decision Support	Staff knowledge of population-based management for chronic illness is variable across the region	Provide region wide staff training on core evidence-based health promotion principles to improve clinician knowledge. Training should have basic element of health promotion activities and evaluation	Health Promotion experts, PCP project officer to facilitate	Planning completed by July 2015, aiming to have a workshop late 2015	Increased clinician knowledge on population-based management for chronic illness care and how this links to traditional management	
Delivery system design	Consistent access to specialist services is variable across the region	Support use of technology (e.g. Videoconferencing), encourage sharing of resources where appropriate	SWARH, IT support at each organisation **note SGGPCP has limited capacity to actively*	Ongoing support of telehealth practice within the region	Increased uptake of telehealth consultations in the region	

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			participate in this process however will keep abreast of progress and liaise with agencies as needed			
	There is limited capacity across the region for inclusion of consumer participation in the design phase of systems	Through the BSW Enhancing Care Coordination project, the region will better understand the power of the consumer story in enabling system development and change.	BSW ECC project working group, participating agencies	2014-2016	Greater consumer engagement in design of chronic illness systems (e.g. program design, delivery, models) etc.	
Clinical Information systems	Inconsistency of clinical information systems across the region	Support organisations with the transition to TRAK community in 2015.	SWARH, IT support at each organisation. **note SGGPCP has limited capacity to actively participate in this process however*	Throughout 2015 as the TRAK community program is rolled out to organisations	Clinicians will feel confident and comfortable using the new TRAK community system as primary clinical information system	

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			will keep abreast of progress and liaise with agencies as needed			

Conclusion

Undertaking the inaugural Assessment of Chronic Illness Care Survey for Southern Grampians Glenelg Primary Care Partnership has highlighted that while we generally have well developed chronic illness care for the region, there continues to be areas of improvement which will further improve the client's experience of the system. The development of the Chronic Illness Improvement Action Plan will further contribute to SGGPCP's commitment to a responsive service system, ensuring that consumers with chronic and complex needs have a streamlined and coordinated approach to their care, and our member agencies build their capacity in providing evidence-based chronic illness care.

Thank you to all participating organisations who are congratulated for their ongoing commitment to chronic illness care and their dedication to supporting their communities.

Assessment of Chronic Illness Care (ACIC) and related quality standards

Organisation of the Health Care Delivery System

NS&QHS	Common Care Standards	EQuIPNational	QIC Standards
1. Governance for Safety and Quality in Health Service Organisation	1.1 Corporate governance 1.5 Continuous improvement	15. Corporate systems and safety	1.1 Governance 1.2 Management systems 1.9 Safety and Quality integration

Community Linkages

NS&QHS	Common Care Standards	EQuIPNational	QIC Standards
2. Partnering with consumers	1.4 Community Understanding and Engagement 2.5 Service User Referral	11. Service Delivery 15. Corporate systems and safety	3.4 Community and professional capacity building

Self-Management Support

NS&QHS	Common Care Standards	EQuIPNational	QIC Standards
1. Governance for Safety and Quality in Health Service Organisation 2. Partnering with Consumers	2.3 Care plan development and delivery 2.4 Service user reassessment	11. Service Delivery	2.2 Focusing on positive outcomes 2.4 Confirming consumer rights

Decision Support

NS&QHS	Common Care Standards	EQuIPNational	QIC Standards
1. Governance for Safety and Quality in Health Service Organisation 2. Partnering with consumers 6. Clinical handover	1.2 Regulatory compliance 3.1 Information provision 3.4 Advocacy	11.1 Service delivery	2.4 Confirming consumer rights 2.5 Coordinating services and programs

Delivery System Design

NS&QHS	Common Care Standards	EQuIPNational	QIC Standards
1. Governance for Safety and Quality in Health Service Organisation 2. Partnering with consumers 6. Clinical handover	1.3 Information management systems 2.3 Care plan development and delivery 2.5 Service user referral	12. Provision of care 14. Infomration management 15. Corporate systems and safety	2.1 Assessing and planning 2.5 Coordinating services and programs 3.1 Service agreements and partnerships

Clinical Information Systems

NS&QHS	Common Care Standards	EQuIPNational	QIC Standards
1. Governance for Safety and Quality in Health Service Organisation 6. Clinical handover	1.3 Information management systems 2.3 Care plan development and delivery	14. Information management	2.4 Confirming consumer rights 2.5 Coordinating services and programs

Compiled by Claire Nailon (Project Officer) August 2014