

# Primary Care Partnerships

Human  
Services



Peoplefirst

## **Integrated Disease Management:** Interim Policy Directions and Guidelines

**Integrated Disease  
Management:**  
Interim Policy Directions  
and Guidelines

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**January 2001**

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# Foreword

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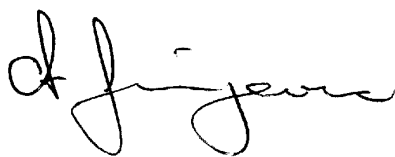
**T**he **Primary Care Partnerships** strategy aims to enable community-based primary care services to deliver better coordinated services and achieve high quality health and well-being outcomes for consumers. People often present in the hospital system with established disease that could have been better managed in the primary care service system—through early intervention, appropriate service identification and disease management support.

Four Primary Care Partnerships will be funded to develop, implement and evaluate disease specific integrated disease management Pilot Projects. This document, the *Integrated Disease Management: Interim Policy Directions and Guidelines* has been prepared to assist these partnerships. The document will also provide all Primary Care Partnerships with the tools for integrated disease management, which may assist them with their service coordination and planning strategies.

An integrated disease management approach incorporates all the components of the Primary Care Partnerships strategy—in particular, the service coordination initiatives, the health promotion strategy and General Practitioner (GP) engagement. Most importantly, integrated disease management has a strong emphasis on consumer and carer participation in the development and decision making processes, in order to provide successful and appropriate consumer outcomes.

These Policy Directions and Guidelines champion an integrated disease management approach, based on the relevant literature and related models of service delivery, both in Australia and overseas. The *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector* is an accompanying resource that will support integrated disease management projects by Primary Care Partnerships. This literature review documents in detail the service models, interventions and mix of services that have been demonstrated to be effective in reducing the impact of disease and disability on the lives of people with a chronic disease or condition.

Community-based integrated disease management projects have the potential to improve population health, reduce the burden of disease and achieve reductions in avoidable hospitalisations. We encourage Primary Care Partnerships to use the *Integrated Disease Management: Interim Policy Directions and Guidelines* in the development of their Pilot Projects and/or community health plans.



Angela Jurjevic  
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# The Consultation Process

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The Community Health Unit of the Aged, Community and Mental Health Division (ACMH) drafted these policy directions and guidelines with input from Department of Human Services Regions, the Health Development Section of the Public Health Division, the Coordinated and Home Care Unit of ACMH and the Commonwealth Department of Health and Aged Care. They are being released to the primary care sector as interim guidelines to allow for a period of 'action learning' in the field—by the funded Integrated Disease Management Pilot Projects in particular.

It is proposed that this interim document be reviewed in December 2001. The consultation process will involve active involvement with the funded Primary Care Partnerships (PCPs), and seek feedback from the field, in both written form and via dialogue through forums and the like. Active engagement with the following relevant groups and agencies will be pursued:

- All Primary Care Partnerships.
- Consumer and carer organisations.
- Relevant peak bodies and statewide health disease/condition specific organisations.
- Statewide advisory committees.
- Academic Institutions.

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# Executive Summary

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## The Victorian Burden of Disease Study

The Victorian Burden of Disease Study highlights six National Health Priority Health Areas that account for 68 per cent of the total burden of disease and injury in Victoria. The six areas are:

1. Cardiovascular disease
2. Cancer
3. Mental health
4. Injury
5. Diabetes
6. Asthma

Cardiovascular diseases (ischaemic heart disease and stroke), chronic respiratory diseases (obstructive pulmonary disease and asthma) mental health (depression) and diabetes are all in the top ten leading causes of disease burden. This study highlights the need to consider better ways to tackle these diseases/conditions at the earliest possible stage.

## Integrated Disease Management (IDM)

Integrated disease management is a relatively new approach, and is an important component of the Primary Care Partnership strategy in Victoria. It is a program that will enhance local efforts to reduce the burden of disease and improve the health and well-being of catchment populations. Appropriate integrated disease management reduces the burden of disease through a holistic approach. It encompasses of the continuum of care—from prevention through to treatment, management and maintenance. Integrated disease management is consumer focused and underpinned by evidence based on appropriate research.

While the emphasis of integrated disease management projects is on populations with, or at risk of the disease/condition, a comprehensive integrated disease management project will also develop and implement

health promotion and primary prevention strategies to prevent disease onset. Integrated disease management projects develop strategies for a population approach, as well as individual care planning. Care planning includes interventions to increase consumer self-management and reduce the requirement for medical intervention. This is positive for both the individual—in reducing their physical, psychosocial and economic burden—and the health system, in reducing preventable hospital admissions and unnecessary costs.

Most studies of integrated disease management programs have tended to evaluate specific elements of care, rather than the overall approach. However, key components of successful chronic disease programs have been identified in the literature. These are:

- The use of explicit plans and protocols.
- Multidisciplinary teams and reorganisation of practice systems.
- Systematic attention to the information and behavioural change needs of consumers, with improved consumer self-management support.
- Ready access to necessary expertise.
- Supportive information systems.

## Pilot Projects

Four Integrated Disease Management Pilot Projects are being established as part of a major reform of the primary care sector in Victoria, known as the Primary Care Partnership strategy. The Pilot Projects will use best practice models of disease management for people with, or at risk of, chronic diseases/conditions. Their aim is to determine which strategies or models are effective in improving health and well-being outcomes, and to reduce hospital admissions for people with certain diseases/conditions.

While the present document sets out policy directions and guidance for the Integrated Disease Management Pilot Projects, it is also designed to guide the development of integrated disease management projects in any PCP or

organisation. This document provides a brief overview of the characteristics of integrated disease management; outlines the key components of successful integrated disease management projects described in the literature; and provides examples of service delivery models that have been implemented elsewhere in Australia and overseas. The processes and tools for the development and implementation of integrated disease management projects are also discussed.

As part of its responsibilities for the National Health Priority Areas Initiative and statewide population health planning, the Department of Human Services will establish broad based advisory groups for selected diseases/conditions. These will comprise clinical and public health experts, statewide non-government organisations (NGOs) and other key stakeholders. It is envisioned these groups will provide further specialist input to the development of integrated disease management projects. They will facilitate pertinent links to NGOs, professional groups and other relevant initiatives. These groups will also provide advice toward the development of information for all PCPs around data, guidelines and strategy development for the particular disease/condition.

In addition, the Department will ensure that the Integrated Disease Management Pilot Projects are carefully monitored and evaluated to determine whether the approaches taken produce acceptable outcomes and represent value for money, and that the learnings from the projects can be utilised by any future disease management projects.

Overseas work strongly suggests that, on average, people with common chronic diseases/conditions have a much better quality of life, experience less complications and co-morbidities and reduce their overall consumption of health care resources (particularly inpatient care) if they participate in a well structured IDM project tailored to their needs.

# Chapter 1 Introduction

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## 1.1 Purpose and Context

Integrated disease management (IDM) is an important component of the Primary Care Partnership (PCP) strategy in Victoria. It is a program that will enhance efforts to reduce the burden of disease and improve the health and well-being of catchment populations. Appropriate IDM planning that aims to reduce the burden of disease should be holistic, encompass the continuum of care from prevention through to treatment, management and maintenance, and be underpinned by evidence based on appropriate research. It should also be based on a population health approach.

This document examines some important theoretical and practical issues to assist the implementation of effective programs for people with, or at risk of, chronic disease. While it has been developed specifically as a resource for those PCPs undertaking the IDM Pilot Projects (see Chapter 5), it will be of assistance to all PCPs or organisations in improving the management of disease. *The Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector*<sup>1</sup> complements this document.

Through the National Health and Development Fund, the Commonwealth Government has provided funding for the IDM Pilot Projects to utilise best practice disease management approaches and coordinate a mix of interventions and services for people with, or at risk of, chronic diseases/conditions. The Pilot Projects will aim to determine which strategies are effective in improving health outcomes and reducing hospital admissions in the Victorian context.

IDM Pilot Projects will undertake the developmental work on effective approaches, systems and tools for IDM projects. Evaluation of the IDM projects will take place throughout the course of the Pilot Projects, with a comprehensive final evaluation at the end of the pilot period. Results of the Pilot Projects will inform the further development of IDM projects in Victorian primary care services.

The project steering committee and Departmental disease specific advisory groups (see Sections 5.3.2 and 5.3.3) will further inform the development of information for all PCPs around data, guidelines and strategy development for particular diseases/conditions. Added to the learnings from the Pilot Projects, this should assist other PCPs to improve their management of disease.

In concert with the IDM Pilot Projects being undertaken in Victoria, the Commonwealth Government has introduced a number of other initiatives related to the management of chronic disease. One of these is the Sharing Health Care (SHC) initiative, which is part of the enhanced primary care package for older Australians and those with chronic and complex diseases/conditions. The initiative aims to improve health outcomes and quality of life for people with chronic disease, with specific emphasis on promoting effective self-management strategies. These initiatives will greatly enhance and complement the IDM projects in the Victorian primary health sector. Coordinated Care Trials (CCTs) are also occurring in Victoria and their relationship to PCPs is explored in Appendix 1.

## 1.2 The Human and Economic Burden of Disease

The costs of chronic disease may be considered in a variety of ways. There are economic costs to individuals, organisations, governments and taxpayers; costs that arise from the use of health care services, equipment and pharmaceuticals; and costs that arise from a person's inability to work. More importantly, there are costs to people's health and well-being, including pain, emotional distress, reduced quality of life for both sufferers and their families, and reduced ability to function independently. Some of these are often overlooked.

As one example, the total financial cost of asthma in Australia has been estimated to range between \$585 and \$720 million each year. Depending on the cost estimate, between 45 per cent and 55 per cent of the total is due to lost productivity, with the remainder due to medical costs.

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<sup>1</sup> Aged, Community and Mental Health, 2000, *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector*, Victorian Department of Human Services.

With regard to medical-related costs, the total value of asthma medication and appliances used for treatment of the disease in 1991 was calculated at over \$120 million. The total cost to the community of nearly 3.8 million GP and specialist consultations for people with asthma in 1991 was estimated at \$98 million. Finally, the in 1991 annual cost of hospitalising people with asthma was conservatively estimated at \$58 million.<sup>2</sup>

It is more difficult to calculate the human costs in terms of quality of life and disease burden. However, the Victorian Burden of Disease Study provides a way of quantifying the impact of disease, injuries and risk factors on people's lives, and identifies areas in which additional health gains can be made. The Study's *Morbidity Report*<sup>3</sup> calculates the impact of various diseases/conditions or 'burden' in terms of Disability Adjusted Life Years (DALYs), which comprise Years of Life Lost (YLL—a measure of premature mortality) plus Years Lost Due to Disability (YLD—a measure of premature morbidity).

The Victorian Burden of Disease Study highlights six National Health Priority Health Areas that account for 68 per cent of the total burden of disease and injury in Victoria. The six areas are:

7. Cardiovascular disease
8. Cancer
9. Mental health
10. Injury
11. Diabetes
12. Asthma

These areas comprise 79 per cent of the YLL and 57 per cent of the YLD. In terms of specific diseases, ischemic heart disease and stroke are the leading diseases, and collectively contribute to over 17 per cent of the disease burden in Victoria. Chronic obstructive pulmonary disease and lung cancer (both closely linked to tobacco smoking) are the third and fifth leading cause of disease burden.

Diabetes is the seventh leading cause of disease burden in Victoria. Inclusion of the attributable burden of cardiovascular disease due to diabetes elevates diabetes to the third leading cause of burden in men, and the fourth leading cause of burden in women.

Asthma is identified as the leading cause of disease burden in children in 1996, accounting for about a fifth of total disease burden in both boys and girls. Asthma is ranked ninth in the top twenty causes of overall female burden and fourteenth in the top twenty causes of overall male burden. Asthma is a disease that may not only cause premature mortality, but can also cause a significant amount of disability in those people living with the condition. In terms of non—fatal burden measured in YLDs, asthma is ranked fifth in the top twenty causes of disability burden in males, and fourth for females. The Victorian Burden of Disease study has recently estimated burden of disease data down to local government areas (LGAs). This information demonstrates the varied distribution of burden across Victoria. LGAs with the best health status (with a burden of 107 DALYs per 1000 population) compare to municipalities with the worst health status (with a burden of 180 DALYs per 1000 population). IDM projects will be able to use this information to identify population groups to target and estimate the burden of disease for their catchment.

The contribution of risk factors and disease symptoms/conditions (such as tobacco, alcohol, obesity, hypertension, high blood cholesterol, poor nutrition and physical inactivity) to the overall burden of disease is also highlighted in the Victorian Burden of Disease study<sup>4</sup>. It is therefore important to emphasise their consideration in preventative strategies, to be incorporated by integrated disease management projects. For example, tobacco is the risk factor associated with the greatest health problems, and is responsible for 16.7 per cent of the mortality burden in men and 9.3 per cent in women. More than half this

2 National Asthma Campaign, 1992, *Report on the Cost of Asthma in Australia*.

3 Public Health Division, 1999, *Victorian Burden of Disease Study: Morbidity*, Victorian Government Department of Human Services, Melbourne.

4 Ibid.

burden is tobacco-related, most of which is cancer mortality<sup>5</sup>. Chronic airway disease is the cause of a further quarter of this burden<sup>6</sup>.

IDM projects have the capacity to reduce this human and economic burden of disease. The key benefit of IDM projects is that they encompass the entire care continuum that may lead to disease burden. While the emphasis of IDM projects is on populations with, or at risk of, the disease/condition, a comprehensive IDM project will also develop and implement health promotion and primary prevention strategies to address risk factors and prevent disease onset. IDM in the context of the social model of health, is outlined later in this chapter.

IDM projects develop strategies for a population approach as well as individual care planning. Care planning includes interventions to increase consumer self-management and reduce the requirement for medical intervention. This is positive for both the individual—in reducing their physical, psychosocial and economic burden—and the health system, in reducing health care burden.

### 1.3 What is 'Integrated Disease Management'?

Integrated disease management is a comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease/condition. It involves several stages:

- Identifying populations with, or at risk of, the disease/condition.
- Implementing planned clinical and non-clinical interventions, based on evidence of 'best practice' and care pathways.
- Measuring consumer outcomes once interventions are put into effect.

The characteristics of IDM are described in detail in Section 2.1.

Through adopting IDM practices, health care and support services can take a more comprehensive and proactive approach to managing a range of factors related to chronic

disease, as well as attending to broader issues of prevention through health promotion, early intervention and secondary prevention.

A key feature of an IDM approach is that health care workers and other professionals work together in a coordinated and cooperative way to achieve the best health outcomes for individuals. There is an emphasis on empowering consumers (and their carers) to manage their disease/condition appropriately, and supporting them to do so in the community.

Although some of these concepts are already part of health care and support services in Victoria, there is a need to ensure that effective IDM practice becomes a more integral part of the health care system, and that care is better coordinated across the service continuum. PCPs, because of their broad base and focus on system improvement, provide an ideal structure for this.

Effective IDM projects can result in better outcomes and a better quality of life for consumers. At a broader level, community-based IDM projects aim to improve population health, reduce the burden of disease and achieve reductions in avoidable hospitalisations, particularly among people with chronic diseases/conditions.

### 1.4 The Social Model of Health and Integrated Disease Management

A social model of health is a conceptual framework for conceptualising health. Within this framework, improvements in health and well-being are achieved by directing efforts towards addressing the social and environmental determinants of health, in tandem with biological and medical factors<sup>7</sup>. It is therefore important to have an understanding of health and disease within the personal, social, environmental and cultural context—

5 Public Health Division, 1999 *Victorian Burden of Disease Study: Mortality*, Victorian Government Department of Human Services, Melbourne.

6 Public Health Division, 1999, *Victorian Burden of Disease Study: Morbidity*, Victorian Government Department of Human Services, Melbourne.

7 Aged, Community and Mental Health Division, 1998, *A Stronger Primary Health and Community Support System: Policy Directions*, Victorian Department of Human Services, Melbourne.

specific to the person or community whose health is being considered. It is not possible to decide how best to support the improvement of health without understanding this context.

Effective health care requires the coordinated effort of a range of providers to assist consumers to achieve optimal health outcomes. This is particularly so where consumers' needs are complex or access is a key barrier to appropriate care. For integrated disease management projects to operate within the context of a social model of health, it is crucial that they target vulnerable groups effectively. Groups such as Aboriginal and Torres Strait Islander people, people of low socio-economic status, and rural and remote populations, have all been shown to have a higher incidence of chronic disease<sup>8</sup>. Other groups, such as those from culturally and linguistically diverse backgrounds (CALD), and those with physical, intellectual and psychiatric disabilities, should also be considered as vulnerable groups, especially in terms of access to services and special needs.

The determinants of health that affect a consumer's ability to participate in, or benefit from, an integrated disease management project are also essential to consider when targeting participants and designing and implementing individual IDM plans. The determinants of health are articulated clearly in the *Primary Care Partnerships Draft Health Promotion Guidelines*<sup>9</sup>.

## 1.5 Evidence of the Effectiveness of Integrated Disease Management Approaches

Most studies of disease management have tended to evaluate interventions or specific elements of the overall care of the consumer—rather than the total IDM approach. However, the literature does provide some useful evidence in the form of randomised intervention trials. These may include testing drugs or other specific therapies, organising programs of care for a given chronic disease, and efforts to improve the primary care of consumers with chronic disease in western European national health care systems<sup>10</sup>.

Randomised controlled trials in chronic disease have tested complex treatment regimens and achieved major improvements in health outcomes. Two such examples are the Hypertension Detection and Follow-up Program (discussed in detail in Appendix 1), and the Diabetes Control and Complications Trial (1993). Both these trials achieved significant improvements in outcomes, using care models that encompassed critical features of IDM projects. These features included:

- The provision of care in accordance with an explicit plan by multidisciplinary teams.
- Regularly scheduled follow-ups.
- Systematic assessments.
- Attention to the self-management needs of consumers.

The programs demonstrated that the provision of consistent management and support to consumers can result in higher rates of compliance with therapy, higher rates of blood pressure and blood sugar control, and significant reductions in the long-term complications of the diseases<sup>11</sup>.

Overseas work strongly suggests that, on average, people with common chronic diseases/conditions have a much better quality of life, experience less complications and co-morbidities and reduce their overall consumption of health care resources (particularly inpatient care) *if they participate in a well structured IDM project tailored to their needs*.

8 Commonwealth Department of Health and Aged Care, National Health Priority Area Reports at: <http://www.aihw.gov.au/inet/publications/health/>

9 Aged, Community and Mental Health Division, 2000, *Primary Care Partnerships Draft Health Promotion Guidelines*, Victorian Government Department of Human Services, Melbourne.

10 Wagner E.H., Austin B.T., Von Korff, M., 1996, 'Organizing Care for Consumers with Chronic Disease', *The Milbank Quarterly*, Vol. 74, No 4, 1996.

11 Ibid.

## 1.6 Primary Care Partnerships and Integrated Disease Management

In April 2000, the Department of Human Services released the document *Going Forward: Primary Care Partnerships*<sup>12</sup>. This document outlines a strategy to improve the planning and delivery of primary care services. The strategy will support providers working together effectively to achieve improved health and well-being for the Victorian community.

Primary Care Partnerships (PCPs) will work with consumers, their local communities and the Department of Human Services to develop and implement Community Health Plans (CHPs). These plans will identify the priority health needs of the local area, and describe how the providers in the PCP will work with each other and other key stakeholders to respond to these needs. The integrated service system that will result from the evolution of Community Health Plans will provide an ideal environment for the planning and implementation of effective community-based IDM projects.

Community Health Plans will address three key areas of: Partnerships, Service Coordination and Service Planning. Each of these areas includes specific components, which are important for IDM planning.

### Partnerships

Defining how the partnership will work together to implement the Community Health Plan. Partnership strategies will identify governance structures between partner members and the processes for consumer participation, community engagement, general practitioner engagement and linkages with other relevant service providers and statewide health enhancement agencies. All of these strategies are vital for IDM planning.

### Service Coordination

Describing how local systems and infrastructure, such as information management, needs identification and referral will enable services to be better coordinated. The Better Access to Services draft policy framework<sup>13</sup> outlines ways to ensure effective consumer access to a cohesive service system, through the development of processes and practices that facilitate improved identification of needs and coordination of services, including consideration of good practice IDM models and approaches.

Other initiatives that will enhance service coordination include the Information Management project and Local Service Information service strategy. These initiatives are important and relevant to IDM planning for the development of critical pathways, consumer information kits and data collection, information sharing and project evaluation.

### Service Planning

Identifying the population health needs of the community and proposing strategies to address these needs, such as integrated, multi-sectoral health promotion and IDM projects and services. IDM planning should have strong links with catchment needs assessments, priority setting processes and the development of PCP health promotion strategies.

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<sup>12</sup> Aged Community and Mental Health, 2000, *Going Forward: Primary Care Partnerships*, Victorian Department of Human Services.

<sup>13</sup> Aged, Community and Mental Health, 2000, *Better Access to Services: A Draft Policy Framework for Discussion*, Department of Human Services, Victoria.



# Chapter 2 Characteristics and Principles of Integrated Disease Management

In this chapter, we examine the key characteristics and principles underlying effective IDM. For those embarking upon a change in their current model of care, it is important to consider what makes IDM different from traditional treatment approaches, and what notions are significant to the practice of quality IDM.

## 2.1 Characteristics of Integrated Disease Management

IDM can be more easily understood by examining the key characteristics of its approach. Table 1 compares IDM with the traditional approach to disease care. While much disease care practice in Victoria has shifted forward from the traditional approach outlined in this table, the IDM approach demonstrates the optimal in reducing the burden of disease.

**Table 1 IDM Compared to the Traditional Approach to Disease Care**

<b>Integrated Disease Management</b>	<b>Traditional Approach</b>
Systematic, coherent care	Less systematic care
Integrated care, care continuum	Disease episodes
Care focus on whole course of disease	Responding to events
Population, group orientation	Individual
Demand-oriented	Supply-oriented
Active consumer (sick and healthy); consumer management tools (health education, empowerment, self-care)	More passive consumer
Primary care focus + prevention + health promotion	Acute care focus
Multidisciplinary, medical and non-medical, specialists and generalists	Mono-disciplinary, medical
Relatively objective, evidence-based (evidence-based treatment, outcomes assessment, economic evaluation)	Professional judgment
Guidelines, protocols, care paths	Therapeutic freedom
Accountability, Information technology (decision support systems, intelligent information systems)	Relative autonomy
System solutions	Individual solutions
Continuous quality improvement	No systematic continuous quality improvement

Source: modified from a table presented by Kesteloot<sup>14</sup>.

<sup>14</sup> Kesteloot, K, 1999, 'Disease Management: A New Technology in Need of Critical Assessment', *International Journal of Technology Assessment in Health Care*, 15:3, p. 509, Cambridge University Press.

Concepts such as integrated care, active involvement of consumers and a focus on multidisciplinary team care and evidence-based best practice are essential to the planning and implementation of IDM projects. In IDM, care is comprehensive, as well as proactive, rather than reactive, and aims to improve long-term health outcomes and quality of life for consumers with chronic diseases. Appendix 1 outlines examples of different service delivery models and disease management practice.

## 2.2 Key Principles of Integrated Disease Management

By giving consideration to the key principles that underpin IDM, the crucial elements of disease management practice are highlighted and clarified.

Key principles of IDM projects include:

1. Appropriate targeting of population sub-groups of greatest need.
2. Integrated and comprehensive assessment of need, to identify the most appropriate management approach.
3. Coordinated and planned care based on evidence of 'best practice' and care pathways.
4. Flexible levels and approaches to care, which take account of individual needs, as well as a consumer's cultural, linguistic and socio-economic circumstances.
5. Reorganisation of practice systems and multidisciplinary care and support.
6. Empowering consumers and supporting effective self-management for people with disease and/or disability, wherever possible.
7. Social and psychological support for consumers, where appropriate, to complement the medical management of chronic disease.
8. Maximising uptake of IDM projects by targeted sub-groups.
9. Appropriate early intervention strategies and prevention of onset of disease, acute episodes, complications and relapse.
10. Focus on improved health outcomes for consumers.

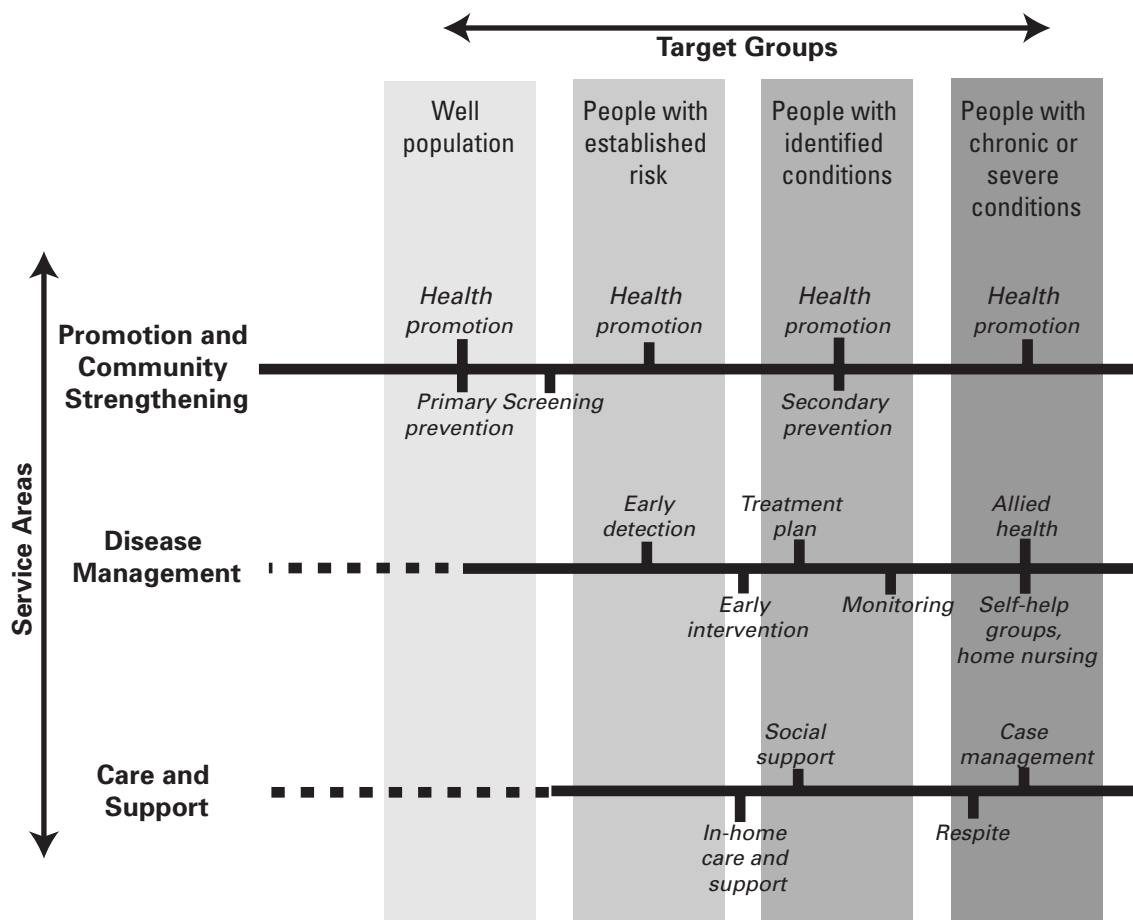
## 2.3 Primary, Secondary and Tertiary Models of Care

In a successfully integrated primary care system, there will be overlaps and interconnections between programs across the care continuum. Of particular importance is the interface between IDM and health promotion.

Health promotion forms a critical part of IDM—both in terms of prevention or delay of chronic disease in those 'at risk', and in secondary prevention for people with identified chronic diseases/conditions. In addition to these preventative aspects, health promotion should be an essential aspect of a consumer's care, so that a focus is placed on enhancing health—not merely preventing the escalation of disease.

The diagram below represents the care continuum that may be found in Primary Care Partnerships and some individual agencies, and highlights the relationship between health promotion, IDM and care and support programs for broad population-based target groups. The recognition of the importance of each service area is essential in the development of IDM projects.

**Figure 1 Model for the Care Continuum in Primary Care Partnerships**



*These are examples only, and do not represent the full range of services and programs.*

## 2.4 Key Components of Successful IDM Projects

Key components of successful chronic disease programs have been identified from the literature. These components follow:

### 2.4.1 The Use of Explicit Plans and Protocols <sup>15 16</sup>

Documented health care plans should be tailored to the individual consumer and based on 'best practice' evidence-based or consensus guidelines. Local development or modification of standardised care guidelines, critical resource tools and care plans are required to ensure they meet local needs. Carers, as well as consumers, must be involved in care plan development and implementation.

Particular responsibility should be assigned for overseeing the implementation of care plans. This is practically undertaken by the consumer's key worker, with long-term follow-up built into the care plans.

The shift to evidence-based, planned care should be facilitated by working within a care system or group practice that values guidelines and has created a plan at organisational level to assist practitioners in their efforts to comply with guidelines.

<sup>15</sup> Wagner E.H., Austin B.T., Von Korff M., 'Organizing Care for Consumers with Chronic Disease', *The Milbank Quarterly*, Vol. 74, No 4, 1996

<sup>16</sup> Institute for Public Health and Health Services Research and Centre for Community Child Health, *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Health Sector*, Final Report (unpublished), December 1999

#### 2.4.2 Multidisciplinary Teams and Reorganisation of Practice Systems

A multidisciplinary team consists of a range of different professionals, each contributing their particular area of skill and expertise to a consumer's care. International evidence strongly suggests that successful IDM projects require the effective integration of multidisciplinary teams of professionals, including doctors, a range of allied health professionals, nurses, service planners and coordinators, and paramedical staff, such as community support workers. The team must also include consumers and/or carers as participants in the design, development and implementation of their IDM plans. Specific strategies are required to ensure that projects involving a diverse range of stakeholders can be sustained, and that the various stakeholders share important values and expectations.

Practice redesign approaches for chronic disease range from efforts to enhance usual primary care, to separate, specialised care programs. In the middle of this continuum are models that add specialised personnel to primary care teams.

Care must address a range of clinical, behavioural, and psychosocial variables. Multi-dimensional care of this kind requires a multidisciplinary team approach, in which intervention strategies are coordinated, and there is regular contact between the various disciplines and training of staff involved in care. The delegation of key tasks to appropriate members of the practice team, especially non-physicians is a central feature of successful projects, and an important element of team care planning. Successful IDM projects rely heavily on non-physician personnel to conduct routine assessments, take responsibility for key preventive tasks like vaccinations, and provide much of the counselling and support for self-management.

Successful projects ensure regular follow-up (in the form of return visits, home visits or telephone calls), through to planned, frequently provider-initiated contacts with consumers.

A further critical element of successful IDM projects is ensuring that IDM plans are *adjustable* to meet consumer needs. The focus therefore, is on meeting the consumer's needs, when those needs arise.

#### 2.4.3 Systematic Attention to the Information and Behavioural Change Needs of Consumers, with Improved Consumer Self-Management Support

Provision of consumer education and self-management skills is critical to achieving successful outcomes in chronic disease management programs. These skills must be reinforced on a regular or ongoing basis if behavioural changes are to be sustained. Strategies need to be developed to empower individuals to self-manage effectively, to discriminate between the severity of problems, and to determine when assistance should be sought.

There needs to be a continuum of self-management and training and support services. For most chronic diseases, this should include instruction in IDM, behavioural change support programs (for example, smoking or dietary interventions), exercise options and interventions to deal with the emotional demands of chronic disease.

There is substantial evidence that structured self-management and behavioural change programs improve outcomes in diabetes, hypertension, arthritis, coronary heart disease and other chronic diseases. The literature suggests that the method of delivering the program, whether by group, one-on-one counselling or through information technology, may be less important than the project's ability to identify and respond to individual needs and priorities of consumers.

#### 2.4.4 Ready Access to Necessary Expertise

Input from specialists and decision support systems can all support and enhance the work of the team—and consequently increase the potential to achieve better outcomes for consumers. Specialists may include specialist medical practitioners, relevant statewide health enhancement agencies, or relevant consumer and

population health organisations, such as the Health Issues Centre, Chronic Illness Alliance, Local Ethnic Councils or Aboriginal controlled health organisations. (Specific roles and responsibilities for these agencies and IDM Pilot Projects are outlined in Section 5.3.)

Access to specialist expertise may take the form of referral or consultation, direct communication between generalists and specialists by telephone or other means, collaborative care, whereby specialists and generalists manage health consumers together in the primary care setting, or a panel of specially trained local experts who are available to IDM project teams to advise on the management of particular consumers.

#### 2.4.5 Supportive Information Systems

Effective information systems are crucial to supporting the implementation of IDM projects, particularly for the recording, transfer and analysis of key consumer information.

Computerised consumer registers and recall systems are also important in ensuring a proactive approach to IDM is taken. This emphasises follow-up and secondary prevention.

As technology continues to develop, consumer-held care records such as the 'smart card', and information systems such as the Internet, will revolutionise the management of those with chronic disease. (Information management and technology are discussed in greater detail in Sections 3.7 and 3.8.)

Monitoring processes established by the IDM projects should be resource-efficient, and make the best use of existing information technology systems and data sources. Projects should explore the potential to establish systems interfaces with local general practices and hospitals, to assist in capturing and analysing essential clinical and service delivery information for tracking and monitoring purposes.



# Chapter 3 Developing and Implementing Integrated Disease Management Projects

This chapter discusses the specific processes and tools required to develop and implement IDM projects successfully.

## 3.1 Sustainable Partnerships

Partnerships between medical professionals, pharmacists, allied health and community support workers provide an important basis for improved coordination of care. In such partnerships, each worker's strengths can be built upon and enhanced within the team environment. To achieve and sustain collaborative partnerships, it is necessary not only to recognise complementary skills and knowledge, but also to identify and address potential barriers that may pose a threat to the success of the partnerships. Communication, commitment, changing practice patterns and an understanding of professional roles and responsibilities are all central to the development of sustainable working partnerships.

### 3.1.1 Overcoming Potential Obstacles to Effective Partnering

#### *Involving Medical Professionals*

A lack of physician and General Practitioner involvement and commitment may be a potential obstacle to collaborative partnering for the implementation of IDM projects. There are several techniques that may be employed to improve the likelihood that medical professionals will be involved in a meaningful way. These include:

- Involving medical practitioners early in project development to promote 'ownership' and commitment.
- Informing clinicians about the potential benefits, both for consumers and themselves, of IDM projects that have support from a multidisciplinary team.
- Marketing the team appropriately, and promoting what they can offer.
- Establishing effective information management systems and administrative processes to help make the most efficient and effective use of clinicians' time.

The introduction of the Enhanced Primary Care<sup>17</sup> payments to GPs for case conferencing, care planning and annual

health assessments (for consumers aged over 75 and Aboriginal and Torres Strait Islanders aged over 55) will greatly aid collaboration. GPs or other providers may initiate the case conferencing and care planning Medical Benefits Schedule items. Medical practitioners should be encouraged to make use of available funding structures to participate in IDM activities through comprehensive assessments of health status or counselling and educational activities in support of self-management.

GP Divisions are important partners in IDM projects to help facilitate GP engagement. The Department of Human Services will continue to work with the Commonwealth Government to encourage mechanisms that support practitioner involvement in population health initiatives, such as IDM projects.

#### *Professional Boundaries*

In team situations, there is always the potential for the issue of 'professional boundaries' to arise. Professionals, who may be used to working on their own, may initially find a team environment somewhat threatening, and may wish to guard their particular area of knowledge and expertise. Concentrated effort and 'quick wins' that demonstrate the benefits of collaboration can help people appreciate that a team approach can be an empowering experience as they establish networks, and gain knowledge of, and confidence in, what others can provide.

Professional boundaries can also apply between sectors, such as between providers in the primary care and acute health sectors. It is essential that community-based service providers with relevant hospitals forge effective working relationships, and maintain a level of trust, which will support the effective management of consumers common to both the hospital and the primary care providers.

#### *Communication and Information Sharing*

Information sharing and effective communication between each member of the team is critical to facilitate effective teamwork. Although this can be a resource intensive and

<sup>17</sup> Further information on the Enhanced Primary Care Package is available at:  
<http://www.health.gov.au/hsdd/primcare/enhancpr/edutrain.htm>

time consuming process, appropriate use of technology and effective communication protocols can save time and effort, and lead to better quality care.

Communication issues should be addressed from the inception of the partnership. There must be an understanding and strategies in place to ensure that each partner knows what is taking place, in relation to the care of the consumer and how the consumer is managing and responding to the planned treatment and support. Mechanisms to gain feedback of consumer satisfaction should also be put in place.

#### *Overcoming Resistance to Change*

Support for individuals and the team process, as well as for the partnerships that evolve as a result, is essential in bringing about the necessary change in the way care is provided. However, for support to be effective, the reasons for the resistance to change need to be identified and analysed, so that the appropriate support strategies can be initiated. Supporting and managing change may involve a range of activities, such as:

- Engaging the support of local leaders.
- Securing a common understanding of respective roles within the multidisciplinary team.
- Providing training opportunities that educate individual workers and assist them to review and change their practice where necessary.
- Building time into team meetings for reflection and open discussion of successes (and failures) of the work.<sup>18</sup>

#### *Lack of Early Evidence of Success*

Development of the project plan that enables some early 'runs on the board' is important, in order to retain the commitment and enthusiasm of partners. Demonstrated success, or efficient development of strategies and tools, will enable partners to recognise the worth of the partnership and its future sustainability; this may also attract other partners. Demonstration of the worth of the project to the partner's individual agencies, in improving

and benefiting their service delivery, will also assist in strengthening the partnership.

#### 3.1.2 Some of the Keys to Successful

##### Integrated Disease Management Partnering

Various researchers and analysts have examined the elements of what makes a successful team or partnership over the past few decades. Todd (1997) notes that success in IDM partnerships necessitates the alignment of the values, cultures, expectations and systems of the respective partners. Ultimately, however, success hinges on the strength of interpersonal relationships within the team or partnership. Todd emphasises that a careful engineering of leadership mechanisms and team-building principles is critical.<sup>19</sup> However, the foundation of a successful team or partnership involves the recruitment of partners who fit in—not only in terms of their knowledge and expertise, but also their beliefs and vision.

For the development of a successful team or partnership, commitment and mutual support are essential. The team should also be skilled at managing conflict, and should have a plan for developing and maturing the partnership over time, and needs to include shifting the outlook from 'I' to 'we'.<sup>20</sup>

Giving consideration to the 'basics' of forming successful partnerships and teams, takes on particular importance in the context of IDM projects, where the mix of partners is necessarily diverse. In a typical IDM project, there may be:

- Large organisations (for example, hospitals).
- Smaller organisations (for example, community health services).
- Public services (for example, allied health and counselling services from publicly funded organisations).

<sup>18</sup> NHS Centre for Reviews and Dissemination, University of York, 'Effective Health Care: Getting Evidence into Practice', *Effective Health Care Bulletin*, Volume 5, No.1, February 1999.

<sup>19</sup> Todd, W.E. and Nash D., (Eds), 1997, *Disease Management: A Systems Approach to Improving Consumer Outcomes*, American Hospital Publishing, Chicago.

<sup>20</sup> *Ibid.*

- Private services (for example, GPs, private allied health practitioners, medical specialists, community pharmacists).
- Medically oriented services (for example, nursing).
- Community support services (for example, domiciliary assistance).
- Involvement of different levels of government in funding and planning (for example, local, state and federal government).

While the Department of Human Services will provide assistance to ensure the sustainability of Primary Care Partnerships, most of the work to sustain them—and to sustain the usually smaller partnerships, which are the active part of IDM projects—will have to be undertaken by the partners themselves. It is therefore essential that the members enter into genuinely collaborative enterprises, and have clear understandings about important issues such as recruitment, roles and responsibilities, resource allocation and GP and consumer participation.

## 3.2 Priority Setting through Population Health Planning Processes

IDM activities must be planned and prioritised in the context of a detailed analysis of the specific health and well-being needs of the catchment population. Such an analysis should be based on relevant population health data, service utilisation data and local community input. This will provide a common understanding of the health status and health and well-being needs of the population.

Setting priorities for IDM projects should be informed by the population health profile and needs analysis, as well as a consideration of national and state priorities (see Appendix 2). In addition, priorities should be selected in conjunction with evidence of amenability of certain diseases/conditions (for example, cardiovascular disease, hypertension) to IDM programs and evidence of effectiveness of particular interventions.

A Community Health Plan will incorporate and build on

elements of Municipal Public Health Planning by local governments, and draw on other plans, such as Divisions of General Practice Strategic Plans. The Department of Human Services will develop a comprehensive database to enable consistent data to be used as a basis for planning. This will include relevant population health data, such as data from the Victorian Burden of Disease Study, and service utilisation data.

By working through the community health planning and priority-setting processes, service providers may identify one disease/condition as a focus of IDM effort, or they may identify a cluster of diseases/conditions with common causal factors and management regimes.

## 3.3 Health Promotion, Early Intervention and Secondary Prevention

### 3.3.1 Health Promotion

Health Promotion incorporates disease prevention, reduction of disease advancement and effect, and enhancing quality of life—as demonstrated across the continuum of treatment, care and rehabilitation. However, health promotion action extends beyond specific disease prevention to address the broader determinants of health. Appropriate health promotion action should combine the three approaches below:

- **The medical or preventive medicine approach**, which is directed at improving *physiological risk factors*, such as high blood pressure, high cholesterol and lack of immunisation. This approach also includes early detection of diseases such as cancer.
- **The behavioural or lifestyle approach**, which is directed at improving *behavioural risk factors*, such as smoking, poor nutrition, physical inactivity and substance abuse.
- **The socio-environmental approach**, which is concerned with the totality of health experiences and the factors that help to maintain health (including the *risk conditions* and *psychosocial risk factors*). This approach directly targets the determinants of health in the environments in which people live and work.

The *Primary Care Partnerships Draft Health Promotion Guidelines*<sup>21</sup> provides a guide to health promotion planning, implementation and evaluation.

### 3.3.2 Early Intervention

Early intervention is an essential component in the IDM process. Its focus is on ensuring that appropriate treatment is received as quickly as possible and, as a result, the overall recovery process is accelerated.

For those consumers with chronic disease, the emphasis is on intervening early, modifying behaviour where appropriate, and adhering to identified and planned strategies—so as to minimise symptoms or the risk of complications.

To enable intervention at an early stage, mechanisms must be established to identify priority individuals or target groups at the time of, or immediately following, diagnosis. Local PCPs should have referral protocols with diagnosticians, such as local general practitioners or key medical staff, from major hospitals in or near the catchment area. In addition, linking the care plan to relevant and appropriate health promotion programs and activities is important, in order to foster behavioural change and self-management.

### 3.3.3 Secondary Prevention

IDM incorporates a strong emphasis on secondary prevention, which is aimed at enhancing the health of those with diagnosed diseases/conditions and preventing them from developing comorbidities or experiencing acute episodes, complications or relapse. An example of a secondary prevention activity is regular screening and monitoring of an individual with diabetes for retinopathy, microvascular disease, peripheral neuropathy and kidney problems.

An individual's IDM plan should incorporate actions that are aimed at secondary prevention, including appropriate linking to relevant health promotion activities or programs and access to follow-up systems.

## 3.4 Identification of Participants

IDM projects will also have identified key population groups to target for entry into the IDM pathway. Potential participants for IDM projects may be identified by any of the consumers' contact workers. However, it is important that the local IDM project team develops entry criteria early in the life of the project, so that the target group is clear to both consumers and providers. Strategies to recruit the identified key population groups need to be carefully planned to ensure the projects success. (Chapter 4 deals more specifically with consumer issues to consider in developing strategies for the identification and recruitment of participants.)

## 3.5 The Integrated Disease Management Clinical Pathway

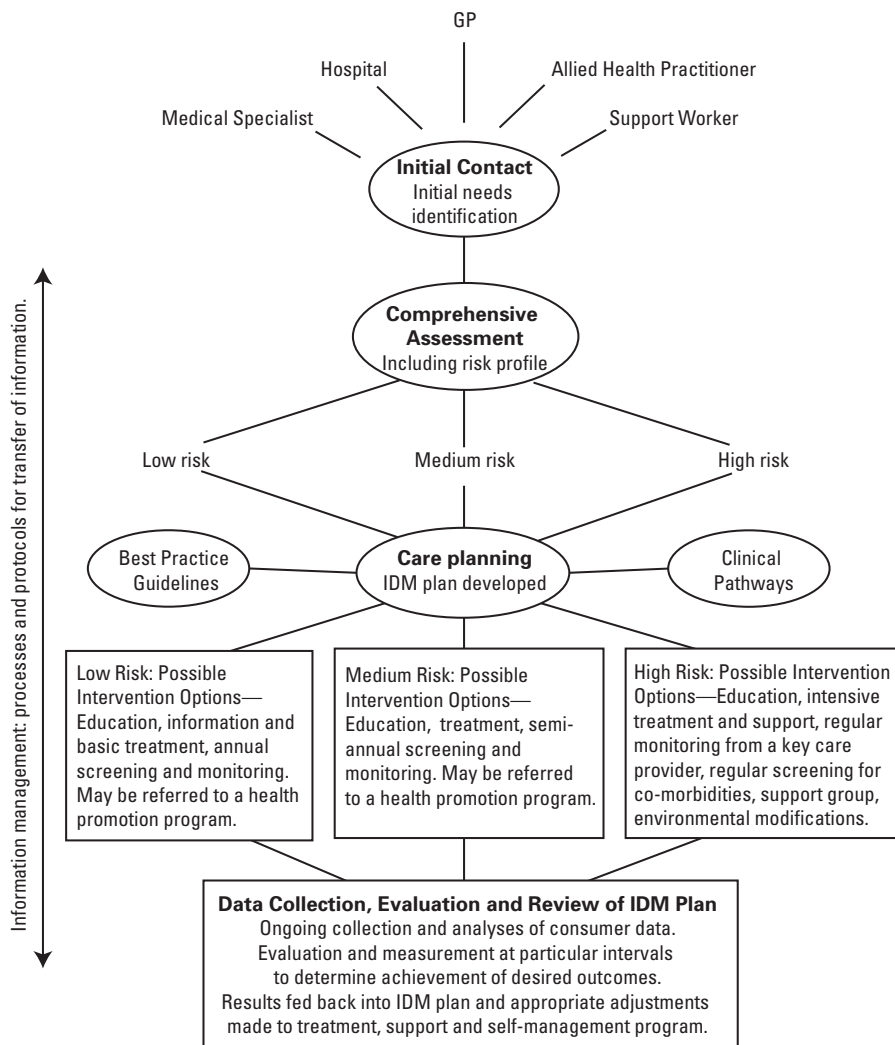
The IDM clinical pathway is the path that the identified consumer will take to improve the management of their disease or decrease their risk of disease. PCPs will need to link this pathway specifically with the *service coordination* component of Community Health Plans—that is, the better access to services, information management and service information initiatives. These three initiatives are interdependent; there is little point in developing changes to assessment and service delivery practices if they are not supported by consistent and quality information management practices and underpinned by accessible and relevant services information. The interface between each of the initiatives must be given priority in the establishment of the partnership, and organisers need to acknowledge that one element or provider may be influenced by the constraints or strengths of another. There is a need to progress the development and implementation of IDM projects systematically, alongside these three initiatives.

Figure 2 depicts the possible IDM clinical pathway, and its specific links with the service coordination initiatives. The critical steps of the IDM clinical pathway that the IDM project team should consider are:

<sup>21</sup> Aged, Community and Mental Health Division, 2000, *Primary Care Partnerships Draft Health Promotion Guidelines*, Victorian Government Department of Human Services, Melbourne.

- The **initial contact** with those with, or at risk of, the disease will either include an *initial needs assessment*, or refer the client on for one. The *initial needs identification* will determine the individual's risk, eligibility for the IDM project and priority for service (see Section 3.5.1).
- The **comprehensive assessment** (including assessment of their medical needs), to obtain a detailed picture of the individual's health and support needs. A risk assessment would also be undertaken and a risk profile developed as part of the comprehensive assessment (see Section 3.5.2).
- **Care Planning**—referral to IDM project for an IDM plan (see Section 3.5.3).
- **Information management and technology**, to collect, transmit and analyse information on consumers and track utilisation across services along the IDM clinical pathway (see Section 3.5.4).
- Data collection and evaluation (see Section 5.2)

**Figure 2 Integrated Disease Management Clinical Pathway**



### 3.5.1 Initial Contact

One of the most important issues in IDM is ensuring that potential participants are identified and given the opportunity to be involved in a relevant IDM project. The initial point of contact, as identified in the PCP Better Access to Services initiative, will result in the individual moving through the service system. It might also be the point of basic information provision, where the consumer receives printed literature or access to health-related information, and receives no further service or intervention.

An initial needs identification may be undertaken at the point of initial contact, or the initial contact will facilitate direct access to initial needs identification. The initial needs identification will utilise established administrative and clinical protocols to assist in the identification of individuals who are likely to benefit from an IDM program. It is important to appreciate that IDM is not necessarily universally applicable, and that some individuals may not wish to participate for a variety of reasons. Consumers should be fully informed about what the program entails, *prior to commencement*, so that they can make an informed decision about their involvement.

The initial needs identification may identify additional *service specific assessments* or *specialist assessments*, which may be necessary to obtain more specific information about the consumer's disease/condition and care or support needs. For example, the dietician may wish to assess the consumer's diet, particularly if they have diabetes or have cardiovascular disease.

### 3.5.2 Comprehensive Assessment

A comprehensive assessment has these features:

- It gathers information about medical, physical, social and psychological needs, from a wide range of sources, to reflect a comprehensive picture of consumer/family/carer strengths, resources and problems.
- It facilitates a more extensive process of inquiry, which requires analysis and interpretation of the assessment information and a clinical judgment, diagnosis and differential diagnosis.

The comprehensive assessment incorporates a **risk assessment** for those identified for an IDM project. Risk assessment is a way of assessing an individual's risk (as defined by appropriate clinical guidelines) of morbidity or mortality, taking account of their disease/condition and existing risk factors/behaviours. By employing a specific risk assessment approach within comprehensive assessment, consumers will be stratified according to the severity of their illness or health risk (typically, into low, medium and high risk groups), with different strategies employed according to the risk profile of each consumer<sup>22</sup>.

The analysis of individual risk is important because overseas experience suggests that some of the most critical elements of the overall IDM approach are early intervention and secondary prevention. This involves intervening at an early stage in the course of the disease/condition and preventing acute episodes, the deterioration of the disease/condition and/or comorbidities—as well as enhancing health, where possible.

When undertaking risk assessment, it is important to take account of a range of factors that may affect a person's risk profile. For example, older people are at greater risk of complications, the dangers of polypharmacy and comorbidity. The PCP Health Promotion Guidelines<sup>23</sup> outline the importance of recognising the determinants of health in designing effective health promotion programs, and these should be considered in the comprehensive assessment and risk profiling.

**Screening** of high risk individuals can also assist in identifying those people who may be in the early stage of disease but who may be undiagnosed. Once the individual has been identified, they should be assessed and where appropriate, entry into the IDM project should be offered as soon as is practically possible.

22 Todd, W.E. and Nash D., (Eds), 1997, *Disease Management: A Systems Approach to Improving Consumer Outcomes*, American Hospital Publishing, Chicago.

23 Aged, Community and Mental Health and Public Health Divisions, 2000, *Primary Care Partnerships Draft Health Promotion Guidelines*, Victorian Department of Human Services.

### 3.5.3 Care Planning

Following a comprehensive assessment, the next stage is the development of a care plan.

At the care planning stage of the service coordination pathway, as illustrated in Figure 2, the consumer identified for the IDM project will be provided with a specific IDM plan.

The IDM project team, in conjunction with the consumer (and their carer, where appropriate), should develop an IDM plan (based on the comprehensive assessment and service specific and/or specialist assessment results and the risk profile) for the ongoing management of the consumer's disease/condition. Plans may include a treatment and pharmaceutical regime and input from support services as well as self-care strategies, encompassing ways for the consumer to effectively self-manage—including how to evaluate, resolve and prevent problems. IDM plans may also contain regular review times in order to check whether the plan is still meeting the consumer's needs and whether any modifications are required to the balance of interventions as a result of changes in the consumer's health status.

A shared IDM plan is an essential element of effective IDM projects, providing structure and coherence as the consumer negotiates the string of care episodes and associated providers that characterise long-term care and support. To maintain a high level of quality of care, IDM plans should be informed by 'best practice' guidelines and recognised clinical pathways.

Implementation of the IDM plans will differ with the intensity and nature of care and self-management, varying according to the consumer's identified level of risk, skills and circumstances. Ongoing measurement, analyses and evaluation, as part of a quality improvement cycle, will continually inform the care plan and its implementation.

#### 3.5.3.1 'Best Practice' Guidelines

A wide range of 'best practice' guidelines exists, which provide comprehensive recommendations for the diagnosis and management of particular diseases/conditions.

Practice guidelines provide a useful scientific foundation for IDM activities. However, as numerous guidelines exist on a variety of diseases/conditions, there needs to be a sound selection process to choose the most appropriate guidelines and local adaptation of the selected guidelines undertaken, in order to assure workability and relevance.

In selecting appropriate guidelines, providers should ask the following questions:

- Do the guidelines have credibility and has a recognised professional body produced them?
- Have the guidelines gained a high level of utilisation in the field?
- Have the guidelines been endorsed by a recognised body, such as the National Health and Medical Research Council (NHMRC)?
- Do the guidelines have local relevance, and do they have applicability to an Australian population?
- Are the guidelines the most recent and relevant to this area?
- Does the highest level of evidence currently available underpin the guidelines?

It is also important for providers to complement 'best practice' guidelines by reviewing the latest research findings to continually inform their clinical practice.

#### 3.5.3.2 Clinical Pathways

Clinical pathways capture and address the components of care, and incorporate these into a sequence of action or intervention points. They are designed to standardise care, while still allowing innovation and flexibility. Local health care providers who wish to enhance care quality and reduce treatment variation are increasingly using clinical pathways. Clinical pathways, or care maps, have been a focus of clinical practice for several years now, particularly in acute settings, but their use in non-acute settings has remained undeveloped.

### 3.5.3.3 Uptake of Guidelines and Pathways

Several approaches to facilitate uptake and implementation of guidelines and pathways have been identified in the literature. These are:

- **Formatting or readability.** Surveys indicate that clinicians prefer short manuals or executive summaries of guideline recommendations. Time-task matrices used to express clinical pathways are also considered useful.
- **Early involvement of respected peers** in the program and throughout the implementation and evaluation phases is likely to be important to overall success, since opinion leaders have been shown to change physician practice patterns.
- **Education and information strategies**, such as small group sessions, may be useful to describe specific guidelines and pathways. However, personalised one-on-one sessions (for example, academic detailing) have been shown to change clinician behaviour. It has also been shown that consistent and ongoing feedback can improve compliance with guideline recommendations and delineate the reasons for lack of compliance.
- **Multi-pronged approaches** to implementation have been shown in the research to be the most effective.
- Identification and removal of any barriers to the implementation of 'best practice' guidelines and clinical pathways is suggested, wherever possible, making it easier for providers to achieve optimal care.<sup>24</sup>

### 3.5.3.4 Other Integrated Disease Management Tools

In addition to care plans, 'best practice' guidelines and clinical pathways, there are a range of other tools that may be used in IDM projects.

One of these is a consumer registry. A consumer registry is a list of consumers with a certain disease/condition coupled with several other critical data elements related to care (for example, date of diagnosis). Registries enable providers to be proactive, inviting or reminding consumers to participate in accordance with their documented plan of care. They can be used to maintain surveillance and

remind health consumers and providers of required follow-up or preventive interventions.

Development of consumer information kits may be another tool to complement the IDM project. These kits may contain relevant disease information, self-management education strategies and available treatment/management options. Consumer participation in the development of these kits will ensure their appropriateness.

### 3.5.4 Information Management and Technology

Effective information management (IM) systems are necessary to collect, transmit and analyse information on consumers, and track utilisation across services. IM systems are also essential for managing consumer care planning information. For example, information regarding physiological factors, such as blood pressure, heart rate, weight and symptom information, can be recorded, analysed and matched with intervention and service usage information, to provide a picture of how the care plan is being implemented and flag the need for possible modifications.

Information management and technology issues that should be considered by PCPs undertaking IDM projects are discussed below.

#### 3.5.4.1 Departmental IM/IT Projects

The Department of Human Services has engaged consultants to develop strategic directions in information management for the PCP strategy. Following extensive consultation with PCP stakeholders, the directions will guide partnerships in their planning for the management of information to the objectives of the PCP strategy.

The identification of business processes or between practitioners, providers and organisations involved in PCPs, and the information management capabilities needed to support them, are central to the exercise. Once these have been mapped, plans can be developed to address the need for practices, protocols and systems to support information management (including data and communication

<sup>24</sup> Ellrodt, G. et al, 1997, 'Evidence-Based Disease Management', *Journal of the American Medical Association*, Vol. 278 No. 20, November 26, 1997.

standards, mechanisms to handle consent and meet information privacy and security requirements, and training and IT infrastructure requirements).

For IDM projects, providers will need to consider how to operationalise the IM/IT aspects of a particular IDM model, for example:

- What is necessary for data about disease/condition x to be 'mined' from database y?
- What provisions are required to ensure privacy is protected in conducting referrals or establishing a shared consumer record, which would be referenced by a range of providers involved in the individual's care plan?
- What sorts of systems are required to ensure secure transfer of consumer information (whether they be electronic or traditional means)?

By examining 'what needs to be done' in order for PCPs to manage information, the Information Management Strategic Directions (currently being developed), will provide the framework within which partnerships can establish the necessary IM and IT systems for their effective operations.

#### 3.5.4.2 *Technical and Practical Issues*

Modern information systems have greatly improved the accessibility of data from different types of computer systems. However, the use of standardised data protocols, a standard vocabulary of database fields, and standard communication protocols (especially if data is encrypted), still facilitate data transmission and interpretation.

The Department of Human Services, in conjunction with IDM Pilot Projects, will develop common minimum datasets and advice on communications protocols, to facilitate evaluation and data transfer within PCPs and with other stakeholders, especially collaborating GPs. In this context, each Pilot Project will consider the need for consumer held records.

There is also a need for a single consumer identifier, in order to facilitate the integration and coordination of care

and track service utilisation. The Privacy Commissioner in the National Principles for the Fair Handling of Personal Information has addressed the use of a personal health identifier. Within this framework, strict guidelines would need to be agreed to and enshrined in legislation. The Victorian Government has recently passed the Victorian Health Records Bill<sup>25</sup>, which considers this issue, and the Commonwealth Department of Health and Aged Care are currently examining it.

Consumer-held records can assist in consumer education and empowerment, because they facilitate consumer involvement in planning their own care. One of the most important benefits of such a system can be improvement of communication between consumers and health care professionals—as well as between professionals. However, measures need to be in place to support the successful implementation of consumer-held records. Systems need to be established to enable the health professional to update the record at each visit, without having to enter information twice. Also, the consumer needs to value the record sufficiently to keep it safe and accessible. It is possible that, in the future, many consumers will hold their records electronically in some form (such as on 'smart' cards).

Another significant issue for integrated care generally is the issue of a *single* consumer record. A single consumer record, whether 'virtual' in character (that is, comprising linked separate records) or literal, offers health professionals, administrators and consumers some important advantages. For example, most forms of electronic medical/consumer record can be accessed at more than one point simultaneously (the obvious exception is the smart card). Electronic consumer records allow the ready exchange of desirable clinical data between providers, improve continuity of care, greatly facilitate research, reduce the need for multiple histories to be taken, remove the need for consumers to provide basic demographic data repeatedly, can be readily updated (from multiple sites if necessary) are much less susceptible to

<sup>25</sup> Victorian Government, 2000, Victorian Health Records Bill, <http://www.dhs.vic.gov.au/ahs/healthrecords/>

being 'lost', and can be retrieved much more quickly than paper-based records.

#### 3.5.4.3 Privacy

The creation of a single consumer record, or its logical equivalent (the indexing of several records to form a 'virtual' single consumer record), raises the important issue of privacy and consumer consent to the use and disclosure of information collected about them. In 1998, the Department released the *Information Privacy Principles*, to which all publicly funded agencies were required adhere to from mid-1999. An important concept articulated in this document is that personal information should not be used for a purpose other than that for which it was collected, unless authorised either by law or by the person concerned, or if particular exceptions, specified in the Principles, apply. The consumer must be told, understand and consent to the purpose for which information is collected. The recently passed Victorian Health Records Bill<sup>26</sup> also addresses privacy issues and sets out information privacy principles in relation to health information.

Informed consumer consent is a critical concept in management of consumer information. As long as the consumer consents to use of the information collected about them for an agreed purpose, then this is consistent with the principle of 'privacy protection'. However, it is generally held that individuals can only give consent to *specific* acts of distribution, and not a *general consent* to any necessary distribution as a provider may see fit.

## 3.6 Innovative Approaches Using Technology

In the future, it is clear that the Internet and other innovations, such as computer assisted decision making support systems and computerised self-monitoring and recording systems, will revolutionise the management and self-management of consumers with common chronic diseases/conditions. In Canada research is being undertaken into the use of home computers and the Internet to investigate how communication technology can be used to manage chronic disease. In one particular study, information flows both ways: consumers enter daily vital signs which are monitored by a nurse who notifies the consumer's doctor if any changes are noted, and consumers receive coaching, medication reminders and encouragement electronically. A similar approach, using telephone technology undertaken in the United States, resulted in a reduced number of emergency hospitalisations amongst a group of congestive heart failure consumers, cutting health care expenditures by 25.3 per cent<sup>27</sup>.

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<sup>26</sup> Ibid.

<sup>27</sup> O'Reilly, M., 'Is Internet-based disease management on the way?' *Canadian Medical Association Journal*, April 1999.

# Chapter 4 Consumer Issues: Rights, Participation, Self-Management, and Adherence

This chapter discusses a range of important consumer issues that need to be considered and reflected in IDM practice.

## 4.1 Rights of Consumers

All consumers of health services are entitled to high quality health care, provided without prejudice or discrimination. Providers of IDM projects should ensure that the rights of consumers are recognised and that practice reflects these entitlements. In particular, consumers (or their representative) have the right to be:

- Involved in decision making about their own care.
- An equal partner in the IDM project team.
- Fully informed about treatment and support options and recommended best practice.

Health outcomes can be improved by involving people in their own care and treatment. Benefits include:

- Being able to identify relevant members of the team and their respective roles.
- More frequent use of appropriate health services.
- Improved knowledge of, and access to, other services.
- A sense of control over one's health, which can extend to other areas of life.
- A positive impact on the peer group and extended family.
- More positive feelings about the value of local culture and the community.
- Reduced use of inappropriate services, including hospital and medical services.

In consultation with the community, partnerships (including those that are conducting IDM Pilot Projects) will develop a Consumer Charter of Rights and Responsibilities in their first year of operation. The Department of Human Services has provided a basic framework for the charter<sup>28</sup>.

## 4.2 Consumer Participation

Consumer participation is a process of establishing working relationships and listening organisations.

Both current and prospective consumers need to be involved as active and informed participants in the development of the PCP service models—and in decision making about their care. Including consumers as full and equal partners in their own health improves health and care outcomes. Only when consumers are *informed* can they accept the increased responsibility of decision making, and only then can partnerships achieve consumer focused services. Some consumers and providers will find this increased responsibility challenging, as it may require changes in current practice.

In order to ensure that the consumer perspective significantly influences the development, implementation and evaluation of IDM project models and processes, it is essential to actively invite and facilitate consumers' participation.

Partnerships can facilitate consumer involvement, by ensuring the systemic structural and process barriers to consumers' full participation are identified, and, to whatever extent possible, reduced.

The Commonwealth Department of Health and Aged Care's Quality Branch have recently developed a Toolkit for Consumer Participation<sup>29</sup>. This resource contains strategies and approaches for engaging consumers and communities, and is valuable for staff at all levels. Partnerships need to ensure that staff fully understand and encourage the involvement of consumers (and carers, where appropriate) in decision making, and that they fully understand consumers' rights and how to respect and protect them. Training and support for both staff and consumers may be required.

28 Aged, Community and Mental Health, 2000, *Preparing a Consumers' and Carers' Charter. A draft guide for discussion*, Victorian Government Department of Human Services, Melbourne.

29 Commonwealth Department of Health, Flinders University and the South Australian Community Health Research Unit, 2000, *Improving health services through consumer participation: A resource guide for organisations*, Commonwealth Department of Health and Aged Care, Canberra.

Partnerships should also develop processes to ensure they collaborate with the diversity of consumers within their catchment areas. This might require services developing a range of strategies for working with consumers, or adapting existing strategies so that they are appropriate to different groups. A useful starting point for health services can be to identify and collaborate with relevant community organisations (such as ethno-specific groups) community workers and consumers themselves, to identify strategies that will enable consumers from those groups to participate. This can include finding out about how to approach, consult with and frame questions for different groups of consumers. It is also useful to find out about the support needs of consumer groups and the best times and venues for consultation (for example, are they likely to need child care, respite, assistance with transport, interpreting?).

### 4.3 Self-Management

Self-management interventions are increasingly acknowledged for their potential contribution to effective IDM programs. Social support, a sense of personal control and self-esteem, and certain coping skills also make a significant difference in preventing or reducing physical and mental health problems arising from disease and disability.<sup>30</sup> Self-management programs recognise the psychosocial factors involved in having a chronic disease, and aim to help sufferers to learn and practice the skills and develop the confidence necessary to carry on an active and emotionally satisfying life in the face of one or more chronic diseases<sup>31</sup>.

Effective self-management is based on a partnership between consumers, their families and health professionals, in which the consumer is encouraged to play an active role in monitoring and managing symptoms of disease.

Where consumers are taught the skills to deal with their symptoms and learn the value of effective communication with their health care team, including accurate self-reporting of symptoms, then a partnership can be formed that is constructive and rewarding for all those involved. Given the opportunity, most consumers are capable of

managing their disease in partnership with their care team<sup>32</sup>.

Upon entry to an IDM project, consumers should be assessed in terms of their ability to self-manage and cope with their disease/condition, so that programs can be tailored to assist consumers to develop or enhance self-management skills where possible.

### 4.4 Strategies for Facilitating Consumer Adherence

Adherence to medical, pharmaceutical or therapeutic regimens is an important component of self-management. If a consumer is to self-manage their disease/condition effectively, it is necessary for them to follow the agreed plan of care.

Most people do not follow self-administered medical treatments as prescribed. Many reasons exist for non-adherence to regimens, including problems with the regimen (such as adverse effects), poor instructions, poor provider-consumer relationship, consumers' disagreement with the need for treatment or inability to pay for it.<sup>33</sup> Also, consumers may simply regard their disease/condition as insufficiently uncomfortable or life threatening to justify inconvenient or time consuming self-treatment.

Studies in the literature, mainly focusing upon medication compliance, have described the use and testing of a number of interventions, such as:

- More instruction for consumers (verbal and written material and programmed learning).
- Counselling (including automated, telephone, computer-assisted consumer monitoring and counselling).

30 Thoits, P., 1995, 'Stress, Coping and Social Support Processes: Where Are we? What Next?' *Journal of Health and Social Behaviour*, (extra issue) pp 53-79

31 Department of Health and Aged Care, 1999, 'Chronic Disease Self-Management Program', Information Sheet

32 Phillips, J., 'Consumers can educate doctors about long term disease', Letter to the Editor, *British Medical Journal*, Volume 319, September 1999.

33 Haynes, R.B. et al, 1999, 'Intervention for helping consumers follow prescriptions for medications', *Systematic Review*, Cochrane Collaboration.

- Family intervention.
- Various ways to increase the convenience of care (for example, provision at the worksite).
- Simplified regimes.
- Involving consumers more in their care through self-monitoring.
- Reminders in a variety of forms.
- Reinforcement or rewards for both improved adherence and treatment response (for example, reduced frequency of visits)<sup>34</sup>.

It has been found that combinations of more thorough consumer instructions and counselling, reminders, close follow-up, supervised self-monitoring and rewards for success can improve adherence and treatment outcomes.<sup>35</sup>

Behavioural theories are relevant to issues of adherence or compliance. If individuals are feeling ill, they are much more likely to comply with a treatment regimen than if they are feeling well. Further, if a person perceives more benefits in adherence than 'costs' (or more 'positives' rather than 'negatives'), then they are also more likely to comply. Basically, beliefs and the motivation of the consumer are key aspects of adherence and should be taken into account in the management of a person's disease/condition.

The following factors influence motivation:

- Information that embraces emotional or psychosocial factors is more motivating than mere facts.
- Experienced effects are more motivating than other kinds of effects.
- Observed effects on others are more motivating than ones simply heard about.
- Effects on those known to the individual are more motivating than those on anonymous others<sup>36</sup>.

Drawing from the literature on adherence, some of the implications for effective IDM projects are as follows:

- IDM projects should, as a matter of good practice, incorporate strategies such as consumer education, follow-up and supervised self-monitoring, as part of the standard approach. Given the proven benefits of these interventions, providers have an excellent opportunity to build on these to develop further innovative strategies for increasing consumer adherence.
- Through a multidisciplinary team approach, each and every provider involved in the consumer's care and support can encourage adherence.
- Involving the consumer in the design of their care plan should result in tailored interventions that fit the consumer's lifestyle and environment. This should assist in supporting the effective implementation of the plan and overcoming some of the barriers to adherence.
- Providers need to communicate effectively and persuasively with their consumers and build strategies into their treatment and support which assists in maintaining motivation, such as involvement in support groups and peer education.

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<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> National Asthma Campaign, 1997, *Report of Proceedings of the Asthma Adherence Workshop*, Commonwealth Department of Health and Family Services.



# Chapter 5 Primary Care Partnerships: Integrated Disease Management Pilot Projects

## 5.1 Key Expectations of Integrated Disease Management Pilot Projects

It is anticipated that the IDM Pilot Projects will put into practice a range of desirable features of IDM projects, and that findings from the Pilots will inform the development of future IDM projects.

The project development in IDM Pilot Projects will consider and reflect:

- The key principals of IDM projects (see Section 2.2).
- The key components of successful IDM projects (see Section 2.3).
- The processes and tools to develop and implement IDM projects (see Chapter 3).
- Consumer issues such as rights, participation, self-management and adherence (see Chapter 4).
- Organisational and service models (see Appendix 1), in particular any cross-links with Coordinated Care Trials.

IDM Pilot Projects also need to be mindful of linking with the other initiatives being developed for the PCP's community health plan; in particular, the service coordination initiatives and health promotion strategy.

## 5.2 Reporting Requirements and Administration Tasks

Although they will be based on evidence and accepted notions of 'best practice', the IDM Pilot Projects are essentially trialling new and developmental approaches to the care of people who have, or are at risk of, specific diseases/conditions. IDM Pilot Projects will focus on planning, developing and implementing effective models of IDM. The pilots will also undertake self-assessments and participate in the overall evaluation of the projects, to:

- Provide evidence that such approaches produce acceptable outcomes and represent value for money.
- Ensure that the learnings from the project can be incorporated into future IDM projects.

### 5.2.1 Self-Evaluation and Measurement of Outcomes

Primary Care Partnerships undertaking IDM Pilot Projects are required to implement a self-evaluation process that:

- Defines the desired outcomes of the project.
- Defines indicators of the success of the project in producing the desired outcomes.
- Collects and analyses data needed to measure performance.

The process for self-evaluation of IDM Pilot Projects will be determined at the outset of each project. With regard to some of the key elements of IDM Pilot Projects—namely: early intervention, coordination of care and self-management—there are a number of outcome-related indicators that could be devised. For instance, stage of disease at the time of diagnosis, and time of intervention could be a measure of early intervention associated with better coordination of care.

Alternatively, a reduction in late stage complications for some diseases could be a measure of better early intervention, coordination of care and self-management<sup>37</sup>. There are also health outcomes related to process-style indicators that may be of relevance, such as admissions or readmissions to hospital or health services for certain diseases/conditions, as well as adherence to evidence based practice. Health-related quality of life, functional health status, consumer satisfaction and consumer/carer participation are other measures that could be considered in determining the success of a program in a more comprehensive, consumer focused way.

The ultimate outcome is improved health status, which can be attributed to the intervention or program. Where research is unclear or unavailable with respect to attribution, some outcome-related indicators may reflect upon, predict or be associated with outcome<sup>38</sup>.

<sup>37</sup> Ibid.

<sup>38</sup> Sansoni J., 1999, 'Health Outcomes-Made to Measure', *Health Outcomes and Community Care Workshop Paper*, March 1999, Melbourne.

Self evaluation—in Pilot Projects that fall within a Coordinated Care Trial (CCT) boundary—should also consider the impact of the CCT on the IDM project, including beneficial links, strategies that have avoided duplication and encouraged collaboration, and all outcomes specific to the IDM project and not related to the CCT.

### 5.2.2 Independent Evaluation

Evaluation of the Pilot Projects is essential to the process of testing out new models of care. Through evaluation, learning can be gained about mixes of services, interventions and models of care which have, or have not, been effective in improving health outcomes and reducing hospital admissions for individuals with chronic disease.

A team of experts in health service evaluation, who will be independent of the funding body and the Pilot Project participants, will undertake an external evaluation of individual projects, and the initiative as a whole. Each Pilot Project will be evaluated on an annual basis, with the provision of a comprehensive evaluation of the project at the completion of the pilot period. The team of evaluators will also assist Pilot Projects in the design and implementation of their own project assessment processes.

### 5.2.3 Administrative Tasks

Pilot Projects will also undertake a range of administrative tasks over the pilot period. These include:

- Compiling comprehensive 12-monthly reviews of the project's implementation.
  - Identifying a coordinating body with day-to-day management responsibility for the Pilot Project.
  - Participating in the IDM Pilot Project Steering Committee.
  - Reporting on a quarterly basis to the Department, using a reporting framework developed by the Department in consultation with the steering committee and Pilot Projects.
- Ensuring that an independent financial audit is undertaken at the end of each financial year.

It will be critical that information and experiences are shared between Pilot Projects and other Primary Care Partnerships regarding IDM approaches, so that this learning can be used to progress and refine IDM projects in Victoria.

While the Department of Human Services will take primary responsibility for publishing and disseminating findings of the projects, it is expected that Primary Care Partnerships will create and participate in opportunities for more informal exchange of information and experiences.

## 5.3 Roles and Responsibilities of Other Key Players

### 5.3.1 The Department of Human Services

The Department of Human Services will have a key role in overseeing, supporting and resourcing the IDM Pilot Projects.

This will include providing assistance to those Primary Care Partnerships undertaking the Pilots, in the form of:

- Information about effective IDM models.
- IDM policy directions and guidelines.
- Relevant data and data analyses for project planning.
- Facilitation of interface arrangements with hospitals.
- Facilitation of linkages with specialist Department of Human Services advisory committees, GPs, GP Divisions, pharmacists, medical and professional colleges and other NGOs.
- Facilitation of linkages with relevant consumer groups.
- Ongoing advice and support through a steering committee and regional Department of Human Services contact staff.
- Facilitate the dissemination of learnings to all PCPs to assist with future planning.

### 5.3.2 Pilot Project Steering Committee

A Pilot Project Steering Committee will be established, with representatives from the four IDM Pilot Projects, Department of Human Services staff, members of Department of Human Services advisory committees, consumers and experts in chronic disease management. The steering committee will oversee the Pilot Projects and provide advice and guidance on planning, implementation and evaluation issues.

The self-evaluation process to be used by each IDM Pilot Project will require approval from the IDM Pilot Project Steering Committee. The Committee will be responsible for ensuring a consistent standard and overall approach to evaluation across the four projects.

### 5.3.3 Department of Human Services Advisory Committees

As part of its responsibilities for the National Health Priority Areas Initiative and statewide population health planning (including PCPs IDM Pilot Projects), the Department will establish broad based advisory groups for selected diseases/conditions. These will comprise clinical and public health experts, statewide non-government organisations and other key stakeholders. These groups will provide one useful mechanism for linking the IDM Pilot Projects with other significant initiatives and facilitate provision of advice and support. They will also provide a conduit for feeding the experience of local projects back into state policy and program development. More specifically they will enable:

- Specialist input to specific IDM Pilot Projects.
- A reference point for PCPs who may not be undertaking IDM Pilot Projects, but who are willing to pursue some of the ideas in their project proposals.
- Links between national, statewide and local initiatives.
- Links to relevant NGOs and professional groups.
- Advice to be provided on common needs, such as training, guidelines, and data.

### 5.3.4 Statewide Disease/Condition-Specific Organisations

It is important for Pilot Projects to form links with relevant statewide organisations, such as Diabetes Australia–Victoria and Asthma Victoria, so that partnerships can draw on the pool of expertise and knowledge from within these organisations. For a Pilot Project with a focus on cardiovascular disease, for instance, links could usefully be formed with organisations such as the Heart Foundation.

In addition to their significant skill and knowledge base, these organisations can not only provide up-to-date information regarding disease management and prevalence data, but have often developed useful practitioner guidelines and/or consumer information kits and resources which could be of great practical use to Pilot Projects. Wherever possible, Pilot Projects should avoid 'reinventing the wheel'.

Links could be made between Pilot Projects and relevant statewide organisations by:

- Developing individual partnering arrangements.
- Arranging for a statewide organisation to provide advice and support on a PCP or regional basis.
- Implementing a statewide approach to the establishment of linkages, which could be brokered by the Department. This approach would enhance efficiency, and could build on activities across the Pilot Projects. It could also provide a systematic way of identifying and disseminating existing resources, products, or communication vehicles developed by statewide organisations, which are of relevance to the Pilot Projects.

These organisations have an excellent track record of working collaboratively with community based health and support organisations. Pilot projects provide a unique opportunity for a closer working relationship to be forged with the statewide organisations to further advance the care of those with chronic disease.

### 5.3.5 Academic Organisations

Involvement of academic institutions in local IDM projects can potentially enhance the planning, implementation and evaluation of these projects.

In particular, universities and similar organisations may provide critical skills and experience to assist providers in determining the effectiveness of their programs. This can be a mutually advantageous relationship, as academic institutions and research institutes may require access to service delivery organisations and consumers, to carry out field research in actual primary care contexts to reflect current experience in academic work.

Options for creating linkages include:

- The inclusion of a university or research institute into the Primary Care Partnership and more specifically, the IDM project team.
- A less formal 'spirit of cooperation' agreement which articulates the roles and responsibilities of the university or research institute and the Primary Care partnership in the IDM project.
- Contracting technical support services as required from the university or research institute by the Primary Care Partnership.

### 5.3.6 Other Consumer and Population Health Organisations

Agencies such as the Health Issues Centre, Chronic Illness Alliance, Local Ethnic Councils or Aboriginal controlled health organisations can provide valuable expertise to IDM project planning and implementation. Developing consumer engagement and recruitment strategies are key areas where these agencies could provide input.

Links could be made between Pilot Projects and relevant consumer and population health organisations by:

- Developing individual partnering arrangements.
- Consultation arrangements for relevant components of the projects.
- Participation on relevant steering committees.

The Department of Human Services' PCP Consumer and Carer Advisory Group will also provide input to the development of consumer engagement and recruitment strategies.

# Appendix 1 Integrated Disease Management and Other Related Models of Service Delivery

This section highlights some health system organisational approaches that support IDM approaches that provide insights that may be of assistance in establishing integrated IDM systems in Victoria. In describing examples from other contexts, most of which are outside Victoria, and some of which are from overseas, the researchers are aware that Victoria has systems, practices, organisations and traditions, which are in some senses unique. For example, Victoria has a strong tradition of independent community health centres, and administratively independent public hospitals, unlike most other states. While there are probably no 'perfect' models, observations of the strengths and weaknesses of a number of related models can assist PCPs in developing and executing their own ideas.

## Organisational Models

The models outlined below are examples of service system or organisational arrangements to support service delivery and IDM approaches.

### Primary Care Groups, United Kingdom

Primary Care Groups are groups of doctors, community nurses and other primary care providers who are linked together to form multidisciplinary primary care teams within the UK National Health Service. The teams are intended to perform a number of important functions, including ensuring a better integrated primary care system, helping to plan and run services in a given area and, in many cases, acting as a funds holder who effectively purchases secondary and tertiary level services for their consumers. Attempts are being made to achieve integrated and more effective care through reorganisation of delivery structures and funds holding mechanisms. As the teams have only been in operation for a short time, and are not yet widespread, it is not possible to draw conclusions, at this stage, about this model's effectiveness.

### Health Maintenance Organisations, United States of America

Leading Health Maintenance Organisations (HMOs) in the United States have undertaken a great deal of work in areas of IDM. First, they have developed best practice clinical care guidelines, which assist HMOs to determine

effective treatments, especially for common and/or high cost diseases/conditions.

Second, HMOs have undertaken a great deal of work into self-management, management of chronic and complex diseases/conditions and both primary and secondary disease prevention—all of which is highly relevant to IDM projects, and could be of assistance to Victorian projects.

Some of the lessons that can be learned from HMOs are summarised below:

- There is a need for careful targeting of compliance strategies: what works for teenagers doesn't work for elderly people, and vice versa.
- There is a need to provide incentives for clinicians to participate and change their traditional practices.
- The opportunities for reducing total cost to the community (principally through reductions in hospital inpatient care) are substantial.
- Trying to minimise *each* component cost is a mistake. The costs of some factors (commonly, medication and primary care) may actually *rise* with good IDM projects.
- There is a need for a multidisciplinary team approach that includes specialists in education.
- Action plans aimed at consumers and family doctors (GPs) should be succinct.

### Primary Care Organisations, New Zealand

There have been significant changes to the organisation of primary health care services in New Zealand in the last decade. A range of primary care organisations (PCOs) have evolved, providing comprehensive, generalist care with primary medical care as the core service. The key achievement of PCOs has been the organisational commitment to achieving the best health outcomes for a defined population within a set of limited resources. To achieve these goals, PCOs have established a range of organisational models, quality initiatives and information systems, and are providing many new services.

Apart from PCPs undertaking their own IDM initiatives, including diabetes and asthma guidelines and cardiac rehabilitation, disease coding and respiratory education, the Government's Health Funding Authority is supporting ten national integrated care pilot projects, seven of which are disease-based. The diseases being focused on in these pilot projects include mental health, asthma and chronic obstructive pulmonary disease<sup>39</sup>.

One of the aims of these pilots is to test five hypotheses about the viability of integrated care. The five hypotheses being tested are:

1. Decision making guidelines for service provision improve health outcomes and are cost-effective.
2. Promotion of collaboration across traditional service boundaries improves health outcomes and is cost-effective.
3. Contracting strategies that align incentives and promote collaboration across traditional service boundaries improve health outcomes and are cost-effective.
4. Budget responsibility for a specified bundle of services improves health outcomes and is cost-effective.
5. Consumers who make a choice about health service options have improved health outcomes and more cost-effective choices.

Each of the demonstration pilots is testing one or more of these hypotheses. Evaluation of the pilots is to be completed in December 2000.

### Service Models

It is always useful to examine existing service models so that apparently successful elements can be replicated and lessons can be learned from less successful approaches. The following Australian and international examples are just a few of the innovative models being tried throughout the world to examine ways of improving chronic disease care.

**The Amsterdam 'Diabetes Service'**  
A shared care intervention was established through a 'diabetes service', which supported the introduction of structured diabetes care for adult consumers with non-insulin-dependent diabetes mellitus (NIDDM) from general practices in Amsterdam. The 'diabetes service' provided a computerised consumer register and recall system; education and home visiting services; laboratory services; professional support from a dietician, diabetes nurse educator and podiatrist and the supervising diabetes physician offering twenty-four hour contact.

Diabetes care was based on guidelines for both the intervention and control groups. The study provided a step-up treatment regime to intervention GPs for hyperglycaemia, based on three monthly assessment of consumers' glycaemic levels. Education and follow-up were provided to consumers moving to insulin therapy. GPs were referred to guidelines for management of hypertension and dyslipoproteinaemia.

At two-year follow-up, metabolic control was significantly improved in the majority of intervention consumers, compared with control consumers. However, in contrast to the improvement seen in glycaemic control, a considerable number of intervention consumers did not achieve target levels for serum lipid levels, blood pressure and smoking.

The Amsterdam 'diabetes service' provided a number of the major elements thought to be important in management of chronic disease, and particularly diabetes care—a consumer register and recall system, individual care plans based on guidelines, education and self-management capabilities, professional collaboration and support from a network of health professionals, adjustable

<sup>39</sup> Malcolm, L. et al, 1999, *The Development of Primary Care Organisations in New Zealand*, A paper developed for Treasury and the Ministry of Health, New Zealand, November 1999.

service levels to meet demand, and systematic quality assessment.

The contrast between the results for treatment of hyperglycaemia and cardiovascular risk factors suggests that provision of laboratory results and guidelines alone were not a successful strategy for management of risk factors.

de Sonnaville, Bouma, et al, 1997 cited in the *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Health Sector*, Institute for Public Health and Health Services Research and Centre for Community Child Health, December 1999

#### Asthma Self-Management, Education and Regular Practitioner Programs

Gibson et al (1999) evaluated twenty-six randomised control trials with 4,382 subjects, comparing self-management training programs with usual asthma care in adults over 16 years. Fifteen trials incorporated both asthma education and regular practitioner review in their self-management programs.

Asthma self-management programs, incorporating education and regular practitioner review, reduced hospitalisations and Emergency Department visits, unscheduled doctor visits due to asthma, days lost from work due to asthma, and episodes of nocturnal asthma. Training programs, which also incorporated a written action plan, with self-monitoring of either peak expiratory flow or symptoms, led to better outcomes for the intervention group compared with the control consumers.

Gibson et al, 1999, Cochrane Review, cited in the *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Health Sector*, Institute for Public Health and Health Services Research and Centre for Community Child Health, December 1999.

#### The Hypertension Detection and Follow-Up Program (HDFP) (HDFP Cooperative Group America, 1979)

The Hypertension Detection and Follow-Up Program (HDFP) evaluated stepped care for mild to moderate hypertension. In this program, consumers received their care from specialised clinics that were established to meet their needs and ensure that the care protocol was applied properly. Critical features of the model were the provision of care in accord with an explicit plan, which included regularly scheduled follow-up, systematic assessments, and attention to the self-management needs of consumers. The HDFP reduced all-cause mortality by 17 per cent. Almost 40 per cent of the reduced rates could be traced to noncardiovascular causes. High rates of compliance with therapy were achieved and long-term complications associated with hypertension were significantly reduced<sup>40</sup>.

40 Wagner E.H., Austin B.T., Von Korff M., 1996, 'Organizing Care for Consumers with Chronic Disease', *The Milbank Quarterly*, Vol. 74, No 4, 1996.

#### Coordinated Care Trials (CCTs)

CCTs are a major Commonwealth and State initiative designed to develop and test innovative service delivery and funding arrangements. Their aim is to achieve improved health and well-being outcomes, produce more responsive service delivery, and more efficient funding. By removing program boundaries and funding channels, through pooling of Commonwealth and State funds, they allow service flexibility, leading to improved access to allied health services, community support and hospital services for those people with long-term, complex care needs.

The trials tested the hypothesis that the provision of care coordination to those with chronic complex diseases will improve health outcomes within existing resources. The trials pooled funds from various sources: public hospitals, sub-acute and

rehabilitation services, Home and Community Care (HACC), the Medical Benefits Scheme (MBS), and Pharmaceutical Benefits Scheme (PBS). Nine trials were conducted across Australia, two of which were in Victoria, and they ended last year. All Trials were evaluated locally, and a National Evaluation was also carried out. The Interim Report was equivocal about the findings in relation to the original hypothesis, but consumers and carers who participated in the trials found the care coordination role beneficial. GPs also found the role and the multidisciplinary team approach useful. The Final Report should be available early in 2001.

Lessons from the trials have the potential to assist PCP IDM programs. Some trials developed best practice clinical guidelines for the diseases/conditions they focused on, and all were required to develop assessment tools and clinical information systems.

**Differences from PCP IDM Projects**  
CCTs have a greater emphasis on vertical integration between the acute and community-based sectors, particularly GPs. IDM Pilot Projects have a stronger focus on horizontal integration between a range of community-based primary care providers.

Funds pooling is a core strategy of CCTs (including a minimum of MBS, PBS and hospital funding), whereas in PCPs there is no requirement for agencies involved in IDM Pilot Projects to pool funds. Funding will be provided to support Pilot Projects on a recurrent basis for three years.

The target group for CCTs is people with a variety of chronic and complex diseases/conditions, who tend to be high users of hospital services and health services more generally. The focus of the CCTs is on improving the health-related quality of life for older people with chronic and complex diseases/conditions. IDM Pilot Projects will target population groups with a specific disease/condition,

and who may be described as ambulatory—care sensitive that is amenable to community-based care and treatment.

The first round of trials demonstrated that there were many potential models for 'coordinating care' to a sub-population of people with chronic illness. All of the trials developed risk profiling, to enable the right level of care to be delivered to clients. For example, in several of the first round trials, medium and high risk consumers would have care plans, whereas lower risk clients might only have assessment and monitoring of their health status. High risk consumers usually had designated service coordinators to coordinate services for them across service boundaries. Most often, GPs would act as care coordinators and implement the medical part of care plans.

In IDM projects low, medium and high risk consumers all have care plans, but these will vary in content and detail across the risk continuum. Key workers will be identified for each consumer, to ensure that care plans are implemented.

Participating practitioners in IDM projects are strongly encouraged to follow best practice clinical guidelines and accepted care pathways. In CCTs there is no requirement for participating practitioners to follow best practice clinical guidelines or recognised care pathways, however some may do so. However, there is likely to be a greater emphasis in the second round of trials on promoting best practice in the development of care.

While health promotion is not the main thrust for CCTs, IDM projects consider health promotion to be an integral component. For both CCTs and IDM projects, the care planning process will include effort on secondary prevention of illness.

Further information about CCTs can be obtained at: <http://www.health.gov.au/hfs/hsdd/cocare>

# Appendix 2 National and State Health Priorities

## National Health Priority Areas

The Commonwealth and State/Territory officials and Ministers have agreed on six National Health Priority Areas. These are:

1. Cancer control
2. Injury prevention and control
3. Cardiovascular health
4. Diabetes mellitus
5. Mental health
6. Asthma.

The National Health Priority Areas initiative represents Australia's response to the World Health Organisation's global strategy Health For All by the Year 2000, and its revised strategy, Health For All in the 21st Century. The initiative is a collaboration between the Commonwealth, State and Territory governments. It seeks to improve the health of Australians by targeting those diseases/conditions that impose a high social and financial cost, and with targeted intervention offer the opportunity for significant health gain.

The National Health Priority Areas (NHPAs) initiative aims to identify the most appropriate promotion, prevention and intervention strategies for the health areas targeted. It also recognises that specific strategies for reducing the burden of illness should be holistic, encompassing the continuum of care from prevention through to treatment, management and rehabilitation, and should be underpinned by evidence based on appropriate research. It should also be noted that the National Health Priority Areas represent a clustering of individual diseases/conditions and their contributing factors.

The *First Report on National Health Priority Areas 1996* focused on the health of Australians by documenting progress towards goals and targets for the five priority areas of: cardiovascular health, cancer control, injury prevention and control, mental health, and diabetes mellitus. In 1999 Asthma was declared the sixth National Priority Health Area. Individual reports on each of the

National Health Priority Areas, describing relevant data, trends, and activities for each of these areas is available at: <http://www.health.gov.au/hfs/hsdd/nhpq/npha.htm> or <http://www.aihw.gov.au/inet/nhpa/index.html>

## Policy Priorities for Victoria

Given the importance of enhancing and complementing work being undertaken at a national level, it is preferable that IDM activities in Victoria concentrate on one or more of the national health priority areas where local significance can be demonstrated. Due to the focus of chronic disease and prevention of chronic disease in IDM projects, priority areas, such as injury prevention and control and some cancers, are not as relevant.

Consideration may also be given to other major chronic diseases/conditions as a focus for IDM projects, such as arthritis, depression, chronic obstructive pulmonary disease and stroke-related conditions because of their significance in terms of burden of disease and the opportunity to build upon existing momentum in these areas.

Equally important is the need to explicitly link health promotion and primary prevention activities with IDM strategies, so that service providers target the risk factors associated with particular priority diseases/conditions—as well as the diseases/conditions themselves. PCPs are encouraged to undertake initiatives that address overlapping risk factors and support needs for a number of diseases/conditions or health issues.

Action areas for health promotion have been identified by the Department of Human Services, and should be used to guide PCPs in setting priorities for combined health promotion and IDM projects. The action areas are listed below:

Health promotion action areas for Victoria<sup>41</sup>

- Tobacco control
- Physical activity
- Healthy eating and weight

<sup>41</sup> Aged Community and Mental Health and Public Health Divisions, 2000, *Primary Care Partnerships Draft Health Promotion Guidelines*, Victorian Department of Human Services.

- Illicit and licit drugs—harm minimisation
- Injury prevention
- Reproductive and sexual health
- Cancer prevention, early detection (including sun protection)
- Heart disease and stroke risk reduction
- Mental health promotion
- Oral health promotion and disease prevention
- Diabetes prevention and management
- Asthma prevention and management
- Vaccine preventable disease control.

