

Incorporating CDSM support into an Aboriginal Health Service

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Development of a sustainable Chronic Disease Management model: the Living Improvements for Everyone (LIFE) Model

Purpose

This guide aims to give a structured 'walk through' of activities required to implement the LIFE model in any organisation. Implementation requires significant organisational change both at a systems level and practice level so consideration needs to be given for the support structures and management strategies needed to ensure smooth transition. For some organisations, it may be about recognising the work that is already occurring and coordinating activities to maximise efficiency and ultimately have bigger impact on the core reason for being, which is to improve Aboriginal health. This step by step guide begins by explaining the background to the development of this guide, and then presents the context including the state of indigenous health in Australia. The guide then outlines the preparation phase including organisation capacity building and change management, then moves on to the three main elements of the LIFE model describing how they could be developed into an integrated model of chronic disease management.

Background

The Sharing Health Care SA Project and the Rural Chronic Disease Initiative occurred simultaneously at Pika Wiya Health Service. Both projects had similar aims but different methodology. The result was a flurry of new activities: community involvement, innovations, implementing Enhanced Primary Care Medical Benefits Scheme item numbers and numerous health promotion activities targeting prevention, early intervention as well as chronic disease self-management. The Stanford self-management course commenced and adaptation of the program started and was renamed 'Living Improvements for Everyone' (the LIFE course). Around the same time, the Learning Centre was completed, a centre of Aboriginal Health Education where Health workers and nurses could study in a supportive environment. Bureaucrats visited from across the nation, media attention was high and activity levels were unprecedented. While this was happening, the Sharing Health Care Aboriginal Project workers were recruiting people to be in the project. They successfully recruited over 100 community people from across the Pika Wiya catchment area, most of them residing within the Port Augusta area, with some from Copley, Nepabunna and Quorn.

The LIFE model was developed to show the interdependence between many of the new activities happening in the health service and how teamwork can help to improve the health of clients. It highlights the many role overlaps and

how all health workers including GP's and visiting allied health workers can have input at different stages of the clients journey through the health service. Aboriginal Health Workers are imperative in this process because they are the link between client and other health workers; they are advocates and role models. Recognising the many challenges faced is also important for building their confidence to continue to provide a quality service

Context

Indigenous health in Australia is significantly worse than the health of non-indigenous people living in Australia. The incidence of chronic disease is higher; mortality rates in several categories are also higher. The following is a collection of statistics collected from a variety of sources to put Indigenous health status into the context of this guide.

Mortality and morbidity statistics

- Indigenous Australians have an average life expectancy of 17 years less than non-Indigenous Australians. And that is the national average – in many regional and remote communities the gap is closer to 30 years. And it is getting wider.
- Only about three percent of the Indigenous population will live beyond the retirement age of 65, compared to 13 percent of the non Indigenous population.
- Aboriginal children aged under 4 are more than twice as likely to be hospitalised for infectious diseases than non Indigenous children.
- Indigenous infants are almost three times more likely to die than non Indigenous infants.
- The incidence of kidney failure in some Aboriginal communities is more than 30 times the national average.
- A 2004 quality of life index of people from 100 different nations ranked Australia fourth overall, behind Norway, Iceland and Sweden. Indigenous Australians were ranked separately. They came second last. Only the Chinese had a worse quality of life.
- Adult Indigenous people serving time in jail make up 21 percent of the national prison population, despite accounting for less than two percent of the adult population.

Incidence of Chronic Disease

- Heart disease is 3 times more prevalent than in the general population
- Diabetes 8 times higher
- Respiratory conditions are 9-11 times higher
- Kidney disease is also 9 times higher

The Health and welfare of Australia's Aboriginal and Torres Strait Islander peoples (ABS & AIHW 2005).

<http://www.aihw.gov.au/publications/index.cfm/title/10172>

Aboriginal Wellbeing Targets, Department of the Premier and Cabinet SA 4 April 2006

Oxfam Australia, Aboriginal and Torres Strait Islander health March 2006

http://www.oxfam.org.au/campaigns/indigenous/docs/health_15032006.pdf

Why Chronic Condition Care is so important

Aboriginal people are not ageing like the rest of the population, in fact when compared; they are essentially a young population. However, chronic disease is much more prevalent, Aboriginal people are diagnosed with chronic disease at much younger ages and have higher death rates from essentially preventable chronic diseases. Growing evidence suggests that the acute care model is largely ineffective in dealing with chronic disease (Refer to Section 2 Resource Kit) and does little to prevent chronic diseases from occurring. An integrated approach to the prevention, early detection, early intervention and management of chronic disease is imperative to lessen the impact these diseases have on the health of Australian indigenous peoples.

<http://www.nt.gov.au/health/cdc/preventable/chronicdisease.shtml>

L.I.F.E Program

Living Improvements For Everyone

A Model of Integrated Care

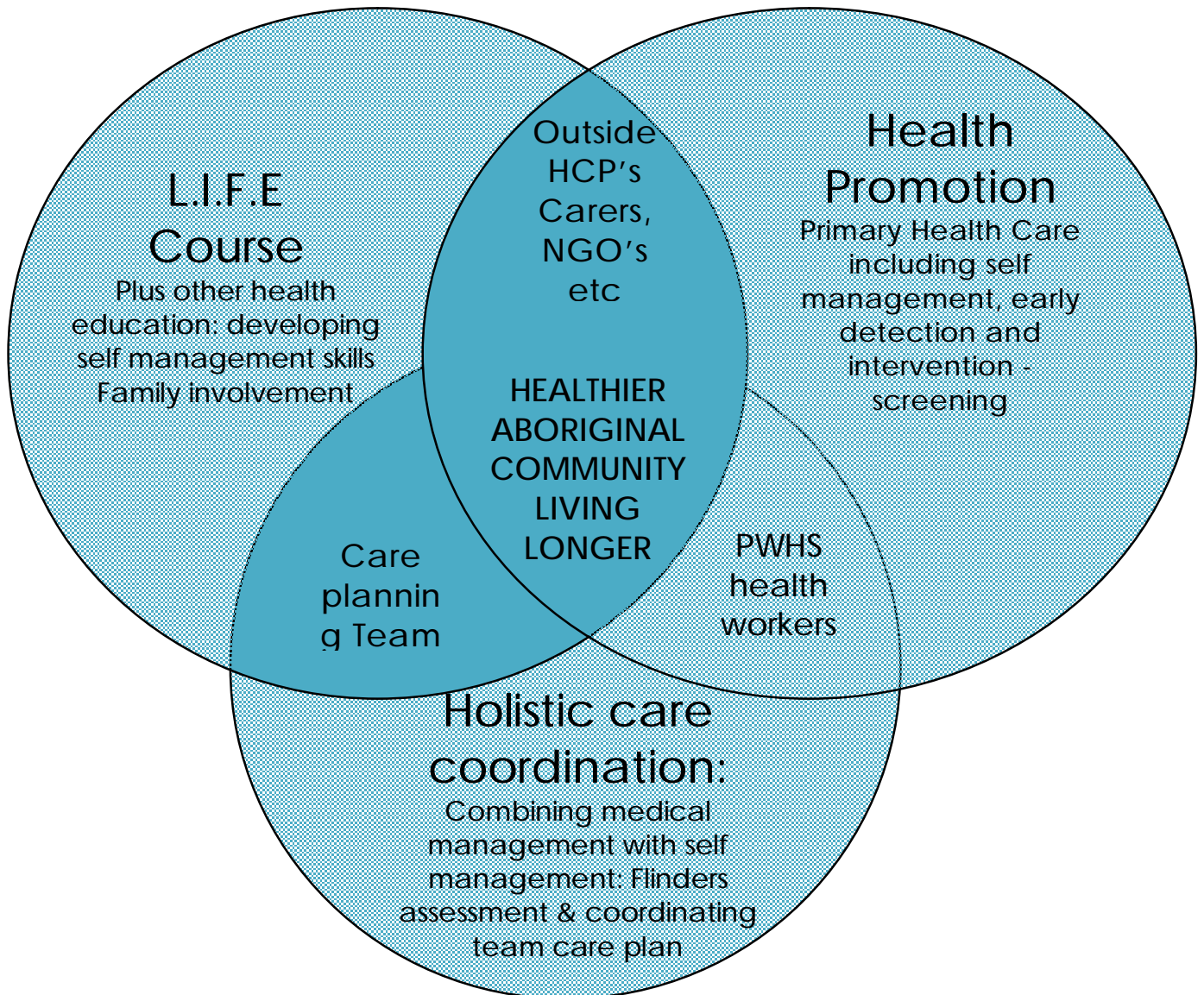


Diagram 1

What is the LIFE Model?

It is the model describing the LIFE program, a collection of activities that contribute to the improvement of chronic care services to Aboriginal people in a health service. Activities that encompass the prevention, early detection and intervention, as well as management of chronic diseases for the clients of an Aboriginal Medical Service. All activities and practices are based on currently available evidence based best practice. The three main essential elements are the large circles of the Venn diagram as above. The overlapping of the circles aptly represents the interdependence between the activities and the sharing of resources and care that occurs when the model is successfully implemented. These overlaps contain the people who contribute to the care of the clients, from inside and outside of the organisation: the health care team. The three circles congregate over the central aim of the model which is to improve the health of Aboriginal people so that they live long and healthy lives. This aim was developed through discussion and reflection of health workers, participants of education sessions, clients and project workers, all working and talking together. The wording of the aim is their words.

Each of the main elements has specific tasks and activities associated and are described in detail as follows:

1. Health Promotion

This part of the model is largely Primary Health Care, focussing on *prevention, early detection and early intervention*. Self-management has a role in all of these elements.

The National Chronic Disease Strategy defines Health Promotion as:

“The process of enabling people to increase control over, and to improve, their health. This incorporates actions not only at the level of the individual, but also aimed at building healthy public policy, creating supportive environments, strengthening community action, developing person skills and reorienting health services.”

Health promoting activities may include:

Health Service level

- Screening
- Adult Health Checks
- Child Health Checks

- Chronic Disease Triage
- Information & Education sessions
- Physical activities

Community events involving whole families

- Community Open Days
- Crocfest
- Elders lunches
- Celebrations

Using multimedia to get messages across

- Umewarra Radio – Aboriginal Community Radio
- Newspaper articles
- Posters
- Traditional artwork
- Pamphlets and brochures using language
- TV advertising
- DVD's (in waiting room)

Self-management has a large role to play in prevention and health promotion and is encouraged by health workers who participate in community activities, often volunteering their time to model self-management to the community.

2. Holistic Care Coordination

Chronic Disease Triage process

Triage is an extension of the client screening process described below:

Client Screening Process:

- Reception retrieves file and puts into screening basket. Flagged (this could be done by inserting red cardboard maker to alert health workers) as client requiring screening by health worker.
- Receptionist notifies health workers that client is ready
- Baseline observations to be completed:
 - Temperature
 - Pulse rate (note if regular or not)
 - Respiratory rate
 - Blood Pressure
 - Blood sugar level (BSL) also called Blood glucose level (BGL)
 - Urinalysis

The Health Worker conducting the chronic disease triage assessment will also look for other indications that the client requires further investigations, immunisation updates, and check eligibility for a range of structured Medicare Item number health assessments designed to detect problems early and initiate interventions before problems become unmanageable or complications occur. These Health Assessments cover Aboriginal people from birth to elder.

- Child Health Check
 - Adult Health Check
 - Aged Health Assessment
 - Men's Health Check
 - Women's Health Check
- } These can be done in conjunction with the Adult
- AND/OR
- Care Plan (for people with one or more chronic conditions)
 - GP Care plan
 - Team Care Arrangement

While a range of EPC and chronic disease management items is listed above, it is important to appreciate that the range and requirements of the items vary over time. It is, therefore, highly recommended that practices periodically check the full current details and requirements of the items at <http://www9.health.gov.au/mbs>. Details, sample pro formas, and checklists associated with the EPC items are available at www.health.gov.au/epc

What is a Care Plan?

A care plan is a useful mechanism for recording comprehensive, accurate and up to date information about the patient's condition and all of the treatment they are receiving. It can integrate a schedule of events that needs to occur over a period of time to ensure health is maintained, for example, blood tests, visits to podiatrist for foot care. Development of a care plan can also help encourage the patient to take some responsibility for their care, including by identifying any actions the patient might take to help achieve the goals of treatment.

Care planning helps in coordinating the services and treatment that a patient requires. It can be used as a tool for organising all of the care a patient needs and can help reduce the need for frequent visits to see the doctor.

http://www.aasw.asn.au/adobe/medicare/CDM_QAs.pdf

If the client has a chronic condition, then they are eligible for a GP care plan. If they have had a care plan in the past, the status of that plan needs to be checked. Is it current? Is a review due? Does it need to be updated because the health of the client has changed recently? For example, a new diagnosis means the care plan needs to be reworked to include the new diagnosis and new care needed to maintain health.

If the client has multiple chronic conditions and needs complex coordination of treatment and services, they are eligible for a Team Care Arrangement care plan, where multiple health care providers contribute in some way to the care of the client. More information about Medicare item numbers is available in the guide to 'Incorporating CDSM into General Practice'.

Care Planning in an Aboriginal Medical Service

It is recognised that Aboriginal Health Workers have a pivotal role in screening, assessing and identifying client's needs, being a role model and client advocate as well as a member of the community themselves. Clients often tell health workers many details about their lives and their health that they do not tell the doctor in a formal consultation, therefore it is absolutely imperative that Aboriginal Health Workers are involved as part of the care plan team.

The team approach to care planning is advocated in this guide. GPs cannot possibly undertake every task associated with care planning for people with chronic conditions on their own. There are tasks in the care planning process that are legally a GPs responsibility and there are many more that can be successfully delegated to an Aboriginal Health Worker, nurse or allied health worker. Who does exactly what needs to be negotiated by the whole team and then be coordinated to ensure that a quality patient centred care plan is completed, documented, reviewed and followed up when scheduled. The GP is the central responsible health worker in this process but does not have to necessarily coordinate all activities to provide good quality chronic care. A guide to care planning using Medical Director in an Aboriginal Medical Service is included in the CDROM

Aboriginal Health Workers involved in care planning processes should be able to:

- Identify clients who are eligible for and have a need for a care plan
- Explain care planning process to clients
- Complete a Partners in Health Framework including explanation to client, administer self assessment, perform Cue and Response, Problems and Goals and self-management plan
- Open Medical Director, access and print relevant sections to care planning
- Integrate the Partners in Health findings and recommendations into the Medical Director care plan
- Compile report of care plan recalls due and initiate review process
- Initiate recall system via Medical Director
- Demonstrate awareness of the basic relevant screening and preventative tests (pathology) and procedures depending on the client's age, health status, sex, and chronic conditions. Others may be initiated by the GP according to their assessment and needs analysis.

- Recognise which clinical observations are needed for specific chronic conditions
- Communicate and collaborate effectively with a multidisciplinary team (internal and external) and integrate third contributor's findings and patient goals into care plan
- Follow care plan check list to ensure all health workers responsibilities completed prior to booking care plan finalisation with GP
- Initiate follow-up referrals

Introducing Self-Management concepts to clients

All aspects of the care plan need to be explained to the client for them to give an *informed* consent – that is they know what they are consenting to, what the benefits for them are, what the process will be and how much it will or won't cost them. At any stage of the care planning process, they have the right to withdraw their consent and stop the progression of the care plan. In this instance, it may be better to re explain the benefits and then give them some time to reconsider. Ask them next time you see them whether they wish to continue. Never become pushy or bossy in this process, one bad experience for a client will equate to many clients not being willing to give it a go. It's all about how you sell the idea to the client; focus on the benefits the care plan will give them, how it will make management of their condition easier for the doctor as well, therefore improving their health by picking up complications earlier, ensuring all preventative screening and measures are completed promptly and including them in decision making.

Flinders CCSM Assessment tools

It is imperative that this process is completed prior to starting the care plan. This will form the basis of the plan and ensure that all social and emotional issues are included and strategies developed with the client to address issues. There may be many issues that cannot possibly be dealt with all at once. Let the client lead the priorities according to the problems and goals assessment. Their greatest problem right now might not be what you think and it may be a huge barrier to their self-management. The process will also foster the relationship building and rapport necessary for open and honest communication to occur for the better management of the client's condition(s). (Refer to Section 3 of Resource Kit) or visit the website for more information <http://som.flinders.edu.au/FUSA/CCTU/>

Patient Information systems

Using electronic care plan templates is a quick and easy way of ensuring the care plan is medically relevant to the patient's condition. There are a few different systems available, the most common one being Medical Director Software. An in-depth look at setting up care planning using Medical Director Software is included as an attached guide.

The accuracy of the data that is moved across from the client database depends on how up to date the patient information is. Always check the relevant sections before commencing the care plan to save yourself and the GP a lot of work.

Integration of Partners in Health findings

Information discovered in the cue & response and problems & goals should be included in the care plan under the client's medical problem list. It is important to include all those issues that the client believes has an impact on their life, as these issues could be barriers to their self management. All efforts are made to help the client problem solve these issues and develop goals to meet their needs. It is also important that the client develops their own way of coping with these issues instead of relying on the 'quick fix' offered by health workers, as is the case all too often. So don't automatically give answers, help them to find what will suit them best.

Recalls for reviews and renewals

Follow up with the client is necessary to track progress and give them feedback about how they are doing. Reviews can be done every 3 months but should be adjusted according to the client's health status and their self-management abilities. Reviews can be changed to six monthly as clients get better at managing their health. An annual renewal is recommended to review every part of the care plan including the multi disciplinary input. It is assumed that the collaboration with a third party, an allied health worker, carer, outside GP, optometrist etc is continuous and is updated when there are any changes. It is vital, therefore to keep in contact with each other and keep up to date with any change in management goals.

3. The LIFE Course

Living Improvements for Everyone: LIFE – A course in chronic condition self management

The Stanford model of Chronic Disease Self-Management is described in detail in the Guide to implementing a Stanford course included in this resource. Guidelines regarding how to set up the course is also described in detail, therefore it won't be repeated here, rather what else needs to occur to ensure the successful launch of the course in an Aboriginal Medical Service setting.

Background and Introduction

The LIFE course has been adapted culturally specifically for the local Aboriginal community from the Stanford Chronic Disease Self-Management Program. Using a process of participatory action research, the original

Stanford course was delivered in whole to a group of clients who had been attending other health education sessions. Participants were encouraged to give feedback during and after the sessions. Focus groups were held and the course was facilitated again in a slightly different way. Again, feedback was sought. Using this method, the course was changed over time to be more culturally relevant to Aboriginal people in regards to language, life examples, learning settings and approach.

The manual was then further refined to ensure that Aboriginal Leaders facilitating the course could do so with competence and confidence. The course is a 'Peer Education' based course, therefore it is vitally important that the facilitators be peers, that is, that they have things in common with the participants and that the participants can relate to them. Because peer education is the underlying philosophy for the course, the aim is for enabling communities to facilitate their own courses to be delivered locally by their own peer educators.

Building Health Worker capacity for CDSM

Training

The LIFE Leader's training is a 5 day course held over two weeks. Two days the first week and then three days the following week, with a week's gap in between. This way the Leaders experience the entire course content, make an action plan and report back the following week just as participants would do in a six week course. The first 4 days are the same as the Stanford generic program training. This is important to ensure Leaders have a complete grasp of the whole program and can qualify for the Leader status for the fully evaluated Stanford program. The extra day of training is focused entirely on the Aboriginal adaptation the changes to the course and the reasons for those changes. There is extra practice teaching using the new manual and participants are encouraged to use local language in their presentations just as they would in their own community.

For further information regarding training contact Kate Warren

kate.warren@unisa.edu.au

Translation

The manual has not been translated into any Aboriginal language. There are so many, it would be impossible to choose which one to start with and there is not much complete documentation of translations of specific Aboriginal language to assist in the translation. It would also be an expensive and time consuming undertaking that may have little or no value. It is considered that local people who can be trained as Leaders and translate to their participants while in the process of facilitating the course, would be the best

model of course dissemination. In the future, there may be an opportunity to translate into a specific language, given enough resources and support.

Commencing Community Education Sessions

Getting the word out

- Using social and family networks, word of mouth
- Client base
- Flyers, posters, pamphlets
- TV advertising, classified ads
- Local newspaper or newsletter
- Aboriginal run radio stations

Be sure to offer lunch or afternoon tea, transport and any other support needed to get people to where the event is. Advertise the fact that these will be provided.

Implementing the LIFE Model

Preparation

Know the health services clients

It is easy to make assumptions about what the needs of our community are and to put resources into a program without really knowing whether it is doing any good or reaching the people at most need. To really know what the health needs are, good information and reporting systems need to be developed so that at any given time you can see, for example, how many clients have diabetes, how many of those are men, how many are children. This system doesn't have to be computer based but for large health services with many clients, it would be the most efficient and use less time to build and extract information. However, if the computer systems are not already in the service or there are not staff trained in the use then using paper or card based systems can be just as effective although it may take more hours to build and maintain.

The basic information that is needed:

- Total number of clients (of course this will change over time but a good system will be continually updated)
- Total number of males and females and their age breakdown
- Incidence of chronic disease (so in effect a chronic disease register)
- Incidence of risk factors in the client population, factors which greatly increase peoples chance of developing a chronic disease, for example smoking, overweight or obese, high blood pressure and inactivity

Staffing considerations

- Know the health workers and other staff in the organisation
- What skill mix is there – what is needed
- Identify areas that need improvement - training needs analysis
- What systems are in place – what is needed?

For example, Aboriginal Health Workers who are involved in the care planning process must be proficient in:

- Flinders Self-Management Assessment tools
- Medical Director Software (or the equivalent used in their service)
- MBS Care planning (with GP), Care plan reviews, Team Care Arrangements
- Liaising with relevant and appropriate allied health and other sector staff who are involved in the ongoing care of the client.

Building Organisational Capacity

An organisation needs to have underlying supportive structures in order to successfully develop any initiative to improve the health of clients.

Many of those structures are listed here and must be robust to support and manage the organisational change that needs to occur to underpin the initiative.

- Relationship with board
 - Board approval and information sharing with regular feedback and communication
- Planning
 - Project planning, strategic planning, business planning and ongoing review involving as many staff as possible.
- Governance including clinical
- Policy & Procedures
- Steering committee – relevant stakeholders
- Organisational structure
- Management Structures
- Workforce Management & Human Resource Management
 - Staff development: to build the skilled workforce needed to implement the model and improve client health
 - Succession planning
 - Performance management: a supportive process to assist people reach their potential while ensuring optimal performance and productivity
 - Recruitment & Retention
- Information technology: equipment, hardware, software
- Information management: systems and trained people to use the technology effectively

Change Management Strategies

Any change can cause people in the organisation to resist. Too much change at once can cause higher level of resistance; people just can't cope with it. There are ways of integrating the changes that occur when introducing new activities into an organisation can mean the difference between success and failure. These are based on experiences and are by no means exhaustive:

- Develop some 'change champions'. People/staff in the organisation that are respected and seen as role models to champion the cause and support the change
- Forming a Steering Committee of relevant stakeholders in the organisation is important to obtain a wide range of input and opinion from the people within the organisation who are going to make most of the changes. Having them on side will determine success and affect the time take to implement the program.
- Have ready evidence of the benefits of the element of the program to 'sell' the idea to staff. Do not focus on financial benefits to staff who are not affected by financial considerations – they want to know how it benefits clients and staff.
- Hold regular meetings and updates for all of staff
- Hold regular information sessions: these can be regarding other important topics that support the model, for example, making a complaint vs. reporting something gone wrong; continuous quality improvement: health workers role; process mapping the client through the health service
- Build staff in-service and ongoing training into regular business of the service to encourage the 'learning organisation' ethos
- Advertise progress in tea rooms and meeting room, for example a graph of progress over a few months can show staff how their efforts are making a difference.
- Give credit where it's due: congratulate staff on success
- Regularly seek advice from people experienced in the model