

BRIEF (11) July, 2008

Implementation Framework to Support Care Coordination, Nurse-led Model

This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland.

Background

This briefing presents a developmental framework which has the potential to be trialled in the general practice setting. This model is currently being trialled by participating practices supported by the Gold Coast Division of General Practice. Briefings 9 and 10 provide the background to the development of the Implementation Framework. The full article (in journal publication review) can be found at www.gpqld.com.au/Programs/Collaborative_Research_Hub

Developmental Implementation Framework (Based on the AHRQ Framework)

The current study reported in briefings (9-11) has indicated the need for a supportive developmental process that incorporates a range of broad structures to assist practices to engage in the delivery of coordinated care. An appropriate developmental implementation system could be based on the Putting Prevention into Practice framework (Agency for Healthcare Research and Quality [AHRQ], 2002)¹ that has been used successfully to increase the prevention orientation of general practice. The AHRQ framework has a staged approach to systematically supporting the care coordination process.

Stage One

To improve the systems within the practice, the model needs to integrate all aspects. This will involve firstly identifying:

- Practice Readiness – Assess readiness for change including staff values and beliefs and patient opinion;
- Consensus about the concept of care coordination;
 - Definitions of care coordination
 - Presentations on culture change
 - Resources including practice-specific business modelling
 - Consumer stories

Stage Two

Practices need to audit their current care processes, systems and patient flow to inform:

- Areas of need
- Gaps and flaws that could be rectified through a care coordination model

Stage Three

Create a supportive process in determining their own localised model of care coordination. Appendix 1 provides a step by step process (which can be adapted to meet the capacity of the practice) to help develop localised standards, goals, processes and tools for their practices.

To further support practices, a range of resources should be developed using either existing repositories or developed collaboratively (all staff should be involved in this process to help support the adoption of the tools in practice). Examples include:

- Templates for referral and reporting
- Planning tools
- Health checklists
- Service directories

Stage Four

Practices should develop tasks, responsibilities and flow charts to define how they will operate. Tasks should include:

- Participatory evaluation process – involves
 - Sharing information with other practices
 - Collecting a minimum data set for process and outcome evaluation
 - Engaging in quality improvement activities

AHRQ system is supported by a range of checklists and worksheets which supports data collection and evaluation processes with minimal impact to practice staff.

Partnerships and Networks

Partnerships

To support the implementation and adoption of the AHRQ system and proposed framework, partnerships and networks are emerging as important links. Higher-level support with Divisions, District Health Services, NGO services and agencies within government are required to support partnership development and negotiation with key external services.

Networks

Inter-organisational networks have developed in a range of clinical areas. Chronic disease related networks are beginning to emerge and it is recommended that more formalised networks are established. The Divisions Network, SBO and other inter-agency and government sectors are well placed to support chronic disease networks. Advantages of networks include:

- Responsiveness
- Service flexibility
- Robustness
- Cross-disciplinary opportunities across sectors and organisations to seed innovation
- Connection between agencies
- Coordination of resources
- Advocacy and lobbying

Localised Solutions

This series of briefings highlight strategies to support the adoption of localised approaches to models of care coordination. Nurses need to be supported through the process of cultural change, defining their roles, providing support resources and tool kits and mentoring them through the practice change. Practices also need to be supported in the broader context by Divisions of General Practice through partnership approaches and collaborative networks.

Acknowledgments

This briefing is a summary of a research paper (in journal publication review)

Paper Title: **A Practice-Based Model of Care Coordination for Chronic Disease Management: The Role of Nurses in General Practice**

Available at: www.gpqld.com.au/Collaborative_Research_Hub

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Appendix 1

CDM Task 1: Assess (*Identify chronic conditions and risk behaviours*)

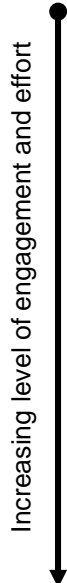
	Practice-based Actions	Patient-based Actions
Increasing level of engagement and effort 	File audit to identify all active patients who have been diagnosed with an “in-scope ¹ ” condition, are at risk of a chronic disease or require review. Maintain an active register of patients with chronic conditions for future review.	Brochures and posters to encourage patients to identify themselves to the nurse if they are at risk of having an in-scope condition
	Passive screening of risk behaviours and chronic conditions among patient population (i.e., survey mail-out, phone call, email/SMS, or in practice waiting room).	A chronic disease website for patients containing a screening tool to self-identify symptoms of in-scope conditions and risk behaviours – prompt to contact nurse.
	Active screening of risk and condition in the practice waiting room (i.e., BMI calculations, blood-glucose tests while waiting etc.).	
	Diagnosis of a chronic disease automatically triggers a referral to the nurse for assessment of symptom management, risk behaviour and needs	

CDM Task 2: Advise (*Offer brief advice*)


	Practice-based Actions	Patient-based Actions
Increasing level of engagement and effort 	Generic checklists for healthy behaviours and diet	Relevant videos, posters, brochures or books in waiting rooms to provide brief information
	Designated “question time” sessions with nurse for diagnosed patients immediately following diagnosis	Provision of a “Recommended Readings” sheet for patients following diagnosis
	Health Prescriptions completed by nurses for exercise, diet changes and self-management strategies	
	Advertised information sessions conducted by peak organisations such as Heart Foundation	Provision of self-directed guidebooks or manuals

¹ In-scope refers to the specific chronic condition that has been selected by the practice as its focus for CD Management by nurses

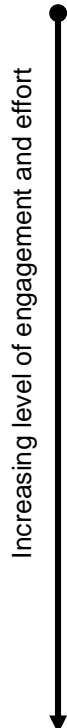
CDM Task 3: Agree (Set collaborative goals and action plans)

	Practice-based Actions	Patient-based Actions
Increasing level of engagement and effort 	Capitalise on opportunities for nurses to get to know patients and their goals	Relevant videos, posters, brochures or books in waiting rooms to provide brief information about in-scope conditions and healthy behaviour
	A needs and barriers assessment tool or checklist to help patients and nurses to identify areas for action/support	Provision of a "Recommended Readings" sheet for patients following diagnosis
	A planning and goal-setting process and template for working with patients to set collaborative goals	A "Readiness for Change" checklist and resources to support patients to monitor their commitment to goals
	Regular "case conference" times between nurse and GP to discuss Plans	A summary sheet for patients containing their agreed goals and strategies for achieving goals
	Guidelines to support the use of MBS item numbers that pertain to CDM	

CDM Task 4: Assist (Provide intensive education, coaching or case management)

	Practice-based Actions	Patient-based Actions
Increasing level of engagement and effort 	Practice hosts seminar/workshop series by local support groups/ specialists/allied health practitioners	Checklist for patient on Reasons to Contact your GP
	Practice-based self-management training, activity/diet support group with nurse and/or peer leaders	Checklists for patients about self-care behaviours and healthy living, Practical suggestions for healthy cooking, daily exercise
	Engagement of families in treatment discussions and solutions with consent of patient	Education sessions or brochures for family about how to support patients – engagement of natural supports
	Weekly/monthly telephone coaching with patients around specific goals	Coordination and dissemination of information about local self-management courses, support groups and education sessions
	Motivational interviewing sessions to assist patients to address barriers in their goal achievement	Illness calendars/activity logs or health and diet diaries for active monitoring of CD
	Workbooks and active homework assignments for guided self-management of CD	Provide devices for self-monitoring symptoms and risk behaviours (i.e., pedometers, BP etc.)

CDM Task 5: Arrange (Organise services, follow-up and reinforce change)



Practice-based Actions	Patient-based Actions
Planned networking opportunities with NGO services	Waiting-room displays of brochures from NGOs and community organisations/available services
Specialist, allied health and service registers/databases	Regular advance-booked schedule of check-up appointments following diagnosis/identification of risk
Agreed communication systems and templates between practice and specialists/allied health/hospitals regarding referral, reminder and reporting	Patient hand-held diary of health-related activities and outcomes record to be updated regularly with nurse
Telephone/SMS/Email follow-up with patients immediately following referral/appointment with specialist/allied health/hospital or NGO.	Patient feedback sheets conducted by email/SMS/website/phone and satisfaction surveys following appointments at practice and referral to specialist/external service
Documentation of patient achievements for GP and patient – celebrations of success	Patient progress charts or goal attainment scales for patients to reflect on progress and report to nurses (via email surveys, SMS, phone).

1 - AHRQ, Agency for Healthcare Research and Quality. (2002). Put Prevention into Practice: A step-by-step guide to delivering clinical preventive services: a systems approach. AHRQ Pub. No. APPIPO1-0001.