Implementation of an Integrated Care for People with Chronic Conditions (ICPCC) program in practice in Sydney, Australia

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Background

- Care Coordination is part of the New South Wales (NSW) Health's Integrated Care strategy.

  "deliberate person-centred organisation of patient care activities between providers to facilitate self-management, appropriate care, health outcomes and greater efficiency" *(CPHCE 2017)*

- Care coordination in NSW
  - A successful model trialled in one area scaled up to other areas.
  - NSW Health's *Integrated Care for People with Chronic Conditions* (ICPCC) program implemented differently in Local Health Districts
- ICPCC program in South Eastern Sydney Local Health District
  - Risk stratification algorithm is generating a list of patients who need assistance, but sometimes sourced patients are at end stage of their disease trajectory and are unable to self-manage
  - Importance of local health professional referral to the program to ensure best fit
  - With constant change in Integrated Care policy and practice, there is a need to understand how programs are implemented in practice to ensure effective management and delivery.

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Aim and objectives

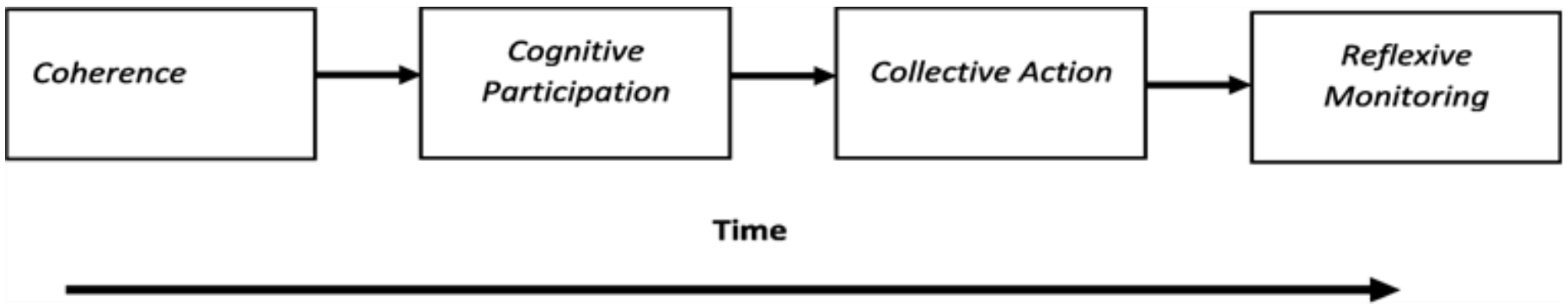
Aim: How is the ICPCC program conceptualised and implemented in practice?

Research questions:

How is the ICPCC program implemented at the consumer, clinician, District and NSW Health levels?	What are the characteristics of patients identified for inclusion to the program through risk stratification processes versus local health professional referrals?	What are some case studies of patients included in the program that highlight the type of patient and care provided at the local level?

Project methodology

- Qualitative – 15 interviews and a focus group with different levels of staff
- Quantitative – to assess the characteristics of program patients identified through the algorithm versus referrals.
- Normalisation Process Theory of how ICPCC program intervention is implemented in practice



Alharbi et al 2014 in May et al 2018

Erica identified through an algorithm

66-year-old woman living alone with six admissions to the hospital in two months for atrial fibrillation or ‘heart flutters’. After arriving at the hospital, staff could not make any clinical assessments. She was investigating her health privately although on a low income. Erica was assessed as having potentially preventable hospitalization through a risk stratification algorithm in the Patient Flow Portal which generated a score above 8 and therefore eligible for the Integrated Care Program for People with Chronic Conditions program. Erica was allocated a Care Coordinator who did an assessment of her needs and health goals. Interventions:

Health coaching manage her high blood pressure

Care coordination and navigation linked with a multi-disciplinary team of a General Practitioner, heart specialist and a psychologist.

> She wanted a management plan, she wanted to know what she had to do. … she was ready to change. **Care Coordinator**

Self-management plan enhanced her understanding of heart failure and setting a self-management plan to understand risk before needing to come the hospital.

Client outcomes Erica was in the program for six weeks. 4 months after, she had not had any hospital admissions. She was back working

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Bruce identified through referral

Bruce is a 53-year-old man who is morbidly obese, has Coronary Obstructive Pulmonary Disease and some respiratory problems. He had poor management of his oxygen supply and had not seen a specialist for 18 months. He had not been in hospital because he can not get down the 30 stairs in in his accommodation. He had poor health hygiene and had not showered in eight months. His 22-year-old daughter is obese and agoraphobic. An aged care social worker from the local hospital contacted the ICPCC Care Coordinator.

Types of interventions

Bruce was added to the Patient Flow Portal and the ICPCC program. His CCPIA score was 4, under the risk threshold of 8 for the District.

- Care navigation and health coaching
- Respiratory chronic care program and team
- GP
- Social work support
- Occupational therapist
- Dietician

He was [an example of] a good partnership. That is the kind of patient we share. **Care Coordinator**

Outcomes The respiratory team provided tubing for him. The Care Coordinator worked with the social worker and Department of Housing to get Bruce accommodation downstairs and with the Occupational Therapist to get the Department of Housing to provide a bariatric shower chair and rails in his bathroom.. Bruce has lost a little bit of weight and can easily get access outdoors. He has regular contact with the health team.

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Findings

Coherence – sense making work	Cognitive participation – relationship work	Collective action – enacting work	Reflexive monitoring – appraisal work
Distinctiveness of ICPCC holistic approach compared to other programs Program flexibility in an evolving integrated care context	Relationship building, flexibility and networking to other chronic disease programs Moving beyond the legacy of the previous duplicative program	Finding the right patient cohort that can self manage Knowledge of other programs in the District ICPCC staff skillset and competency	Disseminating ICPCC benefits and need for coordinatedcare approach Communicating and implementing locally

Table 1: Implementation of ICPCC program using Normalisation Process Theory

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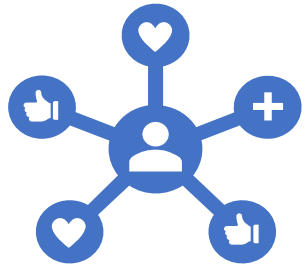
NPT - Coherence

Distinctiveness of ICPCC Program integrating and coordinating care for patients with complex multi-morbidities at risk of potentially preventable hospitalization. It focuses on patient self-management and providing a holistic assessment of physical and social needs.

"There are a lot of chronic care teams to deal with specific chronic illnesses, like the respiratory team or the heart failure team, which these [patients] may already be involved with. But for some people, they have a range of comorbidities or they have some other issues or social issues that actually might make it more difficult for them to manage their chronic condition". Care Coordinator I.10



Program flexibility and adaptability in an evolving integrated care context

It probably has a different purpose in different districts, because we need that level of flexibility to be able to implement the program, looking at what other resources are already available in the district… We were pretty aware of not duplicating what's already out there, and of course what's out there keeps changing. Middle Management

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NPT - Cognitive participation

- Relationship building, flexibility and networking linking programs

A lot of [the implementation] was around the networking that we started to pursue quite actively with the Clinical Nurse Consultants and particularly around the chronic disease committee and then also the linkages with our practice nurses … Most of the programs that are out there are usually aligned to specific disease processes … we tried to market ourselves as 'the linkers'. Looking at the whole picture of filling those gaps around the edges [for patients] … a lot of it is about relationship building and being available when they need it. Care Coordinator

- Moving beyond the previous Care coordination program

What we found when we started, was a lot of preconceived antagonism particularly in the southern sector, where Connecting Care had been [which] required a lot of networking. **Care Coordinator, FG**

NPT - Collective action

- Finding the right patient cohort

> People at the upper end of the algorithm are less able to respond. They are more advanced in their disease … [but] should we be targeting people who aren't as advanced. If one scores lower in the algorithm, because they still have more functional capacity to respond to the interventions, we actually might get essentially a bigger bang for our buck by intervening early, in that chronic disease process. The characteristics [of suitable patients]… are those ones who may not be so far down their chronic disease pathway. Middle Management

- Knowledge of other programs in the District
- ICPCC staff skillset and competency

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NPT - Reflexive monitoring

- Dissemination of ICPCC benefits

I would expect that there's a clearly articulated model of care with an inclusion criterion that we have adequately promoted, or informed, … that people who need to know, do know about what the service is and how to access that service, and for what purpose." SESLHD Manager

- Communicating and implementing locally

I don't understand how the service is structured… The integrative care service sent me this email... I don't quite understand why there were three people working in this service, with nine people [patients] on their books, and we have one and a half [staff] for 90 [patients]. Referrer

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Discussion

- Implementation of the ICPCC in SESLHD is driven by context
  (coherence + health change = flexibility)
- Balancing patient health goals and systemic goals to prevent hospitalisation – both present in program practice
- Importance of local referrals and algorithms
- Work done – relationships and communication essential to care coordination
- Importance of local networking and care coordination working with other programs (reduce duplication)
- Normalisation process theory usefulness (less judgemental of program)