Rapid Review: Integrated Care Interventions

Final report

Prepared by the Centre for Primary Health Care and Equity, University of New South Wales

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INTRODUCTION

The NSW Ministry of Health has commissioned a review of integrated care interventions delivered or commissioned by NSW Health, with a focus on chronic disease health coaching.

Delivering integrated care is one of three strategic directions of the NSW Health Plan: Towards 2021. The NSW Integrated Care Strategy launched in 2014 aims to reduce the fragmentation of health services through the delivery of seamless effective and efficient health care. For people with chronic and complex conditions, who are high users of health services, this translates to a system of care that is responsive, multidisciplinary and coordinated and one which maximises the empowerment of patients and their carers, and reduces unnecessary demands on acute health services.

The review has been conducted by the Centre for Primary Health Care and Equity over the period from August through December 2016. The team who conducted the review is listed in Appendix 1.

This work was overseen by a steering group comprising representatives from the NSW Ministry of Health (Health & Social Policy, Population Health, Health System Information & Performance Reporting, System Performance Support), Local Health Districts, Primary Health Networks, Agency for Clinical Innovation and Healthdirect Australia.

Review Objectives

The specific objectives of the project are to:

- develop definitions for health coaching for chronic conditions, care coordination and care navigation;
- review the integrated care interventions of care navigation, care coordination and health coaching (with specific emphasis on the latter), describe their components and what each aims to achieve in relation to chronic conditions management;
- explore the relationship/s between chronic conditions health coaching and interventions designed to improve coordination and navigation of services generally for people with chronic disease; and to explore the relationship between health coaching and support services offered to patients transitioning from acute care;
- provide a comprehensive understanding of the care navigation, care coordination and health coaching currently being utilised in NSW Local Health Districts (LHDs) and networks including the systems, processes and infrastructure supporting service delivery and how these can be recorded and reported under Activity Based Funding (ABF); and
- based on this review, comment on the ability of LHDs to support the three integrated care interventions and make recommendations for future service delivery within the current policy context.

Context

In NSW the Chronic Disease Management Program (CDMP) was established in 2010-11 as a state-wide program to improve care coordination and self-management for those people identified as being at risk of unplanned hospitalisation/emergency department (ED) use. The evaluation of the CDMP found considerable variation between and within LHDs in their models of care coordination and self-management, including health coaching. LHDs developed their own models that reflected their history and local circumstances reflecting the absence of clear definitions or expectations

about care coordination and self-management or the desire to standardise programs. It is currently undergoing a redesign process and being aligned with the Integrated Care Strategy.

Integrated care is one of three strategic directions in the NSW State Health Plan: Towards 2021. It is defined as follows:

'Integrated care involves the provision of seamless, effective and efficient care that reflects the whole of a person's health needs; from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and family. It requires greater focus on a person's needs, better communication and connectivity between health care providers in primary care, community and hospital settings, and better access to community-based services close to home' [1].

Innovative approaches to integrated care are being implemented within all LHDs and Specialty Health Networks (SHNs), supported by a number of enablers: eHealth, Patient Reported Measures, Risk Stratification and Monitoring and Evaluation.The Commonwealth government has invested in supporting better chronic disease management through primary care with the introduction of Medicare items supporting the development and review of GP management plans (GPMP) and multidisciplinary team care arrangements (TCA). However uptake of these items has been variable. A recent study found that fewer than one-third of people with one to three or more chronic conditions had a GPMP or TCA, and fewer than 12% had a review of these plans and arrangements [2]. Review of these plans is especially important in preventing hospitalisation [3]. These findings highlight the need to consider the infrastructure, systems and processes required to support implementation of care coordination initiatives. In part to address these issues the Commonwealth Department of Health (DOH) will be introducing a number of pilot Health Care Homes in 2017. This initiative along with NSW Health and Primary Health Network activities based on the principles of the Patient Centred Medical Home, such as Health Care Homes/Neighbourhoods, may have a significant impact on LHD integration strategies.

Internationally health systems are responding to the increasing prevalence of chronic and complex conditions through reorienting towards primary health care, and developing new models that support patient-centred care and integrated care. Strategies to coordinate care have been identified [4] and there is increasing evidence of the value of self-management and care coordination interventions [5-7]. There is also evidence for the effectiveness of telephone health coaching for some population groups with chronic conditions, and unscripted telephone health coaching enabling more tailored approaches for vulnerable groups [8]. However implementation within complex health systems has been incomplete and fragmented [9]. This body of evidence points to the need to consider the impact of uncovering unmet need and what works, for whom, under what conditions and in what context in identifying best practice models.

The current review aims to inform the development of a shared understanding of care navigation, care coordination and health coaching based on the literature and the experience of existing programs[1] in NSW.

SECTION 1A: SUMMARY OF FINDINGS

In this section the three integration interventions are defined and key characteristics of each are identified. Comparisons are made between evidence from the literature and current practice. This is based on the literature review, consultation processes and qualitative and quantitative data collected from the LHDs which is fully described in Section 2.

Health Coaching

Working definition:

A patient-centred approach to goal-setting, active learning and self-management that guides, empowers and motivates an individual to change their behaviour (Modified from Wolever [10]).

Components of health coaching

Health coaching programs predominantly support patients to modify behaviour, self-manage and monitor their chronic conditions and medications. Some health coaching programs were incorporated into usual care. Some reported discordance between coaching as defined and as provided in practice.

Areas for further development

Current practice tends to focus health coaching on health problems identified by health services rather than supporting patients to identify their own goals. There is potential for greater emphasis on patient empowerment in health coaching.

	Evidence-based practice	**Current practice**	***Areas for further development***
1. Component activities	Core components are [10]: • Patient directed goal setting, • Self-discovery/active learning, • Motivational interviewing and support.	Current practice most frequently includes: • Assessment of needs and readiness to change • Behaviour change techniques (such as motivational interviewing	*Increased emphasis on active learning and patient-directed goal setting in the design of coaching programs and the training of staff to deliver them.*

[1] The term 'programs' is used here rather than 'interventions' to reflect LHD usage. Throughout the report, 'interventions' will be used to refer to health coaching, care coordination and care navigation as described in the literature or used in a general sense, and 'programs' will be used to refer to health coaching, care coordination and care navigation in the context of service delivery in LHDs.

	Evidence-based practice	Current practice	*Areas for further development*
	However, the exact mix of components may be tailored according to risk and condition [8].	• Goal setting and self-monitoring • Providing information/education.	
2. Target group	• Higher risk patients with long term conditions [11, 12]. • Includes patients with cancer, chronic infectious diseases, diabetes, cardiovascular disease, chronic respiratory and neurological diseases, musculoskeletal conditions, and mental health conditions. • Lower risk patients with obesity and lifestyle risk factors.	• Most LHDs had formal eligibility criteria with the majority focusing on specific chronic conditions or high risk patients enrolled in programs (rehabilitation, care coordination). • Some targeted a population group such as pregnant women with risk factors/ behaviours.	*Some patients were not higher risk although they had long term conditions. It may be better to focus face-to-face coaching resources on patients at higher risk and possibly offer others telephone coaching.*
3. Who delivers	There is evidence for the effectiveness of coaching delivered by a wide variety of coaches including: - • Health professionals (nurses*, doctors, health care assistants, pharmacists, dieticians, psychologists, social workers) • Community health workers, trained peers • IT-based coaches (avatars).	Internal • Nurses (RNs and ENs) • Allied health • Aboriginal health workers. External • GPs • Psychologists or counsellors	*There is scope for involvement from a broader range of appropriately trained coaches, especially community health workers who speak the language of the patient and understand the culture.*
4. Training and skill set	• Providers should have specific coaching training additional to their professional qualification. • **Core competencies include** 1. Assessment of needs 2. Goal setting and addressing barriers 3. Motivational interviewing	• Most coaches have received training in coaching but it is very variable. • **Core competencies addressed in training include** 1. Ability to assess goals and readiness to change 2. Behaviour change techniques including motivational interviewing	*There is potential for more standardised training reflecting core competencies and includes knowledge of local community resources and provision of social and emotional support.*

	Evidence-based practice	Current practice	*Areas for further development*
	4. Provision of social and emotional support 5. Knowledge of local community resources.	3. Teaching self-monitoring.	
5. Mode of delivery	• May be delivered individually face-to-face, by phone, videophone online or in a group. • Should be guided by protocol or computer algorithms to ensure fidelity.	• Mostly delivered face-to-face, by telephone or combination. Few examples of web-based coaching. • Most did not use computer algorithms or protocols.	*Coaching could be guided by protocols or computer algorithms to ensure fidelity with evidence based practice.*
6. Duration and intensity	• Coaching should continue for 6-12 months (with weekly to monthly sessions- average 10 sessions in total). • Follow up is required to help maintain behaviour change and address relapses.	Coaching programs are of variable duration depending on individual patient need. Most last 3-6 months.	*Coaching could continue for a minimum of 10 sessions delivered over at least 6 months.* [2] *There should be follow up or reminders beyond this time to help maintain change.*

*Most frequently cited.

[2] Coaching duration is not intended to be prescriptive. Coaching can be tailored to meet individual patient need, but should still be structured around a framework. Duration recommendation is based on evidence that a minimum of 10 sessions is found to be of greatest benefit for patients.

Care navigation

Working definition:

Facilitating access to services for the care of a patient, their carers and family for a defined episode of care. The aims are to improve the timeliness and appropriateness[3] of care and reduce barriers to access to care and loss to follow up [13].

Components of care navigation

Only two LHDs reported distinct care navigation programs with most reporting that this was an aspect of care coordination. Care navigation is often a key part of the role of care coordinators (especially in cancer care). The aim is to support patients to navigate the health system with the aim of reducing barriers, improving outcomes and reducing unplanned admission to hospital [14].

Areas for further development

Care navigation is infrequently a stand-alone activity distinct from care coordination or intake systems. Care navigation may result in opportunities to assist patients who do not require care coordination to access care.

	Evidence-based practice	**Current practice**	***Areas for further development***
1. Component activities	• Providing information about treatment or referral options, advocacy or brokering of access, shared decision making • Identification of barriers can include poor health literacy, language or culture, cost, distance and complexity of care pathways • Patient support to address these barriers (including home visits, interpreters, transport, child care), • Monitoring use of services and follow up [13, 15, 16].	Support for timely access to services and organisation of referrals through: • Scheduling and reminders, • Arranging transport, home visits, • Providing education and care plans, • Linking patients to community resources. This was often through a centralised contact or referral intake centre.	*Greater emphasis on identification of barriers to access or follow-up activities. Monitor attendance and service use following referral.*

[3] 'Appropriateness' in this context refers to delivering the right care to the patient, in the right place, at the right time. It is not intended to be a quality measure.

	Evidence-based practice	Current practice	*Areas for further development*
2. Who should receive	Patients with long term conditions requiring complex care from other providers or services where the complexity is high or their ability to negotiate the care pathway is reduced. The latter may include Indigenous, CALD, low income or rural patients.	Patients with chronic conditions, complex care needs or enrolled in a particular service or care coordination.	*Care navigation could prioritise those patients who face significant barriers to accessing referral pathways for an episode of illness. These will not necessarily require care coordination if the care is not ongoing.*
3. Who delivers	Can be professional or non-professional groups. Often peer navigators were considered most appropriate because they share language, culture, and lived experience with patients.	Mostly by nurses and allied health or by staff of access and referral centres. Not by lay people. Usually combined with care coordination or intake or referral centre role.	*Peer navigators based in community organisations or primary health care may be a viable option.*
4. Training and skill set	Training varies depending on level of prior training and familiarity with the health system. Competencies include: • Identification and management of barriers to access or the pathway, • Communication and education skills delivered face to face and by phone, • Familiarity and knowledge of the health system and referral pathways.	There was insufficient information about the training or skills required.	*Training needs to be provided to those involved in the care of vulnerable groups or those with complex care needs including those working in central intake services. This should provide information not only about the referral services and pathways, but also skills in identifying priority groups, addressing barriers, communication and education.*
5. Mode of delivery	May be delivered face-to-face or by telephone.	Face-to-face or phone with email support.	*Nil*
6. Duration and intensity	Duration varies on complexity of referral pathway. Patients need to be supported through the episode of care. Duration of contact may be from 20-60 minutes.	As part of normal care.	*Navigation should be provided throughout the episode of care or until the patient is able to access the services independently.*

There was no evidence of widespread implementation of care navigation as described in the literature. The major differences between the literature and reported practice were that there was not a specific focus on assessing and addressing barriers to access and that care navigation was delivered largely by health professionals rather than by lay people who shared language, culture and

lived experience. In most LHDs care navigation was an activity of care coordination or done as part of routine care and not seen as a stand-alone activity.

Care coordination

Working definition: *Deliberate person-centred organisation of patient care activities between providers to facilitate self-management, appropriate care, health outcomes and greater efficiency.*

Components of care coordination

Organisation of care to address patient needs and to reduce unnecessary hospitalisation.

Areas for further development

Emphasis on patient-centred needs.

	Evidence-based practice	**Current practice**	***Areas for further development***
1. Component activities	Individual level: Identification (single entry), assessment, self-management support, education (including coaching), care plan and review, medication review. System level: facilitated information exchange, shared accountability, guidelines/standards.	Individual: Collaborative needs assessment, care planning, coordinating monitoring, self-management support, seamless transfer of care, medication management, psychosocial support, monitoring and review of plan. System: communication and teamwork, referral, little focus on shared accountability.	*Systems and processes to promote shared accountability, communication and referral.*
2. Who should receive	Used for patients requiring long term complex care (e.g. for multimorbidity, frailty). Mental and physical conditions including cardiovascular, diabetes, respiratory, musculoskeletal conditions, blood born viruses, substance abuse, aged care.	Patients at high risk of hospitalisation due to chronic conditions (especially multimorbidity), enrolment in care programs, multiple ED presentations, high risk pregnancy. Most referred from hospital or LHD. Few from GP.	*Nil*
3. Who delivers	Care coordinator: nurses, social care staff, primary care providers, allied health.	Predominantly nurses, social workers, allied health.	*Nil*

	Evidence-based practice	Current practice	*Areas for further development*
4. Training and skill set	Few have received specialist training as care coordinators beyond professional qualifications. Formal training varies (eg 4 weeks) or may be apprentice-like with a care coordinator. Knowledge of local systems is considered essential. **Desirable skills** included "good people skills" and knowledge of the local community.	Variability in professional training of those providing care coordination. Many care coordinators trained on the job rather than formally. Some LHDs felt that care coordinators needed clinical skills. Some commented that ongoing training and mentoring was lacking. **Desirable skills** included assessment of needs, providing psychosocial support, self-management support, care planning, and knowledge of local referral services, monitoring and review of care plans, facilitating communication between providers.	*Potential to develop formal training standards.*
5. Mode of delivery	Mix of telephone, electronic communication and face-to-face with patients and other providers	Face-to-face and/or phone and electronic delivery. Some group.	*Nil*
6. Duration and intensity	Not described	Most for an indefinite period. Some 3, 6 or 12 months.	*Nil*

Practice was generally consistent with the literature. LHDs reported a stronger focus on prevention of hospitalisation than was evident in the literature. The literature showed equivocal evidence of care coordination in preventing hospitalisations.

SECTION 1B: FUNDING IMPLICATIONS

Reporting and funding implications associated with defining the interventions

Following agreement and standardisation of working definitions, Health Systems Information and Performance Reporting Branch plan to work with LHDs to:

- Define Integrated Care as a new Establishment Type
- Map the Integrated Care Establishment Type to the Tier 2 Class 40.58 (Hospital avoidance programs)
- Have each Local Health District create one or more Integrated Care Service Units that map to the Ministry Integrated Care Establishment Type and allocate all designated integrated care positions to these service units
- Using the definitions included in this report, define integrated care interventions (care coordination, care navigation and health coaching) for reporting as an element of the occasion of service. The Health System Information and Performance Reporting Branch will use existing logic to convert these to service events for reporting and ABF purposes.

SECTION 1C: FUTURE DIRECTIONS

Reaching consensus on intervention definitions and component activities

The working definitions and activities presented in Section 1A could be tested with the sector with a view to reaching a consensus agreement. Following consensus, ensure all LHDs/SHNs are aware of and apply the same definitions for health coaching, care navigation and care coordination. While roles, job titles and day-to-day tasks will vary depending on local context, standardisation of definitions will enable improved quality of service and understanding of approach, and will facilitate consistent measurement and reimbursement.

Potential areas for future development

These recommendations are based on the current evidence and knowledge of practice.

- Health coaching – include greater emphasis on patient empowerment and active learning; broaden service providers to include health assistants or community workers; more standardised training and establish standard/minimum duration of intervention and outcome measures.
- Care navigation – include greater emphasis on identification and management of barriers to access; targeting vulnerable patients with low health literacy; peer navigators based in community organisations or primary health care.
- Care coordination – include greater emphasis on patient-centred needs; shared accountability, communication and referral systems; formal training standards.

Develop models of service delivery

- It is not proposed that a single model of service delivery for each of the programs be adopted.
- Consideration should be given to establishing standards that will guide delivery through a variety of models and may be the basis of quality improvement activities, performance measures and reporting.
- Consideration should be given to ensure that the core competencies and skill sets required to undertake the activities identified for each of the programs form the basis of training programs.
- It would be beneficial for future programs to be better aligned with clinical pathways in the LHDs to facilitate referral into the programs.

SECTION 2- SUPPORTING DATA

DATA COLLECTION METHODS

We used a variety of qualitative and quantitative methods to collect data. This mixed method approach was essential to gain a broad understanding of each of the interventions, as they are depicted within the current literature and applied in current clinical practice in NSW. Our methods sought to gain the perspectives of chronic disease management coordinators, integrated care program managers, policy makers and academics. Through the collection of data from multiple sources and methodologies we were able to more comprehensively describe and understand the integrated care interventions.

Literature search

To identify current definitions for health coaching, care navigation and care coordination being used in the literature, a focused and targeted search of two biomedical databases (Medline and Evidence Based Medicine (EBM) Reviews) was conducted (Appendix 2). A separate search was conducted for each intervention/model, and a filter was applied to maximise the identification of systematic reviews. Additionally a range of reports and reviews were identified from Australian and international research and government organisations (Appendix 3). Experts in the field and stakeholders from the LHDs and Ministry of Health (MoH) were consulted about any known works. Information related to our brief was extracted from the literature using a data extraction template.

Stakeholder consultation

A stakeholder consultation was held on 23rd September 2016 with participants from the research team, Steering Group, Agency for Clinical Innovation (ACI) and various Primary Health Networks (PHNs) and LHDs. The purpose of the workshop was to describe the differences between health coaching, care coordination and care navigation and to establish the relationship between these concepts to other aspects of coordinated and patient-centred care. The workshop also aimed to identify the core elements of a definition for each of the three interventions. The workshop discussion was audio-taped and summarised (see Appendix 4).

Collection of program data from LHDs/Specialty Health Networks (SHNs)

Existing definitions currently being utilised in LHDs/SHNs were provided at the request of the MoH by email. Profile data on existing programs was provided by LHDs and SHNs at the request of the MoH using a web based survey format. The research team conducted semi-structured telephone interviews of a sample of LHDs and SHNs.

Web based surveys:

A description of the service delivery models of health coaching, care coordination and care navigation activities was requested from each LHD/SHN using an online questionnaire (see Appendix 5). The questionnaire was informed by the literature review and discussions between the research team and steering group and was piloted to refine the questions and structure with two LHDs prior to distribution to 17 LHDs/SHNs.

Semi-structured telephone interviews with LHD staff

The semi-structured interviews built on the data obtained from the survey. Interviews were conducted with respondents from a sample of six LHDs[4]. We used a mixed sample of LHDs to provide representation from geographic location (rural and urban), the range of approaches to each program (determined by LHD program information provided by the MoH) and the service development context. The Integrated Care Program Manager (or similar) from each site was invited to participate and informed consent was obtained. These semi-structured qualitative interviews focused on identifying enablers, barriers and opportunities for the implementation of each type of program, including the infrastructure, systems and processes required for implementation (see Appendix 6). Interviews were conducted by one of three senior members of the research team with prior experience working with LHDs and knowledge of the local areas. Interviews were audiotaped and a scribe took notes during the interview. Verbatim transcripts were also developed from the recordings. Ethics approval for the interviews was received from South Eastern Sydney Human Research Ethics Committee (HREC number 16/274) and site specific approval received from each of the participating LHDs.

In consultation with two experts in health coaching (see Appendix 1), the findings of the literature review and analysis of program information collected from the LHDs were used to develop a model describing how health coaching fits in relation to the other two interventions.

Method of analysis

Data from the literature review was compiled against a number of headings and narratively described. Headings included definitions, aspects of delivery (who and how), major components and evidence for effectiveness.

Data from the completed surveys were exported into SPSS for analysis. Responses were received from seven metropolitan and four rural/regional LHDs. The surveys were predominantly completed by Integrated Care or Chronic Disease program/project managers. Some respondents consulted additional staff such as nurse managers and broader services such as drug and alcohol, midwifery and dietetics. As the number of respondents was small (11 LHDs), only descriptive statistics were used. Apart from the overview provided by each LHD, detailed information on each type of program (health coaching, care navigation and care coordination) was collated for analysis. Thus for example the 11 LHDs provided detailed information on 18 health coaching programs. The data was cross checked for consistency between the programs and with information provided in the interviews. As is noted in the findings this cast doubt on the accuracy of the information on care navigation programs as is discussed later.

A framework for analysing data from the interviews was developed, reflecting the objectives of the study, including history and context, interactions with NSW Health, how the programs were organised and supported, barriers and facilitators, and future directions. The transcripts and notes

[4] Eight interviews were originally planned, however, site specific approval was not received in time to conduct the interview in one rural LHD and the survey was not completed in time by another rural LHD (which meant that the interview had to be cancelled as the program information from the survey was needed to inform the interview).

from the interviews were then summarised and thematically coded to analyse the relevant context of the programs, how they linked with other programs and services and barriers and enablers to their implementation and sustainability. This was conducted by two researchers who between them had performed five of the six interviews. Cross checking of coding and interpretation was conducted within the team and the findings were discussed to improve the rigor of analysis. The resulting material was then checked, combined and summarised for inclusion in the report by one of the interviewers. Interviewees across the six LHDs (four metropolitan, two rural/regional) were generally either the Integrated Care Program Manager or Chronic Disease Program Manager. Some interviewees chose to involve other participants in the interview, such as clinical coordinators and community nursing staff.

FINDINGS

Definitions and concepts

Within this section we describe the definitions and the concepts, (components, target group,delivery, training and evidence), related to health coaching, care navigation and care coordination as identified through:

- a consultation processes with stakeholders
- a literature review; and
- requests from MoH to LHDs to provide their working definitions of the programs[5].

Stakeholder consultation

During the stakeholder workshop, we found general agreement that all three interventions aim to address the unmet needs of patients with poor health literacy which may impact on how they either managed their health or access the health system. Discussion of the key features of each intervention highlighted the complexity and range of approaches used and emphasised the difficulties in defining these interventions. Generally, health coaching was seen to address poor motivation and inability of people to self-manage their condition/s. Care navigation was considered to be administratively focused and to overcome the complexity and barriers of the health care system as experienced by people trying to access care. Care coordination was perceived to address complex conditions or multimorbidity through the coordination of multiple providers.

Notably, some of the participating stakeholders challenged the perception that health coaching, care coordination and care navigation were three discrete interventions separate from each other or clinical practice. They suggested that care coordination should be viewed as a component and enabler of integration rather than a specific intervention. They also suggested that care navigation and health coaching could be seen to be part of the delivery of care coordination. Communication and information sharing facilitate multidisciplinary teamwork, which is an essential component of care coordination. Care navigation was described as engaging both the patient (and carer), and the provider through a shared decision-making process. The components of health coaching were considered by the group to be more easily identified. These components included assessment of readiness/health literacy (needs assessment) and comprehensive and collaborative goal setting (focused on both clinical targets and quality of life).

Health coaching

LHD definitions

Documented definitions for health coaching were reported by five LHDs (see Appendix 7). Of these, one LHD used the definition that was consistent with Palmer (2003)[17], and two referenced the definition included in the publication *"Patient Identification and Selection Handbook. NSW Guide to*

[5] We received eight responses from LHDs/SHNs to the MoH's request for their working definitions for these programs (five metropolitan and three rural/regional). These are further discussed under each program.

Risk Stratification" (ACI 2015)[14]. One LHD had developed a definition, and one LHD referred to the goal of health coaching, rather than a definition.

Literature

We identified ten reviews of health coaching conducted between 2007 and 2015. The lack of a standardised definition for health coaching was noted as problematic for both an accurate assessment of the evidence for and detrimental to the advancement of health coaching research and practice [10, 12, 18-20]. Two definitions frequently cited and built upon were definitions by Palmer (2003) [17] and Lindner (2003) [21].

Wolever [10] conducted a systematic review of over 200 peer-reviewed empirical articles and 70 expert opinions as a foundation for developing their definition for health and wellness coaching. This definition was also put forward by the Evidence Centre UK [12].

Health Coaching is *"a patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The coach is a healthcare professional trained in behavior change theory, motivational strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being."* [10]

Components

A major limitation identified by the literature was a lack of detail in reporting of health coaching interventions and the variation in components incorporated into health coaching interventions. The literature also suggested that the core components could reasonably vary according to the intervention being used [19] or the risk level of the patients being targeted [8], and that interventions focused on a sub-set of components that frequently come under the umbrella of health coaching [18]. Dennis [8] suggested that behaviour change, goal setting and empowerment are essential components and Olsen [22] argued that goal setting and motivational interviewing are the only two consistent components of a health coaching intervention. Butterworth [11] concluded that motivational interviewing based health coaching is the only model to be consistently described and causally and independently associated with positive behaviour outcomes. He argues a strong distinction between this model and those purely based on education.

Target group

From the identified literature health coaching interventions were directed predominantly at those people with longer term, enduring conditions [8, 12, 18-20, 23]. Butterworth [11] suggested that 'high risk' patients were suitable to target and many studies have identified that the people who appeared to benefit most from health coaching were those who had the most to improve (i.e. with the greatest amount of weight to lose), the most severe symptoms or the most poorly controlled condition/s [12]. There was very little information reported around the processes of enrolment or eligibility as a basis for offering health coaching.

Delivery

Health coaching interventions were delivered through a range of modalities (see p. 52- Additional Tables section: Table 1) with telephone being the most frequent method. One review [12] reported

that there was no difference in outcomes between face-to-face or telephone coaching approaches, and although most people preferred face-to-face contact there was no evidence that it was more effective than telephone delivered coaching. This review cautions however that there may be some demographic variables where this is not the case.

There was no consensus within the literature as to the optimal duration of health coaching, frequency or number of coaching sessions (Additional Table 1), or the number of calls that should be made when delivered by telephone [8]. Wolever [10] found that in the majority of articles reviewed, it was not possible to calculate the "dose" of coaching in terms of length of individual coaching sessions, number of coaching sessions, or duration of the coaching intervention. Within the Olsen review [22] significant behaviour changes were reported in studies lasting six months, eight months, and 12 months. Kivela [19] stated that health coaching outcomes were consolidated when the intervention lasted for six to eight months. The results from these reviews support a health coaching intervention of six to 12 months for optimal success and behaviour modification.

Provider training and skill set

Health coaching was delivered by a mix of health professionals and also peer groups (Additional Table 1) with nurses being the most frequent provider [8, 12, 19, 22]. There was very little information reported about the optimal training or qualifications for health coaches (other than their particular professional qualification). Some reviews state that there is insufficient evidence to draw conclusions about the most effective ways to provide training and not enough detail provided by studies to extract the competencies for coaches or the content for training programs [12, 23]. The former review does however also state that both practical and emotional support should be provided to people delivering health coaching [12]. Obviously specific training may impact the ability of staff to deliver some components often provided in health coaching such as motivational interviewing. The most comprehensive information related to coach training was provided in the Wolever review [10]. Intensity of coaching-specific training ranged from less than two hours to two years (median 6-40 hours) [10]. Three broad types of training were identified: (1) behaviour change skills, (2) health information briefing (content education), and (3) job training [10].

Evidence for health coaching as an intervention

The variation among the components provided within interventions along with different delivery methods and also the variation in the outcomes assessed made it very difficult to assess the state of the evidence. While the overall assessment within the literature was positive about the impact of utilising health coaching, the evidence for the effect on health status, cost and physiological outcomes was inconclusive. There was slightly stronger and more consistent evidence to support the use of health coaching to address behaviour change (particularly around physical activity and diet). The results for medication use/adherence were mixed. Motivational interviewing and goal setting appeared to be the more successful strategies used however there was no standardisation around how these should be undertaken. Despite these positive trends the Evidence Centre [12] listed a number of caveats that should be taken into consideration when reviewing the evidence for health coaching. These include the variations within the interventions themselves, the variation in the quality of the research undertaken to date, a lack of comparative evidence and the generalisability of evidence produced in different systems, most notably the United States.

Care navigation

LHD definitions

Care navigation was described/defined by six LHDs. The ACI definition *("provides information and referral support that enhances timely access, for example, between primary and specialist care, for diagnostics and for social support, as well as ensuring timely review")* [14] was used by two and the other four LHDs had developed their own local definitions. In most LHDs, care navigation was described as an aspect of care coordination and not a separate program. Common components of care navigation included supporting patients to navigate health and community (e.g. social and welfare) systems; improve, maintain and optimise their health, well-being and functioning; supporting timely access to services and reducing unplanned readmissions to hospital. There was little information on the mode of delivery.

Literature

We identified nine reviews of care/patient navigation conducted between 2008 and 2016 and an additional four non-review publications. There was variability in the way care navigation was defined in the literature. The most common term used was 'patient navigator' or 'navigator' with care navigation being the overall objective. The concept of a patient navigator has its origins in cancer care but has also been adapted to chronic and long term conditions, HIV/AIDS, substance abuse and underserved populations [16]. Given its origins in cancer care, the majority of definitions identified specifically relate to cancer care such as this frequently cited definition by Wells [13]:

Patient navigation is generally described as a barrier-focused intervention that has the following common characteristics: (1) Patient navigation is provided to individual patients for a defined episode of cancer-related care (eg, evaluating an abnormal screening test); (2) Although tracking patients over time is emphasized, patient navigation has a definite endpoint when the services provided are complete (eg, the patient achieves diagnostic resolution after a screening abnormality); (3) Patient navigation targets a defined set of health services that are required to complete an episode of cancer-related care; (4) Patient navigation services focus on the identification of individual patient-level barriers to accessing cancer care; and (5) Patient navigation aims to reduce delays in accessing the continuum of cancer care services, with an emphasis on timeliness of diagnosis and treatment and a reduction in the number of patients lost to follow-up. [13]

Commonly, definitions emphasise that care navigation addresses patient 'barriers'. This can be a barrier to access created by complex health systems and a need to negotiate multiple departments, multiple providers, undertake different treatments, and to do this in the context of severe or complex and long term conditions. The barrier can also be related to vulnerability such as poor health literacy, socioeconomic disadvantage or diverse ethnic or cultural background. Care navigators frequently share similarities with the patient, either in terms of language (frequently bi-lingual) or culture or shared/lived experience of disease e.g. cancer, hence developing a deeper rapport and relationship with the patient. Removal of these barriers resulted in the patient receiving more timely care and better quality of care [13, 15, 16].

Components

Multiple components that might be included under the umbrella of care navigation include advocacy, discharge planning (if transitioning from hospital), care or treatment planning,

coordination of care, service or care provider access and coordination, collaboration with healthcare providers, home visits, brokering access to care, budgeting or purchasing community services, education and emotional support, appointment scheduling and reminders, transport and linking the patient to community-based resources and support [24].

Target group

Care navigation interventions in the identified reviews targeted patients with longer term conditions.

Delivery

Information on duration, frequency and number of sessions was extremely limited. The Manderson review [24] of navigation models for older adults with chronic disease reported that the duration of interventions ranged from one-18 months. One study within the Paskett review [25] of cancer patient navigation reported that navigators spent on average two and a half hours addressing barriers for each client. Within the Baik review [26] of patient navigation for breast cancer, one study reported weekly contact or as needed by telephone and patients received navigation services at least once a month or as needed, and two studies provided navigation from diagnosis to end of cancer treatment. Because of the personal nature of the interaction between the patient navigator and the patient, delivery is most frequently a personal, face-to-face encounter. There is some support in the literature that ongoing supportive activities and follow up can be provided via telephone [13].

Provider training and skill set

Most studies did not thoroughly document patient navigation training practices, and of the studies that did describe training, there was wide variation in duration, format, content, location, type of trainer and learning strategies employed [27]. In the reviewed studies, training duration ranged from 12 hours to greater than 12 months and patient navigation training was most frequently conducted by a research investigator [27]. Training was conducted in a variety of formats, ranging from classes, staff meetings, training programs/conferences, telephone-based training/webinars, and workshops. Some studies used multiple training formats [27]. Training content most commonly related to patient care and involved training in coordination of care, overcoming barriers to care and addressing psychosocial needs [27]. Differences in training were not assessed against outcomes and the authors highlight the need for future research on optimal delivery and content of patient navigation training [27].

Evidence

The evidence relating to patient navigation specifically for cancer is more comprehensive and recent than the evidence for general chronic conditions (see p. 55- Additional Tables section: Table 2). Manderson [24] is the only review where navigation interventions were targeted at the latter (older adults transitioning care settings) and where efficacy was assessed. The evidence from this review provides some support for the use of a navigator role for this target group. Significant positive economic outcomes (including reduced hospital readmissions, fewer hospital days and lower mean hospital and reimbursement costs) were reported in six of nine studies, significant positive psychosocial outcomes (including improved short term quality of life, patient satisfaction and adherence to self-care) were identified in four of nine studies and significant positive functional outcomes were reported in two of nine studies (short term improvement in physical quality of life

and 12 month improvement in function measured by the Functional Status Index). There were no negative outcomes reported. However, two studies revealed 'little or no effect' and the authors call for further research to assess effectiveness and cost of different approaches.

Care coordination

LHD definitions

All eight LHDs reported documented definitions/descriptions of care coordination. The ACI definition referred to by some LHDs identified the mode of delivery as being principally by telephone or via electronic means, and delivered by clinicians (nurses, social workers or allied health, with additional experiences and skills). In addition to the ACI reference, one definition was taken from the CDMP Data Dictionary v5.0 [28] which describes a diverse range of components (see Appendix 7).

Literature

We identified sixteen separate pieces of literature related to care coordination conducted between 2006 and 2016. Possibly the most widely cited definition was that by McDonald from 2007 [16]. These authors conducted an extensive review of the literature and developed the following consensus definition:

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. [16]

Some newer definitions have added to the comprehensiveness by highlighting the multidimensional nature of care coordination [29]; the importance of case identification in attempting to produce better outcomes [30] and the end point of quality and safety (including the avoidance of adverse events) [29].

Care coordination interventions varied widely in structure and style across organisations, but generally the primary goals were consistently to improve disease outcomes while containing healthcare costs [16].

Components

The care coordination interventions described in the literature tended to be multi-component [31]. While no prescriptive set of components was identified across the literature, in general, care coordination activities spanned both system and patient levels and followed the chronic care model of care. At a system level, care coordination generally involved integrating and facilitating information exchange to enhance continuity and shared knowledge. This was found to occur through a variety of activities, such as working in multidisciplinary teams, case conferencing, shared meetings and records, joint care planning, and integration of services through co-location [32]. At a patient level, this included self-management support [33-35] and education [32, 34, 36].

Target group

Care coordination is particularly relevant to patients with long term or complex conditions navigating fragmented health care systems [33] and historically has been aimed at patients with

chronic disease [16]. The studies identified included complex patients with chronic and multi-morbid conditions [33, 34, 37] and multiple chronic conditions and frailty [31, 38].

Delivery

Minimal information about the methods of delivery and duration of care coordination could be identified from the literature. In one UK model reviewed [33], referrals were accepted from multiple sources (including patients and family) via a single point of entry. All programs then filtered cases through to their multidisciplinary teams to undertake case reviews, initiate assessments and develop care packages. It should be noted that these programs had a focus on supporting people to live at home and used multidisciplinary and community-based teams as a means to achieve this. These teams typically utilised specialist nurses, primary care professionals, social care staff, allied health professionals and the voluntary sector, to conduct holistic assessments and to tailor the care to the patient's individual needs. The single point of entry was frequently a 'care co-ordinator' whose role it was to engage with the patient, their carer(s) and the multidisciplinary team to develop a care plan, and then to work with the team, the patient, the patient's family and other care providers to deliver coordinated and coherent care.

Training and skill set

Although there were no specific reviews on the role of the care coordinator identified, many of the studies described the use of a specific person who was designated as a 'care coordinator'. The conceptualisation of what this role entailed differed in the literature, with some studies considering care coordination to be a primarily clinical role for someone with a qualification [34, 35] and others noting that the person delivering the care coordination could be from a healthcare background or be a lay person, depending on the needs of the individual [30, 33]. Within the Kings Fund program review [33] the type of person undertaking the care coordinator role varied considerably. Most care coordinators had been community or specialist nurses, yet the role had also been taken on by non-clinical '*link workers'* and *health and social care coordinators*. Within this review none of the care coordinators had received any specialist training for the role, but all reported having good 'people skills' and in-depth knowledge about the local community. Most had lived and worked in their community for several years, acquiring a good understanding of the local health or social care system, which helped them to support patients in negotiating between care providers. Building effective working relationships between care coordinators, multidisciplinary teams and wider service providers was noted as important in supporting better coordination.

Evidence

Multi-component strategies were generally accepted to be more successful than single element or simplistic approaches [4]. The systematic reviews assessed by McDonald mostly reported improved outcomes for each strategy (categorised as use of teams, case management, disease management, integrated care, and interprofessional education) but within these reviews there was insufficient evidence that one particular strategy was more effective than others in improving outcomes [16].

Description of program delivery

History and trajectory of programs

The cross-sectional picture of program delivery presented in this section should be understood in the light of the recent history and current directions of chronic disease management programs within LHDs in NSW.

In developing their programs, LHDs have had to make a number of strategic decisions, reflecting local history, service structures and opportunities, and leading to considerable variation across and within LHDs. Some of the variation includes:

- Standalone programs vs integration into clinical care: in many LHDs health coaching, care navigation and care coordination occur as a part of normal clinical care as well as standalone programs. The main exception is care navigation, which appears to be provided as part of normal care, supported in some places by access and referral centres.
- Specialised vs more generalist programs: some programs are restricted to a single condition, some to a grouping of common chronic conditions, some focus on risk factor management and a few respond to unexpected hospital attendance.
- Centralised vs decentralised provision: some programs operate from a single location, some from a number of locations across the LHD.
- Single management of programs vs management through other services: where programs are part of clinical services (e.g. rehabilitation) they tended to be managed through that service, whereas LHD wide services have their own dedicated management structure.
- Focus on LHD services vs engagement with general practice and other community based services. Most programs have been largely internally focused, although some have engaged with other services, partly for referrals but in some cases as fellow providers of care.

Some LHDs have used their care coordination and health coaching programs to create a system of care with (in some cases) three levels of intervention: care coordination for those with most complex care needs, health coaching for those ready to focus on self-management and low level contact and follow up for those discharged from the first two, and care navigation pathways between the levels. This has enabled LHDs to assign patients to the level of care they need (sometimes using an algorithm). Patients can move between levels and remain within the system when no longer in need of active intervention.

Some LHDs are currently reviewing their programs, and some have recently undertaken redesign projects. Reasons for this include preparing for national reforms (NDIS, aged care, development of PHNs), planning how to deal with current or expected resource constraints, and trialling new systems (e.g. e-health planning). Some are attempting to engage better with primary care, and at least one is considering whether any aspects of these programs should be outsourced.

In response to the CDMP evaluation findings, the MoH led the redesign of the CDMP with a renewed focus on early diagnosis and intervention to slow the progression of chronic disease and reduce avoidable hospital admissions. This will be facilitated by strengthening partnerships between Local Health Districts, Primary Health Networks, general practice and hospital specialty teams.

Profile of programs

The survey of all LHDs (11 responses) and interviews conducted with a sample sought information about the programs they offered. The survey questions asked only about standalone programs, with summary information on the full range of LHD programs (Table 1) and a more detailed profile on a smaller sample of programs (Table 3). The LHD response tables include only health coaching and care coordination, as the terms 'care coordination' and 'care navigation' were used interchangeably by some LHDs, with some LHDs describing the same programs as care navigation and care coordination. The interviews (six responses) sought information about the way programs were organised including those that were integrated into normal care (rather than being standalone), and barriers and facilitators to successful programs.

Table 1: Number and characteristics of standalone programs reported by LHDs (survey)

Item	HC	CC
No. of programs (LHDs reporting a program)	35 (10)	26 (10)[6]
Median (range) of programs per LHD[7]	3 (1-7)	2 (0-7)
Focus of program: - Specific condition	20	14
- CDM/risk factor management	11	11
- Other	4	1
Programs with referrals - from within LHD*	30	20
- from outside*	24	17
Coverage - whole of LHD	25	17
- geographical area	7	7
- clients of specific services	1	1
- specific population group	2	0

* These response options are not mutually exclusive so do not add up to the total number of programs

Most LHDs have several standalone health coaching and care coordination programs. They focus most commonly on specific conditions rather than chronic disease or risk factor management in general. The majority of both types of programs take referrals from within the LHD, and a smaller majority accept them from outside. Most programs cover the whole area of the LHD, with some serving a more limited geographical area, and fewer clients of a particular service or population group.

Types of LHD-reported health coaching programs

- health coaching provided as part of the chronic disease management program;
- rehabilitation related programs (cardiac, respiratory);
- programs for specific conditions including musculoskeletal, diabetes and stroke;
- programs for pregnant women (with high BMI, gestational diabetes, smoking).

[6] One LHD reported 0 CC programs but then described a CC program in the next survey section

[7] Including those not reporting a program

A mix of proprietary programs (e.g. Get Healthy, Healthways, COACH, Health Change Australia and the Stanford Chronic Disease Self-Management program) and locally developed programs were reported.

There was a similar broad range of care coordination programs reported.

Types of LHD-reported care coordination programs

- care coordination provided as part of chronic disease management program;
- specific disease related programs (COPD, cardiac, heart failure, diabetes);
- non-specific chronic conditions programs (not provided as part of chronic disease management program);
- innovator projects or demonstrator initiatives funded under the integrated care strategy;
- other program types: patients with end stage cancer (1 LHD), mental health clients (3 LHDs), Aboriginal chronic and complex care (1 LHD), high risk pregnancy (2 LHDs), vulnerable families (1 LHD).

The following section summarises the health coaching and care coordination program aims and components and then the operational aspects of the programs that the LHDs chose to profile in greater detail. These were broadly reflective of the overall range of programs.

Aims and components of programs described in detail

Respondents reported that the majority of the health coaching programs aimed to support participants to modify health behaviour (94%), self-manage their chronic conditions (94%), manage their medication (89%), and manage their physiological risk factors such as weight (17%).

Respondents reported that all care coordination programs aimed to assist patients to manage complex needs and engage with their treatment. Of the programs, 93% aimed to ensure that patients receive care in the care plan and manage their medication, 87% reported that they aimed to help patients access the health services they needed and self-manage their health care, 80% aimed to help patients access the social services they needed, 73% aimed to achieve seamless transfer of care and 60% aimed to help patients attend appointments (both of which are elements of care navigation). Other aims included advocacy for patient needs, increasing patient confidence, chronic disease education/management and the provision of allied health interventions to increase psychosocial wellbeing and physical functioning.

The core components of the programs reflect these aims (Table 2).

Most of the reported health coaching programs reported the same core components: self-monitoring, behaviour change techniques, providing information, assessing goals and readiness (Table 2). However only two-thirds of programs were reported to include strategies for supportive environments and just over half provided structured education as part of health coaching (Table 2).

Most respondents reported that care coordination programs included information provision, supporting information sharing between providers, care planning, assessing needs, monitoring and review of care plans, developing skills, referral to other programs and provision of telephone support (Table 2).

There was some overlap between health coaching and care coordination in terms of assessing and advising of patients. However LHDs reported that health coaching did not address care coordination activities associated with assisting patients directly and arranging referral or follow up.

Table 2: Core components of LHD health coaching and care coordination programs

Activities	**Components**	**Health Coaching N = 18 (%)**	**Care Coordination N=15 (%)**
Assess	Assessing goals	15 (83)	Not asked
	Assessing readiness (stage of change)	15 (83)	11 (73)
	Assessing individual needs/capacity to benefit	13 (72)	14 (93)
Advise/Agree	Behaviour change techniques	16 (89)	
	Providing client/caregiver information	16 (89)	15 (100)
	Structured education	10 (56)	
	Providing client/caregiver skill development to support self-management		14 (93)
	Self-monitoring	17 (94)	
	Motivational interviewing	13 (72)	
Assist	Facilitating access to other support programs such as Quitline, GetHealthy		14 (93)
	Accompanying the patient on appointments		11 (73)
	Providing psychosocial support		11 (73)
	Advising consumers to use Healthdirect services for additional support, such as After-Hours GP Helpline or Palliative Care After Hours Helpline		10 (67)
Arrange/follow up	Monitoring and review of client needs and care plan		14 (94)
	Providing phone support and follow up		13 (87)
	Reminders for appointments		11 (73)
	Following up attendance at appointments		11 (73)
Coordinate others	Developing a coordinated multidisciplinary care plan		14 (93)
	Facilitating/supporting communication and information sharing between providers involved in care		15 (100)
	Other		3 (20)

Operational aspects of programs

Table 3 provides details of the organisation of the distinct programs reported by the LHDs.

Table 3: Operational aspects of LHD programs

Item	Health Coaching N= 18 (%)	Care Coordination N= 15 (%)
No. of programs (LHDs reporting a program)	18 (10 LHDs)	15 (11 LHDs)
Service provider: - LHD only	12 (67)	10 (67)
- LHD + external	4 (22)	5 (33)
- external only	2 (11)	0 (0)
Self-referral: - referral and self-referral	15 (83)	10 (67)
- referral only	3 (17)	5 (33)
- self referral only	0 (0)	0 (0)
Referrals: - most from hospital	8 (44)	9 (60)
- some from hospital	4 (22)	4 (27)
- most from other programs (e.g. rehab)	1 (6)	2 (13)
- some from other programs (e.g. rehab)	9 (50)	11(73)
- most from general practice	2 (11)	1 (17)
- some from general practice	5 (28)	8 (53)
- most from community health	0 (0)	4 (27)
- some from community health	12 (67)	6 (40)
Formal eligibility criteria for referral	16 (89)	15 (100)
Family included: - always	7 (39)	5 (33)
- sometimes	9 (50)	10 (66)
Delivery: - always/mostly by phone	11 (61)	8 (53)
- always/mostly face-to-face	9 (60)	14 (78)
- always/mostly phone and face-to-face	4 (56)	12 (80)
Delivered by: - Registered nurses	14 (78)	15 (100)
-Enrolled nurses	7 (39)	5 (33)
- Allied health	11 (61)	7 (47)
Staff guided by a computer program	4 (22)	4 (27)
Electronic communication with external providers	Not asked	14 (93)
Consistent relationship with service provider where possible	18 (100)	15 (100)
Staff who have received specific training: - all or most	17 (94)	8 (53)
Program is formally assessed	12 (67)	10 (67)
Patient data collected	12 (67)	12 (80)
Summary data collected	9 (60)	11 (73)
Patient data submitted to MoH	4 (22)	8 (53)

The key features of health coaching and care coordination are:

- Provision: most programs were provided by the LHD alone, with only 20-30% of each type of program involving external providers. Two LHDs reported having only externally provided health coaching.
- Access: most programs accepted referrals and self-referrals, with care coordination (perhaps the most clinically focused) the least likely to accept self-referrals. Hospitals were the most common source of referrals, with care coordination programs particularly likely to receive referrals also from other LHD services such as rehabilitation, and from general practice. Community health was the least common source of referrals for all programs. Nearly all programs had formal eligibility criteria.
- Family involvement: most programs sometimes or always involved families.
- Delivery mode: most programs were delivered by phone and face-to-face. None involved any significant use of the web. Most programs were led by nurses (usually registered), followed by allied health.
- Information management: Few programs were supported by a computer program. However electronic communication with external service providers was very common. The health coaching programs described did not include computer algorithms to guide the process.
- Staff training: In most of the programs, all or most staff have received some specific training for the roles. This was especially high for health coaching.
- Assessment: Most programs were formally assessed, and summary and patient data collected for internal LHD use.

Governance

Governance varied across LHDs and across programs, reflecting the different ways programs are organised. Programs were provided by a dedicated area-wide team (for example a care coordination team), a specialised clinical service (e.g. mental health, diabetes or cardiac rehabilitation) which might operate across the LHD or for a particular facility or sector, or an external organisation (for example Healthways for health coaching). At least some LHDs have dedicated area wide structures to coordinate a number of different programs.

Structures and systems

The programs themselves were usually part of a model of care supported by a variety of tools and systems. These included flags and algorithms used to identify patients (often on admission to hospital) who might benefit from the programs; processes for assessing patients and referring them to appropriate programs, and pathways for transferring patients between programs as required; some facility for recording and tracking care in LHD patient records and communicating electronically with other service providers; and in many cases an access and referral service which assists with referrals in and out, and sometimes maintained contact with people no longer receiving regular care. In many cases, patient record and information systems are in a state of flux, with new systems coming online.

Resources

Apart from the systems described above, staffing and funding were the resources most often discussed. Several LHDs commented that they had experienced and well-trained staff, and that these provided a sound foundation for their programs, although some were not confident that they would

have the numbers needed for the anticipated level of demand. Funding had been at a reasonable level, thanks in part to the CDMP, but this could not be taken for granted if chronic disease management became a lesser priority (although it is understood that this has been rolled into the base budgets of the LHDs).

Reporting

Patient level and summary data were collected for most programs. Patient data reported to the MoH was confined to less than 25% of health coaching programs (three relating to the CDMP, and a cardiac coaching program). The majority (75%) of the care coordination programs reporting patient data to the MoH were associated with the CDMP, and the other two programs were initiatives associated with the integrated care strategy. Three LHDs providing CDMP related care coordination programs did not report patient data to the MOH. The higher level of patient data reporting identified for care coordination programs compared to health coaching programs may reflect the greater level of clinical care in care coordination, or perhaps specific reporting requirements.

Comparison between rural and urban programs

We compared health coaching and care coordination programs from the four rural LHDs who participated in the survey with those in the other seven LHDs.

There were no differences noted in health coaching programs with respect to their focus on specific conditions or target population groups, links to other programs or who referred to the program. There were a small number of programs that were outsourced from the urban LHDs only. In terms of the elements or components of the programs, rural LHDs were more likely to report programs which included behaviour change techniques and motivational interviewing. Rural LHD programs were a little more likely to report involvement of enrolled nurses, practice nurses and GPs in delivery of the coaching than urban LHDs. A similar proportion of programs were delivered by registered nurses and allied health in urban and rural LHDs. There were no differences in the proportion of programs which involved delivery face-to-face, by phone, internet or a combination of these.

Care coordination programs were reported as having similar characteristics across urban and rural LHDs. There were no differences with respect to their focus on specific conditions or target population groups, links to other programs,who provides them or referred to them. Urban LHDs were more likely to report program elements or components focused on providing psychosocial support, multidisciplinary care planning and monitoring and review of these. Rural programs predominantly reported program elements or components focused on assessing readiness and needs, providing information, facilitating access to support programs, facilitating communication and information sharing, and developing skills to support self-management. Urban programs were more frequently provided by a registered nurse and rural programs were likely to be delivered by phone most or all of the time.

Comparison of literature and reported practice

Health coaching

There was general consistency between the literature and reported practice. The main difference in literature definition and LHD approach was that some of the LHD programs indicated a stronger emphasis on determining the goals for patients rather than letting the patient direct the goals for coaching. In some LHDs, coaching was used with those patients who did not require high level coordination or as a step down from more intensive care. LHD staff emphasised the importance of assessing individual needs and readiness to change. Health coaching was most often delivered by nurses with no delivery by health assistants or pharmacists. Although they were often delivered by phone, in the LHDs they tended to be individualised to the assessed needs of patients as determined by the health professional rather than an algorithm.

Discussions with key informants with expertise in health coaching provided further perspectives on the findings from the literature and the LHDs. Key themes emerging from these discussions related to definitions of health coaching and the purpose. They noted that the definitions from the literature focused on the patient-centred approach to identifying problems and goals. They felt that the feedback from the LHDs described health coaching as an approach that might support patients to be more compliant with treatment or address health risk behaviours that were problematic. They felt definitions were important to ensure that what was being delivered as health coaching met the description and contained the components deemed to be important. This type of evaluation of the components has been undertaken with a sample of health coaching sessions from Get Healthy.

Linked to the definition of health coaching is the need for health professionals to be trained to provide health coaching. Some health professionals naturally take a health coaching approach in their clinical practice and for some health professionals this is a new approach. In some LHDs training in health coaching has been seen as important to provide staff with skills that may reduce burn out. Skills required for activities reported by LHDs were broadly consistent with the literature.

The relationship of health coaching to other programs was discussed. Several of the LHDs described using health coaching as an exit program to support patients leaving chronic disease rehabilitation programs. Interestingly, one of the key informants thought that health coaching might be more effective first followed by referral to rehabilitation programs when they are ready to fully engage.

It was not clear from the literature or the LHDs how to better integrate health coaching with clinical practice. The informants thought that it was important to explore ways of sharing information between programs and health professionals so that the patient's wider health care team were aware of their progress.

Care navigation

There was no evidence of widespread implementation of care navigation as described in the literature. The major differences between the literature and reported practice were that there was not a specific focus on assessing and addressing barriers to access and that care navigation was delivered largely by health professionals rather than by lay people who shared language, culture and lived experience. In most LHDs care navigation was an activity of care coordination or done as part of routine care and not seen as a stand-alone activity.

Care coordination

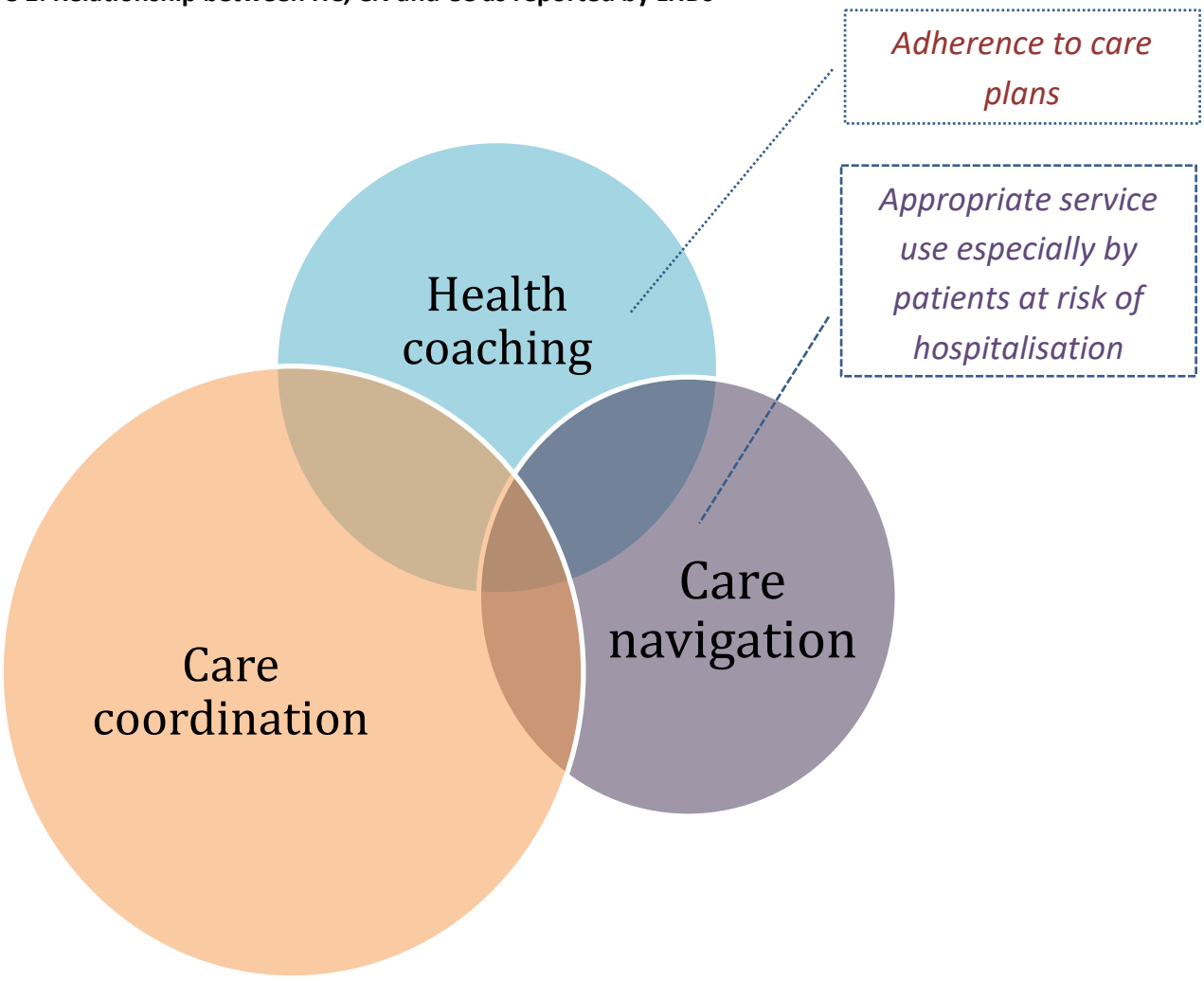
Practice was generally consistent with the literature. LHDs reported a stronger focus on prevention of hospitalisation than was evident in the literature. The literature showed equivocal evidence of care coordination in preventing hospitalisations.

How the programs relate to each other

In the LHDs, patients whose care was being coordinated may also receive care navigation and health coaching- with care navigation seen as a component of coordination to achieve “seamless transfer of care”. Most respondents saw value in some degree of linkage between the three programs either at the clinical or organisational levels. However there were many different approaches in response to local needs including integration into routine care. However several did report difficulty ensuring quality and consistency across different programs as a result.

Although there is some overlap between the programs this is more obvious between care coordination and care navigation. This is shown in the following diagram (Figure 1):

Figure 1: Relationship between HC, CN and CC as reported by LHDs



Health coaching was the most defined of the programs. However although it may be delivered as a stand-alone program (e.g. via Get Healthy), it was often linked to specific services and programs (e.g. delivered on completion of a rehabilitation program) and coaches may need to have an in-depth understanding of these conditions and programs. Health coaching has the most formalised training program and this may reflect the fact that it was described as a stand-alone program whereas care coordination and care navigation were commonly seen as part of a clinician's role. The outcomes were predominantly behaviour change and impact on hospitalisation a secondary outcome. Health coaching seemed to be used by some LHDs as an exit program following rehabilitation or as an adjunct to chronic disease management. Only two LHDs described health coaching as being part of all clinical encounters.

Care navigation was the least well defined and in practice was often part of care coordination or routine care and was sometimes conflated with follow up. Navigators who are peers and "like the patient" were seldom used and barriers to access are not often formally assessed or targeted for improvement. The goal was timely access to comprehensive care and thus it may be better placed in primary health care or in access and referral centre roles.

Care coordination is well developed with a broad range of component activities. It is particularly important in linking to general practice and social care and has a function both at the individual and system levels. Patients are high risk and may be identified by algorithms or previous hospital use. However, as yet, there was little evidence of shared accountability between different services or organisations or services within the LHD.

Enablers and barriers to program delivery identified by LHDs

In the interviews, LHDs identified the main enablers and barriers that they faced in providing effective programs. These are summarised in table 4.

Table 4: Summary of main enablers and barriers identified by LHDs

Theme	Enablers	Barriers
Effect of history, environment and context	Programs developed over many years, largely within the CDMP. Funding as an Integrated Care demonstrator site supported innovation Contracting HC to Healthways provided a consistent program over time	Original rush to meet KPIs with CDMP distorted programs NDIS: may be unclear who is responsible for some patients' needs Lack of positive results from CDMP evaluation discouraging/ reduces confidence of other services in programs Organising care for patients resident in other LHDs. Too many CD programs creates complexity Change from MLs to PHNs (impact on GPs, PHCO based care coordinators) Fragmentation in PHC/community sector Possible changes in priorities at LHD or state level Lack of clear definitions of HC, CC, CN
Interactions with NSW Health	Forums with other LHDs helpful Access to Ministry staff helpful ACI assistance helpful (guidelines, workshops, assistance with redesign)	With Ministry: rushed development of CDM, confusing communication, not knowing history of CDMP and realities on ground. ACI: some inexperienced consultants
Organisation of programs	Integration promoted by: - Co-locating CC with other services making CC part of a larger LHD 'care management' program - basing CC services at a range of different locations Having Area wide team promotes consistency Providing CC and HC from existing services reduces siloing Having access and referral centre (as hub/to keep contact with patients leaving HC and CC) Value of using community events as a forum to promote LHD services	Hard to manage quality/develop services in distributed programs. Some difficulty in engaging mental health and D&A services to coordinate care Lack of clear exit point to palliative care Lack of information sharing between CC and HC No feedback to clinicians on implementation of care plan/from HC/ from My Aged Care Older people dislike telephone services Lack of transport for patients Lack of clarity (for other clinicians) of role of generic HC program. Unclear when LHD or GP take care coordinator role Lack of access to social support services. Focus on demand crowds out equity. CN can be neglected when staff busy
Systems and structures	Use of interpreters promotes access Algorithm supports consistency (HC) Linking with aged care packages	Not enough monitoring/report of what is delivered. No guidelines for new staff (CC)

Theme	Enablers	Barriers
	Use of definitions and models (Chronic Care Model) Ability to write in use LHD IT systems, e-MR, some decision support, using tablets Service directories inc. Health Direct Link to Health Pathways Access and referral centres to support intake, referral, ongoing monitoring	Information systems limited, fragmented (LHD and NSW health) Service directories limited and fragmented. (Health Direct not always useful) Limited use of health pathways in some areas
Governance	Having an overarching committee Single mgt. structure for program	No PIs for CEO relating to HC Sometimes unclear who is responsible for which aspects of managing services
Resourcing (inc staffing)	Experienced staff and clinicians. Broad roles for staff broadens focus Defining qualifications for CC allows RNs/ENs to work at full scope of practice Admin staff assisting with referrals Access/links to specialist teams (multi-cultural, Aboriginal) Widespread training of staff (HC esp) Use of data from 45+ survey to understand population	Staff in specialist HC programs may have narrow range of skills Insufficient resources (through CDMP). Some CDMP staff moved to other roles Capacity of Access and Referral centre. HCA training expensive Lack of training for CC Lack of sustained funding for HC

History, environment and context: In terms of policy, the CDMP provided a foundation for current programs and the Integrated Care program an opportunity to re-think them, but there was some concern that the NDIS may make LHD responsibility less clear. Lack of clear outcomes from the evaluation of the CDMP had reduced confidence in these interventions amongst some clinicians. Contracting out health coaching provided a clearly defined and continuing service.

Interactions with the Ministry and ACI were reported as being both helpful and disruptive. There has been some valued support, but there has also been some uncertainty about future directions (especially for health coaching), about the quality of support and the extent to which the Ministry understood circumstances on the ground in the LHDs and the legacy of the CDMP. ACI models and frameworks have been useful, but not promoted well enough.

Organising programs: Various ways of organising programs were described above. Each tended to assist some aspects of service provision and act as a barrier to others. Area wide programs allowed for greater control of quality and delivery, but sometimes at the expense of working effectively with local services, while more local services may be hard to coordinate at an area level. Specialist programs could be well embedded in clinical care (especially in rehabilitation programs) but may be narrow in focus, difficult to access and somewhat 'siloed'. Engaging general practice and other community based services could improve access to support services and avoid duplication, but can be difficult, especially with the shift from MLs to PHNs, and may lead to unclear service boundaries. Clear relationships with other programs such as palliative care made it easier to provide patients with the right care. Whatever the organisation, a good flow of information between services were seen to be important, but often difficult to achieve, especially where information systems were unhelpful. There were also specific barriers for some patients: for example transport can be a

problem, and telephone services were reported as not being a good way to deliver health coaching for older people.

The right systems and structures were helpful for supporting programs. These included IT systems, algorithms for assessing risk and assigning people to programs, access and referral centres, interpreter services and links to aged care services. Barriers included the lack of systems for monitoring of programs, fragmented and incomplete service directories, and inflexible information systems. Access and referral centres could be a hub for referrals, a common contact point for all three programs and a source of continuity of care.

Governance: integrated governance, either through a district wide service or through an effective overarching committee for all chronic disease programs, assisted with planning, development and quality control. Performance indicators for CEs provide incentives to prioritise chronic disease management.

Resources: skilled, well trained staff were essential, with clear role definitions and a broad understanding of chronic disease management. This supported the provision of health coaching and care coordination as part of normal care as well as separate programs. Access to specialist services for particular groups – for example multicultural health - was also helpful. Some LHDs reported that resources had diminished or were not adequate for the task, and were concerned about future commitment to structured chronic disease management, including training.

FUTURE DIRECTIONS AND DISCUSSION

Shared agreement for intervention definitions and key components

It would be useful to reach a shared agreement across the sector for intervention definitions, key component activities and features of each of the three interventions. This clarity is important to provide a basis for Districts to determine which programs are required to achieve the aims of their service and integration plans. A more consistent understanding of the elements and purpose of each of these interventions can support efforts to establish standards, target programs and maintain quality.

Target cohorts and risk stratification

The future development of the three interventions is linked to the identification of target cohorts at high risk. Objectives include reduced avoidable hospital admissions and emergency department presentations, improved access to services and improvements in well-being and health outcomes. The target groups for the interventions have been variously described in terms of:

- Population sub groups and their characteristics
- Conditions and co-morbidities
- Behaviour risks
- Service utilisation risks

There is a statewide risk stratification tool being developed to identify and target those at risk of hospitalisation, and engage them in appropriate programs. Programs need to be matched to the risk groups or objectives that are intended to be achieved.

Variation in service delivery models

The way in which these interventions have been operationalised is highly variable. LHDs vary considerably in their history, context and the way they are organising chronic disease management programs. This includes how they are balancing the benefits of integration with specialist clinical services against a more generalist, area wide approach, and linking the three programs to create more systematic systems of care. In many LHDs, clinicians/clinical services are providing care coordination and health coaching as part of normal care, as well as through standalone programs. It would make sense to consider the impact of any new arrangements on both approaches (routine care or standalone programs).

Programs are integrated into the broader services of the LHD in several ways. Providing the programs as a part of normal clinical care supports clinical integration, but may miss some of the benefits of a dedicated program. A standalone program as part of a layered organised system of care may provide better coordinated care for patients. Delivering standalone programs through a specialist service (e.g. cardiac rehabilitation) may support strong links with ongoing clinical care but might exclude other conditions and aspects of care, and complicate efforts at LHD-wide service development or quality improvement, particularly for people with multiple chronic conditions. Providing the program from a dedicated LHD-wide service may improve integration with other district wide services but be isolated from sector-based clinical services (although strategies such as

co-location with clinicians at different locations, developing LHD services in consultation with sectors or designing services to incorporate sectors can mitigate this).

This suggests some flexibility in the way LHDs implement any new NSW-wide programs or directions to enable the most appropriate application of programs that takes into account local factors and patient need, and supporting them to learn from their peers and improve quality.

State wide services

Health coaching is the only program that is feasible to deliver as a state-wide service. This is already the case with the programs delivered through Get Healthy or Quitline which were primarily initiated as population health prevention strategies. This has two major advantages – it provides a standardised program and facilitates access especially where local providers may not be available or trained. As Get Healthy has developed to target specific conditions it is important to clearly articulate the role and target group for this program in the overall integration framework. This would enable local services and providers to utilise the state wide service appropriately and align their own services.

Care navigation is supported by local, state wide (and even national) databases and referral and access services. These may be challenging to maintain but help reduce problems with access to care across local boundaries.

System enablers and support

A number of areas were identified as useful for policy and development support:

- **Strategic integration frameworks** with clear aims and outcome/output measures within which the programs will operate. This includes activities that address organisational culture to support system redesign that is more patient focused eg consumer enablement, self management, health literacy.
- **Information management and technology** developments that support care coordination, sharing information, clinical pathway implementation, decision support and reporting of information for accountability and evaluation purposes.
- **Training and shared learning.** Standardising and developing competency assessment and training to support strategy and delivery of programs. Formal training programs for health coaches were well established and there is an identified desirable core skill set which includes ability to assess goals and readiness to change, behaviour change techniques including motivational interviewing, providing education, teaching self monitoring. Training programs for care coordinators are less formalised with many learning “on the job” in additional to their professional or clinical skills. There is a need to formalise both the skills in working with patients (such as assessment, goal setting, care planning, follow up) as well as the system skills (such as working with information systems, addressing barriers, quality improvement, monitoring and reporting). Competencies and training standards need to be defined for both programs.
- **Quality improvement, reporting and performance monitoring regimes based on standards** that support improved service delivery.

Funding and reporting the interventions

There are a number of factors influencing the potential approaches to funding these interventions:

- Service delivery models that incorporate the interventions into routine clinical practice are less likely to be funded separately. When interventions such as these are incorporated into routine practice, their costs are absorbed into the cost of that routine care. Unless the activity and cost data on each intervention is captured, the cost is effectively absorbed and the activity is not counted.
- One or more of the interventions are incorporated in discretely funded roles/positions, for example care coordinators. Under this approach, salaries and other input costs are funded. Activity may or may not be counted but, at least in some circumstances, it may be possible to capture measures of quality and/or outcomes.
- Can the intervention be standardised (repeatable, measurable) to the extent that it is a costed 'activity'? The Activity Based Funding (ABF) model that NSW has adopted to fund its hospitals and hospital outreach services funds discrete 'activities' (products), with each activity weighted for its relative cost. In order to be included under an ABF funding model, an 'activity' needs to be defined in a consistent manner. This requires standardised definitions and counting rules. In the context of the current NSW hospital ABF model, the relevant unit of activity counting is the 'service event'. Service events are not the same as an occasion of service (the usual unit of counting in community health) but occasions of service are mapped to service events. A service event is "an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record". The definition of a service event, and the rules for how service events are collected, are included in Appendix 8.
- Can a population/target group be quantified that requires the intervention? If so, a population needs-based funding model can be used in which the available funding is distributed between LHDs in proportion of their share of the target population, with potential funding modifications to take account of other factors such as structural cost differences between metropolitan, rural and remote locations.

Table 5: Funding approach to interventions

Funding approach	**Interventions that could be funded under this approach**
Absorbed – costs are absorbed within mainstream practice and cannot be discretely identified meaning that interventions cannot be funded as discrete activities	Any intervention that cannot be defined counted and costed.
Input - funding of inputs on a cost recovery basis (cost-based funding)	Designated case managers and care coordinator positions (however named)
Output - funding of outputs on an Activity Based Funding basis (output-based funding)	Any intervention that can be defined counted and costed.
Need - funding on the basis of population need (needs-based funding)	Integrated care as a whole, or its component parts, could be funded on the basis of population need if it is a discrete program allocation at the NSW level.

If integrated care interventions are to be considered for funding using an ABF model in the future, the essential step is the introduction of standard definitions and counting rules. This requires working with the Health System Information and Performance Reporting Branch to:

- Define Integrated Care as a new Establishment Type
- Map the Integrated Care Establishment Type to Tier 2 Class 40.58 (Hospital avoidance programs)
- Have each Local Health District create one or more Integrated Care Service Units that map to the Ministry Integrated Care Establishment Type and allocate all designated integrated care positions to these service units.
- Using the definitions included in this report, define integrated care interventions (care coordination, care navigation and health coaching) that can be reported as an element of the occasion of service. The Health System Information and Performance Reporting Branch will use existing logic to convert these to service events for reporting and ABF purposes.

LIMITATIONS

This rapid review had a number of limitations relating to the method, scope and timeframe.

Method

The service delivery assessment was dependent on information provided by LHDs and specialty networks in the online survey and qualitative interviews. Not all LHDs and networks responded in time for the online survey and the qualitative interviews were only conducted with six of the LHDs. The responses to the survey and the interviews may not be representative of all LHDs' activity: respondents decided which stand-alone programs to highlight in the survey, and interviewees may not have been aware of all the programs within their LHD. Notwithstanding this the data was supplemented by two consultation processes and was broadly consistent.

Scope

The development of indicators and outcome measures for the interventions was outside of the scope of this review.

Time

The study was conducted over 12 weeks which limited the extent of data collection.

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ADDITIONAL TABLES

Table 1. Target groups and delivery of health coaching from the literature

Citation/Year	Aim	Target group	Delivery
Butterworth 2007	To describe the evolution of health coaching	NA	In person – not further described Mode of delivery - not reported 3-5 sessions. Initial sessions range from 30 mins to 1 hr with FU sessions lasting 10-30 mins
The Evidence Centre 2014	To draw out the characteristics of health coaching (including effectiveness) in order to develop a robust definition	Long term conditions	Peer, nurse, doctor, healthcare assistant, pharmacist, other. Face-to-face, telephone, online, email, app Optimal dose unclear
Dennis et al. 2011 Dennis et al. 2013	Examine the effectiveness of telephone coaching for people with chronic conditions, multi-morbid and vulnerable populations	People over 18yrs with Type 2 Diabetes, CCF, Coronary artery disease, COPD, Hypertension including a combination of these, or one or more of these plus another chronic condition e.g. frailty, mental health or geriatric syndromes. Vulnerability included ATSI, CALD, socioeconomic disadvantage, rural and remote living	Health care provider or lay person Telephone delivery Optimal duration of coaching or number of calls unclear
Gale and Skouteris 2013	To review the literature (controlled studies) published between 2000 and 2011 (building on Olsen review) which reviewed the years 1999-2008	Chronic conditions	Health practitioners – not described Delivered by telephone, on-line, mail and face-to-face Optimal dose – not reported

Citation/Year	Aim	Target group	Delivery
Hill et al. 2015	To extend the work by Olsen and Nesbitt by applying the CALO-RE framework to existing health coaching literature. This framework helps identify the key features of HC interventions - behaviour change techniques (BCT)	This review was not restricted to disease category and included a range of population groups including obese, cancer survivors, coronary heart disease, rheumatoid arthritis, chronic conditions, T2 diabetes or aged and included adults, adolescents and children.	Health practitioners Delivered by face-to face, on-line or via telephone Studies differed substantially in terms of the number of sessions provided, session length, duration of intervention, and mode of delivery.
Hutchison 2011	To review the evidence for one to one telephone coaching	People with long term conditions (CVD, Diabetes, mental health, respiratory conditions, CA, arthritis and Parkinson's Disease	Medically trained coaches such as nurse practitioners or specially trained interventionists or lay professional Telephone (56%), videophones (24%), SMS (9%), automated voice messages (9%) - 41% involved remote tele-monitoring Optimal dose not reported
Kivela et al. 2014	To describe the health effects of health coaching on adult patients with chronic disease	Adults (aged >18years) with chronic disease, excluding mentally ill and disabled people	A variety of health care professionals with nurses being the most widely used. Others included dietitians, psychologists, social workers, physical therapists, qualified fitness professionals, health lifestyle coaches and education coaches. Interventions tailored and delivered to patients by telephone (most common), internet or a combination of telephone, face-to-face, Internet or e-mail. The number of coaching sessions ranged from 3-14. Interventions varied in length from 3 weeks to 18 months. The most common study period was 6 months.
Olsen and Nesbitt 2010	This integrative review analysed health coaching studies for evidence of effectiveness and to identify key program features.	Adults and children who require interventions for improving healthy lifestyle behaviours in the context of wellness, aging, and chronic illness.	Nurses were the most commonly cited professional group but also registered dietitians, physical therapists, and physicians. Delivery by telephone, internet or via email, or face to-face.

Citation/Year	Aim	Target group	Delivery
			Duration of coaching ranged from 3 to 18 months, (median 12 months)
Wolever et al 2013	To review the operational definitions of health and wellness coaching as published in the peer reviewed literature - including the approaches and methodologies incorporated.	Not specified although background focuses on preventable chronic conditions	Professionals (93%; 217/234), 7% (17/234) used lay individuals. Professional coaches were overwhelmingly medical (53%) and allied health (51%) professionals. Nurses comprised the clear majority (42%). Mental health providers were the second most common (21%: divided between 11% psychologists [doctorate level] and 10% social workers and other master's-level psychotherapists). Dieticians were the third most common professionals to provide coaching (11%), with health educators/health promotion experts (8%), unspecified health professionals (8%) and exercise physiologists/specialists (6%) also well-represented. Coaching ranged from a single session to 6 years. Frequency of coaching ranged from biannual sessions to twice per week, with the majority reporting weekly sessions. Coaching frequency appeared to be related to length of the intervention, with shorter programs employing more weekly coaching whereas longer interventions were more likely to use monthly coaching. Mode of delivery – not reported The average reported no of sessions was 10.1, ranging from 1 to 90, median = 6. Sessions lasted for an average of 35.8 minutes, ranging from 5 minutes to 2.5 hours.

Table 2: General evidence of benefit for care navigation interventions

Citation/Year	Aim	Target group	Who benefits	Range of interventions with successful outcomes	Not effective?
Baik 2016	To evaluate the efficacy of patient navigation in improving treatment and survivorship outcomes in women with breast cancer	Women with breast cancer in the US	Most studies (11/13) targeted 'ethnic minorities and/or those with limited or without health insurance', but the efficacy of patient navigation for breast cancer treatment and surviorship was 'mixed'. 2 studies that reported significant improvements targeted Hispanic/Latina and African American/black populations that were medically underserved.		5 studies showed no significant reduction in time from either symptom presentation or diagnosis to treatment. 2 studies showed no significant difference in adherence rates to treatment.
Corrigan 2014	To review research on peer navigators as to meet the integrated care needs of people with serious mental illness from minority ethnic groups.	People with serious mental illness.	People presenting with psychiatric emergency to primary care.	Paraprofessional case navigator intervention to connect people presenting with psychiatric emergency to primary care. Intervention included education about fees and services, facilitation to primary care with shared decision making, index cards for primary care providers with psychiatric information about the patient and ongoing follow-up (home visits and mobile outreach).	Not reported
Fillion 2012	To elaborate, refine, and validate the professional navigation framework in a Canadian context	Patients with cancer and patients' families and significant others in Nova Scotia and Quebec.	Not reported	Not reported	Not reported

Citation/Year	Aim	Target group	Who benefits	Range of interventions with successful outcomes	Not effective?
Freund 2008	To present the definitions and measures developed in order to assess the benefits of patient navigation.	Target communities include racial and ethnic minorities and those of low socioeconomic status who have either abnormal cancer screening or an incident diagnosis of breast, cervical, colorectal or prostate cancer.	N/A (protocol)		
Kelly 2015	This systematic review will evaluate the evidence for patient navigator programs, compared to usual care, in patients with chronic disease.	Patients of any age with one or more chronic diseases.	N/A (protocol)		
Krok-Schoen 2016	To provide a summary of the recent literature on patient navigation and breast and gynaecologic cancers from screening through treatment along the cancer care continuum, and to highlight research challenges and opportunities of patient navigation that impact women' s health	Women with breast and gynaecological cancers, often with culturally diverse populations, including African American, Latina, Native American, Serbo-Croatian speaking, refugee, Chinese, and Hispanic. Included women from low socio-economic backgrounds	Significant differences in patient navigation effectiveness with regard to 'age, ethnicity, location of care, type of screening test, and type of treatment.' PN was shown to be effective in helping women who receive cancer screenings, receive more timely diagnostic resolution after a breast and cervical cancer screening abnormality, initiate treatment sooner, receive proper treatment, and improve quality of life after cancer diagnosis. However, several limitations were observed.	Not reported	One study showed no difference in the stage of presentation or the overall survival between intervention and usual care groups.

Citation/Year	Aim	Target group	Who benefits	Range of interventions with successful outcomes	Not effective?
Manderson 2012	To describe existing navigation models and to investigate the potential impact of each model	Older adults with chronic disease who are transitioning between care settings	2 studies targeted patients with heart failure due to the very high risk of rehospitalisation and showed positive post-intervention outcomes	Not reported	2 studies revealed 'little to no effect' of the navigator position. Study described a 'number of navigation models for which there is a mixed record of success in achieving individual program goals.'
McDonald 2007	N/A (definition only)				
Paskett 2011	To update the review by Wells et al (2008). Aim is to evaluate the efficacy of patient navigation regarding cancer screening rates, diagnostic follow-up and in the treatment setting, and in cancer survivorship.	Cancer patients, especially, but not limited to patient populations at higher risk of not receiving adequate cancer care services due to cultural, economic, geographic or social disparities. Inclusion of underserved urban patients, underserved rural populations (especially Native Americans), low-income populations and also inclusion of other patient populations not identified as underserved.	1 out of 17 efficacy studies showed benefit in mammography screening rates for medically underserved female patients (Latina, Native American, Caucasian and African American). 2 studies showed increased colonoscopy rates for intervention group of unspecified composition. One study found patients with head and neck cancers had higher patient satisfaction and quality of life.	Not reported	Overall, 5 out of 17 efficacy studies showed no statistical difference between intervention and control groups
Parker 2011	To define the key elements of the patient navigator role across different clinical disciplines and in different settings and to identify the various outcomes patient	Most studies were in cancer care settings, but also HIV care, palliative care, spinal care, substance abuse, chronic diseases such as diabetes and depression. In many studies, target population	Study did not report on outcomes of intervention	'There were no clear patterns relating to specific navigator activities or outcomes to specific navigation designs.'	Study did not report on outcomes of intervention

Citation/Year	Aim	Target group	Who benefits	Range of interventions with successful outcomes	Not effective?
	navigators are expected to attain in order to refine a conceptual model for patient navigation	was also identified as being vulnerable in terms of language, culture or economic circumstances			
Tan 2015	To understand the experiences of adult patients in patient navigation programs and how patient navigators impact the challenges patients encounter in the cancer care continuum	Adult cancer patients over 18yo who are receiving, or who have received, cancer care in a patient navigation program or had been in a hospital patient navigation program	Not reported	Not reported	Not reported
Ustjanauskas 2016	To review descriptions of patient navigation training in the peer-reviewed research literature and to evaluate the provision of patient navigation training documented in the published research articles.	Populations included people with cancer (including breast, colorectal, cervical, prostate, and unspecified), cardiovascular disease, diabetes, HIV.	Not reported	Not reported	Not reported
Wells 2008	To describe the evolution of patient navigation as a model to address cancer disparities, review current literature that defines patient navigation and its impact in cancer care, and describe the goals of the Patient Navigation Research Program.	Studies mostly included populations at risk for poor cancer outcomes: underserved and disadvantaged populations in the US, including inner-city residents, Native Americans, low income populations, minority populations, rural residents. Some studies	Patient navigation improved screening rates for 3 cancers, improved adherence to diagnostic services following a screening abnormality, reduced the incidence in late stage cancer diagnosis, improved the timeliness of starting breast cancer treatment (one study out of 2).	In one study, telephone intervention was more successful than face-to-face intervention in increasing adherence to mammography screening	Not reported

Citation/Year	Aim	Target group	Who benefits	Range of interventions with successful outcomes	Not effective?
		targeted populations with no vulnerabilities, such as medical centre patients and patients in managed care organisations.			

APPENDICES

Appendix 1: Team list and acknowledgements

Team list

Professor Mark Harris, Centre for Primary Health Care and Equity

Mr Terry Findlay, Centre for Primary Health Care and Equity

Dr Julie McDonald, Centre for Primary Health Care and Equity

Associate Professor Gawaine Powell Davies, Centre for Primary Health Care and Equity

Ms Sharon Parker, Centre for Primary Health Care and Equity

Associate Professor Sarah Dennis, University of Sydney

Ms Louise Thomas, Centre for Primary Health Care and Equity

Ms Rachael Kearns, Centre for Primary Health Care and Equity

Professor Kathy Eagar, University of Wollongong

Acknowledgements

We would like to thank the health coaching experts consulted as part of this review process:

Sue Sims, health coaching trainer

Michelle Maxwell, Get Healthy

Appendix 2. Medline and EBM search strings for part 1 of literature search (definitions)

a) Health coaching – search conducted 18/8/2016

#	Search	Results
1	telephone coaching.mp	88
2	health coaching.mp	196
3	Health and wellness coaching.mp	22
4	1 or 2 or 3	299
5	meta-analysis/ or metaanaly$.tw	74651
6	meta-analysis.pt	73964
7	search$ strategy$.tw	12403
8	selection criteria$.tw	26190
9	systematic review.ab	41786
10	narrative review.ab	2166
11	5 or 6 or 7 or 8 or 9 or 10	121737
12	case report.pt	0
13	editorial.pt	388537
14	letter.pt	898753
15	historical article.pt	335685
16	comment.pt	641616
17	12 or 13 or 14 or 15 or 16	1763635
18	11 not 17	120319
19	4 and 11 and 18	6

b) Care coordination – search conducted 18/8/2016

#	Search	Results
1	care coordinat$.tw	2032
2	coordinat$ care.tw	1223
3	coordinated health care.tw	48
4	1 or 2 or 3	3159
5	meta-analysis/ or metaanaly$.tw	72967
6	meta-analysis.pt	72282
7	search$ strategy$.tw	13772
8	selection criteria$.tw	25918
9	systematic review.ab	40724
10	narrative review.ab	2093
11	5 or 6 or 7 or 8 or 9 or 10	120194
12	case report.pt	0
13	editorial.pt	388356
14	letter.pt	898549
15	historical article.pt	335621
16	comment.pt	641341
17	12 or 13 or 14 or 15 or 16	1742530
18	11 not 17	118796
19	4 and 18	40

c) Care navigation- search conducted 18/8/2016

#	Search	Results
1	care navigation.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	13
2	patient navigation.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	487
3	care navigator.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	3
4	1 or 2 or 3	498
5	meta-analysis/ or metaanaly$.tw	72967
6	meta-analysis.pt	72282
7	search$ strategy$.tw	13772
8	selection criteria$.tw	25918
9	systematic review.ab	40724
10	narrative review.ab	2093
11	5 or 6 or 7 or 8 or 9 or 10	120194
12	case report.pt	0
13	editorial.pt	388356
14	letter.pt	898549
15	historical article.pt	335621
16	comment.pt	641341
17	12 or 13 or 14 or 15 or 16	1742530
18	11 not 17	118796
19	4 and 18	7

Appendix 3. Local and international websites searched

Organisation/URL	Country/region
Australian Association for Quality in Health Care (AAQHC) https://www.aaqhc.org.au/	Australasia
Australian Commission on Safety and Quality in Health Care http://www.safetyandquality.gov.au/	Australia
Department of Health http://www.health.gov.au/	Australia
Primary Health Care Research Information Service (PHCRIS) http://www.phcris.org.au/researchevidence/	Australia
Health Improvement and Innovation Resource Centre http://www.hiirc.org.nz/	New Zealand
Ministry of Health http://www.health.govt.nz/	New Zealand
The Health Foundation http://www.health.org.uk/	UK
Kings Fund http://www.kingsfund.org.uk/	UK
NICE – National Institute of Clinical Excellence https://www.nice.org.uk/	UK
NHS – Improving Quality http://www.nhsiq.nhs.uk/	UK
Nuffield Trust http://www.nuffieldtrust.org.uk/	UK
Accreditation Canada's Leading Practices database https://www.accreditation.ca/leading-practices	Canada
American Public Health Association https://www.apha.org/	United States
Canadian Institute for Health Information http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001	Canada
Canadian Patient Safety Institute http://www.patientsafetyinstitute.ca/English/Pages/default.aspx	Canada
Canadian Public Health Association http://www.cpha.ca/en/default.aspx	Canada
The Change Foundation http://www.changefoundation.com/	Canada
MacColl Institute for Health Care Innovation http://maccollcenter.org/	United States
National Collaborating Centres for Public Health http://www.nccph.ca/2/home.ccnsp	Canada
Public Health Agency of Canada http://www.phac-aspc.gc.ca/index-eng.php	Canada
Institute for Clinical Evaluative Sciences http://www.ices.on.ca/	Ontario, Canada
Agency for Healthcare Research and Quality http://www.ahrq.gov/	United States
Centers for Disease Control and Prevention (CDC) http://www.cdc.gov/	United States
The Guide to Community Preventive Services http://www.thecommunityguide.org/	United States

Organisation/URL	Country/region
Commonwealth Fund http://www.commonwealthfund.org/	United States
Institute of Medicine http://www.iom.edu/	United States
Institute for Healthcare Improvement http://www.ihi.org/Pages/default.aspx	United States
The Henry J. Kaiser Family Foundation http://kff.org/	United States
National Quality Forum http://www.qualityforum.org/Home.aspx	United States
Robert Wood Johnson Foundation USA http://www.rwjf.org/	United States
World Health Organisation – Primary health care http://www.who.int/topics/primary_health_care/en/	International

Appendix 4: Summary of definitions workshop

Notes from integrated care workshop 23/09/16 Ministry of Health

Present:
CPHCE Research team
Gawaine Powell Davies (facilitator),
Julie McDonald,
Terry Findlay,
Louise Thomas,
Sharon Parker,
Sarah Dennis,
Kathy Eager

Michael Crampton GP, Clinical Lead, Western Sydney Integrated Care Program, WentWest PHN
Cynthia Stanton, Primary Care Advancement and Integration, Sydney North PHN
Laura White, Connecting Care Program - Care Coordinator Nepean, Nepean Blue Mountains LHD
Katrina Wilson, Innovator site integrated care, Northern NSW
Deb Donnelly, Clinical Manager, Chronic and Ambulatory Care, Sydney LHD
Julie Finch, Chronic Disease Program Manager, Sydney LHD
Tish Bruce, Deputy Director, Ambulatory and Primary Health Care, South eastern Sydney LHD
Linda Soars, Integrated Care Unity Manager, South Eastern Sydney LHD
Lou-Anne Blunden, Director Clinical Services, Integration, Sydney LHD

Elizabeth Flynn, Preventive Health Policy Branch Commonwealth Dept Health
Erin Lilley, Integrated Care, MOH
Jenny Casperson Primary Care and Chronic Services, ACI
Fraser Powrie, MOH
Julie Osborne, Senior Policy Officer, MOH
Mardi Daddo, Nursing and Midwifery workforce, MOH
Joanne Chicco (for Ray Messom), Data Quality, MOH
Vicki Frost, Senior Policy Officer, Primary & Community Care, MOH

Clarification of discussion: looking at interventions as they relate to integrated care strategy and not CDM

Conceptual map

Key overlaps?

- Coaching within CC and CN circles
- Conceptual map doesn't capture literature- they may sit within each other
- Health literacy- glue (common element)
- Variable- people will have varying amounts needed dependent on capacity, condition etc.

- All have element of behaviour change- although maybe not for all???
- CN and HC- subsets of CC?

Commonalities?

- Behaviour change
- Health literacy
- Definitions all contextual and depend on location
- Providers doing bits of all three types of interventions at different times
- Advocacy

Underlying concepts/models

- Patient activation
- Health literacy
- Multiple providers but also multiple navigators/coordinators- different players doing different bits. Not one locus of coordination- "coordinate the coordinators"
- Care planning
- Risk assessment/stratification
- One size doesn't fit all- flexible, based on client needs
- Related to "patient-centredness"
- Level of input varies
- Dynamic
- Behaviour change (clinicians, systems and patient level) – not everyone agreed that they all had an element of behaviour change
- Planners, commissioners would bring different perspective (commissioning and fundholders would be different)
- Funding silos/providers
- Efficiency/effectiveness- encourage self-management- although is this just delaying time to coordination? SM not achievable for all of the pt experience – people lose capacity to self-manage the system
- Dependence→ independence
- Social determinants- interagency work

Problems addressed by intervention

Care coordination	Care navigation	Health coaching
• Lack of knowledge of system- or is this CN? • Poor Health literacy • Multimorbidity- more than management-threshold- individual-varying- impact of social determinants of health • Coordinating 3rd party • Coordinating multiple providers (CC and CN) • Clinical • Domain rather than an intervention?	• Poor health literacy • Coordinating 3rd party • Name for position • Helping everyone, not just those with particular needs • Complexity of system • Administrative • Getting to appointments • Patient's journey-barriers (care at right time at right place by right person). Multiple providers over time. • Care delivery monitoring (did you go to appointment? Watching - Is the care plan executed? • Domain rather than intervention?	• Poor health literacy • Direct intervention • Motivation • Boxed- defined outcomes set by system- might not be what patient needs. Key feature: targeted outcome

Key features and what it is not

	Key features	What it is not/should not be
Care coordination	• Patient perspective (not provider)→patient-centredness • Supportive care • Empowered provider? →Nominating rather than empowering • Negotiating responsibility and accountability • Clarity of roles • Recognition as coordinator (for ABF) • Intervention, good practice, or both? ○ Different to just good practice • Population health outcomes (CN/HC more individual) • Generic term • Care planning- provides infrastructure • May be ongoing • Responsibility for execution • Derive actions from care plan • Consolidate all care plans floating around • 3 aspects: needs assessment, care coordination, care navigation • Program with eligibility criteria: accepting referrals, interventions falling within particular range, outcome measures	• Working in a silo • Clinical delivery • Not as individually-focused

Care navigation	• Discharge plan rather than planning
	• Care plan/pathway
	• Transition from acute to PC and vice versa
	• Not an intervention
	• Person-centredness
	• Advocacy
	  ○ Explaining and articulating problem
	  ○ Interpreting
		• Discharge planning- although may still be a feature but in a more discrete way than coordination
		• Clinical service delivery
		• Referral (although may facilitate)
		• Care planning

	• Derive action from care plan • May be ongoing • Transactional • Subset of CC?	
Health coaching	• Addressing lack of motivation (can easily become a blame game) • Poor literacy/capacity/competency in relation to what they need to do- ability to self-manage • Goal orientated ○ Mostly patient-centred • Measurable • Time limited (not ongoing) • Defined intervention • What you can control/change within your environment • Individual focus • Structured • Subset of CC?	• Not life coaching? Different perceptions of HC. Lifestyle modifications? • Not interchangeable with self-management- although aim is to end up with this though • Not telling people what to do • Not focused on broader environment • Not peer support intervention

Core dimensions

- Who is it for?
    - Complexity- health and social status
- How accessed/what triggers it?
    - Health coaching: Readiness element
- How delivered?
    - Evidence of delivery
    - Discrete: when does it start and stop
- Type of intervention?
- Amount delivered?
    - Pre-question or outcome?
    - Unit of counting and unit of payment- need to align these two units
    - Overall timeframe
- How delivered?
- Who delivers it?
- Clinical governance/quality improvement
    - Audit trail
    - Paying for best practice- minimum threshold will help with this
    - Useful to have information on outcomes

Overall comments based on core dimensions

- Is another program being delivered with it?
- Usual care-standard of service differs
- HC- readiness component
- Definition of unit of counting just as important as defining tasks
    - HC: Minimum to be different to monitoring
- Outcomes based funding-
    - No evidence that paying by outcomes improves quality or safety
    - risk of stratification by providers (taking easy patients)
    - realistically not feasible
    - best practice- maybe we should focus on this/protocol driven care
    - cost-effectiveness
- Patient equity – need to know that all patients are getting the same thing regardless of where they live/also paying for an equivalent program irrespective of where patients live
- Number of people involved
- Works for HC rather than CC/CN?
- Complexity- sorting out other complexities before you address health needs

Comments on components

Care coordination

- CC includes CN and HC- although navigator positions have been put in place because this hasn't been done in CC
- Are you funded to do this job?
- Service arrangements-brokering- sequencing and connecting
- Proactive role- rather than GP
- Communication and information sharing- agreed

Care navigation

- Assessing→ rearranging based on needs (continuous/ongoing)- review and update existing assessment (rather than continually creating new assessment)
- Terminology- "which care plan?"
    - Shared care plan is ideal but not everyone has one
    - PCMH aiming to address this
- Feedback to CC- explicit communication
- Self-management support (education and psychosocial support)
- Patient/provider/**carer** communication

Health coaching

- Assessment of readiness/health literacy (needs assessment)
- Goal setting- clinical and QOL- comprehensive and collaborative
- Patient-centred but moving patient along to where they need to be
- Developing understanding

Final thoughts

- Context: Multi-provider – provided in a patchwork
- Importance of inadequate health literacy pervades all three
- Not static- ebbs and flows
- Range of integrated care initiatives, not just chronic care
- To operationalise: discrete interventions
- Concept map - Not 3 interconnected circles- more complex
- Tier 2 has use-by-date
- Standards and definitions needed
- Enabling infrastructure important
- Discussion of fundamental aspects- valuable
- CC more of a concept than an intervention
    - Driver of any program implemented in IC programs
        - CN may be part of CC with HC an optional added extra
- Complexity- learning what we don't know and hence has not been done before
- Don't create more walls- need to break them down
- Person-centred approach makes CC a given
    - CN and HC ways to help deliver CC- enablers that sit around CC

Appendix 5. Survey

Introduction

Service delivery assessment component of the rapid review of integrated care interventions

You are invited to take part in this component of the Rapid Review of Integrated Care Interventions that is being undertaken by the Centre for Primary Health Care and Equity (CPHCE) at UNSW Australia for the NSW Ministry of Health between late August-November 2016.

The rapid review covers health coaching, care navigation and care coordination, including but not confined to Integrated Care Innovator or Demonstrator programs or the CDMP program. This review is limited to programs for the population of adults (aged 18 and above) with one or more chronic conditions. Self-management support programs other than health coaching are out of scope of this review, as is the Care Coordination for Aboriginal and Torres Strait Islanders Program (CCAP).

The review includes:

- A survey of all NSW Local Health Districts (LHDs)/Specialty Health Networks (SHNs) (October 17th-28th)
- Telephone interviews with a selection of LHDs (late October/early November)

All LHDs/SHNs are asked to select the person/s best able to answer the survey questions. Completing the survey will require collaboration with other relevant services, for example mental health, data and performance management.

This online survey should take approximately 60 minutes to complete. You may at any stage save the uncompleted survey and return to it later. If you require any assistance, you can contact Louise Thomas Ph: 9385 0534 or email Louise.Thomas@unsw.edu.au.

If you decide to participate, you will be asked three sets of questions about how each program (health coaching, care navigation and care coordination) is implemented in your LHD/SHN. This survey is asking about discrete programs, not health coaching, care navigation or care coordination provided as part of usual care. If there is more than one of each type of program (health coaching, care navigation and care coordination) in your LHD/SHN, you will be able to complete a second set of questions for each program where applicable. However if there are more than two of each type of program, please select the ones that are most relevant or representative. Do not include programs that have been discontinued or are still in planning. You can refer to these in the 'comment' boxes at the end of each section of the survey, but we need to know how each program is currently being delivered. If you have no discrete programs to describe, please use the comment

boxes at the end of each section to outline the approach to health coaching, care navigation or care coordination in your LHD/SHN.

The information you provide will be analysed and reported as part of the final report. No individuals will be identified in any reporting of the findings.

BACKGROUND INFORMATION

Q1.01 Please select your Local Health District or Specialty Health Network.

- ❍ Central Coast (1)
- ❍ Far West (2)
- ❍ Hunter New England (3)
- ❍ Illawarra Shoalhaven (4)
- ❍ Justice Health and Forensic Mental Health (5)
- ❍ Mid North Coast (6)
- ❍ Murrumbidgee (7)
- ❍ Nepean Blue Mountains (8)
- ❍ Northern NSW (9)
- ❍ Northern Sydney (10)
- ❍ St Vincent's Hospital (11)
- ❍ South Eastern Sydney (12)
- ❍ South West Sydney (13)
- ❍ Southern NSW (14)
- ❍ Sydney (15)
- ❍ Western NSW (16)
- ❍ Western Sydney (17)
- ❍ Other (18)

Answer If Please select your Local Health District Other Is Selected

Q1.01b Please specify.

Q1.02 Contact person for this survey

Name:
Position:
Contact phone:
Email address:

HEALTH COACHING

We are interested in understanding health coaching as an intervention/program including who is referred to the service and how it is delivered. It does not include education or self-management support that is delivered as part of ongoing care, although we recognise that these also are important.

Health coaching has been defined as:

…..patient education that guides and prompts a patient to be an active participant in behaviour change. Coaching involves an interactive approach with the patient that helps to identify impediments to behaviour change and methods of teaching and modelling behaviour that empower the patient to achieve and maintain improved health status. Goal setting and empowerment are important features (Linder 2003).

...the practice of health education and health promotion within a coaching context, to enhance the wellbeing of individuals and to facilitate the achievement of their health-related goals…is patient-oriented and motivates them to change their behaviour. The purpose of health coaching is to motivate patients to achieve goals that enhance the quality of their lives and improve their health (Kivela et al. 2014).

Q2.1 How many health coaching programs are there in your Local Health District (LHD) or Specialty Health Network (SHN)?

If How many health coaching pr... Is Less Than 1, Then Skip To End of Block

Q2.1b Please give details of the programs.

	Name any specific conditions that this program focuses on (1)	Describe which services provide the program (2)	Services/organisations referring to this program (3)	Describe what localities or population groups this program covers (4)
Program 1 (1)				
Program 2 (2)				
Program 3 (3)				
Program 4 (4)				
Program 5 (5)				
Program 6 (6)				

2.2 Select up to two of these programs to provide more detail about. Please answer the following questions about the FIRST chosen health coaching program.

Q2.201 What is the name of the program?

Q2.202 Who provides the program?

- ❍ The LHD or SHN (1)
- ❍ One or more external providers (2)
- ❍ Both the LHD/SHN and external providers (3)
- ❍ Other (please specify) (4) _____

Answer If Who provides the program? One or more external providers Is Selected Or Who provides the program? Both the LHD and external providers Is Selected

Q2.202b Please name or describe the external provider.

Q2.203 To what extent does the program aim to achieve the following with clients?

	A lot (1)	A little (2)	Not at all (3)	Don't know (4)
Modify their behavioural risk factors (1)	❍	❍	❍	❍
Self manage their chronic health condition/s (2)	❍	❍	❍	❍
Engage with treatment (eg. medication management) (3)	❍	❍	❍	❍
Other (please specify) (4)	❍	❍	❍	❍

Answer If To what extent does the program aim to achieve the following with clients? Other (please specify) - A lot Is Selected Or To what extent does the program aim to achieve the following with clients? Other (please specify) - A little Is Selected Or To what extent does the program aim to achieve the following with clients? Other (please specify) - Not at all Is Selected Or To what extent

does the program aim to achieve the following with clients? Other (please specify) - Don't know Is Selected

Q2.203b Please list the other aim/s.

Q2.204 Which of the following elements does this program include?

- ❑ Assessing client readiness (stage of change) (10)
- ❑ Assessing individual needs/capacity to benefit (including health literacy) (1)
- ❑ Assessing goals (patient centred) (2)
- ❑ Structured education (3)
- ❑ Providing information (20)
- ❑ Motivational interviewing (4)
- ❑ Behaviour change techniques (5)
- ❑ Strategies to work towards a more supportive home/work environment (6)
- ❑ Encouraging self monitoring (7)
- ❑ Tailoring to individual needs (8)
- ❑ Other (9)

Answer If Which of the following elements does this program include? Other Is Selected

Q2.204b Please list the other element/s.

Q2.205 How do people access this health coaching program?

- ❍ By referral only (1)
- ❍ By self referral only (2)
- ❍ By both referral and self referral (3)
- ❍ Don't know (4)

Q2.206 What proportion of participants come from each of these referral points?

	Most (1)	Some (2)	Very Few (3)	Don't know (4)
Transfer of care from hospital (eg following acute admission) (1)	❍	❍	❍	❍
Transfer of care from other programs (eg rehab) (2)	❍	❍	❍	❍
General practice (3)	❍	❍	❍	❍
Community Health (4)	❍	❍	❍	❍
Other Clinical Service (5)	❍	❍	❍	❍
Self-referral (7)	❍	❍	❍	❍
Other (6)	❍	❍	❍	❍

Answer If What proportion of participants come from each of these referral points? Other - Most Is Selected Or What proportion of participants come from each of these referral points? Other - Some Is Selected Or What proportion of participants come from each of these referral points? Other - Very Few Is Selected

Q2.206b Please list the other referral point/s.

Q2.207 Are there formal eligibility criteria for this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Are their formal eligibility criteria for this program? Yes Is Selected

Q2.207b Is formal eligibility restricted to any of the following?

- ❑ Modifiable risk factor (eg Obesity) (7)
- ❑ Having a specific chronic condition(s) (1)
- ❑ Being enrolled in a particular program (eg. CDMP) (2)
- ❑ Being a client of a particular service (3)
- ❑ Being a member of a particular population group (4)
- ❑ Having special needs (eg low health literacy) (5)
- ❑ Complexity of care (6)
- ❑ Other (8)

Answer If Is it restricted to any of the following? Other Is Selected

Q2.207c Please list the other criteria.

Q2.208 Does this program include family members and/or carers?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q2.209 How would you describe the structure of the program?

- ❍ Set structure with little variation (1)
- ❍ Basic structure adapted to clients needs (2)
- ❍ Highly flexible (3)

Q2.210 Is the number of sessions fixed?

- ❍ Yes (1)
- ❍ No it is determined by client need (2)
- ❍ Don't know (3)

Q2.211 What is the typical length of the program?

- ❍ Less than 3 months (1)
- ❍ 3-6 months (2)
- ❍ More than 6 months (3)
- ❍ Don't know (4)

Q2.212 How is the program delivered to clients?

	Always (1)	Most of the time (2)	Sometimes (3)	Never (4)	Don't know (5)
By telephone (1)	❍	❍	❍	❍	❍
Face to face (2)	❍	❍	❍	❍	❍
Internet (web-based) (3)	❍	❍	❍	❍	❍
Combination of F2F and phone or internet (4)	❍	❍	❍	❍	❍
Other (5)	❍	❍	❍	❍	❍

Answer If How is the program delivered to clients? Other - Always Is Selected Or How is the program delivered to clients? Other - Most of the time Is Selected Or How is the program delivered to clients? Other - Sometimes Is Selected

Q2.212b Please list the other mode/s of delivery.

Q2.213 Is the health coaching guided by a specific computer program (eg. an algorithm)?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Is the health coaching guided by a specific computer program (eg. an algorithm)? Yes Is Selected

Q2.213b Please describe the computer program.

Q2.214 Does the health coaching program work from a script (eg on a computer)?

- ❍ Mostly or entirely (1)
- ❍ Very little or not at all (2)
- ❍ Don't know (3)

Q2.215 Is the program delivered in a group or individually?

- ❍ Individually (1)
- ❍ Group (2)
- ❍ Both individually and group (3)

Q2.216 Do clients have the same coach?

- ❍ Always (1)
- ❍ Mostly wherever possible (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q2.217 Who delivers the health coaching?

- ❑ Nurses (RNs) (1)
- ❑ Nurses (Enrolled nurses) (2)
- ❑ Allied health (please specify) (3) _____
- ❑ GPs (4)
- ❑ Practice nurses (8)
- ❑ Trained lay person (5)
- ❑ Aboriginal health worker (6)
- ❑ Other (please specify) (7) _____

Q2.218 What proportion of staff delivering the coaching program have had specific training in health coaching in the past 10 years?

- ❍ All (1)
- ❍ Most (2)
- ❍ Some (3)
- ❍ None (4)
- ❍ Don't know (5)

Q2.219 Is there any formal assessment of the quality or outcomes of this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q2.220 Do you collect patient or summary level data for the services provided?

- ❑ Patient (1)
- ❑ Summary (2)
- ❑ Neither (3)
- ❑ Don't know (4)

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q2.220b For patient level data, what system is used?

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

2.220c For patient level data, is the data submitted to the MoH under the Non-Admitted Patient Data Collection?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do you collect patient or summary level data for the services provided? Summary Is Selected

Q2.220d For summary level data, which fields are reported?

- ❑ Service Unit & Parent Facility (1)
- ❑ Setting type (2)
- ❑ Service type (3)
- ❑ Provider type (4)
- ❑ Modality of care (5)
- ❑ Funding source (6)
- ❑ Occasions of service (7)
- ❑ Referral source (8)
- ❑ Group/individual (9)
- ❑ Outcomes (10)
- ❑ Other (please specify) (11) _____
- ❑ Don't know (12)

Q2.221 Is there anything else we need to understand about the program? Please write briefly.

Q2.3 Is there another health coaching program in your Local Health District (LHD) or Specialty Health Network (SHN) that you would like to describe?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To End of Block

Q2.301 What is the name of the program?

Q2.302 Who provides the program?

- ❍ The LHD or SHN (1)
- ❍ One or more external providers (2)
- ❍ Both the LHD/SHN and external providers (3)
- ❍ Other (please specify) (4) _____

Answer If Who provides the program? One or more external providers Is Selected Or Who provides the program? Both the LHD and external providers Is Selected

Q2.302b Please name or describe the external provider.

Q2.303 To what extent does the program aim to achieve the following with clients?

	A lot (1)	A little (2)	Not at all (3)	Don't know (4)
Modify their behavioural risk factors (1)	❍	❍	❍	❍
Self manage their chronic health condition/s (2)	❍	❍	❍	❍
Engage with treatment (eg. medication management) (3)	❍	❍	❍	❍
Other (please specify) (4)	❍	❍	❍	❍

Answer If To what extent does the program aim to achieve the following with clients? Other (please specify) - A lot Is Selected Or To what extent does the program aim to achieve the following with clients? Other (please specify) - A little Is Selected Or To what extent does the program aim to achieve the following with clients? Other (please specify) - Not at all Is Selected Or To what extent does the program aim to achieve the following with clients? Other (please specify) - Don't know Is Selected

Q2.303b Please list the other aim/s.

Q2.304 Which of the following elements does this program include?

- ❑ Assessing client readiness (stage of change) (10)
- ❑ Assessing individual needs/capacity to benefit (including health literacy) (1)
- ❑ Assessing goals (patient centred) (2)
- ❑ Structured education (3)
- ❑ Providing information (20)
- ❑ Motivational interviewing (4)
- ❑ Behaviour change techniques (5)
- ❑ Strategies to work towards a more supportive home/work environment (6)
- ❑ Encouraging self monitoring (7)
- ❑ Tailoring to individual needs (8)
- ❑ Other (9)

Answer If Which of the following elements does this program include? (This is a comprehensive list of ite Other Is Selected

Q2.304b Please list the other element/s.

Q2.305 How do people access this health coaching program?

- ❍ By referral only (1)
- ❍ By self referral only (2)
- ❍ By both referral and self referral (3)
- ❍ Don't know (4)

Q2.306 What proportion of participants come from each of these referral points?

	Most (1)	Some (2)	Very Few (3)	Don't know (4)
Transfer of care from hospital (following acute admission) (1)	❍	❍	❍	❍
Transfer of care from other programs (eg rehab) (2)	❍	❍	❍	❍
General practice (3)	❍	❍	❍	❍
Community Health (4)	❍	❍	❍	❍
Other clinical service (5)	❍	❍	❍	❍
Self-referral (7)	❍	❍	❍	❍
Other (6)	❍	❍	❍	❍

Answer If What proportion of participants come from each of these referral points? Other - Most Is Selected Or What proportion of participants come from each of these referral points? Other - Some Is Selected Or What proportion of participants come from each of these referral points? Other - Very Few Is Selected

Q2.306b Please list the other referral point/s.

Q2.307 Are there formal eligibility criteria for this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Are their formal eligibility criteria for this program? Yes Is Selected

Q2.307b Is formal eligibility restricted to any of the following?

- ❑ Modifiable risk factor (eg obesity) (8)
- ❑ Having a specific chronic condition(s) (1)
- ❑ Being enrolled in a particular program (eg. CDMP) (2)
- ❑ Being a client of a particular service (3)
- ❑ Being a member of a particular population group (4)
- ❑ Having special needs (eg low health literacy) (5)
- ❑ Complexity of care (6)
- ❑ Other (7)

Answer If Is formal eligibility restricted to any of the following? Other Is Selected

Q2.307c Please list the other criteria.

Q2.308 Does this program include family members and/or carers?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q2.309 How would you describe the structure of the program?

- ❍ Set structure with little or no variation (1)
- ❍ Basic structure adapted to patient need (2)
- ❍ Highly flexible (3)

Q2.310 Is the number of sessions fixed?

- ❍ Yes (1)
- ❍ No it is determined by client need (2)
- ❍ Don't know (3)

Q2.311 What is the typical length of the program?

- ❍ Less than 3 months (1)
- ❍ 3-6 months (2)
- ❍ More than 6 months (3)
- ❍ Don't know (4)

Q2.312 How is the program delivered to clients?

	Always (1)	Most of the time (2)	Sometimes (3)	Never (4)	Don't know (5)
By telephone (1)	❍	❍	❍	❍	❍
Face to face (2)	❍	❍	❍	❍	❍
Internet (web-based) (3)	❍	❍	❍	❍	❍
Combination of F2F and phone or internet (4)	❍	❍	❍	❍	❍
Other (5)	❍	❍	❍	❍	❍

Answer If How is the program delivered to clients? Other - Always Is Selected Or How is the program delivered to clients? Other - Most of the time Is Selected Or How is the program delivered to clients? Other - Sometimes Is Selected

Q2.312b Please list the other mode/s of delivery.

Q2.313 Is the health coaching guided by a specific computer program (eg. an algorithm)?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Is the health coaching guided by a specific computer program (eg. an algorithm)? Yes Is Selected

Q2.313b Please describe the computer program.

Q2.314 Does the health coaching program work from a script (eg. on a computer)?

- ❍ Mostly or entirely (2)
- ❍ Very little or not at all (3)
- ❍ Don't know (4)

Q2.315 Is the program delivered in a group or individually?

- ❍ Individually (1)
- ❍ Group (2)
- ❍ Both individually and group (3)

Q2.316 Do clients have the same coach?

- ❍ Always (1)
- ❍ Mostly where possible (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q2.317 Who delivers the health coaching?

- ❑ Nurses (RNs) (1)
- ❑ Nurses (Enrolled nurses) (2)
- ❑ Allied health (please specify) (3) _____
- ❑ GPs (4)
- ❑ Practice nurses (8)
- ❑ Trained lay person (5)
- ❑ Aboriginal health worker (6)
- ❑ Other (please specify) (7) _____

Q2.318 What proportion of staff delivering the coaching program have had specific training in health coaching in the past 10 years?

- ❍ All (1)
- ❍ Most (2)
- ❍ Some (3)
- ❍ None (4)
- ❍ Don't know (5)

Q2.319 Is there any formal assessment of the quality or outcomes of this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q2.320 Do you collect patient or summary level data for the services provided?

- ❑ Patient (1)
- ❑ Summary (2)
- ❑ Neither (3)
- ❑ Don'know (4)

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q2.320b For patient level data, what system is used?

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q2.320c For patient level data, is the data submitted to the MoH under the Non-Admitted Patient Data Collection?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do you collect patient or summary level data for the services provided? Summary Is Selected

Q2.320d For summary level data, which fields are reported?

- ❑ Service Unit & Parent Facility (1)
- ❑ Setting type (2)
- ❑ Service type (3)
- ❑ Provider type (4)
- ❑ Modality of care (5)
- ❑ Funding source (6)
- ❑ Occasions of service (7)
- ❑ Referral source (8)
- ❑ Group/individual (9)
- ❑ Outcomes (10)
- ❑ Other (please specify) (11) _____
- ❑ Don't know (12)

Q2.321 Is there anything else we need to understand about the program? Please write briefly.

Q2.4 If there are no discrete health coaching programs, please describe the approach to health coaching in your LHD/SHN.

CARE NAVIGATION

We are interested in understanding care navigation as a separate and identified program/intervention including who was referred and how this service was delivered. This does not include care navigation that occurs as part of care coordination or as part of ongoing care, although we recognise that this is also important.

Care navigation has been defined as:

"...a model of care which entails a trained personnel providing individualized and assistive care to … patients to help them overcome barriers and achieve continuity of care as they experience the complex healthcare system." (Tan et al 2015)

"Patient navigation refers to support and guidance offered to persons …in accessing the [health] care system, overcoming barriers, and facilitating timely, quality care provided in a culturally sensitive manner. Patient navigation is intended to target those who are most at risk for delays in care, including racial & ethnic minorities and those from low income populations." (Freund et al 2008)

Q3.101 How many care navigation programs are there in your Local Health District (LHD) or Specialty Health Network (SHN)?

If How many care navigation pr... Is Less Than 1, Then Skip To End of Block

Q3.101b Please give details of the programs.

	Name any specific conditions that this program focuses on (1)	Describe which services provide the program (2)	Describe which services/organisations refer to this program (3)	Describe what localities or population groups this program covers (4)
Program 1 (1)				
Program 2 (2)				
Program 3 (3)				
Program 4 (4)				
Program 5 (5)				
Program 6 (6)				

Q3.2 Select up to two of these programs to provide more detail about. Please answer the following questions about the FIRST chosen care navigation program.

Q3.201 What is the name of the program?

Q3.202 Who provides the program?

- ❍ The LHD or SHN (1)
- ❍ One or more external providers (2)
- ❍ Both the LHD/SHN and external providers (3)
- ❍ Other (please specify) (4) _____

Answer If Who provides the program? One or more external providers Is Selected Or Who provides the program? Both the LHD and external providers Is Selected

Q3.202b Please name or describe the external provider.

Q3.203 To what extent does the program aim to achieve the following with clients? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

	A lot (1)	A little (2)	Not at all (3)	Don't know (4)
Receive the care identified in their care plan(s) (8)	❍	❍	❍	❍
Manage complex needs (9)	❍	❍	❍	❍
Attend appointments (1)	❍	❍	❍	❍
Access the health services they need (10)	❍	❍	❍	❍
Access the social services they need (11)	❍	❍	❍	❍
Self manage their health care (5)	❍	❍	❍	❍
Engage with treatment (6)	❍	❍	❍	❍
Receive seamless transfer of care (12)	❍	❍	❍	❍
Manage medications (13)	❍	❍	❍	❍
Other (please specify) (4)	❍	❍	❍	❍

Answer If To what extent does the program aim to achieve the following with clients? (This is a comprehensi... Other (please specify) - A lot Is Selected Or To what extent does the program aim to achieve the following with clients? (This is a comprehensi... Other (please specify) - A little Is Selected Or To what extent does the program aim to achieve the following with clients? (This is a comprehensi... Other (please specify) - Not at all Is Selected Or To what extent does the program aim to achieve the following with clients? (This is a comprehensi... Other (please specify) - Don't know Is Selected

Q3.203b Please list the other aim/s.

Q3.204 Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

- ❑ Assessing readiness (stage of change) (1)
- ❑ Assessing individual needs/capacity to benefit (17)
- ❑ Developing a coordinated multidisciplinary care plan (10)
- ❑ Reminders for appointments (19)
- ❑ Accompanying the patient on appointments (3)
- ❑ Following up attendance at appointments (21)
- ❑ Providing phone support and follow up (4)
- ❑ Monitoring and review of client needs and care plan (20)
- ❑ Providing client/caregiver information (5)
- ❑ Providing client/caregiver skill development to support self-management (22)
- ❑ Facilitating access to other support programs such as Quitline, GetHealthy (23)
- ❑ Advising consumers to use Healthdirect services for additional support, such as After-Hours GP Helpline or Palliative Care After Hours Helpline (24)
- ❑ Providing psychosocial support (6)
- ❑ Facilitating/supporting communication and information sharing between providers involved in care (18)
- ❑ Other (9)

Answer If Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply). Other Is Selected

Q3.204b Please list the other element/s.

Q3.205 How do people access this care navigation program?

- ❍ By referral only (1)
- ❍ By self referral only (2)
- ❍ By both referral and self referral (3)
- ❍ Don't know (4)

Q3.206 What proportion of participants come from each of these referral points?

	Most (1)	Some (2)	Very Few (3)	Don't know (4)
Transfer of care from hospital (following acute admission) (1)	❍	❍	❍	❍
Transfer of care from other programs (eg rehab) (2)	❍	❍	❍	❍
General practice (3)	❍	❍	❍	❍
Community health (4)	❍	❍	❍	❍
Other clinical service (5)	❍	❍	❍	❍
Self-referral (7)	❍	❍	❍	❍
Other (6)	❍	❍	❍	❍

Answer If What proportion of participants come from each of these referral points? Other - Most Is Selected Or What proportion of participants come from each of these referral points? Other - Some Is Selected Or What proportion of participants come from each of these referral points? Other - Very Few Is Selected

Q3.206b Please list the other referral point/s.

Q3.207 Are there formal eligibility criteria for this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Are their formal eligibility criteria for this program? Yes Is Selected

Q3.207b Is formal eligibility restricted to any of the following?

- ❑ Having a modifiable risk factor (eg obesity) (8)
- ❑ Having a specific chronic condition(s) (1)
- ❑ Being enrolled in a particular program (eg. CDMP) (2)
- ❑ Being a client of a particular service (3)
- ❑ Being a member of a particular population group (4)
- ❑ Having special needs (eg low health literacy) (5)
- ❑ Complexity of care (6)
- ❑ Other (7)

Answer If Is formal eligibility restricted to any of the following? Other Is Selected

Q3.207c Please list the other criteria.

Q3.208 Does this program include family members and/or carers?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q3.209 How is the program delivered to clients?

	Always (1)	Most of the time (2)	Sometimes (3)	Never (4)	Don't know (5)
By telephone (1)	❍	❍	❍	❍	❍
Face to face (2)	❍	❍	❍	❍	❍
Internet (web-based) (3)	❍	❍	❍	❍	❍
Combination of F2F and phone or internet (4)	❍	❍	❍	❍	❍
Other (5)	❍	❍	❍	❍	❍

Answer If How is the program delivered to clients? Other - Always Is Selected Or How is the program delivered to clients? Other - Most of the time Is Selected Or How is the program delivered to clients? Other - Sometimes Is Selected

Q3.209b Please list the other mode/s of delivery.

Q3.210 Who provides the care navigation? (tick all that apply)

- ❑ Nurses (RNs) (1)
- ❑ Nurses (Enrolled nurses) (2)
- ❑ Allied health (please specify) (3) _____
- ❑ GPs (4)
- ❑ Practice nurses (8)
- ❑ Trained lay person (5)
- ❑ Aboriginal health worker (6)
- ❑ Other (please specify) (7) _____

Q3.211 Is care navigation guided by a specific computer program (eg. Health Pathways or a decision support tool)?

- ❍ Yes (1)
- ❍ No (3)
- ❍ Don't know (2)

Answer If Is care navigation guided by a specific computer program (eg. Health Pathways or a decision support tool)? Yes Is Selected

Q3.211b Please describe the computer program.

Q3.212 Do care navigators communicate electronically with external providers?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do care navigators communicate electronically with external providers Yes Is Selected

Q3.212b How do they communicate?

Answer If Do clients have a consistent relationship with a single care navigator? Yes, wherever possible Is Selected

Q3.213b How long does the care navigator work with the patient? (eg from diagnosis to end of treatment)

Q3.213 Do clients have a consistent relationship with a single care navigator?

- ❍ Yes, wherever possible (1)
- ❍ Rarely or never (2)
- ❍ Don't know (3)

Q3.214 What proportion of staff delivering the care navigation program have had specific training in care navigation in the past 10 years?

- ❍ All (1)
- ❍ Most (2)
- ❍ Some (3)
- ❍ None (4)
- ❍ Don't know (5)

Q3.215 Is there any formal assessment of the quality or outcomes of this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q3.216 Do you collect patient or summary level data for the services provided?

- ❑ Patient (1)
- ❑ Summary (2)
- ❑ Neither (3)
- ❑ Don't know (4)

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q3.216b For patient level data, what system is used?

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q3.216c For patient level data, is the data submitted to the MoH under the Non-Admitted Patient Data Collection?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do you collect patient or summary level data for the services provided? Summary Is Selected

Q3.216d For summary level data, which fields are reported?

- ❑ Service Unit & Parent Facility (1)
- ❑ Setting type (2)
- ❑ Service type (3)
- ❑ Provider type (4)
- ❑ Modality of care (5)
- ❑ Funding source (6)
- ❑ Occasions of service (7)
- ❑ Referral source (8)
- ❑ Group/indiidual (9)
- ❑ Outcomes (10)
- ❑ Other (please specify) (11) _____
- ❑ Don't know (12)

Q3.217 Is there anything else we need to understand about the program? Please write briefly.

Q3.3 Is there another care navigation program in your Local Health District (LHD) or Specialty Health Network (SHN) that you would like to describe?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To End of Block

Q3.301 What is the name of the program?

Q3.302 Who provides the program?

- ❍ The LHD/SHN (1)
- ❍ One or more external providers (2)
- ❍ Both the LHD/SHN and external providers (3)
- ❍ Other (please specify) (4) _____

Answer If Who provides the program? One or more external providers Is Selected Or Who provides the program? Both the LHD and external providers Is Selected

Q3.302b Please name or describe the external provider.

Q3.303 To what extent does the program aim to help people to do the following? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

	A lot (1)	A little (2)	Not at all (3)	Don't know (4)
Manage complex needs (9)	❍	❍	❍	❍
Receive the care identified in their care plan(s) (8)	❍	❍	❍	❍
Access the health services they need (10)	❍	❍	❍	❍
Access the social services they need (13)	❍	❍	❍	❍
Attend appointments (1)	❍	❍	❍	❍
Self manage their conditions (5)	❍	❍	❍	❍
Engage with treatment (6)	❍	❍	❍	❍
Receive seamless transfer of care (12)	❍	❍	❍	❍
Manage medications (11)	❍	❍	❍	❍
Other (please specify) (4)	❍	❍	❍	❍

Answer If To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - A lot Is Selected Or To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - A little Is Selected Or To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - Not at all Is Selected Or To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - Don't know Is Selected

Q3.303b Please list the other aim/s.

Q3.304 Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

- ❑ Assessing readiness (stage of change) (1)
- ❑ Assessing individual needs/capacity to benefit (17)
- ❑ Developing a coordinated multidisciplinary care plan (10)
- ❑ Reminders for appointments (19)
- ❑ Accompanying the patient on appointments (3)
- ❑ Following up attendance at appointments (21)
- ❑ Providing phone support and follow up (4)
- ❑ Monitoring and review of client needs and care plan (20)
- ❑ Providing client/caregiver information (5)
- ❑ Providing client/caregiver skill development to support self-management (22)
- ❑ Facilitating access to other support programs such as Quitline, GetHealthy (23)
- ❑ Advising consumers to use Healthdirect services for additional support, such as After-Hours GP Helpline or Palliative Care After Hours Helpline (24)
- ❑ Providing psychosocial support (6)
- ❑ Facilitating/supporting communication and information sharing between providers involved in care (18)
- ❑ Other (9)

Answer If Which of the following elements does this program include? (This is a comprehensive list of items... Other Is Selected

Q3.304b Please list the other element/s.

Q3.305 How do people access this care navigation program?

- ❍ By referral only (1)
- ❍ By self referral only (2)
- ❍ By both referral and self referral (3)
- ❍ Don't know (4)

Q3.306 What proportion of participants come from each of these referral points?

	Most (1)	Some (2)	Very Few (3)	Don't know (4)
Transfer of care from hospital (eg after acute admission) (1)	❍	❍	❍	❍
Transfer of care from other program (eg rehab) (2)	❍	❍	❍	❍
General Practice (3)	❍	❍	❍	❍
Community health (4)	❍	❍	❍	❍
Other clinical service (5)	❍	❍	❍	❍
Self-referral (7)	❍	❍	❍	❍
Other (6)	❍	❍	❍	❍

Answer If What proportion of participants come from each of these referral points? Other - Most Is Selected Or What proportion of participants come from each of these referral points? Other - Some Is Selected Or What proportion of participants come from each of these referral points? Other - Very Few Is Selected

Q3.306b Please list the other referral point/s.

Q3.307 Are there formal eligibility criteria for this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Are their formal eligibility criteria for this program? Yes Is Selected

Q3.307b Is formal eligibility restricted to any of the following?

- ❑ Having a modifiable risk factor (eg obesity) (8)
- ❑ Having a specific chronic condition(s) (1)
- ❑ Being enrolled in a particular program (eg. CDMP) (2)
- ❑ Being a client of a particular service (3)
- ❑ Being a member of a particular population group (4)
- ❑ Having special needs (eg low health literacy) (5)
- ❑ Complexity of care (6)
- ❑ Other (7)

Answer If Is formal eligibility restricted to any of the following? Other Is Selected

Q3.307c Please list the other criteria.

Q3.308 Does this program include family members and/or carers?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q3.309 How is the program delivered to clients?

	Always (1)	Most of the time (2)	Sometimes (3)	Never (4)	Don't know (5)
By telephone (1)	❍	❍	❍	❍	❍
Face to face (2)	❍	❍	❍	❍	❍
Internet (web-based) (3)	❍	❍	❍	❍	❍
Combination of F2F and phone or internet (4)	❍	❍	❍	❍	❍
Other (5)	❍	❍	❍	❍	❍

Answer If How is the program delivered to clients? Other - Always Is Selected Or How is the program delivered to clients? Other - Most of the time Is Selected Or How is the program delivered to clients? Other - Sometimes Is Selected

Q3.309b Please list the other mode/s of delivery.

Q3.310 Who provides the care navigation? (tick all that apply)

- ❑ Nurses (RNs) (1)
- ❑ Nurses (Enrolled nurses) (2)
- ❑ Allied health (please specify) (3) _____
- ❑ GPs (4)
- ❑ Practice nurses (8)
- ❑ Trained lay person (5)
- ❑ Aboriginal health worker (6)
- ❑ Other (please specify) (7) _____

Q3.311 Is care navigation supported by a computer program (eg. Health Pathways or a decision support tool)?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Is care navigation supported by a computer program (eg. Health Pathways or a decision support tool)? Yes Is Selected

Q3.311b Please describe the computer program.

Q3.312 Do care navigators communicate electronically with external providers?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do care navigators communicate electronically with external providers? Yes Is Selected

Q3.312b How do they communicate?

Q3.313 Do clients have a consistent relationship with a single care navigator?

- ❍ Yes, wherever possible (1)
- ❍ Rarely or never (2)
- ❍ Don't know (3)

Answer If Do clients have a consistent relationship with a single care navigator? Yes, wherever possible Is Selected

Q3.313b How long does the navigator work with the patient? (eg from diagnosis to end of treatment)

Q3.314 What proportion of staff delivering the care navigation program have had specific training in care navigation in the past 10 years?

- ❍ All (1)
- ❍ Most (2)
- ❍ Some (3)
- ❍ None (4)
- ❍ Don't know (5)

Q3.315 Is there any formal assessment of the quality or outcomes of this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q3.316 Do you collect patient or summary level data for the services provided?

- ❑ Patient (1)
- ❑ Summary (2)
- ❑ Neither (3)
- ❑ Don'know (4)

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q3.316b For patient level data, what system is used?

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q3.316c For patient level data, is the data submitted to the MoH under the Non-Admitted Patient Data Collection?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do you collect patient or summary level data for the services provided? Summary Is Selected

Q3.316d For summary level data, which fields are reported?

- ❑ Service Unit & Parent Facility (1)
- ❑ Setting type (2)
- ❑ Service type (3)
- ❑ Provider type (4)
- ❑ Modality of care (5)
- ❑ Funding source (6)
- ❑ Occasions of service (7)
- ❑ Referral source (8)
- ❑ Group/individual (9)
- ❑ Outcomes (10)
- ❑ Other (please specify) (11) _____
- ❑ Don't know (12)

Q3.317 Is there anything else we need to understand about the program? Please write briefly.

Q3.4 If there are no discrete care navigation programs, please describe the approach to care navigation in your LHD/SHN.

CARE COORDINATION

This survey is concerned with care coordination as a separate and identified program/intervention to which people are referred and that occurs as part of the LHD's integrated care strategy (including the CDMP 'Connecting Care'). This does not include care coordination that is delivered as part of ongoing care, although we recognise that this is also important.

Care coordination has been defined as:

"…the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care" (McDonald 2007).

Q4.1 How many care coordination programs are there in your Local Health District (LHD) or Specialty Health Network (SHN)?

If How many care coordination ... Is Less Than 1, Then Skip To End of Block

Q4.1b Please give details of the programs.

	Name any specific conditions that this program focuses on (1)	Describe which services provide the program (2)	What services/organisations refer to this program (3)	Describe what localities or population groups this program covers (4)
Program 1 (1)				
Program 2 (2)				
Program 3 (3)				
Program 4 (4)				
Program 5 (5)				
Program 6 (6)				

Q4.2 Select up to two of these programs to provide more detail about. Please answer the following questions about the FIRST chosen care coordination program.

Q4.201 What is the name of the program?

Q4.202 Who provides the program?

- ❍ The LHD or SHN (1)
- ❍ One or more external providers (2)
- ❍ Both the LHD/SHN and external providers (3)
- ❍ Other (please specify) (4) _____

Answer If Who provides the program? One or more external providers Is Selected Or Who provides the program? Both the LHD and external providers Is Selected

Q4.202b Please name or describe the external provider.

Q4.203 To what extent does the program aim to help people to do the following? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

	A lot (1)	A little (2)	Not at all (3)	Don't know (4)
Receive the care identified in their care plan(s) (1)	❍	❍	❍	❍
Manage complex needs (8)	❍	❍	❍	❍
Attend appointments (5)	❍	❍	❍	❍
Access the health services they need (6)	❍	❍	❍	❍
Access the social services they need (4)	❍	❍	❍	❍
Self-manage their chronic condition/s (10)	❍	❍	❍	❍
Engage with treatment (11)	❍	❍	❍	❍
Receive seamless transfer of care (12)	❍	❍	❍	❍
Manage their medications (13)	❍	❍	❍	❍
Other (please specify) (9)	❍	❍	❍	❍

Answer If To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - A lot Is Selected Or To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - A little Is Selected

Q4.203b Please list the other aim/s.

Q4.204 Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

- ❑ Assessing readiness (stage of change) (1)
- ❑ Assessing individual needs/capacity to benefit (17)
- ❑ Developing a coordinated multidisciplinary care plan (10)
- ❑ Reminders for appointments (19)
- ❑ Accompanying the patient on appointments (3)
- ❑ Following up attendance at appointments (21)
- ❑ Providing phone support and follow up (4)
- ❑ Monitoring and review of client needs and care plan (20)
- ❑ Providing client/caregiver information (5)
- ❑ Providing client/caregiver skill development to support self-management (22)
- ❑ Facilitating access to other support programs such as Quitline, GetHealthy (23)
- ❑ Advising consumers to use Healthdirect services for additional support, such as After-Hours GP Helpline or Palliative Care After Hours Helpline (24)
- ❑ Providing psychosocial support (6)
- ❑ Facilitating/supporting communication and information sharing between providers involved in care (18)
- ❑ Other (9)

Answer If Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply). Other Is Selected

Q4.204b Please list the other element/s.

Q4.205 How do people access this care coordination program?

- ❍ By referral only (1)
- ❍ By self referral only (2)
- ❍ By both referral and self referral (3)
- ❍ Don't know (4)

Q4.206 What proportion of participants come from each of these referral points?

	Most (1)	Some (2)	Very Few (3)	Don't know (4)
Transfer of care from hospital (eg following acute admission) (1)	❍	❍	❍	❍
Transfer of care from other programs (eg rehab) (2)	❍	❍	❍	❍
General practice (3)	❍	❍	❍	❍
Community Health (4)	❍	❍	❍	❍
Other clinical service (5)	❍	❍	❍	❍
Self-referral (7)	❍	❍	❍	❍
Other (6)	❍	❍	❍	❍

Answer If What proportion of participants come from each of these referral points? Other - Most Is Selected Or What proportion of participants come from each of these referral points? Other - Some Is Selected Or What proportion of participants come from each of these referral points? Other - Very Few Is Selected

Q4.206b Please list the other referral point/s.

Q4.207 Are there formal eligibility criteria for this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Are their formal eligibility criteria for this program? Yes Is Selected

Q4.207b Is formal eligibility restricted to any of the following?

- ❑ Having a modifiable risk factor (eg obesity) (8)
- ❑ Having a specific chronic condition(s) (1)
- ❑ Being enrolled in a particular program (eg. CDMP) (2)
- ❑ Being a client of a particular service (3)
- ❑ Being a member of a particular population group (4)
- ❑ Having special needs (eg low health literacy) (5)
- ❑ Complexity of care (6)
- ❑ Other (7)

Answer If Is formal eligibility restricted to any of the following? Other Is Selected

Q4.207c Please list the other criteria.

Q4.208 Does this program include family members and/or carers?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q4.209 How is the program delivered to clients?

	Always (1)	Most of the time (2)	Sometimes (3)	Never (4)	Don't know (5)
By telephone (1)	❍	❍	❍	❍	❍
Face to face (2)	❍	❍	❍	❍	❍
Internet (web-based) (3)	❍	❍	❍	❍	❍
Combination of F2F and phone or internet (4)	❍	❍	❍	❍	❍
Other (5)	❍	❍	❍	❍	❍

Answer If How is the program delivered to clients? Other - Always Is Selected Or How is the program delivered to clients? Other - Most of the time Is Selected Or How is the program delivered to clients? Other - Sometimes Is Selected

Q4.209b Please list the other mode/s of delivery.

Q4.210 Who provides the care coordination? (tick all that apply)

- ❑ Nurses (RNs) (1)
- ❑ Nurses (Enrolled nurses) (2)
- ❑ Allied health (please specify) (3) _____
- ❑ GPs (4)
- ❑ Practice nurse (8)
- ❑ Trained lay person (5)
- ❑ Aboriginal health worker (6)
- ❑ Other (please specify) (7) _____

Q4.211 Is care coordination supported by a computer program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Is care coordination support by a computer program? Yes Is Selected

Q4.211b Please describe the computer program.

Q4.212 Do care coordinators communicate electronically with external providers?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do care coordinators communicate electronically with external providers? Yes Is Selected

Q4.212b How do they communicate?

Q4.213 Do clients have a consistent relationship with a single care coordinator?

- ❍ Yes, wherever possible (1)
- ❍ Rarely or never (2)
- ❍ Don't know (3)

Answer If Do clients have a consistent relationship with a single care coordinator? Yes, wherever possible Is Selected

Q4.213b How long term is the relationship (eg. from assessment to end of active care coordination)?

Q4.214 What proportion of staff delivering the care coordination program have had specific training in care coordination in the past 10 years?

- ❍ All (1)
- ❍ Most (2)
- ❍ Some (3)
- ❍ None (4)
- ❍ Don't know (5)

Q4.215 Is there any formal assessment of the quality or outcomes of this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q4.216 Do you collect patient or summary level data for the services provided?

- ❑ Patient (1)
- ❑ Summary (2)
- ❑ Neither (3)
- ❑ Don't know (4)

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

4.216b For patient level data, what system is used?

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q4.216c For patient level data, is the data submitted to the MoH under the Non-Admitted Patient Data Collection?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do you collect patient or summary level data for the services provided? Summary Is Selected

Q4.216d For summary level data, which fields are reported?

- ❑ Service Unit & Parent Facility (1)
- ❑ Setting type (2)
- ❑ Service type (3)
- ❑ Provider type (4)
- ❑ Modality of care (5)
- ❑ Funding source (6)
- ❑ Occasions of service (7)
- ❑ Referral source (8)
- ❑ Group/individual (9)
- ❑ Outcomes (10)
- ❑ Other (please specify) (11) _____
- ❑ Don't know (12)

Q4.217 Is there anything else we need to understand about the program? Please write briefly.

Q4.3 Is there another care coordination program in your Local Health District (LHD) or Specialty Health Network (SHN) that you would like to describe?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To End of Block

Q4.301 What is the name of the program?

Q4.302 Who provides the program?

- ❍ The LHD or SHN (1)
- ❍ One or more external providers (2)
- ❍ Both the LHD/SHN and external providers (3)
- ❍ Other (please specify) (4) _____

Answer If Who provides the program? One or more external providers Is Selected Or Who provides the program? Both the LHD and external providers Is Selected

Q4.302b Please name or describe the external provider.

Q4.303 To what extent does the program aim to help people to do the following? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

	A lot (1)	A little (2)	Not at all (3)	Don't know (4)
Receive the care identified in their care plan(s) (1)	❍	❍	❍	❍
Manage complex needs (5)	❍	❍	❍	❍
Attend appointments (6)	❍	❍	❍	❍
Access the health services they need (8)	❍	❍	❍	❍
Access the social services they need (9)	❍	❍	❍	❍
Self-manage their chronic condition/s (11)	❍	❍	❍	❍
Engage with treatment (12)	❍	❍	❍	❍
Receive seamless transfer of care (13)	❍	❍	❍	❍
Manage medications (14)	❍	❍	❍	❍
Other (please specify) (4)	❍	❍	❍	❍

Answer If To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - A lot Is Selected Or To what extent does the program aim to help people to do the following? (This is a comprehensive... Other (please specify) - A little Is Selected

Q4.303b Please list the other aim/s.

Q4.304 Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply).

- ❑ Assessing readiness (stage of change) (1)
- ❑ Assessing individual needs/capacity to benefit (17)
- ❑ Developing a coordinated multidisciplinary care plan (10)
- ❑ Reminders for appointments (19)
- ❑ Accompanying the patient on appointments (3)
- ❑ Following up attendance at appointments (21)
- ❑ Providing phone support and follow up (4)
- ❑ Monitoring and review of client needs and care plan (20)
- ❑ Providing client/caregiver information (5)
- ❑ Providing client/caregiver skill development to support self-management (22)
- ❑ Facilitating access to other support programs such as Quitline, GetHealthy (23)
- ❑ Advising consumers to use Healthdirect services for additional support, such as After-Hours GP Helpline or Palliative Care After Hours Helpline (24)
- ❑ Providing psychosocial support (6)
- ❑ Facilitating/supporting communication and information sharing between providers involved in care (18)
- ❑ Other (9)

Answer If Which of the following elements does this program include? (This is a comprehensive list of items relating to all integrated care interventions so not all will apply). Other Is Selected

Q4.304b Please list the other element/s.

Q4.305 How do people access this care coordination program?

- ❍ By referral only (1)
- ❍ By self referral only (2)
- ❍ By both referral and self referral (3)
- ❍ Don't know (4)

Q4.306 What proportion of participants come from each of these referral points?

	Most (1)	Some (2)	Very Few (3)	Don't know (4)
Transition of care from hospital (eg post acute admission) (1)	❍	❍	❍	❍
Transition of care from other programs (eg rehab) (2)	❍	❍	❍	❍
General practice (3)	❍	❍	❍	❍
Community health (4)	❍	❍	❍	❍
Other clinical service (5)	❍	❍	❍	❍
Self-referral (7)	❍	❍	❍	❍
Other (6)	❍	❍	❍	❍

Answer If What proportion of participants come from each of these referral points? Other - Most Is Selected Or What proportion of participants come from each of these referral points? Other - Some Is Selected Or What proportion of participants come from each of these referral points? Other - Very Few Is Selected

Q4.306b Please list the other referral point/s.

Q4.307 Are there formal eligibility criteria for this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Are their formal eligibility criteria for this program? Yes Is Selected

Q4.307b Is formal eligibility restricted to any of the following?

- ❑ Having a modifiable risk factor (eg obesity) (8)
- ❑ Having a specific chronic condition(s) (1)
- ❑ Being enrolled in a particular program (eg. CDMP) (2)
- ❑ Being a client of a particular service (3)
- ❑ Being a member of a particular population group (4)
- ❑ Having special needs (eg low health literacy) (5)
- ❑ Complexity of care (6)
- ❑ Other (7)

Answer If Is formal eligibility restricted to any of the following? Other Is Selected

Q4.307c Please list the other criteria.

Q4.308 Does this program include family members and/or carers?

- ❍ Always (1)
- ❍ Sometimes (2)
- ❍ Rarely or never (3)
- ❍ Don't know (4)

Q4.309 How is the program delivered to clients?

	Always (1)	Most of the time (2)	Sometimes (3)	Never (4)	Don't know (5)
By telephone (1)	❍	❍	❍	❍	❍
Face to face (2)	❍	❍	❍	❍	❍
Internet (web-based) (3)	❍	❍	❍	❍	❍
Combination of F2F and phone or internet (4)	❍	❍	❍	❍	❍
Other (5)	❍	❍	❍	❍	❍

Answer If How is the program delivered to clients? Other - Always Is Selected Or How is the program delivered to clients? Other - Most of the time Is Selected Or How is the program delivered to clients? Other - Sometimes Is Selected

Q4.309b Please list the other mode/s of delivery.

Q4.310 Who provides the care coordination? (tick all that apply)

- ❑ Nurses (RNs) (1)
- ❑ Nurses (Enrolled nurses) (2)
- ❑ Allied health (please specify) (3) _____
- ❑ GPs (4)
- ❑ Practice nurses (8)
- ❑ Trained lay person (5)
- ❑ Aboriginal health worker (6)
- ❑ Other (please specify) (7) _____

Q4.311 Is care coordination supported by a computer program?

- ❍ Yes (1)
- ❍ No (3)
- ❍ Don't know (2)

Answer If Is a computer program used to assist care coordination? Yes Is Selected

Q4.311b Please describe the computer program.

Q4.312 Do care coordinators communicate electronically with external providers?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do care coordinators communicate electronically with external providers? Yes Is Selected

Q4.312b How do they communicate?

Q4.313 Do clients have a consistent relationship with a single care coordinator?

- ❍ Yes, wherever possible (1)
- ❍ Rarely or never (2)
- ❍ Don't know (3)

Answer If Do clients have a consistent relationship with a single care coordinator? Yes, wherever possible Is Selected

Q4.313b How long term is the relationship (eg. from assessment to end of active care coordination)?

Q4.314 What proportion of staff delivering the care coordination program have had specific training in care coordination in the past 10 years?

- ❍ All (1)
- ❍ Most (2)
- ❍ Some (3)
- ❍ None (4)
- ❍ Don't know (5)

Q4.315 Is there any formal assessment of the quality or outcomes of this program?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q4.316 Do you collect patient or summary level data for the services provided?

- ❑ Patient (1)
- ❑ Summary (2)
- ❑ Neither (3)
- ❑ Don't know (4)

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q4.316b For patient level data, what system is used?

Answer If Do you collect patient or summary level data for the services provided? Patient Is Selected

Q4.316c For patient level data, is the data submitted to the MoH under the Non-Admitted Patient Data Collection?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Answer If Do you collect patient or summary level data for the services provided? Summary Is Selected

Q4.316d For summary level data, which fields are reported?

- ❑ Service Unit & Parent Facility (1)
- ❑ Setting type (2)
- ❑ Service type (3)
- ❑ Provider type (4)
- ❑ Modality of care (5)
- ❑ Funding source (6)
- ❑ Occasions of service (7)
- ❑ Referral source (8)
- ❑ Group/individual (9)
- ❑ Outcomes (10)
- ❑ Other (please specify) (11) _____
- ❑ Don't know (12)

Q4.317 Is there anything else we need to understand about the program? Please write briefly.

Q4.4 If there are no discrete care coordination programs, please describe the approach to care coordination in your LHD/SHN.

Before you go

Q5 Thank you for completing the survey.

Q5.1 Please enter the Participant ID Number.

Q5.2 Please enter date of completion.

Q5.3 Please enter the positions of other people consulted during the process of responding to this survey.

Appendix 6: Semi structured interview guide

Review of integrated care intervention: Assessment of service delivery models

*The following questions relate to **care navigation, care coordination and health coaching** interventions provided under the Integrated Care Program including but not restricted to the NSW Chronic Disease Management Program (CDMP) for people with chronic long term conditions living in the community in NSW.*

Question No.	Question	Prompts
1	Please can you tell us about your current position and your involvement in each of these interventions?	– Health coaching – Care navigation – Care coordination Probe extent of knowledge of interventions
2.	Now I want to ask about health coaching. What are your perceptions about what's in place (i.e. systems, processes & infrastructure) to support the implementation of **health coaching** and how adequate these are?	– Organisational structures – Information systems – Workforce skills – Resources (financial, human, physical and decision-making) – Access arrangements Distinguish at what level these operate: Local, regional, state-level capacity) How adequate are these supports?
3.	What are your perceptions on what's lacking (i.e. systems, processes & infrastructure) to support the effective implementation of **health coaching**?	As per question 2
4.	Now I want to ask about care navigation. What are your perceptions on what's in place (i.e. systems, processes & infrastructure) to support the implementation of **care navigation** and how adequate these are?	As per question 2
5.	What are your perceptions on what's lacking (i.e. systems, processes & infrastructure) to support the effective implementation of **care navigation**?	As per question 2
6.	What are your perceptions about what's in place (i.e. systems, processes & infrastructure) to support the implementation of **care coordination**? How adequate are these are?	As per question 2
7.	What are your perceptions about what's lacking (i.e. systems, processes & infrastructure) to	As per question 2

Question No.	Question	Prompts
	support the effective implementation of **care coordination**?	
8.	In your opinion is there anything else that is needed to support the effective implementation of these interventions and if so, please describe	
9.	In your opinion, what support from the NSW Department of Health has been most helpful? What has been less helpful?	
10.	In your opinion, to what extent do you see these interventions as being sustainably implemented in your LHD over the long term and why?	Probe re threats to their sustainability eg funding
11.	If these are provided as discrete interventions separate from routine care, in your opinion could they be better linked and why/why not?	
11b	If yes, how could they be better linked together these interventions?	Probe re arrangements/ mechanisms
12	Do you have any other comments?	

Appendix 7: LHD Definitions

Health coaching				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
FWLHD	No information	HC is the practice of health education and health promotion with a coaching context to enhance the well-being of the individual and facilitate the achievement of their health related goals etc **(ie Kievela et al; Osborn & Nesbitt def'n)** + HC provides patients with the support, knowledge, skills, ability, confidence and willingness to manage their own health and healthcare needs, to improve their current and long term health outcomes. HC promotes a patient's health literacy to support patients to confidently make changes in their lifestyles to improve and manage their own health	No information	No information
Murrumbidgee LHD uses def'n from : Patient Identification & Selection Handbook. A NSW Guide to Risk Stratification (2015)	No information	"HC provides services in health literacy, patient activation and motivation, psychological aspects of illness impacting health status and adherence to care plans, and self-management skill building."	Telephone Face to face (as per Patient Identification & Selection Handbook. A NSW Guide to Risk Stratification (2015)	Psychologist, social worker, or has undergone training in HC Health coaching can be based in hospital, community care or primary care. (as per Patient Identification & Selection Handbook. A NSW Guide to Risk Stratification (2015)

Health coaching				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
SNSW LHD uses def'n from:: Patient Identification and Selection Handbook. (2015)		"Provides services in health literacy, patient activation and motivation, psychological aspects of illness impacting health status and adherence to care plans, and self-management skill building." Health Coaching is offered as part of an integrated and multidisciplinary approach to the management of consumers with chronic and complex conditions.	Telephone Face to face (as per Patient Identification & Selection Handbook. A NSW Guide to Risk Stratification (2015)	Psychologist, social worker, or has undergone training in HC Health coaching can be based in hospital, community care or primary care. (as per Patient Identification & Selection Handbook. A NSW Guide to Risk Stratification (2015)
CCLHD	Clients with a Chronic Disease CAD, HF, COPD Diabetes	No information	Actions • Review client Care plan portfolio, (GP management Plan, client goal plan, Disease specific management plan and ongoing care plan) • Determine the frequency, and intensity of the coaching based on risk profile • Undertake proactive coaching of the client to provide ongoing support and information • Provide condition specific information to patients • Promote adherence to Care Plan Portfolio. • Promote client attendance at other appointments etc as per Care Plan Portfolio.	No information

Health coaching				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
			• Promote disease self management principles • Ensure client has contact details to be able to access support in case of deterioration or exacerbation • Review client care plan portfolio at appropriate intervals • In case of admission to hospital act as liaison between GP Carer and hospital on admission and transfer back to community.	
NSLHD	No information	HC is an intervention that helps people with chronic conditions to make behavioural changes to improve their health and wellbeing. It aims to empower, prepare and support people to be more confident in self-management of their chronic condition and is seen as a partnership between the health care provider, patient, carer or family. People with chronic conditions may have some basic knowledge about what they 'ought' to do to improve their chronic condition, but these self-care behaviours are not necessarily the most important priority in the patient's life. People tend to prioritise what is important to them at the time and sometimes other issues need to be worked through before they are ready to make	No information	Delivered by Complex care coordinators (located in Sydney Home nursing Service, NSLHD Chronic disease Community Rehab Service, NSLHD Diabetes & Heart Failure Education Centres)

Health coaching				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
		changes that will impact on their health.		
CDMP Service Model(2013)		Describes HC as an approach to self- management support Health coaching supports people with chronic disease by: – Increasing their knowledge of their conditions – Helping to address barriers to making lifestyle changes – Helping people to take control of symptoms by monitoring them and responding appropriately – Encouraging people to actively share in decision making with their health professionals. – Encouraging people to better manage the physical, social and emotional impact of the condition on their lives.	Coaching is based on a shared care plan and follows the goals and actions specified in that plan, developed by the person, their carer (where appropriate) and agreed by the patient's care providers	

Care navigation				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
Justice H	Patients with chronic disease and/or complex health problems	The care navigation and support program ….. aims to support and enhance existing chronic disease management services through care coordination and case management of patients with chronic disease and/or complex health needs. The overall aim of the program is to ensure a smooth patient journey by connecting and coordinating care from entry to exit from the custodial system and thereafter. The CNSP also aims to provide an integrated approach to chronic disease and/or complex health care management through the establishment of linkages and collaborative partnerships with external care providers such as Local Health Districts, Aboriginal Medical Services, Divisions of General Practice and Ageing and Disability Homecare Regions.	Linkages and collaborative partnerships with external care providers Connecting and coordinating care from entry to exit Case management	No information
ISH & SESLHD	No information	No definition as such An alternative term was included **Informational continuity** (use of information on past events & patient circumstances to make the current care appropriate to the individual) Purpose – Continuity of care	– Individualised/patient centred – Assessment – Goal setting – Planning – Linkages with GP and community service providers – Education in self-management – Monitoring – Evaluation	No information

Care navigation				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
		– Navigate the health & community systems – Meet an individual's health & social care needs & goals – Achieve patient wellness & autonomy – Optimise functioning – Reduce the number of unplanned readmissions to hospital	– Reassessment – Boundary spanning (across health & community)	
Far West	No information	A role providing direction and support to assist patients to navigate the healthcare, social and welfare systems required to support patients to improve or maintain their health. The role is the key contact and support for the patient in providing information, enabling them to access care services and providers, diagnostic testing, referrals, scheduling appointments and social supports.	Face to face appointments Telephone consults	No information
Murrumbidgee LHD Taken from Patient Identification and Selection Handbook. A NSW Guide to Risk Stratification		"Provides information and referral support that enhances timely access, for example, between primary and specialist care, for diagnostics and for social support, as well as ensuring timely review."	Telephone	Can be delivered by a non clinician

Care navigation				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
SNSW LHD Patient Identification and Selection Handbook. A NSW Guide to Risk Stratification (2015)	No information	"Provides information and referral support that enhances timely access, for example, between primary and specialist care, for diagnostics and for social support, as well as ensuring timely review. Care navigation can be delivered via telephone by a non-clinician" Navigation, as it suggests, guides the consumer/carer through the complexity of the LHD system. It assists with planning and navigating the post-discharge options of care, and then if necessary, short-term care coordination for complex presentations of older consumers, and those with chronic disease in both the acute and community settings is provided. Care navigation in SNSWLHD includes ensuring an effective transfer of care to the most appropriate key health professional who will assume the ongoing coordination of care. This relates directly to the service model in SNSWLHD.	Care navigation is used in tandem with care co-ordination.	Can be delivered by a non clinician
NSLHD	No information	Care Navigation involves assessing patients and listening to their unmet needs, and identifying potential services to address these	Care Navigation is not a stand-alone intervention and is incorporated into the Health Coaching and Care Coordination roles.	Delivered by Complex care coordinators (located in Sydney Home nursing Service, NSLHD Chronic disease Community Rehab Service, NSLHD

Care navigation				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
		needs. There are many reasons navigating the health system is confusing and difficult for people with high levels of education, income and health literacy, and vulnerable people with obvious disadvantage struggle the most with identifying appropriate health services to meet their needs.		Diabetes & Heart Failure Education Centres)

Care coordination				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
ISH & SESLHD	Very high /complex needs with existing services	Alternative term: Interpersonal continuity (Ongoing therapeutic relationship between a patient & more or more clinicians) Purpose: – Continuity of care – Navigate the health & community systems – Meet an individual's health & social care needs & goals – Achieve patient wellness & autonomy – Optimise functioning – Reduce the number of unplanned readmissions to hospital	– Individualised/patient centred – Assessment – Identification of participants involved in the patient's care & their role – Facilitation/communication/coordination – Boundary spanning (across health & community) These components are dependent on each patient's situation – Planning – Monitoring – Evaluation – Reassessment – Adjustment to plan	No information
FWLHD (taken from CDMP Data Dictionary V5.0)	No information	Care coordination is a collaborative process to assess, plan, implement, coordinate and monitor options to meet an individual's health needs. Care coordination facilitates the provision of appropriate supports & services for participants and carers.	– continuity of care, – integration – a collaborative care plan – Communication and information sharing between the participant, carers and other providers (inc other sectors) – Face to face consultations – Teleconferences – Group activities	MDT
MLHD Taken from Patient Identification and Selection Handbook. A NSW Guide to	No information	"Provides support in the identification of patient-level clinical requirements, the communication of clinical information across the care team (including the shared care plan, routine clinical assessment and	"Service is principally delivered by telephone or electronically. Care coordination can be based in hospital, community care or primary care."	"The person delivering care coordination has a clinical background, e.g. in nursing, social work, or allied health; is familiar with a range of medical conditions, health services and medical

Care coordination				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
Risk Stratification (2015)		uploading of clinical metrics) and tracking of follow-up to care plan."		terminology; and is capable of writing clinical notes."
SNSW LHD Patient Identification and Selection Handbook. A NSW Guide to Risk Stratification (2015)		"Provides support in the identification of patient-level clinical requirements, the communication of clinical information across the care team (including the shared care plan, routine clinical assessment and uploading of clinical metrics) and tracking of follow-up to care plan."	"Service is principally delivered by telephone or electronically. Care coordination can be based in hospital, community care or primary care."	"The person delivering care coordination has a clinical background, e.g. in nursing, social work, or allied health; is familiar with a range of medical conditions, health services and medical terminology; and is capable of writing clinical notes."
NSLHD		Care Coordination involves engaging people with complex medical comorbidities and social disadvantage that have a very high risk of avoidable hospitalisations, with the aim of developing a self-management plan for their chronic conditions.	The duration and intensity of care coordination varies according to the stability of patients and their capacity for self-management. Generally the patients do require long-term support; as it is often about improving their quality of life, providing advocacy and improving access to services; due to their reduced capacity to effectively self-manage	Registered Nurses with additional qualifications and advanced assessment skills, together with considerable person-centred care, communication and organisation skills required to engage a range of appropriate stakeholders to work collaboratively towards achieving the patient's goals, especially the patient's General Practitioner.
CDMP Service delivery model		"….as the deliberate organisation of care to a person to facilitate the timely delivery of care in a manner that is consistent with the person's clinical and psychosocial needs. This usually involves assembling the personnel and other resources needed to provide care and effectively exchange information between the person and all	CDMP staff can provide active assistance in implementing shared care plans by: – Coordinating services and appointments as per the participant's care plans and needs – Encouraging attendance at appointments/services – Organising transport – Connecting participants with and navigating them through the various community and health services	CDMP staff

Care coordination				
Citation	**Target group**	**Definition provided**	**Components of the intervention**	**Delivery**
		providers involved in care **(ie McDonald definition)** It can also be expressed as ensuring that a person can access the right care, at the right time, in the right place and by the right provider.	– Supporting development of self-management skills by providing education – Supporting participant's adherence to treatment regimens – Supporting self-care and activities of daily living – Undertaking scheduled monitoring and review. Coordination includes aspects such as a medication review, falls clinic referral and assistance to access appropriate services and self-care supports including meals on wheels, respite and day care. Referral to appropriate services involves advocacy and consideration of the person's financial and social situation. The intensity of care coordination can vary according to the participant's needs ranging from occasional telephone support to intensive care coordination (also known as case management) and regular home visits.	

Appendix 8: Definition of a non-admitted patient service event[8]

Definition:	An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.
Context:	Jurisdiction, Local Hospital Network or Hospital non-admitted patient care. This definition applies to non-admitted patients of a jurisdiction, Local Hospital Network or Hospital and includes all in-scope non-admitted services funded or managed by a jurisdiction, Local Hospital Network or hospital.
Specialisation of:	Service/care event

Collection and usage attributes

Guide for use:	The Non-admitted patient (NAP) data set is intended to capture instances of healthcare provision from the point of view of the patient. This may be for assessment, examination, consultation, treatment and/or education. One service event is recorded for each interaction, regardless of the number of healthcare providers present. **Events broken in time:** The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a healthcare provider is called to assess another patient who requires more urgent care. Where a healthcare provider is unable to complete the interaction, it is considered to be a service event only if the definition of service event (above) is met. **Setting:** Service events can occur in an outpatient clinic or other setting. **Mode:**

[8] http://meteor.aihw.gov.au/content/index.phtml/itemId/583996

Service events delivered via Information and Communication Technology (ICT) (including but not limited to telephone and where the patient is participating via a video link) are included if:

- they are a substitute for a face-to-face service event, and
- the definition of a service event (above) is met.

Accompanied patients:

If a patient is accompanied by a carer/relative, or the carer/relative acts on behalf of the patient with or without the patient present (e.g. the mother of a two-year-old patient, or the carer for an incapacitated patient), only the patient's service event is recorded unless the carer/relative interaction meets the definition of a service event (above).

Note: carer refers to an informal carer only.

Service events delivered in groups:

Care provided to two or more patients by the same service provider(s) at the same time can also be referred to as a group session.

One service event is recorded for each patient who attends a group session regardless of the number of healthcare providers present, where the definition of a service event (above) is met.

Service requests:

A service event is the result of a service request (including formal referral and self-referral or attendance at a walk-in clinic).

Activities which do not meet the definition of a service event include:

- Work-related services provided in clinics for staff.
- Non-attendances for a booked outpatient or booked outpatient services that did not go ahead.