ACI NSW Agency for Clinical Innovation

LEADING BETTER VALUE CARE

CHECKLIST

Osteoarthritis Chronic Care Program

Assessment Tool

Musculoskeletal Network

Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- *service redesign and evaluation* – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services
- *specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- *initiatives including guidelines and models of care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- *implementation support* – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
- *knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- *continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

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Contents

1. Introduction

Osteoarthritis Chronic Care Program

The model of care for the Osteoarthritis Chronic Care Program (OACCP) describes a comprehensive, multidisciplinary, conservative management program for osteoarthritis (OA) of the hip and/or knee. The model engages a nominated coordinator who works within a multidisciplinary team, utilising conservative care interventions for the management of OA. It provides comprehensive assessment, health education, self-management support and access to services that are holistic, person-centred, collaborative and evidence-based to support optimal management of OA, as well as any social, psychological and co-morbidity needs of the person. This OACCP assessment tool has been developed to assist with the implementation of the OACCP model of care.

To support the implementation of the Osteoarthritis Chronic Care Program, a toolkit has been developed including

- Model of Care
- Site Manual
- Assessment tool
- Evaluation package

2. About the Assessment Tool

Purpose of the Assessment Tool

The purpose of conducting the implementation assessment is to help OACCP services to identify current alignment with the model of care and to assist with the preparation and planning to implement or improve the delivery of the model of care.

This assessment tool has been designed to;

- Generate awareness and understanding of the Osteoarthritis Chronic Care Program model of care including underlying principles and elements of care delivery
- Assist in developing a comprehensive and shared understanding of what currently exists for Osteoarthritis Chronic Care Program at a local level
- Help plan for service delivery in sites without an existing OACCP
- Help identify current strengths and weaknesses in relation to implementation of the model of care
- Identify the current gaps between what exists now and best-practice care as described in the model of care
- Inform the development of local solutions to address gaps and issues
- Highlight areas to target for improvement
- Assist in the prioritisation and planning for action and improvement
- Track implementation progress over time and report back to peer mentoring workshops
- Identify health system changes required to support implementation

When to use the Assessment Tool

- For sites where there is no current provision of an Osteoarthritis Chronic Care Program, the Assessment Tool can be used to aid the planning process for new service development
- For sites that are already providing an Osteoarthritis Chronic Care Program (or elements of that service) this tool should be completed quarterly to identify progress made and priority areas for action. In order to identify implementation enablers and barriers and to facilitate discussions across LHDs, each site will be requested to submit their assessment two weeks prior to the quarterly peer mentoring workshops.

How to complete the Assessment Tool

1. Read and become familiar with the model of care- this is the service model with which you are comparing your service.
2. Read the accompanying site manual. This is a practical interpretation of the model of care developed through prior experiences of implementing the model of care.
3. Read the monitoring and evaluation plan
4. Complete the self-assessment tool:
    - It is recommended that a broad and diverse range of views are considered when completing the assessment as it is not expected that any one person will have a complete and accurate understanding of what is currently in place. This may be achieved by multiple stakeholders

(e.g. OACCP coordinators and team members, clinical leads and executive) completing the assessment from their perspectives, or completing the assessment as a group.

- The tool is divided into two components- the assessment tool to fill in and the supplementary information following. The supplementary information should be used to guide your decision making and provides examples of the types of evidence you can use to justify the rating chosen.
- A four point scale to assess the level which **current practice** achieves each service component.
    i. **Not met**: Many of the requirements for successful implementation are not in place nor planned to commence
    ii. **Planned:** Planning is underway to progress with requirements identified for successful implementation.
    iii. **Partially Met:** Most requirements identified for successful implementation are in place
    iv. **Met:** All requirements identified are successfully implemented and embedded as business as usual.
- This tool references both core elements and key resources described in the model of care.
- When using the tool, include comments on the evidence used to determine how you met or did not meet each component of care.

5. Prioritise action:
    - Foundational components are the minimum requirements for an operational OACCP and should be prioritised highest and addressed first. These include governance and workforce resources and assessment, conservative care, management plan and access to surgery elements.
    - Once the foundational components have been met, prioritisation is based on the local context taking into consideration the following examples:
        i. Risk/ Safety
        ii. Resources
        iii. Ease of implementation
        iv. Local environment
    - A maximum of 5 priorities should be addressed at any one time to ensure efficient and effective implementation.

3. The Assessment Tool

There is an excel version of this checklist available on the ACI OACCP website which will allow you to view the summary of your implementation status and record actions you plan to take regarding implementation.

4. Supplementary Information

4.1 Resource: Governance

A governance structure provides clear strategic direction and leadership, promoting and enabling the use of chronic care principles for the management of OA within the LHD. A steering committee is responsible for the governance of OACCP with representatives from all key stakeholders. This committee meets to drive service establishment and delivery, provide advice, and to advocate or escalate issues.

Components of Care

1. **Osteoarthritis Care delivery is based on chronic care principles**

   The OACCP service is governed by a shared understanding, clear vision and strategies supporting the delivery of chronic care services for the management of OA

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Senior leaders visibly participate and show commitment (dedicate resources) to allow utilisation of **chronic care principles** in musculoskeletal services
- Documented local service delivery model (structure, content, locations) complying with elements of care
- Formal arrangements for delivery of services (e.g. contracts for external allied health providers, VMO or GPs)
- Structures are in place for clinicians to provide evidence based/guideline recommended care (e.g. professional development, quarantined administrative support, room/clinic space)

2. **There is collaborative decision making for planning, implementation and evaluation**

   A musculoskeletal steering committee responsible for the governance of OACCP, consists of representation of all key stakeholders and promotes the achievement of the vision and strategies to achieve program outcomes

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Executive and Clinical leads identified
  - Executive Sponsor: someone who authorises, legitimises and demonstrates ownership by driving the change. They must have sufficient power in the organisation to initiate and reinforce the resource commitment.
  - Clinical Lead/s – clinicians with local credibility and ability to influence a range of people
  - Site specific clinical champions: clinician who believe in and want the change to happen
- Engagement of a medical officer to provide clinical governance and leadership

- Formalised Service/ Clinical Governance Framework: The OACCP service is referred to in local operational or clinical service plans
- Engaged and active OACCP service delivery team
    - Service Lead – CNC2 or senior allied health 4
    - Service Coordinator – CNS, RN8, Allied health professional 3
- Inclusion and engagement of all key stakeholders in an initial round table discussion
- A musculoskeletal steering committee
    - Membership and representation of all key stakeholders
    - This group will be responsible for governance of ORP, OACCP and (ALBP if that model of care is implemented locally).
    - May utilise existing governance structure if available with evidence of musculoskeletal service and cohort needs addressed
    - Documented terms of reference (including clear definition and understanding of roles, responsibilities and expectations of members)
    - Minutes and actions for steering committee meetings
- Clinicians are supported in their delivery of evidence based/guideline recommended care (e.g. professional development, quarantined administrative support time, room/clinic space)

4.2 Resource: Workforce

A skilled workforce with expertise and capacity to deliver evidence based and person centred chronic disease management for people with OA. The provision of care should include care coordination, a multidisciplinary approach, health education, collaborative personalised management planning and self-management support.

Components of Care

3. **A dedicated coordinator who is skilled to provide care coordination and case management with the capacity to successfully meet the need of each OACCP service site.**

   The OACCP coordinator has a dedicated role leading program delivery and is appropriately skilled in the management of patients with OA. There is dedicated FTE with the capacity to successfully meet the need of each OACCP site and achieve full coverage of the Local Health District's geographical area (consideration of baseline service data as well as determination of the realistic operational performance capacity for the coordinators will inform this allocation)

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Recruitment of a suitably qualified and experienced dedicated program coordinator for each service site
  - Service Coordinator – CNS, RN8, Allied health professional 3
- There may be a Service Lead to oversee the program coordination across the LHD.
  - Service Lead – CNC2 or senior allied health 4
- Current position descriptions for coordinator roles

4. **Multidisciplinary team access is facilitated to support the individual's chronic care needs**

   The local OACCP service delivery model provides access to a multidisciplinary team to meet the chronic care needs of individuals and for efficient and effective service delivery (including administrative support)

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Formal documentation of staffing resource allocation for OACCP service delivery
- Access to multidisciplinary (MDT) members (may include physio, nurse, OT, dietician etc.)
- Formalised and structured referral pathways to MDT care
- Dedicated administrative support for efficient OACCP service delivery
- OACCP is fully staffed with capacity to meet requirements of the SLA /KPIs and quality standards
- Clinicians delivering care should be appropriate skilled in best practice chronic care principles

- Staff have attended training programs to support program delivery (e.g. Health Change Training, Peer Mentoring)

5. A Medical Officer is engaged to support for the OACCP Service

Engagement of a medical officer to provide clinical governance and champion program

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Allocation of medical officer to provide clinical governance
- Clear communication channels and processes in place between the OACCP team and allocated medical officer.

4.3 Resource: Technology

Information Technology (IT) and electronic communication is utilised to support efficient access and sharing of information across the continuum of care, and to enable continuous improvement of the OACCP service through more effective recording and reporting of health outcome information.

Components of Care

6. **IT functionality supports efficient and effective service delivery**

   IT infrastructure supports the identification of eligible individuals, captures and monitor outcomes, supports care coordination, sharing of the personalised management plan and the extraction and analysis of data for reporting and quality improvement activities

EXAMPLES OF HOW TO MEET THIS COMPONENT

- All staff involved in the OACCP service have unhindered access to electronic patient records (eMR)
- eMR integrated assessment and outcome forms are available and in use
- Data extraction functionality from eMR is utilised
- There is electronic access to patient records when delivered over multiple sites
- Access to and utilisation of digital tools to support the identification of eligible patients (i.e. OACCP staff have access to digital referral for admissions information and/or specialist referrals)
- Data collection tools are utilised to enable timely and efficient reporting
- Automated and electronic communication is utilised between providers within the LHD and community and primary health
- Electronic referral processes are available and in use between the LHD and community and primary health
- Discharge letter functionality within eMR is available and utilised
- Access to alternative tools to provide care delivery (Telehealth, web based tools, phone support, internet/phone supported care models etc.)

4.4 Core Element: Identification and Access to Care

People who are referred for admission for elective hip and/or knee joint replacement surgery and/or are referred from their specialist within the hospital receive conservative OA care prior to and in consideration of their need for surgery. (Additional referral pathways may be identified locally such as through primary care.)

Components of Care

7. **There is equitable access to the service**

   The OACCP service model has appropriate reach and access for local community and priority population groups

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Provision of care that is wherever possible close to home and location of service is appropriate for those accessing the service (shorting walking distance from car park/public transport, lift access etc.)
- Clear identification of priority populations within the LHD (Aboriginal Australians, CALD groups)
- Provision of culturally appropriate services (as well as ongoing self-management opportunities) for Aboriginal people and locally relevant culturally and linguistically diverse group
- Resources to support and enable access and appropriate interventions for local community and priority population groups (i.e. interpreter, aboriginal health workers, telehealth)
- Written information about the program and eligibility is available in a variety of languages and appropriate formats (i.e. literacy, language and cultural needs)
- Communication regarding access to the OACCP includes the involvement of a carer, friend, family as preferred by the person
- There are documented systems (electronic if possible) for auditing access to the OACCP service.

8. **Easy identification of eligible individuals**

   Effective and efficient processes for identification of person requiring access to OA conservative care

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Clear and documented eligibility criteria and referral pathways
- Automated electronic identification tools are used by staff to identify eligibility for the service (i.e. OACCP staff have access to digital referral for admissions information and/or specialist referrals)

- Targeted engagement with key stakeholders responsible for identifying/referring individuals regarding eligibility and purpose of the OACCP.
- There are standard processes for:
    - Communication received by the referrer, patient and GP regarding outcomes of identification/referrals to OACCP
    - Managing ineligible referrals/identification
    - When individuals decline the OACCP
    - Managing out of area referrals/identification
- There are documented systems (electronic if possible) for auditing eligibility and identification processes

4.5 Core Element: Comprehensive Assessment

All patients who are eligible for the OACCP receive a comprehensive assessment that is holistic and patient centred, using validated clinical and patient reported measures. This allows for a better understanding of the individual's needs and circumstances and for all factors that impact on an individual's wellbeing to be considered when planning the person's management.

Components of Care

9. Conduct a comprehensive assessment based on the holistic needs of the individual

A comprehensive assessment is completed for those identified that is holistic and patient centred, using validated clinical and patient reported measures and in consideration of physical, social, psychosocial and co- morbidity needs of the person.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- There is a standardised assessment tool and process used across the LHD
- There is a documented process for engagement of appropriate professionals/services such as an aboriginal health worker or health interpreters as part of the comprehensive assessment
- Patient reported measures are always included as part of the comprehensive assessment process (i.e. Patient-Reported Outcomes Measurement Information System (PROMIS-29))
- Validated tools are used to assess patient reported or clinical outcomes (e.g. VAS, DASS-21)
- A comprehensive assessment is completed by all staff which covers the physical, social, psychological and comorbidity needs of the patients including:
    - Pain
    - Function
    - Quality of life
    - Disease specific factors
    - Comorbidities
    - Psychosocial assessment
- The comprehensive assessment is accessible to all health professionals involved in care
- The comprehensive assessment is documented in the medical record
- When assessment is completed outside of the OACCP, the coordinator documents the encounter and updates the medical record as required
- Assessment resources are available in appropriate formats for low literacy, language and cultural needs.

4.6 Core Element: Health education and self-management support

Health education and self-management support is an integral part of any chronic disease management program. Services will provide health education about osteoarthritis and will promote the necessary treatment, interventions as well as a healthy lifestyle to support chronic disease management. Utilisation of behaviour change methodology is required to support the required lifestyle and behaviour changes.

Components of Care

10. Health education builds understanding, engagement and empowerment for self-management

Health education is provided to all people within the OACCP on their condition and effective treatments and interventions to facilitate active and informed decision making.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- There is a flexible and tailored person centered approach to information and education.
- Health education is delivered in a variety of different formats to meet the needs and preferences of the individual, including written, one to one, group and digital options
- Health education given is documented within the medical record
- Health education includes disease management, effective treatments and interventions (including surgery readiness)
- Education is based on evidence based care
- The principles of adult learning, behavior change methodologies and health literacy are considered in the delivery of health education.

11. All individual's engage in conservative care treatments and identified health behaviour changes

There is access to and behavioural support to promote exercise, weight loss, education, self-management support, pain management and psychosocial and co-morbidity management.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Information and communication practices consider the principles of adult learning, behavior change methodologies and health literacy
- Self-management support is provided by clinical staff and designed to empower the individual and support engagement in behaviour change activities
- Staff have undergone training in behaviour change methodologies (e.g. health change Australia)

- Care pathways and community resources are available to support self-management (e.g. MDT support, community exercise classes)
- Available list of information and self-management resources

4.7 Core Element: Development of a personalised management plan

A management plan is developed to address the individual's physical and psychosocial needs, bringing together all the management options and self-management supported offered through the multidisciplinary providers. In collaboration with the person and their carer, friends or family, self-management goals and action plans are developed. It will include relevant personal details and disease outcomes, clinical and medication management plans, list of service providers and referrals and their self-management goals. This should be shared with all care providers, their GP and/or referrer and the individual.
Management options should aim to address the key elements of education, exercise, weight loss, pain management and psychosocial and comorbidity management within the persons' needs and preference.

Components of Care

12. Collaborative personalised management plans cover the individuals' holistic needs

There is collaborative development of a personalised management plan that addresses both the physical and psychosocial needs with their specific goals and actions plan.

HOW THIS COULD BE ACHIEVED

- All people attending the service have a personalised management plan developed
- There is a standardised template for the management plan including personal details and diagnosis, list of service providers and referrals, clinical and medication management plans and self-management goals.
- Management options and self-management support are offered for:
    - Health Education
    - Exercise
    - Weight loss
    - Pain management
    - Psychosocial and comorbidity management
- The personalised management plan is person centred and user friendly in terms of language, literacy and format.
- The personalised management plan demonstrates collaboration, active involvement and ownership of the individual in their plan (e.g. specific goals and action plans, "their" language, signature/tick box)

13. Personalised Management Plans are shared with all relevant stakeholders

The personalised management plan is provided to the individual as well as being available to all care providers.

HOW THIS COULD BE ACHIEVED

- Communication about the personalised management plan includes both the clinical interventions offered and the specific goals and actions set by the individual
- The personalised management plan is able to be shared, reviewed and updated by all relevant stakeholders and is integrated within the eMR if available.
- A copy of the personalised management plan can be viewed by all health professionals involved in care
- A copy of the personalised management plan is provided to the individual and/or carer
- A copy of the personalised management plan is provided to the individual's referrer/GP
- Communication utilises safe and secure electronic transfer platforms for delivery of the personalised management plan

4.8 Core Element: Routine and planned reviews

Routine and planned reviews are included as part of the chronic disease management of OA, at agreed intervals to assess progress, provide ongoing self-management support and to evaluate, follow up and make adjustments to treatment and management based any changing needs.

Components of Care

14. There is ongoing care through routine and planned reviews

Care should include planned reviews at agreed intervals that are documented in the personalised management plan.

HOW THIS COULD BE ACHIEVED

- There is routine and planned reviews as part of OACCP service delivery
- There are flexible options for reviews based on individual's needs (e.g. availability, time, location)
- Responsibility for completion of the review is clearly defined.
- Reviews are conducted and documented using a standardised template (within the eMR if available)
- The review uses the same patient reported measures and clinical outcomes as in the comprehensive assessment.
- Management plans are reviewed and updated with outcomes and actions
- The planned review includes self-management support to celebrate progress, problem solve barriers and reinforce empowerment of the individual as actively involved in their care.
- There are flexible systems in place for further support as required by the individual i.e. deterioration of the individuals condition
- Procedures and guidelines for routine reviews include documentation, communication processes, protocol for additional reviews/informal support (e.g. prior to surgery, after initiation of new medication, worsening of symptoms, telephone follow-up)

4.9 Core Element: Access to surgery

Timely surgery should be available for people who are not responding to conservative management. There are clear and consistent processes that support the identification and management of people requiring escalation to surgery. Services work collaboratively and communicate effectively with the relevant stakeholders and departments to support ensure continuity of care. Additionally the OACCP will play an important role in ensuring people who are progressing to surgery are adequately prepared, this includes the provision of information and education to enable informed decision making about surgery, optimising comorbidity management, home modifications and post-operative care needs.

Components of Care

15. There is appropriate access to surgery

Appropriate waitlist management based on clinical need and people progressing to surgery are adequately prepared

HOW THIS COULD BE ACHIEVED

- Appropriate waitlist management of individuals on the waiting list for elective joint replacement surgery or referred to the program meeting clinical criteria
- There are processes in place to allow collaboration and integration between OACCP and Pre -Admissions Clinic in regard to preparation for surgery
- There are processes in place to allow clear communication between OACCP, Pre -Admissions Clinic, referrer and individual regarding surgery (e.g. surgery date, removal from waitlist, surgery deferral etc.)
- Documented discharge protocols (including communication and re- entry requirements)
- Flexibility in the OACCP to extend past 12 months if clinically justified (e.g. surgery put on hold, individual is yet to receive surgery date etc.)
- There is education and advice provided to ensure readiness for surgery

16. There is timely access to surgery

Appropriate procedures are in place to allow timely surgery for people who are not responding adequately to conservation care

HOW THIS COULD BE ACHIEVED

- There are standardised local escalation procedures and associated documentation (including communication to referrer/GP) that includes:
    - Consideration of both clinical presentations and outcomes scores
    - Consideration of psychosocial needs

- There are processes in place to allow clear communication between OACCP, Pre -Admissions Clinic, referrer and individual regarding surgery (e.g. surgery date, removal from waitlist, surgery deferral etc.)
- Documented discharge protocols (including communication and re- entry requirements)
- Flexibility in the OACCP to extend past 12 months if clinically justified (e.g. surgery put on hold, individual is yet to receive surgery date etc.)

4.10 Core Element: Reporting and Evaluation

Reporting and evaluation of the OACCP is necessary to assess and monitor key outcomes including service access, patients reported outcomes and experience measures, health service utilisation and fidelity to the model of care. The OACCP service should use appropriate tools and data systems to efficiently collect, record, analyse and report on interventions and outcomes and will use this data to inform OACCP service improvements.

Components of Care

17. Data systems support quality and timely evaluation and reporting

Appropriate reporting and evaluation capabilities exist allowing for quarterly reporting, service review by the steering committee and use in quality improvement activities.

HOW THIS COULD BE ACHIEVED

- Data collection systems and tools exist to capture relevant patient reported outcomes and OACCP service provision data
- Patient reported and clinical outcomes are measured
    - PROMIS 29
    - HOOS/KOOS etc.
- Patient reported experience measures (PREMS) are used to provide direct feedback about care received
- Health service utilisation data collected including accessing of conservative care/treatments, MDT access, removal from waitlist, deferment of surgery and length of stay.
- KPIs and Clinical Indicators
- A minimum data set is completed for all individuals and recorded electronically
- There is a formalised system for analysis and reporting that utilises a standard format for the quarterly reports.
- Data tools and/or resources are provided to enable timely reporting and identifying quality improvement needs
- There is an embedded audit schedule that includes analysis and reporting processes

4.11 Core Element: Quality Improvement

Regular reviews are conducted to ensure the quality of service delivery. This may be achieved by obtaining feedback sought from individuals, staff and key stakeholders; audit of OACCP service and clinical data; or the analysis of systems and processes. Effective information technology systems allow efficient collection and analysis of data. There is a structure in place for teams to reflect on service outcomes and processes, and identify opportunities to make changes and quality improvements.

Components of Care

18. Improved quality of care is driven by patient outcomes and experiences and staff and stakeholder feedback

Quality improvement activities are embedded in ongoing practice and related to patient report measures as well as staff and stakeholder feedback

HOW THIS COULD BE ACHIEVED

- Patient reported measure and experiences are routinely collected and analysed to identify, inform and review quality improvement activities
- Staff and stakeholder feedback is routinely collected to inform or review quality improvement activities
- Resources (data tools and/or staff time) are provided to enable identification and reviews of opportunities to make changes and quality improvements
- There is a proactive review of care pathways and community services available to support management and where gaps are identified, plans developed to address the need.

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