

CARE FOR COMPLEXITY IN COMMUNITY HEALTH

THE 3C TRIAL

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Executive Summary

Project Summary

This study focused on new care pathways for people with (multiple) chronic health conditions (CHCs).

Traditionally self-management approaches are used, which focus on building individual capacity and self-efficacy. These can be overwhelming for disadvantaged and low-income populations, and in general for people with few resources.

The role of burden and capacity can help to explicate the challenges faced by this population. People need sufficient capacity, including social support, socioeconomic resources, and adequate mental/physical functioning, to cope with the workload, or burden, associated with living with a CHC, such as self-management tasks, health system interactions and other life demands. Limited capacity (e.g., poverty, social isolation) or overwhelming burden (e.g., multimorbidity) may reduce adherence and lead to disease escalation. In response to disease escalation, healthcare systems typically respond by intensifying treatment, increasing burden further and resulting in 'cumulative complexity'.

Minimally Disruptive Medicine (MDM) is a practical model of care that builds on the

concepts of burden and capacity. The key elements of MDM are: (1) to assess burden and capacity levels and (2) to undertake practical actions designed to reduce burden and/or increase capacity. Healthcare providers are typically trained in the use of this method before it is implemented in practice.

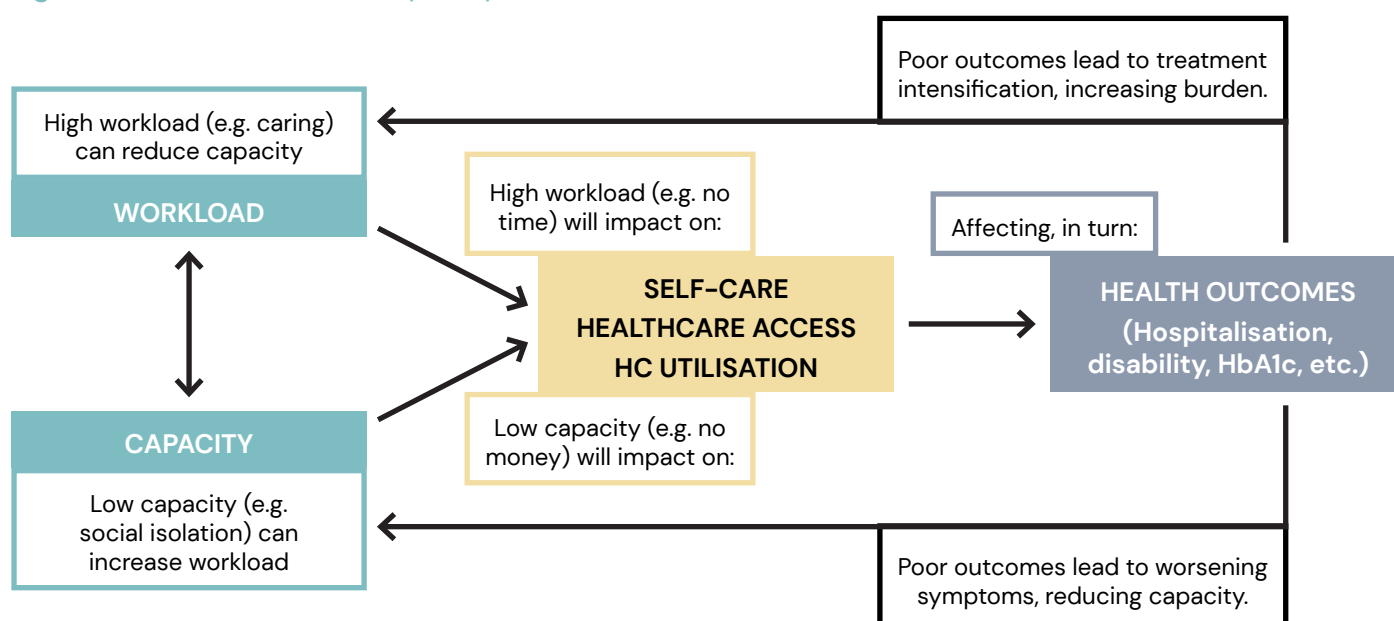
To introduce this new pathway, a trial was developed in Mildura at Sunraysia Community Health Services (SCHS). As a community health service, SCHS provides services for many clients experiencing multimorbidity and socioeconomic disadvantage.

Aims

This study aimed to assess:

1. The feasibility of a training programme for healthcare providers (HCPs) working in Chronic Disease Management, based on the principles of MDM.
2. The feasibility of an MDM approach to chronic disease management for rural community health clients with multimorbidity and social complexity.

Figure 1. The Cumulative Complexity Model



Methods

A two-stage intervention was introduced:

- Healthcare provider training in a model of care based on MDM.
- Trial an MDM model of care with community health clients by utilising several of the upskilled HCPs as care coordinators (CCs).

A feasibility study was undertaken, with mixed methods data collection. Feasibility outcomes were explored using the framework developed by Bowen et al., covering acceptability, demand, implementation, practicality, integration, and efficacy.

Results

Twenty-six clients participated in the trial and three care coordinators were involved. Both qualitative and quantitative data were collected and analysed.

- **Acceptability** was high amongst both clients and clinicians. Both groups stressed the importance of relationship building and clients greatly valued the sense of being cared for, listened to, given time, and befriended. For many clients this provided an increased sense of control over difficult circumstances. Clinicians valued the emphasis on burden and capacity and reported that this approach enabled them to step away from their disciplinary lens and gave them a deeper understanding of their clients' needs and priorities.
- In terms of **demand**, whilst fewer clients engaged than expected, there was a pattern of gradually increasing referrals into the CC program over the 9-month period. Those who engaged were a good fit for the intervention, with high levels of treatment burden, chronic health conditions (especially pain and mental health conditions), social isolation and financial stress reported.
- **Implementation** of the 3C trial was feasible. Review of trial documentation demonstrated fidelity to the burden-capacity focus. This focus was clear to clients and provided direction to clinicians. Important enablers included the supervisions and health literacy resource. Adapting the assessment and burden/capacity tools was discussed, although the overall model was considered to be a good fit for the clients and clinicians.
- The trial appeared to be **practical**. Much of the care coordination happened over the phone rather than face-to-face, and utilizing text and email messaging was helpful for clients and clinicians. Allowance for ongoing indirect time (which was highly variable between clients) and the availability of supervision/case conferencing were important components.
- **Integration** of the trial model into the organization longer term was enthusiastically supported by all CCs. The focus on burden and capacity, rather than care coordination per se, was felt to be the most important element. The focus group reported that skills in rapport building and listening were foundational for the CC role. Specifically, a willingness to step away from one's disciplinary boundaries and be open to the clients' needs and priorities, rather than maintaining preexisting ideas about what constitutes chronic disease self-management, was crucial. Clinicians had many suggestions to help integrate the model into the organization, which are listed under recommendations.
- There was limited exploration of **efficacy** given the small sample size and lack of a comparison group. Clients reported feeling less overwhelmed by their health conditions and experiencing an increased sense of control over their lives. The clinicians concurred with these observations. The quantitative outcome data trends suggest that the benefits described by clients may be helpful in reducing treatment burden and improving quality of life, which could be explored in a larger sample size over a longer time period.



Recommendations

Care coordination using an MDM model of care is feasible in the community health setting. More importantly the results show the importance of an embedded pathway with a focus on burden and capacity for clients with chronic health issues and multimorbidity. The sense of control clients experienced in this trial is exactly what self-management should be about.

Further work to embed pathways and explore how this can be supported and funded in SCHS is recommended. This would include:

- 01** Restructuring the intake process to enable easy identification of clients and direct referral into a CC program.
- 02** Reviewing internal referral processes to ensure that clients involved with CC are given priority access to other services.
- 03** Provide education about the CC role and the MDM model across the organization, especially to other clinicians involved in the clients' care. This could include working more closely and flexibly with teams who provide complementary services (e.g., community paramedicine), or see similar clients (e.g., mental health services).
- 04** Explore increased engagement with GPs and practice nurses. Consider having a referral pathway into a CC program that could be flagged as part of a GP management plan.
- 05** Adapt the care plan and ICAN tool, in conjunction with the CCs and the Mayo clinic, to develop a single tool appropriate for SCHS clients.
- 06** Refresher training in capacity-burden concepts is recommended, bolstered by the learnings on this trial.
- 07** Any CC program should include ongoing allocated time for case conferencing, supervision, and indirect consults to be used flexibly according to client needs.
- 08** Quantitative and qualitative evaluation of this approach should continue and be embedded in the model of care.

The 3C trial project is a post-doctoral project following the PhD undertaken by Dr Ruth Hardman.

Acknowledgement

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Introduction

Self-management of Chronic Health Conditions

For effective management of chronic health conditions (CHCs), people need to commit long term to self-management. Studies have shown that disadvantaged and low-income populations face many barriers to doing this [1–3]. In a nutshell, traditional self-management approaches, which focus on building individual capacity and self-efficacy to manage ones' health [4, 5] can be overwhelming for those with few resources [6, 7].

Burden and Capacity

The role of burden and capacity, as outlined in Shippee et al.'s Cumulative Complexity Model [8], can help to explicate the challenges faced by this population. People need sufficient capacity, including social support, socioeconomic resources, and adequate mental/physical functioning, to cope with the workload, or: burden, associated with living with a CHC, such as self-management tasks, health system interactions and other life demands. Limited capacity (e.g., poverty, social isolation) or overwhelming burden (e.g., multimorbidity) may reduce adherence and lead to disease escalation.



Minimally Disruptive Medicine

In response to disease escalation, healthcare systems typically respond by intensifying treatment, increasing burden further and resulting in 'cumulative complexity' [8]. An alternative approach is needed for these people, especially when multimorbidity is involved. Those with multiple health conditions are often dealing with a high number of healthcare tasks (increasing their burden) whilst simultaneously experiencing a wide range of disabling symptoms (reducing capacity). Lack of social, financial, or personal resources can further diminish capacity. Minimally Disruptive Medicine (MDM) is a practical model of care that builds on the concepts described in the Cumulative Complexity Model [9, 10].

The key elements of MDM are:

1. to assess burden and capacity levels
2. to undertake practical actions designed to reduce burden and/or increase capacity.

Examples of actions are medication deprescribing, shared decision-making, and teaming with social welfare agencies. Although many of these strategies are recommended when managing multimorbidity [11, 12], incorporating them into a systematic approach which targets burden-capacity deficits, is less common.



Positive impact of MDM for patients and healthcare providers

While integration of MDM into primary care settings is still in its early days [13–15], interventions that focus on burden and/or capacity in disadvantaged or multimorbid patients have reported improvements in adherence and quality of life, with reductions in hospitalisation and treatment burden [16–18]. For healthcare providers (HCPs), managing complex multimorbid clients in socially deprived circumstances is a well-known stressor and can contribute to burnout [19, 20]. Interventions designed specifically for these settings, rather than current single disease models which ignore burden and capacity [21, 22], may reduce HCP burden and promote truly client-centred care [19, 20, 23].

Trial at Sunraysia Community Health Services

Community health centres are important providers of chronic disease management services for low-income and disadvantaged populations [24]. Therefore, at Sunraysia Community Health Services (SCHS), we proposed a feasibility study of an MDM-based intervention for multimorbid community health clients.

Our intervention consists of two stages:



Stage 1 Training

To expand the expertise of healthcare providers working in chronic disease management (CDM), by providing training in a model of care based on MDM.



Stage 2 Trial

Trial an MDM model of care with community health clients by utilising several of the upskilled HCPs as care coordinators, in line with recommendations for undertaking complex interventions [25, 26]. The model of care will include specific assessment and care planning tools to support assessment and prioritisation of burden and capacity.

The intervention is described in more detail in appendix 1.

Because this is a new intervention in community health care, the focus in this study is on feasibility. This will enable us to test and modify aspects of the recruitment and intervention process and determine the likely benefits of expanding this to a cluster randomised trial [27–29].

Objectives

This study aimed to assess:

1. The feasibility of a training programme for healthcare providers working in CDM, based on the principles of MDM.
2. The feasibility of an MDM approach to chronic disease management for rural community health clients with multimorbidity and social complexity.

Methods

The trial was undertaken as a mixed methods study. For a feasibility study, using a mixture of quantitative and qualitative methods will enable us to understand barriers to participation and implementation, as well as to estimate response and recruitment rates.

- Qualitative data included interviews, focus groups, meeting notes, care planning documents and reflective vignettes, to explore the views and experiences of all stakeholders.
- Quantitative data consisted of client demographics; measures of treatment burden, individual capacity, and quality of life; and demand, servicing, and referral patterns in SCHS.

Feasibility outcomes were explored using the framework developed by Bowen et al [30], covering acceptability, demand, implementation, practicality, integration, and efficacy.

Table 1. Summary of the outcomes and methods of data collection

Outcome	Source of data
Acceptability	<ul style="list-style-type: none"> • 1-1 interviews and focus groups with clients and HCPs at trial conclusion
Demand	<ul style="list-style-type: none"> • From EMR: number of clients referred, number who engage; attrition rates; number of inward/outward referrals and sources. • Baseline client demographics and self-report measures (DBIS, Dip-CareQ) • Assessment data (ICAN, care plans) to establish level of complexity
Implementation	<ul style="list-style-type: none"> • Interviews and focus groups with clients and HCPs at trial conclusion. • Records of meeting notes and supervisions throughout course of trial.
Practicality	<ul style="list-style-type: none"> • EMR: Time spent on intervention (direct and indirect) by HCPs. • Focus group with HCPs at trial conclusion intervention.
Integration	<ul style="list-style-type: none"> • Focus group with HCPs at trial conclusion. • Records of meeting notes and supervisions throughout course of trial
Efficacy	<ul style="list-style-type: none"> • Measures of quality of life, treatment burden, self-efficacy (EQ5D5L; MTBQ; PMCSMS-4) 6 months after baseline; follow up ICAN results; reflective vignettes by HCPs completed throughout trial. • 1-1 interviews and focus groups with clients and HCPs at trial conclusion

The measures are described in more detail in appendix 2.



Data analysis

Qualitative data was analysed thematically. In view of the small sample size and lack of control group, quantitative analysis was descriptive with limited exploration of data trends.

Recruitment

HCP recruitment

All interested SCHS clinicians were invited to attend an initial lunchtime session which outlined the planned trial and the model of care being explored. Following this, 2 training sessions of 3 hours each were offered to chronic disease clinicians to develop practical skills in the MDM approach.

Thirteen clinicians attended the training sessions and following this, three chronic disease clinicians expressed interest in acting as care coordinators for the duration of the trial. The chief investigator (CI) provided ongoing clinical supervision for the project and two other senior clinicians (one in diabetes, one in mental health) were able to provide secondary consult services and support as needed to the care coordinators.

Client recruitment

Clinicians were informed about the trial by presentations at meetings and forums and were encouraged to refer any clients who they thought might benefit. A checklist was developed and placed on the EMR outlining inclusion and exclusion criteria and potential clients were referred (with their permission) to the CI who reviewed eligibility, provided detailed information about the trial, completed informed consent and recorded baseline measures. If the client was new to the organisation, a 'warm handover' was arranged by the CI to connect the client to their allocated care coordinator.

Timeline and key intervention components

The trial began with a series of training workshops which took place over April–June 2022. This was followed by the identification of CCs, completion of informed consent and a series of planning meetings to map trial pathways and embed assessment tools. Clients were recruited to the trial between August 2022 and March 2023 and all data was collected by the end of August 2023.

The key elements of the intervention were as follows:

- Use of the ICAN and care plan tool to assess and document burden and capacity (see appendix 3)
- Treatment choice and priority to be based on burden/capacity assessment.
- Ongoing management of clients by care co-ordinators to be guided by the above tools, secondary consults, additional referrals, and the health literacy document.
- Aim to address multimorbidity and social demands – not just a single health condition.
- Undertake regular supervision and case conferencing, secondary consults as needed.
- At least 2 ICANs and care plans to be completed over the course of engagement.
- Discharge based on clients' needs and preferences.

Table 2. Client inclusion/exclusion criteria

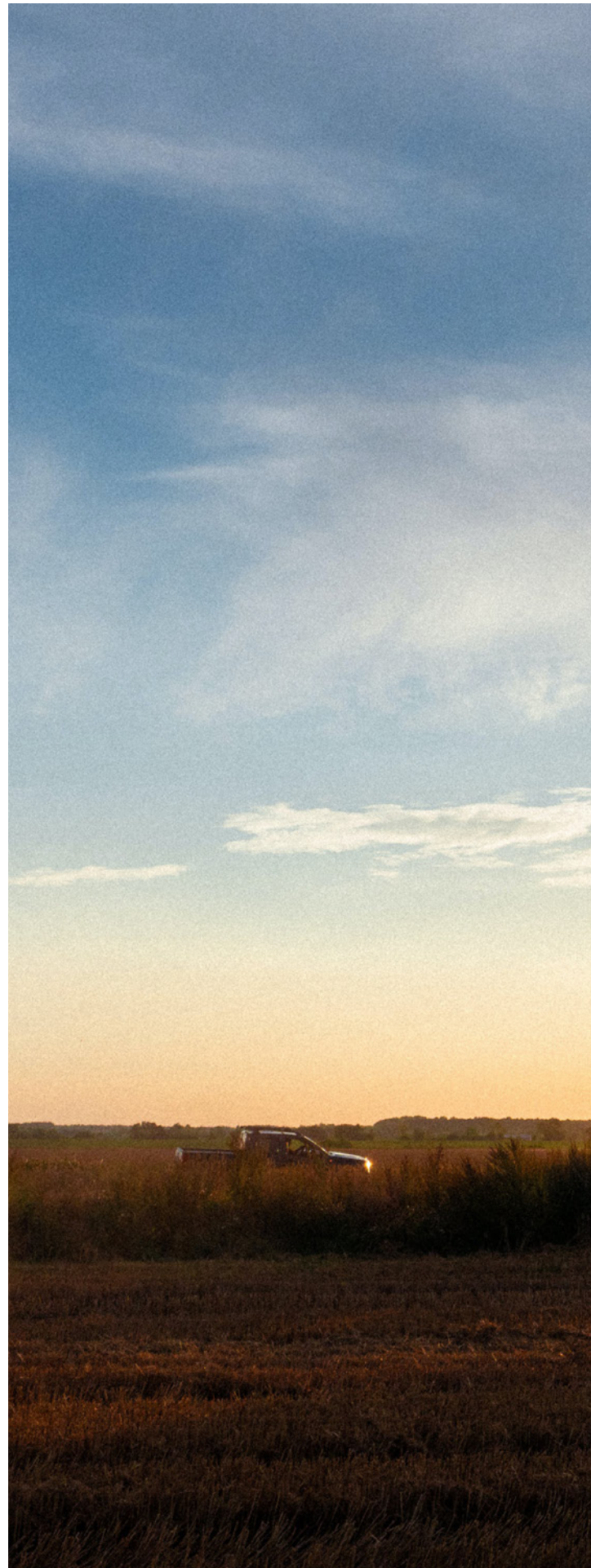
Client inclusion criteria	Client exclusion criteria
<ul style="list-style-type: none"> • Over 18 years • At least 2 CHCs • Low-income or in receipt of government income support • Additional psychosocial complexity, such as a mental health diagnosis, major social stressor (e.g., social isolation, complex family situation, housing insecurity) or low literacy. 	<ul style="list-style-type: none"> • Palliative patients • Those in residential care, dependent on a full-time carer, or already in receipt of care coordination • Unable to consent (e.g., dementia, psychosis, significant learning disability) • Medical conditions preventing engagement in self-management (e.g., unstable angina) • Unable to understand spoken English.

Results

Results were reported under the Bowen et al [30] feasibility framework of acceptability, demand, implementation, practicality, integration, and efficacy.

Results data was obtained from the following sources:

1. Client quantitative data: Initial demographics and pre-post outcome measures. Initial data was gathered for 26 clients who were enrolled in the trial and post-trial data for 19 clients.
2. Trial process data: Care coordinator (CC) assessment documents (the ICAN and care plan); reflective vignettes completed by the CCs for every client; CC time (recorded in the EMR) and notes taken during case conference/supervision sessions. This provided details regarding the services provided by CCs; initial recording of clients' capacity, burden, and priorities; reflections by CCs about enablers, barriers and impacts, and client engagement data.
3. Qualitative client interviews. At the conclusion of the study, interviews were undertaken with 12 of the 19 clients who completed all trial documentation. Interviews were all undertaken by phone and length ranged from 4 to 19 minutes. All interviews were transcribed and coded under the feasibility framework headings.
4. Qualitative focus group with care coordinators. The three care coordinators participated in a focus group to explore feasibility. The focus group duration was 60 minutes and was transcribed verbatim.



Acceptability

Acceptability explores the perceived benefits or otherwise of the intervention from the perspective of clients and HCPs, including suggested improvements and comments regarding for whom the service might be suitable.

Client perspectives

All clients spoke very highly of the service and stressed the importance of continuing the program into the future.

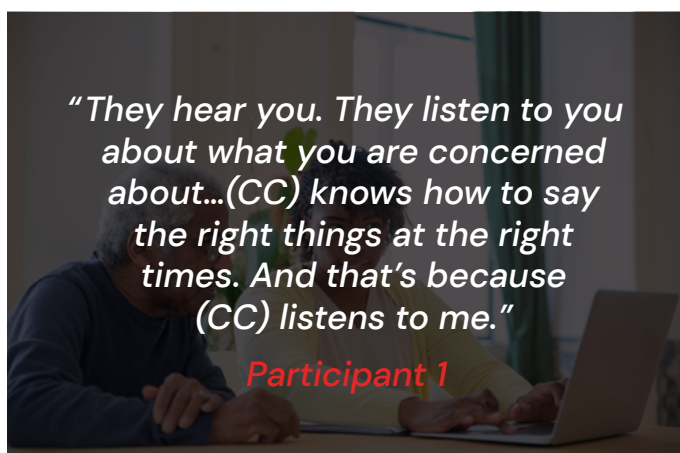
"I just think it worked really well. For me, and hopefully for others too, and I think they should try and keep it going for as long as possible." (3)

No interviewee was able to identify specific improvements to the service, but several participants thought that the service should be offered to a greater range of clients, particularly those living alone or with fewer resources.

"I think it would be good for others maybe the elderly and people living alone especially people who haven't got family around." (12)

When considering what was different about the service and what was most helpful, participants identified several themes:

Listening. Care coordinators expressed genuine concern for the clients and took the time to develop a relationship. Clients often felt dismissed by other HCPs or that there was never enough time to explore their complex issues, and they valued the CC time. Several clients referred to their CC as a friend, who they enjoyed spending time with and with whom they could have 'a laugh'.



"(CC) seemed to be more interested in my problems. A lot of professionals – they are what I said. They are professionals. They don't have much feeling. They just do the job and that's about it. But (CC) had feeling." (6)

Working collaboratively. Care coordinators focused on what was important to the client and worked with them, rather than telling them what to do. Clients felt that their priorities and concerns were being listened to and acted on. This made them feel empowered and increased their sense of control.

"That (the CC) did work together, we worked together. It was an individual thing... (CC) didn't try and tell me what to do, and they didn't expect me to do it all on my own either, so that was very good." (3)

"(CC) has been able to listen for my concerns rather than just telling me what to do." (9)

Care navigation. Clients valued the CCs' ability to provide a range of options and ideas; to assist with linking and direct onward referrals; especially the fact that the CCs would follow up and resolve concerns properly rather than simply handing them on. Another valued element of the service was the ability of the CCs to address a wide range of needs beyond their healthcare, for example financial and housing concerns.

"The difference is that (CC) has never promised me anything they have gone ahead with things – like other workers have promised me things and done nothing. (CC) has gone ahead and done what they said they would do." (10)

"I've just found that I have been able to make comments to (CC) and they have been able to offer that ear and have said, Oh well, maybe you can try this or maybe you can try that... So I just found with (CC) it opened doors." (4)

"(CC) just said anything... Any problem I have got they can work out something or they can send you off to somewhere else to get help....and they follow up too." (5)

Clinician perspective

A key benefit of CC perceived by clinicians was having a single contact point for the client.

"good to have that one contact for them, so they know just if they need help, they can contact that one person...otherwise it's... they're trying to ring 15 different people... that's when they get overwhelmed..."

All clinicians felt that the care coordination process, but particularly the focus on burden and capacity, had been beneficial for their clinical practice. They reported that this focus changed their perspective on their clients' needs, enabling them to look beyond their specific disciplines and be more open to client priorities. Other benefits identified were deepening collaboration between other parts of SCHS and having a better understanding of the working of the organization.

"I think it eliminated our clinician bias and... Obviously, each clinician is in their own realm and then this sort of, a program or a tool like the ICAN or the care plan sort of eliminates that sort of area, right?"

Although the eligibility criteria specified multimorbidity, clinicians felt that the psychosocial complexity aspect was a more important element for most clients, and a better indicator of those likely to benefit from CC.

"Additional psychosocial complexity is the biggest issue, not the health conditions... quite often they come in and you don't address the health issues you address the social issues..."

Demands

Demand is an exploration of the numbers of people engaged, both clients and HCPs, and whether those engaged were the intended target population for the intervention.

26 clients were referred into the program and completed all baseline measures. There were equal numbers of men and women with a mean age of 66.5 years. 16 clients (62%) lived alone. Similar to other studies of people with multimorbidity and psychosocial complexity [31,32] chronic pain and mental health conditions were the most commonly reported conditions, experienced by 92% of participants. 73% of participants reported high levels of deprivation and 73% reported a high treatment burden.

Further details can be found in table 3.

Table 3. Demographic and health characteristics

Number of clients commenced	26 clients
Gender	13 male, 13 female
Age	Range: 48–82 years. Mean: 66.5 years
Employment status	<ul style="list-style-type: none"> • Unemployed: 4 • Disability Support Pension: 7 • Aged pension: 14 • Self-funded retiree: 1
Living status	<ul style="list-style-type: none"> • With spouse: 8 (4 spouses were the primary carers for the client and 1 client was the primary carer for their spouse) • Alone: 16 • Other family: 2
Number of chronic health conditions (self-report, DBIS)	Range: 6–16 ; Mean: 11
Commonest conditions	<ul style="list-style-type: none"> • Mental health condition: 24 (92%) • Musculoskeletal/chronic pain: 24 (92%) • Cardiovascular condition: 18 (69%) • Respiratory condition: 14 (54%) • Diabetes: 12 (46%)
Treatment burden (MMTBQ) initial scores	<ul style="list-style-type: none"> • High treatment burden: 19 (73%) • Med treatment burden: 5 • Low treatment burden: 2
Deprivation (DiPCare-Q)	<ul style="list-style-type: none"> • Moderate/high material deprivation: 15 (58%) • Moderate/high social deprivation: 22 (85%) • Moderate/high total deprivation score: 19 (73%)

Table 4. Engagement pathways

Six-month post-trial data was collected for 19 clients. The table below details client engagement. For some clients there was a process of disengagement then re-engagement later on.

Remained engaged throughout course of trial, discharged/transferred to other service	12 clients
Remained engaged throughout course, still some level of engagement	5 clients
Partially engaged (limited follow-up data obtained)	3 clients – all disengaged due to health deterioration (prolonged hospital admission, surgery, mental health exacerbation)
Disengaged after several sessions (no follow up data), unable to contact	3 clients – 2 unable to contact; 1 client relocated.
Disengaged following trial registration (no CC input, no follow-up data), unable to contact.	3 clients (2 clients re-engaged after trial concluded)

Although the exclusion criteria specified that no-one have medical conditions which prevented engagement in self-management, the reality was that some clients experienced significant fluctuations in their CHCs. This meant that at times, their ability to engage with self-management was very limited whilst at other times, they were able to engage. This suggests that the medical condition exclusion criteria may not be useful since it does not reflect the variability of CHCs nor the spectrum of self-management engagement.

Identified capacity and burden

Burden and capacity factors were explored through the ICAN assessment, care plan and reflective vignettes (see appendix 3).

The most common capacity factor was support from family or friends (reported by 50% of clients). Lowest levels of capacity were reported in the areas of emotional well-being, physical functioning, and financial capacity, with fewer than 20% of clients reporting satisfaction in these areas.

Burdens were largely related to psychosocial factors, specifically poor mental health, social isolation and limited practical resources (finances, transport, housing).

Organisational demand

Despite anecdotal reports across SCHS about the need for care coordination, referrals into the program were generated largely by the CCs themselves. Eighteen of the 26 clients were transferred directly into the program by the CCs, from clients that had been referred to

them in their other roles. In the last 3 months of recruitment there was an increasing referral base from other clinicians in the chronic disease, community paramedic and allied health teams, suggesting that the referral base would widen over time and greater familiarity with the service.



Implementation

Implementation explores fidelity to the key elements of the intervention; adaptations made to the intervention; and barriers and enablers to implementing the programme as planned. The key elements in the intervention are documented in the methods section but can be summarized as the assessment and management of burden and capacity, and the broad focus on all health and social needs rather than on a single health condition.

The tasks completed by CCs (as documented in the EMR and reflective vignettes) demonstrated fidelity to these key elements:

Table 5. Tasks completed by CCs

Care coordinator tasks	Examples of services provided
Onward referrals	GPs, continence, OT, mental health, home medication review and medical specialists (via GP); dietician, memory and pain services, HECHT, diabetes and COPD.
Warm handovers, case conferencing, joint consults	Mental health, GPs, diabetes, and pain services – joint consults, case conferencing, assistance with referral processes, locating GPs for clients without them.
Navigating support services	Assistance with home help/cleaning services, NDIS, My Aged Care, DSP and home care package applications and processes; carer supports; Webster packs; information about aids, equipment and home modifications.
Social supports	Financial services, emergency food relief, transport services, housing services and maintenance, legal aid.
Community linkages	Local exercise groups, social, craft and hobby groups, volunteer services.
Self-management support	Motivational interviewing and health coaching, social and exercise prescribing, regular 'touch base' phone support, behavioural activation, text/email supports, sleep training, education re medication and specific health conditions (especially diabetes, respiratory and pain).

Client and clinician perspectives on the key elements of the intervention

Clients identified the coordination role – helping them to **prioritise their concerns** and **providing navigation and linkage** – as a crucial aspect of the service.

"(the CC) sat there and said, is there anything I can do for you in any way or any form? Be that financial or medical, healthwise, whatever. And what I loved about it is that (CC) said, if I don't know the answer, I will find out for you or refer you to someone who does." (5)

"I arrived in front of (the CC), ...they started to talk about the trial. And [the community health organisation] just opened up to me like an oyster...And [the CC] was the sheep dog at the back...they were following up everybody and everyone." (10)

"(to) work out what I needed and what my goals were. That was really good." (3)

A secondary element, also identified by most clients, was the **ongoing encouragement and support** provided by the CC, especially in terms of self-management and health education.

"(the CC) gets along with me and encourages me and gets me going and back up again. Mentally, physically, you know." (1)

"(the CC) does give you an incentive to keep going." (2)

Clinicians perceived that the **focus on burden and capacity**, and the use of tools to support this and to focus on client priority, was the most important part of the intervention.

"it sort of forces you to 'OK, maybe, ... that's clearly not, your priorities don't align with the clients..."

"...it's sort of seeing it from more their point of and working out what their main things are, whether it's to fix their broken toe or fix their broken window in the house."

Implementation facilitators (clinician perspective)

The [health literacy resource](#), developed for the trial intervention to provide accessible information about local services and education resources, was important and well used by the clinicians.

[Case conferencing of clients](#) was viewed as highly beneficial, especially the fact the regular time was put aside for it. This was considered a 'must' for the care coordination service. Although two support clinicians were initially also involved in the case conferencing, their limited availability meant that they weren't well used by the clinicians and the CCs generally found it more useful to approach other clinicians in the organisation who were engaged with their client. The presence of the CI at case conferences to provide expertise in chronic disease management was appreciated.

the case conferencing with like the three of us and [the CI] was very beneficial. Just touching base and seeing what [the other participants] are doing differently to what I am, what ways we can help the clients, was really good

However, there was considerable [debate over the benefit of the iCAN tool and care plan](#) in their current form. The iCAN was not adapted from its original use (Mayo clinic, USA) for the trial although the care plan was simplified to align more closely with the capacity/burden model after an initial trial of a care plan format already used in the organisation. Clinicians found the burden/capacity focus very useful but felt the tools could be combined and modified to suit the client population better whilst still assisting clinicians to document capacity, burden, and priority. Clinicians had several suggestions on how these tools could be modified whilst still achieving the aim of being focused on client priorities.

Barriers to implementation

Challenges in the care coordination role

Clinicians identified that at times there was 'blurring' of roles especially where they had seen a client in their other clinical role first, and then they transferred that client into the CC trial. At times the client was unsure about the role of the clinician. This was less of an issue for clients referred by other clinicians (e.g. the intake clinician) into the programme. All clinicians agreed

that it was less confusing if the client saw you as a care coordinator for all their issues (health and otherwise), rather than in terms of a specific health discipline or as the provider of a disease-specific service.

Challenges with referrals and working with other clinicians

Overall, CCs found that they were able to strengthen their connections with clinicians in different teams across the organisation and the trial gave them a greater insight into the services across SCHS. Two areas that were challenging was the My Aged Care referral process, which is a slow and complex piece of bureaucracy, and the difficulty in communicating with GPs. This was perceived to be related to GPs lack of time and hence limited engagement with highly complex clients. A suggestion for the longer term, if CC were to be embedded in SCHS, was to promote the service to GPs and practice nurses as a way of supporting more complex clients.

Are these areas of your life a source of **satisfaction**, **burden**, or **both**?

Leave blank if not part of your life	😊 Satisfaction	😞 Burden
My family and friends	<input type="checkbox"/>	<input type="checkbox"/>
My work or finances	<input type="checkbox"/>	<input type="checkbox"/>
Free time, relaxation, fun	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality or life purpose	<input type="checkbox"/>	<input type="checkbox"/>
Where I live	<input type="checkbox"/>	<input type="checkbox"/>
Getting out and transportation	<input type="checkbox"/>	<input type="checkbox"/>
Being active	<input type="checkbox"/>	<input type="checkbox"/>
Social media, TV or screen watching	<input type="checkbox"/>	<input type="checkbox"/>
My emotional life	<input type="checkbox"/>	<input type="checkbox"/>
My memory or attention	<input type="checkbox"/>	<input type="checkbox"/>
The food I eat	<input type="checkbox"/>	<input type="checkbox"/>

Sample of iCAN tool

Practicality

Practicality includes the time spent on the intervention (direct and indirect) by HCPs, the time needed for training and supervision, and any additional admin support. Data was obtained from the EMR.

Initial training consisted of 6 hours (2x3 hour blocks). CCs suggested that periodic refresher training would be beneficial. Supervisions consisted of one hour per fortnight and were deemed essential for performance of the role.

There was a median of 4 face to face appointments and 8 phone calls per client. Care coordinators reported that an initial or early face-to-face appointment was important to make a connection and build rapport and empathy but after that much of the contact and follow up happened over the phone and for most clients this was ideal and helped to reduce burden. The use of email and especially texts to and from clients was highlighted as a simple way to remain in touch with minimal client burden.

All clients required indirect time for follow up of specific issues, but this varied from 15% to 70% of total client contact time. Some clients received more direct contact for health coaching purposes, whilst those who required multiple onward referrals and liaison had more indirect time recorded.

Integration

Integration explores the extent to which the intervention could become part of the routine organizational practices and policies.

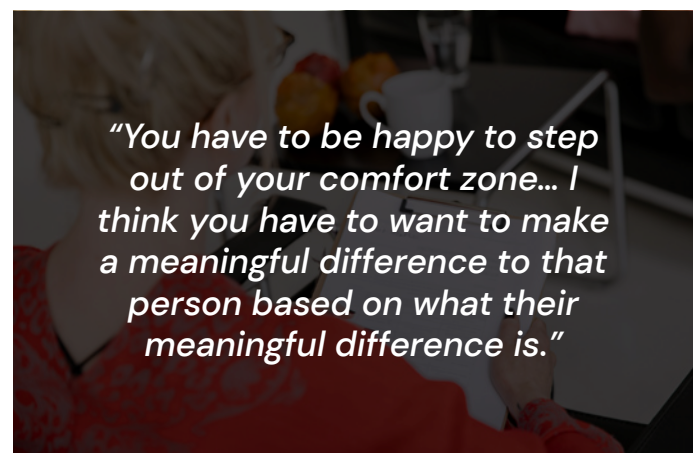
All CCs were keen for the trial to become embedded in the organizational practice, and the following themes emerged in the focus group discussion.

What skills and training are needed?

- A willingness to step away from ones' comfort zone or discipline and be open to explore or research whatever was needed to support the client.
- Ability to build rapport and empathy.
- The capacity/burden training was helpful and a refresher program could be useful
- Regular case conferencing

It was notable that what the clinicians identified as most important was not related to care coordination per se, but the burden-capacity and patient priority focus of this model.

"another attribute they need to have... someone that can say, I actually don't know, but I will find out, rather than try and fumble their way through it."



What are the practical integration issues that should be considered?

Have a limited number of named CCs in the organization

Clinicians felt that rather than everyone in the organization doing a bit of care coordination as part of their role, it would be more effective and less confusing to have several named CCs acting across the organization. Clinicians described clients they encountered in their other roles who were being managed by another CC, and how useful it was to have one person taking the lead for managing all the other services and ensuring consistent messaging. Discipline or disease-specific care coordination was not considered necessary or even desirable, since for most clients the psychosocial rather than medical issues were paramount.

Early identification and clear pathways

Identifying clients early and having a clear pathway to refer to care coordination through the initial intake screening was important. This would include reviewing the intake process; more strongly embedding and screening for the social determinants of health; utilizing the ICAN or similar burden-capacity identifier; and having a clear and accessible location to record this in Mastercare.

Fee-free service

Care coordination should remain a fee-free service, especially since all those in need of CC will by definition, be experiencing low capacity/high burden.

Ability to reengage as needed.

CC should not be a time-limited process. Despite the complexity of the clients, most were discharged during the 9-month period; however, the CCs thought it was important that clients were able to return as needed given their long-term complex social and medical scenarios.

Building connections with and supporting

GPs and practice nurses around complex clients. Promoting the service amongst GPs and practice nurses and providing GP clinics with clear pathways to engage with the service was an area that the CCs thought should be explored in the future.

"I think you might connect with... the GP management plans. Because they are very medically focused, but then when it comes down to finance, social and all those other kind of things, it could be a referral into a care coordinator program."

"I think flagging the trial from like... from the GP's to referring in to as well could help the clients greatly as well."

Barriers

The primary barrier identified was related to organizational commitment and system challenges with the MDM model of care, which requires people to work across teams and doesn't fit into standard discipline or disease specific models of care or funding. A second concern was that the model was very dependent on the commitment, drive and ongoing involvement of the CI.

Efficacy

Since this is a feasibility trial with a small sample and no control group, efficacy cannot be established. However, early indicators of potential benefit were investigated through clinician and client interviews and 6-month data on treatment burden, quality of life and capacity/burden status.

Client Perspectives

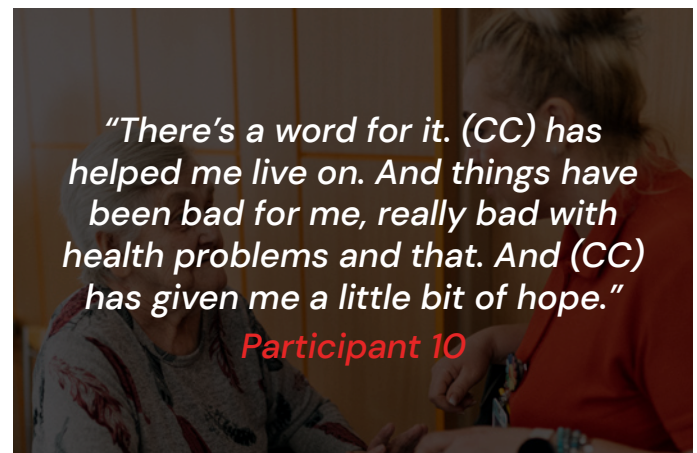
Clients were asked whether they thought there had been a change in their healthcare following

engagement in the trial. Consistent with the focus on reducing treatment burden in multimorbid clients, one area of change reported by clients was feeling that they had more supports in place to manage their health.

"At the moment everything is in place. And I said that to (CC), everything is in place because (CC) has organised it. It's all just flowing along beautifully." (5)

"(getting the supports in place) that release of pressure was fantastic. It was just like 'oh thank goodness'... All this clutter has dropped away... It's just a different outlook on life." (11)

The second key change identified by clients was an increase in control and confidence in managing their lives, and feeling more hopeful about the future, which they related to the consistent support provided by the CC.



"I'm feeling a lot more in control. I feel a lot more confident in handling myself and knowing that there is health help out there if you need it." (3)

Clinician Perspectives

Clinicians echoed the above themes. The reduction of treatment burden associated with identifying priorities and providing appropriate linkages was an important benefit, but as a result of this, clients also felt empowered and more in control. This in turn increased their ability to communicate and engage with the services they needed.

"it allows them to be able to take control a little bit more of their burdens... said, you're sort of acting as almost like a bit of a voice for that client when obtaining other services."

"... it improves their ability to communicate with the health professional that can then educate them."

Although the small numbers mean that firm conclusions cannot be drawn, for those who recorded post-trial data a trend towards improvement was noted in treatment burden scores, the EQ-VAS, EQ-pain, mood, and mobility.

Table 6. Post-trial data

Outcome measure	Initial n=26	Initial (clients who recorded post-trial data) n=19	6 month data n=19
Treatment Burden ¹ (MMTBQ)	19 (73%)	12 (63%)	10 (53%)
EQ-mobility ²	20 (77%)	15 (79%)	13 (68%)
EQ-personal care ²	8 (31%)	7 (37%)	10 (53%)
EQ-activity ²	16 (62%)	11 (58%)	12 (63%)
EQ-pain ²	25 (96%)	19 (100%)	17 (89%)
EQ-mood ²	19 (73%)	14 (74%)	12 (63%)
EQ-VAS ³	39	32	57

¹ Number(%) recording high treatment burden score >22. Lower score indicates improvement.

² Number(%) reporting at least moderate difficulty (scoring 3–5). Lower score indicates improvement.

³ Mean score from 0–100. Higher score indicates improvement.



Conclusion

The aim of this study was to assess:

1. The feasibility of a training programme for healthcare providers working in chronic disease management, based on the principles of MDM.
2. The feasibility of an MDM approach to chronic disease management for rural community health clients with multimorbidity and social complexity.

The training program was well attended, and CCs felt that it equipped them to work with clients using the MDM model. The trial was successful in targeting and engaging clients with high levels of multimorbidity who were experiencing social disadvantage as well as poorly managed physical and mental health.

Acceptability was high amongst both clients and clinicians. Both groups stressed the importance of relationship building and clients greatly valued the sense of being cared for, listened to, and befriended. For many clients this provided an increased sense of control over difficult circumstances. Clinicians valued the emphasis on burden and capacity and reported that this approach enabled them to step away from their disciplinary lens and gave them a deeper understanding of their clients' needs and priorities.

In terms of demand, whilst fewer clients engaged than expected, there was a pattern of gradually increasing referrals into the CC program over the 9-month period. Those who engaged were a good fit for the intervention, with high levels of treatment burden, chronic health conditions (especially pain and mental health conditions), social isolation and financial stress reported.

Implementation of the 3C trial was feasible. Review of trial documentation demonstrated fidelity to the burden-capacity focus. This focus was clear to clients and provided direction to clinicians. Important enablers included the supervisions and health literacy resource. Adapting the assessment and burden/capacity tools was discussed, although the overall model was considered to be a good fit for the clients and clinicians.

The trial appeared to be practical. Much of the care coordination happened over the phone rather than face-to-face, and utilizing text and

email messaging was helpful for clients and clinicians. Allowance for ongoing indirect time (which was highly variable between clients), and the availability of supervision/case conferencing were important components.

Integration of the trial model into the organization longer term was enthusiastically supported by all CCs. The focus on burden and capacity, rather than care coordination per se, was felt to be the most important element. The focus group reported that skills in rapport building and listening were foundational for the CC role. Specifically, a willingness to step away from one's disciplinary boundaries and be open to the clients' needs and priorities, rather than maintaining preexisting ideas about what constitutes chronic disease self-management, was crucial. Clinicians had many suggestions to help integrate the model into the organization, which are listed under recommendations.

There was limited exploration of efficacy given the small sample size and lack of a comparison group. Clients reported feeling less overwhelmed by their health conditions and experiencing an increased sense of control over their lives. The clinicians concurred with these observations. The quantitative outcome data trends suggest that the benefits described by clients may be helpful in reducing treatment burden and improving quality of life, which could be explored in a larger sample size over a longer time period.

The success of this trial supports an approach to care coordination that is focused on burden and capacity. The trial was truly client-centred, by prioritising what is important to individuals, and systematically identifying and addressing their burdens whilst building capacity. Traditionally, self-management focuses on building client skills, which can reduce engagement in poorly resourced individuals. In this trial, we placed the emphasis on self-management support (the role of the HCP supporting the client), rather than self-management (what the client does).

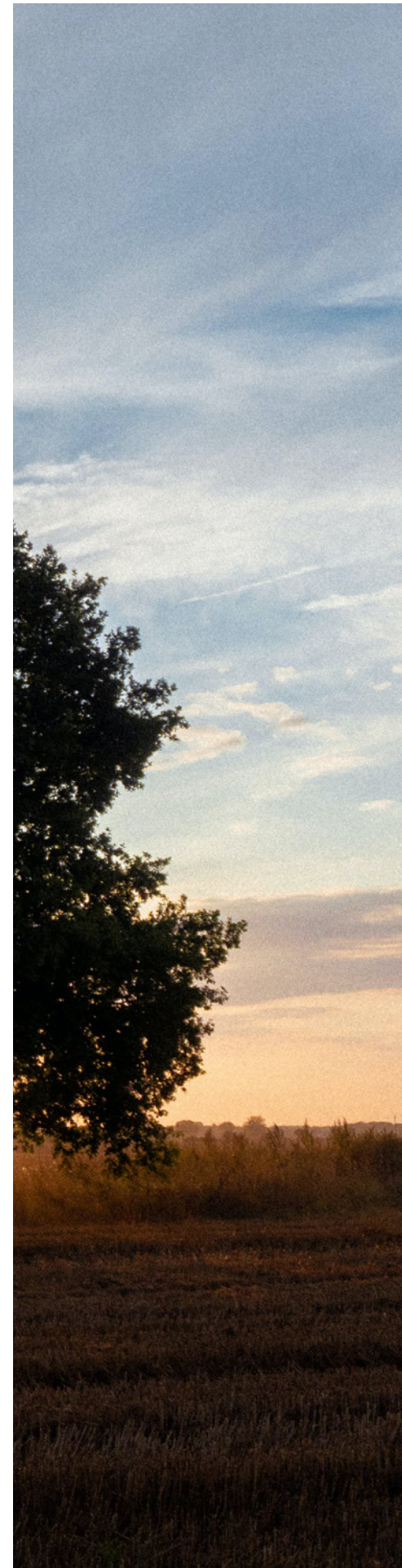
Self-management can be sometimes conflated with the idea of 'taking responsibility for yourself' or used as a proxy to reduce client dependency on the health system [33,34]. The reality is that people with complex medical and psychosocial will always need support. The 3C trial suggests that providing the additional targeted support

that people want and need (by focusing on reducing burden, which may initially mean more work for the HCP) might over time make people less dependent, by building their sense of control and hence their capacity.

Recommendations

Care coordination using an MDM model of care is feasible in the community health setting. Further work to embed pathways and explore how this can be supported and funded in SCHS is recommended. This would include:

1. Restructuring the intake process to enable easy identification of clients and direct referral into a CC program.
2. Reviewing internal referral processes to ensure that clients involved with CC are given priority access to other services.
3. Provide education about the CC role and the MDM model across the organization, especially to other clinicians involved in the clients' care. This could include working more closely and flexibly with teams who provide complementary services (eg. community paramedicine), or see similar clients (eg. mental health services).
4. Explore increased engagement with GPs and practice nurses. Consider having a referral pathway into a CC program that could be flagged as part of a GP management plan.
5. Adapt the care plan and ICAN tool, in conjunction with the CCs and the Mayo clinic, to develop a single tool appropriate for SCHS clients.
6. Refresher training in capacity-burden concepts is recommended, bolstered by the learnings on this trial.
7. Any CC program should include ongoing allocated time for case conferencing, supervision, and indirect consults to be used flexibly according to client needs.
8. Quantitative and qualitative evaluation of this approach should continue and be embedded in the model of care.



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Appendix 1

Description of intervention

Intervention stage 1: Training of Healthcare Providers (HCPs)

Since the cohort is clinicians who already work in CDM, they will be expected to already have some experience in self-management support, including skills in behaviour change and care planning. Additional training will focus on expanding those skills to address treatment burden and multimorbidity.

Health Providers will undergo training in the following areas:

- MDM theory, measuring burden and capacity, and the practical application of MDM. Training will be provided by the research co-ordinator.
- How to use the shared decision-making tool (ICAN) in care planning. Training will be provided by the research co-ordinator.
- Building skills in generic/synergistic treatments that apply across multiple conditions, such as sleep hygiene, stress management, establishing daily routines and behavioural activation. Training will be provided by support clinicians, focusing on simple strategies and useful resources to support these interventions, as well as clear guidance on when the client may need onward referral. It is recognised that some of the care co-ordinators may already have skills in these areas, and this will allow for peer-to-peer teaching. Utilising existing skills amongst care co-ordinators and support clinicians will complement one of the organisational goals for this intervention: namely, to increase collaboration, reduce siloing and improve awareness of expertise within the organisation.

Additional supports provided for care co-ordinators during stage 2:

- Resource registry for social support services,
- Support clinicians will be available to contact for advice, secondary consults, or onward referrals.
- Clear referral pathways internally to different disciplines, which can bypass waitlists.
- Fortnightly supervision sessions once the trial begins to address treatment fidelity, review clients, troubleshoot barriers, and monitor HCP burden.

Intervention stage 2: Care co-ordination with complex multimorbid clients

Currently, patients engaging with CDM at the community health centre receive 1-1 tailored support or group sessions and are engaged with one or more clinicians. The key differences with this intervention are as follows:

- Care co-ordinators will not be limited to or expected to focus on a single condition, but on holistic management of multimorbidity, based on prioritisation of the clients' concerns.
- The ICAN discussion aid will be used on assessment and care plan review to enable HCPs and clients to systematically explore burden and capacity issues.
- Care planning will be informed by the values and preferences expressed when using the ICAN tool and directed toward the dual aims of reducing burden and maximising capacity.
- Care co-ordinators will be encouraged to directly provide generic treatments and mental health support to their clients initially, rather than immediately referring them to another provider. Support clinicians will provide advice as needed, including pathways for onward referral when necessary.
- Care co-ordination will include indirect client time to liaise with other providers and arrange external service provision for health and social needs as required.
- Clients will continue to engage with any existing external health service provision, but for clients engaged with multiple community health services, their clinicians will liaise directly with the care co-ordinator to improve integration and reduce treatment burden.

Appointment frequency and location (in clinic, at home or by phone) will be based on preference and need and be informed by the ICAN discussion aid. The trial will be conducted over a period of nine months, to allow for rolling recruitment. Clients will complete self-report measures at baseline, 3 months, and 6 months, and will be invited to participate in a qualitative interview six months after their engagement with the programme. Due to varying levels of complexity, clients may still be engaged with the community health service after this time, but no further data will be collected. Discharge from the programme, either before or after the 6-month period, will be based on client-identified needs and measured capacity/burden level.

Appendix 2

Measures used and data collection

For a feasibility study, using a mixture of quantitative and qualitative methods will enable us to understand barriers to participation and implementation, as well as to estimate response and recruitment rates.

Primary outcome: feasibility

This will be measured under the following categories:

- **Acceptability of the intervention:** assessed via 1-1 qualitative interviews with patients and focus groups for care co-ordinators and support clinicians. Clients will also complete the short-form Patient Assessment of Chronic Illness Care (PACIC-11) at baseline and 6 months.
- **Demand:** Recorded quantitatively: numbers of clients eligible; numbers who initially engage/are referred; numbers who refuse; attrition rates; numbers of clinicians involved in intervention; numbers of clinicians who refer into the programme. Data will be obtained from the EMR, along with client demographics (age, gender, living situation, education level, employment status and income). To ascertain the level of complexity in the trial population, clients will also complete self-report tools recording illness burden (Disease Burden Impact Scale, DBIS) and deprivation level (Deprivation in Primary Care Questionnaire, DiP-CareQ) at baseline and at six months.
- **Implementation:** Qualitative interviews with HCPs and patients will be conducted to explore barriers, facilitators, and suggestions for improvement. Fortnightly supervisions with HCPs, to discuss issues raised during the intervention, will be documented and reports generated.
- **Practicality:** Time spent on intervention (direct and indirect) by HCPs, time for training and supervision and time needed for administrative support will be recorded from the EMR. Difficulties associated with completing self-report measures or documenting the intervention will be explored during qualitative interviews.
- **Integration:** A focus group interview with clinicians at the conclusion of the trial will be undertaken.

Secondary outcome: Efficacy

Although this study is not powered to assess efficacy, we will be using the following outcome measures in preparation for a powered efficacy trial in the future. Self-report data will be collected at baseline, 3 months and 6 months into the intervention as a hard copy (paper) survey. Clients may choose to complete the survey independently or with face-to-face or phone assistance from a researcher as preferred. We will be recording quality of life, treatment burden and self-efficacy.

- **Quality of life** is a key outcome measurement for multimorbidity and we will be using the EQ-5D5L, a widely used 5-item Likert scale plus VAS score with good psychometric properties and strong correlations to longer-term outcomes including cost-effectiveness.
- **Treatment Burden:** Since this is an intended target for our intervention, we will record this using the Multimorbidity Treatment Burden Questionnaire (MTBQ), which is a thirteen-item Likert scale measure ranking the difficulty of healthcare tasks.
- **Self-efficacy** will be assessed using the short form Perceived Medical Condition Self-management scale (PMCSMS-4), which is a 4 item Likert scale measuring self-efficacy in management of CHCs. We included a self-efficacy measure since it is a well-established and researched concept known to be important in chronic disease self-management and responsive to change.

Appendix 3

1. ICAN tool

What are you doing to manage your stress?



Where do you find the most joy in your life?

What else is on your mind today?

My Life My Healthcare

How does your healthcare fit with your life?



This discussion aid will help you and your clinician talk about how your healthcare fits with your life.

[http://www.mayo.edu/research/labs/knowledge-evaluation-research-unit/programs/Minimally Disruptive Medicine](http://www.mayo.edu/research/labs/knowledge-evaluation-research-unit/programs/Minimally%20Disruptive%20Medicine)

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Are these areas of your life a source of **satisfaction**, **burden**, or **both**?

Leave blank if not part of your life	Satisfaction	Burden
My family and friends	<input type="checkbox"/>	<input type="checkbox"/>
My work or finances	<input type="checkbox"/>	<input type="checkbox"/>
Free time, relaxation, fun	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality or life purpose	<input type="checkbox"/>	<input type="checkbox"/>
Where I live	<input type="checkbox"/>	<input type="checkbox"/>
Getting out and transportation	<input type="checkbox"/>	<input type="checkbox"/>
Being active	<input type="checkbox"/>	<input type="checkbox"/>
Social media, TV or screen watching	<input type="checkbox"/>	<input type="checkbox"/>
My emotional life	<input type="checkbox"/>	<input type="checkbox"/>
My memory or attention	<input type="checkbox"/>	<input type="checkbox"/>
The food I eat	<input type="checkbox"/>	<input type="checkbox"/>

What are the things that your doctors or clinic have asked you to do to care for your health?

Do you feel that they are a **help**, a **burden**, or **both**?

Leave blank if not part of your life	Help	Burden
Take medications	<input type="checkbox"/>	<input type="checkbox"/>
Monitor symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Manage my diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>
Get enough sleep	<input type="checkbox"/>	<input type="checkbox"/>
Come in for appointments or labs	<input type="checkbox"/>	<input type="checkbox"/>
Reduce alcohol use, smoking, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Insurance or support services	<input type="checkbox"/>	<input type="checkbox"/>
Manage stress	<input type="checkbox"/>	<input type="checkbox"/>
Write in any others	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 3

2. Care Plan

SUNRAYSIA COMMUNITY HEALTH SERVICES
Form regarding: **Goal Directed Care Plan**



Name:		Mastercare ID:	
Date Care Plan developed:			
People involved:			
Priority			
What matters the most to me?			
Capacity			
Things that help (treatments, supports, activities) with what's important to me			
Burden			
Things that interfere (treatments, symptoms, demands) with what's important to me			
What would I like to work on or change?			
What is my first step?			
A copy of this care plan has been provided to:		Client: <input type="checkbox"/> Yes	

Prompt Doc No: SCH0000598 v4	Approved by: EMCS	Custodian: MCD&AC
First Issued: 24/07/2014	Page 1 of 2	Last Reviewed: 06/09/2021
Version Changed: 06/09/2021	UNCONTROLLED WHEN DOWNLOADED	Review By: 06/09/2023

Appendix 3

2. Care Plan (cont.)

SCHS form regarding: Goal Directed Care Plan

Simple & specific steps to work towards achieving what is important to you.				
Goal/s	Actions	Person Responsible	Timeframe	Progress
Date				Review Date Fully/Partially/Not Achieved No Further Action/Still working/New Goal

Prompt Doc No: SCH0000598 v4	Approved by: EMCS	Custodian: MCD&AC
First Issued: 24/07/2014	Page 2 of 2	Last Reviewed: 06/09/2021
Version Changed: 06/09/2021	UNCONTROLLED WHEN DOWNLOADED	Review By: 06/09/2023

Appendix 3

3. Vignette for clinicians to record client engagement

Suggested vignette structure to record interventions for 3C clients

Care co-ordinator	
MC number	
Gender	
Age	
Living situation	
Health conditions	
Additional stressors	
Initial capacity factors	
Initial burden factors	
CC reflection	
Referrals made	
Organisational tasks	
SM support	
Impact	
Barriers	
What worked, what didn't.	

Appendix 4

Expanded client quotes under evaluation headings

All interviews were transcribed and coded under the feasibility framework headings. The three headings relevant to client interviews were: acceptability; implementation; efficacy.

Acceptability

- There is such a great need for it now – because of all the shortage of practitioners.(4)
- I just think it worked really well. For me, and hopefully for others too, and I think they should try and keep it going for as long as possible. (3)
- I feel that if you can do this, you can be put on a path where there is light at the end of the tunnel. And things aren't so difficult. And that you can do things. (5)
- ...people who don't know where to go with their health and anyone who is not sure about what they should be doing for themselves. I just wonder, there are probably more people like me. I'm sure there are a lot of people on the lower income scale, for example, who don't know the help that is available to them.(3)
- Especially for people who are by themselves to have that sounding board. Have someone there to advise if you have an issue, a health issue or whatever? It makes a lot of difference.(7)
- I think it would be good for others maybe the elderly and people living alone especially people who haven't got family around (12).
- They hear you. They listen to you about what you are concerned about...(CC) knows how to say the right things at the right times. And that's because (CC) listens to me. (1)
- (CC) never made me feel that I was a nuisance or that my concerns were ridiculous. There was none of that....'Oh, you'll get over that ... You'll be right'. It was a genuine concern.(5)
- (CC) seemed to be more interested in my problems. A lot of professionals – they are what I said. They are professionals. They don't have much feeling. They just do the job and that's about it. But (CC) had feeling.(6)
- It was much more relaxed. I did not feel as if I was rushed. Like when you go to most people, they're waiting for the next person in line to come along... I always felt that I was heard and listened to in a relaxed manner (7)
- (CC) was really more of a friendly support.. they were easier to get on with...they rang me to see how I was going. (12)
- It is hard to get that sort of conversation happening with the doctor. They're there to say, well, we will do this and that and will write a script. I don't think they have a listening ear. That's what worries me about medicine now – or not, at least until something is really wrong. But that's what I felt with (CC). You just felt it was someone who gave you that little bit of time to listen (4)
- (CC) shows genuine concern...they are not just a person sitting there saying, oh, here's another one coming along, lets send her off. When you walk in there downtrodden, you need someone there who is able to show you the slightest bit of light or hope, to tell you that you're not a nuisance and that you're not silly.(5)
- I never felt (CC) was condescending or looking down on me. It was always calm.(7)
- It is nice to know someone cares about you...(CC) catches on to what you are talking about really quickly. Which is helpful for me because of my education.(10)
- (CC) is passionate about their clients....When I first met (CC) I was really down...I was depressed but (CC) was so encouraging (11)
- That (the CC) did work together, we worked together. It was an individual thing... (CC) didn't try and tell me what to do, and they didn't expect me to do it all on my own either, so that was very good. (3)
- (CC) is actually working with me to get things done. (8)
- (CC) has been able to listen for my concerns rather than just telling me what to do. (9)
- The difference is that (CC) has never promised me anything they have gone ahead with things – like other workers have promised me things and done nothing. (CC) has gone ahead and done what they said they would do.(10)
- There have been other people that I have been with and they haven't really helped me or done anything for me.(8)
- They haven't helped me...like getting to what the problems are, understanding what the problems are I have with my health...in the past, no doctor has gone into anything like that...Whereas (CC) has mentioned everything to help me in every way possible. People have been telling me what to do, but that's all. There is no guidance or help. Whereas (CC) says this person can help you with this, this person can help you with that and that is what I need.(9)
- Being able to support the person to take their story and their situation to the next worker or to the next department, is a really important component.... if (the CC) is able to actually do that, to navigate it, to say 'hey look I've told this person about where you're up to, I've got an appointment for you', does that so, here you go. It just takes that layer of work and burden of their shoulders. And it just flattens it out and the person is able to move towards it so much more easy.(11)

- I've just found that I have been able to make comments to (CC) and they have been able to offer that ear and have said, Oh well, maybe you can try this or maybe you can try that... So I just found with (CC) it opened doors.(4)
- (CC) points you in all the right directions – who you need to be seeing, what you need to be doing and any help that is available.(3)
- (CC) just said anything... Any problem I have got they can work out something or they can send you off to somewhere else to get help...and they follow up too. I remember once, (CC) said I will get back to you. And they did. They got back to me the next week and said I have found this out.(5)

Implementation

- And probably in my mind having (CC), who I know I could ring at any time.(4)
- I do feel more confident. Especially in knowing that if I need anything, I can just ring (CC) up and there will be someone there for me.(3)
- I'd like to think that there was an opening still there, if I had other problems. If I had physical problems, (CC) would be the one I would turn to.(5)
- (to) work out what I needed and what my goals were. That was really good... (the CC) points you in all the right directions – who you need to be seeing, what you need to be doing and any help that is available (3) Just to have someone who you feel has got their fingers on the pulse. (the CC) sort of fills the gap because you know, at least there is someone who you could ring and say, you know, I'm frustrated or whatever.(4)
- (the CC) sat there and said, is there anything I can do for you in any way or any form? Be that financial or medical, healthwise, whatever. And what I loved about it is that (CC) said, if I don't know the answer, I will find out for you or refer you to someone who does. That is so refreshing. In lots of cases people will just say I'm sorry, I don't cover that or I don't know that. (5)
- (the CC) listened to me... they have also given me information that I didn't know about what's available up here...they've helped me to navigate things around the town(7)
- All these things, I have never had anyone do this for me in the past. Whereas (the CC) she has really helped me a great deal.(9)
- I arrived in front of (the CC), ...they started to talk about the trial. And [the community health organisation] just opened up to me like an oyster... And [the CC] was the sheep dog at the back, if I needed to get somewhere, they made sure I got an appointment and they were following up everybody and everyone.(10)
- (the CC) spent a lot of time working through solutions for my problems that I had at the time and was able to show me how I could rectify them and how to manage them...they checked into all my

doctors that I was going to and looked into that to see what they had been doing (5)

- (the CC) gets along with me and encourages me and gets me going and back up again. Mentally, physically, you know.(1)
- (the CC) does give you an incentive to keep going.(2)
- (the CC) would sit there and explain things to me, and talk to me (12)
- (the CC) kept ringing to check that I was OK, which was really good to see how things were going.(3)
- Sort of like encouragement. To make the effort to go to the pool. And their reaction when I went to the pool was very positive. It made me feel better.(7)
- I like to sit there and talk. And I can talk, bring things up, (the CC) has more understanding of me. And I find that is really, really good.(9)

Efficacy

- At the moment everything is in place. And I said that to (CC), everything is in place because (CC) has organised it. It's all just flowing along beautifully.(5)
- (I'm feeling more in control)...Because I feel now that I am getting this help from (CC), that things are actually going to happen in the future...like getting the help I need for my mental health in place (8)
- Yes, I'm connected up now...It does make a lot of difference. If I don't have that someone (the CC) backing me up then I feel lost. It's very important.(9)
- (getting the supports in place) that release of pressure was fantastic. It was just like 'oh thank goodness'... All this clutter has dropped away. And I find that my thinking is clearer, I'm back doing more creative things. It's just a different outlook on life. (11)
- There's a word for it. (CC) has helped me live on. And things have been bad for me, really bad with health problems and that. And (CC) has given me a little bit of hope.(10)
- I'm feeling a lot more in control. I feel a lot more confident in handling myself and knowing that there is health help out there if you need it.(3).
- Just having that someone at your back...It's just made me try and look at myself and I have been in the habit of thinking, well, it has to be done this way. But I think you just can keep learning that you can do things differently (4)
- My self-esteem has been lifted a lot...I remember when I first went to see (CC) I was very downtrodden and I did not think life was really worthwhile and going on with it (5)
- I had recently moved and I had gone into a really deep depression...there'd been a lot of muck up with doctors as well...(but) the fact that (CC) was encouraging, so that I went to the pool and (CC) made me feel good about it...So my mood started to lift...I didn't realise how depressed I was until I came out of it, but I think that (CC) was pivotal to that happening.(7)



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