Care for people with chronic conditions

Summary of the guide for the Community Health Program

About the guide

The aim of the *Care for people with chronic conditions* guide is to ensure chronic care services provided by the Community Health Program improve the health and wellbeing of people with chronic conditions, and reduce avoidable hospitalisations.

It does this by promoting targeted and team-based approaches that engage people with chronic and complex health conditions to achieve their health goals.

Chronic care services are guided by the care principles outlined in the Community Heath Integrated Program (CHIP) guidelines and the *Victorian service coordination practice manual*. These principles provide a foundation for person-centred practice in the Community Health Program.

The objectives of the Community Health Program in relation to chronic conditions are as follows:

Service delivery

- Provide integrated multidisciplinary care that addresses physical, social and mental health needs.
- Provide comprehensive assessment and evidence-based interventions tailored to the individual's needs and documented in a collaborative care plan.

Person-centred care

- Provide care that is accessible and appropriate, and meets the diverse needs of individuals and groups in the community.
- Provide information and promote skills that support people's
  - understanding and access to healthcare
  - management of their own health
  - ability to make informed decisions about their own healthcare.

System support

- Support coordination and continuity of care between providers.
- Support access to, and integration of, specialist services into care provision.
- Contribute to coordinated, collaborative approaches across the service system.

What is effective chronic care?

In order to improve outcomes in chronic care, people need to be informed and activated. This requires prepared and proactive healthcare teams that carry out the following functions:

- systematic, planned interventions based on best practice guidelines
- comprehensive assessment and care planning, and systematic monitoring and review
- emphasising the person's central role in managing their health
- providing people with information and skills that support them to manage their health and healthcare.

Organisational requirements to support this include:

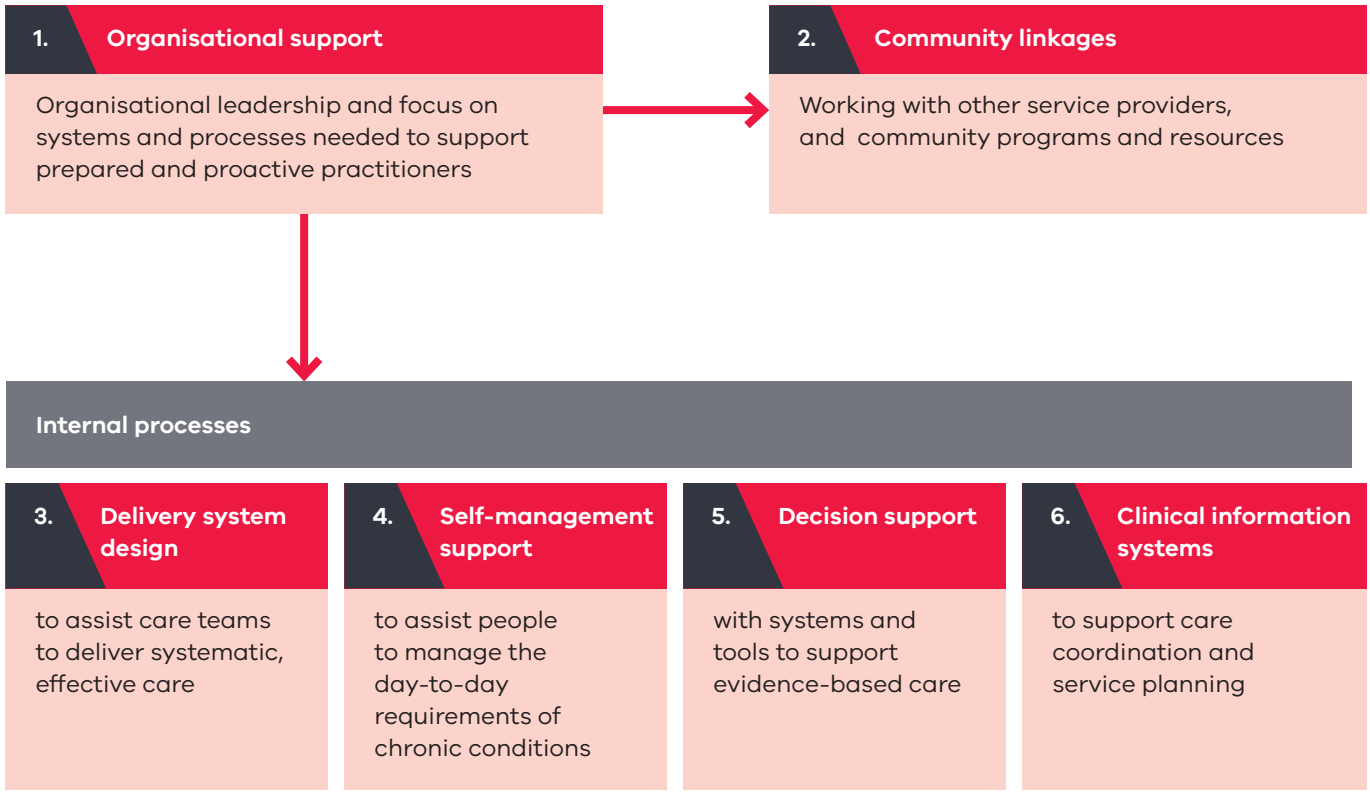
- arranging healthcare teams and delivery models that provide integrated multidisciplinary care both within the organisation, and with external providers
- using clinical information systems to support sharing and collating of data, to measure performance and plan services
- engaging individuals and the community in planning, delivery and evaluation of care
- a commitment to monitoring outcomes and evaluating care processes.

VICTORIA State Government | Health and Human Services

Chronic Care Model

For the past 10 years community health services have used the Chronic Care Model as a framework for improving care for people with chronic conditions. The Chronic Care Model has six core elements that organisations must focus on in order to support a care delivery system that provides high-quality care for people with chronic conditions.

Figure 1: The six core elements of the Chronic Care Model



How effective is the chronic care your organisation provides?

This quick reference checklist lets you see how well your organisation's chronic care aligns with the six core elements of the Chronic Care Model.

Give each element a score from 1–4.

Organisational support

Care of people with chronic conditions is more effective if the overall system in which care is provided is orientated, and led, in a manner that allows for a focus on chronic condition care.

Does your organisation have:	Score
A long-term vision and clear mission statement for how the organisation will deliver effective services that meet the needs of people with a chronic condition	
A strategic plan and flexible and responsive work plans that articulate how the organisation will implement chronic care programs	
Delegated responsibility for implementing and monitoring service provision for chronic care at the executive level of the organisation	
Allocated appropriate resources – including access to a multidisciplinary care team	
A suitably qualified and experienced practitioner to manage the multidisciplinary care team	
A plan to routinely evaluate services using a range of processes and indicators including consumer, community and practitioner experiences	
A quality improvement plan and a proven improvement strategy to implement and monitor organisational goals	

Community linkages

Delivering effective care for people with chronic conditions requires community health services to work in partnership with other service providers, community organisations and people with chronic conditions.

Does your organisation:	Score
Consult with, and actively involve, community members in planning, delivery and evaluation of its chronic care services	
Routinely link people with chronic conditions to community/online support groups and condition-specific peak bodies	
Work with other services involved in care for people with chronic conditions in the region, to develop agreed care pathways and coordinate services that ensure people with chronic conditions receive care in the most appropriate setting and in a timely manner	
Have partnerships with community organisations to provide formal supportive programs that will help to deliver coordinated care for participants in programs such as the National Disability Insurance Scheme, My Aged Care, and mental health programs	

Delivery system design

Providing effective chronic conditions care requires a focus on the processes of care delivery and building effective care teams that work together to provide holistic care. Arranging work flows to support practitioners to provide coordinated and integrated care is also key element of effective care delivery.

Does your organisation have:	Score
Intake and initial needs identification processes that identify people with a chronic condition and an agreed care pathway based on needs	
Standardised assessments that are shared by all members of the multidisciplinary team	
Processes and protocols to support the development of one shared care plan across the organisation	
Processes/agreements for communicating/sharing care plans and referral and treatment outcomes with other practitioners in your organisation and with external service providers	
Processes and protocols to support the identification of a key-worker who is responsible for coordinating the care plan, and communicating with the person and other service providers	
Discharge processes and protocols	
Appointments systems and appropriate time allocated to practitioners to support the delivery of assessment, care planning and review processes	
Processes to ensure the chronic care multidisciplinary team meet regularly to review care practices, caseloads and share expertise	
Peer support workers as part of the multidisciplinary team with clearly defined roles and responsibilities	

Self-management support

Effective self-management support requires skilled practitioners to support people to manage the physical, social and emotional challenges of living with a chronic condition. Organisational commitment to improving health literacy and peer support are important components of self-management support.

Does your organisation:	Score
Have a standardised assessment process to assess self-management needs	
Include collaborative goal setting and shared decision making as part of the care planning process	
Have a process to ensure people are always provided with a copy of their care plan	
Ensure staff have the appropriate skills and resources to provide effective self-management support using evidence-based approaches and practices	
Offer self-management support through a range of modalities to accommodate client preferences, such as groups, telephone and online programs	
Always offer to link people with condition-specific organisations and peer support	
Always provide people with information about their condition, healthy lifestyle and actions to take for acute changes in their condition	
Support people to access emerging technologies that provide self/remote-monitoring, and applications that support monitoring of conditions and motivation for lifestyle changes.	

Decision support

Effective chronic care programs ensure that practitioners have access to evidence-based information, including disease based guidelines, internal care protocols, speciality consultation and education/professional development.

Does your organisation:	Score
Ensure care delivery processes are consistent with evidence-based guidelines	
Ensure practitioners have ready access to evidence-based guidelines and are provided with professional development opportunities	
Have systems and protocols in place with other services and program areas to support access/compliment specialist services	
Have condition-specific protocols and care pathways with other care providers in the region	
Ensure practitioners have access to secondary consultation from experts – for example, mental health, drug and alcohol counsellors or refugee health specialists	
Have routine clinical audit and review processes in place to monitor adherence to agreed practices and protocols	

Clinical information systems

Timely access to information, and the capacity to share and collate data for individuals and groups of individuals, is a critical feature of effective care delivery and program planning.

Does your organisation's clinical information system support:	Score
The development of a common and shared assessment and care plan	
Implementation of routine reminder and recall mechanisms	
Identification of active and discharged people	
Secure communication with other service providers	
Sharing/developing care plans with other organisations electronically	
Identification and organisation of individual and population data	
Identification and organisation of data on care delivery that supports file audits, ongoing service mapping and program monitoring, reporting and evaluation	

The full version of the guide has a more detailed chronic care self-assessment checklist that includes a rating scale and suggestions for how to implement a full organisational review of chronic care.

Acknowledgements

These guidelines were developed in consultation with representatives from community health services, Primary Care Partnerships, key experts in chronic conditions management, and related Department of Health and Human Services program areas.

The Department of Health and Human Services gratefully acknowledges the considerable time and effort of those involved in the planning and development of the guidelines

To receive this publication in an accessible format phone 03 9096 8618 using the National Relay Service 13 36 77 if required, or email partnerships.primary@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Available at https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines

Printed by Mercedes Waratah Digital, Port Melbourne (1610001)