Care for people with chronic conditions

Guide for the Community Health Program
Care for people with chronic conditions

Guide for the Community Health Program
These guidelines were developed in consultation with representatives from community health services, Primary Care Partnerships, key experts in chronic conditions management, and relevant 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.
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Introduction

The Community Health Program delivered by Community Health Services provides over one million service hours of allied health, counselling, nursing and coordination each year. Much of this is associated with delivering coordinated, integrated and effective person-centred care for people with chronic and complex conditions.

Chronic conditions have a major impact on quality of life and are a main cause of premature mortality for Australians. They contribute significantly to Australia’s overall burden of disease, including death, disability and diminished quality of life, as well as accounting for a significant proportion of healthcare costs.

Chronic conditions occur across the life cycle and are broad ranging in their development, progress and effects. They are more prevalent with older age, and the number of conditions that a person may have also increases with age.

The prevalence of most chronic conditions is low in young people, and consequently they may have difficulty accessing age-appropriate services and support from peers. Young people with chronic conditions also face an increased rate of morbidity and mortality as they get older. This highlights the importance of access to comprehensive and integrated care in their community from an early age (Department of Health, Western Australia 2009).

Ongoing actions on a long-term basis are required to manage chronic conditions, including adjusting to living with the social and emotional impact of chronic conditions. In most situations, ongoing involvement with healthcare providers and the community is required.

The complexity of care needs can relate to the nature or number of conditions that a person may have, but may also be due to other social and psychological issues such as mental illness, homelessness, family violence or a disability that can impact on a person’s condition or their self-care activities.

People with chronic or complex health conditions often access services from a number of different public and private healthcare providers. To deliver coordinated, integrated and effective person-centred care, community health services need systems and processes to work in partnership with other providers.

In addition, the broad variation in the nature and complexity of conditions people experience requires community health services to provide person-centred service models that are grounded in current evidence, and that address the needs of local populations.
Purpose of the guide

This guide is for all services delivered through the Community Health Program. It details the planning and delivery of care for people with a chronic condition.

The guide:

• aims to ensure a consistent approach to care for people with a chronic condition
• outlines the principles that underpin good practice in the delivery of care for people with chronic conditions within a community health setting
• provides a guide for program managers to develop, plan and monitor services for people with chronic conditions
• outlines how chronic care services contribute to, and are integrated with, the wider service system (in particular how community health services are expected to work with general practice and other specialist services to support a comprehensive and integrated approach to chronic conditions).

The primary audience is organisations funded to deliver the Community Health Program. However, given the integrated nature of service provision, the guide is also relevant for other partner organisations and programs delivering services to people with chronic conditions.

This guide should be used together with the Community Heath Integrated Program guidelines <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

These provide overall directions for delivering the Community Health Program.

Scope of the guide

Care for chronic conditions occurs across a continuum, as shown in Figure 1. This guide focuses on the individual level of early intervention and established disease, because this is predominantly where community health services work.

People with very complex healthcare needs are likely to be in the care of acute and specialist services, but community health services are often involved in supporting people with complex care needs through engagement with the Health Independence Program and other acute care services.

Community health services may be involved in shared care arrangements with people accessing the Health Independence Program. Alternatively, people receiving care through the Health Independence Program may be referred back to community health services for ongoing support.

This guide provides recommendations to community health services for the planning and delivery of care for people with chronic conditions and their families. It is not intended to be a detailed guide for clinical practice.

The complexity of people’s chronic care needs relates not only to the nature of their condition, but also to the social, environmental, financial and cultural factors that affect their health and wellbeing. Community health services need to provide a flexible response and a mix of services for people with chronic conditions, within a local context.

Population-level health promotion planning that supports prevention and reduces the risk of chronic conditions is addressed in other policy documents such as:


Terminology

In this guide, the term ‘chronic conditions’ is used as an overarching term for all long-term conditions that affect a person’s quality of life.

The terms ‘person’ or ‘people’ are used to refer to people who receive services through the Community Health Program – this encompasses consumers, service users and clients. Providers of services are referred to as ‘practitioners’ – this encompasses clinicians of all disciplines and types.
Figure 1: Continuum of care and intervention points for chronic conditions

<table>
<thead>
<tr>
<th>Level of intervention in community health</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention Individual</td>
<td>Whole</td>
</tr>
<tr>
<td>Secondary prevention Individual</td>
<td>Targeted</td>
</tr>
<tr>
<td>Early intervention and focus on self-management support</td>
<td>Individual</td>
</tr>
<tr>
<td>Self-management support with some care coordination needs to prevent avoidable hospitalisation</td>
<td>Established disease</td>
</tr>
<tr>
<td>Risk of frequent hospitalisation</td>
<td>Complex condition</td>
</tr>
</tbody>
</table>

Note: ‘Self-management support’ refers to all types of interventions offered by community health, including education, treatment, linking with peers and group programs, and social and psychological support.
The Community Health Program principles of care are the foundation for person-centred practice, and apply to all aspects of service delivery and support across the program including chronic care management.


Community Health Services need to align with these principles of care in all aspects of planning, program design and service delivery. The principles of care are reflected in the Chronic Care Model adopted by the department (see p. 13).

In summary, the principles call for high-quality and supported person-centred care that:

- is culturally responsive
- is goal-directed
- encourages health literacy
- is health promoting
- facilitates self-management
- focuses on early intervention
- uses evidence-based practice
- takes a team approach.

**Figure 2: Principles of care as outlined in the Community Health Integrated Program guidelines**
Aim and objectives of chronic care services in community health

The aim of chronic care services is to improve the health and wellbeing of people with a chronic condition and reduce avoidable hospitalisations.

The specific objectives of the Community Health Program in relation to people with 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.
Developing an effective chronic care service

The department has endorsed the **Chronic Care Model** framework [www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2].

This model informs and guides the service redesign that community health services need to undertake to support people with chronic conditions.

The model has been modified to better fit the Victorian healthcare system by incorporating elements such as health literacy, peer support and well-functioning multidisciplinary teams.

**Identifying areas for improvement**

See Appendix 1 for a chronic care self-assessment checklist for community health services to review current care delivery systems and practice.

Services can also use the **Assessment of Chronic Illness Care tool** [www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35] to identify areas for improvement.

**Expanded Chronic Care Model**

Many Primary Care Partnerships have adopted the **Expanded Chronic Care Model** [http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf].

This is an adapted version of the Chronic Care Model that includes population health measures to support the adoption of healthy lifestyle behaviours. Community health services, through working with other organisations and partners, can play a significant role in supporting catchment-wide approaches to population health interventions.

The key premise of the Chronic Care Model is that in order to improve outcomes in chronic care, people need to be informed and activated.

This requires well-organised healthcare organisations within an integrated healthcare system, and a prepared and proactive healthcare team that carry out the functions outlined below.

**A prepared and proactive healthcare team**

A prepared and proactive healthcare team:

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

Organisational requirements to support this include:

- arrangement of healthcare teams and delivery models that provide integrated multidisciplinary care both within the organisation, and with external providers
- use 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.

*Source: Improving Chronic Illness Care website*
Implementing effective chronic care

Implementing the Chronic Care Model will support community health services to deliver effective evidence-based chronic care. The model has six core elements for organisations to focus on.

The six elements of the Chronic Care Model are outlined below, in the context of Victorian community health services. They include aligning practice with the Victorian Service Coordination Framework (see Appendix 2).

The authors of the model stress that organisations must focus on all six areas in order to provide effective care that supports people with chronic conditions.

**Figure X: Core elements of the Chronic Care Model**

1. **Organisational support**
   - Organisational leadership and focus on systems and processes needed to support prepared and proactive practitioners

2. **Community linkages**
   - Working with other service providers, and community programs and resources

**Internal processes**

3. **Delivery system design**
   - To assist care teams to deliver systematic, effective care

4. **Self-management support**
   - To assist people to manage the day-to-day requirements of chronic conditions

5. **Decision support**
   - With systems and tools to support evidence-based care

6. **Clinical information systems**
   - To support care coordination and service planning

**Note:** The term ‘multidisciplinary team’ refers to the organisation of teams and care processes, where individuals have access to a range of health professionals needed to manage different aspects of their condition. The team has processes in place to support a common, comprehensive assessment and a shared care plan that is collaboratively developed by participating team members in partnership with the person with the chronic condition. This way of practising can also be referred to as ‘interdisciplinary care’.

The six core elements of the Chronic Care Model are outlined in further detail below.
Organisational support

Organisational vision, leadership and appropriate resourcing are required to deliver effective chronic care.

Demonstrating organisational commitment to delivering effective chronic care requires community health services to:

- have a long-term vision and organisational goals for delivering services that meet the needs of people with chronic conditions
- articulate in their strategic business and individual work plans how the organisation will implement the long-term vision for chronic care services
- delegate overall responsibility for implementing and monitoring service provision for chronic care to the executive level of the organisation
- allocate appropriate resources, including access to a multidisciplinary care team
- have a suitably qualified and experienced practitioner to manage the multidisciplinary care team
- routinely evaluate service processes and outcomes using a range of processes and indicators including consumer, community and practitioner experiences
- use a proven improvement strategy to implement and monitor organisational goals.

Case study

When cohealth reviewed their care process a few years ago, they found their client journey was unnecessarily complex and many clients were experiencing poorly coordinated care. They began a change process led by senior management to implement a new model of care. To view the full case study, see the Community Health Program website [www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines].

More information

- Assessment of Chronic Illness Care tool [www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35]
- Patient Assessment of Chronic Illness Care tool [www.improvingchroniccare.org/index.php?p=PACIC_Survey&s=36]
- Plan Do Study guide (NHS UK) [www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html]
Community linkages

Ensuring coordination and integration of care is an essential component in providing care for people with a chronic condition. This can only be achieved by working with other service providers and by engaging with local communities and community organisations.

Working with service providers

Supporting a more integrated healthcare service for people with chronic conditions requires:

- working with other services in the region in order to develop agreed care pathways, coordinate services, and ensure care is provided in a timely manner and in the most appropriate setting
- developing partnerships with other services that will help to deliver coordinated care for participants in programs, such as the National Disability Insurance Scheme, My Aged Care, mental health programs
- participating in planning and collaborative work of local Primary Care Partnerships and Primary Health Networks.

The Victorian service coordination framework provides a set of statewide protocols and practices that support effective coordination between service providers. It aims to put consumers at the centre of service delivery to maximise their access to the services they need as part of a seamless and integrated response. It also supports a consistent approach to effective care for people with chronic conditions. Community health services should work with a broad range of service providers to strengthen coordination of care for people with chronic conditions. Further information is provided in the section below on delivery system design and in Appendix 2.

Case study

The Central West Gippsland Paediatric Group, an alliance of 10 partnering organisations, worked collaboratively to develop paediatric allied health services that provide the community with access to paediatric allied health services in their local area. This has resulted in the development of children’s allied health services at Latrobe Community Health Service and West Gippsland Healthcare Group. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.
Engaging with general practice
Communication and feedback from community health services to general practitioners is vital for people with chronic conditions to ensure effective multidisciplinary care is provided. This will:

- facilitate follow through of management by the general practitioner
- reduce the risk of duplication of management plans, tests and the need for the person to repeat their personal and medical history.

Community engagement
Engagement with community members with chronic conditions and community organisations is essential to ensure services are person centred, appropriate and accessible, and respond to the needs of the community (Harding, Wait and Scrutton 2015; Australian Commission on Safety and Quality in Health Care 2011).

Community engagement includes:

- consulting with, and actively involving, community members in planning, delivery and evaluation of chronic care services
- routinely linking people with chronic conditions to community/online support groups and condition specific peak bodies
- developing partnerships with mental health services, Aboriginal and Torres Strait Islander community controlled organisations, and organisations representing different cultural groups, in order to develop processes and program modifications that enable individuals from these communities to access chronic care services.

A commitment to promoting health literacy is needed to effectively engage with community members. See discussion on health literacy in the self-management section.

Case study
The board and management of EACH Social and Community Health made a commitment several years ago to improve engagement with their local Aboriginal and Torres Strait Islander organisation and improve access to EACH services for the community. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.
More information

- National Safety and Quality Health Service Standard 2: Partnering with consumers
- Queensland Government Consumer and community engagement framework
- Strengthening diversity planning and practice: a guide for Victorian Home and Community Care services
- Health Issues Centre <www.healthissuescentre.org.au>
Delivery system design

Providing effective care for chronic conditions requires a multidisciplinary team-based approach.

Building effective care teams includes (Fisher 2015):

- defining and expanding roles, and providing training to support role changes
- developing trust and teamwork, including regular multidisciplinary team meetings to review care practices, caseloads and share expertise
- arranging work flows and allocating adequate time to support practitioners to provide coordinated and integrated care
- including peer support workers as part of a multidisciplinary team for chronic care with clearly defined roles and responsibilities.

All people with a chronic condition should have access to a comprehensive chronic care program, delivered by a multidisciplinary team that includes the practice components outlined in Table 1.

Establishing multidisciplinary teams and key worker roles may require the up-skilling of staff to undertake a more generalist, rather than a discipline-specific, role.

Practitioners in a multidisciplinary team need skills in self-management support, client-directed care planning, initiating and facilitating client case conferences and care coordination.

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<tr>
<th>Component</th>
<th>Descriptor</th>
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<tr>
<td>Agreed care pathways for people with a chronic condition</td>
<td>Intake staff have clear protocols that support access to chronic care programs and discipline-specific services based on the nature and complexity of the identified issues, and the individual’s care preferences.</td>
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</tbody>
</table>
| Standardised assessment | Share with all members of the multidisciplinary team, and including the identification of:  
  - lifestyle factors  
  - the social and psychological (including depression screen) factors  
  - self-management support needs.  
  Condition/discipline-specific assessment should be added to the common assessment by appropriate team members as required. |
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<thead>
<tr>
<th>Component</th>
<th>Descriptor</th>
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</table>
| **Standardised approach to care planning** | Care plans clearly document:  
- the person’s stated concerns/problems  
- risk factors  
- appropriate treatment regimes and education interventions according to best practice guidelines  
- agreed goals, actions and timeframes, and how these relate to other goals/care plans the client may have in place with other service providers  
- follow-up/review dates  
- consent to share information with other service providers (SCTT includes a consent to share information template and shared support plan). |
| **Review and recall systems** | Document progress against goals in the care plan in accordance with agreed review dates.  
Recall and reminder processes are set up to support delivery of care in line with best practice guidelines for specific conditions.  
Processes are in place to support recall and reminders for people with chronic conditions. |
| **Shared case/care plan**  
Note the shared support plan template in the SCTT has been designed for use here. | If people are seeing more than one practitioner, processes and protocols are in place to support the development of common shared care plan, for example:  
- multidisciplinary shared case/care plan across the organisation  
- interagency shared case/care plan (when working with outside agencies)  
- use of electronic care planning systems. |
| **Key worker/care coordinator** | If a shared care plan is needed, processes and protocols are implemented to ensure the person has a key worker or care coordinator responsible for coordinating the care plan, and communicating with the person and other service providers. |
| **Case conferences** | Processes are in place to support the person to attend a case conference with members of their care team, when required. |
| **Communication with other providers** | There are:  
- clear and documented processes for communicating/sharing care plans with other practitioners involved in the person’s care (in particular general practitioners).  
- formalised agreements with other services to support the shared care planning.  
- processes to monitor feedback and information sharing. |
| **Discharge policy and procedures** | There are clear criteria for when a person’s care needs have been met and they are eligible for discharge from the service.  
There are processes for documenting discharge and communicating with other internal practitioners and external service providers. |

1 The SCTT information exchange summary template is designed for providers to exchange information at any key point in the consumer’s care.
**Case study**
cohealth has implemented multidisciplinary collaborative practising teams to deliver person-centred care with a focus on people living with chronic conditions and/or complex needs. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

**Case study**
Rural Northwest Health has three campuses that provide a comprehensive range of acute, aged, and primary health services to people in the Wimmera region. They introduced a screening tool at intake to identify people with a chronic condition and to direct them to the most appropriate service. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

**Case study**
In 2010 Inner South Community Health (ISCH) set themselves a goal that all ISCH clients have access to integrated, coordinated and appropriate client-centred care. They have introduced a number of the processes listed in Table 1 to meet this goal. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

**More information**
- Improving Chronic Illness Care website  
- MacColl Centre For Primary Health Care Innovation  
  <www.maccollcenter.org/our-work/primary-care-teams>
- The Health Foundation  
  <www.health.org.uk/search?content_type=280.284.279&sort=date&theme=12#results>
- Australian Disease Management Association Clearing House  
- Victorian Home and Community Care Active Service Model  
- Strengthening assessment and care planning: a guide for HACC assessment services in Victoria  
- Ways to use team meetings to increase your team’s competence in person-centred thinking tools  
  <www.helensandersonassociates.co.uk/8-ways-use-team-meetings-increase-teams-competence-person-centred-thinking-tools>
- Assessment and care planning documentation  
  <www.cdhb.health.nz/Hospitals-Services/Health-Professionals/Nursing-Documentation/Pages/default.aspx>
- Goal-directed care planning toolkit  
- Interagency care planning – readiness checklist NEPCP  
Self-management support

Effective self-management support helps people and their families cope with the physical, social and psychological challenges of living with, and managing, a chronic condition.

Health service processes and practices for people with a chronic condition in relation to self-management include:

- assessing and documenting self-management needs as part of the standardised assessment process
- collaborative goal setting and shared decision making as part of the care planning process, and giving the person a copy of their care plan
- skilled practitioners who use evidence-based approaches and practices to provide self-management support
- accommodating individual preferences by offering a range of modalities such as groups, telephone and online programs
- routinely linking people with condition-specific organisations and peer support. This is particularly important for young people, and people who have rare conditions, as these two groups often experience isolation from not having access to peers to share concerns/experiences
- processes and training to support the recruitment and involvement of peer support workers in self-management and education programs
- giving people information in accordance with health literacy principles, including strategies to accommodate different learning styles. Minimum information requirements would include:
  - information on health conditions, and consumer-friendly versions of condition-specific guidelines
  - lifestyle activities that promote health and reduce risk of disease/complication
  - actions to take if they experience acute changes in their condition
- team members are sensitive to cultural beliefs, people with diverse needs and to people’s social and economic circumstances
- offering interpreter services to people who need them
- taking an organisational approach to implement health literacy principles (outlined below)
- supporting people to access
  - credible online resources
  - emerging technologies that provide self/remote-monitoring
  - applications that support monitoring of conditions and motivation for lifestyle changes.
The 10 attributes of a health-literate organisation

A health-literate organisation:

- has leadership that makes health literacy integral to its mission, structure and operations
- integrates health literacy into planning, evaluation measures, service user safety and quality improvement
- prepares the workforce to be health literate and monitors progress
- includes consumers in the design, implementation and evaluation of health information and services
- meets the needs of consumers with a range of health literacy skills while avoiding making assumptions about individual health literacy levels
- uses health-literacy strategies in interpersonal communications and confirms understanding at all points of contact
- provides easy access to health information, services and navigation assistance
- designs and distributes print, audio-visual and social media content that is easy to understand and act on
- addresses health literacy in high-risk situations, including care transitions and communications about treatments and medicines
- communicates clearly the costs that funding schemes may cover (for example, Medicare, private health insurance) and what individuals may have to pay for services.

Source: Gippsland Primary Care Partnerships 2015, The Gippsland guide to becoming a health-literate organisation, <www.centralwestgippslandpcp.com/health-literacy>
Case study
West Gippsland Healthcare Group undertook an organisational assessment of their health-literacy proficiency and developed an action plan for raising health-literacy awareness in their organisation. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

Case study
Delivering Multidisciplinary Cardiac Rehabilitation in the Bush: the Wimmera Hub and Spoke model is improving access for rural people to information and interaction with peers using telehealth. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

Case study
Darebin Community Health’s Living Well team is a multidisciplinary team that focuses on providing self-management support for people with chronic conditions. The team has embedded a range of self-management support strategies into their care delivery. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

More information
- National Council on Ageing and Centre on Ageing at the University of Victoria, Online chronic disease self-management program <bc.selfmanage.org/onlinebc/hl/hlMain>
- Stanford chronic disease self-management program <patienteducation.stanford.edu/programs/cdsm.mp.html>
- Chronic Illness Alliance <www.chronicillness.org.au/>
- National Health Service UK <sdm.rightcare.nhs.uk/pda>
- Western Australian Government, Chronic disease self-management framework
- Mayo Clinic, Shared decision making <shareddecisions.mayoclinic.org>
- Health Issues Centre, Peer support <http://www.healthissuescentre.org.au>
Decision support

Effective care for chronic conditions requires care that is planned and delivered consistent with evidence-based guidelines.

This means organisations should:

• plan care delivery processes consistent with evidence-based guidelines
• support practitioners with ready access to evidence-based guidelines, and provide professional development opportunities to ensure staff have sound and current knowledge of management recommendations
• have systems and protocols in place with other services and program areas to support access to, or complement, specialist services. Examples include:
  – working with acute services to have outreach specialist services within community health services
  – providing staff with access to secondary consultation from experts – for example, mental health, drug and alcohol counsellors or refugee health specialists. This also includes work with other services, such as general practice and acute services, to identify how community health services can be embedded in their care pathways
• develop condition-specific protocols and care pathways with other care providers in the region in order to support clients receiving care from the most appropriate service for their needs
• work with other service providers to develop care pathways that support young people transitioning from child-specific services to adult services
• have routine clinical audit and review processes in place to monitor adherence to agreed practice and protocols.

Case study

Carrington Health has been working with a number of different services to ensure people with chronic conditions have access to specialist services.

The IDEAS program is a collaboration with the Eastern Health Endocrinology Department which provides comprehensive specialist medical and allied health consultations for people with type 2 diabetes. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

The Integrated Falls Assessment Service provides a specialist assessment service with a geriatrician and a physiotherapist. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.

Case study

Community health services in the Hume Whittlesea Primary Care Partnership have worked with Northern Health to develop a common tool to assess diabetes risk and to prioritise care. To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>. 
Clinical information systems

Efficient and effective chronic care requires clinical information systems that organise individual and population data, and support sharing of data with other care providers.

Community health services should have a clinical information system that supports:

- development of a common and shared assessment and care plan
- routine reminder and recall mechanisms
- secure communication with other service providers
- capacity to share/develop care plans with other organisations
- organisation of individual and population data – including a range of health and social indicators that allow the organisation to identify and respond to:
  - changing and emerging local issues
  - population groups that experience poorer health
  - people with greater economic and social needs
- provision of data on care delivery that will support ongoing service mapping and program monitoring, reporting and evaluation.

The Service Coordination Tools and Templates (SCTT) are designed to facilitate the collection, recording and shared of some client information in a standardised way.

Exchanging the right information can help to reduce the burden on consumers to repeat the same story to each service provider, provide more timely access to required services and reduce duplication of assessments and services.

Using the technical standards of the SCTT can also help e-referral because they enable information to populate directly into the receiving service’s client management system.


The chronic care self-assessment checklist in Appendix 1 provides a summary of the key indicators of the six elements of the Chronic Care Model for good chronic care. The checklist enables community health services to review current care delivery systems and practice.

Case study

Latrobe Community Health Service uses an electronic care planning system to develop shared care plans for clients who access a number of services.

To view the full case study, see the Community Health Program website <www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines>.
Demand management

Demand for a service is reflected in the number of people seeking the service, and the number and type of services they require.

It is influenced by factors such as people’s preferences, the needs of the community and population growth in an area.

If demand for a service is greater than the level of service available, it may need to be managed.

Demand management involves equitably determining which people are clinical priorities for a particular service, and wider decisions about the best response for the population as a whole.

The use of risk-stratification tools and care pathways can support decisions about clinical priority and appropriate services.

The Department of Health and Human Services has developed decision-making tools in this area, including:

- **Towards a demand management framework for community health services**

- **Community health priority tools**

The use of a general screening tool at intake can help intake practitioners identify people with a chronic condition and explore their health needs. For example, services can use the **Service Coordination Tools and Templates (SCTT) health and chronic conditions screener**

This may include identifying the need for services other than those the person was originally seeking and/or referred for.

Risk stratification and identified care pathways can offer a more holistic program for people, including care coordination, self-management support programs or counselling instead of, or as well as, being placed on a waiting list for the referred service – such as physiotherapy or podiatry.

Community health services can also build on this process by working with other organisations and partners in their region, including Primary Care Partnerships and Primary Health Networks, to develop care pathways for individual conditions that prioritise care based on the level of risk, level of intervention required and level of service available across agencies in the region.
Case study

Some community health services have processes that identify people with chronic conditions at intake, and documented care pathways that facilitate access to a range of programs based on the person’s needs. Two examples of this are:

- Rural Northwest Health’s Initial Needs Identification for clients with chronic/complex conditions
- cohealth’s team care for people with chronic conditions.


Case study

Australia’s healthcare system is undergoing significant change with the introduction of reforms to primary healthcare, mental health, disability and aged care. These reforms signal an increasing focus on person-centred care that is tailored to the needs of the individual.

Established multidisciplinary teams, key worker roles and implementation of the other elements of the Chronic Care Model outlined in this guide will support community health services to meet these future challenges.

These challenges include:

- increasing complexity of care related to comorbidity and social factors
- increasing emphasis on the need for coordination of care across providers and settings
- changing funding and service models such as the National Disability Insurance Scheme, Health Care Homes in general practice, and My Aged Care
- adoption of electronic health record systems and electronic platforms for developing multiagency shared care plans
- use of other IT technologies/applications to deliver healthcare
- continued and increasing emphasis on person-centred and person-directed care.

**Case study: Chronic Care Model in the changing world of healthcare**

The following case study was prepared by Inner East Community Health and demonstrates their vision of a model that incorporates the principles of the Chronic Care Model to provide integrated, person-centred care for people with chronic conditions.

The case study highlights the changing world of healthcare, and what it may look like in 2020.

It anticipates that by 2020, the government may be providing less direct funding of health services and those funds will be transferred to individuals.

It is also likely to be more market driven, with individual choice being a key feature with variable funding levels. John’s story is about this new world and how Inner East Community Health – *iehealth* – will provide care.

**John’s story: vision for chronic conditions care in 2020**

John is a pensioner; he gets basic medical care services from Medicare and the government gives him $25,000 a year to purchase services that will support him to continue to live at home.

John recently found out that he has type 2 diabetes and he is quite scared by the horror stories he has heard. He regularly gets glossy adverts on his smartphone asking if he would like to buy health services from *Health Care*, a private health provider.

He speaks to his general practitioner (GP) about the best place for him to go for his diabetes, as he is unsure about what services to use.
The GP checks the diabetes pathway tool that has been agreed on by services in the region, and based on John’s needs, recommends iehealth. The GP explains that iehealth provides a package of care that is far more affordable than the Health Care offer.

He explains that he has a good working relationship with iehealth and is confident that he can work with them to make sure John gets all he needs for his diabetes care.

iehealth receives a referral from the GP and the intake worker calls John. The worker asks some questions and tells him about their services. John agrees to attend for an assessment.

At the assessment, the practitioner explores with John what his concerns are and how iehealth can help him manage his diabetes and address his other concerns about staying healthy and independent. John agrees to enrol in the chronic care program. He is allocated a key worker who is the person that he and his family can call if they have concerns. The key worker is also responsible for coordinating his care and communicating with his GP.

iehealth’s chronic care program has trained community mentors. John’s buddy is Sue, and with her encouragement, John starts attending some walking groups and finds himself doing extra walks with some of the walking group members. They all use pedometers and have set themselves a number of group challenges for extra motivation. John starts playing cards at the community house with some of his friends from the diabetes encouragement classes.

John’s family have registered with iehealth as recognised carers and attended carer classes and online training. The iehealth online portals keep them all up to date with what is happening, making it easy for them to help John, and their involvement reduces John’s stress. Both John and his family know that iehealth is there for them because all costs are given back in services to the community.

John often forgets to take his tablets, so his key worker helped him set up the pill reminder function on the Patient Helper app he got from iehealth. John no longer drives, but he talks weekly with his key worker via video. He visits iehealth for regular reviews and likes the fact that when he does, his entire clinic needs are met in a coordinated way.

He is amazed, sometimes, how everyone at iehealth works together and keeps his GP up to date with what is happening. His family are happy, as the key worker keeps them informed via the online portal and, when needed, organises a case conference with everyone involved in John’s care.

John gives glowing reviews of his care, which feeds into the iehealth quality system. iehealth has the lowest percentage of patients with preventable disease ending up in hospital, which shows that its systems are keeping John as healthy as possible.
Receiving government support

Outcome priorities
Community health services focus on meeting the aims and objectives of service delivery and system support set out in this guide.

Funding
The Community Health Program funds the delivery of nursing, allied health and counselling services.

This funding should be used flexibly to provide support and services that respond to the local needs of people with chronic conditions.

Innovative models, such as the use of MBS-funded allied health services, can also be implemented within chronic conditions models of care to support delivery of services to people with chronic conditions and complex needs.

Some providers of the Community Health Program receive targeted resources through other programs to support chronic conditions care.

Accountability
Community health services are accountable to people with chronic conditions or complex needs, the community and the Department of Health and Human Services.

For people with chronic conditions, this means providing person-centred care in which services work with the person, and each other, to ensure coordinated service delivery across the multiple health and community services required to address a person’s individual needs.

Accountability to the community includes providing chronic or complex care services that respond to current and emerging population health needs, and using resources effectively.

This includes the needs of populations who experience poorer health and have greater economic and social needs.

Accountability to the community is shared with organisations that community health services partner with to deliver care, and other partners involved in planning regional approaches to chronic care.

Community health services are accountable to the Department of Health and Human Service for the delivery of community health services in accordance with policy directions and their funding and service agreements.
Reporting and evaluation

All agencies funded to deliver the Community Health Program are required to report on their service provision to the department.

Reporting requirements are outlined in the Community Health Program data reporting guidelines to assist agencies with the accurate recording of client and activity data and the submission of quarterly data to the Department via the Community Health Minimum Data Set (CHMDS).

Services should ensure the data they submit via the CHMDS is high quality. In particular, agencies should take care to ensure that all relevant conditions are listed for people with chronic and complex conditions.

Reported data provides accountability to government and the community for service delivery, as well as valuable information for use in the operational management of community health services across the statewide program.

The CHMDS gathers information on a range of variables including:

- service user demographics (age, sex, priority)
- service provided (discipline, duration, outcome)
- system performance (demand, wait for assessment and/or service).

Community health services are also required to produce annual quality of care reports describing the systems and processes in place to monitor and improve quality.

Monitoring quality of care

Organisations should maintain sufficient records in order to adequately undertake future evaluation and/or reviews of the services provided to their clients.

Internal review and program development are essential to ensure quality service and support.

The Community Health Integrated Program guidelines provide further direction regarding continuous quality improvement and innovation.

Monitoring and improving quality of care for people with chronic conditions can be supported through regular use of the service self-assessment checklist (see Appendix 1) or the Assessment of Chronic Illness Care Survey (ACIC) <www.improvingchroniccare.org>.

These tools support ongoing monitoring before and after a period of change.

Use the same participant mix, methodology and process each time the tool is applied to optimise consistency and validity of results.

Both the ACIC and the service self-assessment checklist provide community health services with the opportunity to review current practice, identify areas for improvement, inform improvement strategies and review progress.
The service self-assessment checklist is structured around the Chronic Care Model and incorporates aspects of the Victorian service coordination framework so that it will also provide guidance on improvements that can be reviewed through participation in the bi- yearly service coordination survey.

As well as meeting reporting requirements and participating in activities, Community Health Services should engage in processes of continuous quality improvement, starting with the needs of the clients and the communities they are serving.

**Victorian community health indicators**

Community Health Services can also leverage the work undertaken in 2014–15 as part of the **Victorian Community Health Indicators project** (<www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-service-improvement/victorian-community-health-indicators>).

The Victorian Community Health Indicators project was established to improve the quality and safety of care provided by state-funded community health services and build evidence regarding the effectiveness and appropriateness of care.

The project can support and assist in improving the quality and safety of care that community health services provide to clients with a chronic condition.

As part of the project, two sets of indicators were developed and piloted with the sector: the community health practice indicators (CHPIs) and the community health impact indicators (CHIIs).

Both sets of indicators aim to:

- strengthen the culture and practices of continuous quality improvement (CQI)
- contribute to building the evidence for the quality and impact of services
- strengthen clinical governance
- promote reflective and evaluative service delivery by clinicians
- enable services to report to their community and stakeholders in their annual Quality of Care report.

The department is working to embed the community health practice indicators into the CHMDS into the future.

**Client management systems**

Community health services are also encouraged to use their local client management systems to generate reports to understand their client populations, and review their data quality.
Appendix 1: Chronic care service self-assessment checklist

This chronic care self-assessment checklist provides an overall summary of the key indicators of the six elements of the Chronic Care Model for good chronic conditions care outlined within this guide.

It is designed to be used by Community Health Services to review current care delivery systems and practice.

The purpose of the checklist is to review care in order to ensure that systems, policies and practices are in place to support good practice and service planning.

The checklist is aligned with the Assessment of Chronic Illness Care that many community health services use to review chronic care processes internally.

It may also support regional planning if services choose to share results with their Primary Care Partnership.

The checklist incorporates key aspects of the Victorian service coordination framework.2

Using the checklist

A senior staff member should be given responsibility for completing the checklist and providing advice to the relevant executive staff on areas for improvement/practice change.

The senior staff member should consult with all practitioners involved in chronic care program areas.

This can be done through discussions at a team meeting, by consensus or having each team member fill out the checklist and averaging the responses.

Use of the checklist should be accompanied by a quality improvement plan that sets out how improvements will be implemented and monitored.

Scoring the checklist

Each item on the checklist should be given a score between 1–4, using the rating scale below:

1 = Not at all or thinking and planning only (achieved 0–25% readiness/progress toward this criteria).
2 = Implementing in some areas (achieved 25–50% readiness/progress toward this criteria).
3 = Implementing in most areas (achieved 50–75% readiness/progress toward this criteria).
4 = Implemented in all areas of the service (achieved 75–100% readiness/progress toward this criteria).

An overall rating for each element can be calculated by adding the score for each item and dividing by the number of items.

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2 Adapted from The MacColl Center for Health Care Innovation, Group Health Cooperative 2000, Assessment of Chronic Illness Care.
Overall integration score asterisk items

Each element in the checklist has one asterisk item. The scores for these items provide an indication of how well the organisation has integrated all the elements of the Chronic Care Model into care delivery processes.

To obtain an overall integration score for your organisation, sum the scores for each of the six asterisk items and divide by six.

Translating the checklist score into an Assessment of Chronic Illness Care (ACIC) score

The checklist has been designed so that it can be translated into an ACIC score.

<table>
<thead>
<tr>
<th>1. Organisational support</th>
<th>Rating 1–4</th>
<th>Notes and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td></td>
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<tr>
<td>A strategic plan and flexible and responsive work plans that articulate how the organisation will implement chronic care programs</td>
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<tr>
<td>Delegated responsibility for implementing and monitoring service provision for chronic care at the executive level of the organisation</td>
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<tr>
<td>Allocated appropriate resources – including access to a multidisciplinary care team</td>
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<tr>
<td>A suitably qualified and experienced practitioner to manage the multidisciplinary care team</td>
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<tr>
<td>A plan to routinely evaluate services using a range of processes and indicators including consumer, community and practitioner experiences*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A quality improvement plan and a proven improvement strategy to implement and monitor organisational goals</td>
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</tbody>
</table>

Overall rating
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.

<table>
<thead>
<tr>
<th>Your organisation:</th>
<th>Rating 1–4</th>
<th>Notes and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consults with, and actively involves, community members in planning, delivery and evaluation of its chronic care services*</td>
<td></td>
<td></td>
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<tr>
<td>Routinely links people with chronic conditions to community/online support groups and condition-specific peak bodies</td>
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<tr>
<td>Works 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</td>
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</tr>
<tr>
<td>Has 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</td>
<td></td>
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</tr>
<tr>
<td>Has partnerships with mental health services, Aboriginal and Torres Strait Islander community-controlled organisations, and organisations representing other cultural communities, in order to develop processes and program modifications that support people from these communities to access chronic care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall rating</strong></td>
<td></td>
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</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Your organisation has:</th>
<th>Rating 1–4</th>
<th>Notes and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake and initial needs identification processes that support the identification of people with a chronic condition and the identification of an agreed care pathway based on needs</td>
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<tr>
<td>Standardised assessments that are shared by all members of the multidisciplinary team</td>
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<tr>
<td>Assessment processes that include identification of lifestyle factors and social, psychological (including depression screen) and self-management support needs</td>
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<tr>
<td>Conditions/discipline-specific assessments that are added to the common assessment by appropriate team members</td>
<td></td>
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<tr>
<td>Clear and documented processes to support the development and monitoring of care plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Processes/agreements for communicating/sharing care plans and referral and treatment outcomes with other practitioners in your organisation with external service providers</td>
<td></td>
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<tr>
<td>Processes and protocols to support the development of one shared care plan across the organisation</td>
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<tr>
<td>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</td>
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<tr>
<td>Care plans clearly document:</td>
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<td></td>
</tr>
<tr>
<td>• the person’s stated concerns/problems</td>
<td></td>
<td></td>
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<tr>
<td>• risk factors</td>
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<td></td>
</tr>
<tr>
<td>• treatment and education interventions according to best practice guideline</td>
<td></td>
<td></td>
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<tr>
<td>• agreed goals and actions</td>
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<tr>
<td>Processes to support practitioners to follow up and review a person’s goals in a planned and proactive manner*</td>
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<tr>
<td>Processes and protocols to support and document discharge of the person</td>
<td></td>
<td></td>
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<tr>
<td>Agreed processes with other services to share information that minimises duplication and improves the coordination of care</td>
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</tbody>
</table>
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

**Overall rating**

Note: The term ‘care plan’ encompasses care plans, case plans and support plans.
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.

<table>
<thead>
<tr>
<th>Your organisation:</th>
<th>Rating 1–4</th>
<th>Notes and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a standardised assessment process to assess self-management needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes collaborative goal setting and shared decision making as part of the care planning process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a process to ensure people are always provided with a copy of their care plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has processes to ensure self-management support is offered to all people with a chronic condition</td>
<td></td>
<td></td>
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<tr>
<td>Ensures staff have the appropriate skills and resources to provide effective self-management support using evidence-based approaches and practices</td>
<td></td>
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<tr>
<td>Offers self-management support through a range of modalities to accommodate client preferences, such as groups, telephone and online programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always offers to link people with conditions-specific organisations and peer support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always provides people with information about their condition, healthy lifestyle and actions to take for acute changes in their condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses a range of strategies to provide information to accommodate different learning styles, including directing people to credible online resources</td>
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<tr>
<td>Provides consumer-friendly versions of condition-specific guidelines that describe for the person their role in achieving guideline adherence*</td>
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<td></td>
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<tr>
<td>Ensures team members are sensitive to cultural beliefs, and the social and economic circumstances of individuals</td>
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<td></td>
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<tr>
<td>Always offers interpreter services to people requiring them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports people to access emerging technologies that provide self/remote-monitoring, and applications that support monitoring of conditions and motivation for lifestyle changes</td>
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</tbody>
</table>

**Overall rating**
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.

<table>
<thead>
<tr>
<th>In your organisation:</th>
<th>Rating 1–4</th>
<th>Notes and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care delivery processes are consistent with evidence-based guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioners have ready access to evidence-based guidelines and are provided with professional development opportunities to ensure that staff have sound and current knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are systems and protocols in place with other services and program areas to support access/complement specialist services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are condition-specific protocols and care pathways with other care providers in the region to ensure people receive care from the most appropriate service for their needs*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioners have access to secondary consultation from experts – for example mental health, drug and alcohol counsellors or refugee health specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioners work with other services, such as general practice, to identify how community health services can be included in their care pathways</td>
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<tr>
<td>Routine clinical audit and review processes are in place to monitor adherence to the agreed practice and protocols</td>
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</table>

**Overall rating**
6. **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.

<table>
<thead>
<tr>
<th>In your organisation, clinical information systems support:</th>
<th>Rating 1–4</th>
<th>Notes and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The development of a common and shared assessment and care plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of routine reminder and recall mechanisms</td>
<td></td>
<td></td>
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<tr>
<td>Identification of active and discharged people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure communication with other service providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing/developing care plans with other organisations electronically</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification and organisation of individual and population data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification and organisation of data on care delivery that supports file audits, ongoing service mapping and program monitoring, reporting and evaluation*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall rating**

Note: The term ‘care plan’ encompasses care plans, case plans and support plans.
Appendix 2: Working with service providers – service coordination and integration

Service coordination


The key service coordination elements are initial contact; initial needs identification; assessment; and care/case planning. These are particularly important to ensuring an effective and consistent approach to care for people with chronic conditions – a summary is provided below.

Service coordination elements
Initial contact is the consumer’s first contact with the service system. It is an important function of every service provider and usually includes the provision of accurate, comprehensive service information and facilitated access to initial needs identification.

Initial needs identification is a brief, broad, screening process to uncover underlying and presenting issues. Initial needs identification canvasses the consumer’s needs as well as opportunities for intervention and information provision early in their contact with the service system.

Assessment is a decision-making methodology that collects and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering services.

Care/case planning is a dynamic process that incorporates assessment coordination, care/case management, referral, information exchange, review, reassessment, monitoring and exiting. Care/case planning may occur at an individual provider level and both within and across agencies.

Service integration

Partnership models with other services are needed to build services and programs around people’s needs. Partnering with a broad range of services enables care to be provided across the continuum from acute to community, and back again, according to the health needs of the client.

This requires a commitment to develop collaborative models of care with a range of organisations/services including:

- healthcare providers, such as general practice, specialist medical services, hospital networks, allied health, condition specific organisations and support groups, and other community health services
- Home and Community Care and other aged care providers, child and adolescent health services
- government departments/services, such as local government, mental health, drug and alcohol, young people/children services, aged care, disability and housing
- other social and community groups, such as women’s/men’s health groups, gamblers help, Aboriginal and Torres Strait Islander groups and cultural specific groups.

Community health services should also work with other organisations and partners to support broader population base planning that identifies service gaps, reviews service utilisation and identifies opportunities for early intervention for people with chronic conditions.

In this regard, Primary Care Partnerships and Primary Health Networks are a key resource for community health services, and play an important role in strengthening partnership planning and coordination of care.
Appendix 3: Additional relevant policies

A range of other Victorian and Commonwealth government policies, frameworks and procedures provide direction for the development and delivery of care for people with chronic conditions and complex needs by community health services. These policies, frameworks and procedures include:

**Victoria**

**Child health services: guidelines for the Community Health Program 2015**
<www2.health.vic.gov.au/about/publications/policiesandguidelines/Child health services - Guidelines for the community health program>

**Refugee and asylum seeker health services: guidelines for the Community Health Program 2015**<www2.health.vic.gov.au/about/publications/policiesandguidelines/Refugee and asylum seeker health services - Guidelines for the community health program>

**Victorian public health and wellbeing plan 2015–2019**

**Victoria’s 10-year mental health plan**<www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan>

**Koolin Balit: Victorian Government strategic direction for Aboriginal health 2012–2022**

**Health Independence Programs guidelines 2008**<www2.health.vic.gov.au/about/publications/policiesandguidelines/Health independence programs guidelines>

**Victorian Home and Community Care (HACC) active service model**

**Towards a demand management framework for community health services 2008**


**Disability action plans – Victorian Disability Act 2006**


**Cultural responsiveness framework: guidelines for Victorian health services 2009**
<www2.health.vic.gov.au/about/populations/cald-health>

A summative evaluation of *Doing it with us not for us* and the Cultural responsiveness framework has recently been completed.


Commonwealth


My Aged Care website <www.myagedcare.gov.au>

National health reform agenda (including activity-based funding) <www.coag.gov.au/health_and_ageing>


Victorian Primary Health Networks Alliance <vphna.org.au/>
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Department of Health 2009, Paediatric chronic diseases transition framework, State Government of Western Australia, Perth.

Department of Health 2011, Chronic conditions self-management strategic framework, State Government of Western Australia, Perth.


National Institute for Health and Care Excellence (NICE) 2015, Older people with social care needs and multiple long-term conditions: NICE guideline, NICE, UK.


