



Summary of key points

Module One: Coordinated Veterans' Care – Is Your Service Ready?

Section One: Introducing the Chronic Care Model

- Many chronically ill patients are not receiving effective care, have poor management of their own care or are not happy with their care
- Primary care is often oriented toward acute care, which cannot meet the needs of patients with chronic conditions, multiple co-morbidities, complex needs and issues with long-term adherence
- The Chronic Care Model combines a mobilised community, systemised care across service providers, supported self-management, an evidence-based approach and clinical information systems to address these issues. It is both a model that guides service delivery and a toolkit for enhancing care
- The Chronic Care Model approach is particularly effective with veterans because of their often complex care needs, particularly those with multiple and complex conditions who are also elderly
- Supported self-management requires health services and the community to work together and support patients to help themselves
- The Chronic Care Model relies on core supports such as follow-up systems, team-based approaches to patient health, referral pathways and community resource links
- The Chronic Care Model is supported by a wide range of national policy initiatives such as Coordinated Veterans' Care (CVC) Program and the National Chronic Disease Strategy
- Evaluate your skill set in relation to the Chronic Care Model so you know exactly what your development needs are and how to meet them
- The Chronic Care Model approach is funded by a range of incentives from the MBS and DVA.

Section Two: The Health System

- Effective chronic condition care requires a shift from reactive care to a proactive approach that includes planned interactions aimed at preventing disease progression and maintaining health.
- Barriers to effective chronic condition management may be intrinsic to your service, such as a lack of resources to coordinate patient support services or limited use of the automated reminder system. Barriers can also be extrinsic such as the social determinants of health and their impact on the veteran's capacity to engage with service systems.
- Intrinsic to the Chronic Care Model is effective care coordination between providers of patient services and care. Care coordination aims to deliver high-quality referrals and transitions, this can only be achieved when the following conditions are achieved:
 - Patients are supported
 - Providers assume accountability for care and build and maintain relationships and agreements that lead to shared expectations for communication and care
 - Information transfer between providers and community agencies is timely and effective.

Section Three: Improving Quality of Chronic Condition Care

- Making improvements can be successfully managed if well planned and can improve outcomes for your patients, and generally produce positive results for you and those you work with
- The Model for Improvement provides a framework for developing, testing and implementing changes; it break down the change effort into small, manageable steps which are then tested to ensure that things are improving and that no effort is wasted
- Part 1 of The Model for Improvement provides a framework to identify your aims, measurements and change principles
- Part 2 of The Model for Improvement involves using the Plan, Do, Study, Act (PDSA) cycle of change which is designed to test and implement changes you think may lead to an improvement
- Implementing successful change requires thoughtful planning, a collaborative approach between all those who may be impacted by the proposed change, and adherence to a robust framework to monitor progress and effectiveness of the change.

Section Four: Chronic Condition Self-management Support

- Self- management support:
 - aims to empower patients in managing their own health and health care
 - is what health professionals, carers and the health system do to assist the patient to manage their health conditions. Self-management support emphasises the patient's central role in managing their own health
 - is facilitated by the health professional using self-management support strategies such as assessments, problem identification, goal setting, problem-solving, action planning, motivational interviewing and regular follow-up
- The person with chronic conditions is the expert of their experience of having chronic conditions and how it affects their day-to-day life. The health professionals have clinical expertise to share with the patient
- The patient's personal and community resources are mobilised by the health professional to provide ongoing support to patients
- All patients with chronic conditions make decisions and undertake behaviours that will affect their health for better or worse
- As a health professional, the self-management support you provide to veterans is about helping them to foster a sense of control over and responsibility about their own health, not telling them what to do. It is about acknowledging their central role in their own health care and working collaboratively and in partnership with them. Working together you will define problems, set priorities, make goals and action plans and problem solve as you go.

Section Five: Community Sector Support

- Chronically ill patients and their carers exist within a community that is rich with potential supports for you and your organisation in complimenting the provision of high quality care
- DVA provide a number of services and supports for DVA Gold Card holders
- Targeted use of community programs, organisations and supports can help avoid duplication of services and can support and expand the capacity of the health system (and your own practice) in caring for chronically ill veterans
- There are 6 broad strategies you can consider:
 1. Encourage participation in health/disease education classes and support groups

2. Contribute to raising community awareness through networking, outreach and education in collaboration with other service providers in your community
 3. Link to DVA resources
 4. Link to community resources for education resources and materials
 5. Establish links with organisations to access support programs and contribute to local and broader policies
 6. Provide a list of community resources to patients, families and staff
- Your Medicare Local/ Division of General Practice can help with developing a list of local contact organisations. They may already have useful information about chronic disease referral pathways and local services
 - Adopting a collaborative care approach incorporates the strong and clear leadership needed to avoid confusion and fragmentation among the many agencies that are often involved when a veteran has complex chronic care needs
 - Patient-held records completed at each health visit may be useful as a consultation record and communication tool for all providers and the patient, and educational material can also be added. It may be especially useful if integrated with the electronic medical record as a print-out or as a template for a post-visit summary
 - Patient-held records and self-management Care Plans are important ways of engaging patients in their own health care
 - Electronic secure messaging can also be a useful communication tool for care and support coordination
 - For rural and remote or isolated patients, access to videoconferencing or telephone support services can provide assistance if they are unable to attend regular in-person appointments
 - Living with a chronic condition can be isolating for patients. There are a number of community resources available for emotional support
 - By taking the time to actively link your patients with community sector resources as well as DVA resources, you are providing a high quality of care for your patient and ensuring that they receive the best support available.