Government of **Western Australia**
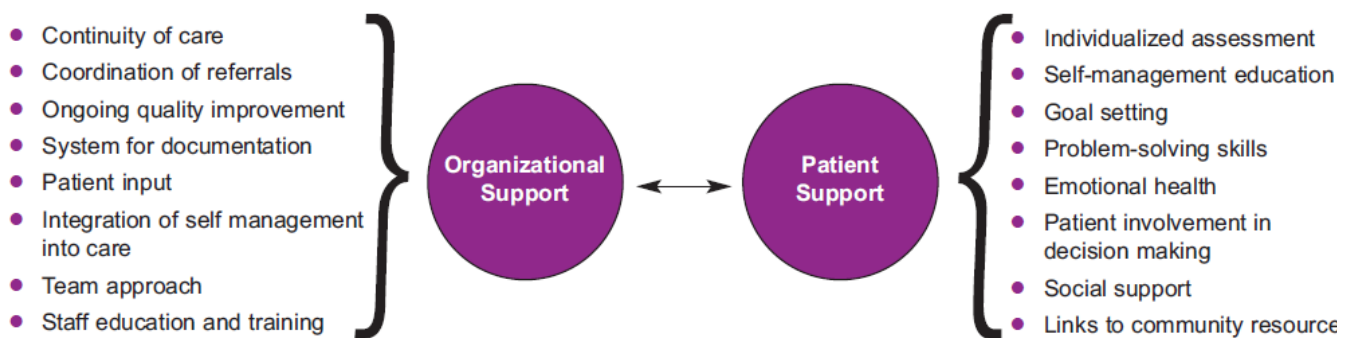Department of **Health**

Chronic Condition Self-Management

Clinical Care Resources and Support (CCRS) *
for Chronic Condition Self-Management

Summary of CCRS Assessment Categories

Assessment of Clinical Care Resources & Supports for Self-Management (CCRS)

- Continuity of care
- Coordination of referrals
- Ongoing quality improvement
- System for documentation
- Patient input
- Integration of self management into care
- Team approach
- Staff education and training

Organizational Support ↔ **Patient Support**

- Individualized assessment
- Self-management education
- Goal setting
- Problem-solving skills
- Emotional health
- Patient involvement in decision making
- Social support
- Links to community resource

Adapted from Joint Commission on Accreditation of Healthcare Organisations, 2007.

SECTION I. PATIENT SUPPORT

1. Individualised Assessment of patient self-management needs.
The process of determining patient-specific educational needs, barriers, skills, preferences, learning styles and resources for self-management.

2. Consumer Self-Management Education.
The interactive, collaborative and ongoing process of providing information and instruction to support people's ability to successfully manage their health conditions, their daily life activities and the emotional changes that often accompany having a chronic condition.

3. Goal-Setting / Action Planning.
The process of providers and consumers working together to identify something the consumer wants to accomplish and agreeing on a plan for getting started. Well formulated goals are "SMART" (Specific, Measurable, Action-oriented, Realistic, and Time-limited).

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*   Clinical Care Resources and Support (CCRS) for Chronic Condition Self-Management was adapted in March 2010 by the Royal College of Australia and New Zealand Psychiatrists (RANZCP) from the Primary Care Resources and Support (PCRS) tool. The PCRS was developed in March 2006 by the Diabetes Initiative with support from the Robert Wood Johnson Foundation in Princeton, New Jersey. Revised in December 2008. Washington University School of Medicine, St. Louis

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4. Problem-Solving Skills.
Skills consumers can learn and use to overcome barriers to healthy self-management. The process involves a series of steps:

- identifying the problem or barrier
- identifying possible solutions
- selecting and implementing the one that best suits
- evaluating the results and
- planning next steps accordingly.

5. Emotional Health.
Mental or emotional health generally refers to an individual's thoughts, feelings and moods. Good mental health can be defined as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." Difficult emotions may be a barrier to healthy self-management.

6. Consumer Involvement in Decision-making.
Patient involvement means that patients or consumers-- and their families--are involved in planning and making decisions about their health care. In this approach, consumers are viewed as key members of the health care team and have access to useful information to promote health and manage conditions. Consumer involvement implies shared decision-making about care and ensuring that the consumer's values guide all clinical decisions.

7. Consumer Social Support.
The assistance or help that is accessible to a consumer through their social ties to others including family, friends, neighbours and peers. Social support can take many forms such as emotional support, tangible assistance, information or helpful feedback.

8. Linking to Community Resources.
Community resources include programs, services, and environmental features that support self-management behaviours. Programs and services that support self-management may be available through community agencies, schools, faith-based organisations or places of work. Examples of environmental support include safe, accessible and affordable places for physical activity and for buying healthy foods.

SECTION II. ORGANISATIONAL SUPPORT

9. Continuity of Care.
This includes the coordination and smooth progression of a consumer's care over time and across disciplines. Continuity of care is supported by systems that use a team approach to care, schedule planned visits and follow up on visits and results.

10. Coordination of Referrals (to other care providers following discharge from your service).

This refers to the effective collaboration and communication among clinical care providers and specialists. Coordination of referrals is supported by systems that track referrals, monitor incomplete referrals, and ensure follow-up with patients and/or specialists to complete referrals.

11. Ongoing Quality Improvement (QI). ★

The process of using data on a regular basis to identify trends, undertake processes to improve aspects of service delivery, and measure the results. Health care teams can use the Plan, Do, Study, Act (PDSA) rapid cycle improvement process to facilitate the improvement process.

12. System for Documentation of Self-Management Support Services.

Standardised processes used by members of the health care team to record consumer self-management goals and progress notes into patient charts (or electronic medical records) and routinely monitor their progress.

13. Patient Input. ★

This is the ideas, suggestions and feedback from consumers about the services and quality of care provided by your team or health care setting. This occurs when there are systems or procedures in place to seek input thought such mechanisms as focus groups, surveys, suggestion boxes, or patient advisory committees.

14. Integration of Self-Management Support into Clinical Care.

Integration occurs when self-management support is a fundamental and routine part of all chronic condition care.

15. Patient Care Team (internal to the practice).

A patient care team is a multidisciplinary group (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioural health specialists, social workers, dieticians, community health workers or others) that works together to manage a consumer's health care.

16. Physician, Team and Staff Self- Management Education and Training. ★

Opportunities for members of the health care team to increase their knowledge and improve skills and practices for improving self-management support. Health care systems can support continuing education and training by setting an expectation for excellence, offering training to all team members, ensuring that new team members have access to orientation and training, assessing and monitoring performance and providing incentives for the adoption of new practices and skills.

Note: National Safety and Quality Health Standards (NSQHS) accreditation criteria 2.6.1 states:

'Clinical leaders, senior managers and the workforce access training on **patient-centred care and the engagement of individuals in their care.'** [i.e. self-management support]

★ Indicates mandatory National Safety and Quality Health Standards (NSQHS) from Standard 2: Partnering with Consumers.

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