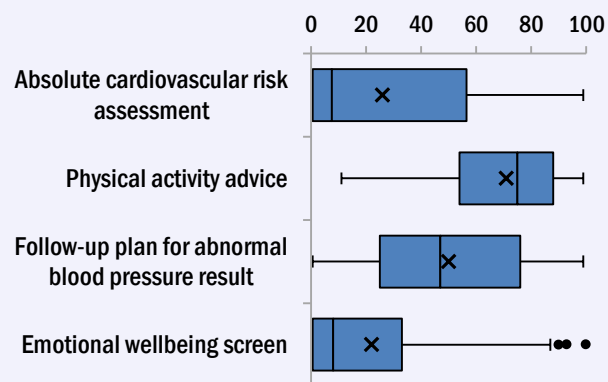


Chronic Illness (based on feedback from 200+ stakeholders)

1. Priority Evidence - Practice Gaps

Aggregate CQI data (2012 - 2013)
Percent delivery to eligible clients
(n=122 health centres; 3,680 clients; x = mean)



Delivery & recording of key aspects of care:

- risk factor measures & enquiry, in particular, absolute cardiovascular risk assessment, healthy weight indicators, tobacco use
- brief interventions & referrals, in particular, physical activity, smoking

Follow-up planning & action:

- for abnormal findings, in particular, blood pressure, total cholesterol & HbA1c levels (for T2D) – review / adjust medication & continue regular monitoring

Emotional wellbeing screening & support

Develop health centre systems:

- more effective links with community & organisational support for CQI systems

Other specific priorities:

- adherence to evidence-based current treatment guidelines in relation to use of specific medications for clients with chronic illness
- coverage of adult vaccinations, in particular for clients with CKD, CHD, hypertension

2. Barriers & Enablers

Staff recruitment & retention:

- lack of adequate staff numbers, particularly A&TSIHs & high turnover
- recruitment focused on applicants having acute/emergency background, limited skill mix with respect to chronic illness care
- use of short term contracts limits stability & places additional burden on permanent staff to continually provide orientation & training

Staff capability (training & development):

- more flexible professional development systems are required (eg inter-/ intra-organisational placements) due to limited time to undertake training outside clinics
- priority competency areas include patient centred care, working effectively in teams, principles of client self-management & principles of population health

Community capacity/engagement/mobilisation:

- inadequate staff skills/systems to connect with & build capacity of communities

Embedding CQI systems:

- managers insufficiently trained to support effective use of CQI tools

3. Strategies

Workforce:

- improve induction, training & mentoring programs to increase skills in chronic illness care
- modify roles & career pathways of A&TSIHs towards patient-centred comprehensive care focus
- introduce workforce measures as KPIs to encourage strategies & actions to improve stability of a qualified workforce (include consideration of adequate staff housing & flexible systems of professional development)
- build cultural capability of PHC staff to develop effective links with communities

Community development:

- invest in strengthening health literacy & community leadership for CQI
- increase community involvement in the development of service delivery frameworks

Health systems:

- develop a CQI culture & practice at all levels (including management) through training & collaborative working