

General Principles of Good Chronic Care

**INTEGRATED
MANAGEMENT OF
ADOLESCENT AND ADULT
ILLNESS**

*INTERIM GUIDELINES FOR
FIRST-LEVEL FACILITY HEALTH WORKERS*



World Health Organization



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GENERAL PRINCIPLES OF GOOD CHRONIC CARE

This is one of 4 IMAI modules relevant for HIV care:

- ❖ Acute Care (including opportunistic infections, when to suspect and test for HIV, prevention).
- ❖ Chronic HIV Care with ARV Therapy.
- ❖ General Principles of Good Chronic Care.
- ❖ Palliative Care: Symptom Management and End-of-Life Care.

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This module, General Principles of Good Chronic Care, was prepared by the IMAI team with special input from the Health Care for Chronic Conditions team, which is located within the Chronic Diseases and Health Promotion Department and the Noncommunicable Diseases and Mental Health Cluster.

This module is part of a larger strategy, the Integrated Management of Adolescent/Adult Illness (IMAI). IMAI extends the benefits of integrated essential care, which is already available for children and pregnant women, to the relatively neglected adolescent and adult groups using an integrated approach based on standardized guidelines. This integrated approach will assist health workers to identify and efficiently manage the most common health problems.

For more information about IMAI, please see <http://www.mayeticvillage.com/who-cds-imai> or contact imaimail@who.int.

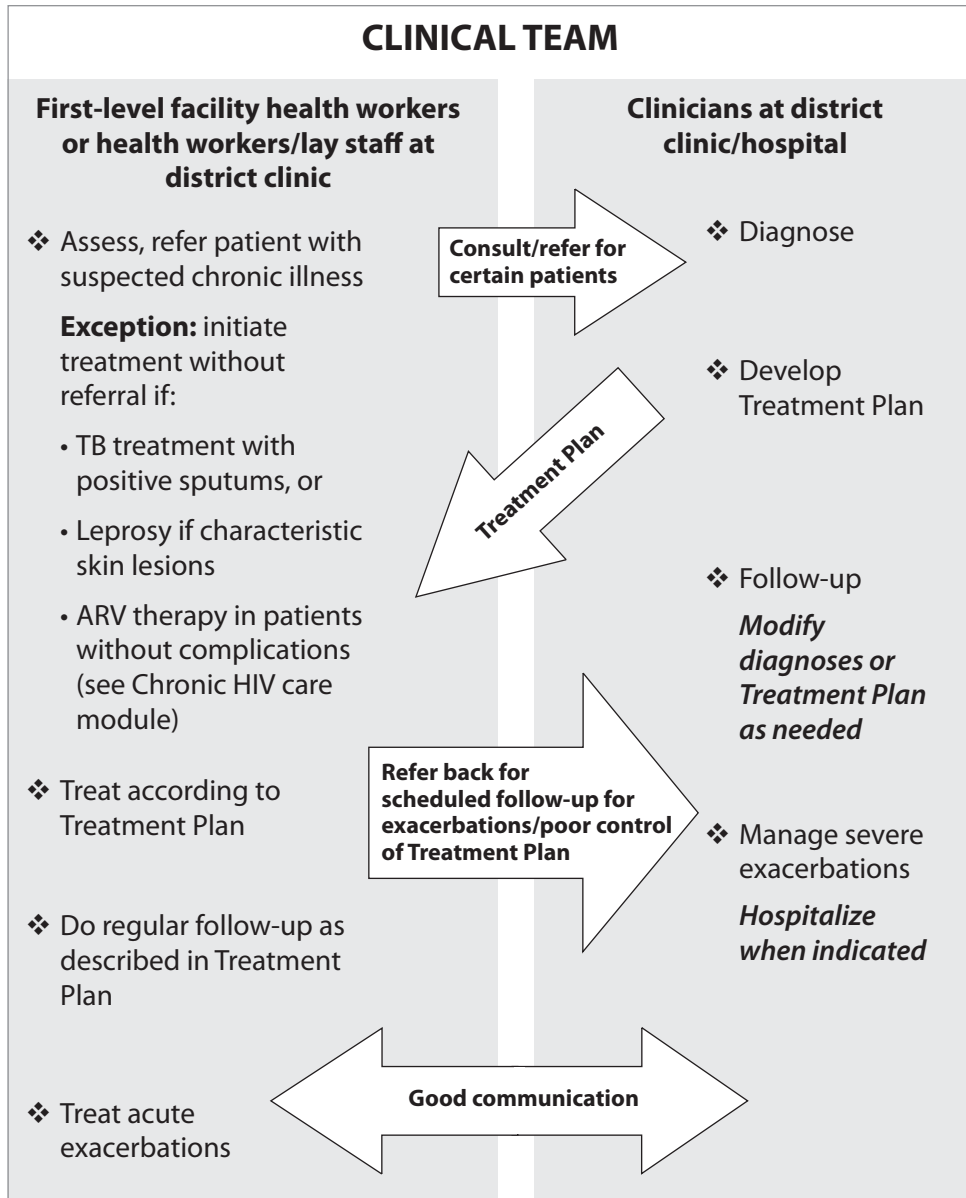
Please send your suggestions how to improve this module to: cch@who.int.

CHRONIC CARE

General Principles of Good Chronic Care

These general principles of good chronic care are relevant to the management of all chronic conditions and their risk factors.

Chronic care based at the primary-care facility near the patient's home



General Principles of Good Chronic Care

These principles can be used in managing many diseases and risk conditions.

1. Develop a treatment partnership with your patient.
2. Focus on your patient's concerns and priorities.
3. Use the 5 A's: Assess, Advise, Agree, Assist and Arrange.
4. Support patient self-management.
5. Organize proactive follow-up.
6. Involve "expert patients," peer educators and support staff in your health facility.
7. Link the patient to community-based resources and support.
8. Use written information—registers, Treatment Plan, treatment cards and written information for patients—to document, monitor and remind.
9. Work as a clinical team.
10. Assure continuity of care.



Coordinated Approach to Chronic Care

Community partners:

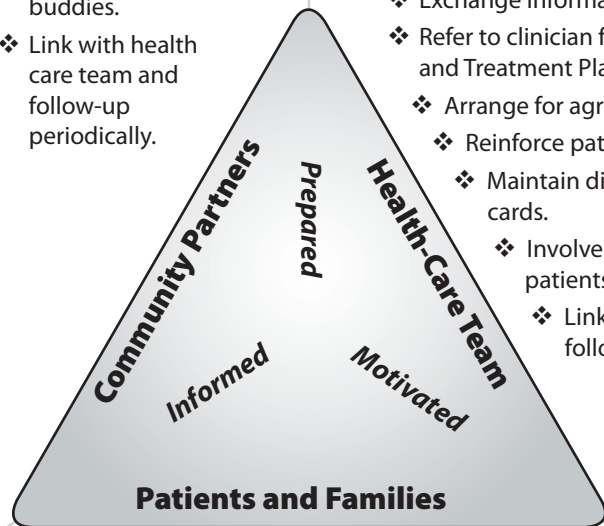
- ❖ Support patient goals and action plans.
- ❖ Provide care and support to patient and family.
- ❖ Provide resources to support patient self-management, including peer support groups.
- ❖ Function as treatment buddies.
- ❖ Link with health care team and follow-up periodically.

Clinicians at district clinic/hospital

- ❖ Perform in-depth assessment, diagnose
- ❖ Elicit patient's goals for care
- ❖ Collaboratively agree upon Treatment Plan
- ❖ Revise Treatment Plan as needed

Health workers at the first-level facility: (This could be a district clinic/peripheral health centre.)

- ❖ Elicit patient's concerns.
- ❖ Assess patient's clinical condition.
- ❖ Assess readiness to adopt indicated treatments.
- ❖ Exchange information about health risks.
- ❖ Refer to clinician for further diagnostic work and Treatment Plan, if indicated.
- ❖ Arrange for agreed follow-up.
- ❖ Reinforce patient's self-management efforts.
- ❖ Maintain disease registry and treatment cards.
- ❖ Involve peer educators/"expert patients".
- ❖ Link with community partners and follow up periodically.



Patients and families

- ❖ Present concerns.
- ❖ Discuss goals for care.
- ❖ Negotiate a plan of care with provider/team.
- ❖ Manage their condition(s).
- ❖ Self-monitor key symptoms and treatments.
- ❖ Return for follow-up according to agreed plan.

Steps to Guide the Chronic Care Consultation

Use the 5 A's at every patient consultation

INITIAL CONSULTATION

ASSESS

- ❖ Assess patient's goals for this consultation.
- ❖ Assess patient's clinical status, classify/identify relevant treatments and/or advise and counsel.
- ❖ Assess risk factors.
- ❖ Assess patient's knowledge, beliefs, concerns, and daily behaviours related to his/her chronic condition and its treatment.

ADVISE

- ❖ Use neutral and non-judgmental language.
- ❖ Correct any inaccurate knowledge (as assessed above) and complete gaps in the patient's understanding of his/her conditions and/or risk factors and their treatments.

If you are developing the Treatment Plan:

- Discuss the options (risk reduction and/or treatment) available to the patient.
- Discuss any proposed changes in the Treatment Plan, relating them to the patient's specific concerns (as assessed above).
- Evaluate the importance the patient gives to the indicated treatment.
- Evaluate the patient's confidence and readiness to adopt the indicated treatment.

Assess

"What would you like to address today?"

"What do you know about ____ (e.g., HIV/AIDS)?"

"Tell me about a typical day including your problem and what you are doing to manage it."

"Have you ever tried to ____ (e.g., change your diet)? What was it like?"

Advise

"I have some information about ____ . Would you like to hear it?"

"It has been shown that ____ (e.g., smoking) does great damage to your health. What do you think about that?"

"What questions do you have about what I just told you?"

AGREE

- ❖ Negotiate selection from the different options.
- ❖ Agree upon goals that reflect patient's priorities.
- ❖ Ensure that the negotiated goals are:
 - Clear.
 - Measurable.
 - Realistic.
 - Under the patient's direct control.
 - Limited in number.

ASSIST

- ❖ Provide a written or pictorial summary of the plan.
- ❖ Provide treatments.
- ❖ Provide medication (prescribe or dispense).
- ❖ Provide other medical treatments.
- ❖ Provide skills and tools to assist with self-management and adherence.
- ❖ Provide adherence equipment (e.g., pill box by day of week).
 - Self-monitoring tools (e.g., calendar or other ways to remind and record Treatment Plan).
- ❖ Address obstacles.
- ❖ Provide psychological support as needed.
 - Help patients to predict possible barriers to implementing the plan and to identify strategies to overcome them.
 - If patient is depressed, treat depression.
- ❖ Link to available support:
 - Friends, family.
 - Peer support groups.
 - Community services.
 - For certain treatments, treatment supporter or guardian.

ARRANGE

- ❖ Arrange follow-up to monitor treatment progress and to reinforce key messages.
- ❖ Schedule for group appointments or relevant support groups if available.
- ❖ Record what happened during the visit.

Agree

"Among the options we've discussed, what would you like to do?"
Followed by: "Okay. So as I understand it, we've agreed that you will _____. Is this correct?"

Assist

"What problems might arise when you follow this plan? How do you think you could handle that?"

"What questions do you have about the plan or how to follow it?"

"Could you explain back to me in your own words what you understand that the plan is?"

Arrange

"I would like to see you again (specify date if possible) to assess how you're doing. It's important that you come for this follow-up even if you're feeling well."

FOLLOW-UP VISIT

ASSESS

- ❖ Assess patient's goals for this consultation.
- ❖ Assess patient's clinical status.
- ❖ Assess risk factors.
- ❖ Compare assessment findings with those from previous examination and discuss with patient.
- ❖ Assess patient's understanding of the Treatment Plan.
- ❖ Assess patient's adherence to the Treatment Plan (by asking, counting pills, checking pharmacy records). If adherence problem, explore the reasons and obstacles to adherence (including depression).
- ❖ Acknowledge patient's efforts and successes with self-management, even if they are limited.

ADVISE

- ❖ Repeat key information concerning the patient's condition and its treatment.
- ❖ Reinforce what patient needs to know to self-manage:
 - Symptoms, when to change treatment or to seek care.
 - Treatment (why it is important; why adherence is necessary).
 - Problem-solving skills.
 - How to monitor one's own care.
 - How and where to seek support in the community.

AGREE

- ❖ Negotiate changes in the plan as needed (for some conditions, a revised Treatment Plan might require a return visit to the district clinician).

ASSIST

- ❖ Address problems or "slips" with the following Treatment Plan; teach patient how to solve problems and learn from them.
- ❖ Discuss problems that occurred in adherence and develop strategies to overcome them in the future.

ARRANGE

- ❖ Arrange follow-up to monitor treatment progress and to reinforce key messages. (These should be part of a programme of care over time.)
- ❖ Schedule for group appointments or relevant support groups, if available.
- ❖ Record what happened during the visit.

Assess

"To ensure we have the same understanding, could you tell me about the Treatment Plan in your own words?"

To assess adherence:

"Many people have trouble taking their medications regularly. What trouble are you having?"

TIPS

Tips for talking with the patient:

- ❖ Express understanding and acceptance.
- ❖ Avoid arguments.
- ❖ Respect the patient's right to choose.

Tips for involving "expert patients" on the clinical team:

- ❖ Choose patients who:
 - understand their disease well;
 - are good communicators;
 - are respected by other patients; and
 - have time to be involved on a regular basis.
- ❖ Ensure they understand and will respect shared confidentiality.
- ❖ Ensure they do not exceed their expertise or areas of responsibility.

Tips for group appointments:

Group appointments can help you make the most of scarce time.

- ❖ Use group appointments to:
 - educate patients about their conditions;
 - develop peer support and expertise;
 - promote self-management;
 - conduct clinical follow-up; and
 - address difficulties.
- ❖ Use peer educators or "expert patient" to help organize group appointments and to present educational material.

Tips for team meetings:

The purpose of team meetings is to communicate, to share efficiently patient information and Treatment Plans, and to share responsibility for all aspects of care and outcomes.

- ❖ Discuss only a subset of patients each week.
- ❖ The team leader should prepare weekly patient list and agenda.
- ❖ Develop among the team a consistent understanding of each patient's goals, the Treatment Plan and key messages to be delivered by the team members.

USE WRITTEN INFORMATION

Written information helps to:

- ❖ Remember the Treatment Plan.
- ❖ Monitor and evaluate progress.
- ❖ Remember when it's time for a follow-up appointment and facilitate response to missed appointments.
- ❖ Transfer pertinent information to others.
- ❖ Arrange for supportive care from community resources.

Written information for patients:

Written or pictorial information helps patients remember the plan and monitor their self-management.

- ❖ Provide patient with a written or pictorial summary of the plan to take home.
- ❖ Provide patients with self-monitoring tool such as a calendar or chart.
- ❖ Review patient self-monitoring tools at each follow-up visit.

Tips for keeping health facility records:

Complete registers by the end of each day.

- ❖ Keep Treatment Plans/cards in a file box, divided by date of the planned follow-up visit.
- ❖ Ensure that registers and cards are kept in a secure and confidential location.

GOOD COMMUNICATION

Communicating with clinicians at the district hospital/clinic:

- ❖ These clinicians are part of your clinical team. If you are in a peripheral facility, methods need to be developed for good communication and at least yearly meetings.
- ❖ Communicate with district hospital/clinic concerning all chronic patients, even when treatment is initiated at the first-level facility.
- ❖ Coordinate care with appropriate clinic/clinicians.
- ❖ Refer patients back to clinicians as appropriate.

