My Goals, My Guide

- Guided Care Model (GCM) in Chronic Disease Management Programs

Aim

This innovative model categorises clients according to ability to self-manage their condition. The categories provide a structured, multidisciplinary approach to care, within which clients participate in goal-setting. This project aimed to embed Guided Care into CDM service delivery and evaluate outcomes.

Methods

Study design: quasi-experimental. Setting: rural community health service. Participants: clients with diabetes and respiratory conditions enrolled in GCM. Process: care plans are completed for new clients to identify health goals. Baseline assessment includes scales from the Health Literacy Questionnaire (HLQ) and the health education impact Questionnaire (heiQ). Clients are categorised according to level of support needed to reach their goals; this determines multidisciplinary team input and follow-up frequency.

Outcomes: changes in the HLQ/heiQ and goal attainment at 6-months. Clinicians were interviewed to identify factors influencing uptake of GCM.

Results

Baseline data from n=162 clients shows 20% required a high level, and 57% a moderate level of self-management support. At 6-month review (n=50) significant increases in all HLQ/heiQ scales were seen. 68% reported achieving their goals. Clinicians viewed GCM as a holistic, client-centred approach. Challenges and enablers to its implementation were also identified.

Significance for Allied Health

The GCM supports clients to build self-management capacity and offers AHPs a structured approach to planning intervention that meets the client’s need. AHPs are better able to support person centred management by actively partnering with the client to understand where they are in their chronic disease journey.

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