WHITEHORSE DIVISION
OF GENERAL PRACTICE

Navigating self-management

A practical approach to implementation for Australian health care agencies

Authors: ***Naomi Kubina, Jill Kelly***

Editor: ***Fiona Symington***

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WHITEHORSE DIVISION
OF GENERAL PRACTICE

With the assistance of the Australian Government Department of Health and Ageing

Good Life
CLUB
SELF-MANAGEMENT FOR A GOOD LIFE
A Sharing Health Care Project

Winner of the Prime Minister's Award
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Victorian Medium Business

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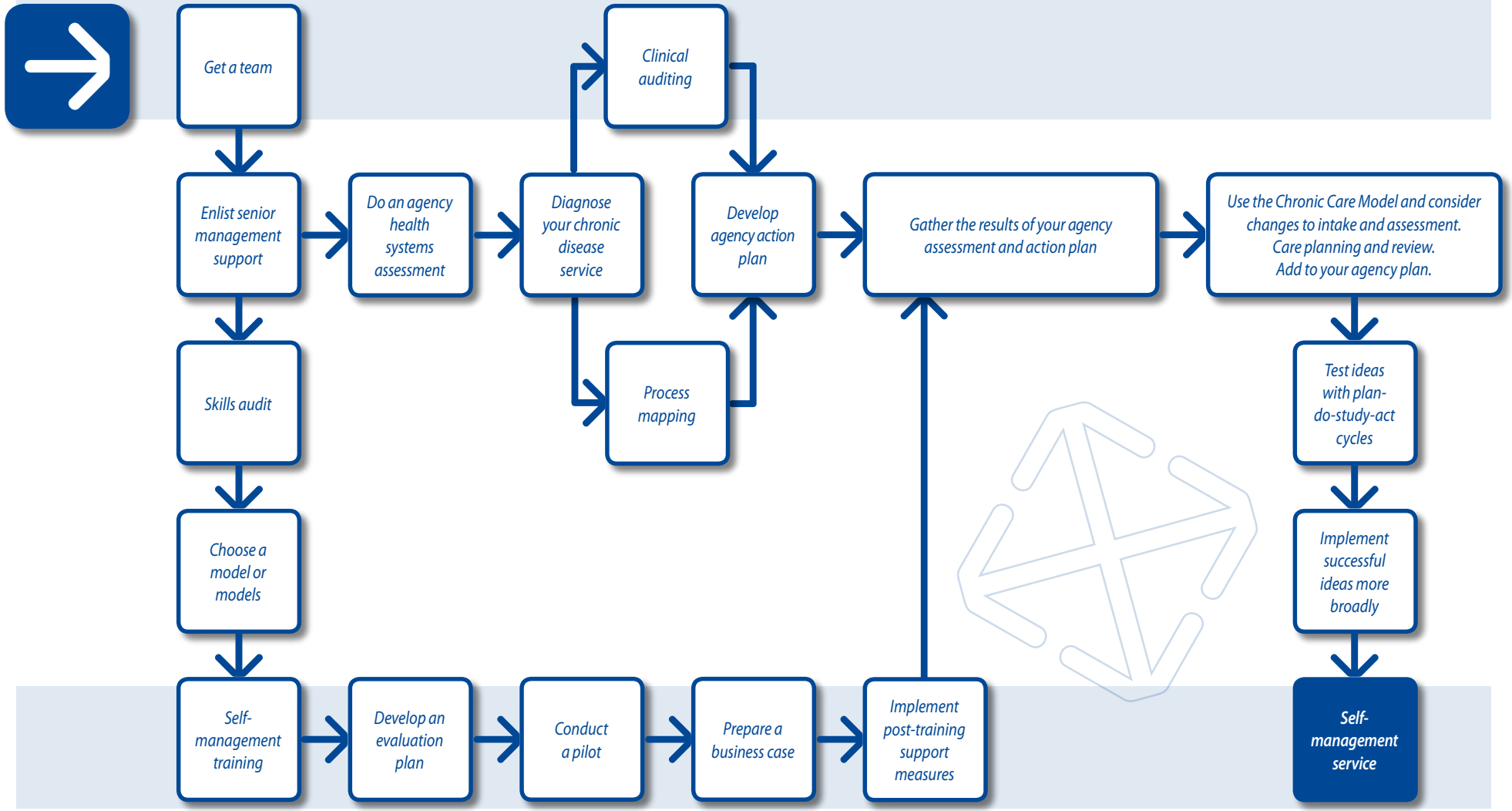
Navigation chart : Your road map to self-management



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Contributors

Authors

Naomi Kubina *is the project manager of the Central Bayside Community Health Service Early Intervention in Chronic Disease Program, where she is leading an organisational approach to self-management. Naomi is an accreditated trainer in the Flinders University model of Chronic Condition Self-Management and has a Graduate Diploma in Health Self-Management. Through her consultancy, Healthly Active Partners, she has worked extensively with agencies to implement self-management. Her expertise is in chronic disease and implementing a systems wide approach to its management within the health sector. She originally trained as a accredited practising dietitian.*

Jill Kelly *is the project manager of the Good Life Club in Melbourne (a Sharing Health Care Initiative funded by the Commonwealth Department of Health and Ageing). The project is based at the Whitehorse Division of General Practice. It was originally a three year demonstration project on chronic disease self-management, followed by a two year transition program to embed chronic disease self-management into practice. She has worked as a project officer within Divisions of General Practice for the last eleven years, managing a range of projects such as healthy ageing, general practice accreditation, health promotion. She currently works with health agencies to promote the local integration of health services. Prior to working in Divisions, she worked as a case manager with work-injured people and her professional background is nursing. Jill has a Graduate Diploma in Management and her interest is in change management.*

Editor

Fiona Symington *worked in public health for seven years specialising in change management and health reform. Before leaving Australia, she was the project manager of the WestBay Alliance HARP Diabetes Project. Adapting the work of Improving Chronic Illness Care to an Australian context, this project undertook comprehensive systems redesign to change how diabetes services were provided to people living in the western suburbs of Melbourne. The impact of this work continues in the west and many of the tools developed by this project have been adopted elsewhere. Fiona currently lives in London where she works as a freelance writer and editor and a communications specialist for a global leadership.*

Contributing Authors

Roy Batterham *is one of the two partners of Plexus Consulting. Roy began his career as a physiotherapist with nine years in clinical and management positions followed by six years as a Research Fellow and Senior Research Fellow at the Centre for Health Program Evaluation, a joint Centre of Melbourne and Monash Universities. He completed many research projects while at the Centre, and taught evaluation theory and methods in graduate and masters level courses at five Victorian Universities and in the Commonwealth Master of Public Health Program. As an independent consultant and as a partner in Plexus Consulting, Roy has undertaken numerous evaluations and other research, project development and strategic planning activities. Roy has high level expertise in designing and conducting evaluations for complex programs, in consultative procedures, and in clarifying and assessing program assumptions. Roy is also an expert in educational design and the evaluation of education and training programs.*

Janette Gale *is a clinical health psychologist and founder of Health Coaching Australia. In her private practice she specialises in health coaching for weight management, healthy lifestyle change and the management of chronic health conditions such as obesity, diabetes and cardiovascular disease. Janette has designed and facilitated a number of innovative community-based, Government and industry funded health promotion and education programs targeting lifestyle change for families and adults. These programs all contain health coaching elements. Janette co-developed Australia's first health coaching course for health practitioners at Deakin University. She currently trains medical and health professionals in health coaching techniques through Health Coaching Australia. She is a committee member on the National Executive of the Australian Psychological Society, College of Health Psychologists.*

Dr Margarite Vale

Dr Margarite Vale is clinical associate professor in the Department of Medicine at The University of Melbourne and is the Founder and Director of The COACH Program. She pioneered the development of The COACH Program in association with Associate Professor Michael Jelinek and Professor James Best. Dr Vale has won international recognition for her work with a Young Investigator Award at the 5th International Conference of Preventive Cardiology in Japan in 2001, the Ralph Reader Prize (Young Investigator Award) for Clinical Science at the 2002 Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand at the XIVth World Congress of Cardiology in Sydney in 2002, a Victorian Premier's Commendation for Medical Research in 2003, a high commendation in the 2005 Victorian Public Healthcare Awards and the 2006 Australian Healthcare Association Baxter Healthcare National Innovation Award for Heath Outcomes. Her ambition is to see The COACH Program permanently embedded in the health care system both in Australia and internationally in both the public and the private sector.

Acknowledgements

Jim Killen, Ruth Azzopardi, Dianne Berryman	*Whitehorse Community Health Service*
Jonathan Pietsch	*Hospital Admission Risk Program (HARP), Eastern Health*
Marianne Shearer, Leigh Barnetby, Pip Bourke	*Whitehorse Division of General Practice*
Dr Malcolm Battersby	*Flinders University*

Foreword

I am privileged to be writing the foreword to this manual because it is at the cutting edge of the implementation of self-management in chronic disease care. As this manual shows, it is equally applicable to the preventive health area because self-management is required for people to address the first stage of chronic illness, that of changing their health risk behaviours.

It is only now that such a manual could be written. It is one of the many outcomes there are from the initiatives that started with the health care reform program, going back to the Coordinated Care Trials in 1996. These were followed by the Sharing Health Care Program Initiative and the most recent embedding of the lessons learned from these programs in the changes to the MBS item numbers to support care planning, monitoring and preventative care under the Australian Better Health Initiative.

Naomi Kubina and Jill Kelly are two practitioners who have been working in this area throughout this time and it is from their experience of working with people, agencies and health services that this manual has become possible. Their experience in working within a health system beleaguered by demand, complex and divided and resistant to change has led them to write this manual. The manual provides a very practical approach for agencies or services (small or large) to embrace a focus on self-management for all people so that genuine partnerships result between practitioners and people aspiring to better health outcomes. This manual is a "how to do it" approach that can be followed step by step.

At the same time there have been significant changes in the way that clinical management is provided. The focus on person-centred care, evidence based care, and the development of best practice guidelines and notions of "the expert patient" have combined with the MBS funding changes for care planning, case conferencing, team care and the provision of allied health care. This provides the potential for more integrated, proactive and integrated care with better health outcomes and the provision of more and better management in the community. These changes can all be facilitated by the reorientation of services to better self-management as outlined in this manual.

There also been a need to provide a framework for behavioural change strategies for people, so that behaviour change with better compliance and adherence to medication use and risk factor reduction can occur. This has seen the advent of "the Flinder's Model", based on cognitive-behavioural therapy that has been applied to health behaviour change. This model makes it possible for people to change successfully and to maintain these changes.

Practitioners and services also need to change if integrated and preventive chronic disease care is to occur and self management is to be supported. The challenge for agencies is to reorientate services to a preventive care model. In so doing there has to be a shift of focus from consumer demand driven services to prevention, planning, self-management and follow up. Teamwork, partnerships with people and carers, integration of data sets and communication across agency and other boundaries become more important. A reorientation of throughput to outcomes becomes necessary for all involved. Funding mechanisms and policy need to support such an evolution of services.

This manual is one that all agencies involved in the care of people across the life cycle of chronic illness should use to reorientate the agency to the preventive, self management approach that is so much needed. It is practical, useful and incorporates many ideas, scales, forms and helpful ways of proceeding.

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November 2007

Introduction

How to read this manual

This manual is a practical guide to the implementation of self-management in your agency. Throughout this manual we provide you with an outline of the journey you will be taking to embed self-management in your agency. It is a summary of five guides and outlines a road map of how to get there. Firstly we give you an overview of best practice chronic disease care, of which self-management is an element. This will introduce you to the Chronic Care Model.

Our second guide describes how to change clinical practice. We recommend you start here as this will provide you with a vision for your work and help you understand how your agency works. At the conclusion of this guide, we introduce you to an improvement model for how to get practice change off the ground. It is a model that not only offers a solution that works but also builds a team in a way that is fun and inspiring.

Our third guide shows you how to implement self-management. We give you a ten step guide on how to get started. We then show you how to select a self-management model from the popular self-management approaches available to us. We talk about starting the self-management journey and implementing the self-management models you have selected. The popular self-management approaches are then described in greater detail, each with their own steps for implementation.

Our fourth guide addresses leadership. No practice change can succeed without it. We specifically address the role leaders need to play and why it is so important. We describe the elements of effective leadership and show you how to foster it within your agency. The guide also illustrates the common tensions between current health care funding and self-management and how leadership can be used to overcome them.

Our fifth guide assists you to develop an evaluation plan to assess the outcomes of your self-management service.

Our sixth guide is for general practice. How general practices are funded and operate has an impact on how self-management can be implemented. Our focus is to show practices that self-management not only can be done but is a viable and beneficial alternative to current practice.

Self-management is one of the most powerful resources we have in health care. It is fundamental to assisting people better manage their health and live fuller, healthier lives and yet it is one of the least utilised approaches to chronic disease.

Self-management changes how we work as health professionals. It is an approach that enables people, sometimes for the first time, to play an active role in their care. For us, it means shifting our role from clinical expert to one of coach.

So how does the role of coach differ to what we do now? Is consumer education really that different?

Education works on the premise that improving a person's knowledge will result in health behaviour change. Unfortunately for all our efforts, this approach isn't particularly successful. Self-management on the other hand is based on improving a person's self-efficacy or self-confidence. Increased self-confidence is far more effective in leading to behaviour change and improving a person's sense of well-being.

Improving a person's self-confidence requires different skills to those we received during our training and probably in any professional development we have undertaken since.

And yet another challenge remains. So, how do we implement self-management into routine practice? Is it enough to do more training?

We have seen many agencies go down this path of investing substantial resources in training with little to show six months later. The training has been done but practice remains unchanged.

Self-management requires additional time and resources. A conversation exploring people's barriers to changing health behaviours cannot be had in five minutes. Nor can it be added to the end of a clinical consultation. As agencies, we need to re-consider how resources are allocated to ensure teams are supported to invest in effective self-management.

Finally, self-management requires a planned approach. This is the simple question of who will do what, when and how. We need mechanisms in place to ensure routine prevention, screening and sustained follow-up. We also need to talk about roles and responsibilities within our team and how our workloads will be divided.

So, how do we translate all of this into daily practice? →

This manual outlines a method for implementing self-management and changing clinical practice. It is based on our experience of working with agencies as well as literature on this subject. The approaches we describe in this manual have been tested all over the world and have been shown to be enormously successful in changing practice and enhancing self-management support.

What's so different about this manual?

This manual differs in its approach to most. We have based the content and description on our experiences of working with agencies.

We have seen the challenges of implementing this work, the wins of seeing real change, and the pitfalls that agencies often make when pursuing self-management. We describe these in the manual and offer practical solutions that if implemented are guaranteed to work.

This manual is not written from an expert approach. You will not find theoretical frameworks for self-management or changing practice. Nor will you find pages of research material. Rather we talk about self-management in the context of best practice and how to implement it as routine business. To do this, we talk from our real on the ground experience of doing this work. We describe the problems agencies have encountered and what they have said.

Much of what we have seen formed the idea for *Navigating self-management*. Too often we have seen self-management implemented as another program only to perpetuate the silos that already exist within health care.

Our aim in this manual is to show agencies how to take self-management and truly embed it into practice, where it is not the responsibility of a few health professionals but routine practice for all.

Getting started

Three things must be discussed before we go any further. These are teams, leadership and chronic disease care.

Let's start with teams or more specifically your team. Your first step is to form a team. Self-management cannot be implemented by individuals. The work is too broad and you will need support. Your team will be your driving force and the catalyst for change. Your team will be made up of people who share a common vision of self-management and chronic disease care and a commitment to that vision.

We talk a lot about teams in this manual - how to create an effective team, who should be included and the common pitfalls when forming a team. In the planner at the beginning of each guide, you will find some tips on the appropriate team for each activity.

Leadership is a key facilitator to practice change. Leadership will drive and motivate your team for change. Without leadership, the practice change we describe will go no further than initial training. We have seen lots of agencies falter half-way through a change initiative. The barriers become overwhelming, frustrations rise and changing practice seems too hard.

So, who is the best person to lead?

We offer no answer to this question as it is very agency specific. What we can say is that a leader will create momentum, inspire and engage people. He/ she will be people-orientated, have the respect of others and be a good communicator. Importantly, a leader will champion your work, get support and drive work forward, negotiating any obstacles or barriers.

Perhaps the more interesting question is what agency support is required to make change happen. A leader whether it is a health professional or manager needs to be supported by senior management, administration, support and technical staff. Self-management will impact on how your agency organises and delivers care.

Finally, we need to discuss best practice chronic disease care. Although vital, self-management makes up one only element of best practice disease care. Self-management cannot exist without the systems redesign work we describe.

In this manual, we look at the Improving Chronic Illness Care (ICIC) Chronic Care Model that identifies the six elements of best practice chronic disease care. This model outlines a system of care that we believe is fundamental to self-management. You will find a separate guide on this model.

And finally

We would like to thank all the agencies that we have worked with, especially for their honesty in talking about their successes and the challenges they have faced. We have found self-management to be an enriching professional experience that significantly changes people's lives.

Good luck with your journey and tell us about the results.

WHITEHORSE DIVISION OF GENERAL PRACTICE

Navigating self-management

A practical approach to implementation for Australian health care agencies

1 The Chronic Care Model

Authors: *Naomi Kubina, Jill Kelly*

Editor: *Fiona Symington*

This resource was funded by the Australian Government Department of Health and Ageing.

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Introduction

How to read this guide

This guide is intended as a very simple introduction to the Chronic Care Model and each of its elements. We do not provide a guide on how to implement it. We leave this to the authors of the model.

Our introduction is a general overview. There have been many papers written and studies undertaken of this model. We have listed them in the resource session at the end of this guide. We also encourage you to go to the ICIC web site to access their tools.

One of the most innovative and exciting models of chronic disease care today is the Improving Chronic Illness Care's (ICIC) Chronic Care Model. It is an approach to redesigning health care that takes us beyond clinical care to how we organise our agencies and engage our communities.

The work of Improving Chronic Illness Care sets a clear agenda for how we need to move forward to improve care for people living with a chronic disease. The approach is daunting in its clarity and demands. It requires a reassessment on how we provide care and a willingness to question what we do and presume to be best practice.

For agencies who have adopted this approach, both in Australia and elsewhere, the results have been very positive. Not only have these agencies reported improved clinical outcomes for people but all have spoken of the rewards for them as health professionals and managers.

Redesigning care is an opportunity for us to proactively define how care should be delivered and how we want to work with our communities.

It is an opportunity to not only think about disease guidelines and clinical best practice but the support we need to achieve the work that is important to us and those living with chronic diseases. What information systems do we need? How should intake work? How do we want to work as a team? What support do we need from our managers? What tools do we need to help people on their chronic disease journey? The Chronic Care Model provides us with a framework to identify all the elements that make up a chronic disease care service.

We start here with the Chronic Care Model because without this critical road map we will only achieve ad hoc results. Silos within health care are entrenched. To think beyond them, we need to step outside them. The Chronic Care Model gives us a map of the bigger picture that goes beyond our role as individual health professionals to population health and the changing needs of our communities and the impact of chronic disease upon them.

The Chronic Care Model

The Chronic Care Model was first developed by staff at the MacColl Institute for Healthcare Innovation in the United States based on available literature about chronic disease management. The model was then refined during a nine-month planning project supported by The Robert Wood Johnson Foundation. The model has been tested nationally across different health care settings, creating the national program, Improving Chronic Illness Care (ICIC).

The Chronic Care Model identifies six critical elements to deliver best practice chronic disease care. It combines the principles of health promotion and community engagement with evidence based guidelines, decision tools for health professionals and self-management support for people and their families.

The six elements of the Chronic Care Model are:

1. Community

The model begins with community, a starting-point that would appear contrary to our own intuitive focus on health services. The inclusion and focus on community reminds us that the health system alone is incapable of addressing the impact of chronic disease for people, their family and environment.

The purpose of this element is to encourage people to become involved in their community and to be linked to community groups and agencies. The role of health care is to develop partnerships with these agencies to better understand the needs of its communities and also to find solutions to the current gaps within existing health services.

The thinking behind this element is very clear. The delivery of chronic disease care should not be viewed as a health care problem but as a community issue where providers of care are not simply health professionals, general practitioners and medical specialists. Support agencies such as Diabetes Australia, National Heart Foundation and ethnic groups are key players in how chronic disease is managed. Such partnerships can then provide the platform in which to advocate for improved care and services.

2. The organisation of health care

The role of agency leaders is clearly defined in this element. Senior managers must support, drive and foster a culture of quality improvement if work to improve chronic disease care is to be successful. There must be a real commitment to improving care and this will be reflected in all strategic and operational planning and policies. Openness and trust will be encouraged. The barriers that inevitably arise when change is placed on the agenda must also be addressed by senior management.

The health system as described is not limited to the activities of individual agencies but how agencies work together locally and regionally. Agreements need to be put in place and partnerships developed that will ensure that care is appropriately coordinated and information is shared between agencies. In this model, great responsibility is given to senior management, whose role is to support and foster quality improvement. Such roles demand a real commitment to change that goes beyond rhetoric to making things happen.

3. Self-management

Self-management follows and emphasises a person-centred model of care through the integration of self-management tools and programs into routine care and practice. This element of the Chronic Care Model is about how we empower people to take control of their management and improve their confidence to manage. Effective self-management will include an assessment of a person's self-management capacity. Goal setting, action planning and problem solving skills will be used to promote behaviour change.

4. Delivery system design

Delivery system design is how we provide proactive care beginning with the chronic disease care team. How should the team work? What are the different roles that team members will need to fulfil? What services should we be providing and when?

Central to delivery system design is care coordination and how services will be planned to meet a person's needs. Cultural and language issues are clearly flagged in this element as is the use of consistent follow-up and planned interactions.

5. Decision support

Decision support includes guidelines, prompts and any tools that will assist health professionals provide the best quality care. The aim of decision support tools is to ensure a consistency of care regardless of where and when a person accesses health care. We talk more about these two elements in our two guides *Changing clinical practice* and *Implementing self-management*.

6. Clinical information systems

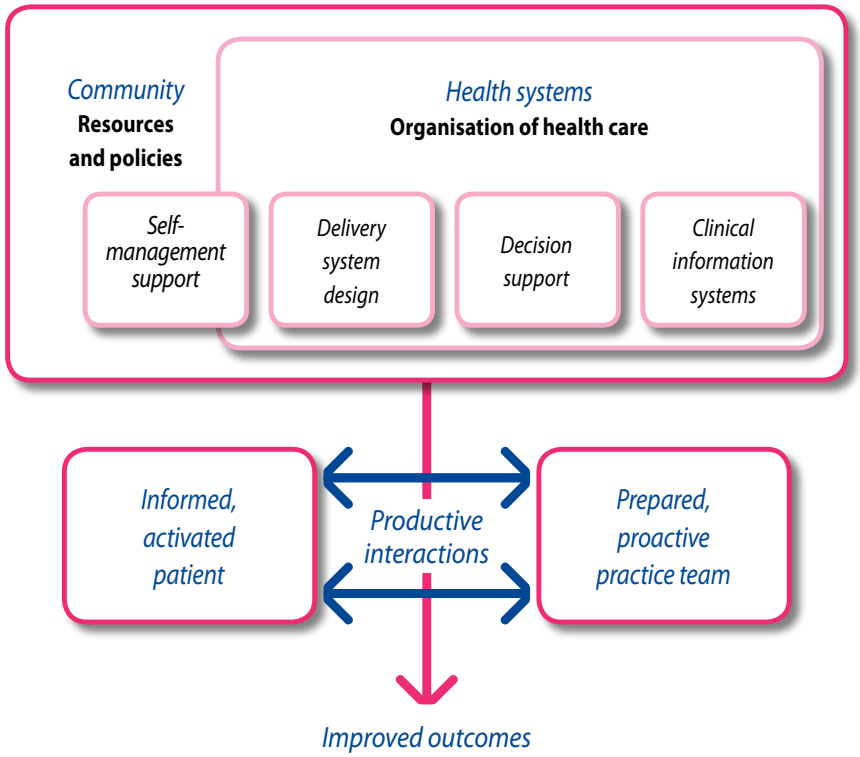
Clinical information systems complete the model. Disease registries, recall and review systems, clinical data: all enable the planned management of populations and individuals.

Supporting each of these elements is what the ICIC has identified as proactive interactions. These interactions can only be achieved by prepared and proactive health care teams and informed, empowered people who are active and ready to participate in their care. →

Informed and empowered people are those with the motivation, information, skills and confidence to make effective decisions about their health. Prepared proactive teams are those that have the information and knowledge about the best science and resources to deliver high quality care.

This is the way forward for how we redesign our chronic disease care services and the systems of care that we work within.

The Chronic Care Model



Developed by The MacColl Institute ©

The Chronic Care Model was developed by Group Health's MacColl Institute for Healthcare Innovation, which is supported by The Robert Wood Johnson Foundation.

The six elements of the Chronic Care Model

Element		Description	Principles for redesigning care	Examples of embedding the principles
1	**Self-management support:** Empower and prepare people to manage their health and health care.	Effective self-management is very different from giving people instruction. Rather it acknowledges the central role people have in determining their care, and fosters in people a sense of responsibility for their own health.	• Emphasise the person's central role in managing their health • Use effective self-management strategies including assessment, goal setting, problem solving and follow-up • Organise internal and community resources for self-management	• Describe the person's role in managing their health at each consultation • Teach people how to use problem solving and goal setting for issues that concern them • Determine the roles of the team to carry out self-management support and provide ongoing training
2	**Delivery system design:** Assure the delivery of effective, efficient clinical care and self-management.	The delivery of chronic disease care requires us to determine what care is needed, and matching roles and tasks to ensure the person gets the care they need. All team members will need centralised, up-to-date information about each person and make follow-up a part of standard procedure.	• Define roles and distribute tasks among team members • Use planned care that supports evidence-based guidelines • Provide clinical case management services for people with complex needs • Ensure regular follow-up • Give care that people understand and is culturally relevant	• Determine processes for care and assign team members to tasks • Organise planned visits to review current status, deliver evidence-based services and optimise disease management • Develop selection criteria, procedures and services for people with more complex needs • Develop a process for follow-up
3	**Decision support:** Promote clinical care that is consistent with scientific evidence and people's preferences.	Treatment decisions need to be based on proven guidelines. Health care agencies need to integrate guidelines into the day-to-day practice of health professionals in an accessible and easy-to-use manner.	• Embed evidence-based guidelines into daily clinical practice • Integrate specialist expertise and primary care • Provide education to health professionals using methods that are successful in achieving practice change • Share evidence-based guidelines and information with people	• Complete a risk assessment prior to visit • Use checklists based on evidence-based guidelines to aid appropriate referrals and monitoring • Use protocols and standing orders to guide treatment and assessment. • Develop a communication tool for referral to specialist care • Use case studies and problem solving exercises for health professional education • Use the Internet to discuss guidelines with people and what it means to them →

The six elements of the Chronic Care Model *(continued)*

Element		Description	Principles for redesigning care	Examples of embedding the principles
4	**Clinical information system:** Organise individual and population data to facilitate efficient and effective care.	A registry is an information system that can track individuals as well as populations of people. It is a necessity when managing chronic illness or preventive care.	• Build in reminders for appointments, tests and self-management for providers and people • Identify relevant subpopulations for proactive care • Facilitate individual care planning • Share information with people and providers to coordinate care • Monitor performance of the team and care system	• Establish a database that contains information to prompt guideline-based care at the time of service • Designate a team member to routinely review sub-populations of people, for example, those with heart failure that smoke • Provide graphs to people of clinical data and develop a care plan with clinical and self-management goals • Develop improvement goals and measurements. Provide feedback to the team
5	**Health care organisation:** Create a culture, organisation and mechanism that promotes safe, high quality care.	Health care systems need to create an environment in which organised efforts to improve the care of people with chronic disease takes hold and flourishes.	• Visibly support improvement at all levels of the organisation, beginning with the senior leader • Promote effective improvement strategies aimed at system change • Encourage open and systematic handling of quality problems • Provide incentives based on quality of care • Facilitate coordinated care within and across agencies	• Incorporate quality into the business plan, mission statement and budget • Regularly review the quality of clinical care according to guidelines • Use an improvement model to continuously improve the system • Create a process for reporting quality problems and reward teams for reaching quality goals • Promote multi-disciplinary teamwork in the care of people
6	**Community resources and policies:** Mobilise community resources to meet the needs of people.	To improve the health of the population, health care agencies need to reach out and form powerful alliances and partnerships with state programs, local agencies, schools, faith organisations, businesses, and clubs.	• Encourage people to participate in effective community programs • Form partnerships with community agencies to support and develop interventions that fill gaps in needed services • Advocate for government policies to improve care	• Make a resource guide of community services and provide it to people • Link people to community services and track outcomes with health programs • Invite community programs to participate in care and redesign efforts • Work with community groups to change policy →

Next steps

We recommend that you select your improvement team and enlist senior management support. Then go to our first guide on *Changing clinical practice* and undertake a health systems assessment. This will enable your team to assess how care is currently provided and highlight areas that need to be improved to support self-management.

Once you have done a health systems assessment, you can then develop strategies through an agency action plan.

Resources

The Chronic Care Model and its use in practice

Improving Chronic Illness Care has produced a number of resources on clinical practice change that will assist you to implement elements of the Chronic Care Model.
Go to <http://www.improvingchroniccare.org/index.php?p=Clinical_Practice_Change&s=3>

The Health Disparities Collaboratives has produced a useful resource on changing and improving diabetes care using the ICIC Chronic Care Model and the Model for Improvement. This document can be found on their web site <http://www.healthdisparities.net/hdc/html/home.aspx>. Click on library, then collaborative processes. It is the diabetes training manual from April 2002.

Better Health Care in Gippsland has developed a resource kit on how to embed the elements of the ICIC Chronic Care Model. This manual can be located on the Victorian Department of Human Services website at <http;//www.health.vic.gov.au/communityhealth/cdm>.

Benefits of prevention and gaps between evidence and practice

UK Prospective Study Group, 1998, 'Cost Effectiveness Analysis of Improved Blood Pressure Control in Hypertensive Patients with Type 2 Diabetes: UKPDS 40', *British Medical Journal,* vol. 317, pp. 720-726.

Institute of Medicine 1999, *Ensuring Quality Cancer Care*, National Academy Press Washington.

The National Institute of Clinical Studies has produced a two-volume report on the gaps between evidence and practice for a range of conditions. Go to <http://www.nhmrc.gov.au/nics/asp/index.asp> Click on the Materials and Resources link. Under the 'By type' link you will find the report in *Evidence uptake guides*.

Ireland, P,& Hannagan, M, 2003, *Evidence-Practice Gaps Report*, National Institute of Clinical Studies, Melbourne, Australia.

Balas, EA & Boren, S.A 2000, *Managing Clinical Knowledge for Health Care Improvement. Yearbook of Medical Informatics*, National Library of Medicine, Bethesda, MD, pp. 65_70.

Cabana, MD, Rand, CS & Powe, NS, 1999, 'Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement', *The Journal of the American Medical Association,* vol. 282, no. 15, pp. 1458_65.

Institute of Medicine 2001, Crossing the Quality Chasm: A new health system for the 21st century, Committee on the Quality of Healthcare in America, National Academy Press, Washington DC. This well-known report on American health care can be found and read online. Go to the reports link on <http://www.iom.edu> and find it under the 2001 section.

Evidence for the Chronic Care Model

Improving Chronic Illness Care has produced numerous articles supporting the implementation of the elements of the Chronic Care Model. Go to <http://www.improvingchroniccare.org>

Renders, CM. Valk, GD, Griffin, SJ, Wagner, EH, Van Eijk, JT & Assendelft, WJ 2001, 'Interventions to Improve the Management of Diabetes in Primary Care, Outpatient and Community Settings: A Systematic Review', *Diabetes Care,* vol. 24, pp. 1821-33

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2 Changing clinical practice

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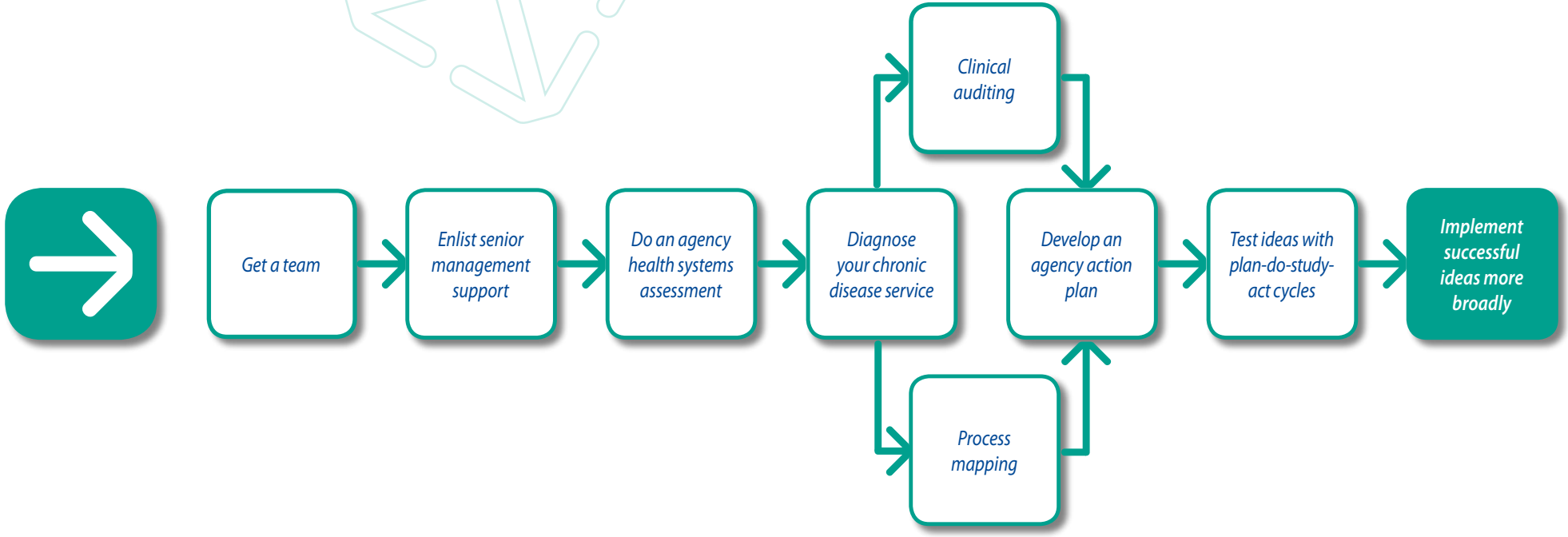
Navigation chart : Your road map to changing clinical practice



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Introduction

How to read this guide

This guide provides you with a step-by-step approach to changing clinical practice. We have organised this guide in the order we recommend you implement these changes. Our approach is based on our experience of working with agencies and the literature available on this topic. Each step will give you additional learning and skills that will build momentum for change.

The guide starts with the big picture and will help you to establish your vision as a team for your chronic disease care service. This step asks you to complete a health systems assessment, which examines your capacity to provide high quality chronic disease care.

We provide you with three different tools, any of which can be used to undertake the assessment. Each can be downloaded or obtained free of charge.

The next stage is to develop an agency action plan, in response to the identified improvement areas from your assessment. We provide you with a guide on how to develop an action plan as well as a template for you to complete as a team.

Next it is time to test and implement your action plan. We outline the Model of Improvement to do this, an approach to improving health care used successfully by many agencies. We discuss the use of this model step by step as a way to test the strategies in your action plan.

Finally, we outline a number of tools and processes that will assist you to assess your service and collect measurable data to support your action plan and demonstrate improvement.

Implementing self-management is about changing practice. The skills we need are different to the way most of us were trained. The evidence tells us that we need a more collaborative approach when it comes to managing people with chronic disease. Numerous recommendations point to the need to provide more people-centred care. If this is the direction we are to take, how do we do this? How do we secure the support of our agencies and our team?

The US Institute of Medicine describes six challenges for health care agencies in embracing best practice care. No matter which health conditions, types of care or care settings you are referring to, these challenges remain constant.

First, we need to redesign our care processes. This requires us to take a step back and look at our systems of care. So often, we react to increased demand for services by increasing staff. Such a response is often short-sighted, as we focus on the symptoms of how we work, rather than looking at the system itself.

Secondly, information technology can be used to dramatically improve care. Current systems often have limited use in that they only record statistical and financial data. There is the capacity to do so much more. Our focus needs to be on managing our whole population not simply the person who comes through our doors.

Managing clinical knowledge and skills is our third challenge. With rapid changes in medical science, it is virtually impossible to know everything. Available guidelines can help us with this challenge. Yet their production often goes no further than the printed page. We need innovative ways to embed these guidelines in such a way that drives decision-making at the time the person comes to see us.

Developing effective teams is one of the most neglected areas in health care. This is our fourth challenge. So often we think about the individual professional and their discipline or program. This is an ineffective way to manage care. We need to build team capacity and think more broadly about how we include others. Strengthening our team and thinking about how we work together to deliver chronic disease care will be vital to managing the burden of chronic disease.

Coordinating care across conditions, services and settings is another challenge. People access many services and providers. Yet they often report the need to tell their story repeatedly and the constant inconsistency of messages. Coordinating their care will involve better communication. It will require us to think about how we work together not only within our agency but also external to us.

Finally, we need to promote a culture of improvement based on performance measures and outcomes. We need to demonstrate with data the quality of our service, so we can reward our teams for their good efforts. We can also evaluate the performance of our service and use it to make improvements to areas that are falling behind. →

Responding to these challenges is not simply about acting on what we are interested or involved in. We need to assess how we deliver a chronic disease care service. We need to ask – what is my contribution to the services we offer? How do we work as a team providing chronic disease care? What is the experience of the person accessing services at our agency?

To answer these questions, we need to take a systems approach. We need to orient our systems to improving quality if we are to meet the expectations of both our communities and ourselves.

Answering these questions and adopting self-management will require significant practice change. Simply increasing our knowledge about best practice will not translate into high quality health care. We actually need to focus on how we organise and plan how care is delivered. We need to ensure a consistent approach is adopted by all.

Increasing our knowledge about best practice will not change the quality of our care. We need to focus on the relationships we build among ourselves and people needing chronic disease care.

To change practice on this scale, we need proven quality improvement approaches. Improvement is best implemented in small changes that allow us to test and evaluate what we do.

This guide will give you tools that will enable you to address these challenges. We describe a method for changing practice that has been used by thousands of health agencies both internationally and in Australia. The model for improvement a method that works. Agencies that have used improvement cycles have experienced tremendous improvements in how they provide chronic disease care and build improvement teams.

This work has the potential to fundamentally change how we deliver care and work as health professionals. This work is fun. It strengthens and unifies our teams and helps us realise the asset that we have when we work together.

Importantly it also results in substantial improvements to how we deliver care and health outcomes for people living with chronic diseases.

The improvement team

Any improvement should start with a team. By this, we don't simply mean establishing a working group but creating a team that will work together to redesign their health care service.

The mere existence of people working together in an agency does not automatically mean they are a team. It may seem an obvious thing to say but a team is more than a sum of its parts. It will have its own identity and share a real commitment to a common vision for chronic disease care. There will be trust and rapport between team members that informs how people work together.

An effective team will not simply think in terms of individual roles and responsibilities but look for opportunities to work together to innovate and provide better care. Such a team will think chronic disease care rather than dietetics, occupational therapy, education, podiatry.

Such a team will know its strengths and weakness. It will communicate and problem-solve in ways that will maximise the skills unique to each member. There will be distribution of roles from meeting organisation, strategy development, to cheerleading to keep the team focused.

From our experience, such teams rarely exist in health care. The reason for this is very simple. There has been little investment in team development that would create the opportunity for such teams to be formed.

Creating your improvement team

We find that most improvement initiatives are hindered by not having the right people involved. It is not unusual to hear of planned changes to agency practice with little or no consultation of the health professionals involved. This occurs frequently in projects, where a project team will design the work and then expect agency staff to simply adopt it.

In your planner at the beginning of each guide, we recommend who should be involved in each of the activities outlined.

Firstly and most importantly, your team needs to include a manager – someone who has the authority to make decisions. Asking a manager to be on your team will ensure that decisions can be made and acted upon. Teams quickly lose momentum and become frustrated without appropriate management endorsement and leadership drive. →

Secondly, your team needs to include technical and support staff. These are the people responsible for all the support you need to deliver care.

Finally, be sure to include health professionals responsible for chronic disease care. Some agencies employ a vast number of staff and you will need to make choices about who will be on the team. If this is your case, who you choose will depend on what you are aiming to improve and the chronic disease.

Professional trust

Professional territorialism and mistrust between health disciplines and sectors is one of the most common barriers to practice change.

Many of us worry that other health professionals may not have the experience or skills required to provide effective clinical and self-management care. These beliefs are often based on misperceptions and a poor understanding of what each other does. This is not surprising given that the opportunity for health professionals to meet and discuss what they do is very rare.

Trust needs to be built and there is a necessity to this. Reluctance to refer to other agencies or professionals is not a sustainable strategy as the burden of chronic disease increases.

So when we speak of the team, we are not simply referring to your agency team. We mean the virtual team made up of health professionals and staff from different agencies that all play a role in a person's chronic disease care.

Meeting regularly

We are surprised how infrequently teams meet.

In our experience, most teams come together on a monthly or bi-monthly basis and talk about people and their care. While such conferencing is important, the effectiveness of such a team to implement change is limited. In such a team, people will think predominately according to their discipline.

Implementing change requires a different level of thinking. Change requires teams to think about how they work together and their combined impact on people needing chronic disease care. We always encourage teams to meet at least fortnightly and to alternate their discussions between care delivery and improving care.

Resources

Through out this guide, we list a number of resources that will assist you through each of the activities described.

Case study

Highway Community Health Centre

Highway Community Health Centre has decided to embark on a journey of changing practice. They are a large primary health service keen to make some significant improvements to diabetes.

With strong agency support, they gather an improvement team. It consists of Mary, Kate and Annette (all diabetes educators); John and Elissa (podiatrists); Holly (dietitian), Ailsa (physiotherapist). Peter (Intake team) and Maria (Client services) from reception are also members as is Lynn (occupational therapist) and Sandra (counselling). It is a large team but everyone is keen to ensure that the right people are at the table. One of the senior managers, Con has agreed to lead the team.

As a first step, the team undertakes a health systems assessment. Con has read about Improving Chronic Illness Care and recommends the team uses the Assessment of Chronic Illness Care.

Over a period of three meetings, the team comes together to work through and discuss the chronic disease capacity of their agency using this assessment tool. At times they struggle with the questions as some touch on areas of care they have not considered before.

They learn a lot about their agency and realise they have a number of strengths. They are a good team and have strong relationships with each other and a number of external partners. They also identify a number of weaknesses. They realise that their agency is not structured to support multidisciplinary teams. Most of their focus is discipline-specific. They have a number of lone rangers, who do not seem to be part of a team at all. They also identify a number of areas for improving care including better use of guidelines and self-management support.

These issues start to form the basis of their agency action plan. They decide on some key priorities by discussing what is important to them as a team, they gain strength and momentum. They realise how they can work together to achieve real change and better service their community.

A major area for improvement is clinical assessment. They identify that they need a more holistic approach. The team decides to process map how care is currently provided. They gather their current assessment forms and map their assessment process. They are surprised by the level of duplication and realise that the process could be more streamlined. They also identify gaps in preventative screening and referrals. They prioritise these and add them to their action plan.

They also collect some baseline data. They start with diabetes and benchmark their current practice against some of the guidelines. The audit reveals that routine screening is not always done. So they decide to introduce a common assessment form to be completed by the first treating member of the diabetes team. This way, they can ensure that the person is being screened for certain aspects of care.

After writing their action plan, they now test the strategies they have chosen. They use the plan-do-study-act approach. The team likes this approach. They are engaged in the process rather than being told what to do. They don't have to get it right the first time and nothing is set in stone until it works. They like that. It is a great relief. They also learn a lot about each other.

The changes they make are many and varied.

They introduce a common assessment form for the diabetes team, diabetes prioritisation at central intake, common assessment for chronic disease across all disciplines and case conferencing.

The team regularly meet to assess the improvements they have made, monitor uptake and plan the next phase of improvements based on their original health systems assessment.

Undertaking a health systems assessment: how good is your chronic disease care?

Contents

Your planner

Team: Assemble a multidisciplinary team of health professionals, technical staff, managers and support staff. Refer to *The improvement team* discussed in the introduction to this guide.

Resourcing: Ten hours.

Meetings: You will need two to three meetings.

Tools: *Assessment of Chronic Illness Care*
Organisational Needs Analysis Tool
ABCD System Assessment Tool

The first step towards adopting a self-management approach to your practice is to undertake a health systems assessment. This tool will help your team assess how care is currently provided by your agencie and highlight areas that need to be improved to support self-management.

The advantage of a health systems assessment is that it looks at populations and systems. The focus is on the care that your agency provides rather than what you provide as individual health professionals. Moreover, the focus is how your agency plans its resources to meet the needs of its communities and those living with chronic disease.

This tool is a real opportunity to reflect on how care is delivered by your agency, the effectiveness of this delivery and its impact. It will enable your team to focus on their chronic disease profile and your collective work as a team, rather than your roles as health professionals.

You can use the results to assess the health impacts and outcomes of your service upon specific population groups. It is a tool for planning service improvements and will help you with the use of evidence-based interventions, data collection and evaluation. All of which will inform how your team will undertake service improvements.

It is for these reasons that we recommend that you begin changing clinical practice with a health systems assessment.

Selecting an assessment tool

There are many different assessment tools available. We analyse them in this guide to help you select one that will work best for your agency. Here we provide an overview of each recommended tool.

Assessment of Chronic Illness Care

The *Assessment of Chronic Illness Care* (ACIC) was developed by the team of Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation (USA). This tool measures the elements of a health service demonstrated to be essential for effective chronic disease care. You are asked to assess and rate your current care against criteria based on from the ICIC Chronic Care Model.

The rating scale ranges from one to eleven. Each rating is described to assist you with your scoring of limited, basic, good and excellent support. Similarly, the different elements of the model are explained. If you are unfamiliar with the work of the Improving Chronic Illness Care team, you can still complete the assessment.

A health systems assessment is an opportunity for you to come together as a team and discuss what you do.

The highest possible score for any item is eleven and describes optimal practice. One of the leading clinicians behind the model, Ed Wagner, has noted that it is very unusual for any agency to achieve this score. He sees this score as a target for what we should be aiming for. We agree. We just don't have the systems in place (yet) to score this level of chronic disease care.

Organisational Needs Analysis Tool

Like the ACIC, the *Organisational Needs Analysis Tool* enables agencies to reflect on their chronic disease management. This tool is designed to assist agencies recognise the skills they have in chronic disease care and identify opportunities and scope for further system and workforce development.

The tool is not a stand-alone improvement strategy. Agency commitment and resources are needed to plan and implement changes identified using this tool. The tool is designed for use in a multidisciplinary or cross-sectoral group facilitated by an experienced professional. The tool aims to assess the workforce as a whole, not just skill or practice deficits of individual professionals or teams. It addresses three key areas of chronic disease care: agency capacity and resources, best practice and planning, and delivery of service.

Firstly, using the criteria of agency capacity and resources, agencies are asked to consider their capacity to provide chronic disease prevention and management according to best practice recommendations.

Secondly, agencies are asked to assess their care delivery - how it is planned, delivered and evaluated according to best practice guidelines.

Finally, the planning and provision of chronic disease care is also assessed. How are chronic disease services including health promotion and early intervention programs planned and implemented for those with or at risk of chronic disease?

The tool has been adapted from the *Health Promotion Skill Assessment Tool for Organisations* developed by the Public Health Branch, Victorian Department of Human Services.

ABCD System Assessment Tool

The *ABCD System Assessment Tool* is an adaptation of the ACIC by the Menzies School of Health Research, Northern Territory, for use in Australian populations.

Like the ACIC, it reviews current service delivery in chronic disease care. However, the focus is the assessment of the quality of systems to support the delivery of best practice preventive services and complementary community activities such as health promotion.

The tool assesses the current health service system, identifies next steps in planning improvements in chronic disease care and assesses progress in achieving system improvement and identifies priority action areas.

It addresses three main areas:

1. Clinical services for people known to have a chronic disease
2. Clinical services for the prevention and early detection of chronic disease such as screening, case finding, interventions and counselling
3. Community or population based program activities and ancillary programs that address major risk factors such as poor nutrition, inadequate physical activity, smoking, alcohol, and deficiencies in oral, mental and/or environmental health.

You are asked to rate the degree to which each principle of the six elements of the ICIC Chronic Care Model is being implemented within your agency.

Choosing a tool to suit your agency

So which of these assessment tools do you choose? How will you know which one will best suit your agency?

Here are some of the fundamental differences between the tools that we hope will assist you with your selection.

The ACIC requires the user to have a sound knowledge of quality chronic disease care and be well versed in the principles of the ICIC Chronic Care Model. The tool provides a description of what to look for in each rating. However, it can lack sensitivity. The descriptions of of each rating are brief; so, it can be difficult for teams to give an accurate rating. For this reason, it is vital that your team has a good working knowledge of the ICIC Chronic Care Model and can make a sound judgement of your agency against these criteria.

The *Organisational Needs Analysis Tool* contains a much more detailed description of best practice care. Unlike the other two tools, this tool does not directly link back to the ICIC Chronic Care Model. Although based on this model, it is not as easy to identify which elements are being referred to.

Once you are more familiar with the ICIC Chronic Care Model, the links become more apparent. This will be an important step, as this model provides the best framework for improving chronic disease care. It is useful for teams that are unsure of best practice indicators or what is required to deliver chronic disease care.

The ABCD tool is similar to the ACIC, with the exception that health promotion initiatives and prevention screening programs are included. For agencies wishing to make improvements to these areas as well as chronic disease care, this tool is the recommended choice.

We summarise the advantages and limitations of each tool at the end of this guide. We have also included the web addresses, or contact details where appropriate, for accessing each tool.

Hints before you get started

- Avoid seeing the assessment as a paper exercise.
- Get the support of senior management. It is one thing to do an audit; it is another thing to act upon the results. Before presenting the case for doing an assessment, stand back and think of the questions your manager is likely to ask: What are benefits to your team and agency? What are the results that you anticipate? What are the resource implications of the results? Who will participate? How will the team respond? How will you balance this work with the demands of clinical practice?
- This is a tool for discussion. It's an opportunity for team building, where you can discuss your roles, how you all work together and the processes and information you need to provide consistently good care to a growing population of people. Our experience is that health professionals very rarely get to discuss how they want to work together, so use this as an opportunity.
- When it comes to selecting a team to undertake the assessment, think agency rather than health care. The team should be made up of managers, technical and support staff, as well as health professionals. The tool will ask you to assess not only how you provide care but your information systems, use of guidelines, self-management information, and strategic planning.
- When completing the assessment, test your presumptions about the services you provide and the strength of the support systems in place. Support your assessment with evidence for each rating score. By evidence, we mean copies of your agency's strategic and operational plans, clinical guidelines, any documented processes such as booking appointments and reviews, self-management tools and schedule of education classes.

How to interpret the results

Once you have completed the assessment tool, you will need to interpret the results. Each tool provides you with instructions of how to score and what the results might mean.

Both the ACIC and ABCD tools are organised such that the highest score, on either an individual item or the overall score, indicates optimal support for chronic illness. The lowest possible score on any given item or overall score is zero, which corresponds to limited support for chronic disease care.

The scoring of the Organisational Needs Analysis Tool differs from the other tools. An A represents best practice, high quality chronic disease care and D indicates the need to consider improvements. Teams are asked to rate each area of chronic disease care with a scoring of A to D.

It is fairly typical for teams to begin their journey with low scores on some or all areas of any of the tools used. After all, if everyone was providing optimal care for chronic disease, there would be no need for quality improvement. Alternately, it is common for teams to initially believe they are providing better care for chronic disease than they actually are.

As you progress, you will become more familiar with what an effective system of care involves. You may even notice your scores on the tools decline even though you have made improvements. Over time, as your understanding of good care increases and you continue to implement effective changes, you should see overall improvement in your scores.

Some of the common areas for agencies to rate poorly include:

- **Information systems:** IT systems were established for financial and statistical monitoring purposes. For teams to plan care, reminder systems for follow-up are needed. Quality chronic disease care monitors populations of people. Such capacity is generally not available in our current IT systems.

- **Team functioning:** Health care is generally organised by programs and/or disciplines with a focus on clinical speciality and expertise. Self-management requires us to rethink these boundaries, as the needs of people don't fit within such silos. As health professionals we need to work together in partnership with a range of disciplines, programs and agencies to address the needs of people with chronic diseases. Communication between us is vital.

- **Decision support:** Most times the implementation of clinical guidelines goes no further than the original research and the writing of the guidelines. To be effective, clinical guidelines and best practice standards need to be implemented in a way that we can use them to make clinical decisions at the time the person comes to see us. Reminders, prompt forms, clinical protocol and systems that have up to date information are all examples of ways we can access clinical guidelines in an easy-to-use format.

- **Agency support:** Leadership is critical to drive change but it is a real variable in health. Embracing quality improvement and leading change initiatives requires skills in change management, project management and leadership that some managers may not possess or not see as important. Such skills are not naturally acquired or innate. Leadership skills need to be learnt and developed.

- **Partnership and links with the community:** Health care agencies have traditionally been established as separate entities. However, people with chronic diseases access multiple services and often have to repeat their story. Partnerships that embed improvements in communication between agencies and promote links with the community will aid the success of any self-management initiatives.

- **Self-management and behaviour change:** We have traditionally been trained to fix problems. We now recognise that the person must take care of his or her own health. In the past we have predominantly relied on education to address this need. Yet education, whilst improving knowledge, has little bearing on behaviour change and improved self-management. We as health professionals must learn different skills and techniques to have success in this area.

Given the issues raised, it is expected that the results of the tools described will be relatively low. Despite the variations in our health care systems, these inherent problems remain the same and are common to us nationally. In fact, these same issues are inherent across western health care.

This said, we recognise that in the last few years significant improvements have been made. In Victoria, Primary Care Partnerships are assisting health care agencies to build community links and create improved partnerships with one another.

How to use the results of your health systems assessment

In our experience, we have found that agencies aren't surprised by the results of their health systems assessment. The results more often than not confirm what most teams know to be the strengths and limitations of their own service.

So, you have your results, what next?

We suggest the following approach to sort through the scores and prioritise what you want to do and when.

- Start by ranking the scores of your assessment from the highest score to the lowest score. Build upon your discussions and look at the evidence you used to support each rating.
- Assess the impact of each score. What does this mean for your team, agency and the chronic disease care you are providing?
- Identify your priorities. What do you want to address first? Who needs to be involved?
- Be very clear about how you select your priorities. You will need to communicate your decision to others. Often improvement initiatives fail to go anywhere because of a lack of support. Engage management and the team from the beginning. Everyone needs to buy-in into the change proposed.
- Present the outcomes of the assessment to your management team, outlining the implications for your agency. Use current agency data to support the outcomes of the assessment. Explain the priorities you have selected and why.
- Get agreement from the management team to commence the work.

Next steps

We recommend that you go to the next guide and diagnose your health service. This will enable you to acquire the evidence to support the results of your health systems assessment. After this step, you can go on to develop an agency action plan.

Remember, a health systems assessment is not a one-off event. Repeat this assessment annually. It is important for teams to receive feedback on improvement. Repeating the process provides everyone with feedback and ensures a process of monitoring.

Resources

Improving Chronic Illness Care has assisted hundreds of agencies to complete the ACIC. This website includes case studies from agencies that have used this tool. <http://www.improvingchroniccare.org>.

The Organisational Needs Analysis Tool for health promotion is listed on the Victorian Department of Human Services web site <http//: www.health.vic.gov.au/healthpromotion/hp_practice/plan_implem.htm). Contact Gill and Wilcox for the adapted version of this tool for assessing chronic disease capacity. Gill and Wilcox have also assisted agencies to use and interpret the Organisational Needs Analysis Tool.

The ABCD Systems Assessment Tool is also listed on the Australian Government Department of Health and Ageing web site <http://www.health.gov.au/healthyforlife>. Contact the consultants listed on the website for information and contacts details of agencies that have completed the tool and can assist you.

Better Health Care in Gippsland in Victoria has developed a resource kit on how to embed the elements of the ICIC Chronic Care Model. Contact East Gippsland, Wellington, Central West Gippsland or South Coast Primary Care Partnerships. This manual can be located on the Victorian Department of Human Services website at <http://www.health.vic.gov.au/communityhealth/cdm>.

Quick guide to health system assessment tools

Tool	Purpose	Advantages	Limitations	Location
Assessment of Chronic Illness Care (ACIC)	A practical assessment tool to guide quality improvement efforts and evaluate changes in chronic disease care.	Based on the six elements of ICIC Chronic Care Model (CCM). Gives criteria for how systems support each element of the CCM. Provides indicators for optimal chronic disease care.	Developed in USA so may require some adaptation for an Australian context. Criteria for the rating scale are broad. It may not be easy to give an accurate score. Can be difficult to understand the implications of the results, you need to for maximum impact. Requires people have a good understanding of quality chronic disease care.	Free of charge to download <http://www.improvingchroniccare.org/tools/index.html>
The Organisational Needs Analysis Tool	Guides best practice in chronic disease prevention and management of services within an agency. Outlines indicators for best practice in chronic disease prevention and management.	Looks at agency performance not individual health professional performance. Provides criteria for best practice recommendations. Focuses on planned care. Includes health promotion and early intervention programs.	Doesn't easily link back to the elements of the CCM, which provides the framework for best practice chronic disease care.	Available by contacting Gill and Wilcox. <marie@gillandwillcox.com.au>
ABCD Systems Assessment Tool	Used as a framework for discussing the organisation and performance of health systems to deliver chronic disease care.	Based on the six elements of CCM. Provides detailed criteria for how systems support each element of CCM. Provides indicators for optimal chronic disease care. Developed for an Australian context. Assesses clinical preventive services and health promotion activities.	Requires knowledge of the CCM prior to use. Developed specifically for indigenous populations. Criteria for the rating scale are broad. It may not be easy to give an accurate score. Can be difficult to understand the implications of the results. Requires people have a good understanding of quality chronic disease care.	Free of charge to download <http://www.health.gov.au/healthyforlife>

Diagnosing your chronic disease care service

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Your planner

Team: Choose the same team who were involved in the health systems assessment. You may need to include some additional team members for the activities outlined. When doing a process map, include everyone who is involved in the process you are mapping. When collecting data as in a clinical audit, include health professionals with expertise in the area you are investigating.

Resources: You will need two hours for a meeting to undertake a process map. Allow four hours to undertake your data collection. We recommend that you put aside two hours to discuss the results of your findings

Tools: For process mapping, you will need a white board or large sheet of paper, a few sticky note pads and pens.

When collecting data, you will need an appropriate database that holds clinical information.

If this is you, you will first need to clean the data to ensure you are able to investigate the population you have chosen. A database will only count known fields, not free text. If you do not have access to a database that records clinical information, you will need to use manual file auditing. This will require an excel spreadsheet of the information you are collecting, a data collection tool and the files of the people you wish to audit.

There is a constant need to improve the quality and safety of our services. It is not always easy to know where to begin.

To improve what we do, we need a variety of quality improvement tools and methods to guide our activities. Any approach that helps us to assess our service is likely to be a useful improvement tool. There are various strategies and tools teams can use, including interviews, focus groups, as well as process mapping and audits. We describe process mapping and audits in this guide.

Process mapping will provide your team with an understanding of the multiple systems and processes that shape how care is delivered. A process map isolates each step of an activity whether it is scheduling appointments or an assessment. By looking at the process in detail, you can identify the gaps and duplications of your service.

A clinical audit will assist you with a population-based approach to chronic disease care. Through this approach, you will be able to identify health problems within a defined population of people, define and assure evidence-based interventions and regularly monitor progress.

Both approaches are fundamental to driving improvement and have a team focus. By working together to identify problems and bottlenecks, your team will find it easier to establish priorities for action and agree on interventions.

The outcome will be an insight into how your team works, the service you provide and a detailed understanding of what you want to improve. The tools outlined in this guide will enable you to probe into the results of your health systems assessment.

These insights will the basis for your quality improvement activities.

Process mapping

It is often tempting to just employ more staff as things get busier. So often we think of the next program and additional funding to meet the ever increasing demand. Yet, this is not a sustainable strategy to address the chronic disease burden. We actually need to take a step back and analyse what we do.

Process mapping is one of the simplest ways to improve care. By breaking down the steps in any process, it is possible to see the gaps, barriers and even duplications in our services. Process mapping can be used to follow a clinical pathway or look at how we make referrals to other agencies.

Your first process map will provide you with a picture of the status quo – how your service currently works. You can use this map as your baseline to measure the impact of changes your team introduces.

The advantage of process mapping is that it is visual. It provides everyone with a picture of what is done and how things happen in your agency. It becomes the basis for assessing the flow of activity and identifying what works well and what doesn't.

Any process can be mapped whether it is clinical or operational. Mapping agency processes can assist you to understand how health professionals currently work and the barriers to achieving fully integrated chronic disease care. A process map will highlight the governance and management arrangements within your agency and how these processes impact on your service delivery.

Process maps can also identify the links between your team and other service providers. Such maps are useful for understanding referral pathways including how information is shared and what communication is used.

Core business processes support the services you as a team deliver. These processes show the main areas of work done by staff and managers.

One of the most common findings of process mapping is duplication. Areas of assessment may be duplicated if there is more than one professional involved in that person's care. Areas of assessment may even be missed. This is the result of discipline or program-specific silos.

Ten easy steps to process map

We recommend using a flow chart when developing a process map. It is easy to follow and provides a picture from start to finish of how a process occurs within your team and agency.

1. Gather a team that includes a manager, administrator and relevant health professionals. Be sure to include staff that are directly affected by the process you are investigating.
2. Decide on a process you would like to improve, for example your client intake process.
3. Identify the start and end points of the process you are mapping using a circle.
4. Identify the second step of the process and decide whether it is a decision or activity. Use the *Constructing a flow chart* instructions in this guide to help you.
5. Identify the next step.
6. Ask the questions- who, what, when and how to describe each activity. Also record the time taken to perform each activity.
7. Assess the flow chart. Can you identify any problems such as any unnecessary steps or delays?
8. Use the method of analysis called root cause analysis. It is simply asking why five times. It will enable your team to clarify what steps are needed and what can be removed. Sometimes we do things from habit rather than necessity.
9. Now re-draw the flow chart as you think it should look without the problems. The map may differ a little or significantly.
10. Identify the main problem areas and agree on priority areas for action. Use the plan-do-study-act approach to test and implement your ideas. In the guide *Testing and implementing your agency action plan*, we discuss this approach in detail.

Case study

Process mapping in action

The team at Highway Community Health Centre decides to map their client Intake process. Their health systems assessment highlighted that intake needs improvement and there have been a number of recent complaints that they want to investigate.

They expand their team to do this exercise. Con leads the team and invites Tony from IT to be involved. He also includes Peter from Intake, Maria from reception as well as John, Holly and Alisa from the chronic disease care team.

Looking at the intake process from start to finish, this is what they find:

- The Intake service is only available three-days a week. This is leading to unnecessary delays in processing referrals, often up to two days.
- People identified as being ineligible for the service aren't being provided with additional assistance. They were receiving frequent complaints from referring agencies and from people contacting them for appointments.
- Referrals are currently placed in the pigeonholes of individual health professionals. This is leading to unnecessary delays of up to three days waiting for the professional to collect it.
- Screening for priority is left to the health professional. This is leading to further delays while the professional attempts to contact the person.
- The screening process varies among different professionals within the same discipline. This is leading to inconsistency.
- People are being given appointments according to the availability of the individual health professional. This means waiting times are inconsistent and people are waiting unnecessarily.

We have included the two process maps developed. The first map shows how their service is currently working and the second, the new improved process.

The team decides to use a plan-do-study-act improvement cycle to address the issues they have identified with the service. Everyone works together to identify how things can be improved and develop a more streamlined intake process.

The following improvements are made:

- A full-time administration worker is employed to answer phones and collect preliminary information including client demographics and eligibility criteria for the service. They also introduce a single contact number for outside services.
- People ineligible for the service are provided with information on other services using a services directory and appropriate referrals are now made. Standard forms are used to ensure consistency.
- Intake staff are trained to collect additional information about the reason for referral and the person's general health to obtain a baseline picture.
- The person is screened for their risk at Intake using set criteria and defined risk categories. The person is given a risk category and a maximum waiting time is determined.
- Appointments are made with the treating health professional during the Intake process.

Six months after making these changes, intake staff report that the new intake process has significantly improved. Waiting times have decreased and importantly they have better relationships with health professionals and feel that they are a part of the chronic disease care team.

Improvement cycles are discussed in *Testing and implementing your organisational plan.*

Figure 1. Process map before change

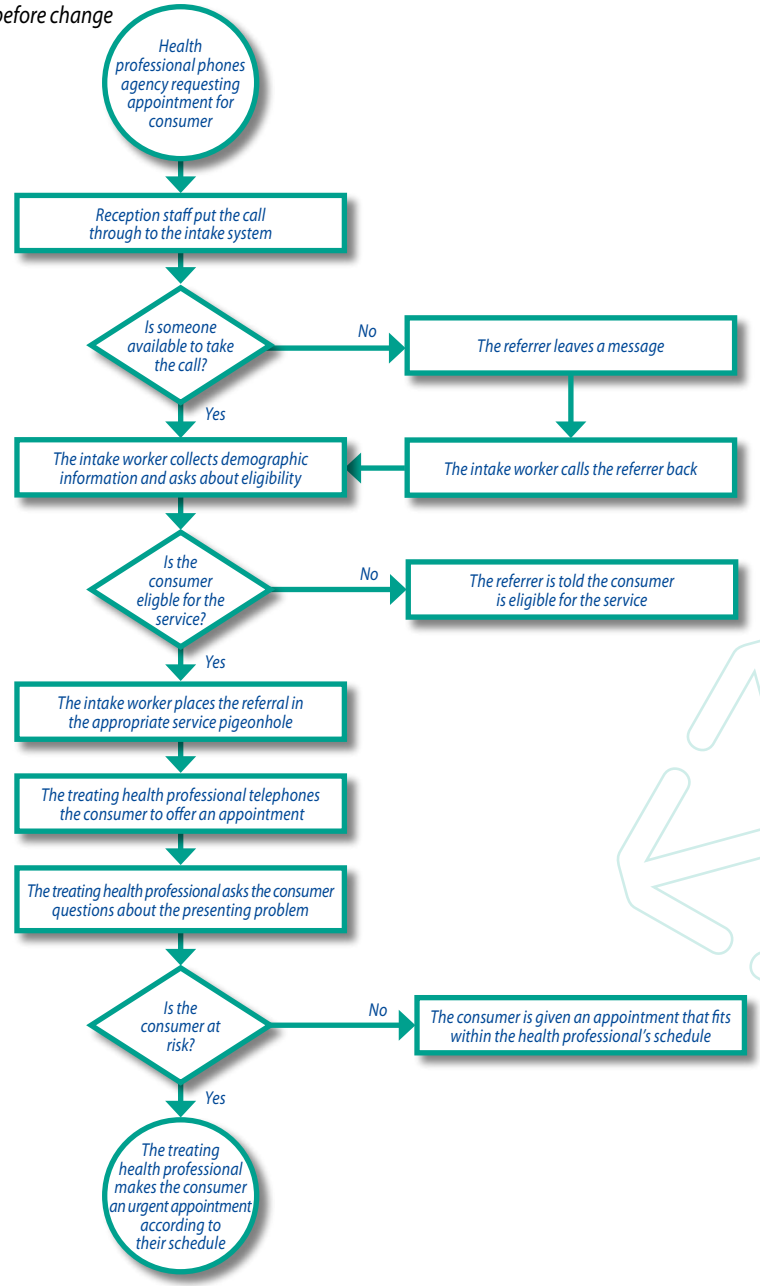
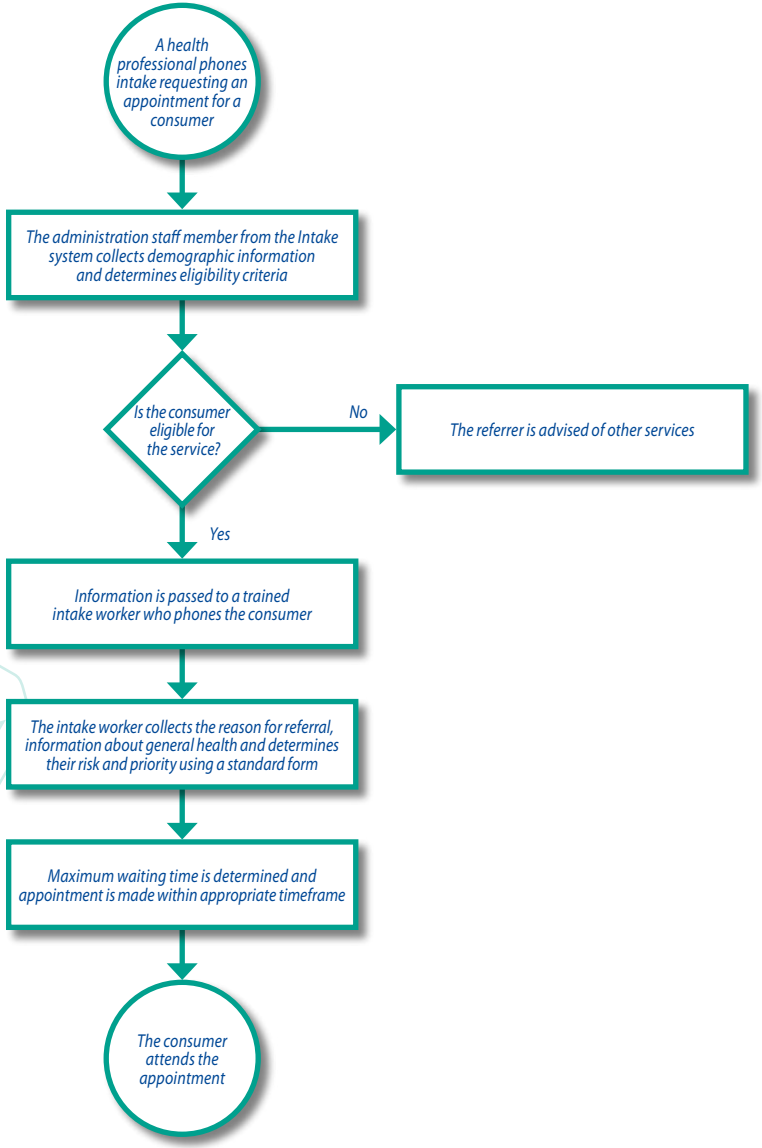


Figure 2. Process map after change



Constructing a flow chart

Arrow		Shows the direction of the process
Rectangle		Shows a task, step or activity of the process that does not involve any significant decision-making
Diamond		Shows a yes/no question that needs to be asked or a decision that needs to be made
Circle		Shows the beginning and end of the process

Hints for successful process mapping

Begin with a health systems assessment, it is possible to see how processes contribute overall to how a health service runs. Think small, when deciding what process to map. The more complicated the process, the easier it is to miss a critical step.

Select a process that involves or has an impact on all of the chronic disease team. It will prove to be a useful team building exercise to think about how they work as a team rather than as health specialists.

After you have completed your process map, place it somewhere it can be seen by the team. It will be a good reminder of why you are undertaking the improvements that you are. It is importantly to see the relationship between different processes. If you change one process, you need to ensure that there is not a negative impact somewhere else in the system.

If you just focus on processes, any improvement will be ad hoc and over time will contribute little to the improvement of your service.

Clinical auditing – a population-based approach

Whereas process mapping will give you an insight into the systems that underwrite and support how you work, it is only through a clinical audit that you will determine the quality of your chronic disease care. In particular, an audit of your team's clinical practice will provide you with important data about how your care compares against evidence-based guidelines and best practice. Auditing takes a population-based approach where attention is paid to the health care needs of populations of people, not just those that show up for appointments.

In our experience, a clinical audit practice is probably the most difficult and challenging of any quality improvement activity. Through an audit, we put our practice under the microscope in a way that is very different from how we analyse and assess our agency systems. When putting a clinical audit on the agenda, it is very important to be aware of the sensitivities. It can be very difficult to remain objective when it is the quality of your work that is being assessed.

It is for these reasons that clinical audits have worked best in pharmaceutical trials and projects, where the expectations are established from the outset and clinical guidelines and pathways are more embedded.

That said, a clinical practice audit will provide insights into how your team works that no other tool will come close to revealing. An audit enables you to compare in detail the information in a person's medical record against standard protocols or criteria for the delivery of a given care item. An audit can identify what is needed to improve chronic disease care and can provide you with very good baseline data.

We recommend that a sampling approach is adopted when undertaking a clinical audit. You will also need to be clear about the group of people that you want to look at and why. Look at *Developing your action plan* in this guide. We talk about the setting of SMART aims that will help you to be clear about what you want to measure and why.

The case study provides some insights into the value of undertaking an audit and its place within the bigger picture of implementing self-management in your agency.

Disease registry

A disease registry can provide your team with similar information to an audit. It enables you to look at data about populations of people and to identify any trends in your chronic disease care.

A registry makes conducting a clinical audit and measuring the status of a population easier and removes the need for manual file auditing. The benefit of a registry in clinical auditing is the ability to produce ongoing reports about clinical care. A manual file audit is time consuming, whereas a →

Case study

Melbourne City Healthcare

The audit: Melbourne City Healthcare decides to audit a sample of people with heart failure who are known smokers to find out whether they have been assessed for their readiness to change their smoking habit (as defined in best practice care). The nurse practitioner, Lynne, develops a simple data collection sheet and conducts a file review of twenty people who are known smokers and have heart failure.

Problem: Much to her surprise, Lynne finds that only twenty-five per cent of people with heart failure have been assessed for their readiness to change their smoking habit. This is despite the efforts of all staff to reduce the number of people with heart failure who smoke. It is also identified that readiness to change is not being documented according to the Transtheoretical Stages of Change model. This is an initiative that the agency is adopting. (We discuss this model in the *Implementing self-management guide.)*

Plan: The team discusses a number of changes to increase the percentage of people assessed for their readiness to change their smoking habits. They also realise that in previous meetings they hadn't been clear about how readiness to change should be documented. It was just assumed that everyone would do it the same way. Everyone also agrees that a prompt is needed and the clinical checklist for heart failure should be updated to include the Stages of Change model.

Outcome: After three months, the percentage of people who have been assessed for their readiness to change has increased to forty-five per cent. Readiness to change is being documented in a more consistent way.

As we hope has been demonstrated by this case study, a clinical audit can provide many insights into how the team is working and the success or partial success of any changes to how you work. There are sensitivities but bottom line, an audit is looking at your chronic disease care capacity.

The results of an audit are detailed. This data will enable you to manage chronic disease in a proactive and organised fashion and produce positive health outcomes for those accessing care.

report from a registry is able to be gathered in five minutes. A registry will enable your team to more readily access data on the services being provided, how frequently and who is being recalled to meet best practice recommendations.

Most registries will need to be designed independently by agencies. The type of data you will need to enter and maintain falls outside the scope of most clinical information systems. Registers should include a minimum data set consisting of demographics, risk profile, complications and risk factors, as well as self-management status. The challenge for most agencies is who will create the registry, enter the data and monitor the quality of the data input.

The value of a registry is the focus on population health. A registry is used to manage populations proactively and provide staff with regular information about care compared to best practice. Evidence-based guidelines can also be embedded into a registry. Having ready access to guidelines enables health professionals to make evidence-based decisions about care at the time of the person's visit.

A registry can be designed so staff can receive an alert when a service is overdue or when a given clinical marker is outside of normal range (e.g. HbA1C>7.0%). People can then be contacted for appointments.

Medical software

General practices are able to develop registries because of the software available to them. There are many varieties of medical software used in general practice that cannot be covered in this manual. That said, we want to highlight how software can be utilised for clinical auditing:

Disease registry: Medical software can generate lists of people with a particular diagnosis, as long as the diagnosis has been coded into the GP's desktop computer. This disease registry can be used to develop a planned approach to chronic disease care and a review of services provided. As you can see from the case study provided, significant outcomes can be achieved by increasing a practice's capacity to utilise such software.

Practice Health Atlas: The Practice Health Atlas is a decision support tool for general practice designed by the Adelaide Western Division of General Practice. The tool provides information on epidemiology, business and clinical modelling systems, information on services and includes a data extraction tool to enable a population based approach to care.

***Australian Primary Care Collaborative* (APCC):** The APCC is an initiative funded by the Australian government to support Australian general practices deliver systematic and sustainable improvements in the quality of primary care. It focuses on three areas: the secondary prevention of coronary heart disease, diabetes and patient access to primary care services. →

Case study

Green Meadows Clinic

Through its local Division of General Practice, Green Meadows Clinic is being assisted to analyse its use of recall and review systems to manage people with diabetes.

At the start of the project, Green Meadows Clinic estimated they had a total of 100 patients with diabetes on their books. Staff from the local division believe that this figure could be much higher. Establishing a registry reveals the practice has an actual population of 537 people with diabetes.

Green Meadows Clinic estimates they are completing an Annual Cycle of Care (ACC) on most people with diabetes. An ACC outlines the steps in best practice care for diabetes management as described in evidence guidelines for diabetes care.

It forms part of the MBS item numbers for GPs and can therefore be claimed through the Service Incentive Payments (SIP) if the practice is registered with the Practice Incentive Program. The registry provides information that indicates that an ACC is being completed on only five per cent of people with diabetes.

By establishing a registry and improving its recall system, Green Meadows Clinic increases its completion of Annual Cycle of Care (ACC) to thirty per cent within an eight-month period.

Not only does this have benefits for the people receiving chronic disease care, the clinic is rewarded financially. Through the Australian Government Medicare Benefits Scheme, the clinic boosts its income by $35,000.

By completing an ACC, GP Management Plan and Team Care Arrangements with three reviews annually for people with diabetes, staff at the clinic realises they can claim much higher MBS rates and provide better care.

The collaborative model is based on methodology designed by the Institute for Healthcare Improvement in Boston, Massachusetts, USA. A collaborative is an improvement method that relies on the adaptation of existing knowledge to multiple settings to achieve a common aim. It consists of a series of learning workshops interspersed with activity periods during which measures common to the participating practices are used to track progress.

A collaborative is *not* a research project, a set of conferences, or a passive exercise. It is about actually doing and improving. The improvement method used is the Model for Improvement described in both the *Developing an agency action plan* and *Testing and implementing your action plan* guides.

Health Summary

A health summary is an information sheet about key aspects of a person's care. A health summary provides an ideal solution to track care and preventive services.

Information a health summary may contain includes a list of past and present diagnoses, social history, medications, risk factors for major chronic diseases, lifestyle choices, depression risk and other factors common to chronic disease. It can also include tick the box questions based on the guidelines for a particular disease.

Health summaries enable information about care to be found more easily rather than having to search through a medical record looking for information. A health summary makes the task of file auditing using a data collection sheet easier.

It is worth investigating other agencies' health summaries prior to developing your own, or adapt your current assessment form.

Developing your agency action plan

When you have completed your health systems assessment and investigated some of the processes supporting your service, you need to decide where you want to start and how you will address your priorities.

This is best done through an agency action plan. As a team, this is an opportunity to develop your service, assess how your agency compares with best practice as well as look at the practicalities of improvement – how long will it take, who needs to be involved and how much will it cost.

Resources

Process mapping

For detailed information on process mapping, go to the OATSIH Healthy For Life program listed on the Australian Government Department of Health and Ageing web site <http://www.health.gov.au/healthyforlife>

The Victorian Quality Council produced a useful guide on process mapping for health service staff http://www.health.vic.gov.au/qualitycouncil/pub/improve/process.htm

The Institute for Healthcare Improvement has useful resources on conducting a process map. Go to <http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools>

Clinical auditing

The OATSIH Healthy For Life program has detailed information on clinical auditing and provides sample data collection sheets for your use. Go to <http://www.health.gov.au/healthyforlife>

Liaw, ST & Kerr, S. Computer aided prescribing. Decision support needs to be evidence based, *British Medical Journal*, vol 328, 2004, p.1566.

Improving Chronic Illness Care provides a number of resources to undertake a clinical audit including excel spreadsheets, data collection forms and how to guides for establishing registries on their web site <http://www.improvingchroniccare.org>

Registries and recall systems

Contact your local Division of General Practice for more information on registries and recall systems. A business case on the benefits of recall and review in general practice can be used for quality improvement activities.

For more information on the Practice Health Atlas go to <http://www.awdgp.org.au>

To set up registries using common general practice software go to the Australian Primary Care Collaborative website and look under user guides in measurement <http://www.npcc.com.au/userguides.html>

Developing your agency action plan

Contents

Your planner

Team: Choose the same team who were involved in the health systems assessment. You may need to include some additional team members for the activities outlined.

Duration: Ten hours.

Meeting: You will need two to three meetings to develop your initial agency plan, followed by quarterly review meetings.

Tools: Result of the health assessment, white board, your agency strategic plan. We also highly recommend that the team dedicates time to understanding the ICIC Chronic Care Model.

A good plan will have been written by the people involved in the work. It will reflect their priorities, identify clear milestones and describe in detail the work to be done. Most importantly, it will be realistic.

The benefit of such a plan is that it will assist your team to clearly articulate its vision for chronic disease care. It is a chance for everyone to commit to the work ahead by identifying what needs to be done. The writing of a plan will build the team and its sense of purpose. And importantly, this plan will be a useful tool for the team to present to the senior management team to secure their support.

An agency action plan should look at the next twelve months for your agency and identify the strategies and resources required to implement the changes to your service.

Questions to get you started

To assist you to develop your agency action plan, we have provided some questions you may wish to consider:

- What are the health issues facing people with chronic diseases using your service?
- What services does your agency offer at present?
- Are there any gaps in your services?
- How does your agency compare with best practice?
- What has your health systems assessment told you about your current service delivery?
- What priority areas did you set after completing your assessment?
- What changes are you planning to make to how you provide care to people with chronic diseases?
- How are you planning to make these changes?

How to write your agency action plan

Your agency action plan will be based on the results of your health systems assessment.

Begin by planning ahead and block out at least two to three meetings with your team. We have found that teams quickly lose momentum if there is no immediate follow-up to their initial work. You should schedule these meetings at the time of your assessment.

The team should determine their priorities by assessing the health systems assessment results. It is easy to be overwhelmed by the potential work involved. So prioritise areas into the categories of immediate (one to three months), short-term (three to six months) and long-term (six to twelve months).

We suggest you begin by writing your priorities on sticky notes (one priority per note). Now place the notes under the three categories based on your initial thoughts. You will move the priorities around to reflect your discussion until you have agreed as a team where you want to begin.

An effective action plan will have a clear logic and have a strong evidence base. We recommend that you use the ICIC Chronic Care Model as the basis for your plan. (In our introduction to *Navigating change: practical approach to implementation for Australian health agencies*, we discuss this model in depth.)

This model offers an internationally renowned framework to improve chronic disease care and has been used by agencies around the world. The model encourages teams to think across all dimensions of chronic disease care, not simply clinical practice. Thinking about the impact of chronic disease upon a community and how it is best managed can lead to more innovative solutions than discussions limited to clinical pathways and processes.

Your plan should address self-management support as well as the other six elements of the ICIC Chronic Care Model. We have provided an example of an action plan and a template to help you do this. Both appear at the end of this guide.

Setting priorities

- Write down all the problems identified on a whiteboard.
- Tell the team they have a budget of $100.
- Give each team member three post-it notes, which will represent the money.
- Ask each team member to indicate how much they want to spend on each problem. People can put all their money on one priority or split it in any way across the three.
- Ask the team to put their post-it notes on the whiteboard next to the problems they want to spend their money on.
- Add up the amount allocated to each problem. The problem with the most money allocated to it has the highest priority.
- Repeat the same procedure for the problems with the second and third most money allocated. You will end up with three priorities.

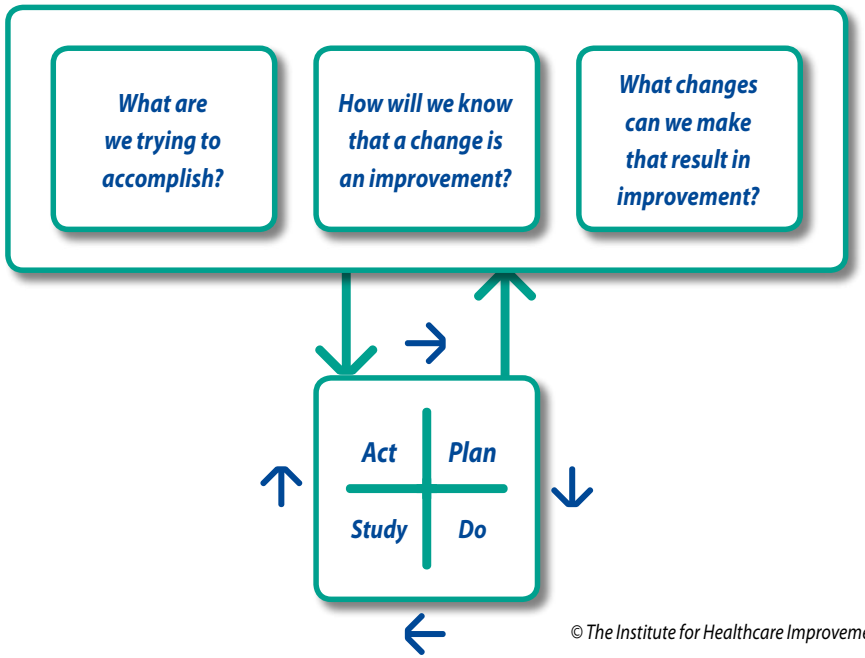
Don't set any more than three priorities. This will enable you to target your improvement efforts and set realistic goals.

Five fundamental questions to answer

Writing an action plan can be overwhelming. Try and keep your plan as simple as possible. It should be a plan to facilitate and organise the work rather than an end result. It also needs to be realistic. We recommend you ask five questions. These questions are adapted from the Model for Improvement a known way to change practice and improve care. If you keep asking these five questions, they will help to keep you on track:

- What are we trying to improve?
- What needs to change?
- Who needs to be involved?
- How long will it take?
- How will we keep on track? →

The Model for Improvement



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What are we trying to improve?

Being clear about what you want to improve is the first step. Your aims should reflect what you want to achieve and should provide a focus for all the team. These aims will be your yardstick with which to measure your progress, achievements and improvements.

By being clear about what you want to achieve, you will commit to the future rather than the status quo. The team will focus on how to overcome barriers to achieve their goals rather than use them as opportunities to stop.

SMART objectives

We recommend that you follow the principles of SMART objectives when it comes to setting appropriate aims for your quality activities.

These are:

- **Specific** to a target group during a particular period with a defined location. Your aim should describe the system to be improved and the approach to improvement.
- **Measurable** against a set target. The target should provide a percentage against which progress can be measured and demonstrated.
- **Achievable** to be able to deliver results. Unrealistic aims result in poor outcomes leaving staff disenchanted and less likely to undertake further improvements.
- **Results-oriented** to allow the team to stay focused.
- **Time-scheduled** to ensure your team remains interested and enthusiastic and to ensure regular review of progress.

More recently, SMART objectives have become SMARTER. The additional letters are useful reminders of how to engage people in improvement cycles and ensure that we are measuring the right things.

The **E** is for exciting. Objectives need to capture people's imaginations, as they are often the focal point of what we are trying to do.

The **R** is for review. Using the same objectives year in and year out does not support any improvement process. So make sure you regularly update your objectives.

The principles of SMART can be applied to the quality aims you develop as a team.

Examples of aims:

- Reduce the population of people with cardiac failure who smoke from thirty five per cent to twenty five per cent within twelve months by involving these people in their care and assessing their readiness to change.
- Increase the number of people with diabetes who report to be eating five serves of vegetables per day from thirty per cent to forty per cent within twelve months by using Motivational interviewing.
- Increase the number of people with diabetes who receive a foot examination from fifty per cent to eighty per cent within twelve months by targeting people that say they have not received one. →

What needs to change?

Having identified what you want to improve; now you need to focus on the detail.

What changes are you going to introduce? How will they improve how your team works?

Some people refer to these actions as strategies; others as interventions. For the purposes of this guide, we will use the term strategies. Either way, it is through these changes that you will begin to put your plan into action.

Examples of strategies relating to the above aims:

- Assess the readiness to change of people with heart failure who smoke using a readiness scale of low, medium and high.
- Identify people with diabetes who eat less than five serves of vegetables per day and use Motivational interviewing as a strategy to encourage changes in their eating behaviours.
- Develop a routine assessment form with a best practice diabetes care checklist. Include prompts for action that indicate appropriate referrals to the team. This will help define the roles and responsibilities of the team.

There are a number of resources that are worth accessing when you come to designing your strategies. Best practice guides are an important starting point. Your energy should not be focussed on reinventing the wheel but on implementing the changes, motivating and securing staff buy-in and management support.

We have included in this guide a table detailing the different professional agencies that you can look to for information on clinical management, intake assessment, risk screening tools, self-management models and care planning tools.

Both the National Institute of Clinical Studies and National Health and Medical Research Council are invaluable resources for information on implementing change and getting evidence into practice. There has been significant research into how to achieve practice change. By using the literature, you will avoid choosing strategies that have proven not to work.

Interventions often fail to be adopted because they are designed in isolation. Talk to staff and team leaders, they often have great ideas that they are willing to share. Build the sense of team by asking everyone what they think. Similarly, look at other agencies and programs.

How long will it take?

For your plan to be realistic, you need to estimate the short and long term time frames for implementing your strategies and achieving your aims. Our experience is we tend to underestimate the time involved by at least half. So calculate a number and double it.

Some parts of your work may take a year or longer, others only a month. Make sure you include in your time calculations – time between meetings, design time, piloting, and potential delays when getting sign-off from your agency.

For a strategy that will take longer than three months, we recommend that you identify different phases and project manage the work.

What are the resources required?

Any improvement activity needs to be resourced. You may be given a budget but resources are more than funding. Releasing staff to be involved in the review and design of new tools is a resource.

For example, we have suggested that a health systems assessment requires a minimum of two meetings. If four team members are involved and each meeting runs for an hour and a half, then it will take twelve hours to do this work. The effectiveness of the assessment is dependent on the number of people involved, so we don't recommend cutting corners. We are simply indicating that understanding the impact of this work is important for getting the resourcing correct.

Clinical supplies or equipment, health promotion resources may also be required. These need to be calculated and included.

We recommend that you discuss the resource implications with senior management, so that the implications as well as the enthusiasm for the work are understood.

Measurement is not the goal, the improvement is.

How to keep on track?

So often in health care, a change is implemented and we forget to evaluate its impact. All our energy is placed into designing and introducing a strategy and we either run out of steam or funding. To keep on track, we recommend that you identify measures to check whether your strategies are delivering on your aims. →

Measuring improvement

Measures tell us what we need to know, so we can see how well we're going against our aim.

When deciding what measures to use, think carefully about what you want to measure. Determine what type of information you will need to collect to show whether there has been improvement. Choose a measure that shows clearly what you've been doing.

There are two main types of measures:

- Process measures are care delivery measures that describe whether the steps or parts of the system are performing as planned. These measures indicate how we do what we do, enabling us to compare where we are in relation to best practice.
- Outcomes measures determine the health outcomes of a particular population.

For example, a process measure might be the number of people with diabetes who are asked about the serves of vegetable they eat each day and the use of motivational interviewing to support health behaviour change. The outcome would be the number of people who report changes in their eating behaviours.

It is worth indicating that health outcomes can take a long time to demonstrate. It is easier to measure whether we are implementing the changes we have agreed to. Furthermore, to motivate and sustain change, teams need to know quickly whether the changes they are making are leading to an improvement.

Measures should be based on evidence-based guidelines and best practice standards whenever possible. The advantage is that you can compare your current care with best practice.

Appropriate measures will focus on clinical as well as health service outcomes. We often just focus on the clinical outcomes rather than looking more broadly at how our health system performs.

Analysing our practice enables us to determine how close we are to providing evidence-based care according to standards and guidelines. The health care team needs to organise itself to deliver effective clinical care and to continuously monitor and improve the quality of care. Understanding how your team operates to meet both these needs is critical to improving outcomes.

This is important as it is unlikely we will see any real improvements in population outcomes without first improving the delivery of care that we know people with chronic disease require.

Next steps

If you haven't already, we suggest that you work through the *Diagnosing your chronic disease care service* guide. This is an opportunity to undertake a detailed analysis of how you provide services.

As you understand more clearly the work you need to do to change your practice, you will need to update your agency plan. Your plan is your map. It will be the point of focus for your team and the only way that you will know whether you are improving the care that you have decided to change.

Once you have your plan and baseline data, you are ready to test the strategies you have chosen. Remember you will have more success if you test ideas before jumping into broad implementation. By taking one step at a time, you can build will and momentum for change.

To test ideas for your strategies, refer to our guide T*esting and implementing your organisational action plan*.

Resources

The following table is a guide to the different resources you can use when it comes to designing your strategies.

Organisations	*Guidelines*	*Website location*
The National Health and Medical Research Council	Various clinical conditions Getting evidence into practice	<http://www.nhmrc.gov.au/publications/subjects/clinical.htm>
The Royal Australian College of General Practice	Diabetes management in general practice Other clinical conditions	<http://www.racgp.org.au/guidelines>
National Institute of Clinical Studies	Tools and resources to get evidence into practice	<http://www.nhmrc.gov.au/nics/asp/index.asp>
The New Zealand Guidelines Group	Guidelines for different clinical conditions	<http://www.nzgg.org.nz>
The Medical Journal of Australia	Guidelines for different clinical conditions	<http://www.mja.com.au/public/guides/guides.html>
The Heart Foundation	Diagnosis, prevention and management of people with chronic heart failure Physical activity recommendations for people with CVD Reducing risk in heart disease Position statement on lipid management Position statement on carbohydrates and CVD Stress and CHD – psychosocial risk factors Cardio-vascular rehabilitation Position statement on tobacco	<http://www.heartfoundation.com.au>
The COPDX Plan Diabetes Australia	Australian and New Zealand guidelines for the management of Chronic Obstructive Pulmonary Disease 2003 National evidence-based guidelines for the management of type 2 diabetes mellitus: primary prevention case detection and diagnosis diagnosis and management of hypertension prevention and detection of macrovascular disease identification & management of diabetic foot disease lipid control in type 2 diabetes	<http://www.copdx.org.au/guidelines/index.asp> <http://www.mja.com.au/public/issues/178_06_170303/tho10508_all.html> <http://www.diabetesaustralia.com.au/education_info/nebg.html>
Health Disparities Collaboratives	Best practice ideas to improve systems of health care. Improving depression, asthma, cancer, diabetes and heart disease. Guidelines and prevention measures are included. Creating teams and setting aims and measures.	<http://www.healthdisparities.net/hdc/html/home.aspx> click on library and collaborative processes
Institute for Healthcare Improvement	Best practice initiatives on how to improve health care and strategies known to work. This website also provides much assistance on developing leadership to drive your improvement initiatives.	<http://www.ihi.org>
National Guideline Clearinghouse	The National Guideline Clearinghouse is a public resource for evidence-based clinical practice guidelines. It is an initiative of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.	<http://www.guideline.gov/ >

Agency action plan template

WORKSHEET

Element of ICIC Chronic Care Model	What are we trying to do? (Aim)	How will we try to do it? (Strategies)	How will we know how we are going? (Measures)	How long will it take? (Time frames)	What is the estimated cost? (Resources)
Health care organisation					
Community resources, policies and linkages					
Self-management support					
Delivery system design					
Decision support					
Clinical information systems					

Example agency action plan

Element of ICIC Chronic Care Model	Problem areas and priorities	What are you trying to do? (Aim)	How are you going to do it? (Strategies)	How will you know how we are going? (Measures)	How long will it take? (Time frames)	What is the estimated cost? (Resources)
Health care organisation	The team is unsure of the percentage of people with diabetes who receive routine preventive screens.	To have the diabetes team regularly review whether clinical care meets guidelines.	Regular updates in the way of graphs will be provided to the team in a newsletter format.	A single page newsletter per month showing two elements of clinical care.	Three hours each month.	Three hours of staff time to put the newsletter together.
Community sections, policies and linkages	The team is unsure of what self-management support is available in other agencies.	To identify gaps in self-management services from the agencies the team regularly refers to.	Map out self-management services within the region and identify gaps.	Choose five local agencies and conduct a map of self-management services listing the major gaps.	Two months.	Five thirty minute meetings with agencies and two hours to collate the results.
Self-management	People do not always understand how their health behaviours are linked to the findings in a clinical assessment.	To advise people by providing specific information about health risks and benefits of change.	Start with the diabetes team and have them link clinical assessment and blood test findings to behaviours in education sessions.	Education sessions have documentation about discussions of risks and benefits of change.	Two months – training session run first	Half-day training for eight staff and scheduled one hour appointment slots for the next month for new diabetics.
Delivery system redesign	People with diabetes have no regular planned appointments making it difficult to determine the health status of this group.	To organise one planned appointment per year for each person with diabetes.	Determine diabetes population using a registry and phone people for an appointment at least once over the year.	The number of people with diabetes identified that have an appointment planned within the year.	One month to determine our population and organise appointments across the year.	Ten hours of time to determine the population and organise appointments.
Decision support	Not all people with diabetes are being referred for eye and foot screening. There are no prompts for this to occur.	To build prompts for guideline-driven care into daily routines.	Use a common assessment form to highlight needed services and refer on to other agencies.	Percentage of people referred to the recommended services each year for feet and eyes.	Two months for development of assessment form.	Two ninety minute hour meetings.
Clinical information systems	People with diabetes are not routinely identified on the database system so it is difficult to identify the numbers within the service.	To identify the numbers of people with diabetes within the service so a registry can be created.	Create a database and have the team record active and new people using diabetes services.	Increasing number of people with diabetes being put on the registry.	Six months to create the registry.	Ten hours to create database. Three ninety minute meetings with the team for training and implementing information.

Testing and implementing your agency plan

Contents

Your planner

Team: Choose the same team who were involved in the health systems assessment. You may need to include new team members for the activities outlined. We encourage you to read our discussion of the improvement team at the beginning of this guide.

Resourcing: Ten hours

Meetings: You will need to schedule two to three meetings: a start-up meeting; a meeting midway through the improvement cycle and then at the end to the review results.

Tools: To successfully test and implement practice change, you will need an understanding of the Institute of Healthcare plan-do-study-act improvement cycles. We have included templates for PDSA cycle planning and progress sheet at the end of this guide. You will need your agency action plan that includes your smart aims, measures and strategies and any data you have collected from a clinical audit or process mapping.

One of the most common mistakes made in health care is how we implement change.

In our enthusiasm to get started, we often rush forward after the initial planning stage. We become tunnel visioned about what we want to introduce – a new guideline, booking system or self-management tool, without looking at the practicalities. We then underestimate the resources involved and who needs to be involved. This is why we encourage you to develop your agency plan.

Changing practice requires people to change how they habitually work. Providing the right motivation, demonstrating the benefits, testing and evaluating the impact are all necessary if we are to really change our practice.

In this guide we outline a step-by-step approach to testing and implementing your agency action plan. This approach will encourage early wins and allow your team to identify potential problems in advance of broader implementation as well as enhance their learning and confidence.

This guide is about being practical. We offer our recommendations on implementing change using plan-do-study-act improvement cycles and discuss the tools you will need to monitor what you do.

To quote the President of the Institute for Healthcare, Don Berwick, there is a significant difference between change and improvement.

Our aim in this guide is to help your team know the difference.

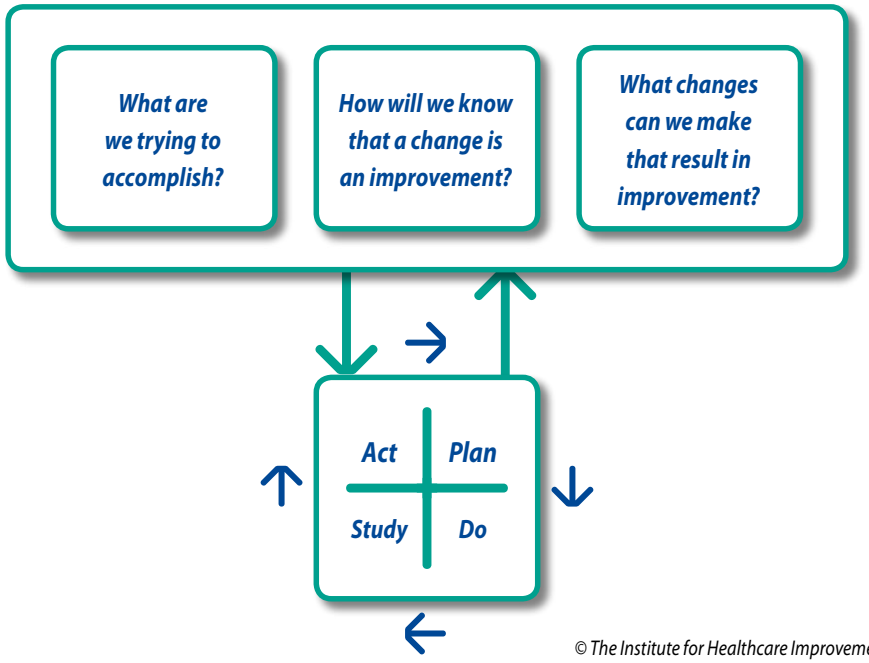
Introducing change

Now that you have assembled your team, we recommend Plan-do-study-act improvement cycles as one of the most successful approaches to introducing change in health care. We will refer to these cycles as improvement cycles. Each cycle is a four-stage approach that enables you to implement change in manageable parts. Together the four stages form a cycle that allows for an initiative to be tested before it is implemented on a larger scale.

The cycle begins with a plan and ends with action based on what has been learnt in the previous stages. This approach stops us from falling into the trap of plan-do, plan-do, where we design a change and then simply implement it. Such an approach doesn't enable us to know whether the change has had its intended impact. In contrast, improvement cycles enable us to distinguish between change and improvement. Have we simply changed how we work or have we actually improved things?

Knowing the answer to this question is critical to achieving an agency wide adoption of a new initiative or be confident that the resources we have invested actually benefit the people that we want to help.

The Model for Improvement



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Over time, the knowledge that we acquire through testing our strategies can be used to predict the impact of things we want to improve and whether they should be implemented. Once a cycle has been completed, it should be repeated again and again for continuous improvement.

Improvement cycles

As we have suggested, improvement cycles will enable you to think of change in manageable stages. Here we look at each stage in detail.

Plan

If you are completing an improvement cycle for the first time, the planning stage begins with your health systems assessment and agency action plan. It starts with the priorities of your team and the areas for improvement that they would like to tackle first. Researching what other agencies have done and looking at the evidence completes the picture.

If you are building upon a previous cycle of activity, you will use the outcomes of the study and act stages. Here you will consolidate the team's experience of introducing change and any ideas they have about the improvements that could be made. This second or maybe third or fourth cycle is about refining what you have put in place to build both the scope and the momentum of improvement you are striving to achieve.

We suggest that you work through the following questions when planning your cycle:

- *What do you want to achieve?* Describe what you would like to see happen. This will be your aim. We refer to aims in the section on *Developing your agency action plan*. Teams are asked to set aims on a smaller scale.
- *What exactly will you do?* Define the tasks and activities that your team will undertake. These will be your strategies. Strategies are practical ideas that can be tested.
- *Who will carry out the plan? Where and when will it take place?* State the people who will be involved. Define a short-time period (one to two weeks) and make it specific.
- *What do you predict will happen?* State what you think will happen as a result of your planned actions.
- *What data will you collect to know whether there is an improvement?* For tips on setting measures, refer to *Developing your agency action plan* and our discussion of SMART objectives in this guide

Do

This is most action orientated phase of the cycle. This is where you design what you want to do and go live. The team defines the tasks and activities, identifies who needs to be involved and when you will start. Ideally, the stage should be short. The team should discuss what it thinks will happen and also design measures to monitor the impact of the change to be implemented. →

Study

This is the stage where we assess the impact of what we have introduced and compare what actually happened with what we thought would happen. There are frequently gaps in what we achieve. Perhaps we didn't get all the right people involved and as a result take-up has been poor. Or we forgot to include a critical step in the process that has subsequently hindered or slowed down the take-up of the change. This is why measures are so critical. In the absence of collecting data, even sample data, we evaluate a change based on opinion rather than evidence.

Act

And finally, we conclude with the act. It is the redesign phase that involves pulling together our experience of the improvement cycle. We record any unexpected events or problems and take them into the plan stage. The cycle begins again.

Planning your improvement cycles

Start your improvement cycle with the belief that you won't get it right the first time because chances are you won't. It is important to be realistic what level of change can be achieved, especially if a model, tool or process is being introduced for the first time.

We recommend the following approaches as you plan for your improvement cycle.

- Present the PDSA approach as a staged approach to improvement, where change will be incrementally introduced.
- Encourage a team-based approach with everyone involved in the monitoring and reviewing of progress against the aims of the agency plan.
- Avoid being too ambiguous. If the scope of the work is too large or too many changes are introduced at once, the team will quickly become de-motivated as they juggle their clinical workload with these improvement initiatives.
- Avoid making the cycles too long. It is very easy to lose sight of what you want to achieve. A recommended time is one to two weeks. Anything over four weeks will be demotivating.
- Find out who needs to be involved by asking whose work will be affected. Avoid silo thinking and think agency.
- Get the support and commitment from your management team. Public statements of support will build your team's confidence and spotlight their work. Seek out opportunities to promote these improvements. →

Case study

Diabetes team

A diabetes team decides to make changes in their delivery of self-management. They begin by defining their aim, measure and strategy, before moving into an improvement cycle.

Aim: To have fifty-five per cent of people with diabetes play a central role in their care through regular goal setting.

Measure: The number of people with diabetes who have a documented self-management goal.

Strategy: Encourage all people with diabetes who attend individual consultations with members of the diabetes team to set their own goals.

Plan: Lynette, a diabetes nurse educator reads about goal setting in the literature and talks to other agencies about how they have introduced goal setting into their practice. She asks the next five people what changes they would like to make and uses what she has learnt to assist each person in setting their own goals.

Do: Lynette begins by inviting Dave one of her regular clients with diabetes if they would be interested in goal setting. She uses a goal setting sheet to guide her and uses the technique of opened-ended questions and other skills from Motivational interviewing.

Study: The response is positive; however, Lynette isn't confident about some of the Motivational interviewing techniques needed. She feels she needs more training.

Act: A training session on goal setting is organised. Lynette continues her testing of this approach to self-management and asks the next five people about the changes they would like to make and help them to set a goal. She feels more confident and other members begin to test the approach.

The next stage is to refer to your agency action plan. On it, you will have identified a number of aims and strategies that you would like to achieve. You will have also chosen some appropriate measures to determine the effectiveness of your strategies.

Using improvement cycles you can test these ideas. The following example may help you with your planning.

Linking improvement cycles

As we have suggested, testing changes is repetitive. The completion of one improvement cycle leads directly into the next.

The focus of the team is upon what worked and what didn't work? What should be kept, changed, or abandoned? The team can use this new knowledge to plan the next cycle. The team continues linking tests in this way, refining the change until it is ready for broader implementation.

Continue to repeat improvement cycles and learn about potential problems. Address these in future cycles, building momentum for ongoing improvement.

Implementing change

Once you have tested your ideas a number of times and you find something that works, you are now ready to make it part of everyday practice. To do this, you will need to communicate and engage everyone who has not been involved in the improvement team.

It is important to identify everyone who has a role in the care you are trying to improve. Be open and share information. Recognise that every member of the team plays a significant part in the person's journey. They will all offer a different and valuable perspective.

We have found that if the team is engaged early and actively involved, there will be greater ownership of the problem and the solutions.

One of the challenges of implementing change is how to measure the impact of what we do and monitoring the changes we have implemented. We also encourage you to look at the guide written by the evaluator, Roy Batterham, on evaluating the impact of self-management programs. Also refer to the guide on *Diagnosing your chronic disease care service* for tools to collect data.

Resources

Improving your practice guide has a number of resources that will assist you to test and implementation your strategies. Go to < http://www.improvingchroniccare.org/index.php?p=Clinical_Practice_Change&s=3>

NSW Health 2005. Improving care for people with chronic disease: A practical toolkit for clinicians and managers, NSW Health and is located on their web site http://www.health.nsw.gov.au/pubs/index.html

Institute for Healthcare Improvement has a range of practical resources and tools to assist you in the development of PDSA cycles. Go to <http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools>

The Health Disparities Collaboratives has produced a useful resource on changing and improving diabetes care. They describe the types of changes that are useful in improving diabetes care using the ICIC Chronic Care Model and how to use the Model for Improvement to change practice. This document can be found at <http://www.healthdisparities.net/hdc/html/home.aspx>. Click on library, then collaborative processes. It is the diabetes training manual from April 2002.

You will also find handy hints on changing practice using PDSA cycles in the resource section of the Health Disparities Collaboratives web site <http://www.healthdisparities.net/hdc/html/home.aspx>.

Australian Primary Care Collaboratives has a range of practical resources to assist you in the development of PDSA cycles. Go to <http://www.npcc.com.au/index.html>

Tips on improving diabetes care are provided on <http://www.betterdiabetescare.nih.gov>. On this site you will find the Model for Improvement, PDSA cycles, embedding evidence guidelines into practice and many other guides for changing practice. The site is based around the recommendations of the ICIC Chronic Care Model.

Improving Chronic Illness Care has much to say about quality improvement. They have a host of resources that will assist you to conduct improvement strategies. Go to <http://www.improvingchroniccare.org>

The National Quality Measures Clearinghouse™ (NQMC) is a database and website for information on specific evidence-based health care quality measures and measure sets. NQMC aims to promote widespread access to quality measures by the health care community and other interested individuals. On the website you can access detailed information on quality measures and information to further the dissemination, implementation and use to inform health care decisions. Go to < http://www.qualitymeasures.ahrq.gov/about/about.aspx>.

Committee on Quality of Health Care in America 2001, *Crossing the quality chasm: The IOM Health Care Quality Initiative*, National Academy Press, Washington. This report can be access online. Go to <http://www.iom.edu/CMS/8089.aspx>. This report makes an urgent call for fundamental change to close the quality gap and recommends a redesign of our health care systems. This report outlines a set of performance expectations for the 21st century health care system and ten new rules to guide consumer-clinician relationships. This report also documents the causes of the quality gap, identifies current practices that impede quality care and explores how systems approaches can be used to implement change.

Langley, GJ, Nolan, KM, Nolan, TW, Norman, CL, Provost, LP 1996, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, Jossey-Bass Publishers, San Francisco.

Plan-Do-Study-Act (PDSA) worksheet for testing changes

WORKSHEET

Aim: Describe the aim of this project

.....

.....

Describe your Plan-Do-Study-Act cycle	Person responsible	When to be done	Where to be done

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do: Describe what actually happened when you ran the test

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Study: Describe the measured results and how they compared to the predictions

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Act: Describe what modifications to the plan will be made for the next cycle from what you learned

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WHITEHORSE DIVISION OF GENERAL PRACTICE

Navigating self-management

A practical approach to implementation for Australian health care agencies

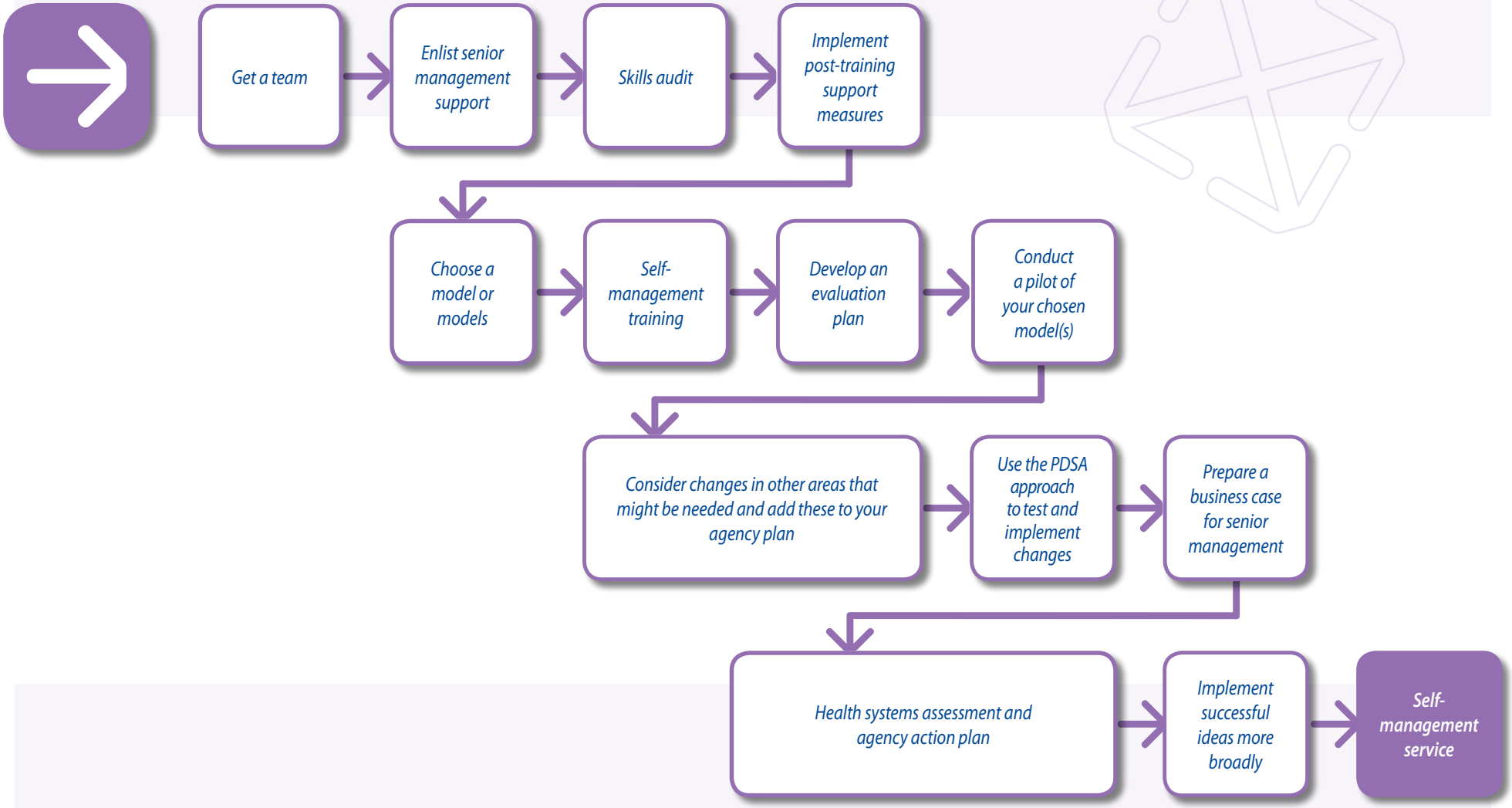
3 Implementing self-management

Authors: ***Naomi Kubina, Jill Kelly***

Editor: ***Fiona Symington***

This resource was funded by the Australian Government Department of Health and Ageing.

Navigation chart : Your road map to implementing self-management



Contents of this guide

Introduction

How to read this guide

This guide will provide you with an overview of the most common self-management approaches available and some practical recommendations to implementing them in your agency.

Implementing self-management is challenging. As a team you will need to determine what self-management model/s will work best in your agency. You will need to assess what training is needed and the changes that need to be made to get you past the post-training hurdle.

You will also want to look at the different self-management approaches you already offer that will follow people along their chronic disease journey.

We will look at each of the available approaches to self-management to help you assess what model will work best for your agency. We have included case studies so you can see each model in action. We also offer some practical suggestions to support your team post-training.

In health care, we talk a lot about the impact of chronic disease and the demand upon our agencies. The language of demand is everywhere from government funding to our own discussions about waiting lists and services planning. Demand has become the shorthand for everything that is wrong with our health system.

We suspect that as health professionals we have an uneasy relationship with self-management. We agree with it and yet feel uneasy about an approach that focuses on behaviour change and not clinical recommendations and treatment.

It is worth acknowledging such concerns from the outset and throughout this guide on Implementing self-management we will explore the challenges and dilemmas that many agencies face when trying to integrate self-management into their everyday care.

Self-management does change the nature of relationships we have with people. It challenges our presumptions about quality care and our role as health professionals. It takes us outside the roles were trained for into the unfamiliar territory of coaching and places the emphasis of care not on assessment and treatment but on the person's motivations and readiness to change.

Self-management is a very positive approach to chronic disease. It enables us to believe in people and recognise that each person has to go on their own journey of self-discovery, to make mistakes, learn from others and feel supported. This is the essence of self-management – reinforcing to people that they can proactively manage how they live.

Implementing self-management requires a shift in culture in our agencies and how we see our roles. We need to let go of the expert role to become a collaborative partner. Such an approach will fundamentally change how we provide care and will only be effective if entire teams embed self-management into usual practice. This is our aim. →

Principles of self-management

You will find that each self-management model has its own methodology and language. There can be significant differences between the tools available and how and where they can be applied. This flexibility is important when deciding how you can best respond to the needs of your communities.

Beyond these differences, self-management is informed by a set of principles that are best described as empowering the person to proactively and confidentially manage their condition.

In all the models we discuss, the role of the person in their care is consistent. This is the principle that we can sometimes find most challenging, as it seemingly contradicts how we perceive our role. Often, what we want to recommend to people – lifestyle changes, weight loss, medical compliance, simply does not match the needs or desires of that person. There is room for both. Self-management allows for a partnership approach to health care.

Self-management belongs to a social model of health. It is an approach that recognises that a person's family, workplace, community can support or impede their self-management. It also recognises that motivation and self-confidence (commonly referred to as self-efficacy) will significantly determine health behaviour change.

Implementing self-management

Five principles of self-management

Self-management involves the person with the chronic disease working in partnership with their carers and health professionals so that they can:

1. ***Know their condition and various treatment options.***
2. ***Negotiate a plan of care and review and monitor the plan.***
3. ***Engage in activities that protect and promote health***
4. ***Monitor and manage the symptoms and signs of the condition.***
5. ***Manage the impact of the condition on physical functioning, emotions and interpersonal relationships.***

Ten steps towards implementing self-management

1. Look at the results of your agency health assessment and action plan. Your action plan will remind you of the gaps you want to address in the self-management support you currently offer and provide you with a plan of where you are heading.

2. Undertake a team skill audit to understand how self-management support is currently being provided by your team. Also look at the different tools and approaches that are being used. We have included an *Audit of self-management skills in the Changing clinical practice* guide.

3. Review each of the different self-management models using our guide. We have found that agencies who successfully implement self-management use and adapt a number of models.

4. Understand your agency barriers and enablers to embedding a model/s of self-management support. Our guide on *Getting started: the road ahead* will assist you with the selection of a self-management model.

5. Consider how your team will be trained. We often hear agencies say, 'we can't afford to do the training'. We encourage you to thinking creatively about how to address this. If funds are limited, adopt a train-the-trainer approach or train some of your team in the key skills outlined at end of this guide. Getting support from your senior management team and making a business case for an investment in self-management is important.

6. Write an evaluation plan that states the outcomes and changes that you want to see as a result of your work. Refer to the guide on *Testing and implementing your agency plan* that is a part of our *Changing clinical practice* guide. This guide will assist you to evaluate what you are doing as a team.

   We have provided a guide on the evaluation of self-management programs. This guide by Roy Batterham, you'll find this guide in *Evaluating self-management*.

7. Prepare a business case for sign-off by your senior management team. Implementing self-management is an investment that will have an impact on how people will be seen and the care they receive. Leadership support will be critical. Refer to our guide *Leading change: leadership and self-management*.

8. Brainstorm all the changes that you will need to make to implement self-management. For example, do you have a diabetes registry and how will you recall people for ongoing assessment and monitoring.

9. Use plan-do-study-act improvement cycles to pilot the use of any self-management model. Refer to our guide on *Changing clinical practice*.

10. Once you have completed your pilot and assessed the outcomes, you will be ready to implement self-management. You will need a plan detailing how you will implement the model or program across your agency.

Resources

The Improving Chronic Illness Care website is an invaluable resource for any team wishing to introduce self-management and improve the quality of their chronic disease care <https://www.improvingchroniccare.org>.

Coleman, MT & Newton, KS 2005, 'Supporting self-management in patients with chronic illness', *American Family Physician*, vol. 27, no. 8, pp.1503-1510

Von Korff, M , Gruman, J, Schaefer, J, Curry, SJ & Wagner EH 1997, 'Collaborative management of chronic illness', *Annals of Internal Medicine*, vol. 127, no. 12, pp. 1097-1102

Jordan, JE & Osborne, RH 2007, 'Chronic disease self-management education programs: challenges ahead', *The Medical Journal of Australia*, vol. 186, no. 2, pp. 84-87

Getting started: the road ahead

Contents

Your planner

Team: When selecting your team, you need to think about the impact self-management will have on your agency. We recommend that you include a manager, support staff and members of the chronic disease care team. Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to *Changing clinical practice*.

Resourcing: Twenty hours.

Meetings: Ten meetings.
We recommend that you organise a series of meetings over a number of months.

The process of implementing self-management seems easy enough. You select a self-management model, undertake the training and then ask the team to implement it.

We have seen this approach frequently and the results are always mixed. Despite much good will and effort, many agencies have had to face the difficult realisation that the uptake of self-management has been poor and at best ad hoc. Yes, awareness of self-management has increased but the team feels frustrated and disillusioned by the process.

Implementing self-management spotlights how we work as a team and how we work as an agency. Effective implementation requires more than just training a few people. It is to embark on a journey that involves everyone. It is an opportunity to identify how you want to work as a team and the supports you need to embed self-management.

Self-management is not a one size fits all. A systems approach will enable you to target and stream people into interventions that will benefit them and match their life stage. A health system that can respond to people's readiness to take on self-management means we can cater to individual needs.

How do we select a self-management model?

Some self-management approaches models offer additional skills to the health professional to promote and motivate health behaviour change, assist people to manage the emotional difficulties of living with chronic disease and support people to self-manage.

Other self-management approaches are targeted to the person with the chronic disease, an example of this are group programs. People attend a group course and learn skills from trained leaders and each other. The emphasis is on peer support and role modelling. All self-management approaches reinforce the person's central role in managing their condition and all the ones we discuss are based on sound evidence.

Choosing a model is a training investment, the benefits of which can last well after the initial training. As we have already suggested, training is not something to be considered as a one-off event, rather it is something that happens over two to three years. Such time-frames reflect the nature of change. Change management is about engaging your team in the process of redesigning how services are offered and the focus of your service. The benefits need to be explored and the tensions and conflicts acknowledged and resolved.

The process can be lengthy because of the need to engage everyone is the redesign process. Enforced change very rarely works. For change to be successful, teams need to be involved in designing how they work and how implementation will take place. Making this substantial change requires effort and will. Changing practice will not occur in a matter of months. We talk more about this in our guide *Leading change*.

Starting the self-management journey

How do you choose a self-management model? What makes one better than another? Is it possible to combine the different models available? How do we make effective use of our resources? All agencies are different and what will work in one agency will differ from what will work in another.

To assist you to choose a model, it is worth considering the following questions.

- Which model fits our overall aim for chronic disease care?
- What is our training budget? What training can we afford to implement?
- Who should use this model?
- Who will we target?
- What skills do we have as a team?
- What challenges are we likely to face? How can we overcome them?
- What post-training support will we need?

We recommend that as a part of your preparations to implement self-management that your team undertake the *Audit of self-management skills* included in this guide.

Eight popular self-management approaches

These are the eight most recognised self-management approaches used in Australia. We will discuss each of them in detail throughout this guide:

- Flinders University Model for Chronic Condition Self-Management
- The Five A's
- Motivational interviewing and the Transtheoretical Stages of Change
- Model of Health Coaching for Chronic Condition Self-Management
- Coach Program: Coacing People on Achieving Cardiovascular Health
- The Chronic Disease Self-Management Programme (known in Australia as the Better Health Self-Management Program)
- Group education
- Group clinics

Guide to implementation

Implementing self-management goes beyond training. To implement self-management in a consistent way, we recommend that you develop a pathway detailing how people will access self-management services that addresses the areas listed:

Intake or prioritisation systems

- Prioritise people with chronic disease according to their level of risk and need.
- Inform people of the focus on self-management, so they are aware that it will be a part of the care they receive.

Screening and assessment

- Train the entire team and involve them in screening people for their self-management needs.
- Train teams to target approaches to the person's readiness to make health behaviour change.
- Standardise assessment processes to include self-management and ensure routine and assessment is based on best practice guidelines. →

Education and care planning

- Consider training your team in the core skills for self-management. This will equip everyone with the basic skills to use the self-management models we discuss. Refer to *Core skills for self-management*.
- Introduce self-management approaches into current client education sessions, so people are not merely provided with information but supported to make and sustain long-term behaviour change.
- Implement care planning that ensures each person with a chronic disease has a care plan that drives their care. A care plan should be the cornerstone of chronic disease care. It identifies the roles and responsibilities of each team member with the person at the centre.
- Standardise care planning processes to include self-management and ensure treatment and management follows guidelines.
- Develop a pathway to target self-management approaches based on readiness.
- Have a system for regular case-conferencing to ensure it is a part of all job roles. This will assist your team to feel supported, especially with the management of people with significant complexity.

Follow-up

- Develop systems that enable team members to initiate follow-up. Good recall and review systems should contain reminders.
- Embed self-management goals into registries to act as prompts for reminders and planned visits.
- Redesign practice to make the most of the entire visit. The process map (at right) is an example of how self-management can used to rethink how services are provided.

Commonly asked questions about self-management

What are the cost implications?
How do we juggle the demands to see more people with doing self-management?

It is important to recognise these tensions within our health system. This is why we encourage the early involvement of your senior management team. Self-management has many implications for an agency. There is the cost of initial training and any tools. Longer term, balancing self-management within funding formulas needs to be addressed. This is outside your role as a team, so you will need to get the support of your manager to address these operational issues.

Who should be involved?

A team should consist of representatives from the chronic disease care team, a manager who has the authority to make decisions about change, and a leader with enough drive to lead the process.

When selecting who should be involved from the chronic disease care team, we recommend you select health professionals who are most involved in the care you are trying to improve. →

Process map - a practical way of making the most out of visits from a general practice setting

When assembling your team include people with different roles from within your agency. This way you will achieve a rich array of expertise, views, thoughts and ideas. An example might be an arthritis team consisting of a physiotherapist, an occupational therapist, a nurse and a podiatrist. Or you might have a district nursing service that includes a number of field nurses, an intake staff member and a receptionist.

We recommend that you read the guide on *Changing Clinical Practice*, in particular our discussion of teams.

Do we start with one chronic disease and then roll out to others?

Start with one chronic disease and use an improvement cycle approach to help you breakdown the work into bite-sized pieces. By narrowing your focus, you can build systems and processes that make it easier to roll out self-management to other chronic diseases in the future. With one disease, it is also easier to analyse your current practices and programs.

What are the benefits of this work?

All the evidence shows self-management has a positive impact on people's health and well-being. People stay well for longer and their need to re-visit their health professional unexpectedly is reduced. Self-management empowers people to take responsibility for their health and most agencies using self-management report that people like the feeling of being in control of their health.

So what are the benefits to you, the chronic disease care team?

We have worked with many agencies and in our experience, we have seen improved team satisfaction and cohesiveness. Self-management improves how we provide care. It is proactive, reduces the number of people that represent with acute problems and promotes more collaborative and streamlined care. As an approach, it enables us to improve and create more efficiency in our systems. We focus on populations of people, how we deliver services and support people through their chronic disease journey.

What do we do if people don't want to self-manage?

We need to encourage people and to shift the expectations people have of health care.

Some people expect to be quite passive – they go to their doctor or health professional with the aim of getting their problem/s fixed. However, chronic disease is often lifelong, many times incurable, and highly dependent on the person's own ability to manage. We need to promote through consistent messages the nature of chronic disease and the vital importance of self-management in improving health.

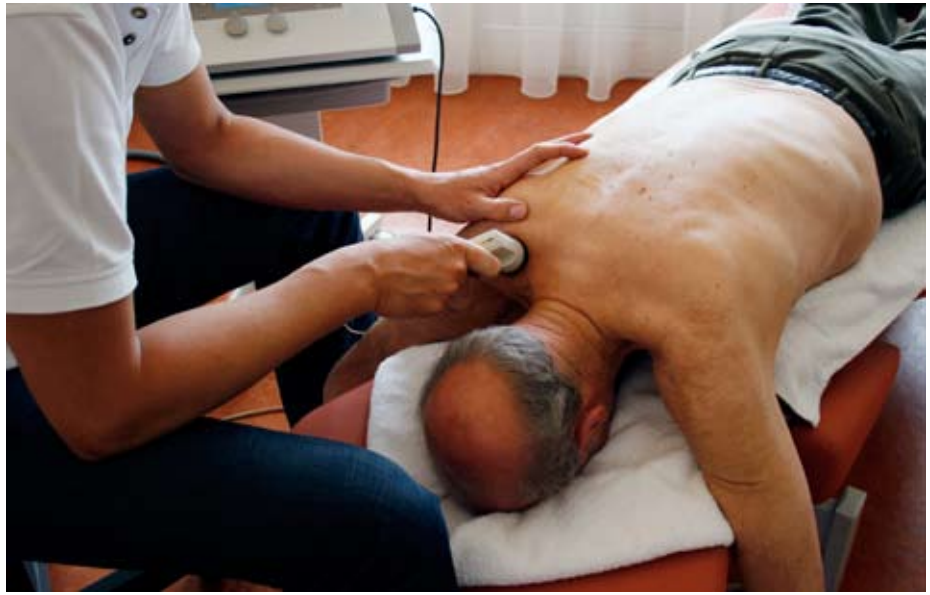
There will always be people who aren't interested in self-management. For this group, making use of the self-management approaches such as Motivational interviewing can be helpful. We discuss this model in this guide.

Do we need additional funding to do this work?

Not necessarily. Agencies can start small by providing basic training in the key skills referred to in this guide. Introductory training can be provided by a local psychologist and should take four to six hours. Many agencies already employ psychologists or have easy access to private ones.

Self-management is a training investment, not a one-off workshop. Many agencies have existing training budgets that can be re-organised to include self-management training. Organisers of training budgets need to involve staff in understanding the investment over the long-term and encourage them to be trained.

It can be useful to obtain a funding grant to undertake a small pilot. This will provide staff with learnings that can inform broader implementation. A grant of $5000 is sufficient to test a self-management model on a small group of people.



Resources

Selecting a team and improving practice

The Improving Chronic Illness Care website provides a range of tools and resources that will assist agencies select an improvement team <https://www.improvingchroniccare.org/tools/index.html>.
The Institute for Healthcare Improvement is also a very useful website <https://www.ihi.org>

The benefits and importance of a systems approach to self-management

Good Life Club offers resources to agencies wishing to embed self-management into practice. Go to the Good Life Club website < http://www.goodlifeclub.info/index.php>.

Managing change and building capacity

NSW Health Department, 2001, A Framework for Building Capacity to Promote Health, Better Health Centre – Publications Warehouse, NSW. A full copy of the report can be downloaded from <http://www.health.nsw.gov.au/pubs/index.html>

QLD Health has developed three key documents on managing change. These guides are designed to be the first point of call for anyone involved in a change process and can be accessed on the QLD Health website <http://www.health.qld.gov.au/publications/change_management/>.

Victorian Department of Human Services, 2007, Victorian Service Coordination practice manual.
Go to <http://www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm

Improving self-management

The California Health Care Foundation website has some great resources to assist you with self-management < http://www.chcf.org/topics/chronicdisease>. Of note is a thirty minute video that can be downloaded free of charge. This video contains useful steps to improve a person's self-management and addresses the topic of designing person-centred personal health records, seven models for successful self-management support, tips for helping people manage medication costs, self-management tools and using telephone support.

Available approaches to self-management

Contents

Your planner

Team: We recommend that your team include a manager, support staff and members of the chronic disease care team. Your decision will be guided by the availability and the size of your team.

Resourcing: 5 hours

Meetings: Two to three meetings.

How to read this guide

Firstly we ask you get to know the core skills required for your team to implement self-management with your client group. We then suggest you undertake an audit of self-management skills of the team and use this as the basis for your team to recommend a way forward.

We then offer some cue questions for choosing a self-management model and a suggestion for how to combine the various models in a health setting.

We then go on to describe the different approaches available in Australia at present, taking particular note of the challenges for agencies.

Choosing a model of self-management for your agency is a training investment so needs careful consideration. We have found that many agencies hear about particular approaches to self-management and choose what other services are using or what might seem easy to implement at the time.

We provide a framework for a more considered approach to this decision-making.

Core skills for self-management for health professionals to undertake self-management

Core skill	Description	Examples of when to use the skill	Further information
Problem solving	Necessary skill for people with chronic disease to learn. Enables people to make confident decisions concerning their health. Health professionals can use it to assist people to identify their problems, solve barriers to change and solve clinical issues.	• When teaching how to apply new information • Difficulties in managing • Difficulty achieving goals • In group sessions	Refer to *Problem solving worksheet* .
Targeting, goal setting and planning	Targeting focuses on one problem at a time. Should be important to the health professional and person. Goal setting is one of the five core skills required for people to self-manage. Health professionals can use it to assist people to focus on a specific problem, establish realistic objectives, and develop a personalised action plan.	• At each assessment • For problems that occur after the last session • When difficulties are identified and people have decided what to do • In group sessions	Refer to *Goal setting worksheet* and *Action-planning worksheet.*
Identifying follow-up needs	People with chronic disease need a proactive approach to care and ongoing follow-up. Follow-up visits should be planned, initiated by the health professional and provide monitoring. Health professionals can use it to assist people to ensure medical care, guide behaviour change and provide emotional support.	• When developing a care plan • After each contact • When organising a series of planned patient visits across a year	
Reflective listening	Active process that reflects back the meaning the person has just communicated. Checks rather than assumes you know what is meant. Less likely to evoke resistance Encourages people to express their own arguments for change.	• During assessments and interviewing • When working through problems • When exploring ambivalence and resistance to change • When discussing target behaviours	Refer to *Using reflective listening.*

Core skills for self-management for health professionals to undertake self-management *(continued)*

Core skill	Description	Examples of when to use the skill	Further information
Open-ended questions	Creates an atmosphere of acceptance and trust. Allows people to explore concerns. People do most of the talking and the health professional listens using reflective listening. Allows people to establish their own reasons for change.	• During discussion in groups • When exploring ambivalence and resistance to behaviour change • During problem solving and goal setting sessions • When discussing target behaviours	Refer to *Using reflective listening*.
Identifying a person's readiness to change	Enables health professionals to assist people to accomplish the various tasks required to transition through the change process. Interventions need to be matched to readiness.	• When discussing target behaviours • During coaching sessions • When working through barriers to change	Refer to our discussion of *Motivational interviewing and the Transtheoretical Stages of Change* in this guide.
Assertiveness skills	Enables health professionals to challenge resistant, defensive or aggressive people. Enhances health professional confidence to raise difficult issues and challenge people about change.	• In resistant, defensive or aggressive situations • Where there are negative health behaviours • When people have not achieved any change	Refer to *Steps to manage resistance guide*.
Depression screening	Depression and a sense of grief and loss are common in chronic disease. Health professionals should be familiar with the symptoms of depression. Provides health professionals with the confidence to assess a person's risk.	• Depression screening should be a routine part of assessment • It should accompany primary assessment	Go to http://www.beyondblue.org.au to download a depression screen or fill it online with the person.
Assessing suicide	Clinical depression in chronic disease is common. Suicide assessment is often omitted due to the lack of training to address such issues. Health professionals should be familiar with the symptoms of suicide risk. Provides health professionals with the confidence to assess person's risk.	• Those at risk of clinical depression • The expression of significant discomfort with life • Discussion of previous attempts at suicide • Talk of ending their life	Ask questions such as: Have you ever thought about killing yourself? Have you got a plan? Have you got the means? Help the person make a counter-plan to suicide. Get emergency help, if needed. →

Audit of self-management skills

WORKSHEET

The purpose of this worksheet is to understand and determine the skills of your team in providing self-management support. The questions are based on how confident health professionals are with the core skill requirements outlined in this guide.

Instructions: Have each health professional in your team complete this worksheet.
This worksheet asks you about how confident you are with using various skills important to practising self-management. Circle the answer that best describes your confidence.

Question	Level of confidence										
How confident are you that you could:	None					Some					Extensive
• Teach people to identify and solve their own problems?	0	1	2	3	4	5	6	7	8	9	10
• Assist the person to focus on one problem only?	0	1	2	3	4	5	6	7	8	9	10
• Assist the person to develop a SMART goal and a personalised action plan?	0	1	2	3	4	5	6	7	8	9	10
• Use reflective listening, that is, reflecting back to the person the meaning of what they have said?	0	1	2	3	4	5	6	7	8	9	10
• Use open-ended questions to explore a person's readiness to change?	0	1	2	3	4	5	6	7	8	9	10
• Ask appropriate questions or use scaling techniques to elicit readiness for change?	0	1	2	3	4	5	6	7	8	9	10
• Match interventions and/or questioning to readiness?	0	1	2	3	4	5	6	7	8	9	10
• Challenge people that are defensive, resistant or aggressive about changes in their health whilst maintaining a therapeutic relationship?	0	1	2	3	4	5	6	7	8	9	10
• Use a depression screening tool during assessment?	0	1	2	3	4	5	6	7	8	9	10
• Know what questions to ask people you think may be at risk of suicide?	0	1	2	3	4	5	6	7	8	9	10

We recommend that you review the results of this audit, to identify the strengths and weaknesses of your team in each of the listed core skills. This information should provide the basis for decisions about training and the levels of support required.

Choosing a self-management model

WORKSHEET

The purpose of this worksheet is to help your team identify the agency barriers and enablers to embedding a model/s of self-management support.

Identifying and targeting suitable people (risk-screening/needs assessment/ intake)

1. Who of the people we see with chronic disease are best suited to our self-management model?

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2. How will we identify these people at intake and who will be responsible?

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Team functioning

3. What changes do we need to introduce for our team to adopt the self-management model/s we have chosen?

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Referral processes and follow-up

4. How can we maximise internal and external referrals to this service?

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5. How can we improve communication so a person's self-management issues are identified and addressed?

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6. How will we reorganise follow-up for people and who will be responsible?

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Training considerations

7. Who will do the training? Will we train everyone?

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8. What support structures need to be in place for people who aren't trained?

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Post-training support

9. What ongoing support needs to be offered to build the team's confidence and use of the model?

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10. How will this support be put in place and who will be responsible for coordinating it?

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Combining self-management models

This tool provides an example of how to combine the various self-management models we describe in this guide. Here we look at how health coaching, Motivational interviewing and the Flinders University models can be used. This is a process used by key workers and coaches in the Whitehorse Good Life Club of Whitehorse Community Health Service, Victoria.

Timelines and the order of processes can be modified according to the person's needs and the clinical judgment of the health professional. The exception to this modification is the evaluation and communication with the person's general practitioner.

Date	Stage of Change	Action	Frequency of contact and length of sessions
First session	Pre-contemplative Up to three month intervals	• Complete *Partners In Health* scale (from Flinders University model) • General discussion using initial interview structure as a guide • Complete evaluation tool • Discuss the options available as part of the Good Life Club (the name of the self-management program) • Complete consent form • Make appropriate referrals	Face-to-face sessions Forty-five to sixty minutes in length
Second session		• Discuss psychosocial issues and health service needs using survey as the basis for discussion • Decide with person whether to proceed to coaching (Flinders University model) or to complete wellness plan from these two sessions and proceed to key worker level of involvement • Letter to general practitioner requesting clinical indicators and advising of initial plan	Face -face sessions Forty-five to sixty minutes in length
Third session	Ensure person is at least in Contemplation	Complete *Cue and Response* interview (from Flinders University model)	
Fourth and fifth sessions	Preparation	• Problems and goals and wellness plan • Ensure initial evaluation is completed (including clinical indicators) • Consider need for case discussion with other health professionals and/or GP	
Up to three months		Regular coaching and working through care plan	→

Combining self-management models *(continued)*

Date	Stage of Change	Action	Frequency of contact and length of sessions
Third to sixth month	Action	• Regular coaching • Consider referrals (letter to GP) • Consider phone coaching • Decrease frequency of contact	Contact decreasing to monthly Length of sessions thirty minutes or shorter
Six months		• Review wellness plan • Evaluation • Feedback to GP (request review of clinical data)	
Seven to twelve months		• Coaching at monthly intervals • Consider linkages and referrals to groups	
Twelve months		• Review wellness plan • Evaluation • Feedback to GP (request review of clinical data)	May be face-to-face or phone call
Thirteen to eighteen months	Maintenance and prevention of relapse	• Phone coaching on a two to three-monthly basis • Encourage self-directed problem solving • Consider community linkages • Relapse prevention	Phone call every two to three months
Eighteen months		• Evaluation • Where to from here • Feedback to GP	Link to community resources
Ongoing	Not ready for Whitehorse Good Life Club	• Continue on newsletter mailing list and involvement in peer directed activities • Door still open for review of needs if requested	

Overcoming the post-training hurdle

Using self-management in clinical practice requires us to adopt a new role in chronic disease care. As coaches, we will motivate, listen and encourage a person to become their own advocate for change. Our role is to explore and coach any motivation for change. This role will challenge our perceptions of who we are as health professionals and the approach and language used in clinical practice.

We have spoken of the post-training hurdle throughout this guide and of the support that chronic disease care teams need to fully implement any training. Such support is critical to gain the confidence to use the skills that underpin each of the self-management models we describe.

Many of these skills will be unfamiliar and cannot simply be acquired at a single event like a workshop. They need to be practised. Opportunities need to be created that give the team time to reflect, reformulate and refine their approach to self-management in clinical practice.

The challenge of self-management is two-fold. First, there are the new skills to be acquired as discussed throughout this guide. Using these skills can be unfamiliar, as we test how we will use them. The second challenge is the unlearning of familiar ways of working and habits. Some of these skills are deeply entrenched and form a part of our identities as health professionals.

Options for training

Miller and Rollnick in *Motivational interviewing: preparing people for change* have recently questioned the efficacy of a workshop as the best approach to learning.

This is worth considering as most of our training is delivered through this format. If the implementation rate of most self-management training is anything to go by, then how we train our teams needs to be re-considered.

Our aim is not to be overtly sceptical but our experience indicates that very few agencies adopt the self-management models they train people in. Self-management has been most successfully adopted by teams specifically funded to do this work. This is fine but the impact will always be limited to the people that this team sees. What about everyone else?

Training workshops provide health professionals with time to reflect, meet colleagues, observe others and discuss clinical issues. However, such training is very detached from routine clinical experience and agency demands. The result is that the team is left with the onerous task of integrating their training after the workshop without the support of the training team and often their agency.

We also know that the one-off nature of workshops does not match what we know about adult learning. It takes more than one go to get something right and importantly, a case study in a training sessions can be very different from dealing with a similar issue with a person with chronic disease.

Practice change takes time and practise. This is why we suggest buddy systems, e-bulletins and regular meetings of teams to discuss the impact, benefits and challenges of introducing new self-management approaches.

We are not suggesting that workshops should be discarded. What we do want to do is to encourage teams to pursue and develop different ways of learning.

Nor are we seeking to devalue our current skills in managing people with chronic disease. Actually the opposite: we are interested in how we can enhance how we provide care by adopting self-management as a part of routine care.

Overcoming the post-training hurdle *(continued)*

Training approaches

So, how do we promote different types of learning? What are the options?

Miller and Rollnick outline a number of options that will enhance learning beyond the attended workshop.

Learners require practice, feedback and encouragement. Closeness to everyday context is particularly important.

Avenue for learning	Description
Simulated care sessions	Using actors is a common learning experience in psychology training. The key is the immediate provision of feedback by a trained supervisor. This process can also offer an assessment of competency.
Tapes and transcripts	This includes tapes of actual practice to discuss and compare experiences with team members. It provides a recent common experience The key is providing an opportunity for reflective practice: learners are given the time to absorb, reflect on and write down what they liked and what they would change.
Peer consultation	This approach enables teams to work together using peer consultation to learn from and encourage each other by discussing cases, reviewing tapes and practising skills. An outside trainer can be involved from time to time by reviewing and commenting on practice examples.
Supervision	This involves having health professionals receive feedback from a person more highly trained. This can be done via all the above methods.
Train-the-trainers	Training trainers (t-trainer) is a cost effective way of rolling out training throughout an agency. The Flinders model has a formal process for becoming a t-trainer. This involves having participants sit a certificate of competency and undertaking further training to teach others. Health coaching is also accompanied by a certificate of competency. Those that demonstrate advanced skills may also be able to become a facilitator/supervisor.

Available approaches of self-management support

Model	Description	Advantages	Challenges	Contact
The Flinders University Model	• Used by health professionals in individual consultations. • Assesses self-management with an exploratory interview and establishes a collaborative partnership through care planning, problem solving and goal setting.	Assesses a person's self-management practices. Uses open-ended questions. Uses core elements of effective self-management support. Tools can be used for screening and evaluation.	Requires agency decisions about which consumers will benefit. Interviews can be lengthy. Can generate health professional resistance due to time issues.	Contact Flinders Human Behaviour & Health Research Unit. <http://som.flinders.edu.au/FUSA/CCTU/home.html>
Five A's Model	• Tool for health professionals. • A counselling approach used to enhance the likelihood of behaviour change in people. • Based on five steps that enable health professionals to understand a person's beliefs and knowledge about their disease. This understanding becomes the basis for how to guide a discussion.	Offers a communication style that acknowledges the expertise people have in living with their condition. Provides only the amount of information and level of detail people desire.	Requires training and support to health professionals. Takes time for skill consolidation. Requires health professionals to reflect on their own practice.	Contact your local university health psychology department or the Australian Psychological Society. Lifescripts resources for use in general practice. Contact <http://www.health.gov.au/lifescripts>
Motivational interviewing	• Assists people to come to their own decision by exploring their uncertainties using directive questions and reflective listening. • Developed by Rollnick and Miller and has an extensive evidence-base. • Ongoing training and support of staff to consolidate skills is required.	Teaches skills to health professionals that help manage resistance and ambivalence.	Requires significant training and support. Takes time for health professionals to consolidate skills. Requires health professionals to reflect on their own practice.	Contact your local university health psychology department or the Australian Psychological Society. Miller, WR & Rollnick, S 2002 ,Motivational Interviewing: Preparing people for change, 2nd edition, The Guildford Press, New York. <http://www.motivationalinterviewing.org/>

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Available approaches of self-management support *(continued)*

Model	Description	Advantages	Challenges	Contact
Health Coaching	• Assists people to achieve positive health and lifestyle outcomes through attitude and behaviour change. • Helps health professionals motivate people toward readiness to change, change unhelpful thinking patterns and encourage self-management of lifestyle risk factors and treatment regimes. • Developed from evidence-based principles and techniques from health and coaching psychology.	Provides health professionals with a range of skills that assist people towards health behaviour change. Provides additional skills to Motivational Interviewing.	Requires significant training and support. Takes time for health professionals to consolidate skills. Requires health professionals to reflect on their own practice.	Contact Health Coaching Australia <http://www.healthcoachingaustralia.com>
The COACH Program	• A prevention program that trains people who have been hospitalised with coronary heart disease to pursue the target levels for coronary risk factors. • People are coached to achieve the targets for their risk factors and to take the recommended cardio-protective medications.	Coaches work in partnership with the person's usual doctor. Tested in two randomised controlled trials. Coaching people specifically about risk factors and to achieve recommended targets.	Currently a hospital or general practice based program. Needs integration into health system to develop GP and primary health professional partnership.	Contact margarite.vale@gmail.com
Better Health Self-Management	• A six-week course that teaches core self-management skills to people with a chronic disease. • Highly structured and to be led by trained lay people or health professionals. • Developed by Professor Kate Lorig and researchers at Stanford University, USA.	Teaches skills that assist people to more confidently self-manage. Generic for multiple conditions. Provides role modelling and peer support. Action planning enhances motivation.	Recruitment of participants. Works better with targeted health professional referral. Needs integration into health system to develop health professional referral base.	Contact the Arthritis Foundation in your state <http://www.arthritisaustralia.com.au> For additional information about this program, contact Stanford University <http://patienteducation.stanford.edu/programs/>

Available approaches of self-management support *(continued)*

Model	Description	Advantages	Challenges	Contact
Group education	• Much of the provision of health education to people in a group setting is information based with little behavioural techniques incorporated. • Group education programs should adopt the five principles of effective self-management support and be based on the person's perceived problems. • Include techniques such as brainstorming, problem solving and action-planning.	Provides opportunities for role modelling and peer support. Opportunities for learning from others. Increased knowledge of participants.	Requires health professional training to incorporate the additional behavioural elements. Needs to be offered as a routine part of care and as a regular element of the group. Requires follow-up support after group completion.	Good Life Club website <http://www.goodlifeclub.info/index.php>
Group clinics	• Differs to usual group education programs as it focuses on clinical assessment and treatment within a group setting. • Also includes self-management strategies, such as problem solving and goal setting, which are a key part of every group.	Helps to manage waiting lists. Promotes an interdisciplinary approach to care. Ideal for the review of people with chronic disease.	Requires planning to implement Requires a team approach, where roles and responsibilities of team members are discussed.	Beck A, Scott J, Williams, P, Robertson, B, Jackson, D, Gade, G & Cowan, P 1997, "Randomized trial of group consumer visits for chronically ill elderly HMO members: The Cooperative Health Care Clinic", *Journal of the American Geriatric Society*, vol. 45, pp:543-549. For a guide on setting up group visits, go the Improving Chronic Illness Care website <http://www.improvingchroniccare.org.

Goal setting

WORKSHEET

A personalised action plan

In writing your action plan, be sure it includes:

- **what** you are going to do,
- **how much** you are going to do,
- **when** you are going to do it, and
- **how many** days a week you are going to do it.

For example:
This week, I will walk (what) around the block (how much) before lunch (when) three times (how many).

This week I will :

..... (what)
.....(how much)
.....(when)
.....(how many)

Level of confidence	Not at all confident										Totally confident
• How confident are you?	0	1	2	3	4	5	6	7	8	9	10
• How much do you believe this will benefit you?	0	1	2	3	4	5	6	7	8	9	10

Day of week	Check off	Comments
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Adapted from Lorig, K, Homan, H, Sobel, D, Laurent, D, Gonzalez, V, Minor, M 2000, Living a Healthy Life with Chronic Condition, 2nd edition, Bull Publishing Company, Colorado.

Problem solving

WORKSHEET

Identify and define the exact and specific problem

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Generate a list of possible solutions

Possible solutions	Evaluate each listed solution	
	Advantage	Disdvantage
1		
2		
3		
4		
5		
6		
7		
8		

Review how you went – what worked and what didn't?
What would you do differently next time?

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Using open-ended questions

Here are some sample open-ended questions to ask about self-management:

1. ***What are you concerned might happen as a result of your health condition?***
2. ***Lots of people have had problems with medications. Tell me about any problems you might have.***
3. ***Self-management decisions are experiments that will lead you to more effective and satisfying management of your condition. Tell me about a self-management experiment you tried that didn't work out well.***
4. ***Can you think of a self-management experiment you tried that worked well and you will continue to do?***

Open-ended questions exercise

It is easy to assume that using open-ended questions is easy. Read through the following exercise to identify which questions are open. Do you use any of these types of questions in your practice?
It is common for us to use leading questions without being aware of it.

- Do you want to stay in this relationship?
- Have you ever thought about walking as a simple form of exercise?
- What do you want to do about your smoking: quit, cut down, or stay the same?
- In the past, how have you overcome an important obstacle in your life?
- When would you like to set a quit date?

Here are the answers:

- Closed question, answered by yes or no. An open question would be 'what would be the good things and not so good things about staying in this relationship?'
- Advice veiled as a closed question, for which the literal answer is yes or no. This is what we refer to as a leading question. It is assuming the person likes walking or would take that as an option. An open-ended question would be, 'If you decided to exercise more, what kind of exercise might be most appealing or acceptable to you?'
- Closed question. Drop the multiple choice options at the end and it becomes an open question.
- Open question.
- Closed question, asking for a specific piece of information – a date.

Using reflective listening

Reflective listening is often mistakenly assumed to be a repetition of the words a person has said to you. A more effective use of reflective listening is to interpret the meaning of what a person has said.

Example:
Susan comes to you in relation to her weight. She is overweight and her doctor feels she would benefit if she lost a few kilos. She has angina and high cholesterol and has a very strong family history of heart attacks. She does not seem too concerned by the problem.

You: Hello Susan, your doctor informs me that you are here because your cholesterol is high and he would like you to lose some weight. What do you make of that?

Susan: He said that, did he? I've lived with this problem for years and it doesn't seem to make much difference.

It would be easy to respond to this statement beginning with 'but...'. However, a reflective response is much more likely to engage Susan in further conversation. For example:

You: You seem surprised by what he said, but don't appear too worried about his concerns in relation to your high cholesterol or weight.

Here you are picking up on Susan's tone of voice, her body language and her words.

Picking up on both non-verbal and verbal forms of communication is important as most of our communication is non-verbal.

Susan is likely to respond to your reflective response with some thoughts on why she is unable to lose weight and some of the problems she might be experiencing.

You are also likely to get some indication into how ready she is to make some health behaviour changes. Her answers will assist you reduce resistance. You can confirm what she had said and help her feel heard.

You can use the techniques of Motivational interviewing to explore her issues and concerns.
You can try this anytime you experience some form of resistance with someone.

Steps to manage client resistance

Four key steps to managing client resistance

1 ***Listen carefully. Listen to verbal and non-verbal cues, as these will tell you how the person feels and thinks about what has been said.***

2 ***Use reflective listening to acknowledge what the person has said.***

3 ***Ask open-ended questions using the Motivational interviewing approach to provoke thought.***

4 ***Ask the person to consider the future of changing and not changing.***

Case study

Sample interview

Susan comes to you frustrated as she is not able to lose weight. Her doctor has told her many times that she needs to lose weight to improve her arthritis.

Susan: I've tried to lose weight. I eat all the right things and I walk and run after the kids. I'm exhausted. And it still won't come off.

You: You do everything you know how to lose weight and it doesn't budge and that frustrates you.

Susan: Right. I try with my diet and I walk at least a couple of times through the week. I might have the odd snack but most times I am pretty good.

You: Tell me a little bit more about what you've been trying, so we can try and get to the bottom of what is happening. Let's start with the walking you're doing.

Susan: Well, I walk every week like I said, usually a couple of times. I don't always get out as it is cold and that makes it hard.

You: How much walking do you believe you should be doing?

Susan: I know I should try to walk every day. But it does get cold now, as it's winter.

You: How do you think what you're doing compares with the amount you believe you should be doing?

Susan: Well I'm probably not walking enough. Do you think that's why I haven't lost the weight?

You: Well it's likely to be one of the factors but what do you think? And importantly, how concerned are you about the fact that maybe you're not walking enough given at the beginning you felt you were doing all you could?

Susan: I don't like it. I know I should do more but it's so hard to fit it in, you know. And this weather, it gets so cold.

You: Let's imagine for a minute, that you were in the same boat in five years time – you were still walking the same amount as you are now. What do you think might happen? What do you think this future would look like?

Explanation of scenario

Firstly, acknowledge Susan's situation and her frustration. The frustration was picked up by her tone of voice and body language. You then ask an open-ended question to get more information from Susan about her situation and what she is doing.

Notice you never told Susan she wasn't doing enough walking. Instead you allow her to explore this for herself using open-ended questions. This enables Susan to go on a journey of self-discovery. You then ask her how concerned she is about it.

Finally you conclude by asking her to imagine the future if she never does any more walking. In this way, she is allowed to explore further reasons for change.

Flinders University Model of Chronic Condition Self-Management

Contents

Your planner

Team: When selecting your team, you need to think about the impact self-management will have on your agency. We recommend that you include a manager, support staff and members of the chronic disease care team. Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to *Changing clinical practice*.

Duration: Two-day training course. Train-the-trainer is also available following awarding of competency.

Training: Initial training is two days. To obtain the certificate of competency, health professionals are required to submit completed self-management assessments on three people.

Competencies: You need to be accredited with a certificate of competency to use the tools.

Meetings: Two to three meetings are required to discuss the options for implementation.

Tools: Flinders does not give permission for the use of their model and tools without appropriate training. The tools are *Partners in Health Scale, Cue and Response Interview, Cue and Response Summary Form, Problems and Goals Assessment and Self-Management Care Plan.*

Flinders University Model of Chronic Condition Self-Management is a tool for health professionals. It provides a structured approach to self-management assessment and care planning. Developed by the Flinders Human Behaviour and Health Research Unit South Australia, the model provides a person-centred framework for collaborative problem definition, goal setting, care planning and review using a series of guided questions that act as decision prompts.

The Flinders Model aims to link the general practitioner, health professionals and people with a chronic disease with community delivered self-management programs. It promotes people to engage in their care to achieve improved compliance with medical care and adoption of lifestyle change. Importantly, it is designed to be a generic program that can be applied to any medical or psychiatric condition and co-morbidities.

The Flinders Model is becoming increasingly recognised as a key model to deliver self-management support. The model has been adopted by a significant number of Australian agencies. In Victoria, the Flinders model is now a key model for self-management programs in both the Hospital Admission Risk Program and the Early Intervention in Chronic Disease in Community Health Centres.

The Flinders Human Behaviour and Health Research Unit have also been involved with Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation in the USA.

Model of Chronic Condition Self-Management

There are four major elements:

Partners in Health Scale

This is a questionnaire completed by the person that addresses six main principles of self-management as outlined in the evidence. It asks twelve questions, each with its own rating scale. The person gives themselves a rating for each question.

Example question:
I share in decisions made about my health condition(s) with my doctor or health worker:

0	1	2	3	4	5	6	7	8
A lot				*Sometimes*				*Very little*

Cue and Response Interview

This is a health professional administered assessment interview based on the same six main principles of self-management.

The health professional asks open-ended questions and uses reflective listening to explore the six principles and gives the person their own score.

Scores are then compared for further discussion at the end.

Example questions:

- How comfortable do you feel discussing your condition and its management with your doctor / health professional?
- How involved do you feel in decision-making with your doctor /health professional?
- Do you tell your doctor everything about how you are feeling? (If no, what do you think are the problems?)
- Do you feel your doctor /health professional listens to you?

Problems and Goals Assessment

This section teaches problem solving and goal setting skills aimed at enhancing the person's self-efficacy (a predictor of behaviour change). People are asked to identify their own problems and set goals they believe are important.

Examples questions:

- What do you see as your main problem?
- How does this problem change the way you live?
- What would you like to be able to do that the problem stops you from doing?
- Is this realistic?

A self-management care plan

This tool establishes a plan to be achieved over the next twelve months. It identifies a team approach and outlines the responsibilities of team members including the person themselves. The care plan incorporates the issues identified from the *Cue and Response Interview* and outlines the aims and interventions tailored to the identified needs and priorities of the person.

Guide to implementation

What do I need to do?

At least, three staff need to be trained. The initial training involves a two-day workshop led by accredited trainers with the Flinders Human Behaviour & Health Research Unit.

The training is a practical skills workshop that provides participants with the skills to use each of the elements of the Flinders model. Underpinning the training is an understanding of the evidence for self-management and philosophy behind people-centred care.

The training provides participants with a number of fundamental skills that can be used in everyday practice even if the tools themselves are not used.

What happens after the team is trained?

It is important for team members to obtain their certificate of competency. This will be their licence to use the Flinders model. To obtain this certificate, the team needs to undertake the follow-up workshop steps by completing the entire Flinders process with a minimum of three people. They will receive feedback from Flinders on these completed documents. →

We recommend that you undertake a skills audit at the end of the *Getting started: the road ahead* to give you a baseline of the skill level of your team. This will provide you with information as to what further training and support is required.

How do we get started? What should we do first?

Start with a pilot to determine the suitability of the model, how long it takes to use and how people respond to the tools.

It is common for teams to say that this model benefits only certain types of people. Note the characteristics of this group, as these are the people that you should be targeting as a team. Common feedback about the Flinders model is about the time it takes to use. Again, we encourage you to record the length of each session. Remember you can use these tools over a number of sessions.

In our experience, teams using the model report that the time taken to use the model is worthwhile because of the improvements they see. Much of this is related to the ability of the model to engage people and encourage and empower them in their own self-management.

To conduct your pilot, you will need three to five people per team member (approx. fifteen people) with sufficient appointment diary time (approximately one and a half hours) to undertake the Flinders process.

Discuss with your team how you will evaluate the outcomes. We suggest you use the Partners in Health Scale, the problems and goal ratings scales, and progress towards the goals in the care plan.

What happens after the pilot?

The team should meet and discuss the outcomes of the pilot, including how the model can be used in wider practice. We recommend that you implement a staged roll-out that includes the following steps:

1. Select a target group and identify selection criteria.

2. With your team discuss and decide on the following questions:
- How and at what point will our target group be identified?
- Who will use the Flinders model?
- How will the care plan be shared and coordinated among the team involved in the person's care?
- How will we ensure that anyone who has not done the training can still participate in and understand the care plan?
- How and where will the Flinders process be documented in the person's notes?
- How can we ensure there is adequate follow-up?

3. Finally, use the improvement cycle in the *Changing clinical practice* guide to test your ideas for broader implementation.

How do I support the team on an ongoing basis?

We have found the best way to support teams is to run regular peer support sessions and/or a buddy system, where team members are paired up and support one another through the implementation process. We recommend that you use more experienced staff (for example, psychologists) to train staff in the core-skills associated with each of these models.

Common mistakes and challenges

Implementing the Flinders model is not simply about running the two-day training workshop and then asking the team trained to use it. The list below outlines a number of common challenges and mistakes that we have seen agencies make:

Lack of organisational support

It is common for health professionals to express great enthusiasm about the model and the benefits to people immediately after the training. What we often hear is how this enthusiasm turns to frustration as the reality of implementing the model becomes obvious. This has more to do with poor agency support than lack of will.

As we have suggested, self-management demands changes to how we deliver care. Training is only the beginning. There needs to be discussion about how the model will be implemented, the resource implications and how to get around these. We encourage your team and managers talk about how the model will be used, who will be targeted and how the impact of the model upon the agency will be monitored.

In the absence of this critical follow-up work, the skills learnt at the training will be lost and the return on the training investment will be very poor.

Self-management applied as a one size fits all

Self-management is not a one size fits all. People will need a range of interventions at different stages depending on their situation and priorities. The Flinders model may not be appropriate for all people and this will vary depending on their situation.

The suitability of the model will depend on the person's readiness to engage in the health behaviour changes we are discussing at the time. We discuss the Transtheoretical Stages of Change later in this guide and encourage agencies to consider how different self-management models can be combined. →

Using the Partners In Health Scale can still be used with all people to determine their self-perception of how they manage their condition. This can offer invaluable information to the team and be used to match self-management interventions to that person.

Furthermore, using Motivational interviewing techniques will assist you to resolve the resistance and ambivalence often associated with health behaviour change. This may then lead to a higher level of readiness where the person would benefit from the Flinders model.

Self-management is limited to a few members of staff

So often, self-management is left to the responsibility of a few staff, either within the chronic disease care team or those who have been employed to do specialist project funded roles.
For these professionals, the workload of providing all self-management support is unduly heavy and unrealistic. Such an approach assumes that one or two people can provide self-management services to all people. It is an approach that fails to see that providing self-management support is intensive.

Self-management support is not a discipline-specific role. We have often heard teams say that it is the responsibility of the diabetes nurse educators to provide this support. We disagree with such an approach. It underestimates the workload but importantly promotes a silo-approach to care that works against rather than for good chronic disease management.

For health professionals working in project roles, the impact of this thinking is also negative and fraught with difficulties. These teams are often viewed as separate from the team providing general care. The result is that they become isolated and referrals to such specialist services are low.

The Flinders model training does not just teach health professionals how to use a set of tools. It teaches a philosophy about how to practice people-centred care. This philosophy needs to be incorporated into usual practice regardless of whether or not the tools are used.

Lack of agency support for the model

The pressure of waiting lists or appointment systems that do not allocate sufficient time for self-management interventions is a considerable barrier to using the Flinders model. If the expectation is to assess and provide advice within the appointment time, there is little time left to assess the person's self-management capacity.

Lack of adequate follow-up

One-off consultations with health professionals do not assist people to address barriers and work through care plan goals. The Flinders process helps to plan care over a twelve-month period, leading to less chance of repeat crisis visits and better coordination of care.

Such an approach strengthens the team, as roles and responsibilities are more clearly defined. Supporting this model with case conferencing is also a recommended strategy to build the sense of team, coordinate care and define team roles.

The team can learn from each other and obtain support to manage care for people with complex needs.

Case study

Frances' story

Frances lives alone in the house she and her husband shared for forty years in the northern suburbs of Melbourne and despite suggestions from her family, she doesn't want to move. She knows her neighbours, feels safe and although she struggles with her health.

Her daughter visits her twice a week and her son lives with her, however, he is not helpful and often doesn't pay for things when he should. Frances wishes he would move out. She looks forward to her daughter's visits but would like to see her more.

There is a lady from the council that does her cleaning and the people from meals on wheels always have a chat. Her neighbours often drop in to see if she needs anything. She used to walk to the shops but she now finds that too hard.

Frances often feels guilty and gets angry about being so dependent on her daughter and neighbours. She suffers from chronic abdominal pain, and chronic heart disease. She doesn't always understand what she needs to do and her doctor has told her that she has clinical depression. All Frances knows is that she feels lonely and that she can't do the things that she used to do.

Frances has agreed to see Diane, a diabetes nurse educator from the local community health centre. After talking to Frances, Diane suspects that she is not coping particularly well and that her isolation is a factor in her poor self-management. She asks Frances to complete the *Partners in Health* scale. Frances does this, despite some initial reluctance.

Diane goes through the Flinders model interview with Frances and discovers the following problems:

Cue and Response Interview

- Frances isn't taking her medications as prescribed because she can't afford them and doesn't see the point ('They don't do anything anyway', she says).
- Frances is not monitoring her symptoms and doesn't feel the need to.
- Frances feels her health limits what she can do. She would like to do volunteer work, however, she often stays at home. She feels down a lot.
- Frances sees smoking as her outlet. She knows smoking is bad for her health but she doesn't know how to stop. She is very sedentary and stays at home a lot.

Problems and Goals Assessment

Diane asks Frances about what she feels is her main problem. Frances identifies her main problem as her fear of getting worse. As a result, she doesn't go out and doesn't enjoy activities as she previously did.

Frances lacks a lot of self-confidence, so Diane uses goal setting as a way to help Frances improve her confidence. Her goal is to go on a holiday. To achieve this, she identifies the first step is going out more. She commits to going out for a coffee once a week with a friend for two hours.

Self-Management Care Plan

Diane helps Frances to develop a care plan for the next twelve months. They identify some aims and interventions to address the problems identified through the *Cue and Response Interview*. Frances agrees to work on a number of things over the next year:

- She will find out more about her medications and their benefits – she agrees to have a session with Louise (practice nurse) at her GP's.
- She will find out more about the symptoms of her different conditions – she agrees to do a monitoring diary and discuss this with Louise.
- She agrees to have more social interaction with people – she will find out more about groups in her local area and get some information about those of interest.
- She feels that she is not ready to address her smoking but was happy to discuss it at a later date.

Frances's plan is initially reviewed every couple of weeks. Much of this is done by phone. The reviews are then every three months, once Frances feels she is doing better.

Six months later, Frances starts to feel more in control of her health. She realises she could do more for herself and is happy at achieving the first step of her goal.

Resources

For all information on the Flinders University model of Chronic Condition Self-Management Model go to the Flinders Human Behaviour and Health Research Unit website <http://som.flinders.edu.au/FUSA/CCTU/home.html>.

The Five A's model

Contents

Your planner

Duration: An estimated six hours for training.

Training: No formal training course, however, some training would be required to learn and gain skills in the elements of the model such as open-ended questions and reflective listening.

Competencies: You need to be confident with the core skills to utilise the model.

Meetings: Two to three meetings are required to discuss options for implementation.

Tools: The *Five A's model worksheet* and F*ive A's prioritisation tool*.

Team: Like the Flinders model, implementing this approach will have implications for teams and resources. We recommend that you include a manager, support staff and members of the chronic disease care team.

Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to Changing clinical practice.

The Five A's model is a tool for health professionals. It is a counselling approach used to enhance the likelihood of behaviour change in people living with chronic disease. It acknowledges the expertise of the person in living with their condition and all information given to the person is based on what they request at the time. The model is based on research about the collaborative management of chronic disease in light of behavioural principles.

The Five A's is appropriate for use by any health professional. It makes use of the key skills of reflective listening, goal setting and questioning with the principles of Transtheoretical Motivational interviewing.

The approach is very accessible. The conversational style of the model is user-friendly and is very relationship based. It is model that can be used with any person regardless of their gender, age or cultural background. Unlike the Flinders model, it is not a model limited to certain groups.

Five A's model

The Five A's is a counselling model used to train health professionals in behaviour change counselling. It is an approach that offers a successful communication style that acknowledges the expertise people have in living with their condition.

The model is based on five steps that will enable your team to understand the beliefs and knowledge that inform a person's perception of their own well-being and disease. This understanding becomes the basis for your discussions with the person. Information and level of detail are provided based on the person's request.

Health professionals who use this model describe it as an accessible model for both themselves and the person with whom they are working. It is an approach that can demystify self-management and allow for a relaxed but very informal conversation with the person about their fears and anxieties, expectations and goals.

The Five A's model is perhaps closest to the coaching model, as it is based on the belief that the person has the answers and solutions to the problems that they bring to a coaching session.

The five steps to this model are:

1 ***Assessment***
2 ***Advise***
3 ***Agreement***
4 ***Assist***
5 ***Arrange***

Active listening follows the simple rule of seventy per cent silence and thirty per cent asking questions.

Assessment

Your self-management session begins with an assessment of the person's knowledge, beliefs and behaviours and your review of the clinical data. This first step provides useful feedback to the person on the status of their health.

Types of open-ended questions that you would use at this stage are:

- How much do you know about your condition for example, your diabetes?
- What sorts of things do you do to control your condition, for example, exercise, healthy eating, etc? (You will need to explore this in detail to understand the healthy and unhealthy behaviours people are engaging in.)
- What do you believe might happen to you with this condition?

Advise

The next step is to tell the person about their health risks and benefits of change and provide specific information.

Specific assessment data (such as test results or assessment findings or functional status) are used together with knowledge about the person to frame and present information in a way that makes sense to them.

The key is to relate the person's self-management behaviours to his or her values and clinical outcomes. Before doing this, it is helpful to assist the person to prioritise issues of relevance to them. This way, you will be targeting your conversation to areas they are more ready to address. We have included a prioritisation tool to assist you.

Types of questions that you would use at this stage are:

- How do you think the clinical picture I have described to you (using their test results or assessment findings) compares with where you should be? What do you make of that?
- What do you think might happen if you do nothing and do not make any change?

Agreement

One of the key steps of any coaching relationship is to achieve agreement and to clarify the aims and goals of the person. By repeating to the person, what you have heard them say is a powerful tool to achieve ownership of goals.

The agreement phase is where people set specific behavioural goals on the basis of their interest, confidence and priorities. We use empathic listening to encourage the person to share their beliefs about their disease to develop a shared understanding and to negotiate management plans. Active listening follows the simple rule of seventy per cent silence and thirty per cent asking questions.

This step requires gathering the information from the previous two steps and prioritising with the person what changes they would like to achieve. Begin by asking the question, 'Given the issues you have identified, where would you like to start and what would you like to see change?' Once you have clarified this, you can identify some specific behaviours they would like to work on.

The importance of this cannot be overestimated. So often we leave people with very broad goals such as losing weight without helping them to identify how they will actually achieve them. People cannot just go out and lose weight. They need to make specific behavioural changes. The same is true of any clinical goal, such as reduce pain. →

Assist

This next step is focussed on developing plans to meet goals. Problem solving is a central element of this stage and should be explored with the person. This is where the use of open-questions (any question beginning with who, what, where, why, when and how) are useful, as they will open your discussion with the person. With open-ended questions, you will avoid yes or no answers.

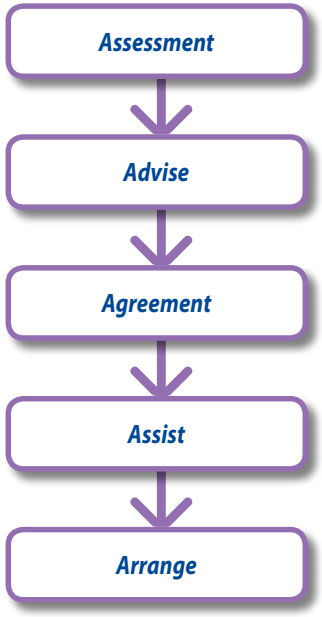
The aim is always to explore the commitment of the person to the goals, barriers and concerns. Some of these concerns may not have expressed before. The person may not even be aware of them. We have included a problem solving sheet with this guide.

Once you have identified what specific behaviours the person will change, you are now ready for the person to develop their action plan. This describes how they will do what they have agreed to. We have included an action planning sheet with this guide.

Arrange

The final step involves arranging a follow-up plan. Your team needs to be aware of the person's action plan and reinforces his or her goals.

The Five A's model of self-management support



Implementing the Five A's

What do I need to do?

The coaching skills required are different and based on the belief that the person is the expert in their own management. Take the skills audit included in this guide and it will give you a baseline of the skill level of your team, providing an idea of the training and support required.

Focussing the team on problem solving and goal setting

Your team will need training in a number of core skills and elements shown to be effective in self-management. These include problem solving, goal setting, behavioural strategies and follow-up. Your team should start with training in the use of problem solving and goal setting. With these core skills, they will be able to assist the person identify problems from their own perspective and set goals to address those problems.

Goals should follow the SMART principle as discussed in *Changing clinical practice*.

What happens after the team is trained?

Ask your team how they would like to be supported to develop their skills. Commit to regular one to two hour follow-up sessions to assist them to use and consolidate their skills. The section on post-training support will provide you with different ways to do this.

How do we get started? What should we do first?

We suggest that you start with a plan-do-study-act improvement cycle. Identify and start with three people. Block out at least one hour per person to enable your team to work through the model and then review it. What worked? What didn't work? Are there any obstacles? How confident does the team feel about the model?

Progress your improvement cycle and select a pilot group and test and assess the impact of the model. Identify three to five people per team member, booking out sufficient time in appointment diaries (approximately one and a half hours) to undertake the Five A's process.

Choose a suitable tool to evaluate the pilot group (refer to the *Evaluation self-management guide*). Analyse your evaluation and discuss it with your team. Explore the results. What was the response? What information came to light? Were there any surprises? →

What happens after the pilot?

Now it is time to establish systems that support this approach. Like the health coaching and Motivational interviewing models, these approaches are best practice for promoting behaviour change and improving self-management in those with chronic disease. Start with a chronic disease that you would like to focus on and consider everything that is likely to impact on the delivery of self-management support.

Hold internal discussions with your team to decide how to roll out the model. You will need to discuss roles and responsibilities. It is likely some members will have a greater role than others. This may involve assigning some specific self-management time to some people's roles.

We encourage you to look at reminders, prompts, teamwork and case planning to embed self-management into routine practice. Discuss the communication channels needed to ensure the whole team is aware of the self-management goals and strategies being set. This may include team strategies such as case conferencing, the inclusion of self-management goals in health records, a standard care plan and or a routine summary of their progress.

Whichever strategy is used, it is important that the team is aware of how self-management has been discussed with the person, their readiness to change and any self-management goals that have been developed.

How do I support the team on an ongoing basis?

Try combining the Five A's model with other self-management approaches such as the Transtheoretical Stages of Change, Motivational interviewing and/or health coaching.

The core skills required for these models are very similar and we have provided an outline of these skills in this guide.

Team support is fundamental to the adoption of a new practice. Be creative in the supports you put in place as the aim is to really build team confidence. Try regular peer support sessions, follow-up consultations with a psychologist and a buddy system. We have seen some agencies use a regular e-bulletin to share common barriers and solutions. Don't forget to include self-management in staff orientation.

What happens next?

We suggest that you continue reading this guide on self-management as well as *Changing clinical practice.*

Common challenges

Agency culture

The Five A's model taps into the person's existing motivations and allows them to take responsibility for decision making. The model is thus very different from the medical model of telling people what to do and expecting them to carry out instructions.

An agency culture geared towards the medical model does little to promote this type of care. If the expectation is to assess and educate in a session, this leaves little time to use a model such as the Five A's, which can be far more open-ended.

Agency culture needs to support health professionals to embed self-management into their normal practice. As we discuss throughout this guide, self-management challenges how we work and the resources traditionally assigned to care in agencies. Support and commitment from the senior management team is critical for the teams that are exploring these new ways of working.

Self-management as a philosophy

It should not be assumed that having one self-management approach is the end of the journey. Self-management is a philosophy that needs to be incorporated into usual practice and extends beyond a particular model. The Five A's model and other models require a cultural shift away from an expert to a person-centred approach.

Case study

Annette' story

Annette lives with her partner of twenty years. Her daughter, her daughter's partner and their two children also live there. Her daughter ran into financial difficulties and Annette felt she could not let her down. She often wishes it was just her and her partner. She loves her grandchildren but at times finds them a burden. They often run riot, leaving her with a mess. They never listen to her and frequently do not listen to their mother.

Annette's health is not good. She has type 2 diabetes and is now starting to feel the effects. She frequently feels pain in her legs and they swell a lot. Her doctor calls it cellulitis. She knows it as extreme pain, especially when she touches it. She is on many tablets but really doesn't understand much about them. Annette is dependent on her daughter because of her health. She feels guilty about this and often finds herself angry.

Recently, Annette went into hospital for her swollen legs. Annette has since agreed to see Jodie the nurse at her local doctor's. Jodie is very understanding. After speaking with Annette, Jodie realises Annette is passive when it comes to her health and feels powerless to do anything about her situation. Jodie decides to use the Five A's model to help Annette become more involved in her care.

Assess

Jodie looks at Annette's recent blood test results. She finds she has raised cholesterol at six and her diabetes is not well controlled with an HbA1c of 8.5%.

Jodie assesses Annette's knowledge and discovers that the results mean very little to Annette. Jodie then asks Annette what she is doing now to improve her situation and what else might help.

After reviewing Annette's health behaviours, Jodie finds out that Annette's biggest weakness is food. She also is very sedentary. She has slowly put on weight amounting to about thirty kilograms. Annette is quite upset about her weight and finds it depressing.

Advise

Jodie gives Annette some information about her recent blood results. She explains the potential risks to her health if the situation remains unchanged. She also explains the benefits if she makes some changes to her lifestyle. Jodie also asks Annette about the potential impact of her diabetes management on her personal life with or without change. She helps Annette think about her own potential risks of not changing the situation and asks her to list some personal benefits.

Agree

After some discussion, Jodie negotiates with Annette what she would like to do to improve her health and how she might make some positive impact on her well-being. Annette agrees to change what she perceives as reliance on convenience foods and Jodie assists her to devise an action plan with healthier eating options.

Assist

Jodie then asks Annette what might stop her from achieving her personal goals as outlined in her action plan. Annette explains that at times she feels rushed and finds she has little time.
Jodie takes Annette through a brainstorming session to identify some solutions. Jodie explains to her that she can use this technique herself when she comes up against another problem. Annette likes this as she feels she has learnt a useful skill.

Arrange

Jodie summarises the main things that have been discussed and then develops a care plan that she explains to Annette. This plan will guide further discussion over the next few months. Jodie explains that Annette is an equal partner in the team and that they will work on things together over time. Annette is asked when she would like to return and Jodie devises a plan to review and monitor the issues that have been discussed.

She wishes Annette all the best with her action plan.

Resources

Glasgow, RE, Davis, CL, Funnell, MM & Beck, A 2003, 'Implementing practical interventions to support chronic illness elf-management', *Joint Commission Journal on Quality and Safety*, vol. 29, no. 11, pp. 563-574

Health Care Education and Training

For a guide on the Five A's model, go to the Healthcare Education and Training website <http://www.hcet.org/resource/psc.htm>. This resource is specifically targeted at smoking in pregnancy, but gives some handy tips and resources on using the model.

Lifescripts was developed specifically for General Practitioners by the Australian Government Department of Health and Ageing. The Lifescripts website includes some great resources and tools to assist you to use the Five A's in clinical practice <https://www.health.gov.au/lifescripts>.

The Five A's model

WORKSHEET

This worksheet assists health professionals to use the Five A's model in their clinical practice.

ASSESS: Beliefs, behaviour and knowledge

ADVISE: Provide specific information about health risks and benefits of change

ASSIST: Identify personal barriers, strategies, problem solving techniques and social/environmental support

AGREE: Collaboratively set goals based on the person's interest and confidence in his or her ability to change the behaviour

ARRANGE: Specify plan for follow-up (for example, visits, phone calls, mailed reminders)

Develop a personal action plan

1 ***List specific goals in behavioural terms***

2 ***List barriers and strategies to address barriers***

3 ***Specify follow-up plan***

4 ***Share plan with the chronic disease care team and person's social support***

We have provided an action planning sheet at the end of this guide that you can use to develop this personal action plan.

WORKSHEET

Five A's prioritisation tool

This tool is for health professionals to use with people in conjunction with the Five A's model. It provides a way of assisting people to prioritise their self-management issues. The health professional would then use the Five A's model to explore these issues.

Instructions
Begin by ticking all the conditions that you have:

- ☐ Diabetes
- ☐ Asthma
- ☐ Hypertension
- ☐ Arthritis
- ☐ Heart disease
- ☐ Others. .....

- Use the diagram at right and circle the issues that are most important to you. The diagram includes a variety of self-management skills. They ALL may be highly important to your health but you don't need to do ALL of them ALL the time
- If there is a topic that is more important to you, add it to the frame
- Nobody does all of these perfectly. It is best to work on one or two of these at a time
- This is a partnership. You will not be pushed.

Choose which one(s) you want to discuss today

Monitoring signs and symptoms	*Quit smoking*	*Reduce drinking*	*Managing fatigue*
Regular visits	*Taking medicine*	*Physical activity and flexibility*	*Attending other services*
Checking feet	*Relaxation and play*	*Managing symptoms*	*Eating: food choices, portion sizes, time of day*

Motivational interviewing and the Transtheoretical Stages of Change

Contents

Your planner

Your team: When selecting your team, you need to think about the impact self-management will have on your agency. We recommend that you include a manager, support staff and members of the chronic disease care team. Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to *Changing clinical practice*.

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Resourcing: An estimated six hours is required for training.

Training: There is no formal training course; however, there are a number of people that conduct training in this approach. Contact your local university health psychology department or websites of other self-management models such as Health Coaching Australia. One day's training is required to learn and gain skills in the basic principles and skills.

Competencies: Asking open-ended questions, reflective listening, understanding the Stages of Change model and the five principles of self-management.

Meetings: Two to three meetings are needed to discuss options for implementation.

Tools: *Assessing readiness to change, Steps to manage resistance; Using open-ended questions and Using reflective listening*.

Motivational interviewing and the Transtheoretical Stages of Change

Motivational interviewing is an approach to working with people with chronic disease aimed at exploring and resolving a person's ambivalence about behaviour change. It is focused and goal directed and is used to assist people to address issues of change for which they are not ready or ambivalent.

Change is a process rather than an event. This is acknowledged in the Transtheoretical Stages of Change model (Stages of Change) that identifies five distinct stages that people move through when committing to health behaviour and lifestyle changes. Motivational interviewing is closely linked to this model as it acknowledges a person's readiness to change. These two approaches are often combined to harness the effort and energy to transition through change.

The techniques of Motivational interviewing explore a person's attitudes to their lifestyle and its health risks. It is an approach that enables a health professional to assess a person's readiness to change and helps the person identify and overcome barriers to adopting a healthier lifestyle.

Motivational interviewing evolved from the experience of treating problem drinkers and is now used commonly in smoking cessation programs such as Quitline. In fact, when a person phones the Quitline, they are assessed for their readiness to change using the Stages of Change model. Telephone coaches then use Motivational interviewing to counsel the person through the various stages.

Motivational interviewing allows us to explore this and uncover a person's own intrinsic motivations. This readiness is something that has found to be a greater predictor of change than external factors, such as the pressure of a relative or health professional.

Stage of Change	Motivational interviewing techniques
Pre-contemplation (Not thinking of change)	• Reflective listening • Increase awareness of personal negative health behaviour, its consequences and personal benefits • Effective questioning • Offer information but avoid offering solutions
Contemplation (Thinking of change. May seek relevant information, looks at current behaviour, looks to others for support)	• Reflective listening • Express empathy • Explore barriers, avoid offering solutions
Determination (Ready for change. Individual is ready to take action in next thirty days. Set goals and develop priorities.)	• Offer encouragement • Use goal setting • Give support for self-efficacious behaviour, for example set goals • Link to peer support • Provide education
Action (Changes behaviour. Have started to make change to behaviour. Susceptible to relapse at this point)	• Offer encouragement • Express empathy • Use goal setting
Maintenance (Maintaining change. Seeks alternatives for the problem behaviours)	• Use skills training interventions, for example, relaxation instead of smoking
Relapse (Returns to previous behaviour)	• Avoid or manage triggers • Use problem solving • Look at alternatives • Need to be aware of triggers to return to previous behaviour

Motivational interviewing

Motivational interviewing involves learning the skills of open-ended questions, reflective listening and summarising. These techniques are particularly helpful for discovering a person's motivations. The aim is to assist the person to understand how their current behaviour is a concern or a problem, there are benefits to changing and that they are able to do so.

Before discussing the key elements of this approach, it is worth considering a definition of motivation. Often we label people who do not follow our treatments and recommendations as not motivated or even non-compliant. A more helpful understanding of motivation is the relationship between importance and confidence. Importance is do I want to change; confidence is can I change.

So how do we assess and enhance a person's motivation?

We begin by encouraging the person to explore what is important to him/ her. Once we know this, we can then identify potential goals and then ask the person to rate both the importance and their confidence in their ability to make the desired changes.

The approach is a very simple one. The challenge is our own confidence in having these conversations. As we have reflected in this guide, many of the skills required for such approaches are not ones that we were trained in and may seem to contradict the more educative roles that we have traditionally held.

Our approach to using Motivational interviewing with people needs to be based on four principles.

The first is expressing empathy. We do this by using open-ended questions and building rapport. For example, 'Tell me more about the difficulty you have with your smoking' and asking permission to discuss a person's behaviour, 'How do you feel about us talking about your smoking?'

Second, we need to explore the good things about the behaviour and the less good things. For example, we need to ask the person 'What do you enjoy about smoking and what's not so good about it?'

You can then look to the future to see how the good/not so good balance might be changed. Ask, 'What do you need to do to change the balance between the two?' And finally, by encouraging the person to present the arguments for change ('What do you think will happen if you continue smoking?'), the person will begin to own the behaviour under discussion.

Resistance can come in the simple form of a 'yes, but". We can avoid this by rolling with resistance. This is the third principle. Avoid using direct persuasion for change. A statement like, 'Your blood sugars are high and I think you might need to do some more exercise to help', is a direct persuasion that does not encourage a person's intrinsic motivation to change. A response that rolls with resistance might be 'Your blood sugar is high. How about you start by telling me what you currently do to manage it and we can then work out what, if anything, you'd like to do to improve the situation'.

This provides the person with a choice, which is often more empowering and reduces resistance. Try responding differently when you receive resistance from the person. For example 'Yes I agree with you, but", is a signal for you to change the course of questioning.

And finally, you can enhance the person's confidence by focusing on the positive things, for example, 'What has worked before when you have tried to do this?'

Motivational interviewing questions

The example of smoking in used in the following questions, but they can be applied to any health behaviour.

- What are the good things about the behaviour of concern?
- What are the not so good things?
- Summarise the pros and cons. Check with the person that your summary is correct.
- Where does that leave you now?

By asking people to score the importance of the behaviour and their confidence in addressing it, you can determine how committed or otherwise the person is. By asking the following questions:

- On a scale of one to ten, *how important* is the behaviour of concern (giving up smoking)?
- On a scale of one to ten, *how confident* are you that you can change the behaviour of concern (give up smoking)?

If the answer to either question is less than seven, you can explore the reasons why and what the person can do to improve the importance of the change and their confidence.

Stages of Change

So what are the Stages of Change?

This model describes six stages through which people pass as they change behaviour. People progress from an initial pre-contemplation stage, where no change is considered to contemplation, where the pros and cons of change are explored. During the preparation stage, planning and commitment are →

secured. Successful completion through these initial stages leads to taking action to make the specific behavioural change. If successful, action leads to maintenance, in which the person works to maintain and sustain long-term change.

During the early stages of change, Motivational interviewing allows people to examine their own situation, assess the pros and cons and make a decision about change. The style is non-threatening, supportive and encourages responsibility.

As people prepare for change, take action and maintain the change, Motivational interviewing is used to coach people to develop a workable change plan, anticipate barriers and identify support systems. This assists to increase confidence (self-efficacy) and reinforces accomplishments. Importantly, there are no quick rules of how quickly people will move through the different stages. People may also relapse into an earlier stage of behaviour, making up the sixth stage.

Motivational interviewing and Stages of Change

The following is a summary of the Stages of Change and the motivation techniques that can be used to support each stage.

Guide to implementation

Motivational interviewing and Stages of Change can be used in any consultation or contact as long as the team is skilled.

What do we need to do?

Begin by undertaking a skills audit, as many of the skills required are not formally taught in our health professional training. We tend to focus on providing people with education, whereas the coaching skills required are different and based on the belief that the person is the expert in their own management.

Take the skills audit included in this guide. The results of your team's skills audit will tell you the level of ongoing training and support required and where to invest that training.

Use a Train-the-trainer workshop to train the team to open-ended questions and reflective listening. These are the core skills behind the techniques. Health professionals will need to be confident in using these skills to use the four principles outline in the introduction to this discussion of Motivational interviewing. Mastering the techniques requires significant training and support to acquire the skills and use them effectively.

What happens after the team is trained?

Ask your team how they would like to be supported. Commit to regular one to two hour follow-up sessions with your team to assist them to consolidate their skills. The section on post-training support will provide you with a number of ways to do this.

Also refer to the guides on reflective listening and questioning.

How do we get started? What should we do first?

After the team has trained in the Stages of Change and Motivational interviewing techniques, look at using a plan-do-study-act improvement cycle.

Pilot the approach with a few clients. The team can then review the outcomes of this initial pilot. Then broaden the pilot with each team member testing the approach with five people each.

Evaluate the pilot by assessing whether the person shifts in their stage of change. This can be done using a multiple choice approach representing each of the six stages. The example we give relates to smoking:

- I am not thinking about quitting smoking.
- I have thought about quitting smoking but am not likely to do this in the next six months.
- I am seriously considering quitting smoking and am planning to do so in the next month.
- I am currently trying to quit smoking and have already made some change.
- I have quit smoking and have maintained this for the last six months.
- I did quit smoking for a while but have gone back to old habits.

The benefit of using this approach is that it identifies a greater level of sensitivity about change than a simple yes or no to questions about a change in behaviour. Analyse and discuss your evaluation with your team.

What happens after the pilot?

Motivational interviewing is an approach that is appropriate for all people with a chronic disease where there is a discussion about changing behaviour. Discuss roles and responsibilities among your team as some members will have a greater role than others.

It is important to establish clear communication channels, so the team is aware of what has been discussed in each session. Design ways to record conversations, so everyone is aware of what has been discussed. People will present at different stages of change. It is common for people with low readiness to change to either be discharged or remain on appointment books without making much progress. It is useful to identify appropriate interventions, for example agreeing to three telephone calls four weeks apart. If there is still no change at the last call, then the person is placed on a yearly recall. →

How do I support my team on an ongoing basis?

We recommend you combine Stages of Change, Motivational interviewing with other models such as the Five A's and/or health coaching. Each of these models is based on theories about behaviour change and offer numerous solutions and options for motivating change in people. This range of approaches enables us to tailor our response to the person and their readiness for change, rather than assume people will be purely motivated by health risks or benefits.

Use more experienced staff (for example, psychologists) to train the team in the core-skills associated with each of these models.

To support the team and encourage their continued enthusiasm for this work, use regular peer support sessions, secondary consultation from psychologists and a buddy system. One of the most common barriers that we see to the adoption of self-management is poor support post-training.

What happens next?

We recommend that you work through this guide on *Implementing self-management* as well as the guide on *Changing clinical practice*.

Common challenges

A change of roles

Health professionals are traditionally trained to be experts. While this is an important clinical focus, motivating behaviour change and improving people's self-management skills requires a different role. Using the techniques of Motivational interviewing necessitates a coaching role dedicated to coaching for behaviour change.

Do not be surprised if some members of the team are reactive or simply hesitant to take on this role. Others may presume that they are already doing it. There will always be early adopters. You need to encourage this group and use them as clinical champions to help team members who may be struggling.

A neglect of duty of care

Health professionals often describe sacrificing the need to provide information at every session as neglect of their duty of care.

Motivational interviewing often forms more effective conversations than time spent on education, as it taps into a person's own intrinsic motivation to change. It must be remembered that an increase of knowledge (what education provides) will not necessarily translate to a change in behaviour.

It is important to have these frank and open conversations within the team to explore and work through any resistance and concerns. Ironically, the discussions you are likely to have will follow the Stages of Change model that you are trying to implement.

Self-management seen as nothing new

Self-management is often seen as 'something' we already do. However, it is more effective to incorporate it into usual practice. This requires us to change the expectations of consultation time away from assessing and providing advice to addressing people's motivations and barriers to change.

Staff training

We often hear teams say that 'we already do this'. In reality, many health professionals have limited training in the principles and skills of Motivational interviewing. The team needs to be trained in these techniques and encouraged to adopt them. A good starting point is training in open-ended questions and reflective listening.

Most teams will be unfamiliar with the art of reflective listening. In its truest form, reflective listening is a reflection of the meaning of what a person has said rather than a direct repeat of the words. The amount of training your team will need will depend upon pre-existing skill levels influenced by professional development and experience.

Skills retention

Most of us have experienced post-training lag. This is when the enthusiasm of the training has waned and the question of 'how do I use this' is left. If the team is to apply its training, then these new skills must be put into practice immediately. This can be challenging, when a team is pressured by waiting lists. The team needs endorsement and go ahead from their managers to undertake this work. This may include changes to how appointments are scheduled and additional time for discussion and coaching within the team.

Supervision and peer support are needed for the team to confidently and competently use their skills from the training. Getting feedback from people receiving chronic disease care is important for guiding skill development. For example, inaccurate or insufficient reflective listening or direct persuasion can lead to a series of disagreements with people during the self-management consultation.

Case study

Helen's story

Helen is thirty-six years old. She leads a busy life helping out at the school canteen and is very involved in school activities. She has made some great friends with the other mums and attends their regular mothers group.

Recently Helen had been feeling dizzy. She puts it down to stress and tries to cut back on her activities but with little success. She talks about it at her mothers group. Connie, one of the mothers, says she had the same thing. Her doctor told her it was high blood pressure and put her on some tablets and advised some lifestyle changes. Connie hasn't acted on these suggestions as she feels that she just doesn't have the time. She is unconvinced that they would make any difference.

Helen decides to see her doctor, who diagnoses her with high blood pressure and prescribes her medication. He too recommends a number of lifestyle changes and advises her to lose weight. He asks her to speak to their clinic nurse about it.

The next day, Helen meets Fran, the clinic nurse. Fran asks Helen a number of questions about her health and lifestyle and feels that given Helen's young age, lifestyle change will be very important to help her reduce her risks. Despite this, Fran hears a degree of reluctance in Helen especially when they talk about her weight.

Fran has the following conversation with Helen in efforts to reduce the resistance:

Helen: The doctor told me I had to speak to you because I'm fat! (angrily)

Fran: I'm wondering how you are feeling about what you've been told? (open-ended question)

Helen: I'm upset because I've been trying to lose weight ever since I've had the children and it's so hard. (bursts into tears)

Fran: You're upset about the difficulties you've had trying to lose weight. Tell me more about that. (Reflective listening followed by an open-ended question.)

Helen: Well, my husband works long hours and it's such hard work with the kids. There's just no time to exercise and I'm exhausted.

Fran: It's difficult for you to find time to exercise, especially with the kids and your husband working long hours. How do you see things? (Reflective listening followed by an open-ended question.)

Helen: When I get stressed with the kids, I just reach for food for comfort and energy and I can't see a way to stop. (Reflective listening followed by an open-ended question)

Fran: So you use food for comfort. Are there any other good aspects of eating for you? (Exploring ambivalence, that is the good things)

Helen: Well, I really enjoy the company of other local mums and we usually get together over food.

Fran: So socialising with new mums is important for you. Tell me about the less good things about eating for you? (Exploring ambivalence i.e. the less good things)

Helen: Well I really don't enjoy eating so many cakes and sweets that we seem to have because it makes me feel unhealthy.

Fran: So socialising with the other mothers is important but it involves eating food that makes you feel unhealthy and sometimes you use food when you're under stress. Yes, it is difficult thinking about some of these changes. Where does that leave you now? (Summarising, highlighting discrepancy, acknowledging a person's difficulty of giving up behaviour, and encouraging self-motivating statements)

Helen: I can see my dilemma! What do you think I could do?

Fran: What has worked in the past? (Encouraging self-efficacy)

Helen: Now that the weather is getting better, I have been thinking of getting our mum's group together in the park and that way we would eat less!

Fran: Anything else you could think of? (Open-ended question)

Helen: I have also discussed with my husband him coming home early two days a week so I can go out for a walk.

Helen and Fran go on to make an action plan around the two suggestions she has made in the interview. Helen agrees to return in two weeks for further discussion. Helen also decides to discuss the interview with Connie. She feels that Connie might join her on a walk if she was more aware.

Assessing readiness to change

WORKSHEET

This worksheet assists health professionals to assess the readiness to change of the person with regard to their problem health behaviour.

After you have identified the problem behaviour/s and assisted the person to prioritise what they would like to address, ask the following questions.

1. The identified problem behaviour, for example, smoking

.....

2. What are the good things about the behaviour of concern?

.....

.....

.....

3. What are the not so good things?

.....

.....

.....

4. Summarise the pros and cons. Check with the person that your summary is correct

.....

.....

5. Where does that leave you now?

.....

.....

.....

.....

Now ask the person to rate their motivation to change.

X	X	X
Not ready	*Unsure*	*Ready*

The ingredients of readiness to change

Determine importance

On a scale of 0 to 10: How important is it to you personally to make this change?

0	1	2	3	4	5	6	7	8	9	10
Not at all important										*Extremely important*

Determine confidence:

On a scale of 0 to 10: How confident are you that you can initiate and sustain this change?

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										*Extremely confident*

Health coaching for chronic condition self-management (Health Coaching Australia)

Janette Gale, MAPS, Clinical Health Psychologist and Dr Helen Lindner, FAPS, Clinical Health Psychologist

Contents

We invited Janette Gale and Helen Lindner to write this guide on health coaching. They discuss the importance of a team approach, the training required and the supervision and peer support needed to successfully implement this approach.

Health coaching is a generic term for a broad range of interventions with varying degrees of applicability to chronic conditions self-management (CCSM), depending on the model used.

Health Coaching Australia (HCA) defines health coaching as a clinical health intervention to be used only by qualified health professionals, to facilitate lifestyle risk factor reduction and support self-management in people with chronic health conditions.

The Health Coaching Australia (HCA) model is a collection of evidence-based interventions and techniques from various applications of psychology that assist health professionals to work with people to change their behaviour *when advice alone is not enough*. In other words, health coaching is particularly relevant when barriers to health behaviour change are present. These evidence-based health coaching elements have a long history in psychological practice and the behavioural medicine research literature. The model and its elements are outlined below.

Health coaching is relevant to individual level intervention; either one-on-one or in small groups of two to six people *that include individual attention and direct assistance in overcoming barriers to change for each participant.*

This evidence-based model of health coaching has been endorsed and/or supported by a number of government health departments, Divisions of General Practice and community health services around Australia. The model was developed by Janette Gale of Health Coaching Australia with input from Dr Helen Lindner of the Australian Psychological Society. Both are clinical health psychologists. This model is similar to the one used for the Good Life Club project, Whitehorse Division of General Practice Victoria, that showcases the efficacy of telephone health coaching by health professionals.

The health coaching model presented is a comprehensive approach to CCSM, with emotional, cognitive, social, and coping factors in health behaviour change being addressed to ensure adherence to medically recommended preventive and management treatments for chronic diseases such as diabetes, asthma, heart disease, obesity and arthritis. It includes basic behaviour change skills and techniques, as outlined in the Flinders and Stanford models of chronic disease self-management.

Many health professionals complete health coaching training to augment their intervention skills, particularly in the areas of mild levels of negative mood, self-talk, and social isolation, for use within the Flinders and/or Stanford frameworks. It is stressed that CCSM needs to be viewed and implemented →

as a team approach to adherence to health care recommendations. This team concept has been endorsed in a report, *Adherence to long-term therapies: Evidence for action*, by World Health Organization (WHO) that states that 'a multidisciplinary approach towards adherence in needed' (WHO 2003, p.24).

Although the health coaching model presents the theoretical and applied skills required of any health professional for an effective CCSM intervention, certain health professionals that have specific expertise should be acknowledged and used within the CCSM intervention. For example, as the medical practitioner plays a fundamental role in diagnosis and treatment recommendations for the physical condition, health psychologists need to be involved in the diagnosis and treatment of elevated levels of cognitive, behavioural, and emotional factors that a person might present.

The health coaching model represents the basic-level of knowledge and skills that all CCSM health coaching health professionals would be required to master to become an effective member of the CCSM team.

Formal definition of health coaching

This Australian definition of health coaching has a clinical health focus that contrasts with definitions from the UK and USA that have a health promotion and education focus. Notwithstanding the focus on the individual or small groups, the health coaching model can be applied in primary, secondary, and tertiary health care situations.

As outlined by WHO:
Simply giving information to patients is unlikely to change behaviour; health care providers must understand the psychological principles that underlie self-management training and comprehend that motivating patients requires more than imparting brief information to the patient.

There is a growing recognition that simply telling patients what to do is not effective in bringing about long-term behaviour change. This creates frustration for both patients and health professionals. Although earlier interventions to increase effective chronic conditions self-management have focused on patient education, more recently, the importance of psychological and behavioural interventions has been stressed as a result of the growing recognition that knowledge alone is insufficient to produce significant changes in behaviour (WHO 2003,p.79). In 2003, the WHO review found five major barriers inextricably linked to health system and team factors:

Health coaching is a practice in which fully trained health professionals apply evidence-based principles and techniques from health psychology and coaching psychology to assist people to achieve positive health and lifestyle outcomes through attitude and behaviour change.

1. ***Lack of awareness and knowledge about adherence***
2. ***Lack of clinical tools to assist health professionals in evaluating and intervening in adherence problems***
3. ***Lack of behavioural tools to help develop adaptive health behaviours or to change maladaptive ones***
4. ***Gaps on the provision of care for chronic conditions***
5. ***Sub-optimal communication between people and health professionals.***

Health coaching interventions help health professionals to motivate people toward readiness to change, assist them to change unhelpful thinking patterns and encourage their self-regulation and self-management of lifestyle risk factors and treatment regimes associated with chronic diseases.

Recommended training for health professionals

In line with recommendations from WHO, a five-element model is recommended for health coaching training. These elements are:

1. Medical conditions knowledge, including:
- Aetiology, symptoms, treatment, and complications of major chronic diseases (for example, diabetes, heart disease, asthma, arthritis, COPD)
- Impact of chronic disease on health and quality of life
- Impact of lifestyle risk factors on health
- The role of health promotion in chronic disease reduction and management
- Adherence to medical and lifestyle prescription

2. Behaviour change counselling techniques, including:
- Motivational interviewing skills
- Solution-focused counselling skills
- Reflective listening and other general counselling micro skills

3. Psychological models of health behaviour change, including:
- Readiness to change framework (Prochaska et al. 1992)
- Models of barriers to health behaviour change and facilitators of change
- Theories of motivation
- The self-regulatory model of health behaviours (for example, Leventhal et al. 1980) and self-management models →

4. Behaviour modification and evidence-based coaching techniques:

- Goal setting, action planning, goal striving techniques
- Learning and reinforcement principles
- Adult learning principles
- Behaviour modification and behavioural relapse prevention strategies

5. Emotion management and cognitive change strategies

- Depression and anxiety management strategies
- Anger and other negative affect management strategies
- Cognitive therapy techniques to address negative thinking patterns that act as barriers to health behaviour change, including cognitive relapse prevention strategies
- Positive psychology strategies and strengths, with a focus to build hope, acceptance, optimism and resilience, and to develop positive affect

Components of the health coaching model of health behaviour change

It is well established in the health and medical literature that providing advice and education alone has limited efficacy. Education is a necessary part of health behaviour change, but not sufficient. Accountability will increase the effectiveness of health behaviour change interventions. However, even when these factors are included in research interventions, there remains considerable unexplained statistical variance that might be accounted for by the omission of psychological factors in the model.

A premise of the HCA health coaching model is that people have many barriers to change that are psychosocial in nature. If you don't help them to work through the factors that are stopping them from adopting more positive behaviours, then they may not be willing and/or able to change.

Component 1 requires that health coaching is conducted by qualified health professionals with an understanding of the reciprocal impact of psychosocial factors, physical health and pharmacological mechanisms.

Component 2. Motivational interviewing (MI) has been recognised as being evidence-based by the Australian government (for example, Lifescripts and other interventions). Solution focused counselling is widely recognised as a valid method of conducting psychological counselling and evidence-based coaching (Stober & Grant 2006).

Component 3 is the important theoretical element that addresses the 'lack of awareness and knowledge about adherence' (WHO 2003). It outlines psychological models of health behaviour change upon which many behavioural medicine researched interventions have been based.

This element of health coaching gives health professionals models to draw from to identify the factors that may be blocking people's change efforts. The models have considerable utility in practice.

The HCA model of health coaching recognises readiness to change as a critical factor to take into account and advocates that health professionals use solution-focused counselling to assist each person to elicit their own strategies for change (given their specific barriers and circumstances). Eliciting a person's intrinsic (or autonomous) motivation is a key factor in conducting effective health coaching.

Component 4 refers to goal setting, goal striving, monitoring, accountability, learning and reinforcement as well as other psychological principles of behaviour change that are supported by fifty years of research within the behavioural psychology/behavioural medicine literature (Locke & Latham 2002). More recently this has been packaged as evidence-based coaching and a new field of psychology has formed called coaching psychology. This field is researching specific types and styles of coaching with a heavy emphasis on using only evidence-based interventions from other psychological and behavioural disciplines (see Stober & Grant 2006).

Component 5 has a vast literature on efficacy. The emotion management and cognitive change techniques are drawn from cognitive behaviour therapy (CBT) (For example, Beck 1995).

The body of evidence for CBT is widely accepted and CBT is a recommended intervention for people under various federal and state government programs that provide assistance to people with mental health conditions and chronic health conditions. Evidence supports the importance of addressing mild and moderate levels of negative mood, such as depression and anxiety, in the effective management of chronic diseases. Additionally, the role of cognitions, such as illness perceptions and health beliefs, has been showed to impact on health behaviours.

In summary, the model elements are well known to clinical health psychologists in particular and to other mental health and health professionals generally. The model specifically dictates the basic training elements recommended for health professionals to optimally assist people to make health behaviour changes and self-manage chronic disease.

The knowledge of CCSM models and the acquisition of relevant intervention skills, as outlined in the health coaching model, will not only direct the individual health professional's behaviour but also direct appropriate referrals within the team.

Delivery modes

The delivery of health coaching interventions is flexible, but should always be implemented within an intervention-team paradigm. It can be implemented clinically in the following ways:

- As an adjunct to usual medical, nursing and allied health professional consultations.
- As a dedicated health behaviour change session, face-to-face with a health coaching trained health professional (eg., a practice nurse during Enhanced Primary Care management plan development).
- As a dedicated one-on-one telephone health coaching intervention conducted by a health professional.
- As an adjunct to program-based CCSM education (for example, the Stanford Model of group education with an individual follow-up session to maintain progress and assist with barriers to progress).
- As an adjunct to assessment protocols such as the Flinders Model of CCSM.
- As a small group health coaching intervention that includes provision of time for individual attention and direct assistance in overcoming barriers to change for each participant within group meetings.
- As an internet-based health coaching intervention that includes direct exchange of information between a health coaching health professional and the person.

Intervention and cost effectiveness of health coaching interventions

The intervention and cost effectiveness of CCSM interventions that have included elements as outlined in the HCA health coaching model, has been substantiated.

A study, called the Good Life Club (GLC), was one of the demonstration projects of the Australian Government funded Sharing Health Care Initiative (Kelly et al. 2003). It was developed to trial a telephone coaching approach to supporting people with diabetes. The health coaches were allied health professionals trained in the health behaviour change model, The Transtheoretical Stages of Change (Prochaska, DiClemente & Norcross 1992), and Motivational Interviewing (Rollnick, Heather & Bell 1992).

The role of the coach was to assist the person to become a confident and proficient self-manager and also to recognise their capacity for self-management within their life context. The emphasis was on gaining control over targeted lifestyle behaviour changes, such as dietary and physical activity behaviours, and adherence to medical recommendations such as blood glucose testing, foot care procedures, and medication prescriptions.

The empirical evidence indicated that the coaches reported a significant uptake of the health coaching skills (Lindner et al. 2003), and that the relative risk of being well-managed was 1.28 (95%CI: 1.04, 1.58) for the GLC intervention as compared to usual care. Furthermore, the GLC intervention compared to usual care involved an additional cost of $1,457, but with an incremental cost-effectiveness ratio resulting in a benefit of approximately $16,000 (Mortimer & Kelly 2006). The GLC members (people with diabetes) reported a significant association between depression and symptom experience, confidence to self-manage their disease, and confidence in self-management to reduce the need to see a doctor.

At the six-month assessment time point, the GLC members reported significant reductions in fearfulness of health, shortness of breath, visits to the GP, and increased confidence in managing condition/disease related activities, such as fatigue, physical discomfort, emotional distress and treatments other than medication (Browning et al. 2003).

Health coaching skills training for health professionals

Introductory level skills training:

The recommended introductory level skills-based training for all health professionals is two days minimum of intensive skills-based training. This should include:

1. ***Explanations and discussions of the health coaching model, evidence base and rationale***
2. ***Health coaching theoretical principles***
3. ***Health coaching practice issues***
4. ***Demonstrations***
5. ***Practice sessions with feedback***
6. ***Discussions of real cases including complex cases from participants' and facilitators' clinical experience***

After completion of high quality introductory level training of this nature, many health professionals possess the skills and confidence to start implementing health coaching as part of their usual practice. More experienced professionals and those with solid counselling skills are able to integrate health coaching techniques more quickly than those professionals who are not already competent in basic counselling skills (such as reflective listening skills).

Workshops should stipulate a maximum number of participants for each workshop in order to facilitate an adequate level of participation in discussion and adequate practice feedback for participants. As a guide, a maximum of twenty participants would be appropriate for a workshop with one facilitator and a maximum of twenty–two to twenty-four participants would be appropriate with two facilitators to supervise participant practice sessions.

Health coaching training is very effective in mixed groups of health professionals. This also builds professional understanding and respect between various health professions. This in turn facilitates better relations and enhances cooperation within multidisciplinary teams in the workplace. →

Trainers

Trainers should be competent in their knowledge of health coaching principles and in conducting health coaching practice. They should have ongoing practice experience of working with people with chronic disease in a health coaching context in order to address concerns and answer specific questions from participants. Trainers require a strong background in the practice of health psychology and chronic disease self-management support.

At least one registered health psychologist should be present in each workshop in order to deal with psychosocial issues that sometimes arise for workshop participants when participating in experiential health coaching practice. Ideally, the primary facilitator will be a practicing clinical health psychologist. She/he will be required to analyse and discuss complex clinical cases that include how to deal with cognitive and emotional factors and other psychosocial issues that arise during health coaching consultations.

Co-facilitators will ideally be a practicing health professional from another health discipline in order to integrate examples from a broader perspective than health psychology alone.

Supervision or peer support

Workplace-based periodic group or individual supervision or peer support sessions including discussion of cases assists health professionals to integrate their health coaching skills into their practice.

These sessions also allow health professionals to discuss difficult cases with peers and build their skill levels.

Ideally, workplaces that have team arrangements for chronic condition self-management would have a clinical health psychologist on the team. The role of the clinical health psychologist would be to assist people with complex health and psychosocial needs and also to support other team members in dealing with people with psychosocial issues.

Additional and advanced training

Additional or advanced training will be required for most individuals in elements where skill gaps have been identified. For example:

- Basic counselling skills, if lacking
- Motivational interviewing techniques
- Solution-focused counselling techniques
- In-depth review of models of health behaviour change and barriers to health behaviour change
- Cognitive therapy techniques applied to health behaviour change
- Coaching techniques and behaviour modification strategies
- Interventions for mild levels of depression and anxiety

Competency assessment

Competency assessment is preferred to workshop attendance only. Assessment should be implemented if training and professional development budgets allow, in order to ensure that health professionals reach the required standard of professional practice in health coaching. Participants report a much higher level of understanding and confidence in using health coaching techniques after submitting written and audio case studies and completing an exam addressing the key model elements (Certificate of Competency in Introductory level health coaching skills).

Positives about the approach

Health coaching provides health professionals and agencies with practical clinical strategies to assist people to manage chronic health conditions and lifestyle risk factors. The interviewing style aims to decrease resistance to change. When conducted by a *competent* practitioner, health coaching techniques elicit intrinsic motivation and thereby increase the probability that people will attempt to make behaviour changes.

In addition, health coaching techniques assist people to identify and overcome their personal barriers to health behaviour change and thereby increase their chances of success in making and maintaining health behaviour changes.

An added advantage of using health coaching techniques is that health professionals often report having greater job satisfaction after integrating health coaching into their professional practice. They report greater success and less frustration in relation to outcomes. Health coaching training will preferably include practice sessions based on real life situations for participants rather than role plays. Where this occurs, health professionals report a greater level of empathy and understanding with people and often report changes in their own health beliefs and behaviours.

In summary, the benefits of implementing health coaching for chronic disease self-management are:

- Enhanced intervention efficacy by all health professionals in usual medical and allied health consultations
- Opportunity to conduct dedicated health coaching sessions for chronic condition self-management
- Widespread application across professional domains
- Enhanced patient responsibility
- Enhanced practitioner job satisfaction
- Enhanced multidisciplinary professional collaboration
- Flexible and cost efficient delivery modes
- Low cost and ease of up-skilling health professionals
- Evidence-based intervention elements
- Good fit with well-known self-management and lifestyle change models

Organisational challenges for implementing health coaching

Breadth of training

Ideally, all health professionals should be trained in health coaching skills to improve outcomes where they are dependent upon people making health behaviour changes. Most health professionals will have received limited training in any of the recommended health coaching training elements. This has obvious cost implications for agencies and presents both an opportunity and an administrative challenge.

Nature of training

Health coaching is not a 'one size fits all' intervention. It is necessary because people require individual assistance with making behaviour changes that fit with their particular circumstances and priorities.

To be competent in health coaching, health professionals need to have a sound understanding of fundamental health coaching principles in order to assess which particular health coaching intervention to use for a particular person at a particular time. The appropriate interventions will depend on the readiness of the person to change as well as other psychological factors and individual circumstances.

The implication of the individual needs is that health coaching techniques cannot be administered in a standardised, highly structured fashion. Health professionals need to understand why they are using certain techniques in order to use them effectively with a particular person, at a particular point in time, for a particular issue.

Health coaching training, therefore, needs to be conducted by skilled professionals. It is not appropriate for trainers to simply teach a set of procedures to participants.

Identification of need for supplementary skills training

The amount of training required for each health professional to reach competency in health coaching will depend upon pre-existing skill levels in each of the training elements. This will be influenced by:

- Professional base level and advanced training – whether it included elements of the recommended training elements.
- Professional development training completed since qualifying in their profession – for example, MI, CBT, psychosocial aspects of illness, management of mild depression and anxiety etc.
- Professional experience. More experienced professionals will integrate the principles faster than less experienced professionals.

During introductory training in health coaching, health professionals should be encouraged to identify the gaps in their skills base and engage in self-directed learning in the lacking areas.

For some professionals, it may be desirable or necessary for them to repeat the introductory workshop in order to fully understand and be comfortable with the health coaching model.

Skills retention

In order to retain skills from training in health coaching, teams need to start using their new knowledge and skills immediately in the workplace. To facilitate this, agencies could require newly trained staff to write up a selected number of case studies for review by a competent health coaching practitioner.

Alternatively, peer support or supervision groups could be conducted periodically. Additionally, it is useful to require the team to audio tape some of their own consultations and review these personally in order to improve their techniques over time.

Ongoing self-directed or required reading of the recommended texts and papers referenced in health coaching training workshops would be desirable in order to continue to develop health coaching skills.

Human resources and agency systems

Health coaching interventions can be incorporated into usual health practitioner consultations. However, in order to optimally assist people to address some barriers to change, it sometimes takes up to thirty minutes to make significant progress on an issue.

In health systems where health professionals have limited consultation times (for example, fifteen minutes) and where they are expected to assess and provide advice to people in this time, there is little time left to assess and address motivations and barriers to change. However, even in short consultations the health coaching interview style can elicit patient where they would otherwise not have occurred. The primary behaviour change aim in very short consultations may be to *not* increase resistance to change in people.

Follow-up consultations

An important implication of the health coaching model outlined above is that it recognises that many people require assistance with the process of change, even after they have committed to making changes. One-off consultations with health professionals do not assist patients to address barriers to change when they occur after the consultation.

People often elect to try behaviour change strategies that they have tried before and continue to fail in their change attempts (for example, crash dieting). Unless people are able to receive follow-up assistance, they may give up when they fail to achieve their health goals on the first attempt. Programming follow-up consultations as a matter of policy can address this problem. →

Agency culture

Health coaching represents an attitude shift away from the historical medical model of assessing people, telling them what they need to do and expecting them to carry out the health professional's instructions. The alternative model relies on eliciting intrinsic patient motivation and allowing patients to take responsibility for the decision-making process in relation to health behaviour change for chronic condition self-management.

If the agency culture does not support professionals and people working in this way and if sufficient consultation time is not allowed to achieve these aims, health coaching interventions will have less chance of success.

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Coaching People On Achieving Cardiovascular Health Program (The COACH Program®)

Contents

We invited Dr Margarite Vale to write this guide on The Coaching Program®. In it, she discusses the impact of this model upon people with cardiovascular disease and the evidence that supports this approach.

THE COACH PROGRAM

The Coaching People On Achieving Cardiovascular Health (COACH) Program® is a prevention program that trains people who have been hospitalised with coronary heart disease to pursue the target levels for their particular coronary risk factors. Coaches work in partnership with the person's usual doctor(s). People are coached to achieve the targets for their risk factors and to take the recommended cardio-protective medications as recommended by the National Heart Foundation of Australia.

The COACH Program® assists people to take up the drug treatments, diet and lifestyle measures indicated by research and other evidence. The coach (a dietitian or nurse) provides education, empowers the person to make changes and monitors achievements until risk factor targets are achieved.
The telephone and mail outs (generated by web-based COACH software) are used to provide regular coaching sessions to people after discharge from hospital over a period of six months.

At the commencement of coaching, the coach determines the person's knowledge of their risk factors, recommended targets and their practice of lifestyle measures and drug treatment. Where there are deficiencies in knowledge, behaviour or drug treatment, the coach educates the person to obtain the information and the treatment requisite for achievement of treatment goals. The coach encourages the person to discuss these goals with their usual treating doctor and sets targets to be achieved by the next coaching session.

People are persuaded to go to their usual doctor(s) and empowered to ask for appropriate prescription of medication, changes in dose, and/or change in drug, if maximal dose of a particular drug has failed to achieve the target. The process is then repeated at subsequent coaching sessions until the target for the risk factor is achieved.

Coaching is directed at the person and not at the treating doctor. In this way, people with coronary heart disease are trained to take responsibility for their disease to prevent its progression. This program aims to enable people to drive the process of achieving and maintaining the target levels for their risk factors.

Why is The COACH Program® needed?

Despite major advances in scientific evidence for aggressive risk factor management, evidence suggests that these advances are not being applied in the real world. In fact, only a minority of people with coronary heart disease are achieving the target levels for their coronary risk factors such as cholesterol and blood pressure.

People undergoing coaching have made and maintained improvements in their risk factors for cardiac disease and have reported they are less breathless and have less chest pain than comparable people who are not coached.

The evidence for The COACH Program®

The COACH Program® was created in 1995. For the first seven years it underwent rigorous testing. It is supported by the highest level of evidence with two randomised controlled trials published in international medical journals. It has been shown to reduce hospital utilisation in people with coronary heart disease by twenty per cent compared to standard care alone.

It is the world's first evidence-based program of coaching for the achievement of specific risk factor targets for the prevention of the progression of chronic disease. The COACH Program® has been the recipient of several prestigious awards, national and international.

For the past five years it has been adopted as standard care in public hospitals in four states in Australia and has recently been launched in the private sector for privately insured people of Australian Unity. The COACH Program® has also been extended to other chronic conditions including COPD, diabetes and heart failure.

The COACH Program® has been tested in two published randomised controlled trials, which prove that The COACH Program® is highly effective in reducing risk factors in people with coronary heart disease. Coached people also reported less anxiety, breathlessness and chest pain than non-coached people and coached people reported better general health, mood and fitness than non-coached people.

A recent four-year follow-up of the second randomised controlled trial conducted by the Victorian Department of Human Services found people who took part in The COACH Program®, spent twenty per cent less time in hospital compared to people who hadn't taken part in the program.

The COACH Program® in clinical practice

The COACH Program® is provided as a package. It involves specialised training of health professionals, ongoing support and feedback, and ongoing clinical audit and quality control provided by The COACH Program® software.

There are a number of advantages to The COACH Program®. Firstly, The COACH Program® is based on randomised controlled trials, a high level of evidence for a disease management program available in Australia.

The coach initiates contact with the person so reducing the likelihood of non-attendance. In addition, person-adherence to treatment and lifestyle measures is monitored through the coaching process. Although The COACH Program® was developed for people with coronary heart disease, The COACH Program® is applicable to other disease states. Research is underway for conditions such as diabetes.

Coaching can be conducted by any group of primary care physicians, a plus in regions where allied health professionals are not permitted to prescribe medications directly to people. People are invited to contact their coach between coaching sessions for questions and further information as required.

There is no need for the person to meet the coach face-to-face, making it time-efficient and accessible. The program is designed to be phone-based contact and does not require the person to attend a centralised assessment centre.

Guide to implementation

Agencies wishing to implement this program need to contact Dr Margarite Vale, University of Melbourne Department of Medicine and the Dept of Cardiology St Vincent's Hospital. Email: margarite.vale@gmail.com.

The program has recently been extended to five Melbourne hospitals and received recognition in international medical journals.

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Resources

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The Chronic Disease Self-Management Programme

Contents

Your planner

Your team: When selecting your team, you need to think about the impact self-management will have on your agency. We recommend that you include a manager, support staff and members of the chronic disease care team. Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to *Changing clinical practice*.

You will also need to train peer leaders to achieve the results reported by Stanford University, USA.

Duration: A six-week program of two hours per week for people with chronic disease.

Training: **Leaders** are those who teach the six-week program. To become a leader, you need to complete leader training (a three-day workshop), teach at least one program and be certified by a master trainer. To remain certified, leaders must facilitate a minimum of one program every two years. Contact the Arthritis Foundation in your state for further information on Leader training.

Master trainers are those who train leaders. To become a master trainer, you need to complete master training, co-facilitate at least two leader-training workshops and be certified by a Stanford t-trainer. To remain certified, master trainers must facilitate one leader training every two years.

T-Trainers are thosewho train master trainers. To become a t-trainer, you need to be authorised after apprenticeship training with a Stanford staff trainer. To qualify for an apprenticeship, you must facilitate at least two master training workshops and two leader trainings.

Competencies: Be able to undertake and deliver the highly structured six-week program. The key competency is the ability to be non-judgemental and lead groups of participants.

Meetings: Two to three meetings to discuss options for implementation.

Tools: *Living a healthy life with chronic conditions* is the book associated with the program.

The Chronic Disease Self-Management Programme developed by Professor Kate Lorig and her colleagues at Stanford University is a six-week group program for people with chronic disease. The program is designed for people to increase their skills in the day-to-day management of their disease through peer support and modelling.

The Chronic Disease Self-Management Programme is designed to give the person with chronic disease skills on how to manage their condition. Originally developed for people with arthritis, the program is now generic to chronic disease.

In Australia, this program is more commonly known as Better Health Self-Management (BHSM). It is offered throughout Australia by the Arthritis Foundation and a range of other health providers including community health services, acute hospitals and other community settings. In our discussion, we will refer to it by this name. However, it is worth noting that agencies offering this course may name it differently.

A key feature of this model is its focus on peer leaders. The program is highly structured, so it can be taught by non-health professionals with a chronic disease. Lorig and her colleagues have shown that the outcomes of this program are more successful when taught by peer leaders. This is because participants more easily relate to those with similar issues.

The model was developed by the Consumer Education Research Centre in the Department of Medicine at Stanford University, California. Lorig and her colleagues have developed, tested and evaluated the program for people for the past twenty-four years.

These programs were originally developed for English-speakers and have since been translated into a range of other languages. In Australia, the program has been tested in Chinese, Vietnamese, Greek and Italian communities by the Peer-Led Self-Management Program at La Trobe University.

In Australia, this program is more commonly known as Better Health Self-Management (BHSM).

Better Health Self-Management Course

Better Health Self-Management (BHSM) consists of a two-hour weekly session over six weeks. Groups have a minimum of eight and a maximum of sixteen participants to facilitate sharing and problem solving.

The program is facilitated by two trained leaders, ideally with one or both having a health problem of their own. It can be conducted by health professionals and/or peer leaders.

The sessions are highly interactive, focusing on building skills, sharing experiences, and enlisting peer support. The BHSM teaches the skills people require in the day-to-day management of their chronic disease, to maintain and/or increase life's activities.

Topics include:

- How to manage symptoms
- How to communicate with your doctor more effectively
- How to lessen frustration
- How to make daily tasks easier
- How to fight fatigue
- How to get more out of life

Brainstorming, problem solving, action planning and goal setting are the key strategies used each week in the program to build the self-efficacy of those involved.

Self-efficacy refers to the belief a person has in themselves to execute or carry out a given task. It is often referred to as self-confident and is gauged by asking people how confidence they are of achieving their goals.

The enhancement of self-efficacy is a key program element and the teaching process is structured to include four major ingredients of efficacy enhancement: skills mastery, modelling, interpretation of symptoms, and social persuasion.

Skills mastery or taking action involves getting people actively involved in behavioural change. Each week, participants are asked to make a specific action plan for something he or she wants to do in the next week.

Modelling is accomplished by having people with a chronic disease teach the program. People act as role models for each other. When participants have problems, other members are asked to make suggestions before the group leader offers any.

Reinterpreting of symptoms is aimed at helping participants form alternative explanations for their symptoms. When people understand there are often multiple causes, they have reason to try new self-management behaviours. →

Finally, *social persuasion* is a powerful means of increasing self-efficacy. People are more likely to follow what those around them are doing. In the group setting, if people in the group are engaging in exercise and experiencing positive benefits, others not currently doing this are more likely to follow.

Guide to implementation

Do we need permission to run the program?

Any agency giving a BHSM program must purchase a license. Any agency receiving training from a non-Stanford master trainer or t-trainer must purchase this license from Stanford prior to the training. Include this cost in any training budget you prepare to run this program.

How do we get started?

Build your health professional referral base. Start with your team. The more your team knows about the program and understands its benefits, the greater the referrals to the program will be. People can self-refer, but the support and enthusiasm of the team is important for how chronic disease care is provided.

Consider how you can integrate this program into your systems such as intake, assessment and/or care planning. Introduce the use of prompt forms at intake and at assessment. Information on self-management can be offered in care planning sessions.

Invest in training leaders (health professionals and/or peers). Consider having at least one peer leader.

What happens after we train our peer leaders?

Appoint a coordinator to support the peer leaders to run regular programs, maximise their skills and ensure they attend twice yearly updates. Set up regular communication with your peer leaders. Offer practical support in running the groups, for example setting up the room.

What other training is required?

Consider training your team in one of the other self-management models such as the Flinders model or health coaching. This way, they can see the importance of self-management within their own work. The Better Health Self-Management course can then become part of the person's care plan as a self-management option.

Training the team in other models enables them to monitor people's readiness to change. Not everyone will be ready to make the changes encouraged in this program. So your team will need to offer it when they are. Consider the criteria and questions the team may want to ask people to identify who is appropriate for the program.

What happens after people have completed the six-week program?

Participants should be linked into local services for follow-up support. Self-management support is also needed to help people maintain the changes they have made.

Common challenges

Participant recruitment

Recruiting participants is a problem common for all self-management programs. The reason is often a result of a poor referral rate from health professionals. Referrals need to come from your team rather than leaders having to rely on social marketing to recruit participants.

In general, the program tends to attract more women than men. A common challenge is how to target different social and cultural groups not currently attracted to the program. The team should investigate time in thinking of how this program could be marketed, perhaps working with community leaders to do this.

Supporting peer leaders

Supporting peer leaders to run the program will require resources from your agency. Peer leaders should not be expected to recruit participants and attend to all the administrative requirements of the program, for example photocopying.

Costs to people

It is common for agencies to charge a small fee to participants attending the program. Participants should also be encouraged to purchase the book *Living a healthy life with chronic conditions*. This book offers guidance on setting goals, managing symptoms, exercising, understanding medicines, communication and finding resources, and includes chapters on major chronic diseases.

Agencies may need to subsidise participants in areas where finances are identified as a common barrier for program attendance.

Case study

Con's story

Con is close to seventy. He is Greek and has been in Australia for more than fourty years. He migrated here when he was a young man in his thirties as he wanted a better life for his family. Like many other Greek people, he came to Australia with very little. Very quickly, he found a job in a factory and began his working life in Australia. Soon he left that job and linked up with someone to set up his own shop. He established a shoe repair business.

He worked hard, which involved many late nights and long hours. But life in Australia was good. He lived in an area with lots of other Greek people and found many friends. Con is now retired and has passed the shoe repair business onto his son. He is glad the business has been left in the family. Now that he is older, things are getting hard.

His health is not so good. He is often out of breath and finds his heart pumps very hard – it is like someone is pounding on his chest. His doctor has told him he has heart disease and has given him some tablets.

He also has very painful knees from arthritis and finds this restricts him a great deal. He used to enjoying taking his wife to the local dance. He now rarely goes out, making him very sad and lonely. His difficulty breathing makes him nervous and he often worries.

He recently went to his physiotherapist at the local community health centre who told him about the Better Health Self-Management. Not being sure what the program might involve, he decided to go and find out. He asks his wife to take him to the local library where the program is being run.

On the first week, participants were asked to set a goal. When he was asked to set his goal, he told the leaders that he desperately wanted to return to Greece to visit his brothers and their families but felt that he could not cope with the long plane flight because of his pain and breathlessness.

He found the leaders very helpful and especially as they had their own health problems. They knew what he was going through. The leaders helped Con to break down his big goal into some small achievable steps such as walking to the front gate and then later, further around the block. He later set another goal of visiting his doctor to review his pain medication.

As he achieved these small steps, he found his confidence grew and he started to understand that by setting smaller achievable goals, he would be able to achieve his dream of returning to Greece. He was also inspired by another participant Kostas who appeared to be in more pain, but was still active. Con found the group very worthwhile and encouraged others he knew to attend.

Resources

For more information about the Chronic Disease Self-Management Programme model, including tools, translated materials and licensing, go to the website <http://consumereducation.stanford.edu/>.

The Peer-Led Self-Management Program, Latrobe University translated the BHSM program into four languages. For information on go to <http://www.latrobe.edu.au/aipc/director/plsmci/about_healthprof.htm>.

To find out more about courses for participants and leaders, go to the Arthritis Foundation in your state <http://www.arthritisaustralia.com.au>.

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Group visits

Contents

Your planner

Team: When selecting your team, you need to think about the impact self-management will have on your agency. We recommend that you include a manager, support staff and members of the chronic disease care team. Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to *Changing clinical practice*.

Resourcing: We estimate you will need six hours to plan and pilot this project. We include a review meeting in this time allocation.

Training: There is no formal training course. The team will need to know and understand how to teach problem solving and goal setting, and how to use self-management support in group settings.

Competencies: Skills in brainstorming in group sessions, ability to facilitate group discussions and create positive group dynamics.

Meetings: Two or three meetings are required to discuss implementation options.

Tools: *Goal setting worksheet* and *Problem solving worksheet*.

When we think of self-management, we normally limit our thinking to individual sessions with people or group education programs. Yet this model developed by the Cooperative Health Care Clinic Kaiser in Colorado USA challenges this thinking.

This model integrates all aspect of the ICIC Chronic disease care model through its education, clinical assessment and treatment programs. The model's success is that it encourages personal empowerment and draws upon group dynamics to initiate behaviour change.

How does this differ to usual group education programs?

The group visit model combines in a group setting self-management strategies, including problem solving and goal setting, and clinical assessment and treatment. This approach is not something we commonly see in Australia, where clinical assessment is undertaken in an individual session.

There are many advantages to this model, especially for agencies where waiting lists are identified as a barrier to self-management. The model promotes a very interdisciplinary approach to care and is ideal for the review of people.

The Cooperative Health Care Clinic Kaiser has reported many benefits since it first introduced this model. They have seen a reduction in emergency department use and hospital admissions, increased satisfaction with care, reduced costs and delayed entry to long-term nursing facilities. These successes mirror our own interest in addressing the impact of chronic disease on our health system.

Most importantly, the feedback has been positive. People value the trusting relationships, hands-on care and time with the provider. These group visits have been shown to address these needs by making efficient use of resources, improving access and using group dynamics to help motivate behaviour change and hence improve outcomes.

Group visit

The group visit is organised into three main activities: the introduction, clinical treatment and topic discussion. The group runs for just under three hours and the room is set up in the shape of a horseshoe to facilitate discussion.

It is a simple format but one that has been successful for both improving clinical outcomes as well as behaviour change.

Introduction

The introduction is aimed at encouraging sharing and supportive relationships between group members. Role modelling is important for setting the expectations for the group visit and how it will run. Beginning with introduction such as 'My name is …, my favourite holiday was…' to make everyone feel comfortable.

An overview of the group visit is then provided to participants with time allowed for interaction and questions.

> ### *Group visit*
> The group visit follows a very simple format. If your group visit occurs in a medical setting, you will need a doctor and a nurse specialist. If the visit is in a community health service, you will need a multidisciplinary team.
> - Introduction (15 minutes)
> - Clinical treatment session (30-40 minutes)
> - Topic discussion (45 minutes)

Clinical treatment session

The nurse starts at one end of the horseshoe and takes relevant tests (for example, blood pressure). The doctor (or other health professional depending on the focus of the group) starts at the other end and covers individual issues. Test results are recorded in people's notebooks and the medical record. Other team members conduct assessments for those who may need an individual visit at the end of the group session.

After the end of this session, the group is reconvened for open questions and answers. This session can be prompted by encouraging people to discuss what they discovered at the treatment session. All team members are involved to demonstrate that the team works together.

Group interaction is powerful, so resist the temptation to take over and lecture. It is important not to overwhelm people with information. Trust the group to lead the way. Our role is to facilitate the group interaction.

Topic discussion

After a short break, a topic is introduced for discussion. Topic sessions are not information driven: they are aimed at enhancing self-management skills and behaviour change. Discussion is determined by the people present in relation to the topic chosen. Problem solving and goal setting exercises are used to assist participants to solve the problems they are experiencing.

People are encouraged to think about and discuss the barriers they have. For example, the topic might be taking medication. Participants are encouraged to discuss barriers to taking medications or the side-effects they might be experiencing. Information is provided in relation to what participants need and are ready for, rather than being curriculum-driven.

The group is then encouraged to write a list of topics they would like to discuss in future visits (typically monthly) with all ideas being written on a flip chart. Group participants are then followed up with individual appointments at ten-minute intervals at the conclusion of the group session for those that require it.

Everyone is thanked for coming.

> When questions arise, we tend to want to give the answers. Learn to leverage the power of the group. Has anyone else experienced this problem? What worked for you? This increases participants' confidence in their own problem solving ability.

Guide to implementation

Plan and coordinate the group visit with your team, as it will be a team effort. Talk to other agencies that have successfully tested this idea, get leadership support, discuss anticipated outcomes and determine a measurement plan. Use our guide on *Diagnosing your health service*, in it we describe how to benchmark your practice against evidence-based guidelines and best practice standards.

It is worth developing a standard agenda to ensure consistency from visit to visit and delegate roles. If the group visit is to be held in a general practice or a hospital, you will want to prioritise time with a doctor and involve a nurse to assist with clinical measurement. If implementing the visit in a non-medical setting, then the team needs to work through how this multidisciplinary group visit will run.

Teams will need to determine who will be targeted and make a list made of all potential participants. A chronic disease registry can assist to target people who might benefit. We describe the use of a registry in our guide on *Diagnosing your health service*.

Your next step is to send letters to potential participants about the group visit, emphasising that it is an actual medical/clinical appointment, not a class or workshop. Explain the purpose of the visit and what is likely to occur and request people have tests prior to attending.

Hold a team meeting prior to the group visit to review blood results for preventive care needs and other concerns. Your team should also organise materials, resources, any assessments or documentation tools and the agenda.

Post visit

After you have conducted your first visit, hold a debrief meeting. This meeting should focus on what went well and what didn't go so well. Discuss things you might want to do differently. However, remember that the basic format of the group has been tested in clinical trials.

Hold a meeting each month to review the requested topics and determine how to address them. Review the roles of each team member and anything that the team would like to try differently at the next session.

Common challenges

Cultural barriers in your agency

Agency culture can either hinder or enhance the desire of your team to work in this way. Group programs to date have predominantly been educational and have rarely included clinical assessment and treatment. Organising group visits will require the removal of some education items, so there is time for people to identify their own concerns and issues.

Many of us may not feel comfortable with incorporating clinical assessment and treatment as part of a group session. Yet the experience of the clinic described is people learn a lot from participating in this way.

An agency culture that is entrenched in the medical model of telling people what to do and expecting they carry out instructions will be less likely to adopt this approach and health professionals will be more reluctant to make the changes required.

The benefits of this approach need to be promoted throughout an agency and endorsed by senior management.

Training

Many health professionals have received limited training in how to conduct problem solving, goal setting and group facilitation. In group visits, these are the skills required as the topics and problems are purely chosen by the participants. Very little information is provided, only as needed to steer the conversation and as required by the group participants.

This is quite a change from traditional programs, where topics are driven by the health professional. It may be necessary to provide some introductory training on these skills by your team.

The tension between education and self-management

In many existing group programs, education and knowledge provision remain the dominant form of self-management support. Conducting this type of group visit can mark a significant shift away from education to the promotion of health behaviour change. Some health professionals may not feel comfortable with this behavioural approach.

Medicare supports General Practitioners to provide advice to their patients about their condition as part of a one-on-one professional attendance. Education programs are difficult to run in general practice due to time pressures, and a lack of physical space for group visits in many general practices is common.

Case study

Sunshine Valley Clinic

The Sunshine Valley Clinic decides to run a diabetes group visit. They are fortunate to have Geoff Smart, a diabetes educator, who agrees to participate in the group through the new Medicare Item numbers for group sessions. The practice has recently set up a diabetes registry and finds they have fifty people on their system with HbA1c test results greater than ten per cent. They decide to make this their target group. They discover only ten have an existing GP management plan.

The team consisting of Dr Anthony Sheldon (GP), Susan Pearce (Practice Nurse), and Geoff (diabetes educator) meet to discuss the roles and responsibilities of the team. Since it is their first group, they decide to discuss the topic of blood sugar monitoring as this seems to be a common issue where people get confused. They make use of the new Medicare Item numbers through Team Care Arrangements and note which people require a GP Management Plan.

Dr Sheldon agrees to participate in the first half of the group for the clinical assessment and treatment session and bills each participant for a long consultation. Geoff, the diabetes educator, makes use of the new MBS item numbers for group sessions to be able to run the group.

The clinic sends a letter to people in their target group with a blood test slip. The letter explains the purpose of the visit and what is likely to occur. People are requested to have their test prior to attendance. They get twenty confirmed responses to this letter.

Before the group, the team holds a case conference to review the blood results of the people who will be attending. They make notes about potential areas of concern for each of the participants. On the day of the group, they start with the clinical treatment session. Susan is responsible for foot assessments and blood pressure checks. Geoff checks the blood sugar levels written in participants books and then Anthony discusses the results of participants' test results and initiates medication where needed.

Geoff then briefly discusses the benefits of monitoring and shows participants using a whiteboard how they can manage their blood sugars. He asks participants about the barriers to monitoring and both he and Susan lead everyone through a problem solving exercise to solve some of the identified barriers. Participants are then asked about the ways in which they manage their blood sugars.

Everyone is asked what works and what doesn't. Geoff then presents some information about options to better manage and asks participants to compare what they are doing.

Geoff clarifies the questions participants have and Susan leads them through a goal setting section on what they have learnt. They then develop a list of further topics with the participants.

After the session there is time for individual appointments. Anthony refers to the GP Management plan completed for each person prior to the group visit and makes adjustments to any medications that might be required. He arranges follow-up appointments for anyone requiring additional time.

The team meets a week later and discusses the outcomes. They identify a number of areas for improvement but agree that the topic session was very beneficial. Participants seemed to be more motivated and understand the message of monitoring. Importantly they seemed to grasp better ways to manage their symptoms.

Resources

Scott JC, Gade, G, McKenzie, M & Venohr, I 1998 'Cooperative health care clinics: A group approach to individual care', *Geriatrics*, vol. 53, no. 5, pp. 68-81

Beck, A, Scott, J, Williams, P, Robertson, B, Jackson, D, Gade, G & Cowan, P 1997, 'A randomized trial of group consumer visits for chronically ill elderly HMO members: The cooperative health care clinic', *Journal of the American Geriatric Society*, no. 45, pp. 543-549.

Heisler, M 2006, *Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success*, California Healthcare Foundation. You can access this report online at <http://www.chcf.org/topics/chronicdisease>.

For a comparison of different group self-management approaches, go to the Improving Chronic Illness Care website < http://www.improvingchroniccare.org>. You will find this document in the resource library.

Improving Chronic Illness Care has produced a guide on setting up a group visit. Go to the website <www.improvingchroniccare.org> for a group visit starter kit that is listed under the resource library. It is available free of charge.

Group education

Contents

Your planner

Team: When selecting your team, you need to think about the impact self-management will have on your agency. We recommend that you include a manager, support staff and members of the chronic disease care team. Your decision in many ways will be guided by the availability and the size of your team. Refer to our discussion of the improvement team in the introduction to *Changing clinical practice*.

Resourcing: We estimate you will need six hours to plan and pilot this project. We include a review meeting in this time allocation.

Training: Courses in adult learning principles and health education are available. The team will need to know and understand how to teach problem solving and goal setting, and how to use self-management support in group settings.

Competencies: Skills in brainstorming in group sessions, ability to facilitate group discussions and create positive group dynamics.

Meetings: Two to three meetings are required to discuss implementation options.

Tools: *Goal setting worksheet* and *Problem solving worksheet*.

Many disease-specific education programs (such as diabetes education, cardiac rehabilitation) provide a great deal of information to the people who attend. There is now adequate evidence available that says while such approaches will improve the knowledge of the people attending, it will little impact on changes in their behaviour.

It is common to feel that there is little time for self-management activities within current group education. Attendance at group education can be poor. It is hard to imagine how problem solving, action-planning and goal setting could enhance your current program, when more often that not group participants seem reluctant to participate.

Yet, if we are to make these groups effective and do more than improve people's knowledge, we must introduce changes that are likely to impact on a person's behaviour.
This guide outlines a number of suggestions to incorporate elements of effective self-management support into existing group programs.

Group education

Problem identification and goal setting are two of the most important self-management skills. Yet our current group programs are information focussed. For our education programs to be more effective, sessions should incorporate problem solving and goal setting.

Current literature identifies four essential elements of effective self-management support.

The first is a collaborative approach. A successful program will allow for both people with a chronic disease and members of the chronic disease care team to jointly identify the problems to be addressed. There will be targeted goal setting and planning.

Secondly, each session will focus on specific problems, set realistic objectives and develop an action plan for attaining those objectives. The discussion will be in the context of a person's preferences and readiness.

Thirdly, there should be a continuum of self-management training and support services. People should be given access to services that teach the skills needed to carry out medical regimes, guide health behaviour change and provide emotional support.

And finally, there should be active and sustained follow-up. People should be monitored for their health status, so potential complications can be identified and checked. This is also an opportunity to reinforce progress in implementing care plans.

Guide to implementation

Making changes to existing group programs is relatively low cost and requires only a small amount of training. Many teams have made changes to existing group programs with a small amount of planning and have noted great success. These programs vary from strength training classes, diabetes education, to other physical activity groups.

In the following guide, we outline a number of steps for making changes to your existing group education programs. We gleamed this information from health professionals who run disease-specific education or exercise programs and who have had experience in implementing problem solving, action planning and goal setting into their programs.

Identify the program you want to change and plan it with your team

Begin by identifying the program you want to change and discuss as a team what changes you will introduce and how. Check the skills you will need to make these and identify any training.

Look at the contents of the current program. Identify any sessions that could be streamlined or removed all together to make more time for self-management. This won't be easy as we often feel quite compelled to tell people 'everything they need to know'. Remember you can always give participants additional information to read or if they have access to computer, a list of websites to where they can get information about a particular topic.

Restructure the group program to allow sufficient time for problem identification. Use the telephone or a questionnaire to identify common concerns. By focussing on a shared problem, this focus will motivate the group and ensure that what is discussed is of relevance to everyone. The more people are engaged, the more they will gain from the experience of participating.

Remember to inform your management team that you will require extra resources. You may need extra time or may wish to run smaller groups or call upon the help of an allied health assistant. Training an allied health assistant to undertake problem solving and action planning with you (as leader) will ensure that there are adequate resources to encourage small group discussion.

Ideas for incorporating problem solving and action-planning into groups

One of the key challenges of running a successful group education session is encouraging people to speak and share their experiences.

It is important to set expectations from the beginning. People are likely to come to the group with the belief that you are the expert. This is a perception that needs to be challenged if any behaviour change is likely to occur. We recommend that you draw upon the different self-management approaches we have discussed.

There are many different ideas that you can explore to change how your education groups are currently run.

Begin by conducting problem solving and goal setting in a smaller group. Split the groups or combine three to four individual appointments together to build your confidence in using these techniques. People are often more confident speaking in small groups than larger ones, so this arrangement will help with your aim of creating a dialogue. →

Alternately, conduct problem solving and goal setting during the break for morning tea. As participants get to know each other and feel more relaxed, you can initiate a discussion of shared issues. Experiment with different ways to explain the focus of the group. For example, have a chart of how to problem-solve (with some examples) on the wall. A brochure on goal setting and action planning sheets could also be made available for people to take home.

Start small and build up

Use the plan-do-study-act improvement cycle approach to get started. This approach will allow you to start small. Avoid making changes every week. Alternate between problem solving sessions, information giving and health information on different weeks of the program. Or choose a specific time within the group program to carry out these tasks.

Use brainstorming questions to identify problems common to the group, for example, the question might be 'what things prevent us from taking our tablets?' Have participants brainstorm possible solutions to the identified problem and ask each person to choose which one suits them best.

Make the most of modelling and skills mastery

Looking to the Better Health Self-Management program, think about how you can use peer modelling. Have problem solving, action-planning and goal setting modelled by the leader of the group.

Train a willing peer to take on the role of supporting other participants to master these skills. As we have suggested, split the group into smaller groups to do the problem solving exercise together. Use the SMART objectives discussed in *Changing clinical practice* to assist with setting achievable goals and specific actions.

Common challenges

Culture barriers in agencies

Agency culture can either hinder or enhance the desire of the chronic disease team to work in this way. The changes we recommend require a shift in how chronic disease care is viewed and the role of the health professional. If the approach is telling people what to do, there will be reluctance and scepticism about the changes identified in this guide.

Training

Many health professionals have received limited training in how to conduct problem solving and goal setting sessions. So, it is likely that teams may not be confident to attempt such approaches within a group.

We recommend you provide some introductory training on these skills. Draw upon the skills of your team such as psychologists. Alternatively, organise training in Motivational interviewing and Stages of Change.

The tension between education and self-management

In many existing group programs, education and knowledge provision remains the dominant focus. We find that people commonly refer to this approach as self-management but it is not. Straight education is didactic in nature and does little to promote empowerment and health behaviour change.

The reluctance of teams to adopt some of the recommendations outlined is understandable. As we have discussed, many of the skills required are not enhanced in our training and the demands of clinical practice often leave very little time for the testing of these different approaches. We can often feel that we are neglecting our duty of care if we do not provide instruction, believing it will promote clinical safety and assist the person to manage their condition.

So, it can be a significant shift to move away from an educator role to a coach. Some health professionals may not feel comfortable with this behavioural approach.

Time to integrate self-management elements

Undertaking problem solving and goal setting will take additional time. It is helpful to always have two leaders, one of which can be an allied health assistant. Allied health assistants can be taught to use these skills and successfully facilitate participants in the group to undertake these elements.

Case study

Bev's story

Bev, a physiotherapist, runs a six-week introduction to strength training for people with a chronic disease, followed by a weekly maintenance program. She has been running this program for the last four years and has recently completed some training in self-management. She has discovered that problem solving and goal setting are meant to be more effective than information alone. She discusses it with her peers to see what they think and how such an approach might be incorporated into her current program.

At first she experiences some reluctance. Her peers are unsure of how to include self-management in the current course. She too is unsure of how to do this and is concerned that some crucial elements of the course might be eliminated if she goes down this path. She decides to attend a program at another local centre where she knows they have incorporated these elements.

She returns excited and decides to test it at the next course. She decides to start each session with fifteen minutes of goal setting. She uses the National Physical Activity guidelines for Australians as the basis for the goal setting. She starts the discussion with some open-ended questions to assist participants think about their importance and confidence for doing more exercise. She then uses brainstorming to assist them to solve their barriers and set realistic physical activity goals.

She finds there are one to two participants who quickly grasp the purpose of goal setting and she uses them to assist and encourage the other participants – a great form of peer modelling.
At the end of the six weeks, she discovers more participants are excited about exercise and the benefits to their health. They form a support group and a number of them start walking together.

By the time the participants are in the weekly maintenance program, they are reasonably competent at goal setting and she finds that many are now talking about other goals.

She continues goal setting in the maintenance group; however, this time it is over a cup of tea at the end of the group.

Resources

Department of Health and Ageing, 1999 *National Physical Activity guidelines for Australians*, Department of Health and Ageing, Canberra.

The Good Life Club website has examples of plan-do-study-act cycles of agencies that have successfully implemented self-management strategies into existing group programs <http://www.goodlifeclub.info/index.php>. They also include a one-page flyer of how to implement self-management strategies into existing group programs.

Improving Chronic Illness Care has a comparison of the different group visit self-management approaches. It is a downloadable PDF and is listed on the ICIC website under resource library <http://www.improvingchroniccare.org>.

Heisler, M 2006, *Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success*, California Healthcare Foundation. You can access this report online at <http://www.chcf.org/topics/chronicdisease>.

WHITEHORSE DIVISION OF GENERAL PRACTICE

Navigating self-management

A practical approach to implementation for Australian health care agencies

4 Leading change

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Contents of this guide

Introduction

How to read this guide

This guide provides some reflections on leadership and driving improvement. The focus of this guide is not about *whether* to lead, rather it is about what tasks leaders must undertake to accelerate change and improvement. This discussion is based on the work of the Institute for Healthcare Improvement who are the leaders in system improvement and leadership in health care, and we offer some steps to approaching and managing change. This is not a detailed review of change management but a simple summary of the things you need to consider when managing change. Finally, we reflect on the tensions you are likely to encounter when implementing self-management.

Contents

Your planner

Team: Before initiating any practice change, we encourage you to appoint a leader to guide your team and drive activities outlined in these guides. You will also need a member of management to drive your cause, addressing barriers as they arise and giving authority to your work. Your team should include a mix of health professionals, managers and support staff. Refer to our discussion of the improvement team in our *Changing clinical practice guide*.

Tools: We discuss a number of team building and problem solving techniques to assist with planning and provide you with opportunities for team building.

Leadership is critical to any change. In our work with agencies we have seen many projects implemented in this area of practice change and self-management. What has struck us more than anything else is the impact leadership has on quality improvement. Many very promising initiatives have failed to go beyond the planning and training stages because of poor leadership. At the same time, we have seen agencies achieve extraordinary success when the drive for improving care by health professionals has received full support from their agencies.

Self-management highlights many tensions between how we currently work and the systems that support self-management. The role of leaders is to respond to and navigate these as a part of health care reform.

Management is operational; it is the delivery of our current services within existing systems. Leadership is about creating a new vision for health, committing to it and making it happen.

When it comes to practice change and implementing self-management, there are two types of leadership that you will need. There is clinical leadership and this manual is written with the presumption that this is the role of health professionals. This work involves looking at what we do, identifying how we need to improve and then pursuing collaborative partnerships with others. Our partners will be people with chronic diseases, other teams and health professionals, and administrative staff.

Then there is agency leadership and by this, we mean those leaders who will promote and champion the work of clinical change. Such leadership will translate our work into new agency structures, funding agreements, partnerships and agency strategy. Such leadership is not the same as management.

Management is operational; it is the overseeing and delivering of our current services within existing systems. Leadership is about creating a new vision for health, committing to it and making it happen.

Delivering effective self-management support requires significant practice change and a re-orientation of our health care services. Implementing self-management goes beyond training. It requires an organised, whole of agency approach focusing on continuous quality improvement using strategies known to be successful in improving clinical practice.

Such culture change will not be brought about by a simple project-by-project approach, or using the same agency structures that have produced our current levels of performance. Rather, this change will require investing in a leadership that focuses us on improvement. →

Using leadership to drive change

Leadership is about the ability to motivate people, to bring people together to work collectively. A good leader will address the barriers rather than deferring action and create a culture of innovation, improvement and quality.

What must a leader do to drive improvement?

The Institute of Healthcare Improvement (IHI) suggests a framework for building a leadership that is capable of producing quality health care. The model outlines the steps needed but also the tension that needs to be created to create change. A push and pull dynamic is described to make the status quo uncomfortable and to encourage people to refocus on the future.

So what does this framework look like?

Setting direction

The first step that the IHI describe is set direction. How do we use the agency's mission, vision and strategy to drive improvement?

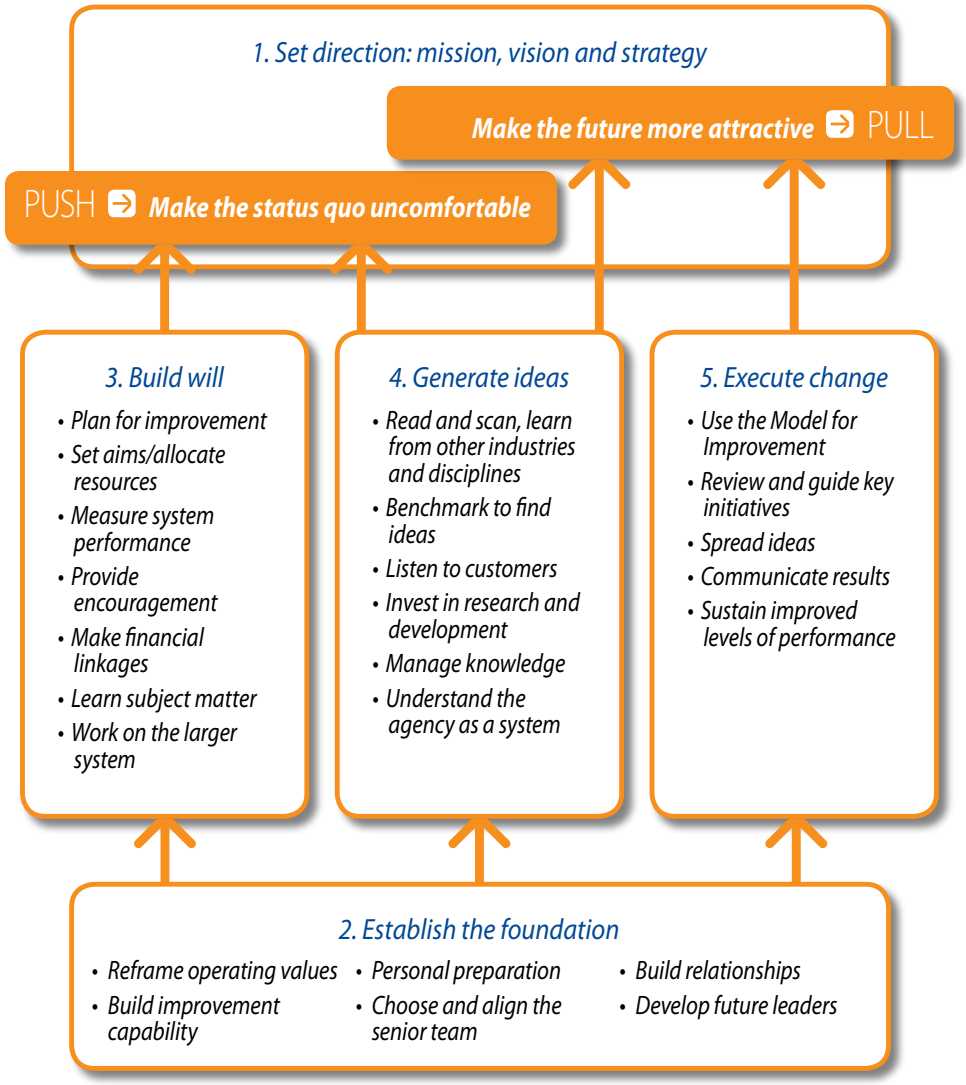
An agency's vision, mission and strategy are statements that represent who we are as agencies and our values. By publicly stating our commitment to chronic disease and self-management, we have increased our accountability to provide a quality driven service. All our work, job roles and team structures should be aligned to this strategic direction and all services should equally reflect this commitment.

Achieving this alignment between agency direction and clinical service is critical, if chronic disease care teams are to receive the support they need to redesign systems. One of the key reasons that projects have limited impact on agency practice is that they are frequently seen as distinct from core business. This is one of the most common mistakes we see in agencies. Any change needs to be embedded into routine practice.

Establishing the foundation

The second step identified is to establish the foundation. Managers need to invest support in leadership skills and build teams capable of redesigning health care. This team must reframe its values and ways of delivering care to be consistent with best practice. Managers need to develop leaders and invest in the measurement and improvement of care.

Figure 1. Framework for Leadership of Improvement



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Building will

The third step is to build will. This is a critical step given the likely resistance to change that most teams experience during any improvement process. It is important to remember that change and improvement go hand in hand. The role of leadership is to prepare teams and agencies by introducing performance systems and plans for improvement. They will generate discomfort with the status quo by highlighting the difference between evidence and practice.

Generating ideas

Generate ideas is the fourth step and one characterised by innovation, research and development. To redesign our systems, we need to challenge how we currently work and to listen to other people's experiences and perceptions of health care. It is important to invest in research and explore how other industries and disciplines work and drive improvement.

Executing change

A clear framework is needed to test and implement change. We recommend that you use the plan-do-study-act model, as it is robust and allows for change to be introduced in manageable parts. It is important to look at the skills required to undertake change such as project management. As agencies, we need tools to support the design and redesign of our structures, processes and services to implement, sustain and spread improvement.

To access your leadership capacity in these five key areas, we recommend you complete the *Understanding your leadership capacity* worksheet at the end of this guide.

Tips for implementing change

So you have achieved some early wins and now it's time to consider how you can implement your changes more broadly. Moving from project to routine practice demands a systems approach. You will need to look at your assessment systems, support tools, guidelines, written policies, training and all aspects of your agency's infrastructure to really change agency practice.

We feel compelled to say that this work is not for the faint-hearted, so with this in mind, we offer the following tips:

Invest in leadership at the top level

- Develop your agency structure to enable planning and implementation of policy changes at strategic and operational levels.
- Integrate self-management into your strategic plan and provide adequate resources (human and time) and priority for the team to understand and action new systems.
- Educate boards of management, teams, people with chronic disease and the community on the policy context of self-management.
- Aim to integrate self-management into service delivery systems and routine practice.

Take a systems approach

- Review pathways to create opportunities for integrating interventions into all parts of the agency such as intake.
- Standardise self-management into processes and review and improve systems to ensure best practice.
- Promote multidisciplinary care planning with GPs.
- Take a continuous improvement approach and utilise agency self-assessment tools to identify areas for improvement in the management of chronic disease. We discuss a number of agency self-assessment tools in our guide *Changing clinical practice*.

Empower action through working groups

- Get a team and promote proactive engagement of everyone.
- Identify obstacles, provide constructive feedback and create short-term wins.
- Foster good communication by reporting and giving feedback to the team and managers.

Use an evidence base

- Utilise an evidence-base to enhance buy-in from other agencies and teams.
- Provide training on technical and content knowledge.
- Communicate information in a way that teams can understand and apply in practice. →

Invest in training

- Train sufficient numbers of health professionals to deliver self-management. Develop a training plan for the whole agency consistent with self-management.
- Invest in train-the-trainers at either an agency and/or local level to support non-health professionals in their roles delivering self-management.

Strategic plans, work plans and job descriptions

- Embed self-management strategies into routine care to ensure sustainability.
- Include measures for self-management as a part of ongoing quality assurance and document strategies into agency business plans, work plans and position descriptions

Engage general practice

- Work with Divisions to build self-management into chronic disease clinics that operate in general practice.
- We talk more about engaging general practice and the role of self-management in our guide *Self-management in general practice*.
- Have practices take a systematic approach to follow-up through regular recall and phone reviews. Incorporate self-management principles into these systems.

Take a regional approach

- Develop key contacts at a regional level to encourage reflective learning within and among local agencies. This contact should provide leadership and promote networks and effective systems change within and between local agencies and general practice.
- Develop regional professional groups to support change management strategies at the team leader level. These groups support health professionals to conceptualise their role in self-management.

Use plan-do-study-act (PDSA) cycles

- Make use of PDSA cycles to manage change by keeping to realistic targets.
- Use PDSA cycles to pilot small interventions and allow reflection and evaluation.

We talk more about improvement cycles in our guide *Changing clinical practice*.

Core skills to be a change agent

Few of us have the skills to be effective change agents. The ability to lead others, influence and negotiate change do not form a part of our health professional training. Yet, we need these skills if we are to be successful in redesigning our systems to improve chronic disease care.

So what are these skills? What does it take to be an effective agent of change? The skills include the ability to:

- Analyse and review systems, to assess and diagnose risk as well as problem solve.
- Model agency values and manage upwards.
- Project manage (design, implement and evaluate new initiatives).
- Ability to consult, negotiate, mediate, coach and facilitate.
- Ability to develop others and gain commitment and support from teams.
- Understand systems theory and the roles required to influence the system in relation to change.

Leadership tools

The process of implementing change can be difficult but with the right tools it is easier to identify problems and plan your strategies. The team will be the focus of this work and the role of the leader is to motivate and inspire this team. The team will no doubt have many questions and at times be unsure or unconvinced about the improvements proposed. Engaging the team from the outset in the redesign work is your starting point. The following tools are designed for your team to promote discussion and get your team thinking. Some of these tools you may have heard of and used before. Others may be new.

Brainstorming

Brainstorming encourages teams to identify causes and solutions to problems. It enables teams to generate a lot of ideas in a short period of time and without criticism or judgement. Brainstorming promotes outside of the square thinking, an important skill if we are to create innovative solutions to improve how we provide chronic disease care services and self-management.

Quick steps

- Set up a team meeting
- Identify a question for the brainstorming session
- Generate ideas and encourage people to think broadly
- List all ideas on a whiteboard and ask people to group them into categories
- Group like ideas and summarise
- Communicate this summary to everyone

Example

Edgeworth Community Health Centre chronic disease care team process maps their assessment of people with heart disease. Much to their surprise, the team finds a lot of duplication in their assessment. Samantha Simmons, occupational therapy and health promotion, sets up a brainstorming session. The team discovers everyone is using a discipline specific assessment form. There are five forms is use. The team then discusses possible solutions to reduce the duplication of assessment. A multidisciplinary form is developed as a team quality improvement initiative.

Affinity diagrams

Affinity diagrams are another way of brainstorming and are particularly useful for groups where there is conflict or difficult personalities. If this describes your team, we recommend that you use this approach.

Quick steps

- Set up a team meeting
- Identify a question for the brainstorming session
- Ask team members to write their ideas on post-it notes and post them on a wall (rather than brainstorm them on a whiteboard)
- Add more ideas as participants see each others suggestions
- Group similar ideas and give each group a headings that is meaningful to everyone involved
- Place an idea in two groups if there is disagreement on how the idea should be grouped
- Summarise the outcomes and communicate the summary to other staff

Example

Edgeworth Community Health Centre is keen to brainstorm reasons for duplication in assessment of people with heart disease. Samantha has recently become aware of a significant conflict between two members of the chronic disease care team. Knowing that both have really useful ideas, she decides to use an affinity diagram.

The meeting goes well and she feels that everyone contributed. The reasons identified were loosely grouped into three broad categories:

- Appointments with multiple health professionals
- Inadequate communication between health professionals
- Poor sharing of information about people with heart disease seen by the team.

The team develops priorities and then works on solutions to achieve the better coordination of team members.

The fish bone diagram (cause and effect diagram)

The fish bone diagram is a simple tool for prioritising ideas after a brainstorming session or affinity diagram. It will enable your detail to explore the possible causes to a problem. It is based on root cause analysis, which simply encourages you to ask 'why' five times. These reasons then become the fish bones. After identifying the cause, the focus turns to finding solutions.

Quick steps

- Select one of your priorities from either the brainstorming session or affinity diagram and write the problem in the fish head (see figure 2).
- Ask the team: What are the causes behind the problem? Each problem will be given its own major fish bone.
- Then ask the team to explore each problem in more detail, by asking why five times. List these reasons on smaller fish bones.
- Write down possible solutions to each of the problems as you go along by grouping these around the problem being discussed. You may wish to split the team into smaller groups and have each group work on different causes.
- Write any solutions in different colours.
- Summarise this and communicate the results to everyone. →

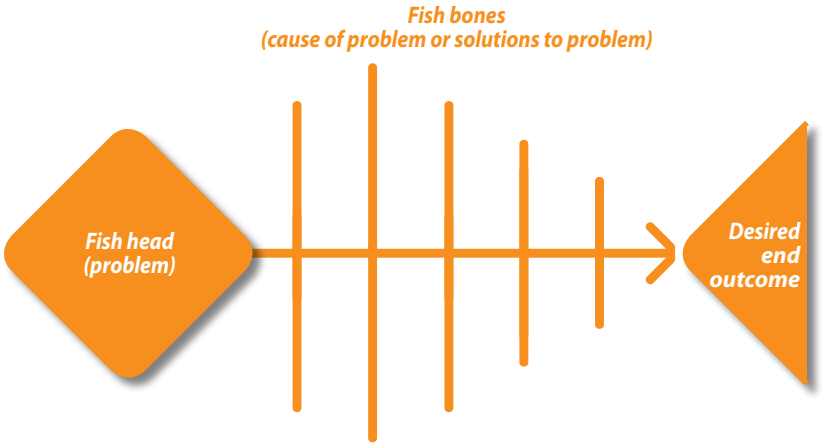

Figure 2. The fish bone (cause and effect) diagram

Example
Edgeworth Community Health Centre uses a fish bone diagram to understand the duplication in their assessment of people with heart disease. They want to understand the three broad problems identified earlier using an affinity diagram. Duplication in assessment is the problem. On each major fish bone they write: appointments with multiple health professionals, inadequate communication between health professionals and poor sharing of information.

As they discuss the issues, they also find other causes and add inconsistent use of internal referrals forms, no systematic way of case conferencing, difficulties in liaising with other health professionals to their list of causes. The team realises they cannot tackle all the issues, so they prioritise two and brainstorm ideas. These ideas are then written next to the corresponding fish bone.

Strategies for managing change

Both self-management and chronic disease care are about change. Both will fundamentally impact on how we provide care and how we work together.

Successful change is relatively simple. It is an approach that acknowledges that there will be resistance and unease but that there are ways to engage and include people in the redesign of care that is being proposed.

There is nothing worse than imposed change. It is disempowering and even alienating. An inclusive approach will be open and transparent. There will be lots of dialogue and exploration of ideas. It is only through frank discussion about our current chronic disease services, its gaps and inconsistencies, that there can be a real commitment to change.

The change process should be simple to follow. Everyone involved should understand what the aims and objectives are, the timelines, who the stakeholders and partners are, and any risks.

We recommend that you take these steps:

Define your purpose
Start by defining the problem you want to address. What do you want to change and why?

Go back to your health systems assessment or any of process maps you have undertaken as a part of diagnosing your service. These tasks are outlined in the *Changing clinical practice guide*. Remember, if your team doesn't understand the purpose, they will be reluctant to get involved.

Get senior management support
Before starting any work, get support. Prepare a very simple one page outline of what you want to achieve, including the drivers for the improvements proposed.

So, what do we mean by support? To begin, it will be more than verbal. Your management team needs to publicly support your work. They will sell the benefits, provide adequate resources and celebrate the successes. They will support your role as change agents through coaching, feedback and accountability. Senior management should be involved in any issue and problem resolution. In other words, they will be visible throughout the change process.

In the absence of this level of support, you have no guarantee that the work will go ahead despite the commitment of your team and your hours of work. Remember you need to continually engage and communicate with senior management throughout the change process.

Develop a project plan
Next step is to prepare a project plan. As we say continually throughout this manual, in the absence of a map you won't know where you are going. A plan will allow you to see where you are going, how you are going to get there and who is going to be involved.

When planing, identify some short-term wins. Change is demanding, especially as it is undertaken in addition to clinical work. To sustain interest, commitment and momentum, celebrate every success.

Success factors for change
- Define your purpose
- Get endorsement
- Prepare a project plan
- Manage the emotional response to change
- Develop a communication plan
- Conduct a stakeholder analysis
- Identify and manage the risks

We have developed a *Project plan template* for you to develop your own plan.

Manage the fallout
All change involves losing something. It is not enough to accept change intellectually, more is at stake. Throughout the manual, we speak of moving from the role of expert to coach in self-management. Such a transition sounds easy enough. For some team members, such a shift will be difficult because of concerns about skill level, role within the team and the demands of providing this level of self-management care. →

If you are leading this change, understanding different reactions to change will prove very important so you don't personalise the response you receive.

A very useful model to explain this change process is SARAH (shock, anger, rejection, acceptance, hope). It is common to see people move through these different stages as change is first introduced and then implemented. People will sometimes sabotage a project, undermining it at every turn. Others will be champions and embrace the initiative.

It is not easy to predict what the response to change will be. It is important to understand the reality of loss and devise ways to explore and work through people's reactions.

Develop a communication strategy

The most common complaint from people is not being in the loop. Develop a communication strategy that includes consultation with everyone who has an interest in the change proposed and will be affected by it. Keep everyone informed about what is going on. Allow for lots of feedback and give the team opportunities to raise concerns and have their questions answered. This will enable the team to work collaboratively, maximising their ideas and skills.

Analyse your stakeholders

It is important to understand who your stakeholders are. This is anyone who has an invested interest in the outcome of your work. Depending on their level of interest and the impact they could have will dictate how you keep them involved.

We recommend that you start by listing everyone who has an interest in the change you are proposing. Define their stake/needs and the extent to which these needs conflict or are in common. The team needs to ask: how will we influence, link and inform these different groups to get their support?

Determine the level of cooperation and resistance that can be expected and workshop how stakeholders will define success.

Manage risk

Finally, identify and manage any risks. This is an area that we don't do well in health care. We tend to start initiatives with full enthusiasm and are then genuinely surprised when things start to go wrong, such as conflicting ideas between agencies or poor buy-in and support from different health professional groups.

Risk management isn't difficult. You need to identify what could go wrong, the likelihood of that event and how you will manage this risk to minimise it. When defining potential risks think broadly: shift in government priorities and funding, difficulties recruiting staff, lack of commitment or morale, poor information systems, tensions over budget allocation and funding between agencies are common risks we have seen agencies face.

The challenges ahead

In the introduction to this manual, we spoke about tensions within the health system that significantly contribute to the challenge of redesigning health care. In this final section of our guide to leadership, we outline a number of these tensions and their likely impact on the implementation of self-management.

We asked people from across the sector to tell us what they thought these tensions and challenges were. The following is a result of this focus group. We have also added our own thoughts based on our experience of working with agencies to implement self-management.

Engaging general practitioners

Health professionals tell us about the difficulties in co-managing people with chronic disease in multi-disciplinary care. Barriers can include time constraints and agency culture.

We recommend working with local Divisions of General Practice to establish communication pathways to promote a shared approach to chronic disease care. It is important to work with local divisions to achieve a more regional response to chronic disease management.

We talk more about how to engage general practice in our guide on *Self-management in general practice*.

Community expectations of health care

The nature and history of health care has meant that people access health services when they are unwell. When they do, they often have the expectation that their presenting problem/s will be 'fixed'.

It is important that we learn how to explain the concept of self-management and give enough time in our practice to have these conversations. This is particularly relevant when using approaches such as the Flinders model as outlined in our guide on *Implementing self-management*.
We need to market self-management and be consistent in how we offer it as a team. We recommend that reception and intake staff discuss the benefits with people. Brochures should be provided. Self-management should be a message that we clearly communicate as agencies to the communities we assist. The more we talk about self-management, the more people will understand the message and its benefits. It will then become an expectation that people have of care. →

Suitability of self-management

We have often heard agencies say that self-management is not suitable for all people, especially those with disadvantage or from culturally and linguistically diverse backgrounds.

We would challenge this thinking. For us, it is not a question of whether self-management should be offered but how it is offered. We have outlined a number of different models in this manual. All can be adapted to the many different people that we see as chronic disease teams. Whatever the approach, we need to focus on effective strategies aimed at creating long-term behaviour change.

We encourage you to explore the role of the community in effective chronic disease management from the ICIC Chronic Care Model. How can we work more effectively with local groups and support agencies to better understand the cultural needs of the many different communities that we work with?

Instead of looking at these challenges from the lens of health care, perhaps we need to refocus and look at health care from the perspective of the community.

Implementation of self-management

There will always be a number of health professionals who think that they already do self-management because of the information that they provide to people with chronic disease. As we have explored throughout this manual, information and knowledge alone very rarely lead to the behaviour change required to improve someone's health and well-being. It has not been our intention to negate this education but more to question the timing and appropriateness of this approach given a person's readiness to change.

Self-management can and will challenge us as health professionals. People will raise issues that fall outside our disciplinary knowledge and take us into areas of care that fall outside a usual consultation. Some of the teams we have worked with have raised concerns about the perceived fine line between self-management and social work and counselling. We recommend that as a team you explore this question. Work with professionals from both of these areas to clearly map how you want to work together and when referrals need to be made.

Coordinating care for people with chronic disease can be a significant barrier to self-management. Current care relies on referrals between health professionals. We have spoken throughout this manual of the mistrust across the health care sector. Such silos are a formidable barrier to providing coordinated care. When referrals do occur, poor communication and coordination is common. Time constraints can conflict with the need for regular case conferencing.

A team approach is needed to address these hurdles. We need to develop good care planning models to underpin self-management and achieve coordinated ways of working. The only way to do this is to address such silo thinking and design care systems that have a regional rather than agency focus.

Agencies and health professionals need to come together to design care that responds to population needs, including how they will work together as partners in care.

Professional expectations

We have spoken of people's expectations of care, yet there are also health professionals' expectations. As health professionals who have worked across all sectors of health care, we believe there is an unspoken peer pressure to retain discipline-specific boundaries. Training and often professional peak bodies promote this. Self-management challenges such silos because the needs of people with chronic disease go beyond disciplinary-specific management.

The health system

Most of us acknowledge the fragmentation of our current health system and the disincentives to providing coordinated care. Most of our funding is episode-based, so usual care often requires people to be discharged upon completion of such episode/s. This is despite policy support for self-management by funding bodies. This tension within funding formulas needs to be resolved for agencies to provide self-management. We need to establish ways to provide ongoing follow-up such as chronic disease registries and recall and review systems. This will require us to rearrange our current structures and how we work as multidisciplinary teams.

Leadership

This guide is dedicated to the importance of leadership and yet as we have said throughout this guide, leadership in health care is varied. To our knowledge, there has been very little investment in leadership and by this we mean skills in the area of team development, creative thinking, people development and performance management. Our health system is predominantly operational with a focus on management rather than leadership. The difference between the two is that management maintains the systems we work in and leadership changes them. Thus this tension is between the management we have and the leadership we require.

Good leadership will challenge some of the myths around self-management. This is understandable to a certain extent given that self-management has been mainly implemented in a 'project' environment. Secondly, that it is self-care, meaning that people will receive less clinical care.

Leadership is required to create an agency vision for self-management. Leaders will need to inspire teams, bring people together to drive change forward and to foster a culture of quality improvement.

The role of inter-sectoral partnerships

Building partnerships to create a seamless system of care is vital for self-management. Yet, rarely do we meet as health professionals to discuss and plan how chronic disease care should look across our regions.

→

We need to build partnerships that go beyond the clinical, yet there are challenges to this because of the tensions and barriers that we have discussed. Pathways often differ between teams making care planning difficult. Some agencies may not see the need for change nor understand the roles of different sectors in self-management.

Our partnerships need to focus on mapping current interventions and creating a common language for self-management. Forums to share learnings and support for change management need to be created. Accessing funding to develop a regional focus and promote integrated care will be vital. Only then will we achieve a seamless journey through multiple sectors for people with chronic disease.

A final note

Resistance is inevitable and something we can guarantee will occur in any change project. Self-management sessions can raise many complexities in people's lives, something that may make us uncomfortable when we first start using self-management as a tool in chronic disease management.

Health professional training essentially prepares us to 'diagnose, fix and treat' problems. Self-management encourages us to work with people to identify and find solutions to their own problems.

The work of self-management will challenge our roles. Some of us will be more comfortable providing treatment and education. Addressing barriers to change will seem 'fluffy' compared to the clinical parameters of a person's disease.

Our health system is characterised by an ongoing pressure for access to services and discharge to meet demand. Self-management is resource intensive but in the longer-term is the best solution we have to managing demand. We have seen the benefits of this approach in our own work as health professionals as well as in the agencies we have worked with.

We need to be confident in our ability to address the tensions we have discussed and to create new systems of care that reflect our dedication to working with people with chronic disease, their families and communities.

Resources

Leadership resources

Institute for Healthcare Improvement, 2006, *A Framework for Leadership of Improvement*, Institute for Healthcare Improvement. This report can be accessed online.
Go to http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent.

Institute for Healthcare Improvement, 2005, *Seven leadership leverage points for organisation-level improvement in health care*, Innovation series white papers, Institute of Healthcare Improvement,. This report can be accessed online.
Go to <http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership>

The Institute for Health care Improvement has a range of resources, publications and tools to foster leadership within agencies. Go to <http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership>

Change management

NSW Health Department, 2001, *A framework for building capacity to improve health*, Better Health Centre – Publications Warehouse, NSW. Go to <http://www.health.nsw.gov.au/pubs>. This paper offers an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvements in health and other sectors, to prolong and multiply health gains many times over.

Tips for implementing self-management

Embedding chronic disease self-management into practice – 10 tips for success, accessed April 23, 2007. The ten tips emerged from the learnings of the Good Life Club Demonstration project (2001-2004) and Good Life Club Transition Project (2004-2006). Go to the Good Life Club website <http://www.goodlifeclub.info/index.php>

Quality improvement

NSW Health Department 2002, *Easy guide to clinical practice improvement*, Better Health Centre – Publications Warehouse, Gladesville, NSW. This guide aims to provide practical advice to clinicians and managers on how to use health care data to improve the quality and safety of health care in a systematic way. Go to <http://www.health.nsw.gov.au/pubs>.

Understanding your leadership capacity

WORKSHEET

The purpose of this worksheet is to identify the leadership required to achieve your chronic disease self-management implementation plan using the Framework for Leadership of Improvement as a basis.

These questions should be discussed between the leader of your change project and a couple of senior managers. They can then be discussed with the team.

1. Describe your vision for the work. What are your team's ideas on the vision?

2. What values and knowledge do your senior managers and teams have for improving care?

3. Who are the current leaders in your team? How will you develop their roles to accelerate change?

4. How will you plan for improvement? Who will set your aims, allocate resources and measure and track performance?

5. What skills and/or training might be required to lead the change?
(for example, leadership, quality improvement, change management and system improvement)

Strategies for managing change

WORKSHEET

This worksheet is designed to assist you to manage the change project. Take some notes on the following areas so you are able to plan the initiative.

Success factor	How will you do this?
Define your purpose People need to understand why a change is being introduced to participate in any initiative.	
Get senior management endorsement Achieving maximum benefit from a change initiative requires higher-level management endorsement.	
Prepare a project plan (refer to our template, next page) The project plan allows you to scope the change process. A good plan will identify reasons for change, the resources required and how to sustain it.	
Manage the emotional response to change All change involves losing something. It is not sufficient to accept the change intellectually – people need to work through their emotional responses if they are to be successful.	
Develop a communication plan Those affected by the change need an opportunity to participate in decisions that affect them. This will enable people to work collaboratively, maximising their ideas and skills.	
Analyse your stakeholders It is important to understand the vested interest of everyone involved to determine their level of interest and impact.	
Identify and manage risk In any project, risks related to political, managerial and team support or resistance needs to be considered.	

Project plan template

WORKSHEET

This template is very simple to use. We recommend that you review the tensions we discuss in this guide when implementing self-management. Identify the top five challenges that you believe exist within your team. Use the following plan to identify how you will address them and allocate a priority rating.

Key steps	Description of activities	Key milestones	Who's responsible?	Timeframes	Key measures

Tension	Description of how it is a tension in your agency	Priority rating for addressing (1 – 5)	Plan

WHITEHORSE DIVISION OF GENERAL PRACTICE

Navigating self-management

A practical approach to implementation for Australian health care agencies

5 Evaluating self-management

Authors: ***Naomi Kubina, Jill Kelly***

Editor: ***Fiona Symington***

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Contents of this guide

Introduction

How to read this guide

We have added to this guide written by Roy Batterham to assist health professionals evaluate self-management programs.

Firstly, we discuss the need to consider issues related to conceptualising your program.

Next, we assist you to select suitable measurement tools and other evaluation methods. The choice of these methods and tools largely depends on the way you establish your self-management program and what you want it to achieve. We then recommend you develop your evaluation plan.

This guide discusses a method to do this using the RE-AIM model. We also provide you with a template.

Contents

Your planner

Team: We recommend you use the same team you have assembled for other work. It should include health professionals, technical staff, managers and support staff. Refer to our discussion of the improvement team in the introduction of the Changing clinical practice guide.

Resourcing: Six hours consisting of at least two meetings.

Tools: The RE-AIM template.

We would like to thank Roy Batterham for this guide on the evaluation of self-management programs. In this guide, he identifies both short-term and long-term measures that will enable us to quantify the impact of self-management using existing tools.

Evaluating self-management can be a daunting challenge. How do we demonstrate the impact of self-management? What do we measure? What method and tools should we use?

The evaluation of self-management programs is complex because these programs usually have diverse end points or differing views on the ultimate outcomes of the program. They frequently have a diverse range of theories about what will help people achieve self-management and a diverse population for whom different individual goals and processes may be appropriate.

This diversity has implications for the selection of evaluation approaches and tools. Taken together, such diversity has led to the development of a vast range of evaluation tools making the choice of tools an overwhelming process. The purpose of this document is to provide a decision support tool to assist in the evaluation of self-management programs.

Selecting appropriate evaluation methods and instruments must be guided by careful consideration of who the program is targeting, what end points are expected and how (by what mechanisms) the program is expected to benefit people with chronic diseases.

Without considering such questions, it is highly probable that evaluators will end up assessing the wrong thing at the wrong time and produce uninterpretable null or mixed findings.

For this reason, this document first considers issues related to conceptualising the program and only then considers the selection of measurement tools and other evaluation approaches. Principles to inform the evaluation of self-management programs are included throughout.

Getting started

Initial questions for consideration

- What is the budget for implementing our self-management program? Are we able to use five to ten per cent of our budget to develop and undertake a thorough evaluation of our program/ service?
- Is our program a defined program, for example, the Better Health Self-Management Program or an amalgam of approaches, for example, Motivational interviewing and the Flinders Model?
- Should we consider obtaining expert advice on evaluation from a consultant? If not, what internal resources do we have to undertake an effective evaluation (includes designing the evaluation, implementing it and analysing the results)?
- What evaluation questions do we want to answer (the information in this guide will help you with this)?
- What tools will we use to measure the outcomes?

Conceptualising your self-management program or service

Define the end point of your program or service

The first step in conceptualising your self-management program is to decide on the end point. What is the ultimate outcome of your program? What do you want it to achieve?

Different self-management programs reflect different views about the end points. The mistake we often make is that the definition of the end point is more often than not implied, leaving it open to question. Be sure that you clearly define what you want the end point of your program to be and be aware of the different views your team may have and the fact that the end point may shift and be quite vague.

Roy Batterham outlines in three different sets of end points programs can have, loosely referred to as:

Model A. Traditional targeted self-management programs
Model B. Integrated chronic disease management programs
Model C. Risk targeted programs

In simplest terms **Model A** targets people most likely to benefit (usually those who actively seek or volunteer to participate, for example, Stanford type courses).

Model B seeks to develop an overall approach to chronic disease care that helps people shift towards increased self-management no matter what their starting point (for example, the ICIC Chronic Care Model). This is the approach most talked about in this manual.

Model C targets those most at risk of deterioration, for example, hospitalisation. Self-management programs vary in their emphasis. They can be classified according to whether their emphasis is primarily educational, self-management or psychological. Programs with different emphases succeed in different ways. For example, programs with a psychological emphasis are more successful in dealing with associated depression.

It is now common for programs to adopt a flexible approach that incorporates educational, self-management and psychological elements. This is an approach we recommend given the impact of chronic disease on people's health and lives. It enables you to broaden the applicable target group and meet the needs of a more diverse range of people.

A flexible approach fits within model B, integrated disease management programs described above, a common theme of this manual and something the authors recommend. A program with a more flexible approach will include an individualised approach to service delivery. It focuses on people's goals and gains their input into methods to achieve these goals.

> *Every effort should be made to ensure that the evaluation reflects the principles, philosophies and aims of the project. Avoid allowing the program to be shaped to fit the evaluation.*

From an evaluation perspective adopting such a flexible approach and customising your program in this way limits the applicability of many available standardised outcome measures. Consequently, more customisable outcome measures and qualitative assessment are required. This guide explains how to do this.

Steps to take here

- Of the three models listed, what type of model is your program or service using?
- Clearly define your end point and what you are hoping your program will achieve. Ensure it is consistent in relation to funding, targeting, program design and evaluation considerations
- Conceptualise and agree on the intermediate and ultimate outcomes for the program including time frames before outcome measures and indicators are selected.
- Decide on the emphasis of your program whether it is educational, self-management or psychological
- Ask yourself if your program is adopting a flexible approach. If so, you are likely to require a mix of standardised, customisable and qualitative outcome assessments.

Define measures in each area of the outcomes hierarchy

For most of us, we will not evaluate our self-management programs as research. In fact, we have dedicated this manual to seeing such a philosophy implemented in 'real life' practice. Given this, it is unlikely we will have or in fact need a control group. How do we then prove the benefits of our program or service?

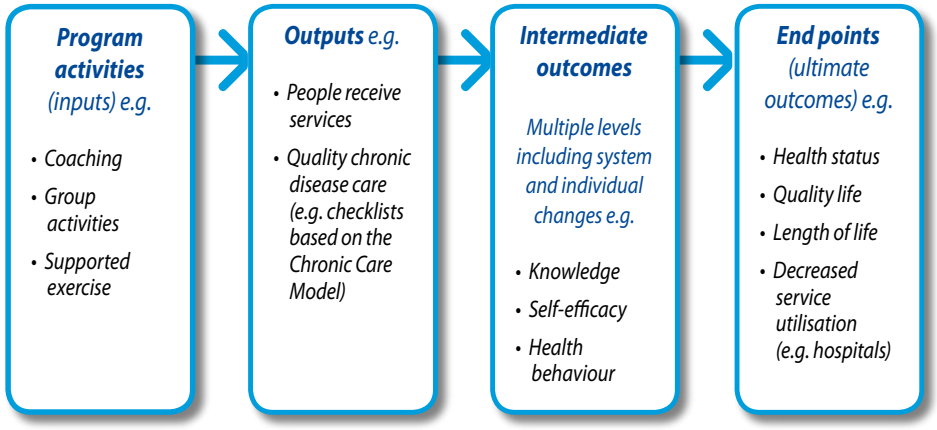
We use a hierarchy of outcomes. A hierarchy of outcomes that fits with your program's model, emphasis and end points makes it easier to argue that it was your program that caused the observed outcomes (rather than chance or other processes). How do you do this?

Firstly, decide on your program activities. What are you offering as part of your self-management program or service?

Secondly, consider your program outputs. Outputs determine whether or not practice change has occurred. For example, are we developing self-management goals with people as evidence recommends we do?

Next, determine your intermediate outcomes. This is how we know whether what we do has made a difference to the population we are targeting. A general illustration of such a hierarchy is shown in figure 1.

Figure 1: General outcomes hierarchy with examples



Steps to take here

- Determine your hierarchy of outcomes. Note your program activities and link them to the desired end points you would like your program to achieve.

Intermediate outcomes

You now need to consider some intermediate outcomes you would like to achieve. This is important because these are shorter-term. They help you demonstrate early wins.

Intermediate outcomes can focus on health system changes and/or changes to people living with chronic disease. Health system changes demonstrate how we operate to provide services and programs.

For example, your aim might be to adopt a team approach. You can evaluate this by determining the number of care plans that are shared with other team members. We talk more about system changes in our guide on *Changing clinical practice*.

The benefit of intermediate outcomes is that your team will be able to understand what is happening when programs work differently for different people. Intermediate outcomes reflect the theories on which your program is based, so you can determine if your program is being implemented as intended. So what exactly is an intermediate outcome and what would we measure? Intermediate outcomes are measures based on theories about what is necessary for people to become effective in self-management. They are based on the short term changes that predict longer-term behaviour change.

There are a number of theories on health behaviour that offer some insight into the prerequisites for people to adopt health behaviour change. Figure 2 summarises these prerequisites in five broad categories. Each is suitable as an intermediate outcome measure of your program or service.

Self-efficacy is a particular concept worth mentioning. Self-efficacy refers to the belief/confidence that a person is able to carry out behaviours they perceive will bring about benefits to their health. It relates to specific behaviours and is therefore a strong predictor of health behaviour change.

Choosing evaluation measures

You will need to ask yourself two questions in order to choose which of the outcomes listed in figure 2 you need to measure. Firstly, what does the evidence say how each of these five prerequisites predicts the target behaviours you are wanting to see change? Secondly, what mechanisms within the target population and their circumstances is your program or service seeking to influence?

Roy Batterham provides some examples:

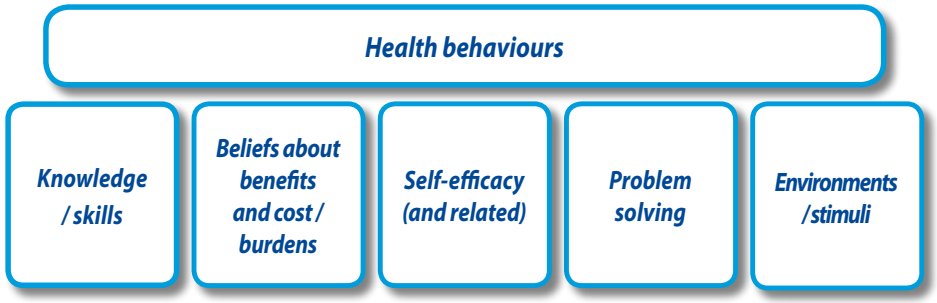
- A program that is focused on giving people skills in medical self-management of diabetes, such as managing high blood sugar levels, would evaluate these skills.
- Programs based on the Stanford model are designed to enhance self-efficacy as the primary means of influencing self-management. They would therefore evaluate the impact on self-efficacy.
- Individualised approaches may emphasise adapting social and environmental circumstances to encourage targeted behaviours and would therefore evaluate these prerequisites.

If your program is seeking to activate specific prerequisites, Roy recommends you choose a standardised measurement tool. You will also find great value in using qualitative methods, such as semi-structured interviews in order to see how the five categories of prerequisites interact in individual cases.

Steps to take here

- Identify and choose intermediate outcome measures that are a) good predictors of health behaviour change and b) relevant to the mechanisms within the target population and their circumstances that the program is seeking to influence. This can greatly enhance the interpretability of results and support the argument that the program causes the observed results.
- Tease out the role and influence of each of the five categories of prerequisites in qualitative interviews with a sample of people, even if you only choose to use standardised tools to assess one of them.

Figure 2: Five prerequisites for heath behaviour change



Selecting suitable measures – standardised, customised and qualitative

How do I choose a suitable measure?

Once you have conceptualised your program, you can now choose a suitable measure/s to evaluate outcomes for people with a chronic disease. Roy has provided you with a range of hints and tools to do this.

As a first step, gather the information from conceptualising your program. The main step is to consider whether your program has a narrow target group with a specific focus, which will require standardised measures. Standardised measures can also be used to measure specific outcomes that make up the five categories of prerequisites for health behaviour change.

For flexible program approaches, you will need to choose a more customised approach to evaluation as many standardised instruments may not reflect the goals that people select. For these programs, Roy recommends you go for a mix of standardised, customised and qualitative measures. Refer to table 1.

Table 1: Standardised and customised outcome measures for standardised and customised program approaches

Target group	Goal setting	Evaluation measure
Narrow target group	Standard goals/outcomes	Standardised tools, disease specific tools
Broad target group – a 'flexible' approach	Individualised goals	Customised approaches (goal attainment, qualitative) Global outcomes (Quality of Life, psychological well-being, global measures of self-efficacy)

Steps to take here

- Determine how you will set goals with people. Standard goals and care lends itself to standardised outcome measures. Individualised goals and care require customised or global outcome measures or qualitative assessment.
- Choose a suitable standardised measurement tool from table 2. This will depend on the information you have collected from conceptualising your program.
- If you have a flexible program approach and are aiming to achieve a number of different things, choose a suitable customised measure, a method for qualitative assessment and/or a global outcome measure.

Sample of standardised measurement tools

Table 2. Standardised measurement tools

Consumer self-management tools	
Measurement tool	Comments
Stanford measurement tools	Professor Kate Lorig and the developers of the Chronic Disease Self-Management Programme (BHSM) have developed an array of tools both in Spanish and English. These tools include measuring health behaviours, self-efficacy, health status and health care utilisation as well as a number of diabetes specific scales . Although these tools were developed for formal research purposes, they remain useful for evaluation. However, the selection of tools should be prioritised to fit the design of the program to avoid imposing an extensive battery of tests on people. The six item chronic disease self efficacy scale and the diabetes self-efficacy scale are likely to be particularly useful. For assessing health behaviours it may be better to use items from the Australian National Health Survey for which comparative data and standards are available.
Health education impact questionnaire (heiQ)	Measures eight domains related to self-management behaviours, self-efficacy and impact of the disease on psychological distress and ability to enjoy life. Most of the domains are sufficiently global to be of use even where there is considerable individualisation of goals. The instrument requires a database or spreadsheet in order to score the eight domains. Although the tool is long (fourty-one items), it has a number of advantages. It is more efficient in its coverage of relevant outcomes than using a suite of Stanford tools. It is easier for people to complete a single questionnaire, with one set of instructions, than to complete multiple smaller questionnaires with different sets of instructions. The tool was developed in Victoria and has been used in numerous Australian trials.

Measures of end points *N.B. some of these are these are 'end points' only in as much as they are treated as such in self-management programs (for example, health behaviours)*	
Measurement tool	Comments
Stanford health behaviour measures	See above
National Health Survey questions	The National Health Survey has standard ways of asking about exercise, diet, smoking and alcohol consumption. The fact that there are national and state comparators available for these questions is a huge advantage. Some of the questions are somewhat complex in what they are asking people to do.
Hospitalisation rates	Reductions in hospitalisation rates can be difficult to assess because of a) the difficulty getting complete data and b) the difficulty of knowing what would have happened if a person had not participated in the program. To fully deal with point b it is necessary to use a high-quality control group. For more information on how to construct this, contact an evaluator.
Clinical measures	Includes clinical indicators of the disease of choice for the target population. If the evaluation plan of the self-management program requires this, the person should be encouraged to obtain relevant clinical indicators at the next visit to their GP or medical specialist. Standard format letters can be developed for people to take at their next visit.
Positive and negative affect scale (PANAS)	A brief global measure of psychological well-being that recognises that psychological distress and the ability to enjoy life are separate independent factors. It should be noted that the heiQ also captures these but the PANAS is a useful addition if other tools are being used.
World Health Organisation Quality of Life instrument (WHOQoL)	The WHOQoL is a quality of life measurement tool. It comes in a shortened version of twenty-six items, the WHOQoL-BREF. Some people may view some items as irrelevant or intrusive. Nonetheless, numerous studies have used it and it is available in numerous languages.
Assessment of Quality of Life instrument (AQoL)	Formerly known as the Australian Quality of Life instrument this Australian developed tool has been used in numerous studies. It can also be used to conduct formal economic evaluations. It is shorter and less intrusive than the WHOQoL. →

Sample of standardised measurement tools *(continued)*

Other measures of self-efficacy and key intermediate outcomes	
Measurement tool	Comments
Partners in Health	The Partners in Health Scale is integral to the Flinders University Model for Chronic Condition Self-Management. Its advantage is that it is frequently collected as part of the process of service delivery in self-management programs. The twelve domains cover aspects of knowledge and ability, including skills and self-efficacy. The tool may be less sensitive to change than some of the other tools and is likely to be of more value as a decision making tool than an evaluative tool.
Health behaviour measures	See information under the National Health Survey.

Measures of health system quality and effectiveness	
Measurement tool	Comments
Assessment of Chronic Illness Care	This is an extensive self-assessment tool for agencies based on the ICIC Chronic Care Model. The scoring system is not particularly intuitive and the tool is designed for use as part of a group discussion rather than by individuals (who may use widely differing scoring criteria). It is a very useful quality improvement tool and the analysis of a group discussion at two points in time would contribute to the evaluation of agency uptake of integrated chronic disease management principles.
Patient Assessment of Chronic Illness Care	The patient assessment of chronic illness care is a brief and simple tool for obtaining feedback on the extent to which the care people receive from an agency over a six month period has encompassed chronic disease management and self-management practices. The author strongly recommends considering this tool where integrated chronic disease management is a major feature of the program.
Howie Patient Enablement Index	This brief tool asks people to reflect on their last consultation with their GP and rate the level of education and self-management support they received. It may need to be modified slightly for use in settings other than general practice.

Disease specific instruments	
Measurement tool	Comments
Stanford Diabetes and arthritis tools	These tools measure improvements in symptoms specifically related to these two diseases. See Stanford measurement tools and clinical measures.
Other tools	See reference list at the end of this guide.

Customised measures and qualitative assessment

In programs that utilise a flexible approach, it is desirable to assess outcomes in a way that goes beyond the outcomes captured by standard tools and that reflect more individualised outcomes and approaches. Doing this requires us to assess the attainment of goals and undertake a qualitative assessment of outcomes. Contributing factors can give a fuller picture of outcomes and significantly increase the interpretability and value of the overall evaluation.

Goal attainment scaling

Goal attainment scaling is a simple scoring framework developed to give a numeric score to the extent to which the person's negotiated goal is achieved.

A relevant Australian example is the Flinders University Model of Chronic Condition Self-Management. Part of this model is a problems and goals assessment that scores the person's progress towards achieving the goal on a scale of zero to eight. The 'most favourable outcome' where complete success is achieved is rated a zero. No progress is rated as eight.

This method can be subjective and highly variable. Roy suggests another scale where better than expected outcomes are given positive numbers and worse than expected negative numbers.

-2 = much deteriorated
-1 = deteriorated
0 = No change
0.5 = Goal partially achieved
1 = Goal fully achieved
2 = Goal exceeded)

The interpretation of results of goal attainment scaling can be complex. Often people with chronic disease and health professionals can place a different importance on the goals chosen. For example, we may consider the goal 'manage toileting so I can remain in my home' to be more important than a person's goal 'to resume my hobby of toy train modeling'. This is a value judgment and open to differing opinions. Furthermore, when discussing health behaviour change, it is likely that the person's goal will be more important and so should always be considered.

To improve the interpretability of results from this method, it may be necessary to calibrate goals. There are a number of approaches to calibrating goals that are outside the scope of this paper.

Qualitative assessment of outcomes

Supplementing the standardised and customised methods with qualitative data greatly increases the interpretability and usability of evaluation findings.

Qualitative data offers the following benefits:

- Enables you to identify any unexpected benefits.
- Enables you to identify any unexpected negative consequences.
- Enables you to tease out the relationship between the various prerequisite factors in figure 2 and how they have been influenced by program activities and influenced the extent to which desired end point outcomes have or have not been achieved.
- Provides feedback on intangible aspects of service delivery.
- Provides a deeper understanding of how contextual factors influence outcomes.

You can conduct qualitative assessment by using things such as interviews and/or focus groups.

Developing an evaluation plan

An evaluation plan helps you to focus your evaluation on what is important to your agency and self-management program or service. Your plan can include process evaluation (was the program implemented as planned?) and outcome evaluation (is the program making a difference to our target group?).

The RE-AIM framework is a simple and useful method to clarify your evaluation questions.
We recommend that you develop an evaluation plan for all your self-management and changing clinical practice activities.

The RE-AIM framework

The RE-AIM framework contains five essential elements that evaluate the health behaviour interventions of self-management programs. Each element relates to simple and effective evaluation questions that should be asked during your planning phase. Below are the elements and associated questions.

Ask your team these questions when developing your plan.

Element	Associated question
Reach: the proportion of the target population participating in the strategy.	Question: How do we reach the targeted population with this strategy?
Efficacy/effectiveness: the impact of a strategy on important outcomes. This includes potential negative effects, quality of life and costs.	Question: How do we know our strategy has been effective?
Adoption: the absolute number, proportion, and representativeness of settings and team members willing to offer the program.	Question: How do we develop agency support to deliver our strategy?
I**mplementation:** at the setting level, implementation refers to how closely your team follows the program. This includes consistency of delivery as intended and the time and cost of the program.	Question: How do I ensure our program is delivered properly?
Maintenance: the extent to which a program or policy becomes part of routine agency practices and policies. Maintenance also applies at the individual level and refers to the long-term effects of a program on outcomes after six or more months after the most recent contact.	Question: How do we incorporate this strategy so it is delivered over the long term?

We include a template for you to develop your plan.

Program planning and evaluation framework template (using the RE-AIM framework) Example

Aim/ goal: (What you ultimately want to achieve?)

To improve the self-management skills of people with diabetes in our community

Target group: (Who is the strategy targeted at?)

English speaking and Chinese speaking people with diabetes in our community

Objectives: (What changes do you want to bring about in the target group)

(Objectives must be specific, measurable, achievable, realistic and timely and should lead to the achievement of the goal)

To increase the use of goal setting of 50 people with diabetes in our English and Chinese speaking community through the use of monthly telephone coaching for 12 months.

Strategies: (What will be done?)

Develop marketing strategies for the English and Chinese speaking communities through consumer focus groups.

Train two Health Professionals (one English and one Chinese-speaking) in telephone coaching skills and goal setting.

Activities (How will it be done)	**Evaluation questions** (Are we measuring the right things?)*	**Success criteria** (What will be in place if this objective is successful?	**Key performance indicators** (Markers that help us to monitor and measure)	**Measuring tool/ data source** (for example, database/ project report)	**Timing of measurement/ who**
Employ & train staff	To what extent was the program implemented as intended? (Implementation)	Appropriate staff employed and trained	Staff employed and trained	Project records	Baseline Manager
Implement marketing and recruitment strategy	Did the program enroll its target number of participants? (Reach) What proportion of participants engaged in the program were Chinese-speaking? (Reach)	50 participants enrolled 25% of participants were Chinese speaking	Number of participants enrolled Number of Chinese-speaking participants	Project records and database	At intake and on-going Project staff
	What were the successful recruitment strategies and why? (Effectiveness)	Description of effective methods in project report	Numbers of participants by recruitment method	Project Records	6 and 12 monthly Project staff
Implement procedures for intake, assessment and evaluation of participants	To what extent were the procedures adopted in our service? (Adoption)	Description of effective implementation of procedures in project report	Number and types of procedures adopted	Project Records	6 and 12 months
	What improvements were made in self-management behaviours? (Efficacy)	60% of participants developed goals 60% of clients improved self-management behaviours	Numbers of participants who developed goals. Level of improvement in self-management behaviours	Survey of participants HEI-Q	Baseline, 6 months and 12 months Project staff
	To what extent are the changes in staff practice sustainable over 12 months? (Maintenance)	50% of staff continue to assist participants to undertake goal setting	Percentage of staff who continue to assist participants undertake goal setting	Survey of Project Staff	12 months from baseline Manager

RE-AIM Developmental Evaluation Design

- **Reach** – proportion of target population participating in the program
- **Efficacy/Effectiveness** - the impact of the strategy on important outcomes. This includes potential negative effects, quality of life, and costs.
- **Adoption** – proportion of settings, agencies and plans that adopt the strategy
- **Implementation** – the extent to which the strategy is implemented as intended in the real world
- **Maintenance** – the extent to which a program is sustained over time.

Program planning and evaluation framework template (using the RE-AIM framework)

WORKSHEET

Aim/ goal: (What you ultimately want to achieve?)

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Target group: (Who is the strategy targeted at?)

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Objectives: (What changes do you want to bring about in the target group)

(Objectives must be specific, measurable, achievable, realistic and timely and should lead to the achievement of the goal)

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Strategies: (What will be done?)

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Activities (How will it be done)	**Evaluation questions** (Are we measuring the right things?)*	**Success criteria** (What will be in place if this objective is successful?	**Key performance indicators** (Markers that help us to monitor and measure)	**Measuring tool/ data source** (for example, database/ project report)	**Timing of measurement/ who**

RE-AIM Developmental Evaluation Design

- **Reach** – proportion of target population participating in the program
- **Efficacy/Effectiveness** - the impact of the strategy on important outcomes. This includes potential negative effects, quality of life, and costs.
- **Adoption** – proportion of settings, agencies and plans that adopt the strategy
- **Implementation** – the extent to which the strategy is implemented as intended in the real world
- **Maintenance** – the extent to which a program is sustained over time.

Resources

Standardised measurement tools

Stanford measurement tools. All tools available for free download from <http://patienteducation.stanford.edu/research/>

Health education impact questionnaire. For information and ordering see <http://www.crd.unimelb.edu.au/heiq/>

National Health Survey. For information see <http://www.health.vic.gov.au/healthstatus/vphs.htm> or the Australian Bureau of Statistics. Go to <http://www.abs.gov.au/websitedbs/d3310114.nsf/Home/themes> Click on health and health statistics.

Positive and negative effect scale. See <http://stressandhealth.stanford.edu/measures/PANAS.html#>

World Health Organization Quality of Life instrument.
See <http://www.who.int/substance_abuse/research_tools/whoqolbref/en/index.html>

Assessment of Quality of Life instrument. For information or to obtain a copy of the instrument and manual see <http://www.buseco.monash.edu.au/centres/che/projects/aqol/aqolinst.php>

Flinders Human Behaviour and Health Research Unit Partners in Health (PIH) scale. For information on the Flinders model and the PIH scale see <http://som.flinders.edu.au/FUSA/CCTU/Hand%20out%20Flinders%20Model%20June%202006.pdf>

Assessment of Chronic Illness Care. For more information go to <http://www.improvingchroniccare.org>

Patient Assessment of Chronic Illness Care. For an article that includes the instrument please see <http://care.diabetesjournals.org/cgi/reprint/28/11/2655.pdf> or go to <http://www.improvingchroniccare.org>

Goal attainment scaling

For a humorous guide and examples on goal attainment scaling,
see <http://www.marson-and-associates.com/GAS/GAS_index.html>

RE-AIM

To download the RE-AIM template, go to <http://www.re-aim.org>. This website describes the five elements of the RE-AIM model and has other related resources.

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WHITEHORSE DIVISION OF GENERAL PRACTICE

Navigating self-management

A practical approach to implementation for Australian health care agencies

6 Self-management in general practice

Authors: ***Naomi Kubina, Jill Kelly***

Editor: ***Fiona Symington***

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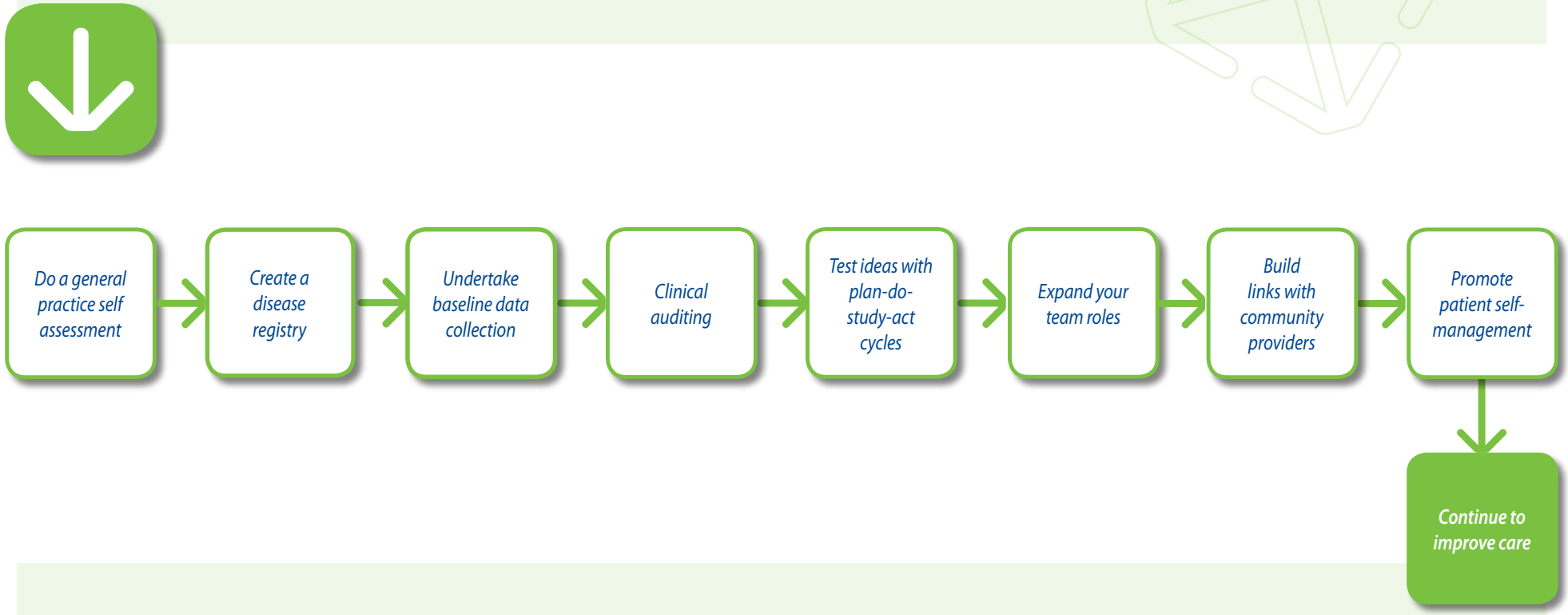
Navigation chart : Your road map to self-management in general practice



Contents of this guide

Introduction

How to read this guide

We have written this guide for general practice with the aim of improving self-management within this setting. We start with some practical suggestions for implementing self-management based on strategies we have used in our other guides.

Next, we explore strategies that will assist practices in this task. These strategies include the use of practice nurses, the Medicare Benefits Schedule Chronic Disease Management Items and the National Primary Care Collaborative program. Each of these strategies will help make implementing self-management easier. We conclude this section with a case study that combines these strategies.

We then provide GPs and practice nurses with a simple framework to start a self-management conversation with their patient. The framework starts with identifying the problem from the person's point of view using the FIFE method. This method asks about feelings, ideas, effect on function and expectations. The framework then takes you through a series of steps to address what has been found in the assessment. It uses strategies such as problem solving and goal setting and is finalised with a self-management care plan.

We conclude this guide with tips for agencies wanting to better engage general practice.

Contents

Your planner

Team: Assemble a practice team that includes a GP, a receptionist, your nurse and your practice manager. The aim is to include people with different roles and expertise within your practice. We refer to *The improvement team* in the *Changing clinical practice* guide.

Resourcing: Twelve hours.

Meetings: You will need five to six meetings.

Tools: *General practice self-assessment, Quick guide to implementing self-management in general practice*, the strategies and steps from the *Changing clinical practice guide*.

Steps to implementing self-management

The role of general practice in chronic disease management is a critical one. A person's general practitioner will know their partner and their family and the community where they live. The GP will more often than not have diagnosed the person, will advise them on treatment options and coordinate services and understand how the person is managing or not managing their disease.

There are significant opportunities for general practice to support self-management, so where do we start?

We encourage general practices to establish an improvement team. This is a message that we have communicated strongly in our guide on *Changing clinical practice*. Investigating how your practice currently works and identifying areas for improvement is an initiative that needs to be undertaken by all members of staff.

Second, we encourage collaborative partnerships. Self-management cannot be done alone. Neither can we be all things to all people. We are simply unable to provide all the services people with chronic disease need in a practice. We need teams, teams that work together across different sectors and programs. In practices that have embraced such an approach, there have been improved workplace efficiency, increased revenue and more organised care. The revolving door syndrome of constant crisis reduces.

Despite the need and benefits for general practice to support self-management, there are a number of challenges within the current health system environment. These challenges include working with the Medicare Benefits Schedules items for chronic disease management, a growing workforce shortage of general practitioners and increased reliance on practice nurses to assist GPs in chronic disease management.

Yet such challenges also present significant opportunities to rethink our teams and how we work together with others.

Our experience of working with general practices and agencies has revealed a number of critical steps to successfully implementing self-management. We recommend the following steps to enhance your delivery of self-management.

1 **Complete a general practice self-assessment**

The general practice self-assessment included at the end of this guide will provide you with a good indication of current practice in the areas that are important for improving chronic disease care and self-management. The assessment outlines crucial indicators for chronic disease care and asks you to assess your practice against them. The results of this assessment will provide the basis for undertaking improvement cycles as we outline in the next step.

2 **Develop a disease registry and recall system**

First and foremost, we encourage you to establish a central registry of people with particular disease types. The registry will provide you will information about how many people you have registered with a chronic disease.

It will enable you to monitor care and schedule routine tests, appointments and follow-up. Ensure your disease registry is kept up-to-date and everyone is coding data in a consistent manner. Extract a report every three months and discuss the results as a team.

A registry will also enable you to establish a recall and reminder system. Most practice computer software includes this feature and allows easy use of Medicare items.

3 **Undertake baseline data collection and clinical audit**

To understand your current service, we recommend that you conduct a clinical audit. An audit will provide you with important data about how your care compares against evidence-based guidelines and best practice.

Auditing takes a population-based approach where attention is paid to the health care needs of populations of people, not just those that show up for appointments.

In our experience, a clinical audit is probably the most difficult and challenging of any quality improvement activity. Through an audit, we put our practice under the microscope in a way that is very different from how we analyse and assess our practice systems.

When putting a clinical audit on the agenda, it is very important to be aware of the sensitivities. It can be very difficult to remain objective, when it is the quality of your work that is being assessed.

An audit enables you to compare in detail the information in a person's medical record against standard protocols or criteria for the delivery of a given care item. An audit can identify what is needed to improve chronic disease care and can provide you with very good baseline data. →

We recommend that a sampling approach is adopted when undertaking a clinical audit. You will also need to be clear about the group of people that you want to look at and why. Look at the *Changing clinical practice* guide for more detail about clinical audit as well as the importance of establishing SMART aims that will help you to be clear about what you want to measure and why.

4 Use the improvement cycles to introduce change

At the end of the general practice self-assessment, we encourage you to select three priority areas. You will then need to identify the changes you wish to introduce and then test them. We recommend you do this using the plan-do-study-act improvement approach. This will enable you to test the changes you want to introduce before undertaking full implementation across your practice.

Improvement cycles will enable you to think of change in manageable stages. Here we look at each stage in detail.

Plan

If you are completing an improvement cycle for the first time, the planning stage begins with your general practice self-assessment and clinical audit. It starts with the priorities of your team and the areas for improvement that they would like to tackle first. Researching what other practices have done and looking at the evidence completes the picture. Contact your local Divisions of General Practice for more information.

If you are building upon a previous cycle of activity, you will use the outcomes of the study and act stages. Here you will consolidate the team's experience of introducing change and any ideas they had about the improvements that could be made. This second or maybe third or fourth cycle is about refining what you have put in place and adding new dimension to build both the scope and the momentum of improvement you are striving to achieve.

We suggest that you work through the following questions when planning your cycle:

- *What do you want to achieve?* Describe what you would like to see happen as a result of your change. This will be your aim.
- *What exactly will you do?* Define the tasks and activities that your team will undertake to achieve your ideas. These will be your strategies. Strategies are practical ideas that can be tested.
- *Who will carry out the plan?* Where and when will it take place? State the people who will be involved. Define a short-time period (one to two weeks) and make it specific.
- *What do you predict will happen?* State what you think will happen as a result of your planned actions.
- *What data will you collect to know whether there is an improvement?* For tips on setting measures, refer to our guide on *Changing clinical practice*.

Do

This is the most action orientated phase of the cycle. This is where you design what you want to do and go live. The team defines the tasks and activities, identifies who needs to be involved and when you will start. Ideally, the stage should be short. The team should discuss what it thinks will happen and also design measures to monitor the impact of the change to be implemented.

Study

This is the stage where we assess the impact of what we have introduced and compare what actually happened with what we thought would happen. There are frequently gaps in what we achieve. Perhaps we didn't get all the right people involved and as a result take-up has been poor. Or we forgot to include a critical step in the process that has subsequently hindered or slowed down the take-up of the change. This is why measures are so critical. In the absence of collecting data, even sample data, we evaluate a change only based on opinion rather than evidence.

Act

And finally, we conclude with the act. It is the redesign phase that involves pulling together our experience of the improvement cycle. We record any unexpected events or problems and take them into the plan stage. The cycle begins again.

5 Expand your team roles

Improving chronic disease care requires us to collaborate, communicate and delegate in new ways. Within your practice, you may need to introduce new roles or expand existing roles and responsibilities.

You will need a structured appointment system that enables you to make appointments with multiple members of the practice team. Good communication will be critical. Be sure to pencil in regular scheduled practice team meetings with pre-determined agendas, actions and minutes.

Comprehensive and systematic record keeping will ensure everyone is informed about the care being provided. All members of your team should have access to relevant areas of clinical records.
→

6 **Build linkages with community providers**

The burden of chronic disease needs to be shared by all and general practice cannot do it alone. T his requires us to build links with external health providers such as private allied health and publicly funded agencies that provide primary health services.

It is important to know who your external providers are by having an up-to-date directory of health care providers and agencies. It will be important to have a systematic approach for maintaining such a directory. Most state government and divisions offer online directories that can be imported in your medical software and are updated on a regular basis.

We encourage you to develop prompts for referral. These should be based on evidence-based guidelines and supported by the Cycle of Care items.

7 **Promote self-management**

To effectively manage their health, people need ongoing support for their own self-management. This not only requires us to provide them with education and knowledge but to encourage behaviour change.

Simply providing people with education and knowledge is insufficient. We need to take a more collaborative approach to equip them with the skills and resources they need to make day-to-day decisions to improve their health. This requires a planned and coordinated approach to education, approaches that promote behaviour change and resources to deal with the emotional challenges of living with chronic disease.

We provide you with a sample conversation you can have with your patients to promote this type of approach later in this guide. We also discuss strategies and approaches to practicing self-management in our guide on *Implementing self-management*.

There are a number of ways to implement a systematic approach to self-management. Firstly, designate appointments for this type of care. Expand roles to conduct regular assessments of a person's self-management. Provide ongoing and supportive follow-up.

Driving this should be a care plan that outlines care over the coming months. Read more about this in the *Enhances Primary Care Program* section of this guide. Templates are available for care planning from your local Division of General Practice. At the conclusion of this guide you will find a table of examples of how you can take a systematic approach to self-management within a practice setting.

8 **Continue to improve care**

Continuing to improve care requires a strong focus on quality improvement. Quality improvement involves planning, implementing, reviewing and refining strategies that improve care. This requires us to take a population health approach. This is not simply about asking 'what does this person need now?' Rather we need to ask ourselves 'what is happening with our whole population and how we can improve it?'

Strategies for general practices to implement self-management

Engaging people in their care and improving their adherence to medical and lifestyle treatment requires a different approach to the more traditional delivery of education.

We need to provide people with interventions that go beyond medical management to those that enhance health behaviour change.

Unfortunately, in the current environment, this time would substantially add to the already long working week of some general practitioners. For this reason, we have described strategies and incentives for practices to bridge this gap and pursue this work. The benefits are worth it.

Practice nurses and self-management

Self-management of chronic disease requires a team approach where we define the roles and responsibilities of the entire practice.

Practice nurses are in a good position to take on some of the work of chronic disease care and provide a complementary role within the practice. Much of the work of self-management can be designated to nurses as they may have more time to spend with people. It is important to remember however, that self-management cannot solely be done by one person. Practice nurses will likely require other community partners to assist in the role.

Part of best practice chronic disease care is the need to have planned appointments at regular intervals with the people we service. The Medicare Benefits Schedule (MBS) item numbers for chronic disease management provide incentives for GPs to provide this type of care. Practice nurses have a vital role to play in these care planning items and can provide significant reward to practices.

Tips to enhance the role of practice nurses in self-management

1. Employ a practice nurse with sufficient skills and interest. Invest in their training and have them attend a couple of half-day courses provided by your local division.
2. Provide them with sufficient time to provide chronic disease care. Remember conversations to enhance self-management cannot simply be added at the end of clinical consults.
3. Allocate office space for your nurse to enable them to provide confidential coaching and support.
4. Apply the concepts in the *Changing clinical practice and Leading change guides* to engage your nurse/s in the change process. Encourage him/ her to undertake tasks other than traditional nursing ones.
5. Make use of MBS chronic disease management items and longer consultations and get your nurses involved in this care. Business cases show the strong financial incentive to undertake this type of care.
6. Build your team within the practice and distribute tasks amongst that team. Refer to our guide on *Changing clinical practice* and make use of other resources that assist you with this.

The Australian Primary Care Collaborative Program

The Australian Primary Care Collaborative program is a significant initiative aimed at enhancing self-management and the quality of chronic disease care within general practice. It is an initiative supported by the Australian Government Department of Health and Ageing.

This program makes use of the Institute for Healthcare Improvement's plan-do-study-act approach to help GPs and primary health care providers work together to improve clinical outcomes for people, reduce lifestyle risk factors, and promote a culture of quality improvement. The program is based on a collaborative approach that provides a forum for interested agencies to come together to learn from each other and from recognised experts in topic areas.

A collaborative brings together dozens of practices to improve care for a designated chronic disease. Teams from each practice attend learning sessions, where they examine proven strategies for improving care and refine plans for incorporating these strategies within their practice. Between learning sessions are action periods, during which teams implement system change plans in consultation with collaborative experts. Each collaborative culminates in a closing event, to showcase results and promote expansion of the chronic disease care strategy.

For more information on this program, contact your local Division of General Practice.

Case study

Jelly Medical Clinic

Jelly Medical Clinic is a busy medical practice with two full-time doctors, Roy and George, and a nurse, Linda. They have just become a part of the Australian Primary Care Collaborative program. Although they have Linda, she only works two days per week, and they have always felt they cannot afford to increase her hours. They are an accredited practice, make use of computer software for clinical management and also employ a practice manager and a receptionist.

During the learning session of the collaborative program, the staff of Jelly Medical Clinic agree to focus on coronary heart disease. They feel they can make some improvements to how they are managed. Despite this, they feel quite confident about their current care at the beginning of the program.

They undertake some baseline data collection. After obtaining some assistance from their local Division to 'clean' their data, they discover that only sixty per cent of their population of people with coronary heart disease have received a blood pressure check in the last twelve months. They are surprised by the results.

They hold a practice meeting to discuss some possible reasons for the results. They agree that they are sometimes too busy to do this simple task and people with high blood pressure may not attend the clinic for some time. They are not actively recalled for appointments.

The practice works on some possible strategies. They agree that the people who have not attended the clinic for a blood pressure check within the last twelve months need to be recalled in for an appointment. Linda agrees to a new role and the team agrees to adjust her hours to three days per week for a period of four weeks. This will enable her to call people for an appointment and use a nurse-led clinic approach she has recently read about.

The team also agrees to make use of the MBS item numbers and ensure each patient has a care plan. This will increase the payments to the practice, providing them with adequate resources to increase Linda's time. They undertake a plan-do-study-act approach to trial this.

Using the plan-do-study-act approach, Linda and the practice team outline how they will address the number of people they suspect aren't being routine tested for their blood pressure. This is what each of the stages looks like:

Plan

What will you do? Send a recall letter to all people with no measured blood pressure in the last twelve months and ask them to attend a coronary heart disease nurse-led clinic.

Who will do this? Linda, the nurse.

When will it take place? Within the next month.

Where will it take place? At the practice.

What do you predict will happen?
We will need to follow the recall letter with a telephone call, however, we predict each person contacted will attend the clinic for the first time and have their blood pressure checked.

What data will you collect to know if there has been a change?
People will be identified from the coronary heart disease registry. We will measure the number of people with blood pressure measurements in the previous 12 months. We hope to have this at ninety per cent following the recall and nurse-led clinic.

Do

The plan described was executed. →

Case study *(continued)*

Jelly Medical Clinic

Study

More than seventy per cent of people recalled responded to the letter. Those that did not respond to the letter scheduled an appointment after the telephone call. All attended a nurse clinic within 10 days of being recalled. The result was 100%. The team was surprised by this and became excited at their success.

They were also able to archive a number of patient files. These people had left the area and telephoned to notify the practice. This was an important step in monitoring people with coronary heart disease because it revealed those who had 'fallen through the loop' and not been followed up. The patients targeted through this PDSA cycle now have a care plan and are in the recall system to attend regular nurse-led clinics. Making active use of the care planning items also rewarded the practice financially. After the four week trial, the practice team decided to continue with Linda working three days per week.

Act

After the success of the trial, the team decides to make this usual practice. The practice has re-examined the way in which it manages recall for patients with coronary heart disease. The team now systematically recalls all patients on the registry to attend the nurse-led clinic. Linda works backwards from those with the highest blood pressure measurements and patients are followed up with a 3-4 monthly recall.

The Enhanced Primary Care Program

The Enhanced Primary Care (EPC) Program was introduced to provide more preventive care for older Australians and improve coordination of care for people with chronic conditions and complex care needs. The program provides a framework for a multidisciplinary approach to health care. There are a number of Medicare items available under the EPC program including various health checks, care planning items, multidisciplinary case conferencing items and medication management review items.

The two main Chronic Disease Management items are GP Management Plans (GPMP) and Team Care Arrangements (TCA). By developing a care plan, a GP can assist a patient to optimise the self-management of their chronic condition(s).

Preparing a GP Management Plan involves assessing a patient with a chronic or terminal medical condition, agreeing management goals (what changes the treatment aims to achieve), identifying any action to be taken by the patient and treatment/services to be provided, setting a review date and documenting these in the plan.

Patients with complex needs requiring multidisciplinary care are also eligible for Team Care Arrangements. These patients would normally have a GP Management Plan as a first step. Team Care Arrangements involve the GP discussing potential treatment or services for the patient with the other participating providers, and documenting the goals, providers, treatment or services, patient actions and a review date in the TCA.

Patients must have both a GPMP and a TCA in place to access Medicare rebates for one-on-one allied health and dental care services. Patients with either a GPMP or a TCA can receive monitoring and support services from a practice nurse or registered Aboriginal Health Worker on behalf of a GP. Patients with a GPMP and type 2 diabetes, can also access Medicare rebates for group allied health services. If Medicare rebates are to be claimed, these treatments and services must be identified in the plan as part of the care arranged by the GP.

To find out more about how to improve self-management in general practice using the EPC program, contact your local Division of General Practice.

Nurse-led clinics

Nurse-led clinics are a way of improving the care for people with chronic disease and for delivering self-management. In this approach, the practice nurse organises a regular clinic for the follow-up of people with a particular chronic disease. For more information contact your local Division of General Practice.

Divisions of general practice

Divisions of general practice are agencies that assist general practices to provide services to the community and achieve improved health outcomes. One of their objectives is to improve the development and embedding of chronic disease self-management into general practice. Over ninety-five per cent of Australia's GPs are members of their local division.

How Divisions can support your practice to implement self-management:

- Training of general practitioners, practice nurses, general practice staff and other providers.
- Promoting, developing and maintaining partnerships between general practice and other service providers at the local level to improve access to quality, timely and coordinated care for people with a chronic disease.
- Keeping abreast of relevant state and national initiatives to identify future directions in primary care and potential opportunities for resource sharing.
- Providing structured shared care programs, focusing on the person as an individual and the group of people with chronic disease as a practice population.
- Understanding the EPC program and using the MBS chronic disease items.
- Establishing disease registries and recall systems.
- Supporting practice nurses to gain skills for chronic disease self-management.

A simple model of self-management to use in the general practice setting

The Royal Australian College of General Practitioners' Chronic Condition Self-Management: a summary for General Practitioners is a set of guidelines for effective interactions and strategies to use with people with chronic disease. The guidelines outline a framework to assist GPs and nurses to facilitate self-management. It provides prompts and tools to use self-management in clinical consults.

The framework begins with undertaking an assessment of a person's needs and acknowledgement of their strengths. The aim is to determine the problem from the perspective of the person. Part of this assessment involves identifying the impact of the disease and determining their experience.
The problem identification part is based on the FIFE method; an approach that addressed the feelings, ideas, effect on function and expectations of the person.

The FIFE method is a series of steps to introduce self-management into a clinical assessment. It uses strategies such as problem solving and goal setting and is finalised with a care plan.

Feelings

Ask the patient about their feelings toward their disease. Many people feel great anger, fear, guilt and frustration. It is important to identify these feelings as they can be a significant barrier to behaviour change.

Ideas

Ask the person about their disease and what it means to them. What are their ideas about their condition? This will tell you a lot about the person's attitudes towards and beliefs about their disease. It will provide you with useful insight and understanding into the blocks you may be up against when attempting to engage the person in behaviour change. You will not alter these blocks by simply providing the person with more knowledge.

Function

Understand the person's daily activities and family relationships and how their disease might be impacting on these. You will also want to explore the impact upon recommended lifestyle change.

In most cases, people are more concerned with the impact their disease has on enjoying things they like or their relationships than with their health. It is not uncommon for people to be overwhelmed with change.

Failing to inquire and address these issues is likely to have an impact upon behaviour change and adhere to any treatment we recommend.

Expectations

Ask the patient about their expectations of us. Some patients will want us to act and make steps to assist them. Others simply want us to listen.

Whichever role people want us to take, it is important we take their lead. We should never underestimate the power of listening. It is a powerful tool to initiate behaviour change in the people we see, especially if the techniques of reflective listening are applied. We talk more about reflective listening in our discussion of Motivational interviewing in our guide *Implementing self-management* (page XxX).

Then also ask information about symptoms as well as any lifestyle factors. From here, we would consider the person's readiness to change their lifestyle habits.

In the resources section at the end of this guide, we list the Royal Australian College Of General Practitioners web site that directs you to these guidelines. On this web site, you will also find a handy desktop prompt card for use in practice.

Tips for agencies to engage general practice

The structure of general practice is inherently different to most health agencies. Practices are small business whose income is dependent on the number of people assessed and treated. Redesigning care is time away from seeing people. The benefits of investing in self-management and redesigning systems must outweigh the loss of consultation time.

If we want to successfully work with GPs we need to be mindful of the severe time constraints that they work under. We will also need to market self-management differently. One of the key messages that we need to communicate is that self-management promotes adherence to medical treatment.

Divisions of General Practice are a trusted source of local information and advice for GPs. To successfully engage any practice, it is vital we use them as a resource. They will help us in our strategies and approaches and any plans we may have to improve coordination of chronic disease care.

Nine tips for health professionals to improve communication with general practitioners

1. ***Don't always expect a phone call to be returned.***
2. ***Avoid sending too much correspondence. Send a letter when you have completed your assessment and send regular up-dates.***
3. ***Keep letters simple, to the point and on one page.***
4. ***Include your name, the days you work and a direct line. Make sure you have voice mail for messages.***
5. ***Don't be afraid to make recommendations to the GP for treatment or referral.***
6. ***Make your plan and recommendations clear, for example, please refer this person for treatment.***
7. ***Add a statement like, 'If you have not advised us of any concerns within two weeks, we will proceed with actions detailed in the attached plan.'***
8. ***Provide the person you are seeing with a copy of the letter to discuss with their GP at their next visit.***
9. ***Visit the GP with the person to have a case conference. Ensure to book a consultation of appropriate length. Set goals for the outcome of the visit with the person prior to the visit.***

We have included a sample letter for you at the conclusion of this guide.

Next steps

At the conclusion of this guide, we have included a general practice self-assessment. We recommend you complete this assessment before looking at our guides on *Changing clinical practice* and *Implementing self-management*.

Resources

Web sites

The Australian Primary Care Collaborative <http://www.npcc.com.au/index.html>

Royal Australian College of General Practitioners (RACGP) have written guidelines to assist practices to implement self-management in the practice setting. Royal Australian College of General Practitioners 2001, Sharing Health Care Guidelines, *Chronic condition self-management: summary for General Practitioners*. WA Research Unit of RACGP with funding from the Department of Health and Aged Care. Go to <http://www.racgp.org.au/guidelines/sharinghealthcare>

The Australian Government Department of Health and Ageing has information about the EPC program and also includes sample care plans. Go to http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Enhanced+Primary+Care+Program-1

University of New South Wales, Centre for General Practice Integration Studies, School of Public Health & Community Medicine. Enhancing the role of non-GP staff in chronic disease management in general practice. Go to < http://www.cphce.unsw.edu.au>. Click on chronic disease under 'our research'.

Medicare Benefits Schedule online <http://www.mbsonline.gov.au>

The Victorian Department of Human Services Primary Health Branch web site provides information to Victorian primary health care agencies who may be looking to build or extend evidence-based models of care that incorporate chronic disease management MBS items. Summaries of these items and their business rules have been developed. Go to <http://www.health.vic.gov.au/communityhealth/gps/mbs.htm>

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General practice self-assessment

We would like to thank UNSW Centre for General Practice Integration Studies for allowing us to reprint this tool for use in this guide on general practice and self-management.

The aim of this self-assessment tool is to assist your practice identify areas where teamwork is used effectively and areas where teamwork could be improved.

The analysis consists of two parts:

Part A: Assessing the systems currently in your practice
Part B: Selecting up to three areas to develop / improve upon

Once you have identified up to three areas for improvement we invite you to identify changes that will assist your practice to operate more effectively and efficiently. We recommend you do this using the Model for Improvement described in the *Changing clinical practice guide*.

NOTE: All indicators relate to people with diabetes, ischaemic heart disease or hypertension

PART A. Assessing systems currently in place in your practice

This part consists of eleven systems for good chronic disease care in general practices. Look at the indicators within each system and identify how your system operates in relation to these indicators.

Assess each indicator from the three perspectives described below and tick the boxes in each column as applicable:

Table 2. Standardised measurement tools

Indicators	
SAT	**SAT**isfatisfactory or in operation
NGP?	Are **N**on-**GP** staff involved?
D / I	Needs **D**evelopment or **I**mprovement

Section 1. Structured appointment system

Indicators	SAT	NGP?	D / I
A flexible system which accommodates urgent, non-urgent, planned chronic and preventative care and supports multiple clinical providers	☐	☐	☐
Patients are informed that longer consultations are available on request	☐	☐	☐
Patients are informed that they can request the practitioner of their choice	☐	☐	☐
Practice provides information to patients about consultation fees and associated costs	☐	☐	☐
All relevant staff understand, can access and operate and have clearly defined roles in maintaining and using the appointment system	☐	☐	☐

WORKSHEET

Section 2. Patient disease registry

Indicators	SAT	NGP?	D / I
Patient disease registries covering minimum clinical data sets	☐	☐	☐
Evidence of a system that is maintained and regularly used to identify patients for recall and reminder follow-up as part of ongoing health management	☐	☐	☐
All staff involved in patient disease registries understand the system and have clearly defined roles in maintaining and using the registry	☐	☐	☐
Written procedures for building, maintaining and using patient disease registries are in place and understood and adhered to by all staff	☐	☐	☐

Section 3. Recall and reminder system

Indicators	SAT	NGP?	D / I
Systematic recall and reminder system is in operation	☐	☐	☐
Practice follows up all patients who do not attend their appointments	☐	☐	☐
All staff involved in patient disease registries understand the system and have clearly defined roles in maintaining and using the registry	☐	☐	☐
All relevant staff are aware of and adhere to the procedures for recall and reminder	☐	☐	☐
Written procedures for an active practice initiated recall and reminder system for ongoing management for diabetes (including reminder to complete annual cycle of care), IHD & hypertension	☐	☐	☐

Indicators	
SAT	**SAT**isfatisfactory or in operation
NGP?	Are **N**on-**GP** staff involved?
D / I	Needs **D**evelopment or **I**mprovement

Section 4. Patient education and resources

Indicators	SAT	NGP?	D / I
Patients receive appropriate education in the practice or are referred to external agencies	☐	☐	☐
All staff involved in patient education and resources have clearly defined roles in maintaining and using up-to-date, relevant and culturally appropriate resources	☐	☐	☐
All relevant staff are aware of and adhere to the procedures for ordering and using patient education and resources	☐	☐	☐
Written procedures for collating, storing, updating and distributing relevant, culturally appropriate patient education and resources from credible evidence based sources	☐	☐	☐

Section 5. Planned care

Indicators	SAT	NGP?	D / I
Documented planned care (including medication reviews) according to best available evidence is systematically implemented	☐	☐	☐
Patients are informed of and are involved in their planned care	☐	☐	☐
All staff involved in planned care have clearly defined roles and responsibilities in providing planned care	☐	☐	☐
Written procedures for accessing, updating according to best available evidence and providing planned care are in place and understood and adhered to by all staff	☐	☐	☐

WORKSHEET

Section 6. Practice based linkages

Indicators	SAT	NGP?	D / I
Referrals contain adequate information to facilitate optimal patient care	☐	☐	☐
Procedure and system for storing, updating and distributing an updated directory of practice based linkages to a broad range of necessary services	☐	☐	☐
All staff involved in practice based linkages have clearly defined roles and responsibilities in updating, reviewing (including patient feedback) and using a directory of practice based linkages	☐	☐	☐
Written procedures for maintaining, storing and distributing an updated directory of practice based linkages to a broad range of necessary services	☐	☐	☐
Written procedures for referral to another health care provider are in place and understood and adhered to by all staf			

Section 7. Roles, responsibilities and job descriptions

Indicators	SAT	NGP?	D / I
All staff involved in providing and supporting planned care have clearly defined roles and responsibilities	☐	☐	☐
Regular reviews of roles and responsibilities, job descriptions	☐	☐	☐
Regular review of performance including remuneration and training needs analyses are carried out	☐	☐	☐
Written job descriptions for all staff involved in providing and supporting planned care are available	☐	☐	☐
Written procedures for conducting the necessary reviews and updating roles, responsibilities and job descriptions are in place and understood and adhered to by all staff			

Section 8. Communication and meetings

Indicators	SAT	NGP?	D / I
Regular meetings are held to discuss clinical and non-clinical issues	☐	☐	☐
Each staff member attends those meetings at which topics relevant to them will be discussed	☐	☐	☐
Meetings have pre-determined agendas, action points and minutes are generated that are accessible to all relevant staff	☐	☐	☐
Formal as well as informal channels of communication are in place	☐	☐	☐
Written procedures regarding meetings and communication are in place and understood and adhered to by all staff			

Section 9. Practice billing system

Indicators	SAT	NGP?	D / I
There is a billing system which supports all elements of multidisciplinary care	☐	☐	☐
All staff understand the relevant Medicare item numbers and patients are informed of any costs	☐	☐	☐
A communication system between clinical and administrative staff is in place to ensure appropriate billing at the conclusion of each consultation	☐	☐	☐
All staff involved in billing have clearly defined roles and responsibilities	☐	☐	☐
Written procedures for billing are in place and understood and adhered to by all staff			

Indicators	
SAT	**SAT**isfatisfactory or in operation
NGP?	Are **N**on-**GP** staff involved?
D / I	Needs **D**evelopment or **I**mprovement

WORKSHEET

Section 10. Record keeping

Indicators	SAT	NGP?	D / I
At least 90% of active patient health records contain a record of allergies in the health summary and at least 50% of active patient records contain a satisfactory health summary	☐	☐	☐
The practice is working towards recording self-identified cultural background and emergency contact people for each patient	☐	☐	☐
All staff have clearly defined roles and responsibilities for record keeping	☐	☐	☐
All staff access and contribute sufficiently to records relevant to their specific role	☐	☐	☐
Written procedure covering comprehensive, systematic, accurate and secure health information management of quality data is in place and understood and adhered to by all staff			

Section 11. Quality

Indicators	SAT	NGP?	D / I
A quality improvement cycle involving planning, implementation, review and refinement (PDSA) is in operation in the practice	☐	☐	☐
All staff have clearly defined and understood roles and responsibilities in adhering to, maintaining, reviewing and updating the quality cycle	☐	☐	☐
Documentation to support the quality cycle is available	☐	☐	☐
Systems are in place to collect data e.g. patient surveys, record audits	☐	☐	☐
Written procedures describing the quality cycle are in place and understood and adhered to by all staff			

Indicators	
SAT	**SAT**isfatisfactory or in operation
NGP?	Are **N**on-**GP** staff involved?
D / I	Needs **D**evelopment or **I**mprovement

PART B. Selecting up to three areas to develop or improve upon

Select up to three sections that you would like to develop or improve upon.

Sections		✔
1	Structured appointment systems	☐
2	Patient disease registry	☐
3	Recall and reminder system	☐
4	Patient education and resources	☐
5	Planned care	☐
6	Practice based linkages	☐
7	Roles, responsibilities and job descriptions	☐
8	Communication and meetings	☐
9	Practice billing system	☐
10	Record keeping	☐
11	Quality	☐

Sample self-management letter to a general practitioner

Name of agency

Dear *Dr <Dr name - mail merge>*

Re: *Referral to <name of self-management service/program>*

Person's name: *<insert name>*

Date of birth: *<insert date of birth>*

<insert name> has been involved in the <name of self-management service/program> service at <name of agency> for self management assessment and support. Following a detailed assessment and goal setting process, a self-management plan has been developed.

I have been assigned as the key worker/self-management coach for this patient, and will provide you regular updates of the patient's progress. As the key worker/coach, my role is to assist people with chronic health conditions to:

- *manage the impact of their health condition on their daily life and*
- *achieve greater adherence to medical treatment for their condition.*

Please find below a copy of our self-management plan, including proposed referrals.

Self-management plan for patient: • <write your plan in dot points>

Recommendations for GP: <write your recommendations to the GP>

If you have any concerns regarding the attached plan, or additional information to contribute, please write your comments in the box below or phone me on 1234 5678 at your earliest convenience.

GP Comments
Please include any comments you as the GP may have here and fax back to me on <your fax number>.

If you feel <patient name> may benefit from a Team Care Arrangement, I would be happy to be involved.

Yours sincerely,

<name of key worker>
<position>

Quick guide to implementing self-management in general practice

Key idea	Description
Use Motivational interviewing	Motivational interviewing is an approach that uses directive questions and reflective listening to allow people to explore their uncertainties, identify problems and find solutions. Refer to our discussion of Motivational interviewing in our guide Implementing self-management.
Make practice changes in visits and organisational systems	Example suggestions: • Schedule individual planned self-management visits to set goals and create plans • Use non-GP staff to assist in planned visits • Embed self-management goals into registries to act as prompts for person reminders and planned visits
Refer people to community interventions	Provide information about community resources that assist people to improve their decision-making and self-management skills.
Use available resources	Use self-management tools to guide discussion that assists the person to: • determine his/her goal, • identify steps to achieve the goal, • ascertain barriers to reaching the goal and establish plans to overcome the barriers
Use a team of professionals	Discuss roles and responsibilities amongst team members and ensure clear communication channels between services and community resources.
Make case management available	Devise plans for people with complex needs to access more intense support. Make use of other service providers to provide this support.
Use interactive technology	Inform people of useful web sites, chat groups and online courses to enhance their self-management.
Use standardised assessment and care planning tools	Use standardised assessment and care planning tools to ensure routine and systematic assessment according to guidelines. Collect measures on aspects of assessment and care planning to ascertain the quality of care.
Use planned visits with regular follow up	Plan visits that allow time to address self-management tasks. Schedule follow-up to allow for learning and change in a person's self-management journey.
Make the most of visits	Redesign practice by making the most of the entire visit. A practical example is included in our guide *Implementing self-management*.

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