Self-Management Mapping State-wide report

Self-management support – a state-wide view
2006-07

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Table of Contents

Introduction

The Department of Human Services (DHS) has endorsed the Wagner Chronic Care Model[1] as a framework for improving care for clients with chronic disease. The Chronic Disease Management program *Guidelines for Primary Care Partnerships and Community Health Services*[2] provides a description of the model and outlines six interdependent elements that encourage high quality chronic disease care. Self-Management Support is one element. Organisations, individually and as a collective, need to focus on these six areas to enable the development of productive partnerships with clients who are empowered to take an active role in their care and ensure providers across multiple services are able to respond to client needs.

What is self-management support

Self-Management support promotes the concept of consumers being actively engaged in their own health care. Self-Management principles aim to optimise people's capacity to manage the risk or impact of chronic illness over the lifespan and along the care continuum. Support is provided to clients through a range of self-management approaches to empower them to manage their own health and health care.

Self-Management support has been identified in the National Chronic Disease Strategy[3] as a key component of routine health care. The provision of self-management support by health professionals is now recognised as a critical aspect of improving the health outcomes and has a legitimate place in client care. For self-management principles to be embedded throughout the continuum of chronic disease prevention and care, a major cultural shift in work practices and service delivery is required.

All Primary Care Partnerships (PCPs) now receive funding to support and facilitate service system integration and change management in support of a coordinated approach to the planning and delivery of services for clients with chronic disease, building on the foundation of service coordination. An identified priority for this funding, reflected in PCP Community Health Plans, is systems support to enhance the provision and coordination of self-management approaches across PCP catchments.

Purpose of self-management mapping

The purpose of the self-management mapping exercise was to provide:

- An insight into the current approaches and uptake of self-management support approaches,
- An insight into current knowledge and understanding of self-management support and ways to move forward to embed self-management principles,

[1] Wagner E., Austin B, Von Koff M., (1996) Organising care for patients with chronic illness, Milbank Quarterly, 74, 511-544

[2] http://www.health.vic.gov.au/communityhealth/downloads/cdm_program_guidelines.pdf

[3] National Health Priority Action Council (NHPAC) 2006, National Chronic Disease Strategy, Australian Government Department of Health and Ageing, Canberra

- Information at the local level about self-management support including: providers; access and equity; types of interventions; service capacity; barriers and enablers and training needs; and
- An overview of current practice to inform future policy development and both integrated chronic disease management and self-management support activity more broadly.

The following report provides an analysis of the findings from the state-wide mapping of self-management support. The report outlines the challenges and enablers to progress this work and the role the Primary Care Partnership structure can play in providing support. It also sets out how the department intends to continue its support in this area. The statewide report will be used to inform the work of the department in responding to the impact of chronic disease.

Executive Summary

The incidence of chronic conditions is increasing and currently represents approximately 70% of Australia's overall burden of disease. Evidence suggests a transformational change in health care is required to support clients with chronic disease. This involves a shift from episodic care to planned, managed care based on client centred goals using a partnership approach between health professionals and clients.

The principles of self-management support are fundamental to this transformational change. The self-management mapping exercise was undertaken to identify current understanding and activity to inform future work.

The statewide mapping of self-management was the first collection of its type, focusing on the application of self-management support principles. Prior to the mapping there was limited information in regard to the saturation of self-management support in practice. The exercise in and of itself was a capacity building exercise across Primary Care Partnership catchments and provided an opportunity for a dialogue around self-management support and what it may mean for both service providers and service users.

The information documented relates to the 2006-07 financial year.

Over 270 completed templates, representing approximately 216 agencies were submitted to DHS. Thirty PCPs submitted templates. Completed templates were received from a variety of agencies and program areas including:

- Health Services – HARP-Chronic Disease Management, Sub-acute Ambulatory Care Services, Hospital-in-the-home, outpatients and acute services
- Community Health Services
- Divisions of General Practice
- Local Government Services including Home and Community Care
- Aboriginal Community Controlled Health Organisations
- Royal District Nursing Services
- Non-government organisations
- Case management services
- Residential care services
- Mental Health and Alcohol and Drug Services[4]

Seventy-one percent of the respondents stated that integrated chronic disease management was an identified organisational priority.

The responses suggest that health coaching, motivational interviewing and the flinders model of care planning are the most common approaches being applied in practice, with 78%, 72%

[4] *Mental Health and Alcohol and Drug Services were not in scope for the state-wide mapping, however some PCPs included as part of their local mapping. Data capture from these services will be excluded in the final state-wide report.*

and 54% of practitioners trained in the approach using it in practice. This may indicate that health coaching is the most practical in terms of transferability into practice.

The major disease states targeted by the various approaches, including generic programs, reported were:
- mixed (and/or multiple) chronic disease/s
- type 2 diabetes
- cardio-vascular disease
- respiratory disease

Key challenges identified in implementing a self-management approach include:
- Access to training (appropriate to role)
- Organisational systems change required to support implementation of self-management approach (including the time self-management interventions take and other priorities for clinicians)
- Development of strategies and/or mechanisms to increase awareness and understanding of self-management support (including the benefits) within the health sector; and
- Creating a culture change to support the paradigm shift required to work with client determined goals within the context of evidence-based best practice achieved

Key cited enablers to successfully embedding self-management support approaches include:
- Providing access to appropriate training relating to self-management support
- Having systems in place to routinely identify client self-management needs; and
- Clinician willingness to change practice

The report concluded that the following areas require further exploration:
- Improving the understanding of the principle of self-management across the various sectors
- Consideration of influencing training bodies to include the principles of self-management as a core component of training modules for health professionals
- Identification of options for providing ongoing support to clinicians engaged in the provision of self-management support
- Increasing the awareness and understanding of the roles of the various services providers
- Increasing health practitioner knowledge and awareness of local services (self-management support, clinician interventions and other community based support programs) and how such services may be accessed
- Consideration of innovative ways to provide self-management support interventions broadly and also to specific target groups should as Culturally and Linguistically Diverse Communities, Aboriginal and Torres Strait Islander Communities. This may also involve exploration of current and newly emerging technology such as web based self-management support.
- Continuing to build on the service coordination practice
- Consideration of self-management support implementation in the context of the 5 other interdependent elements of the Wagner Chronic Care Model

The department is currently reviewing the data to identify key statewide needs and develop a plan to assist and support PCPs develop and implement local action plans. The department is also exploring opportunities to further support integrated chronic disease management activities, including self-management support.

Methodology

Two templates, one generic and one specifically for Divisions of General Practice (refer appendix 1) were developed to collect the data by a working group consisting of department representatives, agency and PCP staff. A series of questions were formulated to capture the relevant data for the 2006-07 financial year. As the exercise also included a capacity building component, a number of open ended questions were incorporated to assist in facilitating discussion and to identify actions required to embed self-management support within the catchment.

The templates were distributed to PCP staff to use to collect the data from services identified as having a key role in self-management support. This enabled additional local detail to be captured to augment the statewide requirements. Further details of the scope of the self-management mapping exercise are included in the Self-Management Mapping Guide[5].

The completed templates were submitted to the department for analysis. Responses to open ended questions were 'themed' for the purpose of analysis. Given the PCP knowledge of the local service system, the reported data may require additional analysis to include the local context. For example; the analysis doesn't take into consideration the size of the various services or relationship of services (roles and responsibilities) within a catchment.

Assumptions and Limitations

The following assumptions and limitations need to be acknowledged in relation to the information reported:

- Data was collected by individual PCPs using a variety of approaches, including facilitated interviews targeted to specialist chronic disease management services or to member agencies more broadly, engagement of a consultation or distribution of template for completion by member agency
- PCP catchments often do not align with Health Services or Divisions of General Practice or statewide services, hence, templates on a number of occasions have been submitted for the same agency or program by different PCPs. In some instances inconsistent responses have been reported
- There is limited quantitative data captured by agencies in terms of the provision of individual self-management support (i.e. not in groups). Hence, definitive information relating to numbers of clients was not able to be captured. The information reported under individual self-management support approaches, for example target groups, relates to the number of agencies and not number of clients.
- There is significant variation in 'catchment boundaries' across the section of core agencies that participated in the exercise. For example Division of General Practice and Health Service boundaries do not align in all cases with PCP boundaries and as such these agencies may be reported across a number of PCPs.
- The data provided a 'snapshot' of information for a defined time period
- Practitioners trained in multiple approaches may be counted more than once
- The number of practitioners trained does not reflect EFT, it is a head count only

[5] www.health.vic.gov.au/pcps/publications/self-management,htm

- The respondents were in the main already engaged in the provision of self-management support, therefore the survey does not capture information about agencies not engaged
- Limited information regarding referral and on-going monitoring and review was sought
- Given that self-management is a relatively new concept there is variable understanding of self-management terminology within and across sectors of health care
- The template did not enable agencies to identify roles or potential roles in self-management support

The data must be interpreted and used accordingly. The data acquired through the self-management mapping exercise are indicative only and should be used to inform the discussion of the role of self-management support in the context of integrated chronic disease management. This may include developing a common understanding of self-management support and the potential roles and responsibilities that agencies within the catchment may fulfil. Information and findings will be used to inform future work to address the needs of people with chronic conditions.

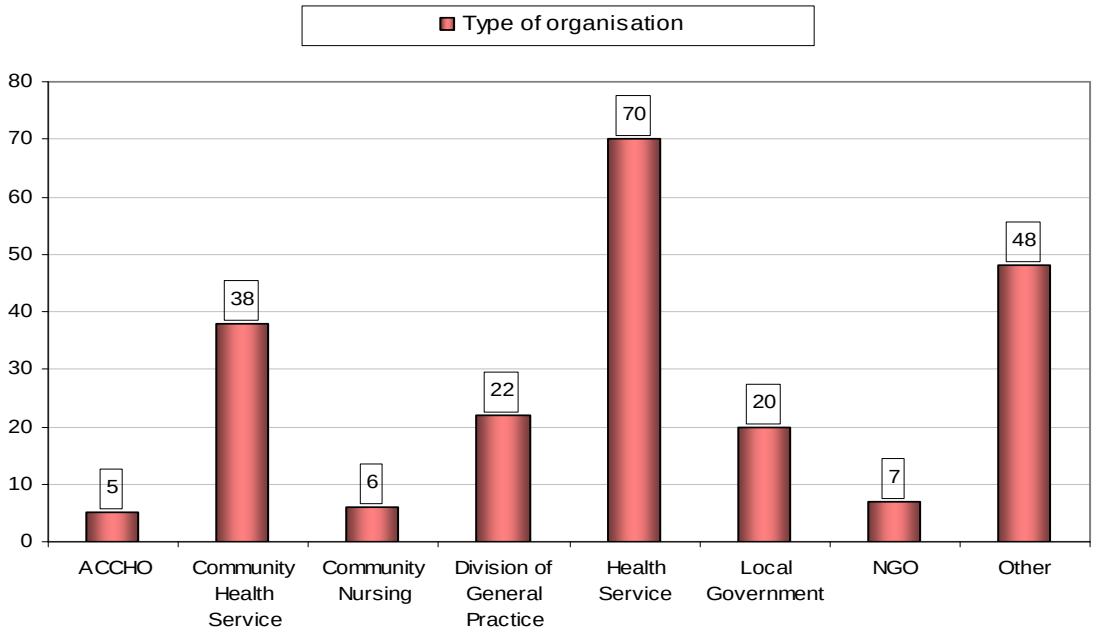
Results

Respondent Information

The following section provides demographic information about the respondents; including agency type and number of agencies that responded and whether integrated chronic disease management and self-management are organisational priorities or goals. It also reports if dedicated chronic disease management programs are provided as part of their service. Regional level detail is provided as part of appendix 2 and is incorporated into the discussion section of this paper.

Over 270 completed templates (responses) were submitted, representing 216 individual organisations. Multiple templates were completed by a number of larger agencies, particularly health services and community health services. The terms respondent is used throughout the document to reflect above.

Figure 1. Number of individual agencies involved in the self-management mapping exercise by agency type.



** Note: For the purpose of this report Health Service includes integrated health services*

The above graph illustrates the types of agencies that participated in the self-management mapping exercise. The agency type 'other' includes bush nursing services, case management services and residential care services. It also includes drug and alcohol services, as per the Self-Management Mapping Guidelines mental health services were excluded from this analysis. The range of organisations responding may be indicative of the level of interest by agencies in integrated chronic disease

management and the identified need to develop systems and processes collaboratively to meet the needs of clients with chronic disease.

Of the completed questionaries, excluding divisions of general practice, the majority of services stated that chronic disease was an organisational priority. Table 1 provides details and also indicates the number of organisations providing dedicated chronic disease related programs across the state. The data suggests that having specific chronic disease management programs may be strongly associated with reporting ICDM as an organisational priority.

Table 1. Chronic disease and self-management support as an identified priority or organisational goal.

	Yes	No	Not stated
Is ICDM an organisational priority?	71%	23%	5%
Is self-management an organisational strategic goal?	67%	25%	6%
Does your organisational provide specific chronic disease management programs?	63%	31%	5%

Figure 2. ICDM as an organisational priority by agency type

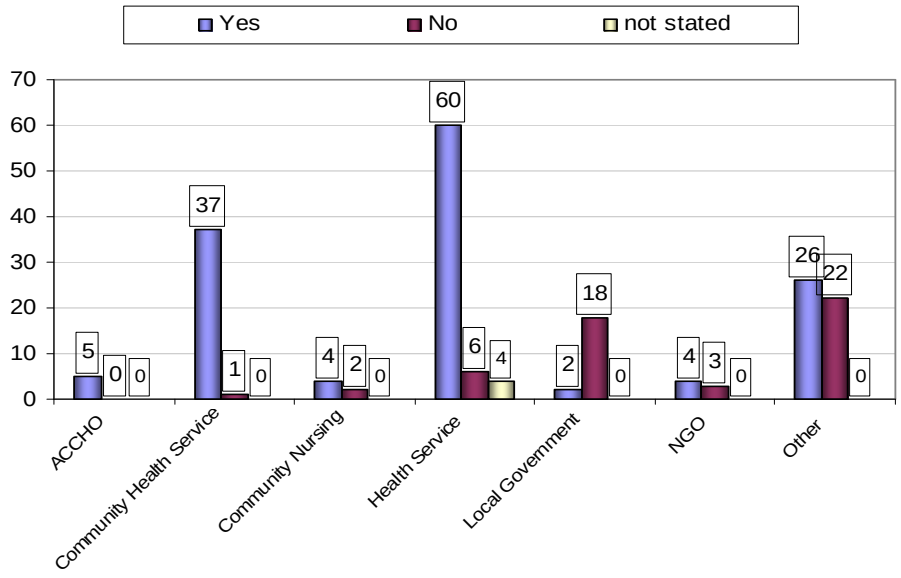


Figure 2 demonstrates that Health Services, Community Health Services and Aboriginal Community Controlled Health Organisations clearly identify integrated chronic disease management as a priority for their services. Organisations such as local government, non-government organisations and 'other' which includes a number of community organisations, it would appear, may not identify as being providers of 'health services'. This may account for integrated chronic disease management not being identified as an organisational priority. The increasing prevalence of chronic conditions in our communities and the focus on prevention and early intervention may lead to such organisations better understanding their role in this area. Working with other organisations through the PCP is one such example of achieving this.

Participation in the self-management mapping exercise may indicate that these agencies are aware that integrated chronic disease management is an important area of work.

Figure 3. Self-management as an organisational strategic goal by agency type

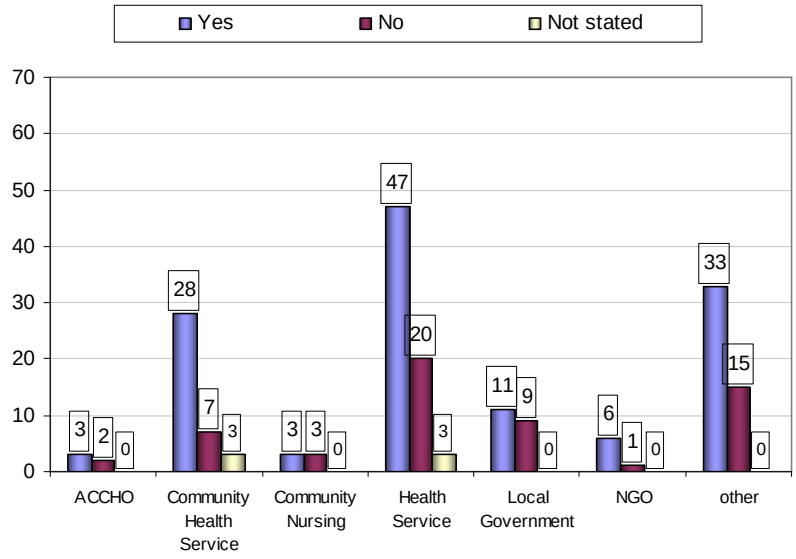
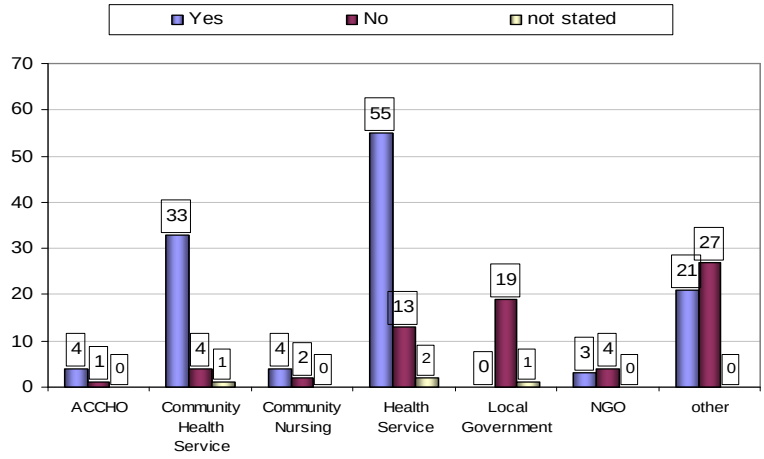


Figure 4. Organisations providing specific chronic disease management programs

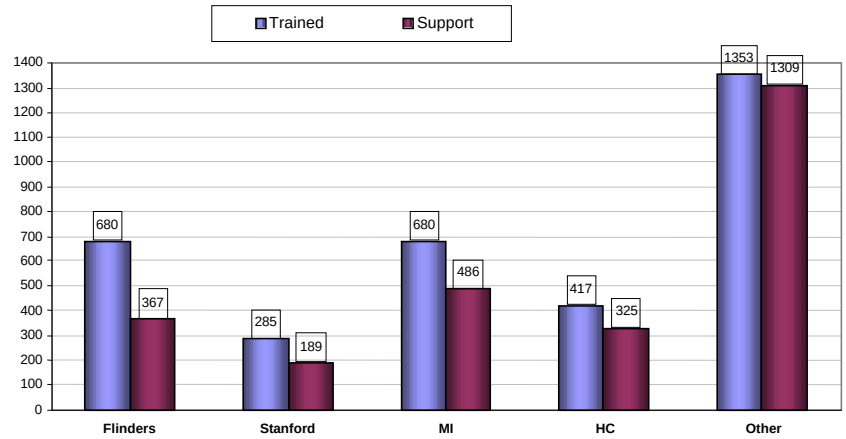


The above 2 charts (Figure 3 and 4), which exclude divisions of general practice, illustrate that self-management is a focus for many agencies across multiple service types. Figure 4 highlights the significant number and variety of agencies that provide programs or services specifically for people with chronic disease.

Health Professional training in self-management support

This section provides information related to training and up take of training in the various evidenced based self-management support approaches. It also includes information relating to other approaches identified as being based on self-management principles and meeting the self-management support criteria[6]. The section provides a state-wide picture with region specific detail included as part of appendix 2.

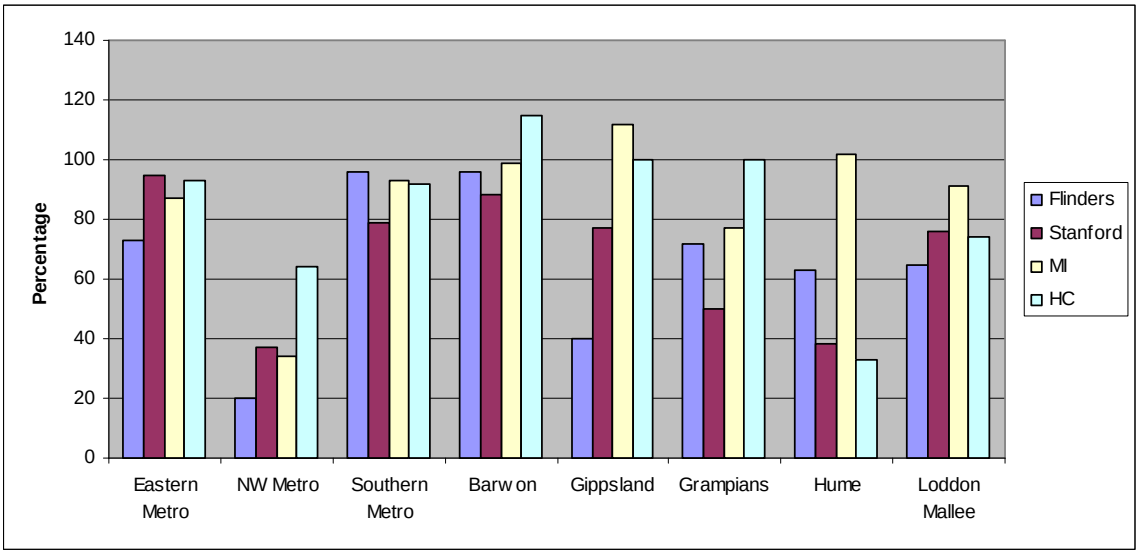
Figure 5. Number of Health Professionals trained in self-management support approaches and providing self-management support



This graph shows the number of clinicians trained in the various interventions, both evidence based self-management support and other training based on the principles of self-management. The support column relates to the numbers of clinicians using a self-management approach in practice. This is a head count rather than a full time equivalent measure and also may include duplication as some clinicians may be trained in more that one approach. As such it does not provide a precise measure of the self-management service availability or capacity across the state. The other column includes a variety of specific training such as diabetes education, various counselling training, exercise related training and a range of health promotion training. The graph indicates, from the evidence-based self-management support approaches (which exclude the column 'other') that health coaching and motivational interviewing training proportional is being adopted into practice more readily that the Stanford or Flinders approaches. This will be further explored in the discussion section. In relation to the Flinders training it should be noted that a number of respondents reported using the approach but only using some or none of the prescribed tools.

[6] www.health.vic.gov.au/pcps/publications/self-management,htm

Figure 6. Regional representation of the proportion of clinicians trained in an evidence-based self-management approach providing support to clients



NB: It is noted that in a couple of instances the proportion of clinicians providing self-management support is greater than the number trained. This is a reflection of the self-reported nature of the information and the misconceptions around self-management support that currently exists.

Self-management support has gained a significant profile in recent years; this is reflected not only in the number of practitioners trained in self-management support but also those using the approach in practice. Figure 6 illustrates the implementation or uptake of self-management training into clinical practice across the state by regions. The transfer of skills acquired during the training into practice is relatively high. In interpreting this graph it is important to recognise that currently there is limited training focusing on chronic disease management principles and the role and benefits of self-management support. In some instances self-management support training has been used across agencies to increase the understanding of chronic disease management. The discussion section will explore this in more detail. The high proportion of clinicians using the various approaches in practice is indicative of organisational and clinician commitment to using self-management approaches as part of routine care for clients with chronic disease.

Provision of self-management support across the state-wide

Self-management support information is not currently collected through departmental reporting and accountability mechanisms. As such, it was not possible in this mapping exercise to report the numbers of clients being provided with self-management support. This was particularly an issue when identifying details related to individual interventions for example flinders model of care planning, motivational interviewing and health coaching. As data is not captured we have limited quantitative data. As part of the mapping exercise, self-management support questions around target populations, disease focus, delivery modes and main source of referral were posed. The rationale for such questions was to stimulate a general discussion about the current self-management support options in terms of the demographic profile of PCP.

The information related to individual self-management support approaches are shown below. The data is reported by intervention type and looks at disease focus, target population, delivery setting and main referral source. The numbers reported refer to the number of respondents.

Flinders Model

Figure 7. Flinders Model – main disease focus as identified by respondents

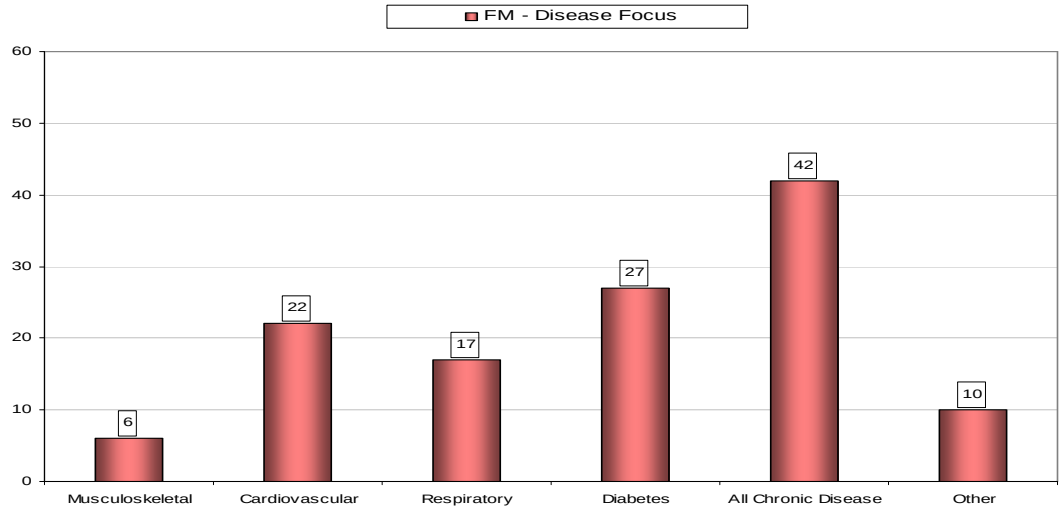


Figure 8. Flinders Model – target population as identified by respondents

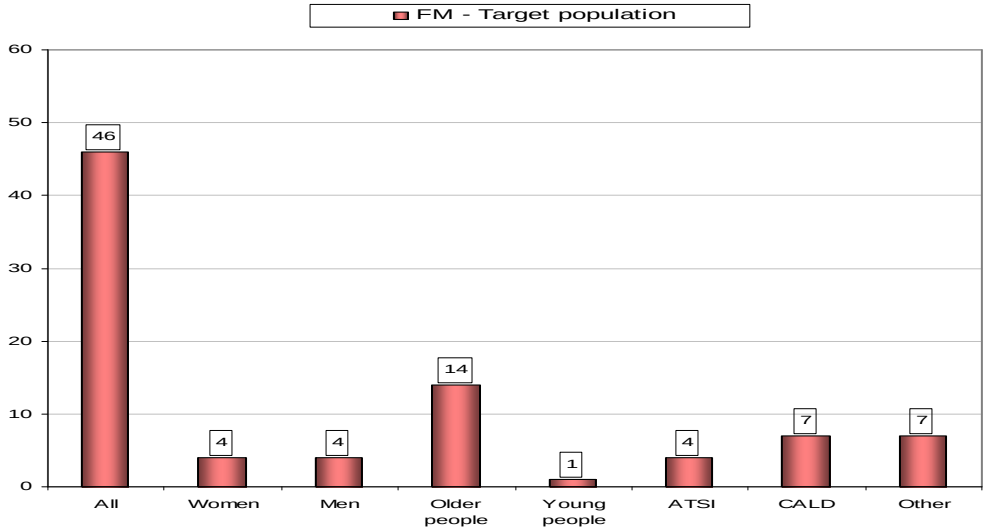


Figure 10. Flinders Model – Delivery setting of interventions as identified by respondents

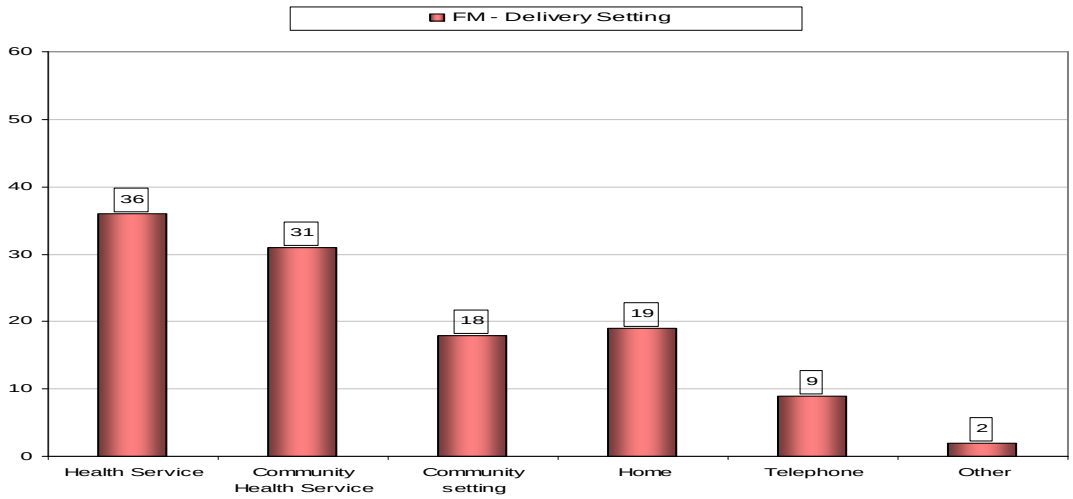
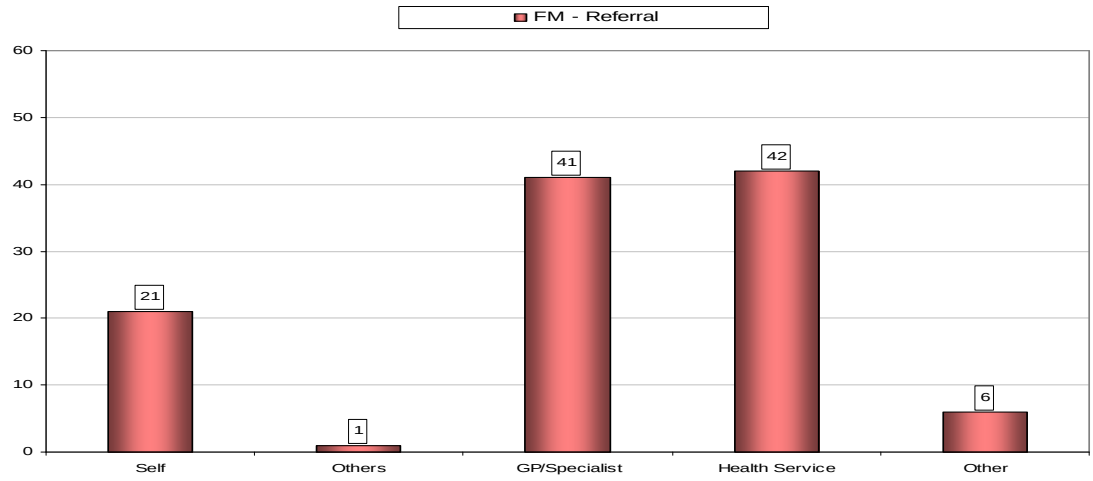


Figure 11. Flinders Model – Main source of referral as identified by respondents



Others refers to significant others (family, friend etc)

These findings indicate that the Flinders model is seen as an approach for people with a range of chronic conditions. Diabetes and cardio-vascular disease were key groups highlighted. This may reflect specific programs related to these disease groups such as HARP-CDM and EIiCD. It also may relate to the high prevalence of both conditions. Not surprisingly the delivery setting identified was health service and community health service. The Flinders model was also provided as a phone based intervention, as indicated by 9 respondents. Referrals for the intervention were provided mainly from the health service but a significant number reported general practice (41).

Motivational Interviewing

Figure 12. Motivational Interviewing - main disease focus as identified by respondents

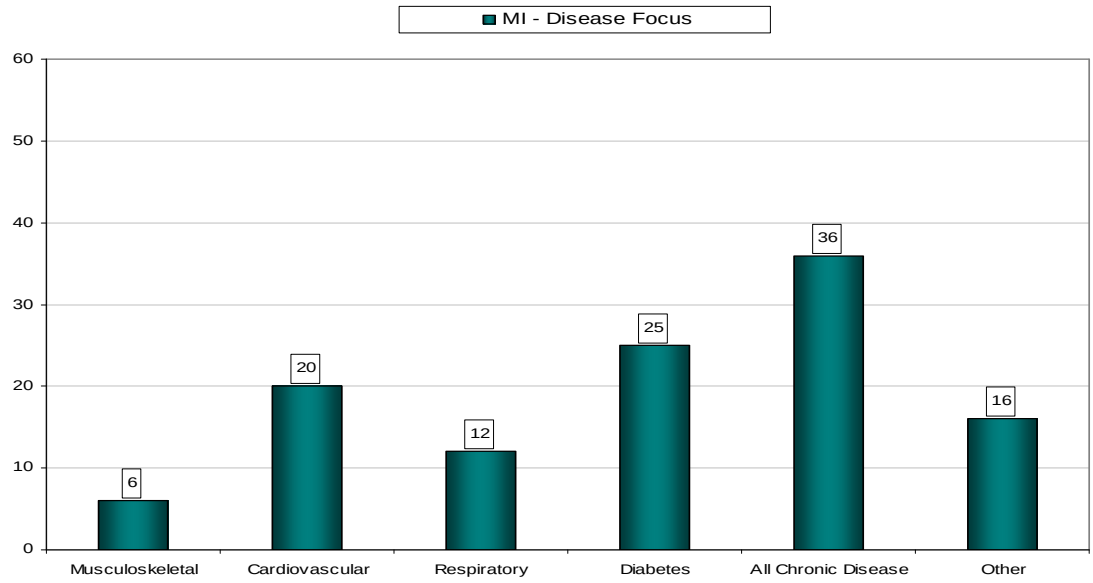


Figure 13. Motivational Interviewing - target population as identified by respondents

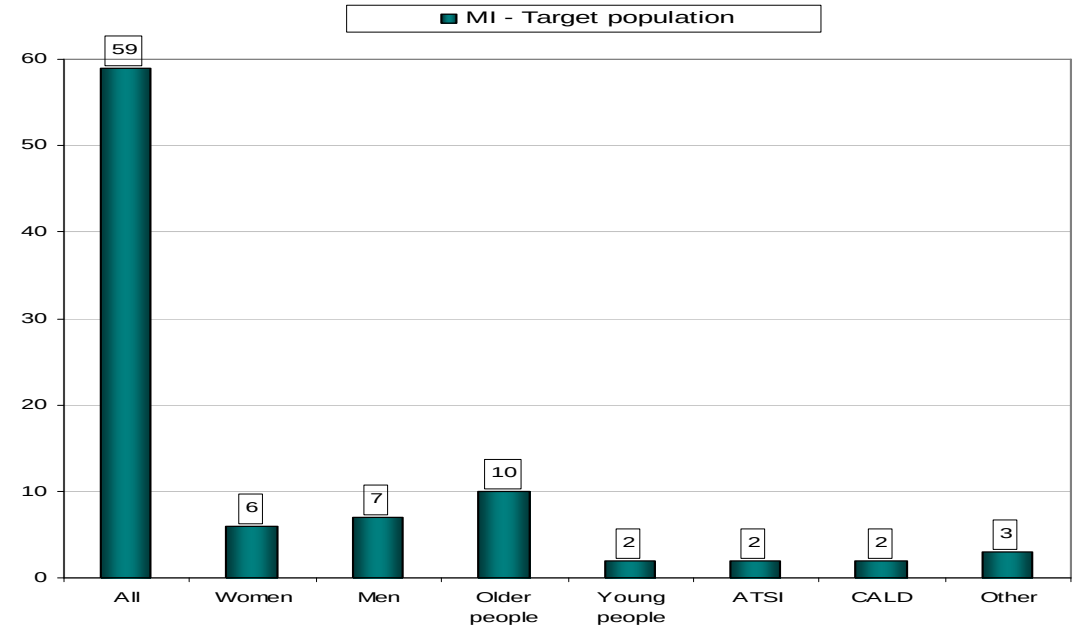


Figure 14. Motivational Interviewing - Delivery setting of interventions as identified by respondents

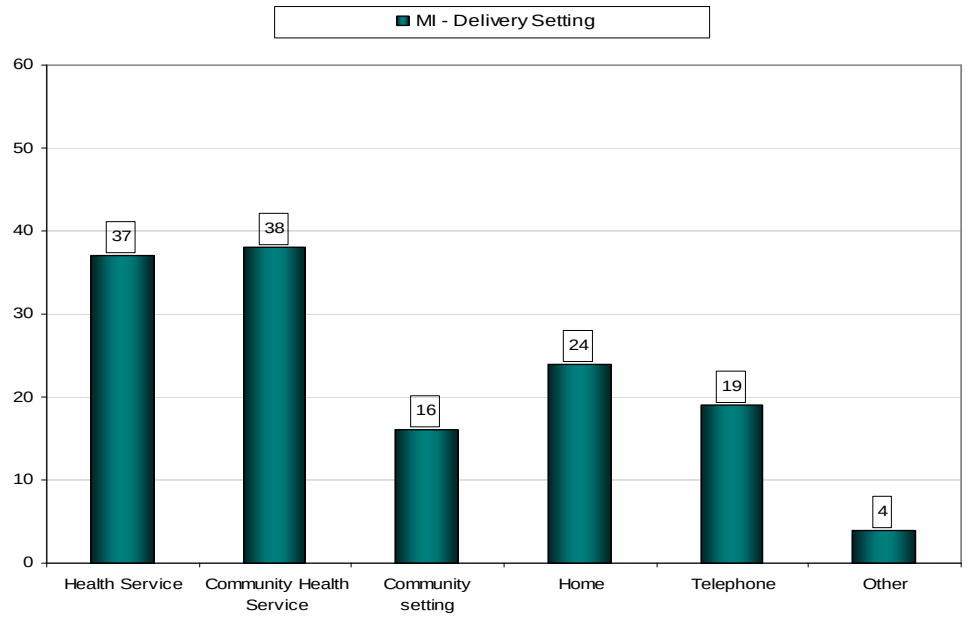
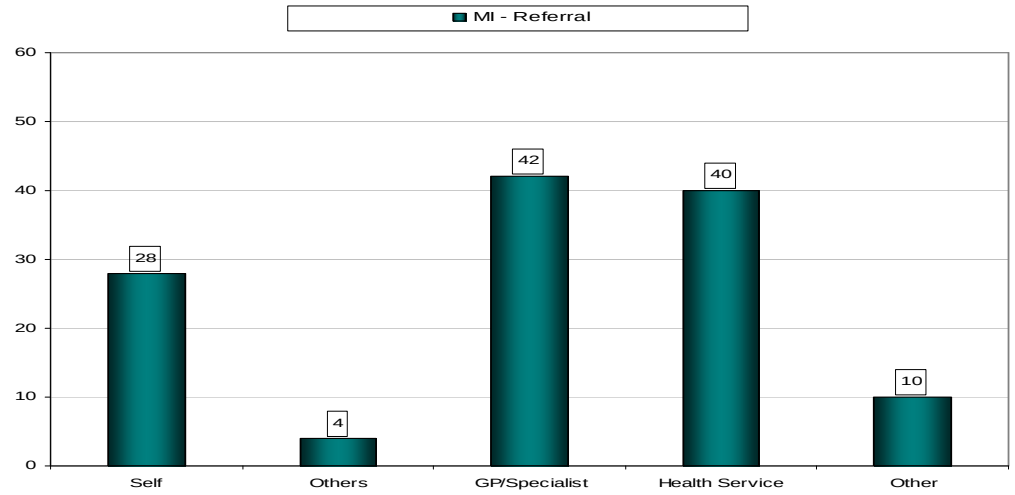


Figure 15. Motivational Interviewing - Main source of referral as identified by respondents



Others – relates to significant other – family or friend

The above 4 figures relating to motivational interviewing show that as for the Flinders model, motivational interviewing is viewed as applicable for clients with any chronic condition, with both diabetes and cardio-vascular disease a major focus. As for the Flinders model and motivational interviewing the target population was reported as people with any chronic disease and older persons. This may also have been impacted by the demographic of clients seeking a service. Motivational interviewing was provided at health services, including community health and also seen as an appropriate telephone based approach. General Practice and health services once again were indicated as the main referral source.

Health Coaching

Figure 16. Health Coaching - main disease focus as identified by respondents

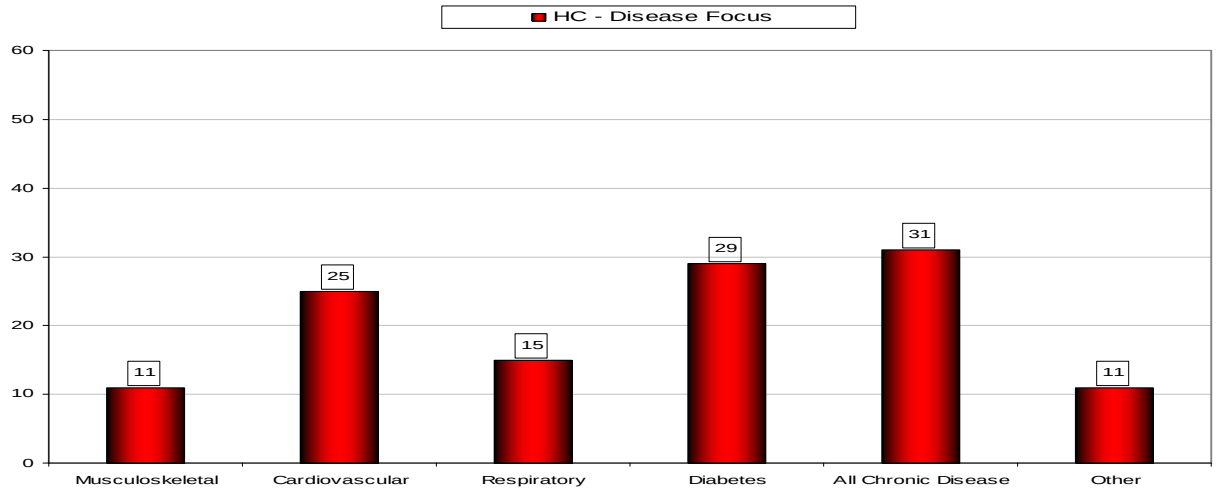


Figure 17. Health Coaching - target population as identified by respondents

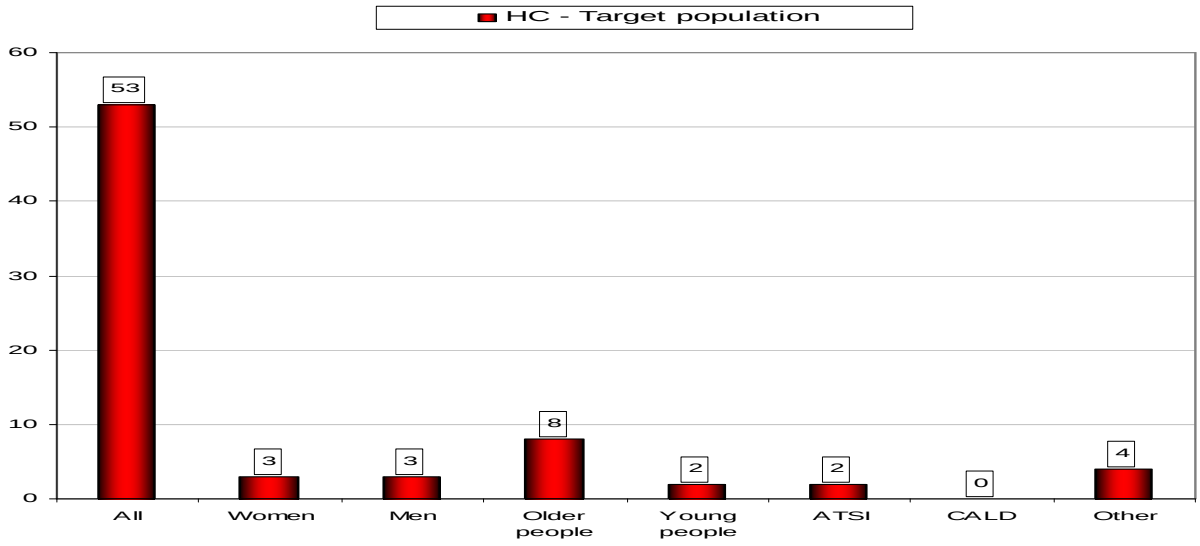


Figure 18. Health Coaching - Delivery setting of interventions as identified by respondents

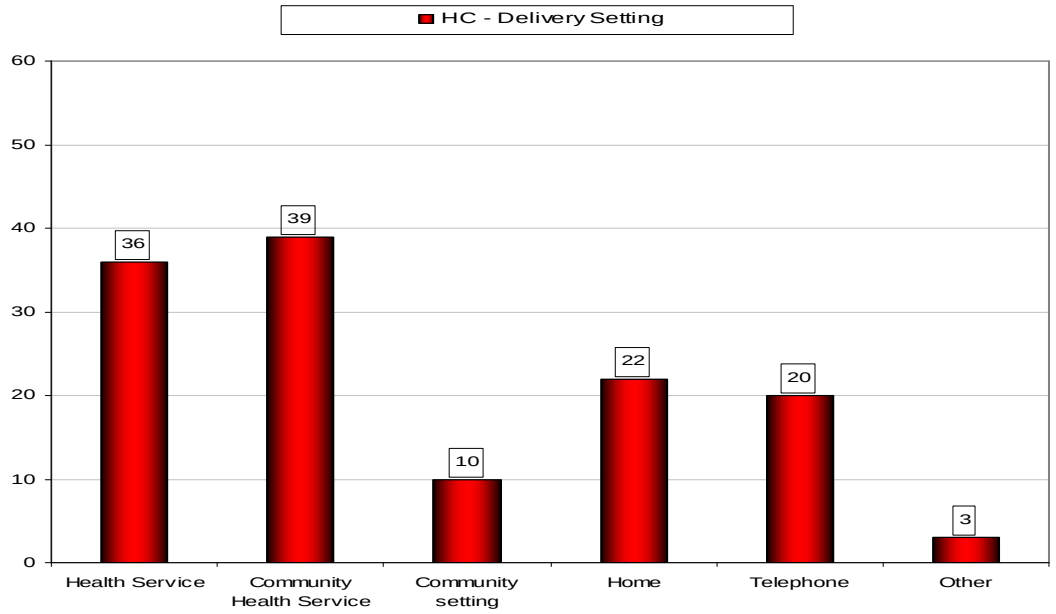
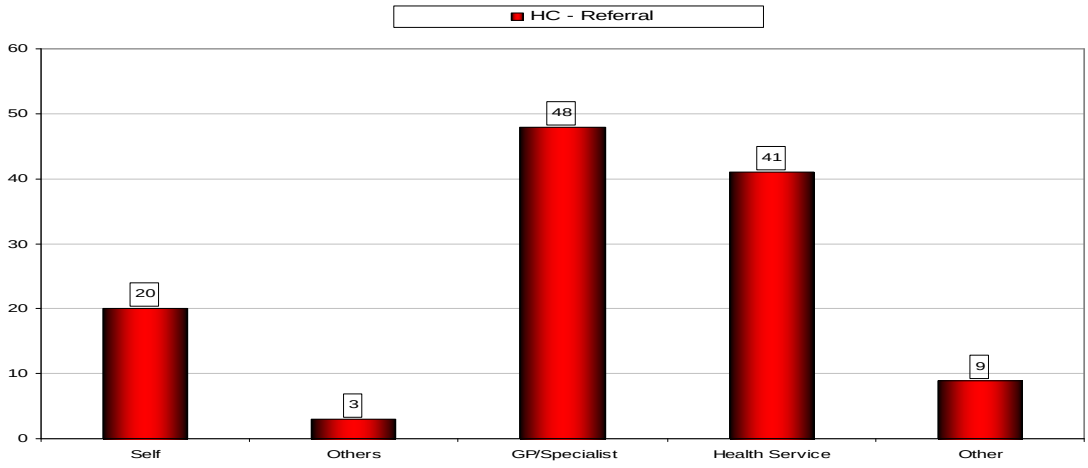


Figure 19. Health Coaching - Main source of referral as identified by respondents



Others – relates to significant other family or friend

The above 4 figures provide a state-wide indicative picture of health coaching. Respondents identified that the approach is useful for people with all chronic conditions, particularly diabetes and cardio-vascular disease.

The approach is amenable to telephone based services, but respondents predominantly provide health coaching face-to-face within a health services or community health service setting. Referrals for health coaching services was reported as being predominantly from within health services and general practice.

Group based self-management support services

In terms of group based self-management support interventions, the mapping sought information about Stanford and other 'generic' group programs that provided self-management support based on the criteria as outlined in the self-management support guide. The 'generic' group programs are based on the principles of self-management.

Information reported in this section was difficult to analyse for a number of reasons including the variability in the understanding of self-management support leading to a significant number of programs being termed self-management. Examples include health promotion activities, exercise groups and education programs. In addition programs were often reported in sessions and not discrete programs. Generic self-management support programs were reported across all regions. Given the limitations outlined it is difficult to make many conclusive statements and as such specific data has not been included in this report.

Stanford Self-Management Program

Across the state there were a total of 102 Stanford groups across 7 regions. The remaining region offered a group, however it did not run due to lack of numbers. A further four regions reported offering the Stanford program but due to limited referrals the programs were cancelled. The average number of participants for the program was reported as 9.64 across the state. This equates to over 980 clients participating in the Stanford self-management program over the 2006-07 financial year. Refer appendix 2 for regional information.

Support needs identified by respondents and potential strategies to address

The following section provides a summary of the information respondents provided to the open ended questions in section 5.1 to 5.3 of the template (refer appendix 1). It explores from the perspective of the practitioner, organisation and PCP catchment what the needs are considered to be to embed self-management support and how the PCP can assist. The responses in this section were free text to promote discussion. Captured responses were then grouped into themes and collated for the purpose of analysis.

Table 2. Self-management support needs for **practitioners** and how the PCP may assist by themes

Practitioner Needs	**Number of Responses**	**PCP role**	**Number of Responses**
Training	146	Coordinate / facilitate training	87
Clarification of organisational direction	53	Provide / source funding	31
Mentoring / ongoing support structure	39	Coordinate / facilitate networks	30
Resources (tools and case studies)	26	Service coordination support	20
Supportive organisational culture	21	Resources – source / provide	16
Increased awareness / understanding of self-management	17	Assist organisations with change management	13
Service coordination – including care planning	16	Increase awareness and understanding of self-management	10
Management support	13	Other	27
Other	21		

The above table demonstrates the overwhelming need for further training in self-management support approaches, including understanding the benefits of self-management support and how self-management support can be implemented into practice. Clarification of the role of self-management within the organisation (from senior management) was identified as a key need. This included self-management support being reflected in organisational policies and procedures and also position descriptions. A common response highlighted the need for on going support structures and/or mentoring to assist in enhancing and embedding the skills learnt during the training.

The table also illustrates the ways respondents believe PCPs can assist. Training was the highest recorded theme. This was followed by suggesting PCPs provide funding to progress self-management support work and also that PCPs facilitate a network to share learnings and provide on going professional development opportunities. It was interesting to note that service coordination was a key theme. Responses that were themed service coordination included identification of client self-management support needs (assessment), care planning, knowledge of available services for referral and working as a multi-disciplinary team. Supporting agencies with change management also rated highly.

Table 3. Self-management support needs at the **organisational level** and how the PCP may assist by themes

Organisational Needs	**Number of responses**	**PCP role**	**Number of responses**
Implementation support	78	Facilitation of networks – strategic and operational	59
Training	59	Training – coordinate / facilitate	38
Access to resources and funding	41	Source / provide funding	21
Review of organisational practices and planning	41	Service coordination	17
Board / Management support for change	38	Support planning and evaluation activities	14
Understanding of self-management philosophy and practice	24	Support organisations with change management	9
Service Coordination	9	Other	39
Other	24		

The table outlines that identified needs at an organisational level requires to embed self-management support into practice. Support for implementation, followed by training and access to funding and resources were the most common themes. The potential PCP role was identified as facilitation of networks to support implementation by 59 respondents. Training and funding were key themes identified by 38 and 21 respondents respectively. Again it is interesting to note that service coordination featured as a key theme by 17 respondents.

Table 4. Self-management support needs at the **PCP catchment level** and how the PCP may assist by themes

Needs identified for at PCP catchment level	**Number of responses**	**PCP role**	**Number of responses**
Networks to share information and undertake strategic planning	92	Facilitation of catchment planning	27
Planning across the PCP catchment	78	Networks to share information and communicate	25
Increased awareness and understanding of self-management support	54	Service coordination work	18
Training	32	Partnership and leadership	17
		Support for change management	10
		Funding	6
		Assistance to change culture	4
		Lobby to the department	3
		Tools and resources	3
		Promotion of what the PCP is and does	3
		Other	24

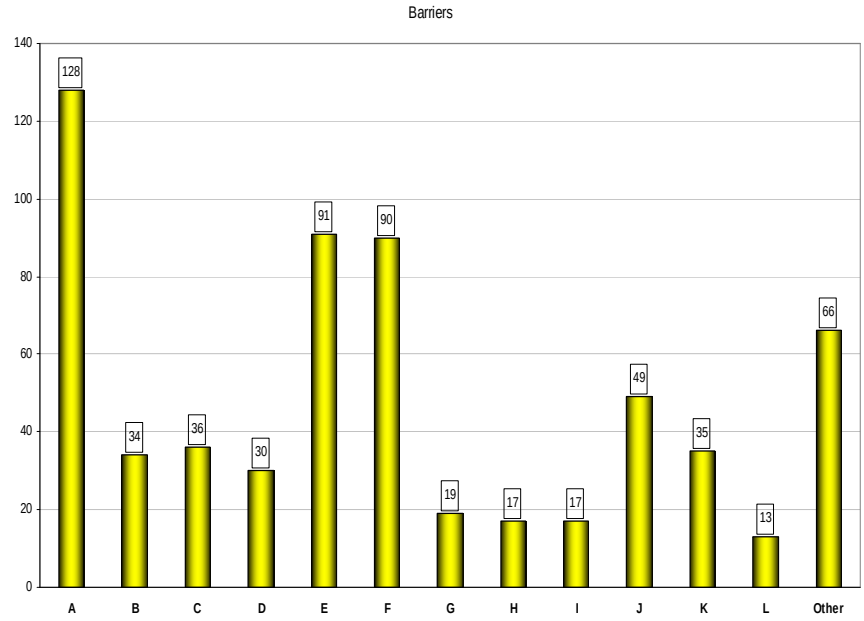
In addressing the impact of chronic disease an understanding of the local catchment is highly important, the majority of respondents reporting a need for networks to share information and also undertake strategic planning reflecting this. In addition, respondents saw a need for increasing the awareness and understanding of self-management support for both health professionals and managers and the broader community.

Catchment planning and facilitating information sharing and communication were seen as a primary role for the PCP. Improving or enhancing service coordination was identified as a way in which PCPs could progress self-management support activities.

Barriers and enablers to embedding self-management support

This section reports the barriers and enablers as identified by respondents to embedding self-management support as an organisation. The responses illustrate the challenges and also highlight the key requirements to successfully embed self-management support into practice.

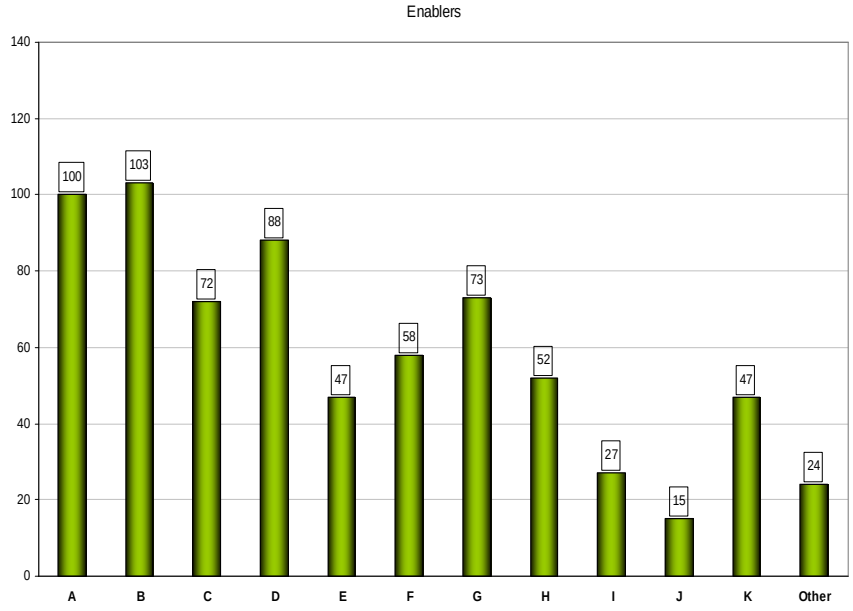
Figure 20. Barriers to providing self-management support at an agency level.



Key:
A – Limited access to self-management training
B – High staff turn over
C- Low demand for self-management interventions
D – Limited facilitation of change management re ICDM including self-management support
E – Time interventions take
F – Other priorities for clinicians
G – Venue availability
H – Venue capacity
I – Peer leader availability (Stanford only)
J – Limited referrals from general practice
K – Staff resistance to change practice
L – Lack of management support
M - Other

Figure 20 highlights the key barriers for agencies in providing self-management support. Access to training, the time self-management support interventions take and other priorities for clinicians were identified as the 3 major barriers to providing self-management support to clients.

Figure 21. Enablers to providing self-management support at an agency level.



Key:
A – Access to self-management training
B – Clinician willingness to change practice
C- High level of staff retention
D – Systems in place to routinely identify self-management support needs of clients
E – High demand for self-management interventions (including GP referral)
F – Internal agency support to facilitate ICDM including provision of self-management support
G – Management support for self-management as part of ICDM
H – Venue availability (for group programs)
I – Venue capacity (for group programs)
J – Peer leader availability (Stanford only)
K – Client understand of self-management principles
L – Other

Clinician willingness to change practice, access to training and systems in place to routinely identify self-management support needs of clients were identified as the top three enablers to embed self-management support as a practice within an agency. Management support and staff retention also rated highly.

Divisions of General Practice results

The template for responses from Divisions of General Practice was a modified version of the generic template. The rationale for this was that Divisions of General Practice are not usually direct service providers and have a specific role in supporting General Practice. In analysing the data, given the small number of respondent, the data is reported as a statewide aggregate.

Twenty-two of the 30 Divisions of General Practice participated in the self-management mapping exercise. Of these 13 Divisions of General Practice were based in rural Victoria. This equates to 22 PCP catchments, however it must be noted that the Division and PCP boundaries do not align in a number of instances.

The Divisions of General Practice respondents reported that they provide support to General Practice to assist with interpreting and using MBS items (2)[7], lifescripts (5), promotion of services for client clients with chronic conditions (15), and self-management support services specifically (5) and training (8). The Division provides this support to assist with referral to services through:

- Practice support visits – 15
- Professional development and information sessions – 4
- Written communications – 12
- Dedicated referral support services (including General Practice Liaison Officers) - 5

Table 5. Represents the number (and type) of staff trained in self-management support interventions by approach through training facilitated by the Division of General Practice

Approach	**Number Practice nurses**	**Number General Practitioners**	**Number of GP practices**
Flinders	3	0	Not stated
Stanford	2	0	Not stated
MI	92	10	51
Other	120	8	81

The column other includes specific modules such as diabetes education, asthma education, lifescripts and care planning. The data highlights the growing interest in self-management support as part of effective chronic disease management. The high number of practice nurses trained in self-management support shows the potential role of the practice nurse in chronic disease related activities.

Of the 22 Divisions of General Practice that responded 3 provided self-management support services through specifically funded activities. In total 51 self-management support group programs were completed with an average of 12 participants per group.

[7] *Bracketed numbers refer to the number of respondents*

Barriers and enablers to providing self-management support

The table illustrates that the key barriers to general practice providing self-management support were:

- Other priorities for clinicians (14)
- Time interventions take (11)
- Limited access to self-management training (9); and
- Staff resistance to practice change (9)

The first 3 barriers identified by the Divisions of General Practice were the same as those identified by respondents completing the generic template. Other priorities for clinicians and time interventions are both related to systems level change required to embed self-management into practice. At a PCP level this may be a consideration for future work.

In focusing on the enablers to embedding self-management support into practice, the Divisions of General Practice identified:

- Clinician willingness to change practice (11)
- Systems in place to routinely identify client self-management support needs (10)
- Access to training (9)

Again, the responses from the Divisions of General Practice were aligned with the enablers identified by other respondents completing the generic template and reflect the need for organisation planning and change to embed self-management support practices.

Potential role of the PCP in progressing self-management support

This section of the template (refer appendix 1) was structured as a series of open ended questions. The intention was to promote discussion. The responses were collated into themes for the purpose of analysis.

Practitioner Level

In addressing the needs of general practice to progress Integrated Chronic Disease Management work, in particular in relation to self-management support 4 key areas of need were identified at the practitioner level:

- Training and professional development (particularly linked to the application in general practice) (8)
- Increased knowledge of the benefits to clients of self-management support (5)
- Increased knowledge of the self-management support services (3)
- Time to provide self-management support (3)

The respondents identified 3 key areas in where PCP could provide support at a practitioner level:

- Training (6)
- Funding (5)
- Culture change (3)

Responses also included assisting with change management and identifying and promoting self-management champions.

Organisational Level

At the organisational level the needs identified to progress self-management support work included:

- Training and Professional development opportunities (5)
- Access to mentoring and support (4)
- Increased knowledge of the benefits of self-management (3); and
- Strategic planning around the role of self-management support and how self-management 'fits' into health service delivery (3)

The Divisions of General Practice reported the role of the PCP in this as:

- Providing and/or coordinating training (5)
- Providing opportunities for networking (3)

Other identified potential roles included continuing to build on the service coordination work, planning, implementation of a self-management quality framework and facilitating partnerships.

PCP Catchment Level

In focusing on what is required to progress self-management work across the PCP catchments, the Divisions of General Practice provided the following responses:

- A network to support both operational and strategic planning (9); and
- Increasing the knowledge and understanding of service available across the catchment (4)

The Divisions reported the role of the PCP platform in this would need to be:

- Facilitation of a strategic (and operational) network (8)

Other suggestions included providing leadership, development of referral pathways and supporting change management activities.

Discussion – what can we learn from the results

The large number of organisations that participated in the self-management mapping exercise, that is 216 individual organisations, demonstrates the strength of the partnership approach in Victoria and that agencies are working as a collective to meet the challenge of managing the impact of chronic disease on our communities. It is evident from the high number of responses and the variety of organisations that Primary Care Partnerships provide an ideal platform for organisations to work together to develop local solutions to meet the needs of their communities.

A significant number of respondents (71%) indicated that chronic disease management was a priority for their organisation. Self-management support was a strategic goal for 67% of respondents. This in itself indicates that organisations are working toward reorientating services to respond to the needs of clients with chronic disease. Historically the health system was designed to respond to accidents, emergencies and infectious disease, all of which, in general, have a resolution. Chronic disease is different. It requires a longer-term series of clinical interventions. Chronic conditions may have periods of exacerbation periodically. Given that chronic conditions rarely have a cure, the partnership between clients and practitioners to minimise the impact of chronic disease is critical. Therefore practitioners having an understanding and skills in self-management support is vital.

The results of the mapping exercise suggest that there has been a large investment by organisations in training and up-skilling staff to improve understanding and to provide self-management support using a variety of approaches. In terms of transferring skills learnt in training into practice the less formally structured health coaching and motivational interviewing appear to be more readily implemented. Comments included as part of the mapping indicated that the flinders care planning approach was highly valuable in providing a sound understanding of self-management support and its role in improving client outcomes for people with chronic disease. A number of agencies have provided training in the flinders approach for staff for this very reason, it provides a sound theoretical base. This is part of the explanation of the gap between training and use of the flinders approach. Other comments relating to the flinders approach suggest that the principles are implemented, however the tools are not used at all times.

The templates completed by the Divisions of General Practice also indicated that self-management information and professional development were required and need to be provided considering the potential role of the provider in the care of the client/s. The purpose of training in self-management and how the training will be used or skills implemented needs to be considered in determining training options. There is currently work being undertaken by the Commonwealth Government to develop competency based training modules around chronic disease management and self-management.

The mapping provided evidence that there is a mixed understanding of what self-management is and its role in chronic disease management. A key enabler to progressing integrated chronic disease management is to ensure that those involved share a common understanding of self-management and roles are clearly articulated. The data included in the mapping related to 'other' self-management support approaches highlights this. This section included a number of activities that may not strictly be considered self-management support such as Tai Chi, exercise classes and a variety of health promotion activities. Such activities provide a vital and essential service to clients; however the primary objective of these activities is not to improve a person's self-efficacy.

A crucial challenge in undertaking the mapping exercise was the limited quantitative data collected about the provision of self-management support as an intervention. This was particularly true for individual self-management support approaches. Given that individual self-management support is gaining increased momentum, there was agreement to capture some information to illustrate that the practice occurring. The information captured is minimal and doesn't provide an insight into the extent of usage or the numbers of clients. It is anticipated that the PCPs will use the data against the local demographic data to assist in planning future work.

The mapping showed that the individual approaches, flinders model of care planning, motivational interviewing and health coaching are most commonly provided by organisations for clients regardless of the chronic condition, followed by diabetes and cardiovascular disease. The disease specific responses may be related to programs within organisations and also be a reflection of the prevalence of these conditions. It is not surprising the most respondents indicated the approaches target all clients and older clients. A small number of respondents indicated that the target group was younger people, Aboriginal and Torres Strait Islands or culturally and linguistically diverse communities. In examining the delivery setting of the interventions community health services and health services were the predominate setting. Over twenty respondents indicated that they provided self-management support service via the telephone.

Interestingly, General Practice was cited as the predominant source of referral followed by health service. This conflicts with comments provided by a significant number of respondents suggesting that referrals for self-management support by general practice were low. It may be due to how referral source is captured and referral being for specific clinical interventions. The need for self-management support may be identified as part of a comprehensive assessment. However, the data does suggest that general practice is exploring opportunities for multi-disciplinary care for clients with chronic conditions more broadly that the provision of self-management support.

In exploring group based self-management programs, the Stanford model is a recognised self-management support program. The Stanford program was offered in every region of the state, however there was one region in which it was offered but due to limited referrals did not run. In four others regions more Stanford programs were offered than were held, this was again related to limited referrals. The mapping exercise also sought information related to other group programs that provided self-management support. As articulated previously, the understanding of self-management support is variable. This has led to a number of group programs being reported as self-management support, such as exercise classes and health promotion activities, which did not strictly meet the self-management support criteria.

What do the findings mean in terms of the Wagner Chronic Care Model

In this section the Wagner Chronic Care Model is used to highlight the findings, the support needs identified by the respondents and how the PCP may support the work. The following table provides a summary, it is not exhaustive or prescriptive, however may assist in progressing work around self-management.

Chronic Care Model element	**Identified support needs**	**Examples of potential strategies to address support needs**	**Potential PCP role**
Organisation of Health Care	- Clarification of organisational direction in relation to self-management support - Increased awareness and understanding of self-management support across services - Knowledge of service availability to support clients with chronic conditions - Time to provide self-management interventions - Mentoring and on going support structures	- Included as part of organisational plan/s - Ensure consistent understanding of self-management support and its benefits - Identify needs and gaps to develop an agreed action plan/s - Progress work to develop protocols and processes - Explore opportunities to address identified training and professional development needs - Include self-management support role in position descriptions	- Networking to share experiences and increase understanding of broader service system - Facilitation of strategic planning group - Facilitate mentoring opportunities to enhance skill development -Facilitate training calendar -Identify options for reducing the variability in understanding of self-management - Assist organisations with change management
Delivery System Design	- Improve service coordination - Identify services available and access	-Develop agreed roles and responsibilities - Identify services providing the various options and how to access - Progress referral pathways for clients with chronic disease	- Build on service coordination activities, ensure work includes a focus on integrated chronic disease management - Provide support in change management
Decision Support	- Review protocols and practices	- Explore options for routinely assessing client self-management capacity	- Consider as part of strategic planning
Clinical Information Systems	- Enhance service coordination practices to ensure agreement across agencies	- Examine capacity to share information, which may include information, clinical information and self-	- Facilitation of network both operational and strategic

		management needs	
Community Resource Mobilisation	- Gain an understanding of services and supports locally available - Develop broader understanding of self-management and its role and benefits	-Work with local community groups to address local needs - Engage local groups to explore ways to increase awareness of the concept of self-management support and its role to the broader community	- Facilitation of local network
Self-Management Support	- Identify training requirements - Provide access to on going support and mentoring opportunities - Resources for both health professionals and consumers - Evaluation of self-management support for continuous improvement purposes	-Provide appropriate training - Provide on going support - Develop systems to routinely audit self-management support activities as part of the quality improvement activities related to chronic disease management - Resources for both health professionals and consumers	- Facilitate networks at both operational and strategic level - Provide support for evaluation - Coordinate training calendar - Research available resources - Provide access to funding to support training

The table is provided as a guide, based on the findings from the self-management mapping statewide data and may not reflect the local findings. It may be a useful tool in future planning work.

Next steps

The self-management mapping exercise was the first such exercise across the state. The key objectives of the mapping were to:

- Build a state-wide picture of self-management support across the state
- Examine at a PCP catchment level current self-management support provided, identify needs based on outcomes of the mapping and inform local analysis of needs
- Develop an action plan for the PCP catchment to build on the existing work in integrated chronic disease management

In summary, key findings of the mapping suggests the following is required to progress this work:

- Improvement of the understanding of the principles of self-management across the various sectors
- Development of a plan to support integrated chronic disease management, including self-management support for PCP catchments
- Influencing of training bodies to include the principles of self-management as a core component of training modules for health professionals
- Provision of training and / or professional development that is relevant to the professionals role
- Exploration of options for providing ongoing support to clinicians engaged in providing self-management support
- Increase the awareness and understanding of the roles of services providers
- Increase health practitioner knowledge and awareness of local services (self-management support, clinician interventions and other community based support programs) and how such services may be accessed
- Consideration of innovative ways to provide self-management support interventions broadly and also to specific target groups should as Culturally and Linguistically Diverse Communities, Aboriginal and Torres Strait Islander Communities. This may also involve exploration of current and newly emerging technology such as web based self-management support.
- Continue to build on the service coordination practice
- Consider self-management support implementation in the context of the 5 other interdependent elements of the Wagner Chronic Care Model

The department is currently reviewing the data to identify key statewide needs and develop a plan to assist and support PCPs develop and implement local action plans. The department is also exploring opportunities to further support integrated chronic disease management activities, including self-management support.

The department is currently working to identify Key Performance Indicators to more accurately reflect integrated chronic disease management. This may include a focus on improved client self-efficacy. This work is in the preliminary stages only. Information from the self-management mapping will inform ongoing development of the Community and Women's Health data set to more accurately reflect integrated chronic disease management.

In terms of ways PCPs (both staff and agencies) can progress the work it is imperative that the local context is taken into consideration when interpreting the findings. As outlined earlier in the report, there

was a number of limitations and assumptions made in undertaking the mapping exercise. It is important for PCPs (group of agencies) work together to use the data to develop an action plan by identifying key gaps and challenges, building on identified strengths and focus on local demographic information.

List of Abbreviations

ACCHO – Aboriginal Community Controlled Health Organisations
NGO – Non-Government Organisation
PCP – Primary Care Partnership (voluntary alliance of organisations)
MI – Motivational Interviewing
HC – Health Coaching
PCP – Primary Care Partnership

Appendix 1. – Generic and Divisions of General Practice templates

Generic Self-Management Mapping Template

This template should be completed using the Self-Management Mapping Guide (SMM Guide). Both the SMM Template and the SMM Guide are available at: http://www.health.vic.gov.au/pcps/.

The template is to be completed by the relevant person in an organisation or where more appropriate, a relevant person in a program area within an organisation with support from their local PCP. Where required, support from DHS is also available.

1. Primary Care Partnership Details (ref. p 14 SMM Guide)

1.1	PCP Name	

2. **Organisation Details** (ref. p 14 SMM Guide)

2.1	Organisation Name	
2.2	Type of organisation	
2.3	Campus / site (if applicable)	
2.4	Program/Department (if applicable)	
2.5	Contact Person – Name	
2.6	Contact Person – Email	
2.7	Contact Person - Phone	

2.8 Is Integrated Chronic Disease Management (ICDM) an organisational priority? **Yes/No**

2.9 Is self-management an organisational strategic goal? **Yes/No**

2.10 Does your organisation provide specific chronic disease management program/s? **Yes/No**

3. Self-Management Staff Profile

(ref: p 15 SMM Guide)

How many staff are trained in the following self-management approaches? And, of these how many are active in service delivery?

	Approach	Number trained	Number completed accreditation (if applicable)	Number providing self-management support	Additional comments
3.1	Flinders				
3.2	Stanford				
3.3	Expert Patient Program (EPP)				
3.4	Motivational Interviewing				
3.5	Health Coaching				
3.6	Action Planning				
3.7	Building Habits				
3.81	Other – please specify				
3.82	Other – please specify				
3.83	Other – please specify				

4. Program based and other approaches (2006/07 only) (ref. p 16-18 SMM Guide)

4.1 Stanford

4.11	Number of groups held in 2006/07	
4.12	Number of groups offered in 2006/07*	
4.13	Average size of groups in 2006/07	

* 4.14 only if relevant	Please explain why the number of groups offered was higher than the number of groups run:

Select one of the following program characteristics for each DISEASE focus program held using the code set supplied*:

Disease Focus	**Target population**	**Delivery setting**	**Most common referral source**
Musculoskeletal - 1	All - 1	Health Service - 1	Self - 1
Cardiovascular - 2	Women - 2	Community Health Service - 2	Significant others - 2
Respiratory - 3	Men - 3	Community setting - 3	GP/Specialist - 3
Diabetes - 4	Older people - 4	Home - 4	Health Service (external) - 4
All chronic disease - 5	Young people - 5	Telephone - 5	Health Service (internal) - 5
Other (specify) -6	ATSI - 6	Other (specify) - 6	Other (specify) - 6
	CALD - 7		
	Other (specify) - 8		

* Please note this table may need to be repeated to allow multiple program details to be recorded.

4.2 Flinders Model

Select one **or more** of the following program characteristics (tick box):

Disease Focus

- ☐ Musculoskeletal
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Diabetes
- ☐ All chronic disease
- ☐ Other

_____

Target population

- ☐ All
- ☐ Women
- ☐ Men
- ☐ Older people
- ☐ Young people
- ☐ ATSI
- ☐ CALD
- ☐ Other

_____

Delivery setting

- ☐ Health Service
- ☐ Community Health Service
- ☐ Community setting
- ☐ Home
- ☐ Telephone
- ☐ Other

_____

Most common referral source

- ☐ Self
- ☐ Significant others
- ☐ GP/Specialist,
- ☐ Health Service
- ☐ Other

_____

4.3 Motivational Interviewing

Select one **or more** of the following program characteristics (tick box):

Disease Focus

- ☐ Musculoskeletal
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Diabetes
- ☐ All chronic disease
- ☐ Other

_____

Target population

- ☐ All
- ☐ Women
- ☐ Men
- ☐ Older people
- ☐ Young people
- ☐ ATSI
- ☐ CALD
- ☐ Other

_____

Delivery setting

- ☐ Health Service
- ☐ Community Health Service
- ☐ Community setting
- ☐ Home
- ☐ Telephone
- ☐ Other

_____

Most common referral source

- ☐ Self
- ☐ Significant others
- ☐ GP/Specialist,
- ☐ Health Service
- ☐ Other

_____

4.4 Health Coaching

Select one **or more** of the following program characteristics (tick box):

Disease Focus	**Target population**	**Delivery setting**	**Most common referral source**
☐ Musculoskeletal	☐ All	☐ Health Service	☐ Self
☐ Cardiovascular	☐ Women	☐ Community Health Service	☐ Significant others
☐ Respiratory	☐ Men	☐ Community setting	☐ GP/Specialist,
☐ Diabetes	☐ Older people	☐ Home	☐ Health Service
☐ All chronic disease	☐ Young people	☐ Telephone	☐ Other
☐ Other	☐ ATSI	☐ Other	_____
_____	☐ CALD	_____	
	☐ Other		
	_____		

4.5 Disease Specific and Other self-management approaches - Please specify

4.51	Number of groups held in 2006/07	
4.52	Number of groups offered in 2006/07*	
4.53	Average size of groups in 2006/07	
4.54	Does the approach/s meet the criteria (refer p 11 of SMM guide)	

* 4.55 only if relevant	Please explain why the number of groups offered was higher than the number of groups run:

Select one of the following program characteristics for each DISEASE focus program held*:

Disease Focus	**Target population**	**Delivery setting**	**Most common referral source**
Musculoskeletal - 1	All - 1	Health Service - 1	Self - 1
Cardiovascular - 2	Women - 2	Community Health Service - 2	Significant others - 2
Respiratory - 3	Men - 3	Community setting - 3	GP/Specialist - 3
Diabetes - 4	Older people - 4	Home - 4	Health Service (external) - 4
All chronic disease - 5	Young people - 5	Telephone - 5	Health Service (internal) - 5
Other (specify) -6	ATSI - 6	Other (specify) - 6	Other (specify) - 6
	CALD - 7		
	Other (specify) - 8		

* Please note this table may need to be repeated to allow multiple program details to be recorded.

4.6 Additional comments:

5. Supporting Implementation and Embedding of Self-Management

(ref. p 18-19 SMM Guide)

	What is needed to further embed self-management into practice	How can the PCP support this?
5.1	At the practitioner level	
5.2	At the organisational level	
5.3	At the PCP catchment level	

5.4 Is feedback about self-management support provided to general practitioners as part of client care?

Routinely ☐ Sometimes ☐ Occasionally ☐ Never ☐

5.5 What are the **barriers** to providing self-management support at an agency level?
Select up to three of the following.

A	Limited access to self-management training	☐
B	High staff turn over	☐
C	Low demand for self-management interventions	☐
D	Limited facilitation of change management re ICDM including self-management support	☐
E	Time interventions take	☐
F	Other priorities for clinicians	☐
G	Venue availability	☐
H	Venue capacity	☐
I	Peer leader availability (Stanford only)	☐
J	Limited referrals from general practice	☐
K	Staff resistance to change practice	☐
L	Lack of management support	☐
M	Other: please specify	☐

5.6 What are the **enablers** to providing self-management support at an agency level?
Select up to three of the following as are appropriate.

A	Access to self-management support training	
B	Clinician willingness to change practice	
C	High level of staff retention	
D	Systems in place to routinely identify self-management support needs of client	
E	High demand for self-management interventions (including referral from general practice)	
F	Internal agency support to facilitate ICDM including provision of self-management support	
G	Management support for self-management as part of ICDM	
H	Venue availability (for group programs)	
I	Venue capacity (for group programs)	
J	Peer leader availability (Stanford only)	
K	Client understanding of self-management principles	
L	Other: please specify	

Division of General Practice Self-Management Mapping Template

This template is designed to provide an overview of self-management support within the General Practice environment. It should be completed using the Self-Management Mapping Guide (SMM Guide) which together with the SMM (DivGP) template, is available on line at: http://www.health.vic.gov.au/pcps/

The template is to be completed by the relevant person in a Division of General Practice or where appropriate a person in a general practice with support from their local PCP. Where required, support from DHS is also available.

3. Primary Care Partnership Details (ref. p 14 SMM Guide)

1.1 PCP/s Name	

4. Organisation Details (ref. p 14, p 20 SMM Guide)

2.1 Organisation Name	
2.2 Type of organisation	Division of General Practice
2.3 Areas covered – list postcodes	
2.4 Contact Person – Name	
2.5 Contact Person – Email	
2.6 Contact Person - Phone	

2.7 What are the specific self-management programs that your Division promotes?
Please list / describe. (refer section 3 of SMM Guide)

2.8 In what ways is the Division supporting GP referral to these programs / services?

Is support provided via written information or is information provided face to face and/or tailored to practices eg practice visits?

3. Self-management courses/training facilitated by the Division of General Practice during the 2006-07 financial year for practice nurses and general practitioners.

(ref. P9-13, 20-21 SMM Guide)

	Approach	Number practice nurses trained	Number General Practitioner trained	Number of General Practices involved	Number completed / accredited*	Additional comments
3.1	Flinders					
3.2	Stanford					
3.3	Motivational Interviewing					
3.41	Other – please specify					
3.42	Other – please specify					
3.43	Other – please specify					

* N/A if unknown

4. Program based and other approaches (2006/07 only) (refer p 16-18 SMM Guide)

Did the Division provide any of the following self-management approaches? Yes/No
If yes, please complete the following as appropriate:

4.1 Stanford

4.11	Number of groups held in 2006/07	
4.12	Number of groups offered in 2006/07*	
4.13	Average size of groups in 2006/07	

* 4.14 only if relevant	Please explain why the number of groups offered was higher than the number of groups run:

Select one of the following program characteristics for each DISEASE focus program convened using the code set provided*:

Disease Focus	**Target population**	**Delivery setting**	**Most common referral source**
Musculoskeletal - 1	All - 1	Health Service - 1	Self - 1
Cardiovascular - 2	Women - 2	Community Health Service - 2	Significant others - 2
Respiratory - 3	Men - 3	Community setting - 3	GP/Specialist - 3
Diabetes - 4	Older people - 4	Home - 4	Health Service (external) - 4
All chronic disease - 5	Young people - 5	Telephone - 5	Health Service (internal) - 5
Other (specify) -6	ATSI - 6	Other (specify) - 6	Other (specify) - 6
	CALD - 7		
	Other (specify) - 8		

* Please note this table may need to be repeated to allow multiple program details to be recorded.

4.2 Flinders Model

Select one **or more** of the following program characteristics (tick box):

Disease Focus	Target population	Delivery setting	Most common referral source
☐ Musculoskeletal	☐ All	☐ Health Service	☐ Self
☐ Cardiovascular	☐ Women	☐ Community Health Service	☐ Significant others
☐ Respiratory	☐ Men	☐ Community setting	☐ GP/Specialist,
☐ Diabetes	☐ Older people	☐ Home	☐ Health Service
☐ All chronic disease	☐ Young people	☐ Telephone	☐ Other
☐ Other	☐ ATSI	☐ Other	_____
_____	☐ CALD	_____	
	☐ Other		
	_____		

4.3 Motivational Interviewing

Select one **or more** of the following program characteristics (tick box):

Disease Focus	Target population	Delivery setting	Most common referral source
☐ Musculoskeletal	☐ All	☐ Health Service	☐ Self
☐ Cardiovascular	☐ Women	☐ Community Health Service	☐ Significant others
☐ Respiratory	☐ Men	☐ Community setting	☐ GP/Specialist,
☐ Diabetes	☐ Older people	☐ Home	☐ Health Service
☐ All chronic disease	☐ Young people	☐ Telephone	☐ Other
☐ Other	☐ ATSI	☐ Other	_____
_____	☐ CALD	_____	
	☐ Other		
	_____		

4.4 Health Coaching

Select one **or more** of the following program characteristics (tick box):

Disease Focus	**Target population**	**Delivery setting**	**Most common referral source**
☐ Musculoskeletal	☐ All	☐ Health Service	☐ Self
☐ Cardiovascular	☐ Women	☐ Community Health Service	☐ Significant others
☐ Respiratory	☐ Men	☐ Community setting	☐ GP/Specialist,
☐ Diabetes	☐ Older people	☐ Home	☐ Health Service
☐ All chronic disease	☐ Young people	☐ Telephone	☐ Other
☐ Other	☐ ATSI	☐ Other	_____
_____	☐ CALD	_____	
	☐ Other		
	_____		

4.5 Disease Specific and Other self-management approaches - please specify

4.51	Number of groups held in 2006/07	
4.52	Number of groups offered in 2006/07*	
4.53	Average size of groups in 2006/07	
4.54	Does the approach/s meet the criteria to be considered an evidence based approach to self-management support (refer p 11 of SMM guide)	

* 4.55 only if relevant	Please explain why the number of groups offered was higher than the number of groups run:

Select one of the following program characteristics for each DISEASE focus program convened using the code set provided *:

Disease Focus	**Target population**	**Delivery setting**	**Most common referral source**
Musculoskeletal - 1	All - 1	Health Service - 1	Self - 1
Cardiovascular - 2	Women - 2	Community Health Service - 2	Significant others - 2
Respiratory - 3	Men - 3	Community setting - 3	GP/Specialist - 3
Diabetes - 4	Older people - 4	Home - 4	Health Service (external) - 4
All chronic disease - 5	Young people - 5	Telephone - 5	Health Service (internal) - 5
Other (specify) -6	ATSI - 6	Other (specify) - 6	Other (specify) - 6
	CALD - 7		
	Other (specify) - 8		

* Please note this table may need to be repeated to allow multiple program details to be recorded.

4.6 Additional comments:

5. Supporting Implementation and Embedding of Self-Management

(refer p 18-19 SMM Guide)

	What is needed to further embed self-management into practice	How can the PCP support this?
5.1	At the practitioner level	
5.2	At the organisational level	
5.3	At the PCP catchment level	

5.4 Is feedback about self-management support provided to general practitioners as part of client care?

Routinely ☐ Sometimes ☐ Occasionally ☐ Never ☐

5.5 What are the **barriers** to providing self-management support at a Division/practice level? *Select up to three of the following as are appropriate.*

A	Limited access to self-management training	
B	High staff turn over	
C	Low demand for self-management interventions	
D	Limited facilitation of change management re ICDM including self-management support	
E	Time interventions take	
F	Other priorities for clinicians	
G	Venue availability	
H	Venue capacity	
I	Peer leader availability (Stanford only)	
J	Limited referrals options	
K	Staff resistance to change practice	
L	Lack of management support	
M	Other: please specify	

5.6	What are the **enablers** to providing self-management support at a Division/practice level? *Select up to three of the following as are appropriate.*	
A	Access to self-management support training	
B	Clinician willingness to change practice	
C	High level of staff retention	
D	Systems in place to routinely identify self-management support needs of client	
E	High demand for self-management interventions (including referrals)	
F	Internal practice support to facilitate ICDM, including provision of self-management support	
G	Management support for self-management as part of ICDM	
H	Venue availability (for group programs)	
I	Venue capacity (for group programs)	
J	Peer leader availability (Stanford only)	
K	Client understanding of self-management principles	
L	Other: please specify	

Appendix 2. Graphical representation of organisational details by DHS regions

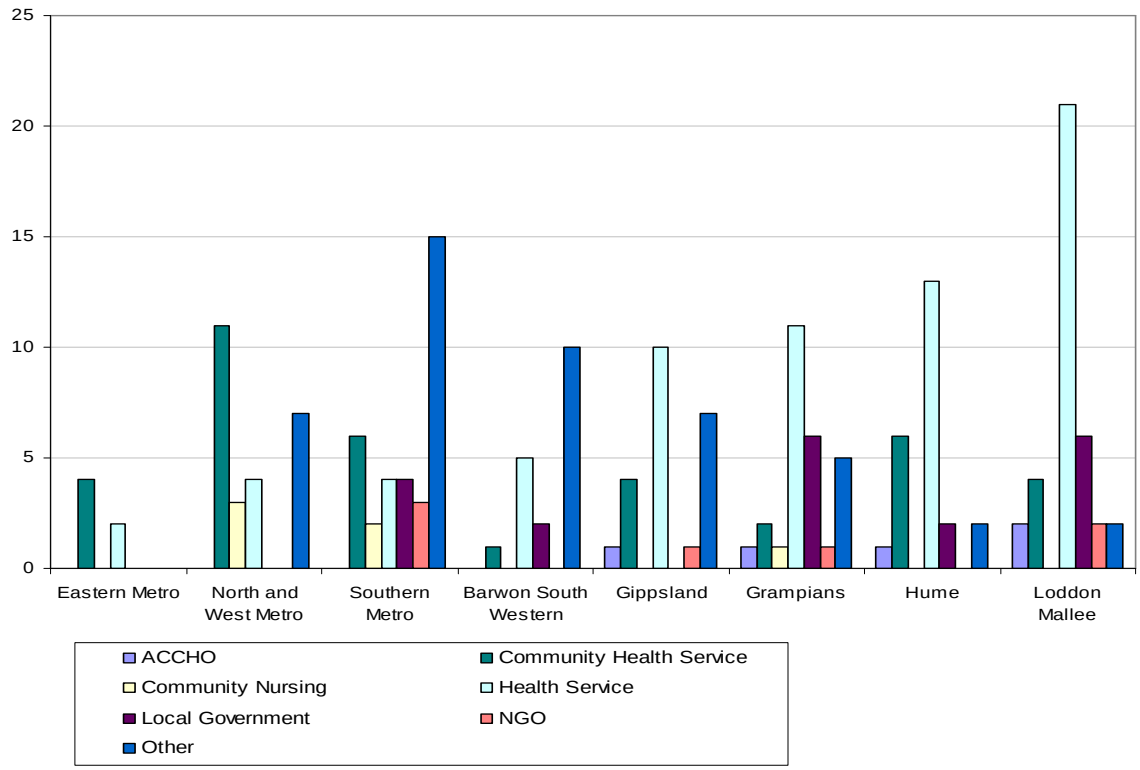
(excludes Divisions of General Practice)

Figure below illustrates the number organisation (by type) that participated in the self-management mapping

Region	ACCHO	Community Health Service	Community Nursing	Health Service	Local Government	NGO	Other
Eastern Metro	0	4	0	2	0	0	0
North and West Metro	0	11	3	4	0	0	7
Southern Metro	0	6	2	4	4	3	15
Barwon South Western	0	1	0	5	2	0	10
Gippsland	1	4	0	10	0	1	7
Grampians	1	2	1	11	6	1	5
Hume	1	6	0	13	2	0	2
Loddon Mallee	2	4	0	21	6	2	2

The above table illustrates the regional breakdown of the number and type of organisations (excluding Divisions of General Practice) that participated in the self-management mapping exercise. This provides an insight into the variety of organisation types from health services, local government to non-government organisations. The 'other' column includes private allied health providers, community groups and residential facilitates.

The figure below is a graphical representation of organisations that participated in the self-management mapping (excluding divisions of general practice) by DHS region.



Region	Type of Organisation	Yes	No	not stated
Eastern Metro	Community Health Service	4	0	0
	Health Service	1	0	1
North and West Metro	Community Health Service	11	0	0
	Community Nursing	3	0	0
	Health Service	3	1	0
	Other	4	3	0
Southern Metro	Community Health Service	6	0	0
	Community Nursing	1	1	0
	Health Service	3	0	1
	Local Government	0	4	0
	NGO	1	2	0
	Other	6	9	0
Barwon South Western	Community Health Service	1	0	0
	Health Service	4	0	1
	Local Government	1	1	0
	Other	9	1	0
Gippsland	ACCHO	1	0	0
	Community Health Service	4	0	0
	Health Service	10	0	0
	NGO	1	0	0
	Other	2	5	0
Grampians	ACCHO	1	0	0
	Community Health Service	2	0	0
	Community Nursing	0	1	0
	Health Service	10	1	0
	Local Government	0	6	0
	NGO	1	0	0
	Other	2	3	0
Hume	ACCHO	1	0	0
	Community Health Service	5	1	0
	Health Service	12	1	0
	Local Government	0	2	0
	Other	2	0	0
Loddon Mallee	ACCHO	2	0	0
	Community Health Service	4	0	0
	Health Service	17	3	1
	Local Government	1	5	0
	NGO	1	1	0
	Other	1	1	0

This table is in response to the question 'Is integrated chronic disease management an organisational priority'.

The table demonstrates that the majority of health services and community health services identify chronic disease as a priority for the organisation. Local government and 'other' are more likely to have reported 'no'.

The table below provides regional information regarding self-management as an identified organisational strategic goal

Region	Type of Organisation	Yes	No	Not stated
Eastern Metro	Community Health Service	4	0	0
	Health Service	0	1	1
North and West Metro	Community Health Service	7	4	0
	Community Nursing	2	1	0
	Health Service	3	1	0
	Other	4	3	0
Southern Metro	Community Health Service	4	2	0
	Community Nursing	0	2	0
	Health Service	3	0	1
	Local Government	4	0	0
	NGO	3	0	0
	Other	12	3	0
Barwon South Western	Community Health Service	1	0	0
	Health Service	5	0	0
	Local Government	2	0	0
	Other	8	2	0
Gippsland	ACCHO	0	1	0
	Community Health Service	1	0	3
	Health Service	4	6	0
	NGO	0	1	0
	Other	3	4	0
Grampians	ACCHO	0	1	0
	Community Health Service	1	1	0
	Community Nursing	1	0	0
	Health Service	5	6	0
	Local Government	3	3	0
	NGO	1	0	0
	Other	2	3	0
Hume	ACCHO	1	0	0
	Community Health Service	6	0	0
	Health Service	10	3	0
	Local Government	1	1	0
	Other	2	0	0
Loddon Mallee	ACCHO	2	0	0
	Community Health Service	4	0	0
	Health Service	17	3	1
	Local Government	1	5	0
	NGO	2	0	0
	Other	2	0	0

The table below relates to the provision of specific chronic disease management program/s by organisations

Region	Type of Organisation	Yes	No	Not stated
Eastern Metro	Community Health Service	4	0	0
	Health Service	1	0	1
North and West Metro	Community Health Service	11	0	0
	Community Nursing	2	1	0
	Health Service	4	0	0
	Other	4	3	0
Southern Metro	Community Health Service	4	1	1
	Community Nursing	1	1	0
	Health Service	2	1	1
	Local Government	0	4	0
	NGO	1	2	0
	Other	4	11	0
Barwon South Western	Community Health Service	1	0	0
	Health Service	5	0	0
	Local Government	0	1	1
	Other	6	4	0
Gippsland	ACCHO	0	1	0
	Community Health Service	3	1	0
	Health Service	8	2	0
	NGO	1	0	0
	Other	1	6	0
Grampians	ACCHO	1	0	0
	Community Health Service	2	0	0
	Community Nursing	1	0	0
	Health Service	10	1	0
	Local Government	0	6	0
	NGO	0	1	0
	Other	4	1	0
Hume	ACCHO	1	0	0
	Community Health Service	4	2	0
	Health Service	10	3	0
	Local Government	0	2	0
	Other	1	1	0
Loddon Mallee	ACCHO	2	0	0
	Community Health Service	4	0	0
	Health Service	15	6	0
	Local Government	0	6	0
	NGO	1	1	0
	Other	1	1	0

Appendix 3. – Graphical representation of self-management support provision by DHS region

(excludes Divisions of General Practice)

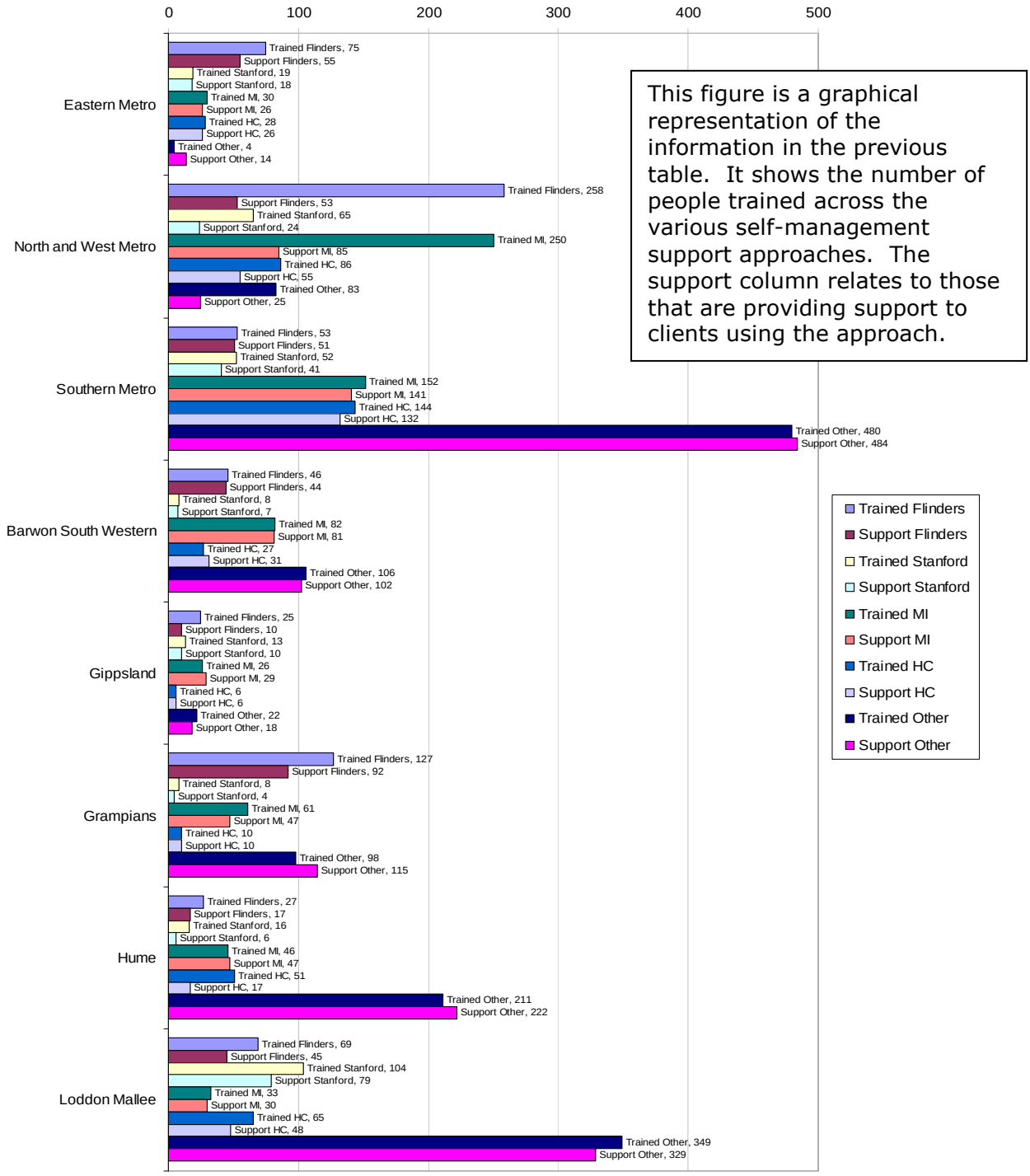
The table below provides a snapshot by regions of health professional trained in and providing self-management support by evidence-based approach. The table reports a head count and not FTE. Practitioner may be trained in multiple interventions and represented more than once.

	Trained	Providing Support	Trained	Providing Support	Trained	Providing Support	Trained	Providing Support	Trained	Providing Support
Staff Trained	**Flinders**	**Flinders**	**Stanford**	**Stanford**	**MI**	**MI**	**HC**	**HC**	**Other**	**Other**
Eastern Metro	75	55	19	18	30	26	28	26	4	14
North and West Metro	258	53	65	24	250	85	86	55	83	25
Southern Metro	53	51	52	41	152	141	144	132	480	484
Barwon South Western	46	44	8	7	82	81	27	31	106	102
Gippsland	25	10	13	10	26	29	6	6	22	18
Grampians	127	92	8	4	61	47	10	10	98	115
Hume	27	17	16	6	46	47	51	17	211	222
Loddon Mallee	69	45	104	79	33	30	65	48	349	329

The table illustrates that across the metropolitan and rural regions the number of practitioners using self-management support approaches in practice is varied. This may be related to the local environment and what the local services determined to be the most appropriate configuration to provide self-management support to meet local needs. For example; specific services may be the local provider of self-management services, with other agencies providing the clinical care. Alternatively, training may have been provided to a number of practitioners within organisations to incorporate into practice.

In interpreting the data the above factors need to be considered. In addition the data collection mechanism may have impacted on the data captured. For example Eastern Metropolitan region PCPs tended to focus the mapping on specific services providing chronic disease management services, whereas other regions appeared to capture activity from a broader range of providers.

A proxy for gauging the level of understanding of what self-management support may be using the figures reported in the 'other' column. A higher figure may suggest that further work is required to improve the understanding of self-management. Again, this needs to be used cautiously and the considered in line with the statements made above.



This figure is a graphical representation of the information in the previous table. It shows the number of people trained across the various self-management support approaches. The support column relates to those that are providing support to clients using the approach.

The tables below provide a regional breakdown of the Stanford programs provided and offered and the average group size over the 2006-07 financial year.

Groups Held & Offered	Stanford Groups Held	Stanford Groups Offered	Average size
Eastern Metro	11	11	9.0
North and West Metro	14	18	9.8
Southern Metro	13	8	12.4
Barwon South Western	22	23	9.8
Gippsland	13	17	7.7
Grampians	11	12	10.5
Hume	0	1	0.0
Loddon Mallee	18	16	8.3

The following 4 tables relate to flinders care planning and provide a regional summary of disease focus, target population, delivery setting and main source of referral

Flinders Model – Disease focus

	Musculoskeletal	Cardiovascular	Respiratory	Diabetes	All Chronic Disease	Other
Eastern Metro	1	2	2	3	2	0
North and West Metro	0	1	1	2	8	0
Southern Metro	1	1	2	2	3	0
Barwon South Western	0	8	5	5	5	3
Gippsland	0	2	0	1	3	0
Grampians	3	2	2	4	6	4
Hume	0	2	2	3	5	2
Loddon Mallee	1	4	3	7	10	1

Flinders Model – Target Population

	All	Women	Men	Older people	Young people	ATSI	CALD	Other
Eastern Metro	2	0	0	1	0	0	1	1
North and West Metro	10	0	0	0	0	0	3	0
Southern Metro	1	1	1	3	1	0	0	0
Barwon South Western	6	0	0	5	0	1	0	0
Gippsland	3	2	2	0	0	0	2	0
Grampians	8	1	1	3	0	1	1	1
Hume	6	0	0	1	0	0	0	2
Loddon Mallee	10	0	0	1	0	2	0	3

Flinders Model – Delivery Setting

	Health Service	Community Health Service	Community setting	Home	Telephone	Other
Eastern Metro	1	4	1	2	3	0
North and West Metro	5	6	3	3	3	1
Southern Metro	1	2	0	1	0	0
Barwon South Western	8	4	2	2	0	0
Gippsland	5	0	0	0	0	0
Grampians	5	4	2	3	0	0
Hume	6	6	3	3	2	0
Loddon Mallee	5	5	7	5	1	1

Flinders Model – Main source of referral

	Self	Others	GP/Specialist	Health Service	Other
Eastern Metro	0	0	3	2	1
North and West Metro	2	1	7	7	0
Southern Metro	0	0	2	1	0
Barwon South Western	7	0	6	7	0
Gippsland	0	0	2	4	0
Grampians	5	0	6	7	2
Hume	2	0	7	4	2
Loddon Mallee	5	0	8	10	1

Motivational Interviewing – Disease Focus

	Musculo-skeletal	Cardiovascular	Respiratory	Diabetes	All Chronic Disease	Other
Eastern Metro	0	1	1	2	4	0
North and West Metro	1	5	2	5	6	2
Southern Metro	1	2	2	5	4	5
Barwon South Western	1	2	2	0	3	3
Gippsland	0	2	1	5	4	1
Grampians	1	1	1	3	6	3
Hume	1	3	2	2	2	2
Loddon Mallee	1	4	1	3	7	0

Motivational Interviewing – Target Population

	All	Women	Men	Older people	Young people	ATSI	CALD	Other
Eastern Metro	3	1	1	0	0	1	0	1
North and West Metro	10	0	0	2	0	0	1	0
Southern Metro	12	1	1	2	1	0	0	1
Barwon South Western	6	0	1	2	0	0	0	0
Gippsland	7	2	2	1	0	0	0	0
Grampians	8	1	1	1	0	1	1	0
Hume	4	0	0	1	0	0	0	1
Loddon Mallee	9	1	1	1	1	0	0	0

Motivational Interviewing – Delivery Setting

	Health Service	Community Health Service	Community setting	Home	Telephone	Other
Eastern Metro	2	4	3	4	3	0
North and West Metro	3	9	5	6	5	0
Southern Metro	6	3	2	4	1	1
Barwon South Western	5	2	0	2	1	1
Gippsland	6	4	0	0	3	0
Grampians	5	6	0	2	0	0
Hume	5	3	3	3	2	0
Loddon Mallee	5	7	3	3	4	2

Motivational Interviewing – Main Source of Referral

	Self	Others	GP/Specialist	Health Service	Other
Eastern Metro	2	0	3	3	2
North and West Metro	0	0	4	8	0
Southern Metro	6	2	7	8	3
Barwon South Western	6	1	5	5	2
Gippsland	4	0	5	3	0
Grampians	5	0	5	5	2
Hume	1	0	4	3	0
Loddon Mallee	4	1	9	5	1

The tables above identify that this approach is used across all regions. Two regions had respondents identifying that the approach is used for young people. The telephone was seen an appropriate delivery mode for this approach with seven of the eight regions providing motivational interviewing phone based.

The four tables below illustrate the regional use of Health Coaching.

Health Coaching – Disease Focus

	Musculoskeletal	Cardiovascular	Respiratory	Diabetes	All Chronic Disease	Other
Eastern Metro	0	2	1	1	2	1
North and West Metro	2	4	3	6	5	0
Southern Metro	0	3	1	4	5	3
Barwon South Western	0	6	4	3	4	1
Gippsland	1	2	1	1	1	0
Grampians	4	5	1	5	2	3
Hume	1	1	2	5	3	1
Loddon Mallee	3	2	2	4	9	2

Health Coaching – Target Population

	All	Women	Men	Older people	Young people	ATSI	CALD	Other
Eastern Metro	1	0	0	0	0	0	0	2
North and West Metro	8	0	0	0	0	0	0	0
Southern Metro	13	0	0	1	0	0	0	0
Barwon South Western	5	0	0	4	0	1	0	0
Gippsland	4	2	2	0	0	0	0	0
Grampians	5	0	0	1	1	0	0	1
Hume	6	0	0	1	0	0	0	1
Loddon Mallee	11	1	1	1	1	1	0	0

Health Coaching – Delivery setting

	Health Service	Community Health Service	Community setting	Home	Telephone	Other
Eastern Metro	2	2	0	2	2	0
North and West Metro	5	6	4	3	4	0
Southern Metro	6	5	0	3	1	0
Barwon South Western	5	4	2	2	0	0
Gippsland	3	2	0	0	1	0
Grampians	1	6	0	1	3	1
Hume	5	6	2	3	2	0
Loddon Mallee	9	8	2	8	7	2

Health Coaching – Main Source of Referral

	Self	Others	GP/Specialist	Health Service	Other
Eastern Metro	0	0	1	1	0
North and West Metro	0	0	7	8	1
Southern Metro	4	1	7	7	2
Barwon South Western	4	1	6	7	0
Gippsland	2	0	4	3	0
Grampians	3	0	5	3	4
Hume	0	0	6	3	2
Loddon Mallee	7	1	12	9	0

The above table highlight the use of this approach across the state by regions and demonstrates that this approach is used for a range of disease states and target populations. There were no regions that reported this approach being used for CALD populations specifically. There were a high number of respondents using this approach phone based.