A framework to support **Self Management**

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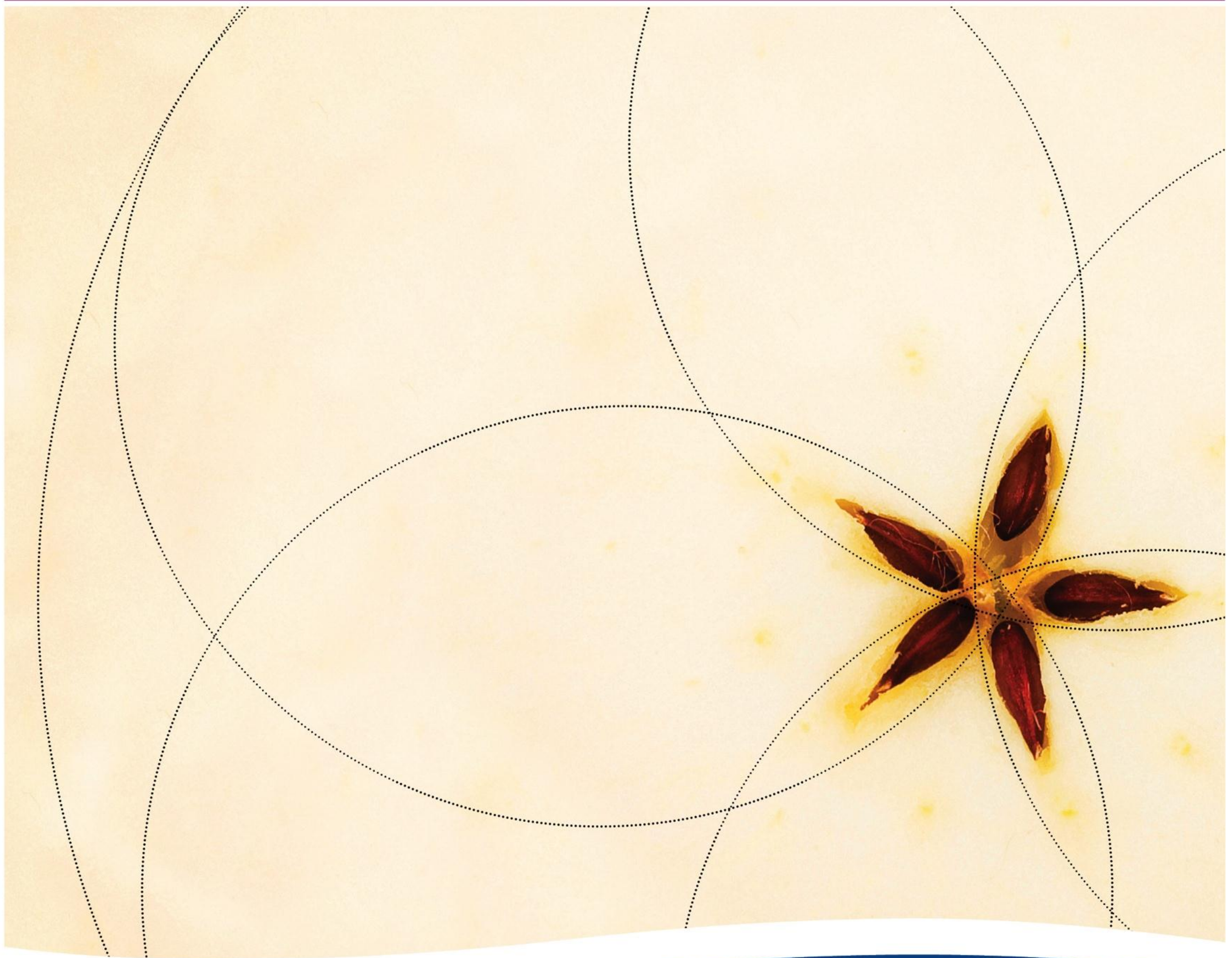

Department of Health and Human Services

Tasmania
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FOREWORD

Chronic conditions now contribute over seventy per cent of Australia's total disease burden, and this is set to increase to eighty per cent by 2020 (AIHW 2008). Tasmania has the highest proportion of people aged 65 and over, along with one of the highest rates of chronic conditions of all Australian states and territories.

For most people with chronic conditions, the condition is not their first priority or focus and they live their lives in spite of their symptoms and disabilities (Wagner et al 2001).

Unlike acute health conditions, significant responsibility for managing a chronic condition rests with the person living with that condition. Every day they make decisions which affect the management of their chronic conditions - without advice from health professionals (Battersby et al 2009). In other words, they self manage to varying extents and play an active role in making decisions about their own treatment and health management.

Self management can provide benefits for services as well as improved health outcomes and quality of life for people living with chronic conditions. Evidence suggests that supporting people to self manage can result in significant gains in health status, improved symptom management and reduced health service utilisation (SA Health Department 2009). Partnering with individuals, health care professionals, other providers and communities will enhance care co ordination and health outcomes (WHO 2005).

Self management requires fundamentally different conversations, interactions and relationships. between individuals and health and human care professionals. The person and their family/carer are at the centre of conversations and decision making about their care. The focus is on managing the illness experience, building individual strengths, promoting health (National Public Health Partnership 2001), and supporting the person to pursue pre-illness health and life-related goals and relationships. Interactions are fair and equitable (not necessarily equal), and the discussion balances the professional's knowledge with the person's knowledge, abilities and decision-making inclination, to achieve a shared decision-making process.

For people with chronic conditions, the ability to self manage impacts on every aspect of their lives. However, capacity to self manage is affected by many things, including mental state, literacy skills, health literacy skills, physical or psychological ability (or disability), motivation, socio-economic status, age, cultural background, self-confidence and the level of support provided by family and friends. It is also largely affected by the support provided by the healthcare system and individual health and human service professionals. Support by service systems and providers needs to be multidisciplinary and collaborative which will require intersectoral understanding, co-operation and action.

This framework to support self management outlines the core components of effective self management and the changes required across the health system. It also includes examples of the great work that is already being done by many services across Tasmania to support self management. The framework is supported by the Chronic Conditions Self Management Background Paper (DHHS 2010) which provides a number of tools to help services support self management. I encourage you to explore how these tools can help your service to support self management.

The framework was developed with significant input from members of the Self Management Framework Reference Group and the Chronic Conditions Clinical Network. Thank you to the many people that contributed.

Dr Roscoe Taylor

Director of Population Health

This framework to support self management builds on:

- work undertaken in Queensland and the resulting *Framework for Self Management 2008-2015* (Spearing et al 2005)
- work undertaken by the United Kingdom Department of Health (UK Department of Health 2007).

Members of the Self Management Framework Reference Group and the Chronic Conditions Clinical Network assisted in the development of the framework.

Self Management Framework Reference Group:

- Anne Muskett, Nurse Unit Manager, Chronic Disease Services, Royal Hobart Hospital
- Nicole Micallef, Coordinator Paediatric, Chronic Disease Services, Royal Hobart Hospital
- Stewart Millar, Manager Social Work Department, Launceston General Hospital
- Karen Linegar, Executive Director of Nursing and Care Redesign, North West Regional Hospital
- Janine Barrow, Psychologist, Alcohol and Drug Services North
- Mark Oakley Browne, Statewide Clinical Director, Statewide and Mental Health Services
- Tessa Saunders, Health Programs Coordinator, General Practice Tasmania
- Graeme Lynch, CEO, Heart Foundation Tas.
- Robynne Rankin, Self Management Policy Officer, Chronic Conditions Prevention and Self Management, Population Health
- Narelle Smith, State-wide Coordinator, Chronic Conditions Prevention and Self Management, Population Health.

1. BACKGROUND

1.1 Who is this framework for?

The framework to support self management (the Framework) is for:

- everyone who is involved in delivering health and human services in Tasmania
- everyone who plays a role in designing Tasmania's health and human service system and related workforce development.

1.2 What is the purpose of the framework?

The Framework has been developed to support health and human services to implement self management approaches to achieve better outcomes for people living with chronic conditions.

The Framework is designed to:

1. Embed self management into everyday practice.
2. Increase understanding of the key elements of self management and how it differs from other approaches.
3. Build self management approaches and practices into planning, development, implementation and evaluation.

1.3 How does this framework link with other initiatives?

The Framework will guide future directions in self management and will be strategically implemented as part of *Connecting Care The Tasmanian Strategy for Chronic Disease 2009-2012* (DHHS 2009a),*Working in Health Promoting Ways: A Strategic Framework for DHHS* (DHHS 2009b) and DHHS *Communication and Health Literacy Action Plan* (DHHS 2011). It aligns with other policy documents, including:

- the *National Chronic Disease Strategy 2006* (National Health Priority Action Council 2006)
- the *National Safety and Quality Health Service Standards 2010* (Australian Commission on Safety and Quality in Health Care 2010)
- *A Social Inclusion Strategy for Tasmania 2009* (Department of Premier and Cabinet 2009)
- *Your Care Your Say: Consumer and Community Engagement Strategic Framework and Action Plan* (DHHS 2009c)
- '*Future Health'* Tasmania's Health Plan (DHHS 2007).

1.4 Definitions

Chronic conditions are illnesses, injuries and social problems that are persistent or long term, cause significant functional impairment, disability or disadvantage, and often require ongoing care and support (Battersby 2009, DHHS 2005). Chronic conditions include mental health and psychosocial conditions as well as physical health issues, and they can affect people of all ages (DHHS 2005).

The approach to self management described in this framework can be applied to the wide range of chronic conditions and illnesses. This includes non-communicable diseases such as diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease and cancer; communicable diseases like hepatitis B and C and HIV/AIDS; neurological conditions including dementia and epilepsy; chronic disability arising from injuries; chronic pain, arthritis and inflammatory bowel disease. It includes poor oral health; social conditions such as obesity, physical inactivity, and smoking; and mental health conditions such as depression, anxiety and Post Traumatic Stress Disorder (WHO 2002).

Self management is the active participation by people living with chronic conditions in managing their own health and care. Effective self management involves the person engaging in activities that protect and promote their health and wellbeing.

Self management incorporates health promotion and risk reduction, informed decision-making, care planning, medication management and working effectively with healthcare providers to attain the best possible care and to effectively negotiate the often complex health system (National Health Priority Action Council 2006).

Self management requires collaboration between health workers and the person living with a chronic disease. It is part of an integrated healthcare system and an important element of delivering high quality chronic care (DHHS 2009a).

Self management support is what healthcare and human service professionals and 'the system' do to support an individual/s and their family/carer(s) to self manage. It requires a

working relationship and a focus on building skills and behaviour change, and building organisational and system capabilities.

Psychosocial support is the provision of psychological, social and spiritual care that is tailored to meet individual needs. People with chronic conditions face practical, emotional and psychological challenges in addition to dealing with physical aspects of their medical condition. These psychosocial needs have a significant impact on the wellbeing of individuals but are often unrecognised and unmet. It is widely recognised that optimal chronic condition care must incorporate effective physical and psychological care.

A working relationship focuses on relating in a way that puts the person with the chronic condition at the centre, and empowers the individual and their family/carer to be partners in their care. It concentrates on the process of relating in a way that empowers people as partners in their care (McWilliam 2009). For a working relationship, it's how you connect that matters.

A working relationship encompasses:

- appropriate communication skills
- collaborative care planning
- assessment of health behaviours and psychosocial health
- health promotion approaches
- use of peer support
- cultural awareness.

An individual, carer and family-centred approach requires:

- understanding of relationships and the cultural context
- inclusion of the home environment and the carer, family members and community in interventions as appropriate to the individual's needs and expectations
- addressing the educational, relational and personal needs of the carer and family as well as those of the person with the chronic condition
- viewing the condition not as a series of acute episodes but as an ongoing process requiring continuity of care between the healthcare team and the individual and their family/carer
- involving carers and family members in decision making processes as the client wishes (to maintain confidentiality)
- including the individual and carer/family in outcomes assessment.

Multidisciplinary care planning and review is a dynamic, collaborative process involving the individual, their family/carer and appropriate multidisciplinary service providers including:

- identifying and assessing the needs of the person
- developing a practical care plan that includes specific goals and actions aimed at achieving desired or optimal outcomes
- regular monitoring and review to ensure that the care plan is revised and adjusted over time to meet changing needs and goals.

The effectiveness of multidisciplinary teams is enhanced by communication between members through well delineated communication structures and processes. Linkages between hospital, primary health and human service providers are also important.

Building skills and behaviour change involves assessing the person's knowledge, skills, motivation, readiness, confidence and barriers to better manage their health and wellbeing. It emphasises the person's central role in their care, encompasses shared decision making, provides effective behaviour interventions, assures collaborative care planning and problem solving, and provides ongoing support and follow-up via peers and professionals. Building skills and behaviour change includes:

- consideration of models of health behaviour change
- motivational interviewing
- collaborative problem definition, structured problem solving and action planning (McWilliam 2009)
- goal setting and goal achievement.

Building organisational and system capabilities involve actions by service providers, services and communities to build self management capacity, and includes:

- working in multidisciplinary and interdisciplinary teams
- inter-professional learning and practice
- information, assessment and communication management systems
- organisational change techniques
- evidence-based knowledge and practice
- conducting practice-based research
- quality improvement
- awareness of community resources (DHHS 2009b).

2. THE UNDERPINNING PRINCIPLES

There are five underpinning principles that are required for integration of self management support into services and practices.

These are:

1. Health and wellbeing is a fundamental human right.
2. Individuals and family/carers are at the centre of care.
3. Community participation and consumer engagement are integral to quality improvement, service design and delivery.
4. Chronic conditions are social, physical and psychological issues.
5. Partnerships and collaboration are undertaken within teams and across sectors.

Table 1 over the page provides more information about the underpinning principles and how they relate to the person with a chronic condition, professionals and the health system.

Table 1: Relationship between the underpinning principles of self management and individuals, professionals and systems

Principles	Health and wellbeing is a fundamental human right.	Individuals and family/carers are at the centre of care.	Community participation and consumer engagement are integral to quality improvement, service design and delivery.	Chronic conditions are social, physical and psychological issues.	Partnerships & collaboration are undertaken within teams and across sectors.
Person	• I know and use my healthcare rights. • I am as healthy as I can be. • I am actively involved in my healthcare and treatment decisions; provide accurate information about my healthcare when I am asked; seek to be informed about treatment; and follow agreed treatment plans.	• I can access high quality care when I need it. • I can access a range of services to meet my individual needs and preferences. • I can find and understand health information, so that I can make decisions about my own care and participate in keeping myself safe. • I have an ongoing and trusting relationship with professionals.	• I look for chances to form partnerships with my health and/or human service providers and participate in decision-making processes for service planning, models of care and service measurement and evaluation. • I provide feedback to health and human service organisations.	• I am more than my chronic condition – in managing my health I understand I need to find what works for me. • I seek support to manage my social, physical and mental concerns instead of relying on medication alone or self-medication.	• My healthcare is co-ordinated because people and systems work with me. • I work as a partner in developing my care plan with my care team. • I am actively involved in decision making with my healthcare team.
Profession	• Professionals promote healthcare rights. • Professionals support people to exercise their healthcare rights in order to improve their experience of health care and human services. • Professionals inform and support people who are harmed during healthcare.	• Professionals know and understand that an empowering and partnering approach to practice has the following elements: ○ dignity and control for individuals ○ information and education ○ mutually respective relationships ○ choice ○ motivation ○ development of self esteem.	• Professionals recognise that health and human service professionals are part of an interdependent system where visions, objectives and resources are shared. • Professionals create relationship centred care – its how we connect that matters.	• Professionals provide psychological support including routine screening for depression and anxiety. • Professionals discuss potential psychological issues. • Professionals undertake holistic social assessment including: ○ vulnerability to violence ○ self harm ○ access to social support etc.	• The multidisciplinary teams provide coordinated, integrated care. • The interdisciplinary teams communicate effectively to deliver a consistent, reliable, non-duplicated, stress-less health service with individuals and their family/carers.
Systems	• Services are more individualised. • There is more focus on prevention of disease and complications. • Greater choice is provided – including supporting people to make healthier and more informed choices. • Health inequities are reduced. • Services are providing local care closer to home.	• People are fully involved and consulted with to plan their care according to their understanding, abilities, needs and preferences. • Flexible, responsive services are organising based on a person's needs and preferences. • Individuals experience a seamless care pathway without artificial boundaries between agencies and organisations,	• Community service users and professionals participate in service design and delivery including monitoring, measurement and evaluation. • Models of care are developed in partnership with the community/service users and deliver person-centre outcomes.	• The person's full social and economic context is taken into account to provide a holistic package of care. • Services extend into the community and home to support independence, independent living, empowerment, engagement and social inclusion.	• The right approaches, systems/structures and processes are in place to support: ○ partnerships and integrated work across all agencies in the health, human services, community and private sectors. ○ integrated information systems and joint business and financial planning across settings, professional and organisations.

3. THE CORE COMPONENTS

There are five core components that are required for integration of self management support into services and practices.

The core components of effective self management are:

1. **Individual participation**: individuals take an active role in managing their own wellbeing and healthcare.
2. **Relationship centred**: how healthcare and human service professionals relate to and connect with individuals has a big impact on self management – it's how we connect that matters.
3. **Quality improvement:** self management support is part of ongoing quality improvement processes informed by evidence, research and evaluation.
4. **Skilled workforce**: workers are supported and skilled in the principles and practices of supporting self management.
5. **Systems and resources**: self management must be supported by systems and resources that are readily available and accessible.

It is important that all five components are implemented together as much as possible. Where this happens, it can be expected that:

- people with chronic conditions are empowered to become more involved in managing their health and healthcare, and the impact of a long-term condition on their wellbeing
- people with chronic conditions have better, faster and more local access to social care across health and human services
- the needs of the workforce are addressed, and there are structures in place to promote integrated service delivery and continuity of care
- health information can be created, used and shared by people with chronic conditions and for their benefit
- there are set standards and toolkits to facilitate best practice and to make sure professionals and people with chronic conditions get the support they need.

3.1 Core Component 1: Individual Participation

Evidence shows that self management by people with chronic conditions improves health outcomes. When individuals and family/carers are supported to take an active role, they are more likely to:

- experience better health and wellbeing
- have greater confidence and a sense of control
- have better mental health and less depression
- have better planned and coordinated care
- have a reduced perceived severity of their symptoms, including pain
- take medications as prescribed

- avoid the need for emergency care
- avoid unnecessary hospital admissions
- remain living in their own home.

It is important to identify the best self management approach for each individual. Self management can be conducted using a self-directed, collaborative or supported model as described below:

A **self-directed model of self management** is where the person with the chronic condition is able to make informed decisions to effectively self manage with little input from healthcare and human service professionals.

A **collaborative model of self management** support is where self management decisions are made through a partnership between the individual and the care provider.

A **supported model of self management** is where the individual's capacity to self manage is low and a range of strategies and supports are put in place to support self management.

3.2 Core Component 2: Relationship Centred

Traditionally, health professionals have been trained in a way that encourages them to take on the role of expert and educator. Self management support provides a different approach which changes the balance of power and the role of the health professional changes from 'expert' to 'partner'.

There are five key principles that underpin an empowering partnership approach in self management support. They are:

1. The working relationship acknowledges that the person lives with and manages their own chronic condition, most of the time.
2. The working relationship is focused on wellness rather than illness.
3. The partnership is centred on the person with the chronic condition(s).
4. The partnership allows for an equitable or fair (not necessarily equal) balance of power, with the person's knowledge, abilities and decision-making inclination valued, alongside the health professional's knowledge and abilities (DHHS 2010).
5. The primary focus of the partnership is on strengths. The partnership aims to work together to identify, affirm and reinforce the strengths of the individual with the chronic condition, and encourage the individual to build upon these strengths.

3.3 Core Component 3: Quality Improvement

A move to self management requires a shift in the way chronic conditions are managed. This means a shift from the acute/treatment model to a model that focuses on prevention and management of chronic conditions.

If we are to achieve this shift, the self management approach needs to encompass ongoing research, training and evaluation. Self management is a dynamic field of practice. For self management approaches and programs to be timely and relevant, they must be evidence-based and require a routine cycle of evaluation and improvement to ensure ongoing effectiveness.

3.4 Core Component 4: Skilled Workforce

Effective self management support requires a highly skilled and well-supported workforce, able to demonstrate clinical leadership and provide multidisciplinary care. Workers should be supported to develop new skills, including skills for mentoring, motivational interviewing, working with others in multidisciplinary and trans-disciplinary teams, and supporting the mental health of those with chronic conditions.

3.5 Core Component 5: Systems and Resources

With the right systems and resources, people with chronic conditions are able to access services across a range of providers. A consistent approach to self management will enable people and their family/carers to participate effectively in their own care.

Having sustainable and supportive systems to support self management requires:

- information technology to facilitate transfer of information and knowledge
- promotion of minimum standards of practice—based on evidence
- support of existing evidence-based self management initiatives
- systems to be in place to embed good self management practice in routine care
- a consistent understanding of self management
- adequate self management resources
- equitable and consistent financing of strategies and resources to support self management
- support, training and mentoring for health and human service professionals.

4. OBJECTIVES AND STRATEGIES

Four broad objectives and a range of suggested strategies have been developed to help staff and services to support self management across a variety of settings:

4.1 Objective

Health and human service professionals support and build the capacity of individuals/families/carers to manage their health and wellbeing.

Strategies:

1. Provide and promote quality, accessible and culturally appropriate information and education to help individuals and family/carers to manage their health and wellbeing.
2. Assist people to share in the planning and make decisions regarding their care to a level of their comfort and choice.
3. Promote self management as a continuous process that occurs across the lifespan, and that a range of services may be required.
4. Provide individuals and their family/careers with access to health and human service professionals that support, promote and build self management knowledge and skills.
5. Implement training, programs and toolkits that support individuals and family/carers to participate in self management and apply self management strategies. An example of a self management program is highlighted in the case study below.

Case Study: Chronic Disease Self Management Program – also known as *Get the Most Out of Life*

About the program: Get the Most Out of Life is a chronic disease self management program that was developed by Dr Kate Lorig and her team at Stanford University USA. This group based program aims to build participants confidence to manage their health and maintain active and fulfilling lives. The program has been extensively researched and this research has demonstrated that participants have improved well being and quality of life and are able to better manage their symptoms.

Who can benefit from the program: This group based program is suitable for people with ongoing health conditions such as chronic kidney disease, arthritis, diabetes, multiple sclerosis and other neurological conditions, respiratory disorders and cardiovascular disease. The program is especially helpful for people who have more than one chronic condition as it provides them with the tools and skills to coordinate all the things needed to manage their health. It is also suitable for people who support or care for people with ongoing health conditions.

The Get the Most Out of Life program involves a 2.5 hour session once a week over a six-week period and is facilitated by two leaders who attend 4 days of training to become accredited. A range of topics are covered during the six-week period including managing difficult emotions, communicating effectively with health care providers, benefits of healthy eating and physical activity, medication management and key self management tools such as goal setting, problem solving and action planning. Programs are provided throughout Tasmania by the Department of Health and Human Services, along with the MS Society of Tasmania and Kidney Health Australia.

For more information about the program telephone 1800 359 589 or visit our website to view:

- Calendar of upcoming programs
- Promotional DVD
- Case studies (from past participants)
- Fact sheet for health and community workers (benefits of referring to the program)

A Stanford Self-Management Workshop developed by Dr Kate Lorig, Virginia Gonzalez and Diana Laurent.

4.2 Objective 2

Organisations and service providers build the capacity of the workforce to support self management.

Strategies:

1. Provide communication skills training to improve staff interactions in relation to supporting self management.
2. Provide useful resources to help health and human services staff to support self management.
3. Include responsibilities and tasks relating to chronic conditions self management in Statements of Duties for relevant health and human service positions.
4. Provide professional supervision for self management practice as a routine part of Professional Development Agreements.
5. Include self management training as part of orientations for new staff working with people living with chronic conditions.
6. Provide professional development opportunities to increase the knowledge and skills of staff working in self management, including community development, social determinants of health, values, cultural appropriateness, health equity, motivational interviewing/health coaching.
7. Offer training in a variety of self management models/approaches such as CENTREd, the Flinders Program™ (explained below) and the Stanford Chronic Disease Self Management Program (Get the Most Out of Life).

Case Study: The Flinders Program ™

The Flinders Program™ aims to provide a consistent, reproducible approach to the key components of self management that:

- improves the partnership between the client and health professional(s)
- collaboratively identifies problems and therefore better targets interventions
- is a motivational process for the client and leads to sustained behaviour change
- allows measurement over time and tracks change

The most common responses by health professionals are that the Flinders Program™ adds structure to how they are already working with their clients with chronic disease and that it encourages the client to have ownership of the management process and their care plan.

Flinders Human Behaviour and Health Research Unit offer a number of options for Chronic Conditions Care education and training including postgraduate certificate, diploma and Masters, as well as shorter workshops:

- Training in the Flinders Chronic Condition Care Planning Process
- Online Training in the Flinders Chronic Condition Management Program™
- Workshop to become an Accredited Trainer in the Flinders Chronic Condition Care Planning Process
- Communication and Motivation workshop in the Flinders Program™

For more information: contact Flinders University, telephone. (08) 8404 2318 or email CCM@flinders.edu.au

4.3 Objective 3

Organisations and service providers use evidence to inform, monitor, evaluate and improve self management approaches and practices.

Strategies:

1. Encourage attitudes and cultures that support self management within health and human services and organisations.
2. Develop standards, policies, procedures of practice and referral pathways that promote the use of evidence-based, culturally appropriate self management approaches.
3. Ensure service processes encourage and support appropriate and optimal participation by people experiencing or at risk of chronic conditions in the management of their care.
4. Use self management principles and evidence to inform service planning and models of care, including individual/group work, behaviour change, community development, engagement, cultural appropriateness, health literacy, and care planning.
5. Focus service provision on prevention and health promotion across the continuum of care, shifting from an acute/episodic focus to a continuous, holistic approach.
6. Conduct evaluation to monitor the impact and outcome of self management practice as part of a quality improvement approach to service delivery. The case study below describes an audit tool to support evaluation.
7. Use service impact and outcome evaluation to contribute to the evidence-base for self management.

Case Study: ABCD SAT Tool

The Audit and Best Practice for Chronic Disease Care Systems Assessment Tool (ABCD SAT) was developed from the Assessment of Chronic Illness Care (ACIC) tool by the Northern Territory Menzies School of Health Research. It covers the broad spectrum from prevention to clinical care and community programs.

ABCD SAT aims to support services to carryout ongoing quality improvement by assessing their competence against a range of health system elements that have been demonstrated to be essential in the delivery of effective chronic disease care. The ABCD SAT enables health services to:

- Assess how well the delivery of clinical services matches best practice guidelines
- Assess how effectively systems support the delivery of clinical services
- Disseminate findings and knowledge gained to relevant stakeholders
- Set goals and develop strategies to improve systems and delivery of care
- Review progress, goals and strategies annually
- Encourage the development of systems and a culture of continuous quality improvement.

The ABCD SAT is a seven-part survey including a section on self management support. The ABCD SAT was piloted in three Tasmanian chronic disease services and the evaluation report is available here. The tool can be purchased from NT Menzies School of Health Research by contacting 07) 3309 3419 or emailing one21seventy@menzies.edu.au. More information is available at the One21seventy website here. Alternatively the ACIC tool is available free here.

4.4 Objective 4

Systems are developed and improved to better resource and support self management across organisational boundaries.

Strategies:

1. Work with education providers, academic institutions and professional bodies to include elf management support knowledge and skills in education courses relevant to the health and human service sectors.
2. Provide integrated self management approaches that coordinate chronic conditions management across services, and involve the person and their family/carer in care planning. The case study below provides an example of this.
3. Identify barriers that prevent services working collaboratively, and implement strategies and systems that promote collaboration.
4. Facilitate self management by supporting the development of effective information systems across health and human services.
5. Provide consistent, quality health messages within and across services, systems and information sources.
6. Develop strategies to ensure self management support is accessible and appropriate to the needs of vulnerable populations, especially Aboriginal peoples, people in low socio-economic circumstances, rural and remote communities, older Tasmanians, detainees and refugees.
7. Provide opportunities for community sector organisations to deliver self management training, for example supporting local people from vulnerable populations to act as health guides in their own community.

Case Study: Pathways to Change
Diabetes Self Management Demonstration Project

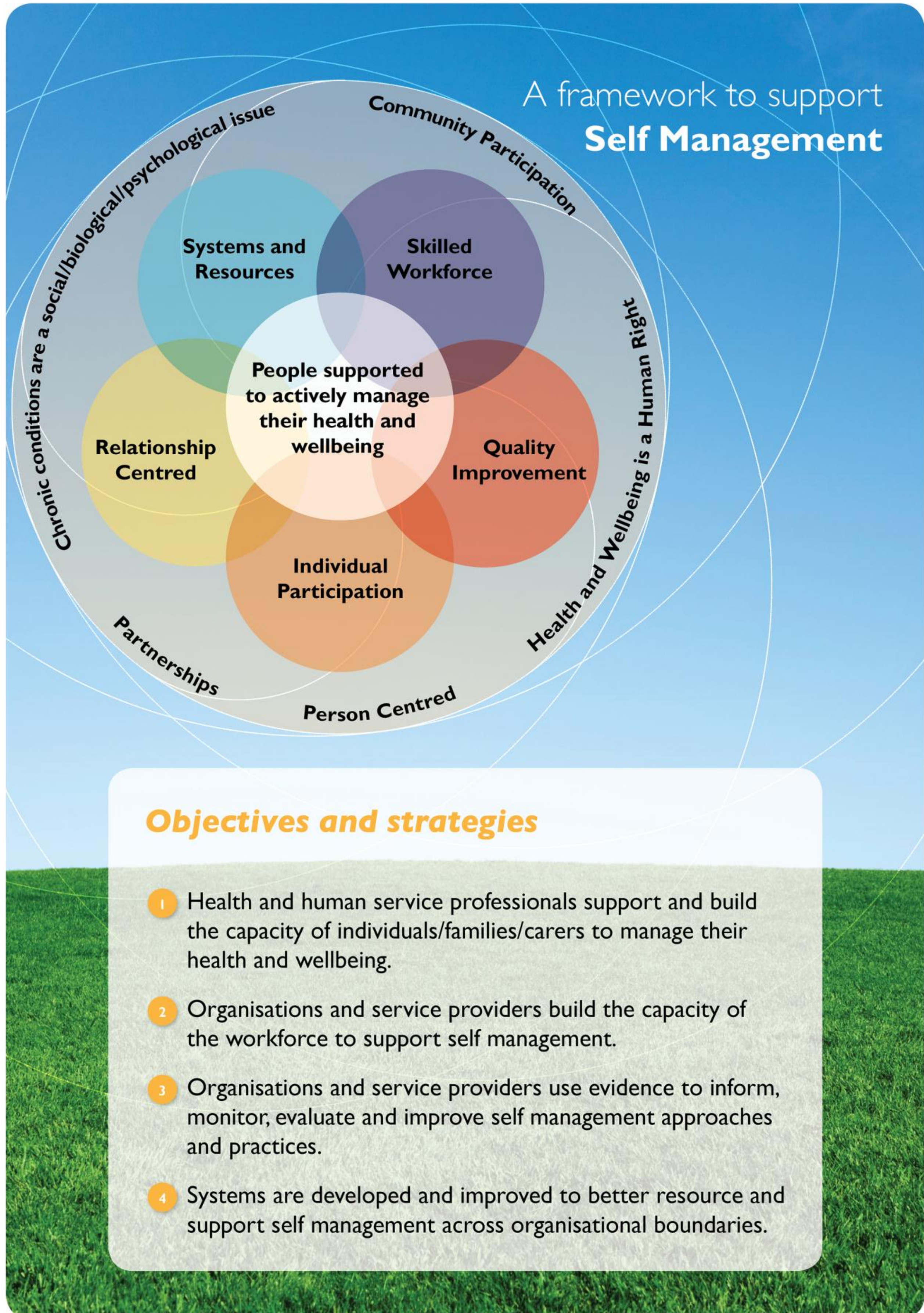
A pilot project was conducted by the Clarence Community Health Centre to increase opportunities to support people with type 2 diabetes in managing their chronic condition. Following the recommendations of the pilot project, the Clarence Integrated Care Centre are running a twenty-four month self management demonstration project. The project focuses on increasing opportunities to share health information in relation to Type 2 Diabetes.

The Demonstration Project aims to improve support and promote self efficacy for people with Type 2 Diabetes. Self management workers will work with up to 40 participants, using self management approaches, with the aim of improving participant health and wellbeing. The project will use a multidisciplinary client centred approach to improve access to the range of support services for people, their families and carers. The Project aims to develop external linkages with other service providers involved in participant care such as GPs, Practice Nurses and Diabetes Tasmania. Finally, the project intends to embed self management as a way of practice across the southern region.

For more information: contact the Clarence Integrated Care Centre, telephone 62820324, or email pathwayscicc@dhhs.tas.gov.au.

CONCEPTUAL DIAGRAM

Table 2 outlines the elements of the Framework.



5. IMPLEMENTATION AND EVALUATION

A move to supporting self management with a focus on health and wellbeing will require significant change. Implementation of the Framework needs to be a dynamic process that occurs in different ways across health and human services in Tasmania over time.

As part of the consultation process undertaken during the development of the Framework, a number of areas were identified as priorities for the implementation phase. These priority areas are:

1. Workforce development – health professional education and training:
    a. communication skills e.g. motivational interviewing
    b. the relationship centred approach
    c. the range of self management programs
    d. self management strategies across the continuum of care
    e. a range of training options including online training
    f. community development and health promotion
    g. appropriate evidence-based clinical practice for chronic conditions.
2. Workforce development – systems and support:
    a. use of the chronic care model to embed self management into practice, systems and organisations
    b. minimum standards of practice
    c. multidisciplinary and interdisciplinary team building
    d. evidence-based self management programs
    e. capacity building in communities to support self management at the local level
    f. a range of resources including online options
    g. a resource depository.
3. Communication processes that link people, resources and information across the sector.
4. Planning, benchmarking and reporting to monitor progress in implementing the Framework and improving self management support.
5. Research, evaluation and monitoring of self management initiatives to build a local evidence base.

The Framework will be available from the Department of Health and Human Services (DHHS) public website here. Health and human services and workers are encouraged to incorporate the elements of the Framework in service design and delivery. Self management outcomes should also be incorporated into other planning and reporting frameworks across health and human services, as appropriate.

Elements of the Framework will be implemented by Population Health as part of the Working in Health Promoting Ways (WiHPW) Framework Capacity Building Action Plan and the Communication and Health Literacy Action Plan. The WiHPW framework is a comprehensive

strategy which uses organisational and workforce development, leadership and resource allocation to embed health promotion and preventive health within health and human services practice and systems. Preventing and managing chronic conditions is one of the priority areas in the WiHPW framework and self management support will be incorporated in implementation strategies.

While the Framework was developed for public health and human services, the information is also relevant to chronic condition prevention and management in the private and community sectors.

Central to this framework is the use of evidence-based approaches, practices and programs shown to be effective in self management. Services implementing aspects of this framework are strongly encouraged to conduct regular evaluation, including evaluation of their effectiveness in the Tasmanian setting. Evaluation strategies should be developed by service areas as appropriate.

Resources to Support Implementation

The following resources provide a range of information to help staff and services support self management in Tasmania:

Recommended Implementation Guides

Navigating Self Management - Authors: Naomi Kubina, Jill Kelly

This manual provides a practical guide to implementing Self management in your organisation and is free to download as a PDF file from the following website : http://www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publications/Navigating_self_management%20March%202008.pdf

Resources

- Chronic Conditions Self Management Background Paper.
- Partnering in Self Management Support: A Toolkit for Clinicians- available through: Improving Chronic Care.
- Motivational Interviewing- DVD's Text – Pip Mason available at: www.pipmason.com.
- Self Management Self Reflective Tool at: Australian Disease Management Association.
- Partners in Health client survey based on The Flinders self management/health literacy survey - Partners in Health Survey
- Flinders Capabilities for Supporting Prevention and Chronic Condition Self Management - Capabilities
- QSMA Quality Assurance Framework: Strengthening Chronic Disease Self Management Support 2012 - QLD Self Management Framework.

Training

- CENTREd Model – contact Dr. Helen Cameron Tucker cameronh@utas.edu.au.
- Health Coaching - www.healthcoachingaustralia.com.
- The Flinders Program™ - http://www.flinders.edu.au/medicine/sites/fhbhru/self-management.cfm
- Stanford Chronic Disease Self Management Program - http://patienteducation.stanford.edu/programs/.

Websites

- Improving Chronic Illness Care - www.improvingchroniccare.org.
- Health Coaching Australia - www.healthcoachingaustralia.com.
- The Royal Australian & New Zealand College of Psychiatrists -Resources to support self management - RANZCP.
- Consumers Health Forum - https://www.chf.org.au/chronic-conditions-project.php
- Working in Health Promoting Ways http://www.dhhs.tas.gov.au/healthpromotion/wihpw
- Communication and Health Literacy- http://www.dhhs.tas.gov.au/pophealth/health_literacy

APPENDIX 1

EXAMPLES OF HOW OTHERS ARE SUPPORTING SELF MANAGEMENT IN TASMANIA

Implementation of a self management model within a general practice setting

This project aims to increase knowledge, skills and confidence in self management strategies amongst GP teams using appropriate parts of the Flinders Model. It is planned to use learnings from the trial to roll out the project to other interested practices.

For more information: contact the Chronic Disease Program Officer, Tasmania Medicare Local, telephone 6331 9296, or email amccaughey@tasmedicarelocal.com.au.

Appetite 4 Change

The first multidisciplinary "Appetite 4 Change" program was conducted in April 2007 by dietitians, social workers and physiotherapists. Since then 15 programs have been run across North West Tasmania. This program aims to enhance self management by encouraging mindfulness based strategies, realistic goal setting, healthy eating and physical activity. Program content has been adapted from mindfulness-based change approaches, chronic condition self management ideals (e.g. Stanford program), and recommendations from lifestyle program evaluations from other services (e.g. Queensland Health – Lighten Up, New South Wales Health – Food for Thought, and many others). Groups are run separately for males and females with emphasis placed on issues pertinent to each gender.

For more information: contact the Appetite 4 Change program co-ordinator, North West Area Health Service–Nutrition and Dietetic Department, telephone 6430 6597 for inquiries, or telephone 6421 7820 to book in (self referrals accepted), or email A4C@dhhs.tas.gov.au.

Appetite 4 Change program co-creator, Southern Tasmanian Area Health Service–Statewide Cystic Fibrosis Service (Paediatrics), telephone 0457 845 189.

Falls Prevention Program North

This program commenced in 2009 and incorporated 15 weeks of once-a-week progressive exercise sessions focusing on improving leg strength, balance, vision, co-ordination, plus an occupational therapist-led education program, and a daily home exercise program. This program has been further developed to become a multidisciplinary falls prevention program with weekly relevant education and health promotion sessions being delivered to the participants by community physiotherapists, occupational therapists, podiatrists and pharmacists. Comprehensive pre- and post-participation assessments are conducted to measure each individual's falls risk status. A home assessment may also be conducted by the occupational therapist when necessary and home environmental safety recommendations made with regard to rails, ramps, lighting etc. Participants who do not wish or are unable to attend a centre-based group session may be offered the OTAGO Home Exercise Program, which is a home-based program taught by the physiotherapist on a home visit to the client and followed up with subsequent periodic review. For more information: contact the Community Physiotherapists at Launceston Community Health Centre Kings Meadows, telephone 6336 5155, or email communityphysionorth@dhhs.tas.gov.au.

Living Well

Living Well is a social support group for people who have lived and lost, surviving and striving, with a positive future health focus.

This initiative arose out of a need identified in the work of the Kings Meadows community health social work service. The group was requested by participants of the service, to provide social interaction with others experiencing similar issues. Monthly afternoon teas have been conducted since 2009. The living well group is an open group and while there is a social side the meetings also provide the opportunity to:

- hear information from guests speaker
- interact with others experiencing similar chronic health conditions and issues
- develop friendship/companionship
- feel welcome, supported, respected, and connected in dealing with social isolation associated with chronic conditions.

For more information: contact the Social Worker, Launceston Community Health Centre, Kings Meadows, telephone 6336 5155.

My CF self management portal

The main aim of the *My CF* self management portal is to provide a comprehensive community support and education program for people and families affected by cystic fibrosis (CF). This project embraces the latest advances in chronic condition management, incorporating a health mentor network to facilitate self efficacy and self management. The project is supported by a comprehensive website and a self-monitoring tool, available as a downloadable mobile phone application or from the website. This project expands on the success of a similar (smaller scale) pathways home project piloted in 2007. In addition to the portal, a mentoring resource tool kit is under development, including a variety of resources to support clinicians to understand self management and empower individuals to self manage.

For more information: contact Cystic Fibrosis Tasmania Inc, telephone 1800 232 823 (1800 BEAT CF), or email general@cftas.org.au.

Relapse Prevention Planning (Mental Health Services North)

Mental Health Services (DHHS) is committed to an early intervention framework. This means that professionals seek to identify any exacerbation or relapse of active symptoms as soon as possible so that people with a mental health diagnosis can address emerging issues as soon as they arise. The Relapse Prevention Plan is a process that the clinician and the person with the condition work on together to assist the individual to identify the signs and symptoms of mental illness. Consistent with the DHHS Statewide and Mental Health Services, Promotion, Prevention and Early Intervention Framework, the Relapse Prevention Plan assists individuals to have a sense of control over their life. This gives them the opportunity to identify the ways that mental illness is expressed in their life and develop strategies to assist them to manage their illness.

For more information: contact Mental Health North, telephone 6336 2185, or email dop.level1@dhhs.tas.gov.au.

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Population Health

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