Chronic Disease Self-Management Education Programs

Perspectives on enablers and barriers to GP and patient engagement

Joanne Jordan BSc, BA, MPH
Joan Nankervis BSW, MEd
Dr Caroline Brand MBBS, BA, MPH
Dr Richard Osborne BSc, PhD

Centre for Rheumatic Diseases
Department of Medicine, The Royal Melbourne Hospital
The University of Melbourne
jjordan@unimelb.edu.au

Why chronic disease self-management?

- Chronic disease primary cause of death in the world *(Yach, JAMA 2004)*
- Governments and health providers are seeking alternative ways to improve treatment quality and patient satisfaction
- Policy shift:
  Medical didactic model → Patient centred care

Chronic disease **self-management** programs have emerged as important components within the patient centred care approach

Self-management education interventions

Stanford CDSMP
- Generic program (caters for broad range of chronic conditions)
- Group based format
- Conducted over 6 weeks
- Led by either health professionals or peer leaders
- Highly structured course

	Intervention	Examples
		Doctor/health professional
	…oaching	COACH
	…al course	NSW Arthritis Foundation
	…ourse	Stanford & NHS EPP partnership
	Grou… …ngoing cycle	Rehabilitation
	Group – formal/structured	CDSMP
	Written information	NGOs / Clinic
Public Health	TV/multi-media	Back campaign QUIT, TAC

Momentum at the government level

- **National Chronic Disease Strategy (NCDS)**
  - self-management identified as one of four key action areas
- **06/07 Federal Budget**
  - $250 million over 5 years as part of the COAG Health Services – *Promoting good health, prevention and early intervention*
  - $14.8 million over 4 years to fund awareness & education self-management of arthritis and osteoporosis
  - $250K for 06/07 for new training program for health professionals to provide self-management education, training and support

Integration of chronic disease self-management education programs into the health sector

Key Considerations from:
Policy & program trends at the international level

International trends in CDSMP

- Focus on generic chronic disease self-management education programs
- UK government leader in field
  - "Expert Patients Programme"
    - Anglicised version of Stanford CDSMP implemented throughout National Health Service
    - ~A$ 60 million dollars spent since 2001
- Canada, Denmark & USA
  - less advanced and less integration into policy and programs

Key trends at the international level

1. Recruitment and retention of a critical mass of individuals (patients and leaders) has posed challenges
   - Programs only reach a small proportion of the target population
   - Concern that some programs might increase health disparities
2. Engagement with health professionals is crucial to the viability and subsequent sustainability of self-management education programs into the health care system

Sharing Health Care Initiative (SHCI)

- Federal government initiative (2001-2004)
  - Tested range of generic chronic disease self-management models for integration into wider health care system
- Evaluation of SHCI
  - Limited reach
  - GP engagement limited
    - Inability to capitalise on MBS / EPC items relating to chronic disease to assist with referral process

Feedback at the grassroots level

Consultation with Victorian GPs & Consumers

Perspectives on enablers and barriers to engagement of chronic disease self-management education programs

Qualitative study

- **Methods**
  - Interviews : 17 GPs and 43 consumers
  - Purposeful sampling employed to ensure:
    - A balance in participants who were both familiar and unfamiliar with chronic disease self-management education programs
    - From metropolitan and rural areas in Victoria
- Consumers recruited through GPs, Rheumatologists
- GPs recruited via 3 Div of General Practices (Northern, Dandenong & South Gippsland)

Common Barriers (GPs & Consumers)

"GPs need to know how beneficial or valuable these programs are so they are able to assess whether this could potentially benefit patients"

- **Lack of general awareness and knowledge about CDSM education programs**

"Lack of knowledge by health professionals, if it was advertised in GP surgeries, hospitals, specialists telling people about it …just make people aware of these programs…"

- **Consumer perceptions that health practitioners are in the best position to advertise or spread information about CDSM education programs**

"…if I'm not feeling well I find it very difficult to motivate myself to get going and doing those things…"

- **Health status plays a significant role on their motivation and willingness to engage in self-management activities**

Barriers (GPs)

"GP is looking for how things are progressing…is there any monitoring of the condition or the persons behaviour so he/she knows what the patient is getting and has achieved which can related to clinical parameters…."

- Absence of a feedback mechanism between GPs and providers of self-management education programs

"Courses come and go or organisations delivering these programs fold…GPs are not well informed about local programs available to them and by the time either the patient is ready or interested in participating (because there is a contemplation process when you have a chronic condition) these programs are not available

- Poor sustainability of locally available programs

Common Enablers (GPs & Consumers)

"If the GP knows the program works and the evidence is there…it is perceived that this will enhance referral of patients to the program"

"Information about the program and types of outcomes…I could take that to my doctor and discuss"

- Broad dissemination of information about CDSMP (including evidence of effectiveness and patient outcomes)

"Programs need to be local, close to home or the workplace, provided at times that are accessible and participants should be able to bring partners or family members"

- Programs that are locally based, easily accessible and provided on an ongoing basis so could be utilised as required

Enablers (GPs)

"Really easy seamless referral system, that is probably number 1 to be able to say do this, you ring there and it will all happen and to know how it happens"

- Convenient and structured referral process

"Feedback from consumers is really important…very much sways us into using the service more…and evidence…is there some evidence by reputable research…"

- Convincing evidence base with formal quality assurance/accreditation process

Enablers (Consumers)

"I think it should be verbal [format of information] *from GP or support person who could call and have a chat…would be more encouraging than an advertisement on TV…is more personable, human contact"*

- Best way to disseminate information about CDSM education programs through health professionals

Summary – Key Issues

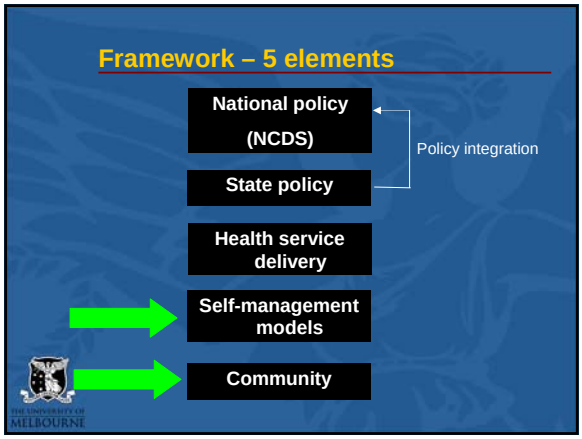
1. Profile of self-management needs to be raised within health sector
2. To engage GPs and health practitioners
   - Structured referral process
   - Convincing evidence base
   - Accreditation/quality assurance of programs
3. Self-management programs need to be flexible
   - There is no 1 generic model that fits all

What needs to be done to take self-management forward?

SELF-MANAGEMENT SERVICE IMPROVEMENT FRAMEWORK

Key actions for integration of chronic disease self-management education programs

Framework – 5 elements



Self-management models

Key actions

1. Flexibility in delivery, content and form
2. Local community context – range of settings
3. Structured referral pathways between acute/sub-acute/primary care settings
4. Feedback mechanism between program providers and health professionals on patient progress
5. Evaluation/Quality assurance

Community

Key actions

1. Health promotion tailored strategies
2. Information resources
3. Availability of courses across care & disease continuums
4. Variety of program formats
5. Local settings
6. Support/self-help groups

Thank you

Centre for Rheumatic Diseases
The University of Melbourne
jjordan@unimelb.edu.au