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Chronic Disease Self-Management Education Programs
Perspectives on enablers and barriers to GP and patient engagement
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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

<table>
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<tr>
<th>Intervention</th>
<th>Examples</th>
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<td>Doctor/health professional</td>
<td>Teaching, COACH</td>
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<td>Stanford CDSMP</td>
<td>Stanford &amp; NHS EPP partnership</td>
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<td>Public Health</td>
<td>Written information, NGOs/Clinic</td>
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<tr>
<td>TV/multi-media</td>
<td>Back campaign, QUIT, TAC</td>
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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

Local context

Sharing Health Care Initiative (SHCI)
- 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)

- Lack of general awareness and knowledge about CDSM education programs
- Consumer perceptions that health practitioners are in the best position to advertise or spread information about CDSM education programs
- Health status plays a significant role on their motivation and willingness to engage in self-management activities

"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..."

"If I'm not feeling well I find it very difficult to motivate myself to get going and doing those things..."
Barriers (GPs)

- Absence of a feedback mechanism between GPs and providers of self-management education programs
- Poor sustainability of locally available 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.

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
- Convincing evidence base with formal quality assurance/accreditation process

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

Enablers (Consumers)

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

Common Enablers (GPs & Consumers)

- Broad dissemination of information about CDSMP (including evidence of effectiveness and patient outcomes)
- Programs that are locally based, easily accessible and provided on an ongoing basis so could be utilised as required

“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”

“Information about the program and types of outcomes...I could take that to my doctor and discuss”

“GP is looking for how things are progressing...Is there any monitoring of the condition or the person's behaviour so he/she knows what the patient is getting and has achieved which can related to clinical parameters...”

Enablers (GPs)

- Structured referral process
- Convincing evidence base with formal quality assurance/accreditation process

“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”

“Feedback from consumers is really important...very much sways us into using the service more...and evidence...It there some evidence by reputable research...”

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

- National policy (NCDS)
- State policy
- Health service delivery
- Self-management models
- Community

### 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

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### 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

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**Thank you**
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