Self-management
An overview
Malcolm Battersby
Presentation overview

- Definitions
- Measurement
- Interventions
- Risk factors
- The future: on-line
What is the problem?

• Living longer
• Getting fatter
• Getting lazier
• Smoke too much (Hong Kong/China)
• More chronic diseases
• Costs too much
• Makes us very unhappy!
Acute
• Episodic
• Cure expected
• QOL highly dependent on professional care
• QOL highly dependent on short term services
• HP generally the expert
• Short term goals
• Compliance expected

Chronic
• Ongoing
• Stigma attached
• QOL highly dependent on pts self management and decision making
• QOL highly dependent on ongoing support services
• Pt often has more knowledge
• Short term goals to meet long term outcomes
• Compliance and self reliance expected
Sub-optimal Care

- Irregular
- Incomplete
- Inadequate
- Inconsistent assessment, treatment, education, motivation, feedback and/or follow up.

Poor Outcomes

- Delays in detection of complications or decline
- Failures in self-management, or increased risk factors as a result of patient passivity or ignorance.
- Reduced quality of care
- Undetected or inadequately managed psychological distress

Wagner Von Korff
Chronic disease management: What will it take to improve care for chronic illness? Wagner EH. 1998; Effective Clinical Practice 1:2-4
Multiple terms and definitions

Chronic disease
Chronic conditions (WHO)
Long term conditions
Self-care (UK) Expert patient
Patient engagement
Patient centred care
Self-management:
  - disease specific self-management education
  - Generic self-management education
  - Behavioural risk factors
  - Bio psychosocial
Self-management support
Self-efficacy
Patient activation
Health coaching
Self-care

Self care is a part of daily living. It is the care taken by individuals towards their own health and well being

- Self care includes the actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health;
- meet social and psychological needs;
- prevent illness or accidents;
- care for minor ailments and long-term conditions;
- maintain health and wellbeing after an acute illness or discharge from hospital’ (NHS, 2005, p.4).

Self-management is a component of self-care that is informed by evidence-based health information.
National consensus operational definition of self-management

• Having **knowledge** of the condition and/or its management

• Adopting a **self-management care plan** agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters

• Actively **sharing in decision-making** with health professionals, significant others and/or carers and other supporters

• **Monitoring and managing** signs and symptoms of the condition
Def’n of self-management

- Managing the **impact** of the condition on physical, emotional, occupational and social functioning
- Adopting **lifestyles** that address risk factors and promote health by focusing on prevention and early intervention
- Having **access** to, and confidence in the ability to use support services
Flinders Program:
7 Principles of Self-Management

K Knowledge
I Involvement
C Care plan
MR Monitor and Respond
I Impact
L Lifestyle
S Services
Self-management support

- Is what health professionals, the health system, carers and family do to assist the person to self-manage their chronic conditions.
Generic measures of self-management

Partners in Health scale (PIH) (Battersby et al)
12 questions – 3 domains

Health Education Impact Questionnaire (heiQ)
(Osborne et al) 40 questions - 8 domains

Patient Activation Measure (PAM, Hibbard et al)
13 questions - uni-dimensional
PIH

Translated into 7 languages

Measures self-management knowledge, behaviours, impacts

Predicts health outcomes at a single point in time

Predicts change in health outcomes over time

Uses:
• screen those who require self-management support and those who don’t
• Tailor self-management interventions to the individual
• Measure change in self-management over time

http://som.flinders.edu.au/fhbhru
PIH measurement

- **Chinese PIH – Chui et al**
  - Wave 1 = 73 – Wave 2 n=136,
  - Cronbach’s alpha 0.890.
  - Test-retest reliability ICC = .818
- **Factors**
  - knowledge,
  - symptom management and adherence,
  - coping
- **Uses**: assess self-management – screening tool
  - tailor self-management support or care coordination to the individual
  - measure change over time
  - assess service effectiveness
Stanford CDSMP

• Peer or health professional led
• 6 weeks group x 2.5 hours
• Skills based
  – Goal setting
  – Action planning
  – Problem solving
• Emotions management, pain management, diet, exercise,
Centre for Disease Control in US
Meta-analysis of Stanford CDSMP

- RCTs: significant small to moderate ES for self-efficacy (ES = 0.427),
- health distress (ES = -0.215),
- social/role limitations (ES = -0.209),
- aerobic exercise (ES = 0.197),
- cognitive symptom management (ES = 0.312),
- days or nights hospitalized (ES = -0.138).
- RCT 954 patients six-month study.
- significant improvements in aerobic exercise, practice of cognitive symptom management, self-efficacy.
- They also had significant improvements in health status and, on average, fewer hospitalizations.
Flinders Program:
7 Principles of Self-Management

K  Knowledge
I  Involvement
C  Care plan
MR  Monitor and Respond
I  Impact
L  Lifestyle
S  Services
Flinders Program: improved outcomes for patients with chronic conditions

- Medical management
- Self-management
- Coordination
- Coaching
The Flinders Program

**Action Plan**
- Agreed Issues
- Agreed Interventions
- Shared Responsibilities
- Review Process

**Problems and Goals**

**Assess Self-Management**
- Self-Management
- Medical Management

**Community / Family Support**

**Psychosocial Support**
Assessment of self-management

Partners in Health Scale (PIH)
- 12 questions
- self assessed and scored on 9 point scale

Cue and Response Interview (C&R)
- 12 questions with cues
- explores the strengths and barriers
- HP assessed and scored on 9 point scale

Leads to collaboratively identified issues
Person with Chronic Health Condition to Complete

Please circle the number that most closely fits for you

1 Overall, what I know about my health condition(s) is:

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

2 Overall, what I know about the treatment, including medications of my health condition(s) is:

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

3 I take medications or carry out the treatments asked by my doctor/health worker:

0 1 2 3 4 5 6 7 8
Never Sometimes Always
Problems & Goals assessment

• Identifies what the person sees as the biggest problem

  and

• Identifies the goal(s) the person wants to achieve
**Client Problem Statement:** Lack of support from my family means I am overwhelmed by the household jobs and I don't go out and I feel depressed.

**Client Goal Statement:** I will go to the community club one afternoon a week for 2 hours.

| Managing impact on emotions and social aspects of life (10,11) | I want to feel more energetic and positive about my life. | - Learn some relaxation techniques from Diabetes Educator  
- Make contact with VVCS to consider contact for counselling  
- Ask GP to assess for depression  
- Attend anxiety management course at community centre  
- Ring community club and ask for a program of activities  
- Contact local council about help with the housework  
- Ask GP for a referral to a Podiatrist  
- Attend Podiatry every month  
- Attend Diabetes update sessions at community centre with husband  
- Read information handouts  
- Ask GP for referral for home medications review  
- Measure my blood sugar levels with the Glucometer every day and away from family and record in a diary  
- Discuss diary record with Diabetes Educator  
- Set up a Symptom Action Plan with Diabetes Educator |
|---|---|---|
| Managing impact on physical activity (9) | To have a clean and tidy house. I want less pain in my feet. | Roger / Diabetes Educator  
Roger  
Roger / GP  
Roger / local council/DVA  
Roger  
Roger / local council/DVA  
Roger / Podiatrist  
Roger / Wife / Diabetes Educator  
Roger  
Roger / Diabetes Educator  
Roger / Diabetes Educator |
| Knowledge of diabetes treatment and medication (1,2,3) | To know about my treatments and tablets and what they do for me. | 2 weeks later  
2 weeks  
4 weeks  
8 weeks  
2 weeks |
| Symptom management (7,8) | To feel better and have more energy | 2 weeks  
2 weeks  
2 weeks  
2 weeks |

| How much of a problem is this for me |
|---|---|---|---|---|---|---|---|---|
| Not at all | very little | somewhat | a fair bit | a lot |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

| My progress towards achieving this goal |
|---|---|---|---|---|---|---|---|
| No success | 25% | 50% | 75% | complete success |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
Coaching and coordination

- Monitoring
  - provider-initiated follow up
  - self-monitoring
- Motivational enhancement
- Review progress on care plan goals
- Problem solving
- Coordination: assist with access, communication and advocacy
Flinders Program Research


Petkov, J, Harvey M, Battersby M,(2010)'The internal consistency and construct validity of the Partners in Health scale: validation of a patient rated chronic condition self-management measure" Quality of life research 19(7) 1079-1085

Flinders

- Generic: individual
- Taught by accredited health professionals to health professionals
- Health professional - patient partnership with patient sharing decisions and taking responsibility
- Assessment and care planning, behavioural change (goal setting)
- Based on cognitive and behavioural principles and techniques

Stanford

- Generic: group
- Taught by health professionals and peers to peers
- Independent of health professional - patient relationship
- Generic skills – goal setting, problem solving, symptom management,
- Based on cognitive and behavioural principles and techniques
Coach Program

Margarite Vale – Victoria

- Telephone coaching for patients discharge from hospitals
- Health professional coaches
- Risk factor goals
- Written and verbal feedback

6 month randomised controlled trials

- Improved cholesterol, Hba1c, blood pressure
- 16% reduction in hospitalisations
<table>
<thead>
<tr>
<th>CCSM Support approaches commonly used internationally</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stanford CDSMP Course</strong></td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
</tr>
<tr>
<td>Peer led / peer sharing / Less threatening than formal groups</td>
</tr>
<tr>
<td>Structured content</td>
</tr>
<tr>
<td>Focus on problem-solving/goal setting</td>
</tr>
<tr>
<td>Doesn’t conflict with other treatments</td>
</tr>
<tr>
<td>Scales to measure change</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
</tr>
<tr>
<td>Structured content – difficult to address individual learning speeds and styles</td>
</tr>
<tr>
<td>Privacy/confidentiality issues</td>
</tr>
<tr>
<td>Not everyone wants or is able to join a group</td>
</tr>
<tr>
<td>Doesn’t change worker behaviour</td>
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</tbody>
</table>
CCSM Support approaches commonly used internationally

<table>
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<th>Flinders Program</th>
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<tbody>
<tr>
<td><strong>Advantages</strong></td>
</tr>
<tr>
<td>Individualised / generic / adaptable tools</td>
</tr>
<tr>
<td>Suited to multi-morbidity &amp; complexity</td>
</tr>
<tr>
<td>MI skills are inherent in the tools structure</td>
</tr>
<tr>
<td>Scales to measure change</td>
</tr>
<tr>
<td>Also changes worker behaviour</td>
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</tbody>
</table>

<table>
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<tr>
<th><strong>Disadvantages</strong></th>
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<tr>
<td>Takes time</td>
</tr>
<tr>
<td>Requires systems to also change their practice / commitment required at all levels of the service</td>
</tr>
<tr>
<td>Requires practice and mentoring</td>
</tr>
</tbody>
</table>
## CCSM Support: commonly used internationally

### The 5 As (assess, advise, agree, assist, arrange)

| Advantages | Straightforward, easy to remember acronym  
Matched with clients’ expectations and existing services  
Quick to deliver |
|------------|------------------------------------------|
| Disadvantages | Best suited to brief interventions / non-complex clients  
Review may not occur / little accountability to how steps are delivered – worker maintains control of decisions? PCC? |
**Motivational Interviewing**

| Advantages | Flexible / applied to any setting or situation  
|           | Lengthy and short consultations  
|           | 3 decades of evidence |

| Disadvantages | Little formal structure / requires extensive training and practice  
|               | Workers often revert back to former processes  
|               | Doesn’t require collaboration with other services/workers |
## CCSM Support: commonly used internationally

### Health Coaching

| Advantages | Uses MI and other CBT approaches  
| Training can be tailored  
| Generic to any chronic condition or risk behaviours |
| Disadvantages | Reliant on one-on-one skills/experience of worker  
| Doesn’t require collaboration with other services/workers  
| Risk of being seen as loose collection of psychological skills |
Disease specific self-management

• Multiple disease specific measures of self-management

Warsi et al:

• Small to moderate effect sizes for diabetes and asthma – equivocal for arthritis

• Multiple cochrane reviews for all diseases:
  • HIV
  • Cancer now considered chronic conditions
Capabilities of health professionals for self-management support

General person centred skills

1. Health promotion approaches
2. Assessment of health risk factors
3. Communication skills
4. Assessment of self management capacity (understanding strengths and barriers)
5. Collaborative care planning
6. Use of peer support
7. Cultural awareness
8. Psychosocial assessment and support skills
Behaviour change skills

1. Have knowledge of models of health behaviour change
2. Motivational Interviewing
3. Collaborative problem definition
4. Goal setting and goal achievement
5. Structured problem solving and action planning
Organisational/Systems Skills

1. Working in multidisciplinary teams / Inter-professional learning and practice
2. Information, assessment and communication management systems
3. Organisational change techniques
4. Evidence based knowledge
5. Conducting practice based research / quality improvement framework
6. Awareness of community resources
ACIC - Chronic Illness Care Self-Management Systems Assessment
Changing health service delivery

Battersby, M Flinders Closing the Gap final report June 2014 commonwealth of Australia
Development of Chronic Disease Self-management Program

Hong Kong

Peter POON

17 May 2015

2000 - Pilot Chinese Version CDSMP (Stanford Model)
2002 - Health In Action Project (2 Year’s project supported by Lotteries Fund)
   1st CDSMP Master Training in (Asia-Pacific)
2003 - Effectiveness Study on CDSMP, Process and Factors Studies

2009 – Enhanced and new Self-management Programs Development
2010 – International Conference on Promoting Chronic Care & Workshops
2010 – Introduced and piloted the Flinder’s Self-management Program
2010 – Commissioned by HA to provide the Patient Empowerment Program
2011 – Training initiatives in HK, Mainland, Macau on CDSMP
2012 – Set up Center on Research and Advocacy
2012 – Launched www.cde.hk (on-line self-management program)
2013 – Confirmed the “e2care Project” (further development of On-line program)
2014 – Service revamping in Community Rehabilitation Network to explore the
   service structure and innovations on self-management support
2015 – Launching of e2Care On-line programs
Key findings of the Studies

- Enhanced Self-Efficacy
- Sustainable Behavioral Change
- Improvement in Health Outcomes
- Improvement in Psychological Well-being
- Improved Utilization of Healthcare Resources
- Understand one’s Responsibility on Self-Management & willingness to Take Action

30 EBP projects were conducted

For details, please visit http://www.rehabsociety.org.hk
e²Care Project
Make your self-healing e way
e2Care Service Framework

- Pre-assessment
- Personal health records
- Health care workers understand YOUR health status
- Creating account
- Enrolment
- Regularly updated / Service information
- Mobile communications tools
- e2care health management e-learning course
- e2care self-management apps
- Health management
- Self and mutual support
- Behavior change
- Blended learning
- Curriculum
- Online interactive group
- Self-management support centre
- www.e2care.hk
- E2care.hk
- CRN +
- Mobile communications tools
- Creating account
- Enrolment
- Personal health records
- Blended learning Curriculum
- Forum
- Hospital
- NGO
- Community
Summary

• People need disease specific and generic self-management skills
• Interventions need to be tailored to the individual based on their preferences and learning styles
• Long term benefits may require long term collaborative processes for some individuals
• People may require different types of self-management support over time
Future directions – www.FlinCare.com

Patients

The Flinders Program™ has been shown to change the lives of patients with chronic conditions by promoting self-management and helping them to take control of their health.

Health Care Organisations

The Flinders Program™ can help your organisation to reduce its healthcare expenditure. Effective self-management of chronic conditions reduces patient hospitalisation rates and improves a patient’s health.

Health Professionals

The FlinCare™ software delivers the Flinders Program™ on a web-based system for use by both health professionals and patients.

What is FlinCare™?

FlinCare™ is a patient-centred care planning tool designed to promote effective self-management of chronic conditions.

FlinCare™ is a web-based system, which contains the components of the Flinders Program™ and provides access for both the patient and health professional.
The good news

- McDonalds profits are down!
- Smoking rates in Australia have decreased to 13%!
- Things can only get better!
THANK YOU

Flinders Human Behaviour Health Research Unit

http://cvcprogram.flinders.edu.au/

http://som.flinders.edu.au/fhbhru (Courses)

http://www.flindersclosingthegapprogram.com

www.flincare.com

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Training to Implementation A
Case study

2010
Management engaged
Implementation Plan
FCTGP training

2008 FP refresher training

2006 FP Training

2012 Implementation
2013 evaluation
Looking a broader application