gill+willcox

Self Management Assessment Tool

for Community Health Organisations

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North Central
Metro PCP

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This tool was developed by gill + willcox for NCMPCP in consultation with the representatives from Darebin, Plenty Valley and North Yarra Community Health.

gill + willcox would welcome feedback on your experiences of using the tool or suggestion for improvements to the tool. Please forward comments to:

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Introduction

At both a national and state level there has been a strong policy focus on improving chronic disease care. Self management is a key focus of these policies. Current evidence suggests that patients with effective self management skills make better use of health care professionals' time, have enhanced self care skills and improved quality of life.[1,2]

What is Self-Management?

Self management involves the individual with a chronic condition working in partnership with their carers and health professionals so that they can:

+ Know their condition and various treatment options
+ Negotiate a plan of care i.e. care plan, and review/monitor the plan
+ Engage in activities that protect and promote health
+ Monitor and manage the symptoms and signs of the condition
+ Manage the impact of the condition on physical functioning, emotions and interpersonal relationships.[3]

Promoting self management

Health care services provide support for self-management by:

+ Emphasizing the client's central role in managing their health
+ Using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
+ Organizing internal and community resources to provide ongoing self management support to patients.[4]

There are a number of self management programs that are being offered in community health settings in Victoria in particular the Stanford University and Flinders University programs. Experience in Australia and the UK (who have attempted to integrate the Stanford program into their National Health Service) highlight that uptake of these programs is limited particularly by CALD and low socioeconomic groups. Lack of engagement and referral by GPs and other health professionals is cited as a key contributor to this poor uptake.[5]

1. The Institute for Public and Health Services Research, Monash Medical Centre, and Centre for Community Child Health, Royal Children's Hospital. Literature Review of *Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector*. Melbourne: Victorian Government Publishing Service, 2000.
2. Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self management program can improve health status while reducing hospitalisations: a randomised trial. *Medical Care* 1999; 37: 5-14.
3. Flinders Human Behaviour & Health Research Unit. What is Self-Management? Online accessed 9/9/05 http://som.flinders.edu.au/FUSA/CCTU/Home.html
4. Bodenheimer, T, Wagner E, Grumbach, K. Improving Primary Care for Patients with Chronic Illness. *JAMA*, October 9 2002 Vol 2888, No. 14.
5. Jordan J, Osborne R. Chronic Disease self management education programs: challenges ahead. *MJA* 2007; 186:1-4.

The chronic disease literature highlights the need for a broader system wide approach to effectively promote self management (SM) skills.[6,7,8] Key factors for achieving this include:

+ Integration of SM into care delivery processes, such as assessment and care planning
+ Offering a range of SM interventions that are flexible in both content and delivery
+ Delivery of programs at the local level (rather than institutionally based) to encourage community ownership and enhance sustainability
+ Effective training and information for GPs and other health care professionals
+ A robust standardised quality assurance and monitoring system
+ Agreed and standardised referral processes across health and community settings.

Self Management Organisational Assessment Tool – An Overview

The Self Management Organisational Assessment Tool that follows has been developed to assist agencies review their capacity to effectively promote self management. The tool highlights key factors identified in the literature that support promotion of self management.[9,10,11,12]

These factors have been grouped into 8 areas and examples of activities/indicators in each of these areas have been given to help services review their current skills and practices in supporting self management.

The tool has been designed to reflect on the collective practice and services of the agency **not** to review the skills of individuals within the agency.

Content of the tool

The tool covers eight key areas in relation to integration of self management into care practices:

1. Agency support
2. Staff skills
3. Initial Contact/Initial Needs Identification
4. Assessment

6. Ibid
7. Bodenheimer, T, Wagner E, Grumbach, K. Improving Primary Care for Patients with Chronic Illness. *JAMA*, October 9 2002 Vol 2888, No. 14
8. Gill M, Willcox J. *Improving Chronic Disease Care: Learnings from the Integrated Disease Management Projects.* Victorian Government Department of Human Services, Melbourne, Victoria. 2005
9. Lorig K, Stewart A, Ritter R, Gonzalez V, Laurent D, Lynch J, *Outcome measures for health Education and other Health Care Interventions.* California: Sage Publications, 1996
10. Robert Wood Johnson Foundation. *Improving Chronic Illness Care, a national program of The Robert Wood Johnson Foundation.* Online from the Improving Chronic Illness Care program. http://www.improvingchroniccare.org/index.html, accessed 18/10/05.
11. World Health Organization Noncommunicable Diseases and Mental Health. *Innovative Care for Chronic Conditions Building Blocks for Action global report.* Geneva: WHO, 2002
12. Wagner H. et al. Quality improvement in chronic illness care; a collaborative approach. *JAMA* 2001; 27:63-80.

5. Care planning
6. Group programs/health promotion
7. Information resources
8. Consumer/peer involvement

The process

1. Individual practitioners across the service who are involved in planning or delivery of chronic disease care complete the Tool.
2. Individual results are discussed and collated within disciplines or teams.
3. Representatives from teams/discipline meet to discuss responses and agree on overall ratings across the organisation. Ideally this process would be facilitated by an experienced chronic disease practitioner.
4. Results are collated and summarised. Priorities for systems change and skill development are identified.

Ratings and priorities can be used to inform development of an implementation plan for integration of self management into care delivery across the organisation.

Note: The role of the facilitator is to clarify/ interpret aspects of the skill components that participants may not be clear about and provide in depth understanding of self management practice and theory.

Completing the tool

1. Complete the tool individually by considering each of the questions and their best practice pointers **related to your team**.
2. Discuss the results with your team or discipline aiming to reach census with a collective rating score for each question. Highlight the boxes next to the best practice pointers that need particular attention for your team or discipline.
3. Representatives from teams/disciplines meet to collate results and identify priorities.

Self Management Organisational Assessment Tool

1. There is agency support for Self Management	Agree	Sometimes	Not Sure	Disagree
a. Support for the promotion of SM is articulated in the overall agency vision and is explicitly supported in agency policies and plans.				
b. Appropriate resources and time are allocated to the provision of SM in the delivery of chronic disease care and prevention.				
c. There is support for team members involved in SM to participate in related committees, working parties and professional activities.				
d. The organisation seeks to work cooperatively with other organisations to promote structured referral pathways and broaden availability of SM programs.				
e. Systems are in place to ensure client information/ record is effectively communicated within the organisation and to external referrals.				
f. Clients have full and easy access to their paper/ electronic record.				
g. Environment and systems support interdisciplinary collaboration.				
Total				

2. Staff members providing chronic disease care have the skills to promote self management	Agree	Sometimes	Not Sure	Disagree
a. Team members have appropriate qualifications and recent experience and knowledge in chronic disease conditions they are providing services for.				
b. Team members have knowledge of and the skills to integrate behaviour change theory into their practice.				
c. Team members have knowledge of and incorporate strategies to promote clients self efficacy.				
d. Team members have appropriate knowledge and skills to work with clients to effectively support skill development in relation to problem identification, goal setting and problem solving.				
e. Opportunities are provided to team members to access relevant professional development activities/resources.				
f. Team members are encouraged and supported to widen and expand their individual skills.				
Total				

3. Support for self management is integrated into agency processes at Initial Contact/Initial Needs Identification*	Agree	Sometimes	Not Sure	Disagree
Individuals eligible for the service are clearly informed of the service being offered and options discussed.				
Individuals eligible for the service are given written information about the service they will be attending and expectations of type of service, standards and client responsibilities are clearly articulated.				
Individuals not eligible for the service are referred to appropriate resources.				
Those at high risk are identified and care prioritised appropriately within the service.				
Referrals from other agencies are acknowledged (receipt of referral) and agencies are informed of progress of referral. Clients are informed of and or provided with copies of all referral communication.				
Total				

*** Initial Contact/ Initial Needs Identification**

Initial Contact is the point at which a consumer makes his or her first contact with the service system.

Initial Needs Identification (sometimes referred to as I.N.I. or INI) is an initial screening process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer's needs. INI is sometimes referred to as triage or service screening.[13]

4. Self management is integrated into assessment* of individuals with chronic disease	Agree	Sometimes	Not Sure	Disagree
Client and family/other are listened to, respected and treated as partners in care.				
Self management needs and activities are assessed and recorded in a standardised form including: beliefs, behaviours, knowledge, skills, confidence, strengths and barriers.				
Client problems are explored and clearly documented.				
Client's role in managing their condition is discussed along with health risk and benefits of change.				
Total				

*** Assessment**

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant issues and to develop a care plan.[14]

13. Primary Care Partnerships Victoria. *Good Practice Guide for Practitioners* A resource of the Victorian Service Coordination Practice Manual. State of Victoria, Department of Human Services 2007.
14. Ibid

5. Self management is integrated into care planning* for individuals with chronic disease	Agree	Sometimes	Not Sure	Disagree
Client and family/other are listened to, respected and treated as partners in care.				
All Clients have a care plan				
Options for management of their condition are discussed with client and their concerns identified and documented.				
Care plan involves collaborative goal setting based on the client's confidence in their ability to make change.				
Care plan identifies appropriate resources/programs that will support self management.				
Care plan documents a specific follow up plan that is regularly reviewed and updated.				
Copy of care plan and follow up plan are provided to the client.				
Care plan is effectively communicated to others involved in the clients care.				
Total				

*** Care Planning**

Care Planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care Planning involves the judgement/determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.[15]

6. Self management is integrated into all chronic care programs and interventions	Agree	Sometimes	Not Sure	Disagree
Goal setting is integrated into all programs.				
Programs focus on skill development including: + Problem solving + Communication + Action planning + Strategies for dealing with the emotional and social impact of a chronic disease				
Programs provide information and options for care/ management and encourage individuals to trial treatment options (within the boundaries of evidence base).				
Symptom management and appropriate action plans are provided where appropriate.				
Programs incorporate peer educators.				
Clients have access to Interpreters/navigators as needed.				
All clients have a key worker responsible for coordinating their care.				
Total				

15. Ibid

7. Information provided to clients is consistent with and provides support for self management	Agree	Sometimes	Not Sure	Disagree
Information in presented in a format that incorporates stages of change.				
Information is presented in a format that individuals can identify with, promotes skill development and self efficacy.				
Information is current, accessible and evidence based.				
Information is available in appropriate language/literacy levels.				
Tools are available to clients to record and monitor their condition and self management activities.				
Total				

8. Programs and interventions offered by the service actively support consumer/peer involvement	Agree	Sometimes	Not Sure	Disagree
Programs are offered in community settings.				
Programs are modified and targeted to engage with minority groups.				
Consumers are involved in program planning/resource development.				
Consumers are involved in Q/A, monitoring and evaluation.				
Consumers are involved in program delivery/support programs.				
Total				

Establishing priorities for skill development/ practice change

Following discussion of team responses in relation to tool components and best practice indicators for each, collate results on the table below by including the number of responses for each category.

Ask the group to indicate what they feel the overall rating for the whole organisation for each component should be. See Table1.

Ask participants to assign a priority rating to each of the components.

Guide to priority rating

High – Skills critical to improving self management within the organisation that must be addressed in the next 6-12 months

Medium – Skills critical to improving self management within the organisation that must be addressed in the next 12-18 months

Low - Skills important to improving self management within the organisation that could be addressed over the next 1-5yrs

Ratings and priorities can be used to inform development of an implementation plan, for improving chronic disease care within the organisation.

Table 1. Self Management Assessment Summary

Key area	Number Agree, Sometimes Not Sure, Disagree				Overall Rating Agree, Sometimes Not Sure, Disagree				Priority (H/M/L)
	A	S	N/S	D	A	S	N/S	D	
1. There is agency support for Self Management.									
2. Staff members providing chronic disease care have the skills to promote self management.									
3. Support for self management is integrated into agency processes at Initial Contact/Initial Needs Identification.									
4. Self management is integrated into assessment of individuals with chronic disease.									
5. Self management is integrated into care planning for individuals with chronic disease.									
6. Self management is integrated into all chronic care programs and interventions.									
7. Information provided to clients is consistent with and provides support for self management.									
8. Programs and interventions offered by the service actively support consumer/ peer involvement.									