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ISSN 1839-6348

Issue 7  
July 2009

R Katterl  
E Kalucy

# Chronic disease self-management

Chronic conditions cannot be 'cured'. Therefore effective strategies are required to manage the illnesses and minimise their consequences for patients, their families and the health system. Self-management programs represent a way in which this care may be realised. Self-management programs focus on teaching patients to control their chronic illness more effectively. These programs can be generic (for those with multiple chronic diseases) or disease specific, and are considered to be a component of the overall management of chronic disease.<sup>1</sup>

The Australian Government has focused on a dedicated push towards self-management practice. The Department of Health and Ageing currently administers the Sharing Health Care initiative as part of a package that is targeting older Australians with complex and chronic conditions.<sup>2,3,4</sup>

## The Chronic Care Model

The importance of self-management for those with chronic disease was first highlighted in the Chronic Care Model (CCM),<sup>5</sup> consisting of six elements which enable successful chronic disease management to occur:

- 1 Self-management support: the provision of tools, information and supports to enable patients to self-manage.
- 2 Delivery system design: clear definition of roles, and separation of acute and planned care.
- 3 Decision support: evidence based clinical guidelines and reminder systems.
- 4 Clinical information systems: use of information technology to improve compliance with guidelines, registries and feedback on performance.
- 5 Community resources: linkages with medical and community resources to facilitate health behaviours.
- 6 Health care organisations: governance structures of the provider organisations that reflect the importance and prioritisation of chronic disease management.<sup>5</sup>

## Models of Chronic Disease Self-Management

The *Stanford Model* was the original chronic disease self-management (CDSM) program which used peers to educate patients about disease to change health behaviours.<sup>6</sup>

The *Good Life Club*<sup>7</sup> was one of eight early Sharing Health Care Initiative demonstration sites. The project aimed to set self-management goals and provide educational information via regular telephone coaching for those who had diabetes and were over 50. It was successful at engaging hard to reach populations (men and those from culturally and linguistically diverse backgrounds).<sup>2</sup> No difference was found in measures of general health, although self-managers used fewer health services and reported that their chronic disease had less of an impact on their financial situation and relationships, and reported increased confidence in managing their disease.<sup>2</sup>

The *Flinders Model*<sup>8</sup> includes structured self-management assessment, goal setting and care planning for chronic disease. Preliminary research suggests the program resulted in increased knowledge of the disease and its management, but this did not translate into a significant impact in physiological indicators at 12 month follow up.<sup>8</sup> Professor Richard Reed at Flinders University is leading a randomised control trial to test the effectiveness of the *Flinders Model*.

While much research on self-management has been conducted on people with diabetes, many of those seeking self-management assistance have arthritis, cardiovascular diseases or mental health issues.<sup>9</sup> The efficacy of CDSM on the full spectrum of disease in Australian society has yet to be evaluated.

## What works?

A systematic review of Australian research on chronic disease management<sup>10</sup> concluded CDSM programs were effective at improving patient-level outcomes for hypertension, diabetes and heart disease. The components of successful programs included patient education, distribution of educational materials and motivational counselling. Group settings appear to be more effective than programs that were individually targeted.<sup>10,11,12</sup> A clear trend in the research is that successful programs enhance chronic disease management self-efficacy. Self-efficacy leads to self-management behaviour change, and develops as a result of programs targeting specific diseases as opposed to generic self-management programs.<sup>10</sup> This makes the benefits of non-targeted programs questionable.

## TO CONTACT PHC RIS:

Web: [www.phcris.org.au](http://www.phcris.org.au)  
PHC RIS Assist: 1800 025 882  
Email: [phcris@flinders.edu.au](mailto:phcris@flinders.edu.au)



A number of elements must exist at both the patient and system level to enable patients to self-manage:

- ⇒ Health literacy, or the degree to which one can obtain and process health information and navigate services, is a foundational element of any effort at self-management.<sup>11,13</sup> Health literacy includes being informed about, and accepting, the need for change.<sup>14</sup>
- ⇒ The Sharing Health Care projects found the reliance on some degree of GP availability for self-management support was a barrier to success in every project.<sup>12</sup> This highlights the importance of other health professionals in self-management coordination and support.
- ⇒ Other critical enablers were: multidisciplinary coordination,<sup>12</sup> well-established clinical information systems and evidence guidelines, increased support by the Divisions of General Practice for CDSM, and Allied Health Medicare items for promoting CDSM in GP settings.<sup>10</sup>

In regional and remote areas CDSM programs are dependant on context; community engagement; flexibility and responsiveness to local conditions; information management; and personal investment by those working on the support programmes.<sup>14</sup>

## Who benefits?

A challenge for CDSM lies in engaging individuals with chronic disease who do not have reliable contact with health or community services.<sup>15</sup> Those who sign up to self-management courses are generally of lower socioeconomic status (SES) and poor health.<sup>16</sup> However, attendance is less reliable for those of lower SES,<sup>17</sup> and ironically incapacity due to chronic disease is one of the main predictors of a failure to participate.<sup>9</sup> Those of lower SES and poor health derive less benefit from self-management programs when compared to the general population.<sup>11</sup> Research indicates that older individuals have a tendency to assume the role of passive recipients of health care rather than active participants<sup>18</sup> so self-management for this group can be challenging.

An implicit assumption of Australian research is that patients have access to housing, electricity, food, clothing, transport and money to buy their medications when this is not necessarily the case.<sup>8</sup> Programs must acknowledge participants' demography and background in order to achieve successful outcomes.<sup>19</sup>

## Reflections on CDSM Research

A great deal of Australian research has focused on the best-fit of the individual to the self-management program. This overlooks the multiple enablers required within the health system to make self-management work. Self-management initiatives are based on patients taking greater responsibility for their health and health care, but a responsive and accessible health system is also essential for effective chronic disease management. Chronic disease care can be difficult to access in a system as fragmented as that in Australia.<sup>11</sup> Self-management programs tend to be developed autonomously rather than as an integrated part of the system, which may lead to failure of uptake of such initiatives.<sup>13</sup> Collaboration and integration between sectors and people will be critical in facilitating program uptake and making self-management work.

## Self-Management Resources to Watch

The Chronic Care Model website: [www.improvingchroniccare.org/](http://www.improvingchroniccare.org/)

Current chronic disease management research in Australia: [www.phcris.org.au/elib/browse.php?search=Chronic+Disease+Self+Management](http://www.phcris.org.au/elib/browse.php?search=Chronic+Disease+Self+Management)

Sharing Health Care Initiative at the Department of Health and Ageing: [www.health.gov.au/internet/main/publishing.nsf/Content/chronicdisease-sharing.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/chronicdisease-sharing.htm)

Flinders Model of Chronic Conditions: [http://som.flinders.edu.au/FUSA/CCTU/self\\_management.htm](http://som.flinders.edu.au/FUSA/CCTU/self_management.htm)

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