



Northern
Territory
Government

**Chronic Conditions
Prevention AND Management
STRATEGY
2010 - 2020**

**The Northern Territory
Chronic Conditions
Self-Management Framework
2012 – 2020**



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PURPOSE

The *NT Chronic Conditions Prevention and Management Strategy 2010-2020*¹ commits the Department of Health and its partners to the development of a chronic conditions self management framework and will identify key elements, which are fundamental for the integration of self-management into current services and practice. This Framework provides a consistent approach and shared vision to self management and it adds value to existing strategies. The Framework will:

1. Inform service providers across a range of health settings about how a self-management approach can be promoted and integrated into current practice
2. Assist health professionals to deliver evidence-based self management support to ensure clients are prepared and empowered to manage their health
3. Guide managers and policy makers on how to better structure and fund the health services in order:
 - a) to support health professionals to provide self-management initiatives to clients, and
 - b) to create a supportive environment conducive to clients participating in self management.

The Framework will remain current for the life of the NT Chronic Conditions Prevention and Management Strategy ie until 2020; as such it will be evaluated together with the Strategy.

DEFINITION

Self management

“Self management involves the people with the chronic disease becoming participants through learning and practicing new skills to carry on an active and emotionally satisfying life in the face of a chronic condition.” (Lorig, K 1993).²

In the Australian context the most common understanding of self management aims and principles is articulated by the National Health Priority Action Council in their National Chronic Disease Strategy. It is an approach that requires the person, the family and carers, service providers and the health system to work together to achieve better health outcomes. Self management is underpinned by the person being at the centre of their own health care and involves the skills and resources that a person needs to negotiate the health system and maximize their quality of life across the continuum of prevention and care.³

Self management is about the client and their family/carers working in partnership with their health care provider to:

- understand their conditions and various treatment options,
- negotiate a plan of care,
- engage in activities that protect and promote health,
- monitor and manage the symptoms and signs of the conditions,
- manage the impact of the condition on physical functioning, emotions and interpersonal relationships.

Self management support

Chronic condition self-management support is what health professionals, carers and the health system do to assist the patient/client to manage their chronic conditions. (NHPAC, 2006)

Self management support differs from traditional approaches to disease management, or case-management. Self management support means acknowledging the client's central role in their care, one that fosters a sense of responsibility for their own health and acknowledges the barriers individuals face in adopting health promoting behaviours. Self management support can be provided through a range of strategies and approaches: individual and group based, face-to-face or by telephone, as part of clinical intervention and/or as a separate interaction with the person with a chronic condition.

Key elements of self management support:⁴

- Collaborative and active partnership between clients and service provider
 - Expertise is shared between client (expert on their life) and provider (expert on chronic condition care).
- Client-centred care
 - Care is planned around the client's individualized circumstances, needs and preference.
- Shared responsibility for outcomes
 - Responsibility for outcomes is shared between the client and often multiple service providers
- Empower and enhanced capacity as goals of care
 - The goal is to empower the client and enhance their capacity to engage in activities that will improve their health and care
- Care is lifelong
 - Long-term change and impacts are addressed and care is an iterative and self-corrected process.

One form or model of self-management support may not be appropriate for everyone or meet all of the needs of any one person. However, there are a number of self management support models and training programs that are well researched and evidence based, and which provide a good underlying understanding of chronic conditions self management support theory and principles. These models can be coupled with other models and systems. When partnerships exist across organisations, a range of self management support opportunities can be offered to meet the needs and preferences of clients. A brief explanation of the common models of self management is at Appendix 4.

NT CONTEXT

In Australia, chronic conditions now contribute to over 70% of the total disease burden, a figure that is expected to increase to 80% by 2020.⁵ In the Northern Territory, within the Aboriginal population, chronic conditions are estimated to contribute to 77% of the life expectancy gap between Aboriginal and non-Aboriginal populations. They account for 40-56% of public hospital resources.⁶

The importance of chronic conditions management has prompted a comprehensive strategy by the NT Government through the development and implementation of the *NT Chronic Conditions Prevention and Management Strategy 2010-2020 (CCPMS)*.⁷

The CCPMS has eight key action areas (KAA). KAA-4 of the CCPMS on Self Management commits the Department and its partners to develop a framework for self management to guide health professionals to implement consistent approaches to support people to self manage their chronic conditions. Other related Northern Territory strategies:

- Territory 2030.⁸
- Closing the Gap of Indigenous Disadvantage: the NT Government Generational Plan of Action.⁹
- The Northern Territory Department of Health Corporate Plan 2009-2012.¹⁰
- The Northern Territory Tobacco Action Plan 2010-2013.¹¹
- Nutrition and Physical Activity Action Plan 2007-2012.¹²
- The Northern Territory Health Promotion Strategic Framework 2011-2015.¹³

WHY IS A NORTHERN TERRITORY CHRONIC CONDITIONS SELF MANAGEMENT FRAMEWORK NEEDED?

Currently in the NT self management programs are being offered to clients by the Department of Health, non-government health services and Aboriginal community-controlled health services. At present this is limited in scope and not well coordinated. Across the health sectors, incorporating a chronic condition self management strategy into current practice has proven challenging, in particular for the delivery of self management programs for Aboriginal clients in remote areas.¹⁴

Many of those affected by a chronic condition struggle with the behavioural changes they need to make to successfully manage their condition. At the same time, they are striving to deal with the uncertainties of life with a chronic condition and the desire to live as normal a life as possible.¹⁵

The Wagner chronic care model (Appendix 1) has been acknowledged as an effective approach to prevention and management of chronic conditions.

The Wagner Chronic Care Model is one of the most influential models of chronic disease management. It recognizes that, with proper training and support, many people can change the progression of disease by becoming active agents in their own health. Chronic disease is best managed by productive interactions between a patient and his/her clinical health team, within a setting that utilizes a reliable, evidence-based approach to self management.¹⁶

Evidence suggests that assisting clients to self manage can result in improved health status, reduced utilization of services by clients to access general practitioner, reduced hospital admissions and increased quality of life.¹⁷ This does not mean that self management is the sole responsibility of the clients; it is **a shared responsibility** between clients and service providers, where health service providers recognize and value the client's role in managing their health and well being. Evidence also suggests that building on-going collaborative relationships between clients and health professionals, as well as

among health service providers, is necessary to realize the long-term benefits of self management.¹⁸

Incorporating self management within the health system requires a significant change in focus, which includes broader change in mission and purpose, structure and culture (values, beliefs, behaviours) of the organization.¹⁹ Further, embedding self management support requires a transformational change process to occur because it is attempting to shift the structure of how services are provided from an acute model of care to a chronic model of care,^{20, 21} which involves knowledge, skills and attitudinal change at the individual, team and system level within organizations.^{22, 23}

CHRONIC CONDITIONS SELF MANAGEMENT IN THE NT

To incorporate a self management approach into current practice, the following needs to be considered to facilitate sustainability:

Health system level

- Continued commitment by leadership of government, non-government and community-controlled Aboriginal health services to appropriately resource health services (human resource and infrastructure) to practice self-management support.
- Incorporate self management into current policy and guidelines.
- Support training and education strategies for health professionals to gain knowledge and skills to routinely support self management.
- Ensure that self management is part of clinical practice through its inclusion in multi-disciplinary care planning.
- Flexible implementation of self management approaches including identification of appropriate timing for interventions.

Addressing cultural issues for Aboriginal and other clients from non-English speaking background

Aboriginal clients:

- Identify community readiness to accept self management concept/principles.
- Foster and encourage engagement based on a whole of community approach, which recognizes the link between a self management approach and other community initiatives, such as responsible serving of alcohol, improving the quality of food at local store, tobacco control activities etc. Capacity and sustainability are the key issues to the success of programs in Aboriginal communities.
- Group sessions are preferred either family or self-selected unit/group.
- Identify and utilize local systems and structures to facilitate community participation and leadership.
- Engage with local champions including Aboriginal Health Workers (AHWs) who are in unique positions to assess the needs of individual clients and their families. This will allow Aboriginal people the opportunities to describe their health needs, including psychosocial, and to seek solutions.
- Support AHWs by providing appropriate training so they can competently respond to clients need; and these AHWs in turn are competent to train other workers in the community.^{24, 25, 26, 27}

Other non-English speaking background clients:

- Recognize the central role that cultural diversity plays in self-management.
- Provision of culturally appropriate information by utilizing an accredited interpreter/translator as well as appropriate form of other communication media such as DVD, brochures, etc. Immigrants from non-English speaking countries confront linguistic and cultural barriers that create an extra layer of challenges not experienced by Australian-born people which affect their ability to self-manage their chronic illness.
- Identify support from family, in particular regarding communication. This is one of the crucial elements for their ability to liaise with health professionals and to navigate the health systems.
- As patterns of migration around the world continue to increase, the strengthening of self management strategies that address these issues is vitally important for ensuring the ongoing good health of the Northern Territory's population from diverse cultural and linguistic backgrounds.^{28, 29}

Key features for health professionals to support client self management

Health professionals must have the full set of skills and knowledge for supporting self management including being able to:

- Listen and ask client their views and perspectives about their health
- Identify client's strength and current capacity to participate in decision making about their health
- Assess client's individual goals and ability to work together with clients to develop an agreed care plan
- Use positive language to build client's confidence in sharing the decision making about their health
- Work with other health professionals in multi-disciplinary teams to ensure clients receive a range of health services to support their ability to self manage
- Have a broad knowledge of available community resources for clients to access.³⁰

The key features for client self management

- Understand the chronic condition and its management
- Adopt a self management care plan agreed and negotiated in partnership with health professionals
- Actively share in decision-making with health professionals, if necessary, involve family and carers
- Ability to monitor and manage signs and symptoms of the condition
- Ability to manage the impact of the condition on physical, emotional, occupational and social functioning
- Adopt lifestyles that address risk factors and promote health by focusing on prevention and early intervention
- Competent and confident to use support services. (NHPAC, 2006)

SCOPE

This Framework can be applied to all chronic conditions. It is aligned with the Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020, and therefore is focusing on:

- Cardiovascular disease
- Rheumatic heart disease
- Type 2 diabetes
- Chronic airways disease
- Chronic kidney disease
- Chronic mental illness
- Cancers (associated with common risk factors for other chronic conditions)

These conditions share similar risk factors within the realm of social determinants of health, thus this Framework will focus on the SNAPE risk factors:

- reducing **S**moking
- improving **N**utrition
- reducing rates of harmful and hazardous **A**lcohol consumption
- increasing **P**hysical activity
- improving **E**motional well being

Priority groups identified for additional support include:

- Aboriginal people, in particular those living in remote communities
- People from culturally and linguistically diverse backgrounds
- People in low socio-economic circumstances, and
- Young and Older Territorians

The Framework can be applied at different settings:

- Primary care
- Hospital, and
- Rehabilitation and other sub-acute care

THE FRAMEWORK

The development of this Framework has been informed through the input of key stakeholders representing the Northern Territory chronic conditions network within the Department of Health, non-Government health services and Aboriginal community-controlled health service providers. Consultations¹ included a series of focus groups conducted in urban and remote Aboriginal communities and attended by health professionals (working in policy/program and operational settings) and consumers (people with chronic conditions and their families or carers). A list of consultation is at Appendix 2.

An NT Self Management Working Group (Appendix 3) provided support for the development of this Framework. The members of this Working Group are clinicians who are currently providing self management support to clients/patients with chronic conditions. The draft Framework was distributed for comment to members of the NT Self Management Working Group, the people who were consulted, members of the NT Chronic Conditions Network Steering Committee, and the Department of Health Executive.

The Framework is based on the evidence of experience elsewhere and builds on the work undertaken in Queensland in their Framework for Self-management 2008-2015³¹ and recent work in Western Australia.³² The Framework consists of the **principles**, which form the foundation of self management approaches for effective service delivery, and the **enablers** that support operationalising a self management approach.

¹ A consultation report is available on request by contacting the Chronic Conditions Strategy Unit, Health Development Branch, Health Services Division, Department of Health, on 08 8985 8071.

Goal:

Health services that promote and support self management and empower individuals with chronic conditions to actively participate in their own health care

Principles			
Person-centred	Deliver across the continuum of health and wellbeing	Capacity building	Sustainability
Enablers			
Partnerships	Equity and access	Continuous quality improvement	Supportive Systems
Objectives			
<ol style="list-style-type: none"> 1. Build a culture that supports self management within health services, clients and their families and/or carers. 2. Provide access to quality services that support the capacity of client with chronic conditions to self manage. 3. Build the capacity health services to deliver evidence-based self management support. 			

Principles

1. Person-centred

This approach values the needs of clients, carers and staff, with emphasis on the reciprocal nature of all relationships.

- a. Place the individual at the centre of the care they are receiving
- b. Respect the individual's preferences, values and cultures
 - i. The Northern Territory health professionals working in remote communities are often challenged with preferences identified by (Aboriginal) clients that may appear to be not directly health-related.
 - ii. Self management must acknowledge the values of Aboriginal history, culture and tradition by supporting them to identify their own priorities, supporting the community to create the solutions they would like to explore, and working with them to secure the resources to implement solutions.

- c. Collaborate and negotiate with other health service providers, the individuals and their families and/or carers to ensure the provision of quality and coordinated care.
 - i. Specific modification to generic self management is required for clients who fall within the 'priority group' of this Framework.

For Aboriginal clients, in particular, health professionals must be able to:

- determine local community's readiness for the delivery of self management program, and
 - utilize local processes, which vary from one community to the other, including identifying local champions (such as Aboriginal Health Workers, Community Workers) and make use of local community initiatives such as 'responsible service of alcohol', 'improving the quality of food in local store', 'tobacco control activities'.
- d. Facilitate information sharing (best available evidence) between health professionals and individuals to support the client's decision making. This information should be delivered in an appropriate environment paying special attention to cultural appropriateness.

2. Across the continuum of health and wellbeing

Action across the continuum of health uses strategies to bring about change from building individual skills to changing systems.

- a. Support clients to practice health promoting behaviours irrespective of their chronic condition or setting.
 - i. Support clients to develop the knowledge, confidence and skills to enable them to change their risk behaviors and sustain a healthy lifestyle.
- b. Promote a self management approach in the health system across the life continuum, acknowledging the changing needs as people age as well as the different health issues faced by people from different socio economic background.

3. Capacity building

- a. Engage local communities in planning and delivering self management approaches by linking with and building on existing local initiatives.
 - i. Accommodating diversity

- ii. In relation to Aboriginal communities, these local initiatives may not be appear to be directly linked with health activities; eg apprenticeship or local training programs, home and community programs, etc.
 - b. Support education and training to build the capacity of health professionals to implement self management approaches.
 - i. Health professionals are provided with opportunities to improve their knowledge and skills required to provide self management support.
 - ii. It is essential that health professionals working with Aboriginal clients are appropriately trained in cultural security including understanding of Aboriginal experience and history related to their understanding of health and response to mainstream health services.
 - c. Promote collaboration among health service providers to ensure the integration of self management approaches into health service delivery.
4. Sustainable self management
- a. Incorporate self management into policy and service delivery guidelines.
 - b. Health programs are adequately resourced.
 - i. Promote innovative ways of using resources, including utilizing the chronic conditions networks to support and maintain the significant and necessary changes required to incorporate self management into current policy and practice.
 - c. Promote the inclusion of self management in curriculum for health students to ensure the emerging workforce is adequately skilled to support consumers in self management initiatives.
 - d. Support existing evidence-based self management initiatives.

Enablers

- 1. Partnership
 - a. Promote collaboration among health service providers and cross-sectorally to ensure clients receive quality and coordinated care.
 - i. Utilise multi disciplinary approach to manage clients with chronic conditions.
 - b. Establish and promote the use of chronic conditions self management network to support health professionals in delivering self management support and sharing outcomes.
 - c. Acknowledge and engage the support provided by family, friends and carers.

2. Equity and access
 - a. Services provided are based on need.
 - b. Services are flexible, provided in a timely manner, in a non-threatening environment and culturally appropriate.
 - c. Provide easy access to resources including web-based resources.
3. Continuous quality improvement (CQI)
 - a. Self management initiatives are based on best practice evidence.
 - b. Promote and support the evaluation and monitoring of self management initiatives.
 - c. Promote and support CQI activities across all health services.
 - d. Identify appropriate education and training for health professionals to sustain the implementation of self management initiatives.
4. Supportive systems
 - a. Promote the sharing of information among health professionals and service providers.
 - b. Promote and encourage the recording of self management goals onto electronic health records for easy recall and sharing of information among health service providers.
 - c. Align any new clinical information system on self management with the NT eHealth agenda.

IMPLEMENTATION AND EVALUATION

The NT Chronic Conditions Self Management Framework provides a strategic and operational direction to inform and guide health service providers and policy makers across a range of sectors. It provides a consistent approach to promoting and integrating self management approaches into current and future service delivery.

This Framework highlights that a move to self management will require significant change. Implementation of this Framework will need to consider the opportunities and challenges arising within a complex and changing health environment, in particular within a resource-constrained environment.

This Framework includes a high level implementation plan; a more detailed plan will be developed following endorsement of this Framework by the Department of Health Executive and its key stakeholders.

The Framework will be monitored throughout its timeframe. Its evaluation will be incorporated into the evaluation of the NT Chronic Conditions Prevention and Management Strategy 2010-2020 and will report against identified performance measures.

IMPLEMENTATION PRIORITIES

The following priorities will be achieved within the first 3 years.

1. The NT Chronic Conditions Self Management Framework 2012-2020 is endorsed by the key stakeholders for the following groups identified as priority to implement the Framework.
 - a. Department of Health:
 - i. Preventable Chronic Disease Educators
 - ii. Chronic Disease Teams (Cardiac, Respiratory, Diabetes), Royal Darwin Hospital and Alice Springs Hospital
 - iii. Renal Services
 - iv. Community Health
 - v. Remote Health
 - b. Non-government and Aboriginal health services
 - i. Healthy Living NT
 - ii. Asthma Foundation NT
 - iii. Western Desert Nganampa Walytja Palyantjaku Tjutaku - Purple House
 - iv. Sunrise Health Service
2. Self management education and training for health professionals.
3. Self management is incorporated into organizational learning and professional development.
4. Implementation of self management tools for use by health professionals.
5. The development of policy, guidelines, and standards on self management.
6. Establish a Self Management Network.

IMPLEMENTATION PLAN

Objective 1: Build a culture that supports self management within health services, clients and their families and/or carers.

Strategy	Action	Performance measures	Timeframe (ST, MD, LT)*
Consistent approach to self management by health services guided by the Implementation Plan of the NT Chronic Conditions Self Management Framework 2012-2020.	The NT Chronic Conditions Self Management Framework is communicated to key stakeholders for endorsement and support	The NT Chronic Conditions Self Management Framework 2012-2020 is endorsed by key stakeholders and implemented by target group (refer Implementation Priorities 1)	ST
Collaborate with key partners to foster and reflect self management in current practice supported by policies, guidelines and standards	Develop or modify policies/guidelines/standards to reflect self management in current service delivery	<p>Policies/ guidelines/standards on self management are developed/modified</p> <p>Self management is reflected in all relevant strategic and operational plans, policies and guidelines across the continuum of health: community health, hospital, Aboriginal health service providers and non-Government health service providers</p>	<p>ST</p> <p>LT</p>
Provide networking and mentoring opportunity to encourage best practice self management development of health providers and the sharing of information	Explore options to establish a self management network, eg through the NT Chronic Disease Network	NT self management network is established	ST

* ST=Short Term 2012-2014; MD=Medium Term 2015-2017; LT=Long Term 2018-2020

Strategy	Action	Performance measures	Timeframe (ST, MD, LT)*
Easy navigation of referral system	Develop or improve clear referral pathways for clients with chronic conditions	Referral pathways are developed to ensure clients are linked into appropriate chronic conditions self management support	MT

Objective 2: Provide access to quality services that support the capacity of client with chronic conditions to self manage

Strategy	Action	Performance measure	Timeframe (ST, MD, LT)*
Strengthen the use of clinical information systems, electronic shared health records, and delivery system design by health professionals to support self management with clients	Self management is recorded (by health professionals) in the electronic client records	Evidence of recording self management components as part of the chronic conditions management plan	MT
Monitor and evaluate self management programs	Support health professionals to develop skills in planning, monitoring and evaluating self management initiatives or programs using QIPPS (Quality Improvement Program Planning System)	Self management initiatives and programs are recorded in QIPPS	MT
Promote the use of evidence-based self management initiatives	Support health professionals to access information on evidence-based self management initiatives through various medium eg on-line training, journal articles, net-working	Self management initiatives or programs utilize the principles outlined in this Framework	LT

* ST=Short Term 2012-2014; MD=Medium Term 2015-2017; LT=Long Term 2018-2020

Strategy	Action	Performance measure	Timeframe (ST, MD, LT)*
Provide clients with a range of access to information on self management	Health services devise appropriate and accessible information on self management for clients using various medium, ie internet, DVDs, leaflets, brochures, talking posters etc	Accessible and relevant self management information for clients is available and used by clients including internet, DVDs, leaflets, brochures, talking posters etc	LT

Objective 3: Build the capacity health services to deliver evidence-based self management support

Strategy	Action	Performance measure	Timeframe (ST, MD, LT)*
Delivery of culturally appropriate evidence-based self management initiatives	Managers support health professionals by providing access to self management training and development opportunities	Health professionals gain accreditation in self management through accessing evidence based training eg through Flinders, Stanford and others	ST
		Self management is incorporated into organizational learning and professional development	ST
		Inclusion of self management in the curriculum for health students at Charles Darwin University	LT
	All health professionals working with Aboriginal clients attend comprehensive and relevant best practice cultural	Health professionals working with	ST

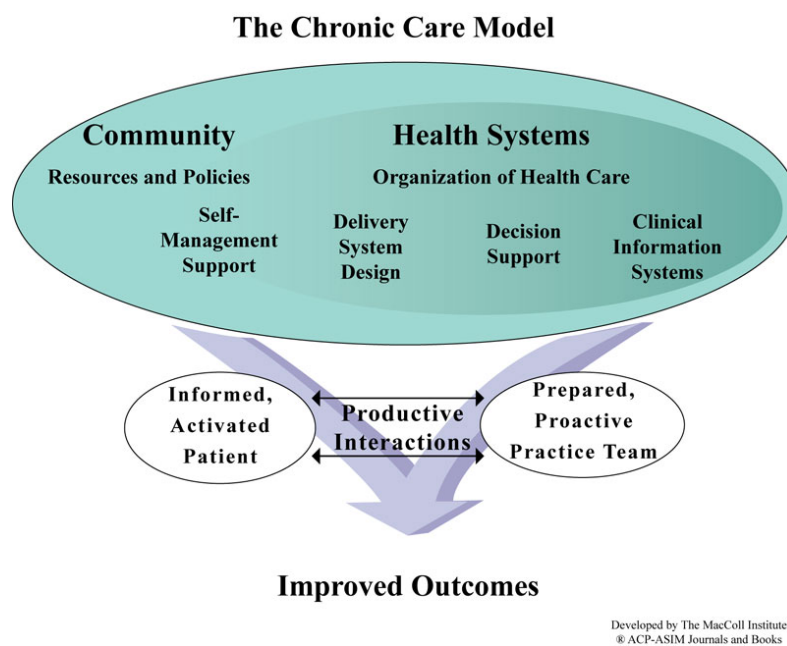
* ST=Short Term 2012-2014; MD=Medium Term 2015-2017; LT=Long Term 2018-2020

Strategy	Action	Performance measure	Timeframe (ST, MD, LT)*
	<p>awareness professional development</p> <p>A range of self management tools for different target groups and settings are identified and utilized by health professionals</p>	<p>Aboriginal clients completed best practice professional development on cultural security awareness</p> <p>Evidence of self management tools being used by health professionals</p>	MT
Empowering clients towards adopting self management strategies	Promote healthy lifestyle and self management support and groups for clients	<p>Evidence of clients involvement in identifying priorities and planning for their care through self management support initiative including groups</p> <p>Increased number of community self management support groups in urban setting</p> <p>Increased number of self management groups or initiatives in remote Aboriginal communities</p>	<p>ST</p> <p>MT</p> <p>MT</p>

APPENDICES

Appendix 1 – The Chronic Care Model

The Wagner Chronic Care model identifies the essential elements of a health care service provider or system that encourages high quality chronic disease care. The elements are interdependent components, building on one another.



- Health systems that create a culture, organization and mechanisms that promote safe, high quality care
- Delivery system design that assures the delivery of effective, efficient clinical care and self-management support
- Decision support that promotes clinical care consistent with scientific evidence and patient choices
- Clinical information systems that organizes patient and population data to facilitate efficient and effective care
- Self management support that empower and prepare patients to manage their health and health care
- The community that mobilizes community resources to meet the needs of patients

Appendix 2 – List of consultation

Consumers

1. Top End Troupers and Breath Easy – Darwin urban
2. Groovy Grans Line Dancing Group – Darwin urban
3. Pirlangimpi community – Top End remote
4. Milikapiti community - Top End remote
5. Wilora community – Central Australia remote

Health professionals

1. Health Development Team Top End and Central Australia, Department of Health
5. Chronic Conditions Coordination Unit, Royal Darwin Hospital, Department of Health
6. NT Renal Services, Department of Health
7. Alice Springs Hospital, Department of Health
8. Remote Health: Clinic Managers and Aboriginal Health Workers at Pirlangimpi and Milikapiti
9. Central Australia Aboriginal Congress
10. Danila Dilba Health Service
11. BakerIDI: Diabetes Educator
12. Healthy Living NT – Darwin and Alice Springs
13. Asthma Foundation, NT
14. Arthritis and Osteoporosis, NT

Appendix 3 – Members of NT Self Management Working Group

1. Team Manager Central, Health Development , Department of Health – CHAIR
2. Diabetes Educator – Top End, Health Development , Department of Health
3. CNC Peritoneal Dialysis, Renal Service, Department of Health
4. Education Manager, Asthma Northern Territory
5. Manager Healthy Living Northern Territory
6. Clinical Nurse Consultant, Respiratory Unit Royal Darwin Hospital
7. Preventable Chronic Disease Coordinator, Royal Darwin Hospital
8. Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation (WDNWPT - Purple House), Alice Springs
9. Diabetes Educator, BakerIDI
10. PCD Coordinators, Sunrise Health Service
11. Palmerston Community Health Centre Manager, Department of Health
12. Chronic Conditions Strategy Unit, Health Development, Department of Health

Appendix 4 – Common models of Self Management

There are three main models of self management in chronic conditions care: the *Stanford Program*, the *Expert Patient Program* and the *Flinders Program*.

The ***Stanford Program*** of self management is based on self-efficacy theory and reasons that improvements in client's self-efficacy about chronic conditions will lead to better health outcomes and lower health system utilization. It is based on the premise that people with chronic conditions have similar concerns, they are capable of taking responsibility for managing aspects of their conditions, and will have better outcomes with specific skills and training. The program uses peer educators and a standardized 6-week group program applicable to many chronic conditions.³³

The ***Expert Patient Program***,³⁴ developed in the United Kingdom and based on the Stanford Model. The aim of the program is to give people the confidence to take more responsibility to self-manage their health, while encouraging them to work collaboratively with health and social care professionals.

The ***Flinders Program*** of self management³⁵ is complimentary to the Stanford Model and promotes the role of the physician or provider in building self-efficacy skills with the client and actively engaging the client in using these skills during client-physician interactions. It is a one-on-one model based on cognitive behavioural therapy (CBT) principles. The Program aims to provide a consistent approach to assessing the key components of self management that:

- improves the partnership between the client and health professional/s
- collaboratively identifies problems and therefore better (i.e. more successfully) targets interventions
- is a motivational process for the client and leads to sustained behaviour change
- allows measurement over time and tracks change
- has a predictive ability, i.e. improvements in self-management behaviour as measured by the Partner in Health scale, relate to improved health outcomes.

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