2012

Self-Management and Primary Care in Manitoba

The Way Forward

DISCUSSION PAPER

Primary Health Care
Manitoba Health
May 2012

Executive Summary

Manitoba's healthcare system is challenged to respond effectively to the growing impact of chronic disease on healthcare delivery and the health of communities. Over half of Manitobans live with at least one chronic condition. A recent report found that Manitobans living with even one of five chronic conditions (including arthritis, asthma and chronic obstructive pulmonary disease, diabetes, coronary heart disease and stroke) over a two-year period used between 2.6 to 8.2 times more health care dollars (~$24,000 for stroke) than those not burdened by the condition (~$4,000).

Self-management is a key element of primary care renewal and one component of person-centred, quality improvement strategies to address the chronic disease burden. Supporting and improving self-management is a concrete action to shift the focus of health care delivery away from institutions and toward the person's own 'home as the hub' from which self-management occurs. Individuals who self-manage their health from their home experience fewer access issues with care and may experience fewer costly hospital re-admissions and reduced utilization of emergency room services. Supports such as TeleCARE can result in increased access to necessary care and promote proactive self-management.

This discussion paper will review available evidence on the effectiveness of self-management initiatives across the care continuum, from the identification of risk to the management of chronic disease, as well on the necessary supports. Gaps in current provincial and regional services in Manitoba will be analyzed and opportunities for strengthening self-management identified from the perspective of systems, health care providers and clients. A number of service and knowledge gaps exist at various levels in relation to strengthening self-management supports and include:

System

- Limited use of alternative funding models and support for practice redesign
- Limited access to electronic information systems to support team-based care
- Lack of an evaluation framework and information on effectiveness of existing initiatives
- Knowledge gap regarding which services are best aligned with which population groups; for example, what is the most effective approach with difficult-to-reach/disadvantaged groups?
- Fragmentation of services between primary care and health sectors, other sectors and community supports
- Telephone self-management supports currently only address two chronic conditions
- What role could self-management play in high risk / high intensity models such as virtual wards?
- What kinds of self-monitoring devices are needed?

Provider

- Lack of understanding regarding how supports such as TeleCARE and Health Behaviour Change training are transforming practice and the patient experience
- Absence of provider self-assessment in terms of education and training needs in order to support patient self-management
- To what extent are providers referring patients to community-based self-management programs?
- To what extent are providers asking patients about their own goals including goals around self-management?
- Limited inter-professional team-based care to allow providers the time needed to support patients with complex conditions

Individual

- Individuals continue to rely on health care providers and the health care system to manage health issues, with limited self-management support
- What level of awareness do health care consumers have regarding available self-management program options?
- How closely does current program availability match need? How should it match their needs in the future?
- Inconsistent and/or limited involvement of individuals and caregivers in changing the quality of care

Recognizing these gaps, a focus on self-management in Manitoba is best achieved through a multi-faceted approach, leading to increased capacity in the following areas:

- Appropriate system supports
- Support from knowledgeable and skilled health care providers
- Improvement in self-care by the individual.

Many jurisdictions recognize the importance of self-management in building system capacity and target resources within this area. Although there are gaps in evidence regarding beneficial components, groups most likely to benefit and resulting impact on health care costs; research and program evaluations assessing the efficacy of self-management programs and other related interventions are promising,

Recommendations

The following actions are recommended to strengthen self-management and the provision of self-management supports in Manitoba:

Year 1

1. That system partners seek to narrow the knowledge gap with respect to the appropriateness of different self-management initiatives for various target groups, identify which key population groups are being missed and reasons for their exclusion*[System]*;

2. That Manitoba Health and regional partners develop and implement a comprehensive evaluation framework for current self-management initiatives in the province and for those under consideration by regions *[System]*;

3. That Manitoba Health, with regional partners, support current self-management initiatives and plan for integration within primary care and other areas of the health care system. *[System/Provider];*

4. That the capacity and reach of TeleCARE be fully utilized and integrated within the primary health care system, then expanded through the addition of another priority chronic condition, such as hypertension, COPD or asthma *[Individual]*;

5. That Manitoba Health ensures that existing self-management services are sustained, improved and enhanced for effectiveness. *[System/Individual];*

6. That Manitoba Health presents a plan for the development of an online health portal that would provide tailored self-management supports that are also integrated into the primary care system. *[System/ Provider/Individual].*

Year 2

7. That Manitoba Health, with regional partners, develops strategies to increase provider awareness of available supports and facilitation of personal self-management. This would be accomplished through existing partnerships, such as with the universities, RHAs and NGOs *[System/Provider];*

8. That as Primary Care Networks (PCNs) are implemented, Manitoba Health promotes a focus on self-management supports within PCNs and primary care in general, with a specific emphasis on at-risk populations, such as those at high-risk of complications and re-admission *[System/Provider]*;

9. That if approved, Manitoba Health begin implementing an online health portal that would provide tailored self-management supports that are also integrated into the primary care system. *[System/ Provider/Individual].*

Purpose

To live well, prevent and effectively manage health concerns, many individuals require supports and tools to be effective self-managers, to understand their condition, to monitor their symptoms and to be supported in decisions about care and available resources. They need to be supported within their communities, by health care providers and throughout the health care system.[1] This is a key component of person-centred care. Individuals living with a chronic disease benefit when they take a proactive role in their health and manage their risk behaviours in order to see health improvement.

Manitoba Health's vision is 'Healthy Manitobans through an appropriate balance of prevention and care'. Self-management and self-management supports are important components of person-centred prevention and care services. A multi-faceted Manitoba self-management initiative integrated within primary care and other areas of the health care system responds to the burden of chronic disease and supports the Department priorities of Health System Innovation, Improved Access to Care, Improved Service Delivery and Improving Health Status & Reducing Health Disparities amongst Manitobans.

This discussion paper will review available evidence on the effectiveness of self-management initiatives across the care continuum, from the identification of risk to the management of chronic disease, as well on the necessary supports. Gaps in current provincial and regional services in Manitoba will be analyzed and opportunities for strengthening self-management identified from the perspective of systems, health care providers and clients. Recommendations will consider essential elements in promoting and integrating self-management, potential barriers and a variety of approaches to develop an effective initiative.

The Problem

Increasing prevalence of chronic disease is a serious, growing problem both in Manitoba and worldwide[2]. Health care resources for chronic illness are increasing, without reducing the burden on the patient, communities or the health care system. Moreover, Manitoba is experiencing overall population growth and an aging population[3]. These factors are increasing the demand across the health care system, be it for primary care, in-patient care, emergency medicine or expensive diagnostic and treatment procedures and therapies.

Over half of Manitobans live with at least one chronic condition. A recent report found that Manitobans living with any one of five chronic conditions (osteo- and rheumatoid arthritis, asthma and chronic obstructive pulmonary disease , diabetes, coronary heart

disease and stroke) use between 2.6 to 8.2 times more health care dollars than those not burdened by the condition. For example, spending on average for all Manitobans without one of the chronic conditions studied is about $4,000 per person over two years. Spending on Manitobans with one of these chronic conditions ranges from twice as much for asthma and COPD to six times as much for people who have had a stroke[4].

The burden of chronic disease extends beyond the direct cost of health services in terms of hospital care, specialized treatment, physician care, prescription drugs and additional direct health expenditures. Indirect costs include the value of economic output lost because of illness, disability or premature death, as well as the impact on individual quality of life and the health of communities[5].

With concerns about future capacity of the health care system to support increasing demands due to chronic disease management, it is necessary to find new, effective and innovative ways to better meet the needs of persons with chronic conditions. A shift in health policy towards person-centred care is inevitable[6]. Such a shift is tantamount to achieving accessible, quality care for all Manitobans. To this end, there is a need for a person-centred care strategy, targeting several key health service challenges within Manitoba including:

- Lack of timely access: Manitoba has a very geographically dispersed population, where health can be further compromised due to lack of timely access to primary care services; in some instances, communities have sporadic access to services. [*System*]

- Provider Capacity:
  - Recruitment of primary care providers in rural and remote communities is a growing problem.
  - Lack of time and absence of multidisciplinary teams in primary care offices limits capacity to provide comprehensive chronic disease management counseling and support *[Provider]*.

- Inappropriate utilization of services: clients with chronic disease have complex and often overlapping medical needs, which are not necessarily best managed in acute settings such as emergency departments. Where alternatives exist, overdependence on acute settings can often unnecessarily overburden the system. [*Systems/Individual*]

Individuals manage their health daily, and those with chronic conditions spend only a small percentage of their time with health care providers[7]. Yet the vast majority of health resources are dedicated to hospital care, provider payments, pharmaceuticals, administration and other institutional care; as much as 80% of all health spending[8]. A systematic approach to self-management from the various levels of health system, provider and individual aligns with a shift to community-focused support and care.

Definition of Self-management and Self-management Support

Numerous definitions of self-management exist in the literature, but all identify similar key elements. *Self-management* is having and demonstrating knowledge, skill, confidence, judgment and appropriate behavior(s) in order to live well and participate actively with health care providers in the management of one's overall health [9,10,11,12]. In addition to education and skill development, self-management includes goal setting, developing action plans, deciding how to overcome barriers and monitoring progress to achieve personal goals. *Self-management supports* are those programs, services, tools or resources which aid individuals to self manage as described above.

Self-management is a key element in primary care renewal and one component of *person-centred care,* a concept that emphasizes the partnerships necessary between individuals and providers in pursuing health and wellness and personal health goals. Seeking and valuing the voice of the individual and family in care decisions is emphasized, as is the responsibility of providers for coordinating care[13]. As a quality improvement strategy, self-management should be one component of a set of integrated person-centred approaches to address chronic disease, including interdisciplinary teams, case management, reminders, client education, an electronic registry, clinical education, self-management support, audit and feedback (integrated into primary care)[14].

The role of individuals in self-management is to take part in the decision making process regarding their care, engage in activities that promote their health, monitor symptoms of their illness, manage emotions and relationships as they relate to their health and engage in a collaborative management and treatment plan. These roles may also apply to informal caregivers, who may need to take on some of these activities. The role of health care providers in self-management is to act as a consultant, interpreting symptoms, being a resource, offering treatment suggestions and assisting the person in achieving self-management goals[15]. Decision-makers in the healthcare system need to engage with stakeholders, ensure that strategic goals and initiatives align in this area, ensure that initiatives are adequately reviewed, evaluated and revised as needed and plan for addressing gaps.

Available Evidence on Self-management

Many jurisdictions recognize the importance of self-management in building systems capacity and are targeting resources within this area. However, the evidence-base for this shift is in the early stages of development. Gaps remain in the understanding of which components of initiatives are beneficial, the groups most likely to benefit from self-management and the resulting impact on health care costs. While these gaps persist, there is positive evidence supporting the promise of self-management and reason for optimism in moving ahead with initiatives to support it.

Relative benefit between supportive components of self-management strategies remains unknown, both between self-management initiatives and as opposed to more provider-led interventions on health. What is known is that effective self-management must be supported by knowledgeable professionals[16], focus on care re-design rather than simply targeting patients[17], be tightly integrated with the patient's regular primary care provider[18] and that self-management can target some conditions and populations better than others.

A 2008 survey of Canadians found that the vast majority of respondents with one or more select chronic conditions have a regular family doctor or place of care, but the figures are less positive when it comes to receiving support for self-management[19]:

- About 1/2 to 2/3 of Canadians with one or more select chronic conditions are asked to talk about their goals in caring for their chronic disease
- About 2/3 are shown that what they did to care for themselves influences their health conditions
- About 1/4 - 1/3 receive a written list of things they can do to improve their health
- At best, 1/4 are referred to a specific group or class or to attend a community program
- At best, 1/4 - 1/2 are told how their visits to specialists or other doctors helped their treatment

Evidence suggests that certain components of self-management strategies can positively impact health, but rarely do evaluations determine relative effectiveness of complex initiatives or their components and they tend to focus on single disease groups, most commonly heart failure[20]. Reviewers have found that the majority of available studies do not provide adequate evidence of the effectiveness of the interventions reviewed[21]. It is not yet well defined where efforts should be targeted to reach the greatest number of people or to target specific at-risk groups. There is promising evidence in support of self-management services on certain specific conditions, namely: diabetes, hypertension, coronary heart disease, asthma, epilepsy and mental health[22]. There is also insufficient evidence for other conditions (for example osteoarthritis[23]) and even evidence against its use (namely anaphylaxis[24]).

Healthcare Utilization: Self-management education has been found to reduce the probability of at least one hospital admission, as compared to control groups, with no detrimental impact on other health outcomes[25].

Cost-effectiveness: There is some support that self-management, particularly through tele-homecare, appears to reduce health care costs[26], although this is not yet definitively supported by available evidence[27]. A review of previous studies found that some may have been flawed in their approach[28].

Targets: Self-management may be more effective by targeting specific groups. In Winnipeg, for example, there is client-informed support for including those with low incomes, socially disadvantaged, low levels of education or literacy and those who are not currently managing their conditions well[29].

Program Design: The United Kingdom Expert Patient Programme (EPP), based on the commonly used Stanford Model, has been viewed by stakeholders as having a positive impact on health. An internal review[30] of the program made a number of recommendations for improvement:

- Further training is needed for clinicians in the core competencies of self care
- A self-management pathway for patients should be developed
- The collective experience of the clinical teams and the patients need to be fed back into the design of services that support patients to self manage
- More effective methods to identify and refer patients with low levels of health literacy are required
- Personal self-management goals should be fully integrated into the care planning process
- Introduction of a self-care case management and whole family approach for patients with the poorest outcomes and highest social barriers to behaviour change

Studies report mixed results regarding lay-led programs, with no definitive conclusions, and further evaluation is needed. Lay-led programs may lead to at least short-term benefits to the patient, but the impact on health care usage or outcomes is indeterminate[31]. The extent to which EPP and the Stanford Model have quantifiably been effective and contained costs or avoided admissions has been questioned[32]. The literature shows that the impact of these programs may be smaller than early reports implied. A recent Cochrane review found that the majority of interventions employing 'lay health workers' targeted low income and minority populations and yielded promising benefits in promoting immunization uptake, improved outcomes in selected infectious diseases and breastfeeding promotion. For other intervention areas, the evidence was not sufficient to determine effectiveness[33]. Inconsistency in findings may be due to the inclusion in the analysis of several different types of lay led programs[34]. There are also some promising examples of using Community Health Workers in supporting self-management and promoting healthy behaviours[35]. However, some studies have suggested that the most effective interventions are those provided by a health care professional and integrated into regular care.

Recently, there have been efforts to take advantage of online and social networking resources (e.g. YouTube, Facebook) which could provide even more accessible information and social support for individuals with high technical and health literacy. These tools have the potential to not only provide health information, but also to connect individuals with each other and with experts through connectivity and interactive dialogue. The effectiveness of such tools has not yet been thoroughly evaluated.

So while the research in self-management is in the early stage of development, the results are still promising and Manitoba needs to understand what is currently in place in order to build and expand on these successes.

Current State of Self-management Initiatives

Canada

Self-management is becoming widely recognized as a necessary part of any treatment plan[36]. In support of this, Accreditation Canada, in its health care accreditation process, now incorporates a set of standards under 'Supporting Clients to Self-Manage their Condition'[37].

Based on an environmental scan of programs and services that foster and/or support self-management of chronic disease across Canada, the dominant model is the Chronic Disease Self-management Program or CDSMP (originating from Stanford University in the USA). In all regions of the country, there is general acknowledgement that self-management programs have had limited success in attracting or retaining large segments of the population, particularly the young, elderly, those living in poverty, those living in rural/remote settings and Aboriginal people. Various jurisdictions are working at addressing this gap[38].

As noted earlier, many Canadians with chronic conditions such as diabetes and heart disease say they don't regularly receive the self-management support recommended to help them better manage their health.[39]

Manitoba

There is a substantial amount of effort dedicated to supporting self-management throughout the regions. The following list is not exhaustive and will be informed by a more intensive review and consultation with the regional health authorities.

Some current or developing Manitoba examples of self-management supports include:

- **TeleCARE Manitoba** *[System/Provider/Individual]*

  This province-wide program is delivered by specially trained nurses and dietitians who provide tools, education and support over the telephone and by videoconference to individuals with heart failure and type 2 diabetes.

  Program Evaluation

  Recent reports on the initial phases of self-management services found that:

- the self-management support component, once integrated with primary care, was central to success
- the total number of hospital visits was significantly reduced by 27% between year 1 and year 2
- participants experienced a 5% drop in weight overall
- the majority of participants maintained targets for blood pressure and HgA1C
- most program participants were in the maintenance stage of change and were maintaining lifestyle behaviours
- participants achieved approximately 70% adherence with target behaviors
- both providers and participants had high satisfaction ratings although physicians felt that communication between themselves and the program could be improved
- there were some challenges with awareness of the service among providers and participants and that use of multiple service entry points improved access
- it is important to plan for incorporating services into existing services and providing complementary care, rather than duplication of service
- change management processes require further review
- there is opportunity to enhance the implementation of Telehealth within the service
- there is a need to develop a range of self-management options for Manitobans
- evidence is lacking with regard to which populations are of greatest need for this intervention (disease severity, age, SES, First Nations status, etc.)

- **Dial-a-Dietitian** *[System/Individual]*

  This telephone-based service provides advice on food and nutrition to help individuals and families maintain health. Nutrition information is provided verbally or through written resources provided directly to the caller. Contact information or referral to other community nutrition support programs for more in-depth nutrition advice or counseling may be offered and provided.

- **Regional Diabetes/Chronic Disease Program** *[System/Provider]*

  This province-wide service delivery model is supported by a community-based multidisciplinary team of health professionals and providers within each regional health authority, providing services for Manitobans with and at risk for diabetes and other chronic diseases. Self-management education is a core component of this program and includes a person-centered needs assessment and adult education principles to ensure appropriate goal identification, interventions and evaluation.[40]

- **Get Better Together! Manitoba** *[System/Individual]*

  This province-wide peer-led group program for people with ongoing health conditions is based on the CDSMP model developed by Stanford University, with central coordination provided by the Wellness Institute at Seven Oaks General Hospital. Participants frequently live with two or more co-morbidities. In 2011, the

Wellness Institute estimated cost savings of $767 per GBT participant, based on program costs weighed against literature-informed projections of savings[41]. Efforts are underway to provide Get Better Together! Manitoba to First Nation communities and explore the feasibility of an online version.

Health Outcomes Measures

A 2011 report[42] from the Wellness Institute at Seven Oaks General Hospital that evaluated 54 programs across Manitoba noted an average participant age of 64.8 years and reported statistically significant improvements among participants in self-rated health, cognitive symptom management, self-efficacy and health behaviours. This program is focusing on increased participation rates, both in program uptake and increased class size, to be achieved in part through greater integration with the health care system. Initial steps have been taken to enhance integration through partnerships with primary care clinics and Health Links - Info Santé.

- **Online Health Portal** *[System/Individual]*

  An online health portal is part of a larger, future consumer health solution strategy for Manitoba, which will serve as an all-encompassing virtual 'one stop shop' to enable interested Manitobans to obtain information and support to assist in managing their lifestyle and health risks. Components within this consumer health solution or portal may include but not be limited to health information, online resources and access to a range of health services, social networking support, online access to a health professional, decision support tools and access to personal health record information. A health portal will provide Manitobans with more choice and control over their health through access to information, improved communication with care providers, more active participation in their care and improved quality of care.

  Manitoba Health is working in partnership with Manitoba Healthy Living, Seniors & Consumer Affairs and Manitoba eHealth to incorporate knowledge gained through the implementation of Health e-Plan, which enables Manitobans to assess and set goals for their own health, learn about available local resources and monitor progress.

  A health portal tool is not intended to replace other forms of support (such as family physician visits and telephone advice or service) but will help to align the intensity of care with the needs of the individual and reduce the burden on the health system. By providing access to a variety of tools and resources through multiple access points, Manitobans can engage the health system when needed and in the proper setting, reducing the burden on acute care centres.

- **Health Behaviour Change Training** *[Provider]*

  Health Behaviour Change training is designed to help health care providers have conversations with people about behaviour change in settings where time is often limited. The theories, models and strategies advocated in this training workshop are based on evidence about how to be most successful in supporting behaviour change. Each health region in the province has a trained Health Behaviour Change facilitator.

- **Arthritis Self-management Program** *[Individual]*

  This health promotion program is offered by trained volunteer leaders through the Arthritis Society. The program, based on the CDSMP model developed by Stanford University, is designed to help individuals understand their arthritis, learn ways to cope with chronic pain and take a more active role in managing their condition. [43]

- **HANS Project** *[Individual]*

  This project is being developed through the Nor'West Co-op Community Health Centre in Winnipeg with funding support from the Public Health Agency of Canada as a follow-up for Get Better Together! Manitoba participants. Groups of 10 to 20 participants with chronic disease meet once a month for two to three hours to discuss health issues, conduct testing (blood pressure, blood sugar, weight, etc.) and exercise together.

- **It's Safe To Ask** *[Individual]*

  This Manitoba Institute for Patient Safety initiative was officially launched in January 2007 to support the 60% of adult Manitobans with low levels of health literacy. 'It's Safe to Ask' encourages patients and families to request the information they need in order to become active participants in their care. It includes easy-to-read materials for patients, as well as information kits for healthcare providers and organizations.

  'It's Safe to Ask' encourages patients and health care providers to discuss 3 key questions:

  - What is my health problem?
  - What do I need to do?
  - Why do I need to do this?

Manitoba Gaps

A number of knowledge and service gaps exist at various levels in relation to strengthening self-management supports:

System

- Limited use of alternative funding models and support for practice redesign
- Limited access to electronic information systems to support team-based care
- Lack of an evaluation framework and information on effectiveness of existing initiatives
- Knowledge gap regarding which services are best aligned with which population groups; for example, what is the most effective approach with difficult-to-reach/disadvantaged groups?
- Fragmentation of services between primary care and health sectors, other sectors and community supports
- Telephone self-management supports currently only address two chronic conditions
- What role could self-management play in high risk / high intensity models such as virtual wards?
- What kinds of self-monitoring devices are needed?

Provider

- Lack of understanding regarding how supports such as TeleCARE and Health Behaviour Change training are transforming practice and the patient experience
- Absence of provider self-assessment in terms of education and training needs in order to support patient self-management
- To what extent are providers referring patients to community-based self-management programs?
- To what extent are providers asking patients about their own goals including goals around self-management?
- Limited inter-professional team-based care to allow providers the time needed to support patients with complex conditions

Individual

- Individuals continue to rely on health care providers and the health care system to manage health issues, with limited self-management support
- What level of awareness do health care consumers have regarding available self-management program options?
- How closely does current program availability match need? How should it match their needs in the future?
- Inconsistent and/or limited involvement of individuals and caregivers in changing the quality of care

Recommendations

The above evidence supports the current direction of self-management initiatives in Manitoba. No single approach to self-management can effectively reach all individuals in need and self-management itself is not always an appropriate response to healthcare demands. However, in terms of improving chronic disease management, self-management support that is integrated into primary care ranks among interventions with the highest potential impact[44].

Improved self-management can reduce dependence on the primary care system, freeing the capacity of family physicians and teams to provide other needed care. Self-management can help Manitobans with chronic disease develop skills and obtain tools to better manage their conditions and improve their quality of life. Supporting self-management allows individuals to take control of their own health, while continuing to have access to the health care system when needed.

Supporting self-management approaches by providers and individuals is a concrete action in moving the focus of health care delivery away from institutions and toward the vision of 'home as the hub' from which health interventions occur. Increased self-management by individuals will lead to enhanced access in their own home; a shift in care setting that has the potential to decrease costly hospital re-admissions and reduce utilization of emergency room services.

Primary Care Networks (PCNs) are well-placed to support self-management as part of client care. PCNs will demonstrate a new level of IT connectivity that will provide an opportunity for more seamless integration of self-management with primary care. The scale of PCNs will also provide an opportunity for greater self-management support through group sessions and outreach. The success of these new supports will require evaluation, as part of the broad Primary Care Network evaluation

The success of existing self-management initiatives needs to be comprehensively evaluated to ensure further lessons can be drawn regarding efficacy and group-specific uptake. These learnings will be especially important in understanding how to better reach the most socially disadvantaged individuals and groups. Based on analysis of the evidence, this paper recommends that Manitoba Health continue to support the promise of self-management, as it appears to positively impact health, be cost-effective in some cases, reduce reliance on in-patient care and allow individuals to take more control of their own health needs. Any future strategy must ensure that provincial efforts to coordinate and enhance self-management supports use a multi-pronged approach reflecting the needs of systems, providers and individuals, recognizing the diversity of abilities, needs and learning approaches of individuals and persons with chronic disease.

The following actions are recommended to strengthen self-management and the provision of self-management supports in Manitoba:

Current Initiatives and Investments

Year 1

1. That system partners seek to narrow the knowledge gap with respect to the appropriateness of different initiatives for various target groups, and identify which key population groups are being missed and reasons for their exclusion. *[System];*

2. That Manitoba Health and regional partners implement a comprehensive evaluation framework for current self-management initiatives in the province and for those under consideration by regions, such as through social marketing *[System]*;

3. That Manitoba Health, with regional partners, support current self-management initiatives and encourage integration within primary care and other areas of the health care system. *[System/Provider];*

   For Example:
   - TeleCARE services could be strengthened to ensure that self-management is appropriately supported through assessment, goal setting and regular communication over the phone, and well-integrated as part of regular care. Referral to TeleCARE will be simplified for primary care providers and promoted, along with other self-management supports
   - Results from TeleCARE evaluations will be used to inform a broader communication plan for all self-management initiatives

With respect to *additional* investments in self-management, it is recommended that the following items be undertaken, in order to enhance self-management resources and strengthen existing supports:

Additional Initiatives and Investments

Year 1

4. That the capacity and reach of TeleCARE be fully utilized and integrated within the primary health care system, then expanded through the addition of another priority chronic condition, such as hypertension, COPD, or asthma *[Individual];*

5. That Manitoba Health ensure that existing self-management services are sustained, improved and enhanced for effectiveness *[System/Individual];*

6. That Manitoba Health present a plan for the development of an online health portal that would provide tailored self-management supports that are also integrated into the primary care system. *[System/ Provider/Individual];*

Year 2

7. That Manitoba Health, with regional partners, develop strategies to increase provider awareness of available supports and facilitation of personal self-management. This would be accomplished through existing partnerships, such as with the universities, RHAs, and NGOs *[System/Provider];*

8. That as Primary Care Networks (PCNs) are implemented, Manitoba Health promote a focus on self-management supports within PCNs and within primary care in general, with a specific emphasis on at-risk populations, such as those at high-risk of complications and readmission *[System/Provider];*

9. That if approved, Manitoba Health begin implementing an online health portal that would provide tailored self-management supports that are also integrated into the primary care system *[System/ Provider/Individual].*

References

[1] Murray, J. (2009, March 31). *Integrating Self-Management across the Central LHIN: A Five Year Plan*.

[2] Manitoba Health. (2009, June 1). *Manitoba Health Population Report.*

[3] Manitoba Health. (2009, May). *Diabetes in Manitoba: A Call to Action.*

[4] Manitoba Centre for Health Policy. (2010). *The Additional Cost of Chronic Disease in Manitoba*. Retrieved from http://mchp-appserv.cpe.umanitoba.ca/reference/Chronic_Cost.pdf.

[5] Patra, J., Popova, S., Rehm, J., Bondy, S., Flint, R. & Giesbrecht, N. (2007, March). *Economic Cost of Chronic Disease in Canada 1995-2003*. Prepared for the Ontario Chronic Disease Prevention Alliance and the Ontario Public Health Association.

[6] Bährer-Kohler, S., & Krebs-Roubicek, E. (2009). Chronic disease and self-management - Aspects of cost efficiencies and current policies. In S. Bährer-Kohler & E. Krebs-Roubecek (Ed), *Chronic Disease and Self-Management* (pp. 2-13). Heidelberg: Springer Medzin Verlag.

[7] Kreindler S. (2008). *Lifting the Burden of Chronic Disease: What's Worked? What Hasn't? What Next?* Winnipeg: Winnipeg Regional Health Authority.

[8] National Health Expenditure Database, Canadian Institute for Health Information. Accessed on July 28, 2010.

[9] Manitoba Health. (2009, June 1). *Manitoba Health Population Report.*

[10] Harris, M. F., Williams, A. M., Dennis, S. M., Zwar, N. A., & Powell Davies, G. (2008). Chronic disease self-management: Implementation with and within Australian general practice. *The Medical Journal of Australia, 189* (10 Suppl), S17-20.

[11] Coleman, K., Mattke, S., Perrault, P. J., & Wagner, E. H. (2009). Untangling practice redesign from disease management: How do we best care for the chronically ill? *Annual Review of Public Health, 30*, 385-408.

[12] Coleman, M. T., & Newton, K. S. (2005). Supporting self-management in patients with chronic illness. *American Family Physician, 72*(8), 1503-1510.

[13] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians & American Osteopathic Association. (2007, March). *Joint principles of the patient-centered medical home*.

[14] Nuovo, J., Balsbaugh, T., Barton, S., Fong, R., Fox-Garcia, J., Levich, B., et al. (2007). Interventions to support diabetes self-management: The key role of the patient in diabetes care. *Current Diabetes Reviews* 3(4), 226-228.

[15] Bährer-Kohler, S., & Krebs-Roubicek, E. (2009).

[16] Harris, M. F., Williams, A. M., Dennis, S. M., Zwar, N. A., & Powell Davies, G. (2008).

[17] Coleman, K., Mattke, S., Perrault, P. J., & Wagner, E. H. (2009).

[18] Coleman, M. T., & Newton, K. S. (2005).

[19] Health Council of Canada. (2010). *Helping Patients Help Themselves: Are Canadians with Chronic Conditions Getting the Support They Need to Manage Their Health.* Toronto: Health Council.

[20] Bowles, K. H., & Baugh, A. C. (2007). Applying research evidence to optimize telehomecare. *The Journal of Cardiovascular Nursing, 22*(1), 5-15.

[21] Coster, S., & Norman, I. (2009). Cochrane reviews of educational and self-management interventions to guide nursing practice: A review. *International Journal of Nursing Studies, 46*(4), 508-528.

[22] Austin Boren, S., Gunlock, T. L., Krishna, S., & Kramer, T. C. (2006). Proceedings from AMIA Annual Symposium. *Computer-aided diabetes education: A synthesis of randomized controlled trials*.

[23] Chodosh, J., Morton, S. C., Mojica, W., Maglione, M., Suttorp, M. J., Hilton, L., et al. (2005). Meta-analysis: Chronic disease self-management programs for older adults. *Annals of Internal Medicine, 143*(6), 427-438.

[24] Choo, K., & Sheikh, A. (2007). Action plans for the long-term management of anaphylaxis: Systematic review of effectiveness. *Clinical and Experimental Allergy: Journal of the British Society for Allergy and Clinical Immunology, 37*(7), 1090-1094.

[25] Effing, T., Monninkhof, E. M., van der Valk, P. D., van der Palen, J., van Herwaarden, C. L., Partidge, M. R., et al. (2007). Self-management education for patients with chronic obstructive pulmonary disease. *Cochrane Database of Systematic Reviews (Online), (4)* (4), CD002990.

[26] Bowles, K. H., & Baugh, A. C. (2007).

[27] Luck, J., Parkerton, P., & Hagigi, F. (2007). What is the business case for improving care for patients with complex conditions? *Journal of General Internal Medicine, 22 (Suppl 3)*, 396-402.

[28] Richardson, G., Gravelle, H., Weatherly, H. & Ritchie, G. (2005, Fall). Cost-effectiveness of interventions to support self-care: a systematic review. *Int J Technol Assess Health Care, 21*(4), 423-432.

[29] Kreindler S. (2008).

[30] Expert Patients Programme. (2009). *Self Care Reduces Costs and Improves Health - The Evidence.* London: Community Interest Company.

[31] Foster, G., Taylor, S. J., Eldridge, S. E., Ramsay, J., & Griffiths, C. J. (2007). Self-Management Education Programmes by lay Leaders of people with Chronic Conditions. *Cochrane Database of Systematic Reviews*, Issue 4. CD005108. DOI: 10.1002/14651858.CD005108.pub2.

[32] Kreindler S. (2008).

[33] Lewin, S., Munabi-Babigumira, S., Glenton, C., Daniels, K., Bosch-Capblanch, X., van Wyk, B. E., et al. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases (Review). *The Cochrane Library (Issue 3)*. Accessed on September 9, 2010 at http://apps.who.int/rhl/reviews/CD004015.pdf

[34] Kreindler S. (2008).

[35] Rosenthal, E.L., Brownstein, J.N., Rush, C.H., Hirsch, G.R., Willaert, A.M. Scott, J.R. et al. (2010). Community Health Workers: Part of the Solution. *Health Affairs, 29(7),* 1338-1342

[36] World Health Organization (2005). *Preventing chronic diseases: A vital investment*. Geneva: World Health Organization.

[37] Accreditation Canada. (2010). Qmentum Program 2010 Standards: Populations with Chronic Conditions, ver.4, p. 9. Retrieved from http://www.accreditation.ca/accreditation-programs/qmentum/standards/populations-with-chronic-conditions/.

[38] Paterson, B., Kealey, L., MacKinnon, R., McGibbon, C., van den Hoonaard, D., LaChapelle, D. (2009). *Chronic Diseases Self-Management Practice in Canada: Patterns, Trends and Programs.* Ottawa, Public Health Agency of Canada.

[39] Health Council of Canada. (2010).

[40] Manitoba Health. (2002). *Regional Diabetes Program Framework*.

[41] Wellness Institute. (2011, January). Internal Document: *GBT Return on Investment Calculation*.

[42] Get Better Together! Manitoba 2010-11 Report. (2011, June) Wellness Institute, Seven Oaks General Hospital.

[43] The Arthritis Society. Retrieved from www.arthritis.ca (Manitoba/Nunavut). Accessed on July 28, 2010.

[44] Kreindler S. (2008).