



Government of **Western Australia**
Department of **Health**

WA Chronic Conditions Self-Management Strategic Framework 2011–2015

Prepared in consultation with
the WA Health Networks



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Suggested Citation

Department of Health, Western Australia. WA Chronic Conditions Self-Management Strategic Framework. Perth: Health Networks Branch, Department of Health, Western Australia; 2011.

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Purpose

The *WA Chronic Conditions Self-Management Strategic Framework 2011–2015* (the Strategic Framework) provides a focus over the next four years for:

- supporting system and practice changes to incorporate self-management into the core principles of chronic condition management
- targeting training for health care professionals to assist consumers with chronic conditions to actively self-manage their health
- developing and implementing chronic conditions self-management programs and services for consumers with adaptations as required for people from culturally and linguistically diverse populations.

This Strategic Framework is targeted at all health service providers and planners in Western Australia.

The Strategic Framework will remain current for the four-year period 2011–2015, but will be reviewed periodically to take advantage of opportunities that emerge as health reform continues and new evidence arises.

Context

This Strategic Framework reflects the need for significant and sustainable changes to be made in a health system environment undergoing significant reform and dealing with the expanding burden of chronic health conditions in our society. Self-management is one of the guiding principles in the *WA Chronic Health Conditions Framework 2011–2016*, and is incorporated in the models of care produced by WA Health Networks.

Recognising that prevention of chronic conditions is important, the draft *WA Health Promotion Strategic Framework 2012–2016* will outline strategies that target the well population and the population at risk of developing a chronic condition.

The reality is that chronic health conditions already impose a significant burden both on the individual and the health system. Data from the 2007/08 *Australian National Health Survey* indicate that 75 per cent of respondents had one or more long-term health condition(s),¹ while some projections suggest that the burden and associated costs of chronic health conditions will increase in Australia.² Such a large prevalence of chronic health conditions represents a significant societal burden, particularly since individuals affected are less likely to participate in the workforce.³

Chronic disease self-management was a priority area for WA in the Australian Better Health Initiative (ABHI) during 2006–2010. Significant progress was made to:

- engage with stakeholders about self-management
- increase the awareness of self-management among consumers, service providers and organisations
- increase the number of consumers attending self-management programs
- evaluate the effectiveness of selected self-management programs
- create referral pathways to increase access to self-management programs

- build capacity of the workforce in self-management support skills through a *Chronic Disease Self-Management Training Strategy*.

Lessons from international literature⁴ suggest that major health and other system changes are required for the care of people with long-term conditions, including enhanced relationships between service providers and consumers to promote active involvement and self-management.⁵

Self-management is a critical component for the effective management of chronic health conditions. The self-management approach emphasises: the consumer's central role in managing their health; links them to personal and community resources; and includes strategies of assessment, goal-setting, problem-solving and follow-up. Following pioneer work by Lorig et al.,⁶⁻⁸ evidence for the effectiveness of self-management approaches continues to emerge.⁹⁻¹²

Scope

Self-management is an approach that has relevance for a wide range of chronic health conditions across the continuum of care.

Consistent with the *WA Chronic Health Conditions Framework 2011–2016*, the specific chronic conditions that are given priority for implementation include:

- cardiovascular disease (coronary heart disease, heart failure and stroke)
- type 2 diabetes mellitus
- chronic renal disease
- chronic musculoskeletal conditions (osteoporosis, osteoarthritis and rheumatoid arthritis)
- chronic respiratory disease (chronic obstructive pulmonary disease and asthma).

Many aspects of self-management are common to all conditions and can be applied across any long-term health condition. The scope does not limit the Strategic Framework's application to other conditions. Rather, it is encouraged that all service providers adopt the principles of this Strategic Framework as part of delivering services to their consumers.

Definition of 'self-management'

Self-management is a shared responsibility between the individual and service provider.

Self-management is defined in the *National Chronic Disease Strategy* as “the active participation by people in their own health care”.¹³ Self-management involves consumers adopting attitudes and learning skills that facilitate a partnership with carers, general practitioners, and health professionals in treating monitoring and managing their condition.¹⁴

Self-management support describes the techniques and strategies that health providers, carers, organisations and systems do to assist those living with chronic conditions to practice self-management. Also known as ‘collaborative care strategies’, these techniques are based on self-management principles.¹⁴

Objective and strategies

Method

The development of strategies has been informed by key stakeholders from the Diabetes and Endocrine; Cardiovascular; Musculoskeletal; Renal; Respiratory; and Primary Care Health Networks. WA Health Networks Branch, Department of Health WA, facilitated the strategy development process during 2011. Consultations included a statewide electronic qualitative survey, four workshops with a task-specific Chronic Conditions Self-Management Strategy Review Group (CCSM Strategy Review Group), and statewide feedback on the final draft.

Members of the CCSM Strategy Review Group were recruited through an expression of interest process and acceptance, based on ensuring representation across stakeholder groups and organisations (**Appendix 2**). It is recognised that the absence of a representative from an academic/research institute is a gap in the diversity of the group.

Priority areas to progress self-management were identified during the consultation process and will be used to shape the implementation phase of this Strategic Framework.

Prioritisation

The CCSM Strategy Review Group prioritised the strategies to guide the focus of activity for the implementation. The prioritisation reflected the capacity of stakeholders to implement the strategies, and the strategies' impact on the vision. All strategies were determined to have a high impact on achieving the vision stated in the **table** on the following pages.

The short-term goals represent strategies that can be achieved within the current capacity. For the medium- to long-term goals, implementation will focus initially on what is required to develop the capacity, reflecting a longer time-frame of two to four years to achieve.

The implementation of this Strategic Framework will occur in different ways across Western Australia, considering local, organisational, and sectoral needs and resources.

WA Chronic Conditions Self-Management Strategic Framework 2011–2016			
Goal	“The active participation by people in their own health care within their communities.”		
Vision	People in WA with chronic conditions are supported in their ability to respond to their health care needs through a self-management approach, by making informed choices in partnership with health providers to optimise their desired lifestyle. This is achieved through accessible consumer-oriented information, connected service pathways, local skilled providers, evidence-based practice, organisational policy and dedicated funding.		
Principles	Promoting life-long health and wellbeing Sustainability		
Consumer-centred care			
Key Drivers			
Partnerships	Building capacity	Information and communications technology	Equity and access
Continuous improvement			
Outcomes			
Provision of direction and resources for WA to support self-management in the community through policy, systems and funding	Referral pathways , information sources and support systems are accessible to sustain self-management behaviours	Support the provision of best-practice programs and services based on population needs and evidence	Build capacity of consumers, carers, clinicians and the community to support evidence-based self-management approaches
Objectives			
Culture	Awareness	Services	Tools and resources (products)
Attitudes and behaviours of consumers, carers and service providers are supportive of self-management	Promote self-management within service provider organisations and communities to increase the ability of individuals to participate in health care decisions	People with chronic conditions have access to appropriate quality programs and services that support their ability to participate in their own health care	Provide quality, accessible and culturally appropriate information, tools and resources to support the active participation of people in their own health care
		Build the capacity of service providers and the community to deliver and support evidence-based self-management	

Strategies				
Culture	Awareness	Services	Knowledge and skills	Tools and resources (products)
<p>C1: An implementation plan for the Strategic Framework is developed, endorsed and resourced with specific strategies/initiatives for each participating sector coordinated within and outside health</p>	<p>A1: A communication, advocacy, promotion and marketing strategy is implemented, with consistent health messages, measurable key performance indicators and targets for each relevant sector</p>	<p>S1: Programs and services are delivered by a variety of providers with flexible delivery options to support the self-management for the WA population needs across the care continuum</p>	<p>KS1: A self-management support competency framework is developed to support service providers' determining individual development needs based on nature of case load and service delivery</p>	<p>TR1: The WA Chronic Conditions Self-Management website is enhanced and maintained as a platform for consumers, carers, health professionals and organisations, that supports access to information, learning and development and sharing of experiences</p>
<p>C2: Work in partnership with government, non-government, professional bodies, universities and community organisations to foster self-management approaches in WA and ensure efficient use of resources and minimise duplication</p>		<p>S2: Foster the involvement of consumers and carers in sustaining self-management behaviours through relevant social networks (such as peer led programs, support groups or community networks)</p>	<p>KS2: A suite of training and development opportunities are available to support the self-management competency framework</p>	<p>TR2: Recognition is provided for chronic condition self-management programs and services engaged in a quality improvement process</p>
<p>C3: Advocacy and networking opportunities are available on a regular basis for the sharing of information, practice examples and advancements in the local, national and international environment</p>			<p>KS3: Service providers are supported in integrating self-management approaches into practice through mentoring or community of practice initiatives</p>	

SHORT TERM - Two year timeframe

Strategies				
Culture	Awareness	Services	Knowledge and skills	Tools and resources (products)
<p>C4: Self-management is reflected and resourced in all strategy, policy and practice across relevant sectors in WA</p>	<p>A2: By 2015, consumers with a chronic condition, their carers and health practitioners can access information on the ranges of CCSM programs and services in WA through a single point via multiple modalities (e.g. the new WA Health consumer's website)</p> <p>A3: By 2015, referral pathways will be clear and easy to navigate within local communities to ensure that the consumer is linked into the appropriate CCSM support (e.g. link to recommendations in the models of care and integrate with the role of Medicare Locals and WA's five new Health Services)</p>	<p>S3: CCSM services provided by non-government organisations, private and public agencies are linked/coordinated and align with models of care to guide consumers, carers and health professionals as to the most appropriate care required</p>	<p>KS4: Self-management is incorporated into inter-sectoral/organisational learning and professional development/educational programs and curriculum</p>	<p>TR3: Service providers are supported in implementing a CCSM quality improvement process such as the Quality Self-Management Framework (QSAF) for current and new programs</p>
LONG TERM - Four year timeframe				

Evaluation and research strategies A robust evaluation framework that links research and practice and effectively evaluates patient outcomes and health care costs.					
	Culture	Awareness	Services	Knowledge and skills	Tools and resources (products)
Two year timeframe	C-ER1: Influence approaches for data collection to support evaluation of effectiveness and impact of CCSM and identify appropriate consumer and system-centred outcome measures including cost effectiveness	A-ER1: Increase awareness of chronic conditions trends to inform strategy and implementation through regular population needs assessments	S-ER1: Provision of guidelines for minimum data collection needs to support service providers contribute to evidence-based practice for self-management		TR-ER1: Measure the use of self-management resources to inform relevance and distribution methods
Four year timeframe	C-ER2: Foster and promote partnerships with academic institutions to support development and implementation of intervention testing and monitoring	A-ER2: Evaluate effectiveness and impact of communication strategy	S-ER2: Evaluate the impact of self-management support interventions on consumers participating in relevant self-management programs and services	KS-ER1: Increase health professionals' confidence in providing self-management support to consumers who are managing chronic conditions KS-ER2: Increase consumer and carer confidence in using self-management skills to manage chronic conditions	TR-ER2: Evaluate effectiveness of self-management support tools and resources

Framework principles and key drivers

Principles

Consumer-centred care

- place the consumer at the centre of the care they are receiving
- recognise the individual as a 'whole' person
- acknowledge that most people with chronic conditions are already doing self-management, respecting that what they need will vary across individuals and circumstances in relation to factors such as culture, language and religion
- engage consumers and carers from diverse backgrounds in health system and service planning, development and implementation through consultation methods that are culturally, linguistically and religiously inclusive
- respect that consumers and carers need access to the best available evidence-based information delivered in the most appropriate and meaningful manner to support informed decision making, with adaptations as required for culturally and linguistically diverse populations
- support consumers and carers to develop their own goals
- evaluate initiatives from the perspective of the benefit to the consumer.

The impact of self-management on health and wellbeing

Comments from consumers who participated in self-management programs

"I lacked motivation at the beginning of the [self-management] course, but am definitely more motivated now. I was reminded how to problem-solve and became more aware of the chronic cycle. I feel I have improved my own wellbeing, health and self-esteem."

"It helped me change my attitude towards aspects of my condition. Through using action plans, I took small steps to start exercising. I realised I was not the only one who experienced the inability to cope. I'm still frustrated with life, but have learnt ways to deal with the frustration."

"I am better informed, have confidence in managing the situation and am more positive than before. I now see that I can lead a normal life even with my condition. I see my condition as something to live with if I can control it well, then it won't control me."

Consumers attended the Living Well Chronic Disease Self-Management Programs delivered through the WA GP Networks

Promoting life-long health and wellbeing

- build on and link with existing health service and health promotion initiatives
- focus on supporting individuals to develop the knowledge, confidence, skills, and behaviours to achieve their desired lifestyle
- acknowledge the changing needs of individuals as they progress through the age, condition and care continuums
- support the transition from paediatric to adult services.

Sustainability

- link self-management with new funding models such as Activity Based Funding and Activity Based Management, as well as innovative funding opportunities such as the WA Health State Health Research Advisory Council (SHRAC) grants program and Quality Incentive Program (QulP)
- support innovative funding models based on achieving outcomes
- incorporate self-management into policy and service delivery guidelines
- use chronic conditions health networks to maintain the significant changes required to embed self-management
- work with local communities to identify and create environments that support self-management
- promote self-management support principles in curriculum for health students to ensure the emerging workforce is adequately skilled to support consumers in self-management behaviours.

Key Drivers

Partnerships

- ongoing consultation with consumers, carers, service providers and stakeholders across sectors in the ongoing cycle of planning, implementing, evaluating and revising self-management initiatives
- organisations work together to achieve consistent self-management services and implementation of policy
- networking and mentoring opportunities are identified to support health professionals translate self-management theory to practice and sharing of outcomes
- build relationships with academic and research institutions to support intervention testing and monitoring, and curriculum change to adopt self-management
- form cross-sectoral partnerships to engage broader support for self-management. Examples of partner agencies include local governments, Medicare Locals, tertiary education institutions, the Mental Health Commission and the Disability Services Commission
- the support of social networks including family, friends, and carers is recognised

- services are linked and coordinated, irrespective of sector or funding body, to support seamless journey for the consumer across services. This is covered under the *WA Chronic Health Conditions Framework 2011–2016*, including linkages with other areas in the health sector and non-health sectors such as prevention, aged care (Commonwealth Department of Health and Ageing), local government, education and housing.

Partnerships: a key to sustainability

Since 2007, WA Health has partnered with organisations to support the delivery of self-management programs for consumers and training initiatives to increase service providers' ability to support consumers with self-management.

Providing self-management programs for people with diabetes

A partnership with Diabetes WA has supported the delivery of the six-week Living with Diabetes self-management programs in areas of unmet need. Recently this program was delivered in Chinese (Mandarin and Cantonese) and was extremely well received by the Chinese community with more programs and translations planned. Diabetes WA has brought the six hour evidence-based Diabetes Education Self-Management for Ongoing Newly Diagnosed (DESMOND) workshop to WA as another option for consumers, following a partnership with DESMOND UK.

Building capacity to deliver self-management for arthritis

Arthritis and Osteoporosis WA recognised that the demand for the evidence-based education and self-management program for osteoarthritis of the knee (OAK) far exceeded delivery capacity through their centres.

Through a partnership with WA Health and Arthritis and Osteoporosis WA, health professionals across WA are being trained to deliver the OAK self-management program to their clients. In addition master training is to be offered for selected health professions to be OAK trainers. This will go towards building sustainable training and workforce capacity.

Building capacity

- engaging local communities in service planning and delivery
- developing a skilled workforce through education curriculum and professional development
- developing a workforce skilled in training and mentoring service providers
- inter-professional and multidisciplinary learning opportunities are explored and encouraged
- consumers develop strategies that support life-long positive health behaviours
- social support structures are considered in supporting self-management
- workforce trained in cultural security and cultural competency.

Information and communications technology

- increased use of information and communications technology (ICT) platforms to support implementation of the strategies
- systems and infrastructure needs are considered in implementation
- share information electronically in a timely and secure manner across different locations and all parts of the health sector
- enable access to data to more effectively monitor and evaluate service delivery outcomes
- align with proposed clinical information systems, for example the e-HealthWA program
- provide access to appropriate information sources and decision support tools at the point of care
- collaborate with other professionals to share expertise and evidence
- enable easy access to clinical knowledge and evidence sources to assist with skill development (e.g. the clinical information system project).

Continuous improvement

- services delivered meet minimum standards of practice based on best available evidence
- evidence-based self-management initiatives are supported
- foster and support services and programs involved in quality improvement processes to achieve best practice
- evaluation, both qualitative and quantitative, is integral to measuring intervention effectiveness and impact as well as contributing to the evidence based practice
- self-management contributes to the development, ongoing review and implementation of the chronic conditions models of care
- seek opportunities to work in collaboration with researchers both inside and outside of WA Health.

Equity and access

- implementation of the strategies addresses the needs of specific population groups including:
 - Aboriginal people
 - consumers from culturally and linguistically diverse backgrounds
 - people in low socio-economic circumstances
 - people in rural and remote areas
- resources are accessible through various methods matching the needs of the target audiences, such as online, hard copy, and/or face-to-face
- services are based on need, supported by data including from consultation with service providers, consumers and the community
- services are provided according to the 'four rights' as per the models of care (right care, right time, right team and right place).

History

In 2006, the Centre for Research into Disability and Society at Curtin University was engaged to develop a scoping document that provided a structure to the implementation and evaluation of the WA Chronic Conditions Self-Management (CCSM) Strategy within ABHI. This document provided a useful framework (**Figure 1**) on which to base future planning for chronic condition self-management in WA and has been used as the basis of planning the strategies required to continue to progress through 2011–2015.

This **framework** captures five essential elements where major shifts are required for the self-management philosophy to be adopted and embedded into health care practices. These include:

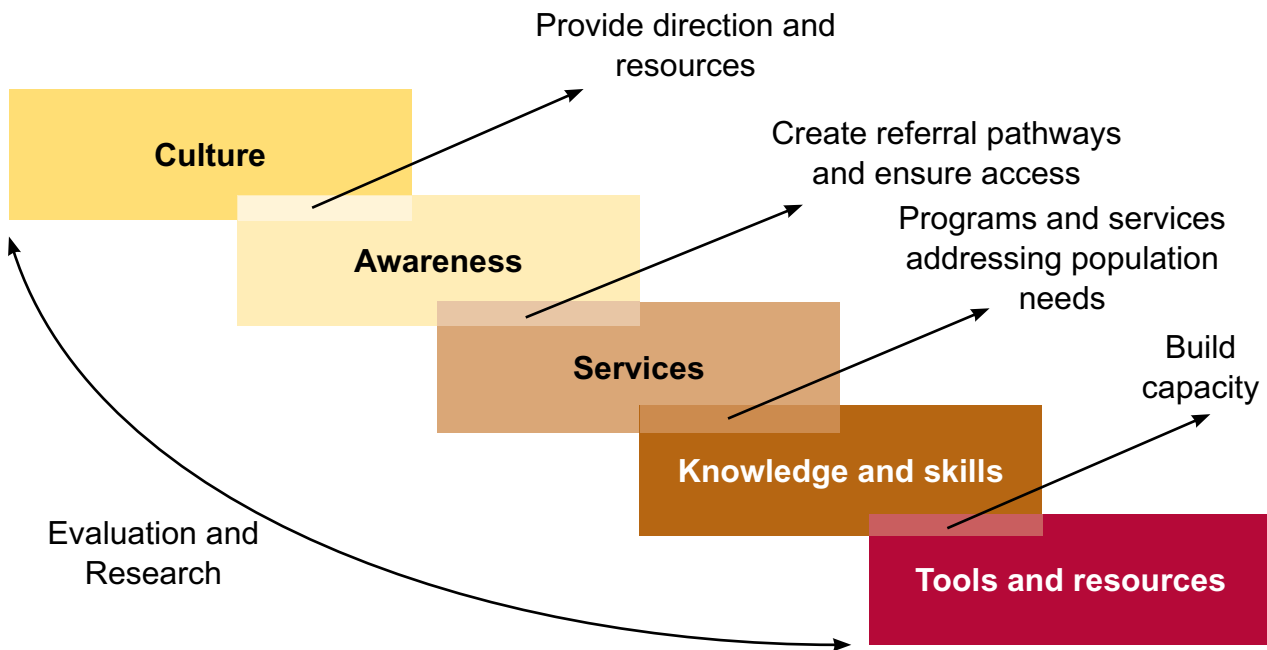
- **Culture:** attitudes and behaviours of consumers, carers, and service providers are supportive of self-management.
- **Awareness:** self-management is promoted within service provider organisations and communities to increase the ability of individuals to participate in health care decisions.
- **Services:** people with chronic conditions have access to appropriate quality programs and services that support their ability to participate in their own health care.
- **Knowledge and skills:** capacity-building of service providers and the community to deliver and support evidence-based self-management approaches.
- **Tools and resources:** providing quality, accessible, and culturally appropriate information, tools and resources to support the active participation of people in their own health care.

These elements are underpinned by a robust **evaluation framework** that links research and practice and effectively evaluates patient outcomes and health care costs. By targeting activities to address each of the five essential elements above, the following outcomes will be achieved:

- **direction and resources** for WA to support self-management in the community through policy, systems and funding
- **referral pathways**, information sources and support systems are accessible to all consumers to sustain self-management behaviours
- the provision of best-practice **programs and services** is based on population needs and evidence
- **capacity-building** of consumers, carers, clinicians and the community to support evidence-based self-management approaches.

Figure 1 WA Chronic Conditions Self-Management Strategic Framework

This Strategic Framework describes a statewide approach to referral pathways, workforce capacity and programs for people with chronic conditions.



Implementation

Initial implementation plans

- establish a WA CCSM Reference Group and Steering Committee with terms of reference that include:
 - informing WA’s chronic conditions self-management evaluation and research priorities
 - developing a set of measurable key performance indicators for the Strategic Framework
 - establishing a governance structure for endorsement of guidelines, principles, policies and resources
 - advising on implementation of strategies through area health services and/or community organisations
 - advising on chronic conditions self-management programs to support
 - forming a website working group (sub-group from the committee and chronic conditions health networks)
 - advising on the self-management support (collaborative care strategies) competency framework
 - advising on the minimum criteria for a chronic conditions self-management program/ service.
- develop the funding and partnership strategy for delivery of chronic conditions self-management programs and services
- develop a targeted communication strategy to increase the awareness of self-management and increase the utilisation of self-management behaviours and support strategies.

Appendices

Appendix 1: Strategic influences

National Chronic Disease Strategy 2004

WA Chronic Health Conditions Framework 2011–2016

WA Primary Health Care Strategy

WA Health Strategic Intent 2010–2015



Appendix 2: Chronic Conditions Self-Management Strategy Review Group representation

Diversity criteria

1. The mix of participants:

- consumers and carers
- management/policy developers/project staff
- service providers
- non-government organisations
- peak body association
- research/evaluation expertise
- chronic conditions self-management educator/trainer.

2. Representing the following areas:

- WA Health Networks
- South Metropolitan Area Health Service
- North Metropolitan Area Health Service
- WA Country Health Service
- WA GP Network Chronic Disease representative
- chronic condition health networks:
 - i. Diabetes and Endocrine/Renal
 - ii. Musculoskeletal
 - iii. Cardiovascular
 - iv. Respiratory
- Chronic Condition Consumer and Carer Executive Advisory Group
- a clinical lead with an interest in chronic condition self-management
- non-government organisations – these may also double-up as the representative for the respective chronic condition health network:
 - i. Diabetes WA
 - ii. Asthma WA
 - iii. Arthritis and Osteoporosis WA
 - iv. Heart Foundation WA/Stroke Foundation
- university/academic representative
- Aboriginal/culturally and linguistically diverse group
- chronic disease prevention/health promotion/local government.

3. Minimum number to have experience working with or representing the interests of chronic condition self-management in remote/regional Western Australia.

4. Minimum number exclusively involved in a chronic condition self-management role.

Chronic Conditions Self-Management Strategy Review Group members and agencies represented*

- Alzheimer's WA
 - Arthritis & Osteoporosis Foundation WA
 - Carers WA
 - Chronic Condition Consumer and Carer Group
 - Department of Health WA – Health Networks Branch
 - Diabetes WA
 - general practitioner
 - Geraldton Regional Aboriginal Medical Services
 - Health Consumers' Council
 - Muscular Dystrophy WA
 - National Stroke Foundation
 - North Metropolitan Area Health Service
 - North Metropolitan Public Health and Ambulatory Care Unit
 - Sir Charles Gairdner Hospital – Pain Management Department
 - Sir Gairdner Hospital – Consumer Advisory Council
 - Rockingham Kwinana Divisions of General Practice
 - Silver Chain WA
 - South Metropolitan Area Health Service
 - South Metropolitan Public Health Unit
 - Chronic Disease Unit
 - Royal Perth Hospital
- Complex Needs Coordination Team
- WA Country Health Service
 - Primary Health and Engagement
 - Wheatbelt Public Health Unit
 - Great Southern Population Health Service
 - WA GP Network

* some members represented multiple organisations

Appendix 3 Acknowledgements

This Strategic Framework has been developed based on consultation with: key statewide stakeholders; best available evidence; and existing frameworks, specifically:

Queensland Health. Framework for Self-Management 2008–2015, Queensland Government Brisbane, 2008

Department of Human Services. Chronic Condition Self-Management Framework, Government of South Australia

Victorian Department of Human Services, Community Health Services – creating a healthier Victoria, Melbourne 2004

Department of Health and Human Services, Connecting Care: Chronic Disease Action Framework for Tasmania 2009–2013, Hobart 2003

Department of Health and Families, Northern Territory Chronic Conditions Prevention and Management Strategy 2010–2020, Darwin 2009



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