

# Engaging GPs in a Chronic Disease Self-Management Program

**Good Life Club Project**  
**A Sharing Health Care Project**  
(Chronic Disease Self-Management)

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# Today....

- Briefly describe project model
- Outline GP engagement strategy & results
- Highlight outcomes for clients
- Identify barriers and enablers to engaging GPs in Chronic Disease Self-Management programs
- Recommendations for future action

# Good Life Club Project

- 12 Sharing Health Care Demonstration projects around Australia
- RACGP Guidelines “Chronic condition Self-Management” (GPs & AHP)
- Education modules from Flinders University

# Objective of project

- Improved self-management capacity of people over 50 years of age with diabetes living in eastern suburbs of Melbourne
- Sub target of older men and Chinese community

# Major Strategies:

- Telephone coaching by Allied Health Practitioners & general practice nurses
- Promotion of Multi-disciplinary care planning
- Client Website [www.goodlifeclub.info](http://www.goodlifeclub.info)
- Club activities



# Chronic Condition Self-Management

- ... involves the person with the chronic disease, engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of the illness on functioning, emotions, and interpersonal relations and adhering to treatment regimes.

*(RACGP Chronic Condition self-management guidelines)*

# Coaching for Self-Management

- Motivational interviewing\* for behaviour change
- Stages of change
- Encouraging adherence to treatment
- Negative affect management
- Improving self-efficacy
- Identifying social support

\* Rollnick 1995

# GP Engagement Strategy

Stakeholder analysis of:

- Board of Management, sub-committees
- Individual practices & GPs
  - ➔ identified resistance & points of influence
- Definition of “Chronic Disease Self-Management” requires debate
- Practical solutions – self-management plans for patients with GPs to “sign-off”

# Marketing Plan to GPs

- Professional marketing materials
- Practice-based marketing  
(visiting practices, letters to patients on diabetes register, payment for staff time, identifying GP & Practice Nurse champions)
- Presentations (AGM, sub-committees)
- Self-management Care Plan template

# Selling Points to GPs

- Easy referral pathways
- Divisions as agent of change – ownership of program
- Regular written feedback from coach
- Coach could be member of care plan team
- Providing follow-up of patients with chronic disease
- Promoting adherence to treatment
- Enhance role of practice nurse (as coach)
- Business model

# Project Enrolment

- 353 clients
- 10% enrolments were Chinese-speaking
- 43% enrolments were men
- High level of patient, GP satisfaction



# Interim 6 Month Client Outcomes (n=85)

- Increased confidence in managing condition
- Increased physical activity
- Less time being fearful/worried about health
- Able to turn taps (results of strength training)
- Fall in mean number of GP visits

# Outcomes of GP Engagement

- One third of enrolled clients referred by GPs
- 50% of GP referrals were via a Care Plan
- 217 GPs had at least 1 patient in the project
- Total of 59 GPs referred patients

# Barriers to GP Engagement in Self-Management Programs

- Lack of evidence
- Funding
- Time to get results
- Not a common understanding of CDSM
- Engaging patients by GPs in a busy practice
- GPs show low interest in Chronic Disease Self-Management training

# Enablers to engaging GPs in Self-Management programs

- Patient feedback
- Enhancing the role of GP to manage chronic & complex patients
- GP & Practice Nurse champions
- Realistic expectations

# Enablers to promoting CDSM

- Get in print
- Get the Division noticed
- Develop and promote a business model via EPC, SIP and other strategies

# Where to from here..

## Transition planning

### Future Opportunities:

- promoting chronic disease self-management in Division programs *e.g.* diabetes & asthma clinics in general practice
- Promoting the role of practice nurses to “coach” patients

# Recommendations

- Roll-out Chronic Disease Self-Management programs via Divisions
- Incorporate into existing CDM programs in Divisions
- Provide evidence esp. from Australia
- Support programs for sufficient time to get results

# More Information

- [www.goodlifeclub.info](http://www.goodlifeclub.info)  
(see Health Professionals/Resources)
- Australian Journal of Primary Health  
Vol. 9 2&3 2003
- [www.chronicdisease.health.gov.au](http://www.chronicdisease.health.gov.au)
- <http://sharinghealthcare.pwcglobal.com.au/SharingHealthCare/healthcare.nsf>  
(PriceWaterHouse Coopers)