

Self-Management Network Newsletter

Welcome to the latest Self-Management Network Newsletter. (This newsletter is best viewed as a html or word document. Any problems, please let us know. Thanks.)

Included in this month's newsletter are the following topics:

- **Publications - Patient-focused interventions - a review of the evidence**
 - **Recovery - a closely related concept**
 - **Websites worth visiting**
 - **Interesting articles**
 - **Conferences & workshops**
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[Patient-focused interventions: A review of the evidence](#)

Author: Angela Coulter and Jo Ellins

Publication date: 29-11-2006

"Patient-focused interventions are those that recognise the role of patients as active participants in the process of securing appropriate, effective, safe and responsive healthcare. Patients/citizens can contribute to quality improvement at both an individual and a collective level.

Patient-focused interventions are generally aimed at one or more of the following seven quality improvement goals, corresponding to the chapters below.

This contribution to the QEI project provides a concise and comprehensive overview of the evidence base for each of the above patient-focused interventions. In so doing, we aim to identify best practice and inform decision-making in healthcare policy, management, practice and research."

[Full report \(warning: large file, 11 Mb\)](#)

[Introduction](#)

[Chapter 1: Improving health literacy](#)

[Chapter 2: Improving clinical decision making](#)

[Chapter 3: Improving self-care](#)

- [Chapter 4: Improving patient safety](#)
- [Chapter 5: Improving access to health advice](#)
- [Chapter 6: Improving the care experience](#)
- [Chapter 7: Improving service development](#)

<http://www.health.org.uk/qquip/>

Recovery - a closely related concept

There is some very interesting literature around the concepts of recovery and resilience. While predominantly quoted in regard to mental health, there is significant overlap with the principles of self-management and as you will see from the excerpts below, the definition of recovery is remarkably similar. The position paper below, provides an interesting introduction to the concept of recovery for all of us wishing to improve care for people with long-term conditions. (Below are 3 short excerpts from the position paper.)

CSIP, RCPsych., & SCIE. (2007, May). *A common purpose: recovery in future mental health services*. Joint Position Paper 8. London: Social Care Institute for Excellence, Care Services Improvement Partnership & Royal College of Psychiatrists.

http://www.spn.org.uk/fileadmin/SPN_uploads/Documents/Papers/SPN_Papers/recovery2.pdf

Websites worth visiting

1. Wise Use of Antibiotics campaign www.kickthatbug.org.nz
New campaign by PHARMAC to encourage wise use of antibiotics.

They have developed three TV ads for the campaign, which will support it over the next few years. They are animated ads of the war between bacteria, viruses and antibiotics. These will be included on the website along with some other interactive information.

Name of the website www.kickthatbug.org.nz.

2. Research Review <http://www.researchreview.co.nz/>
"10,000 medical journals are published each month and for the medical community keeping up is hard. Research Review publications make it easy, bringing the most important studies to your inbox with

commentary from New Zealand specialists. All Research Review publications are free to receive."

(Note: the reviews appear to be very useful, there is however, drug advertising, presumably to offset costs)

3. MindNet.org.nz

New Zealand's mental health promotion and prevention newsletter. For the Autumn 2007 issue, follow this link.

<http://www.mindnet.org.nz/index.php?issueno=9>

4. QUIPP - Quest for Quality and Improved Performance

"QQUIP – the Quest for Quality and Improved Performance – is a five-year, £2.5 million research initiative of The Health Foundation. It has been set up to help answer three fundamental questions about healthcare in England:

- What is the current state of quality and performance?
- What works to improve quality and performance?
- Are we getting value for money from what is spent on the NHS?

The website brings together data from a wide range of sources to reveal national and international trends on diseases and quality of care. It also collates evidence on the impact of various interventions designed to improve the quality of healthcare internationally. It is home to over 150 charts, which provide easily accessible, at-a-glance data on priority areas such as cancer, heart disease, diabetes and mental health.

The website also looks at NHS performance in terms of its effectiveness, safety, responsiveness, efficiency, resource-use and how easily patients can access their care. It collects, analyses and updates data from a wide range of already published and publicly available sources such as OECD Health Data, the Department of Health, the Healthcare Commission, medical Royal College databases and clinical publications."

Interesting Articles

1. Health service patterns indicate potential benefit of supported self-management for depression in primary care.

Bilsker D, Goldner EM, Jones W.

Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University, Vancouver, British Columbia.

OBJECTIVE: To examine health service delivery in a Canadian province (British Columbia) to consider how Canadian health care services might be developed to best address the large number of individuals with mildly to moderately severe depressive illnesses. **METHOD:** We used provincial administrative data to describe patterns of medical services provided to individuals suffering from depression during 3 different time periods (1991-1992, 1995-1996, and 2000-2001) and to determine the frequency with which depression patients receive treatment from primary care physicians and psychiatrists. We then used these findings to consider the feasibility and potential applicability of the various approaches that have been described to decrease the burden of disease related to depression. **RESULTS:** In the fiscal year 1991-1992, the "treated prevalence" rate was 7.7%; in 1995-1996, it was 8.7%; and in 2000-2001, it was 9.5%. In each cohort over the 10-year period, the proportion of individuals who received a diagnosis of depression and who were then treated by primary care physicians alone (no psychiatric services were provided) remained constant at 92%. **CONCLUSIONS:** Supported self-management is identified as a promising intervention that could be integrated into primary health care within the context of the Canadian health care system. It constitutes a feasible and practical approach to enhance the role of family physicians in the delivery of services to individuals with milder forms of depression and promotes the active engagement of individuals in their recovery and in prevention of future episodes.

PMID: 17375863 [PubMed - indexed for MEDLINE]

http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=17375863&itool=pubmed_DocSum

2. Physical activity and depressive symptoms in cardiac rehabilitation: Long-term effects of a self-management intervention.

Scholz, U. Knoll, N. Sniehotta, FF. Schwarzer, R.

3. Benefits of Information Technology–Enabled Diabetes Management

Davis Bu, MD, MA^{1,2,3}, Eric Pan, MD^{1,2,3}, Janice Walker, RN, MBA^{1,3}, et al. *Diabetes Care* 30:1137-1142, 2007

OBJECTIVE—To determine the financial and clinical benefits of implementing information technology (IT)-enabled disease management systems.

RESEARCH DESIGN AND METHODS—A computer model was created to project the impact of IT-enabled disease management on care processes, clinical outcomes, and medical costs for patients with type 2 diabetes aged >25 years in the U.S. Several ITs were modeled (e.g., diabetes registries, computerized decision support, remote monitoring, patient self-management systems, and payer-based systems). Estimates of care process improvements were derived from published literature. Simulations projected outcomes for both payer and provider organizations, scaled to the national level. The primary outcome was medical cost savings, in 2004 U.S. dollars discounted at 5%. Secondary measures include reduction of cardiovascular, cerebrovascular, neuropathy, nephropathy, and retinopathy clinical outcomes.

RESULTS—All forms of IT-enabled disease management improved the health of patients with diabetes and reduced health care expenditures. Over 10 years, diabetes registries saved \$14.5 billion, computerized decision support saved \$10.7 billion, payer-centered technologies saved \$7.10 billion, remote monitoring saved \$326 million, self-management saved \$285 million, and integrated provider-patient systems saved \$16.9 billion.

CONCLUSIONS—IT-enabled diabetes management has the potential to improve care processes, delay diabetes complications, and save health care dollars. Of existing systems, provider-centered technologies such as diabetes registries currently show the most potential for benefit. Fully integrated provider-patient systems would have even greater potential for benefit. These benefits must be weighed against the implementation costs.

<http://care.diabetesjournals.org/cgi/content/abstract/30/5/1137>

4. Do citizens have minimum medical knowledge? - A survey
Lucas M. Bachmann ✉, Florian S. Gutzwiller ✉, Milo A. Puhan ✉,
Johann Steurer ✉, Claudia Steurer-Stey ✉ and Gerd Gigerenzer ✉
✉ *BMC Medicine* 2007, **5**:14 doi:10.1186/1741-7015-5-14 **Open**
Access at <http://www.biomedcentral.com/1741-7015/5/14>

Experts defined a "minimum medical knowledge" (MMK) that people need for understanding typical signs and/or risk factors of four relevant clinical conditions: myocardial infarction, stroke, chronic obstructive pulmonary disease and HIV/AIDS. We tested to what degree Swiss adult citizens satisfy this criterion for MMK and whether people with medical experience have acquired better knowledge than those without. **Method:** Questionnaire interview in a Swiss urban area with 185 Swiss citizens>...**Results:** The mean **MMK (minimum medical knowledge)** was as low as 32% and the range was 0 -72%. **Conclusion:** This sample of Swiss citizens did not know more than a third of the MMK. We found little difference within groups with medical experience (personal or professional), suggesting that there is a consistent and dramatic lack of knowledge in the general public about the typical signs and risk factors of relevant clinical conditions.

5. Sustaining better diabetes care in remote indigenous Australian communities. McDermott, R. Tulip F. Sinha, A. *Quality & Safety in Health Care.* 13(4):295-8, 2004 Aug

PROBLEM: Inhabitants of Torres Strait Islands have the highest prevalence of diabetes in Australia and many preventable complications. In 1999, a one year randomised cluster trial showed improved diabetes care processes and reduced admissions to hospital when **local indigenous health workers** used **registers, recall and reminder systems**, and **basic diabetes care plans**, supported by a **specialist outreach service**. This study looked at whether those improvements were sustained two years after the end of the trial. **DESIGN:** Three year follow up clinical audit of 21 primary health care centres, and review of admissions to hospital in the previous 12 months. **BACKGROUND AND SETTING:** Remote indigenous communities in far northeast Australia, population about 9600, including 921 people with diabetes. **KEY MEASURES FOR IMPROVEMENT:** Number of people on registers, care processes (regular measures of weight, blood pressure, haemoglobin A1c, urinary protein concentration, and concentrations of serum lipids and creatinine), appropriate clinical interventions (drug treatment and vaccinations), and intermediate patient outcome measures (weight, blood pressure, and glycaemic control). Admissions to hospital. **STRATEGIES FOR CHANGE:** Audit and feedback to clinicians and managers; provision of clinical guidelines and a clear management structure; workshops and training. **EFFECTS OF CHANGE:** The number of people on registers increased from 555 in 1999 to 921 in 2002. Most care processes and clinical interventions improved. The proportion of people with good glycaemic control (haemoglobin A1c

7%) increased from 18% to 25% in line with increased use of insulin (from 7% to 16%). The proportion of those with well controlled hypertension (< 140/90) increased from 40% to 64%. The proportion admitted to hospital with a diabetes related condition fell from 25% to 20%. Mean weight increased from 87 kg to 91 kg. **LESSONS**

LEARNT: In remote settings, appropriate management structures and clinical support for people with diabetes can lead to improvements in care processes, control of blood pressure, and preventable complications that result in admission to hospital. Control of weight and glycaemia are more difficult and requires more active community engagement. Priorities now include increasing the availability and affordability of good food, achieving weight loss, and increasing appropriate use of hypoglycaemic agents, including insulin.

6. Assessment of two culturally competent diabetes education methods: individual versus individual plus group education in Canadian Portuguese adults with type 2 diabetes. Gucciardi, Enza. Demelo, Margaret. Lee, Ruth N. Grace, Sherry L. *Ethnicity & Health.* 12(2):163-87, 2007 Apr

To examine the impact of two **culturally** competent diabetes education methods, individual counselling and individual counselling in conjunction with **group** education, on nutrition adherence and glycemic control in Portuguese Canadian adults with type 2 diabetes over a three-month period.

Our study findings provide preliminary evidence that **culturally** competent **group** education in conjunction with individual counselling may be more efficacious in shaping eating behaviours than individual counselling alone for Canadian Portuguese adults with type 2 diabetes. However, larger longitudinal studies are needed to determine the most efficacious education method to sustain long-term nutrition adherence and glycemic control.

7. A systematic review of quantitative and qualitative research on the role and effectiveness of written information available to patients about individual medicines. Raynor, DV. Belenkinsopp, A. Knapp, P. Grime J. et al. *Health Technology Assessment* 2007; Vol 11: number 5

Two main objectives: What are the role and value of written information..... How effective is this information.....

From over 50,000 citations, 413 were considered. Of these, 64 papers reporting 70 studies were included (36 papers reporting 43 RCTs in the effectiveness strand and 28 in the role and value strand).

Key findings

There was consistent evidence that the way in which risk descriptor information is portrayed influences side-effect knowledge. Delivering risk information numerically, rather than as verbal descriptors, ensures a more accurate estimation of the probability and likelihood of a side-effect and the risk to health.

The readability of medicines information is important to patients, with concerns about complex language and poor visual presentation.

Patients value the idea of information that is **tailored**, set in the context of the particular illness of the individual patient, and **containing a balance of benefit and harm information**. Very few studies addressed either issue.

Most patients wanted to know about any side-effects that could arise.

Patients would like written information to help decision-making, first for initial decisions about whether to take a medicine or not. Hence people value information about the range of treatments available (needed before the prescribing decision).

Second, they need information for ongoing decisions about the management of medicines and interpreting symptoms. Patients did not want written information as a substitute for spoken information from their prescriber. Although not everyone wanted written information, those who did wanted sufficient detail to meet their needs.

Conclusions

The combination of a quantitative and qualitative review, an exploration of best practice in information design, plus the input from stakeholder workshops allowed this review to look at all perspectives and explore issues not anticipated in advance. There is a gap between currently provided leaflets and information that patients would value and find more useful. The challenge is to develop methods of provision flexible enough to allow uptake of varying amounts of information on a variety of aspects, depending on needs at different times in an illness.

Implications for healthcare

To improve written medicines information, it is suggested that regulators and producers of written medicines information consider the following:

- Involve patients at all stages of the process, enabling their needs to be better reflected.
- Use findings on information design and content to improve the quality and usefulness of their products.
- Present risk information numerically rather than using verbal descriptors.

Spoken information remains the priority, but should be closely linked to written information so, in the authors' opinion, health professionals should:

- Ensure written information is not used as a substitute for discussion.
- Encourage patients to use written medicines information and welcome the questions this may raise.

 [View/Download full monograph in Adobe Acrobat format \(1.3 Mbytes\)](#)

 [View/Download summary in Adobe Acrobat format \(suitable for printing\)](#)

8. Influence of decision aids on patient preferences for anticoagulant therapy *Ovid MEDLINE(R)* Holbrook A. Labiris R. Goldsmith CH. Ota K. Harb S. Sebaldt RJ. : **A randomized trial.**[see **comment**]. [Comparative Study. Journal Article. Randomized Controlled Trial. Research **Support**, Non-U.S. Gov't] *CMAJ Canadian Medical Association Journal*. 176(11):1583-7, 2007 May 22.

BACKGROUND: **Decision** aids have been shown to be useful in selected situations to assist patients in making treatment **decisions**. Important features such as the format of **decision** aids and their graphic presentation of data on benefits and harms of treatment options have not been well studied. **METHODS:** In a randomized trial with a 3 x 2 factorial design, we investigated the effects of **decision** aid format (**decision** board, **decision** booklet with audiotape, or interactive computer program) and graphic presentation of data (pie graph or pictogram) on patients' comprehension and choices of 3 treatments for anticoagulation, identified initially as "treatment A"

(warfarin), "treatment B" (acetylsalicylic acid) and "treatment C" (no treatment). Results.....

INTERPRETATION: The **decision** aid led to significant improvement in patients' knowledge regardless of the format or graphic representation of data. Revealing the name of the treatment options led to significant shifts in declared treatment preferences.

Full article available at

<http://www.pubmedcentral.nih.gov.ezproxy.auckland.ac.nz/picrender.fcgi?tool=pmcentrez&artid=1867833&blobtype=pdf>

Conferences

1. ASSO - Australian Society for the Study of Obesity - Annual Scientific Meeting: Obesity: Moving beyond the politics". August 31st – September 2nd, 2007

Rydges Lakeside Hotel, Canberra

The ASSO Annual Scientific Meeting is the only conference dedicated to addressing the wide range of issues associated with obesity research, prevention and management.

- *Abstracts will be accepted on a variety of issues around the topic of obesity and are due on the 27th June 2007.*
- *Travel grants to the ASM are available for student members of ASSO.*
- *The prestigious ASSO Young Investigator Award is also available this year.*

For more information, visit the ASSO website <http://www.asso.org.au>

2. Optimising Quality of Care - One Day Seminar

One-day seminar to be held by the Quality Improvement Group, School of Population Health.

WHERE: School of Population Health, Tamaki Campus

WHEN: Friday, 31st August 2007

See attached PDF for seminar registration details and programme/speakers.

3. Understanding the Psychology & Sabotage of Weight Loss – Unlocking Motivation - Dr George Blair-West

The 2 Day Workshop will answer the following questions:

- *Why do traditional weight loss approaches have an 80% failure rate?*
- *What are the necessary psychological requirements for weight loss?*
- *Which proven psychotherapeutic approaches are most relevant to dealing with weight loss?*
- *What are the most common forms of self-sabotage?*
- *What is 'motivation' & why is the amount of dietary self-discipline required a marker of failure?*
- *What is Restraint Theory & how does recent research predict dietary sabotage*

New Zealand

<i>Auckland**</i>	<i>Mercure Hotel 8</i>	28-29 July	<i>29 June</i>
<i>Queenstown</i>	<i>TBA</i>	<i>28-29 Sept</i>	<i>30 July</i>

**Workshops run from 1pm to 7.00pm on Friday, 8.30am to 5pm on Saturday. **Except in Auckland where they run 8.30am to 5pm Saturday, and 8.30am to 1.30pm Sunday.*

Dr George Blair-West will be visiting Auckland again at the end of July to do an extra two-day workshop on the Psychology and Sabotage of Weight Loss. When he was here earlier in the year, his workshops and presentations were very popular.

His next workshop was going to be in September in Queenstown – but the response to his talks and his workshop has been such that he has agreed to return on 28-29 July to do an extra workshop in Auckland.

Dr Blair-West integrates the extensive research into Restraint Theory (all about how dietary deprivation leads to overeating) with the latest psychotherapeutic techniques, to shift the unconscious forces that need to be dealt with to lose weight. He argues that the dismal 80% five year failure rate in treating obesity results from a failure to acknowledge and manage the deep emotional attachment we have to food.

As a world authority on the psychology and sabotage of weight loss, he was invited to present at the 2006 International Congress on Obesity.

*His book **Weight Loss for Food Lovers: Understanding the Psychology and Sabotage of Weight Loss** is now being translated into Dutch and at a recent conference in Melbourne his keynote address was voted the best and 'most informative' of the conference: **Innovations in the Prevention and Management of Obesity**.*

The workshop is primarily designed for Dieticians, GP's, Nurses, Psychologists, Psychotherapists, Counselors and Diabetes Educators

Go to www.weightlosspsychology.com for more information about the venue and registration details.

Peer Support Specialist Training

16th – 27 July 2007, Manukau City
**Peer support specialist training –
Facilitated by specialist trainers from Meta Services in Phoenix,
Arizona**

This training is open to all people with lived experience of mental illness who live in Counties Manukau or want to work in Counties Manukau

Please register your interest by Friday 6th July to Denise Newell at denise.newell@pathways.co.nz

What is the Self Management Network

An informal and voluntary group of people interested in self-management principles to prevent disease development and improve the health of people with long-term health conditions. The group includes doctors, nurses, nurse specialists, consumers, managers, psychologists and allied health professionals. We now have over 150 healthcare providers from throughout NZ , Canada and Australia on the email list.

PURPOSE:

- To raise awareness of self-management & encourage increased self management support
- Forum for meeting like-minded people
- Identify opportunities to work together collaboratively
- Learn from each other

- Promote system changes that recognise & support the central role of individuals & their families
- Promote healthy public policies for prevention and reduction of long term conditions
- Promote training and research in this area

“Self management is about people with chronic conditions having greater control in looking after themselves with the support of their families/whanau (where desired), and in partnership with health care providers.”

(National Health Committee 2005)

Increased self management support has now been recognized internationally as one of the essential components for improving chronic care outcomes and the health of our communities.

If anyone would like **further information about the Self Management Network**, you are welcome to contact either:

Dr Janine Bycroft, jby@ihug.co.nz or 021 43 97 42

Dr Jocelyn Tracey, jocelyn.tracey@phocusonhealth.co.nz

Andy McLachlan AZMcLachlan@middlemore.co.nz or

Mary-Anne Boyd. Mary-Anne.Boyd@waitematadhb.govt.nz

To have your **name added or removed from the newsletter distribution list**, please contact Janine at jby@ihug.co.nz

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