



Self-Management Roles & Responsibilities Agreement

Context

The following Roles and Responsibilities Agreement demonstrates the commitment of Campaspe Primary Care Partnership's member agencies to provide effective integrated chronic disease management that includes evidence-based self-management interventions. This is underpinned by the following concepts;

- Self-management is the ability of the client to deal with all that a chronic disease entails, including symptoms, treatment, physical and social consequences, and lifestyle changes.
- Self-management interventions aim to place the person in control of their life and assist them to be as independent as possible, rather than create health system dependency.
- Agencies work in partnership with the consumer (and/family/carers as appropriate) to:
 - Know their condition and various treatment options
 - Negotiate a plan of care
 - Engage in activities that protect and promote health
 - Monitor and manage symptoms and signs of the condition(s)
 - Manage the impact of the condition on physical functioning, emotions and interpersonal relationships.
- Self-management support is the care and encouragement provided to people with chronic conditions (and their family/carers as appropriate) to help them understand their central role in managing their condition, making informed decisions about care, and engaging in healthy behaviours. Providing self-management support:
 - Requires a focus on building client self-efficacy (as well as client knowledge) and confidence
 - Includes assessment, goal setting, action planning and problem solving
 - Includes providing psychosocial support and motivating behaviour change
 - Can be delivered using flexible approaches.

Evidence-based self-management interventions may include¹:

- Flinders Model of Chronic Condition Self-Management
- Stanford Model (Lorig) Better Health Self-Management Program
- Motivational Interviewing
- Health Coaching

¹ Reference: Victorian Government Department of Human Services 2006; Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services.

Agreed implementation of agency self-management roles and responsibilities

Agencies agree in principle to:

1. Integrate self-management principles and interventions into their services and programs as part of their strategic approach to chronic disease management.
2. Adopt as standard self-management approaches, all, or a combination of, the Flinders, Stanford, Motivational Interviewing and Health Coaching Models.
3. Facilitate internal organisational change processes to enable self-management approaches to be integrated into consumer care. Eg agenda self-management for departmental meetings, allocation of financial, human and physical resources and responsibilities to/for self-management.
4. Provide support for professional development of staff to deliver self-management interventions.
5. To adopt local or regional disease specific pathways that incorporate self-management interventions for chronic disease management ie. Loddon Mallee Regional Diabetes Pathway.
6. To support continuing partnership approaches to Integrated Chronic Disease Management between agencies through participation in the Campaspe PCP – Service Coordination Steering Committee and relevant working groups.

This agreement is underpinned by the Campaspe Primary Care Partnership Memorandum of Understanding.

This agreement will have tenure of 3 years and will be reviewed on expiration by the Campaspe Service Coordination Steering Committee.

Executed as an agreement

Campaspe Primary Care Partnership

OnDay of.....2010

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 Emma Brentnall
 Executive Officer
 Campaspe Primary Care Partnership

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 [Manager]
 [Title]
 [Agency]

Date:

Date: