Darebin Community Health case study
Embedding self-management support in care delivery

The Chronic Care Model element highlighted in this case study is self-management support. Self-management support requires the use of a range of techniques and programs to provide people with information and skills that will support them to manage their health and health care.

Background
In 2007 Darebin Community Health undertook an organisational restructure and created a Health Wise team as part of its Chronic and Complex Care Program.

This multidisciplinary team, which includes diabetes education, podiatry, physiotherapy, dietetics, counselling, occupational therapy and nursing, works within a self-management framework to address clients’ self-management and clinical needs.

The program aims to improve the health and wellbeing of people living with chronic and complex needs who are at low risk of admission to hospital.

What they did
Darebin Community Health was committed to building strong skills and capacity to provide self-management support.

To achieve this, a range of self-management training for members of the Health Wise team was provided including Flinders model, health coaching and motivational interviewing.

The organisation also recognised the need to adapt appointment structures, through allocating additional time, to support the integration of self-management into service delivery.

A generic assessment tool was also developed and integrated across all allied health services to support comprehensive holistic assessment and self-management support.

Over the past six years self-management support has evolved from a team-based approach by the Health Wise team to an organisation-wide approach.

Staff members from other teams have been trained in health coaching and motivational interviewing and are supported by more experienced staff through monthly meetings and buddy systems.

Darebin Community Health has used the Assessment of Chronic Illness Care (ACIC survey) to evaluate their chronic disease systems. The ACIC survey was conducted in 2009 and repeated in 2013. Survey results supported a review of key aspects of chronic illness care and inform a continuous improvement strategy.

In response to the ACIC findings since 2013, 23 Allied Health and Planned Activity Group (PAG) staff have received goal-directed care planning training.

To further support care coordination and access, in 2014 Darebin Community Health consolidated a partnership with Darebin City Council and created a co-located occupational therapy position – based at council to encourage greater collaborative opportunities such as shared goal-directed care planning.
In 2015, Darebin Community Health established a care planning mentor working group that includes the champions from the Health Wise team and other staff to refine the care planning process and move it from a team-based to an organisation-wide approach.

**Outcomes**

Outcomes from the work that Darebin Community Health has completed for chronic disease so far include:

- the development of a care planning policy and procedure that includes shared care planning
- health coaching training is provided across all teams
- the self-management approach has been embedded in individual treatment sessions across every discipline and all group programs
- a generic assessment tool is used by all teams across Darebin Community Health
- case conferencing training has been provided
- case conferencing policy and procedure for the organisation has been developed
- a shared-care planning pilot using an electronic (S2S) platform was undertaken in collaboration with Darebin City Council
- clinical leaders training has occurred to move to professional supervision for all staff
- a PhD student from La Trobe University is working with the Health Wise team leader to investigate how motivational interviewing has worked in community health
- ongoing use of ACIC tool to evaluate progress against best practice. Darebin Community Health will re-evaluate improvements since 2013 using ACIC in 2016.

In 2009 the ACIC survey overall organisational score was 5.5. This increased to 7.2 in 2013, suggesting the organisation moved from providing basic support for chronic illness care in 2009, to providing good support for chronic illness care in 2013.