# Implementation checklist for self-management and shared care programmes

This document provides a checklist of considerations for when implementing programmes that aim to: (1) prevent the progression of pre-diabetes to type 2 diabetes; and (2) help people with a chronic disease to successfully self-manage their condition. It is based on the findings of the pre-diabetes and long-term conditions self-management and shared care pilot projects funded by the Ministry of Health.

##  Engagement of frontline healthcare workers

* Healthcare workers play a key role in identifying people at risk, motivating behaviour change, and referring people onto services that can help. Therefore healthcare workers should be engaged early in the programme planning process.
* Organisations should utilise a range of strategies to help healthcare workers perform these tasks. These include:
  + **Provide training** to staff on how to identify people in need, make an offer of support (including the benefits of enrolling in the programme and what to expect), and how to refer.
  + **Use tools and systems that prompt** healthcare workers to identify patients, make an offer of help and refer. Referrals from healthcare workers should, wherever possible, be electronic and link with practice management systems.
  + **Audit and provide feedback** to healthcare workers on the outcome of referrals and show them how they are performing (eg, number of referrals) relative to their peers. Targets can be helpful in setting expectations, but should be realistic and achievable.
  + **Provide incentives/rewards** to support a change in practice. These may be simple, for example providing morning tea.
  + **Foster and maintain clinical leadership** for the programme.

##  Effective communication

* Plan, implement and maintain regular communication:
  + between projects and frontline healthcare professionals (eg, programme information evenings for practice staff; practice presentations; and sharing of patient case studies)
  + within the project team (eg, regular meetings, team huddles). This is especially important for SMSC programmes where there are multidisciplinary teams.

##  Integration with primary care

* Develop and maintain strong links with primary care. This is beneficial for programme referrals, responsiveness to changing patient needs, and sustainability of the programme.
* Actively promote the programme. Although many people want to change their health behaviour, relatively few know what help is available or see the need for assistance. Any promotional activity should prompt people to make lifestyle changes and direct them to programmes that will help increase their chances of success.
* Simple referral processes.
* Create a supportive practice environment (eg, reinforce messages provided by the programmes using materials such as posters and leaflets).
* Where possible, incorporate patient goals into the practice management system so that frontline staff can opportunistically check on progress, give advice and motivate their patients.
* Provide feedback to practices.

##  Ensure the programme meets the needs of priority populations

* Programmes should be adaptable to meet the varying levels of health literacy in the population.
* Programmes should have the ability to help people address non-health needs (eg, housing and support with financial needs). This may be via links with social organisations.
* Programmes should be appropriate and accessible for Māori and Pacific people. Programmes that serve Pacific populations should be responsive to the needs of Pacific people with pre- and type 2 diabetes.

##  Programme staff

* Consideration should be given to recruiting the right staff for the role, who:
  + - have the ability to develop and maintain rapport with people
    - have sufficient time to provide the level of support needed by patients with chronic illness, or who are trying to make difficult health behaviour changes.
* Mechanisms should be in place to support non-clinical staff to communicate with medical/nursing teams.
* Ensure that staff are competent to deliver the programme. This should involve appropriate training, mentoring and supervision.

##  Programme components

* In general, programmes should:
  + foster participant engagement. For instance, with activities that: are geared to the right level of health literacy; keep the programme interesting and enjoyable; and are facilitated by people who have the qualities and skills to work in partnership
  + be relevant to a wide audience - programmes need to be generic in their content, but allow for tailoring where possible
  + have regular contact with the same practitioner
  + include support from peers eg, peer support groups
  + have a degree of accountability. Establishing elements of patient accountability within treatment programmes can facilitate behaviour change. This may include: using a commitment contract at enrolment that sets out the expectations of the person and the programme; incorporating concrete tasks (eg, doing 30 minutes of moderate intensity physical activity per day); and regular monitoring (eg, review of aims and goals, feedback on progress)
  + integrate behavioural support
  + consider practical issues such as patient time, family and social commitments and transport.

***More specifically***

* **Self-management shared care programmes** **should**:
  + develop care plans in collaboration with the person (adequate time needs to be set aside for creating these), and then revising them throughout the programme as peoples’ needs change
  + be facilitated by a person with qualities and skills in partnership and the change process
  + use a model of care that best fits the needs of the local population
  + give very careful consideration to making any changes to tried and tested models (eg, Stanford model)[[1]](#footnote-1)
  + include a multidisciplinary approach, where possible
  + take into consideration access (or lack of) to mainstream healthcare services
  + closely monitor new models of care to assess outcomes and value for money, and look at the success factors and barriers
  + ensure that IT systems can be used with relative ease within routine consultation and, where appropriate, meet the needs of patients
  + involve clinicians and patients in system design.

##  Programme resources

* Resources should have clear messaging, be easy to read, and have creative presentation.
* Electronic resources, instead of printed, should also be considered.
* Resources should only be used when the person agrees that they will be helpful.

##  Monitoring and evaluation

* Clinical outcome data should be collected from all programmes and analysed in a standard manner. Sensitivity analyses should be undertaken, with those lost to follow-up considered to have made no changes from baseline. The analyses should also examine differences between ethnic groups and any national variation in outcomes.

1. Outcomes from two pilot projects demonstrated that changes to existing models does not lead to better outcomes, despite best intentions. [↑](#footnote-ref-1)