Government of **Western Australia**
Department of **Health**

Chronic Condition Self-Management Support

Supporting people to be actively involved in their own health care



Glossary of Terms

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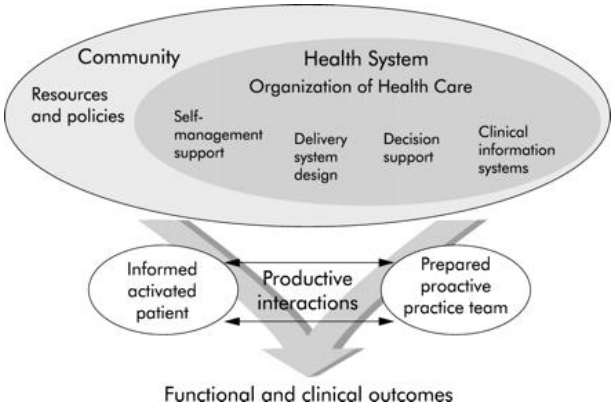
TERM	DESCRIPTION
Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community. (Operational Directive 0435/13)
Accreditation	Accreditation is the status that is conferred on an organisation that has been assessed as having met particular standards. The two conditions for accreditation: • An explicit definition of quality (i.e. standards) and • An independent review process aimed at identifying the level of congruence between practices and quality standards. It demonstrates a health service's commitment to achieving high quality and safe care for patients, residents, carers and families.
Accreditation in WA Health	All public and private hospitals and day hospitals that provide general anaesthesia n WA are required to be accredited to the National Safety and Quality Health Service (NSQHS) Standards using the Australian Health Service Safety and Quality Accreditation Scheme.
Accreditation and Self-Management	As person-centred care is the first principle of self-management support, all NSQHS standards involve a self-management and person-centred approach. **Standard 2:** Partnering with Consumers and Standard 12: Provision of Service have the strongest link to self-management. Standard 2.6.1: 'Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care' [ie Self-Management Support].
Action Plan	An action plan specifies one or two concrete activities that the consumer agrees to engage in to manage their condition. It is specifically focused on the consumer's needs, preferences, experiences and readiness to complete the activity.
Action Planning	• identifies specific steps and strategies to achieve a self-management goal (e.g., what, when, where, with whom, how often) • selection of tools and resources to aid goal attainment • anticipates potential barriers • decide on a specific plan for follow-up on progress towards goal attainment.
Activity Based Funding (ABF)	The way that WA Health service providers are funded for their service activity.

Activity Based Management (ABM)	The management approach used by WA Health to plan, budget, allocate and manage activity and financial resources to ensure delivery of safe high quality health services to the WA community.
Acute	Coming on sharply and often brief, intense and severe.
Acute Care	Care provided mainly to admitted patients with acute or temporary ailments. The average length of stay is relatively short.
Admission	An admission to hospital. The term hospitalisation is used to describe an episode of hospital care that starts with the formal admission process and ends with the formal separation/discharge process.
Advanced Care Directive	An individual's own (written) wishes regarding health care decisions if they should lack capacity at some future time. The vital component of this process is the discussion about preferences and direction regarding treatment and care decisions that takes place with person/s responsible and others as appropriate. The written document provides clarity and accountability for the persons wishes.
Agenda Setting	Agenda setting is a key enabler in assisting individuals to self-manage. People are encouraged to prepare in advance the issues they want to explore and the problems they want to solve. It signals from the beginning that individuals are active partners in their care. At the beginning of the meeting, the individual and the clinician discuss and agree on the agenda for discussion.
Allied Health	Comprises a wide range of health professionals and includes Aboriginal Health Workers, Audiologists, Chiropodists, Counsellors, Dieticians/Nutritionists, Occupational Therapists, Orthoptists, Orthotists/Prosthetists, Osteopaths, Physiotherapists, Podiatrists, Psychologists, Radiographers, Asthma & Diabetes educators, Mental Health, Social Workers & Speech Pathologists.
Ambulatory Care	Describes care provided to people who are not admitted to the hospital for example those attending outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) healthcare services. 'Ambulatory' in these medical contexts implies that the person is 'capable of walking' and is not confined to bed (or, more strictly, a hospital bed). (Ambulare = to walk. Latin)
Assessment of health risk factors	Awareness and effective identification of predisposing factors, factors unique to an individual or are part of their environment that increase a person's chances, or make it more likely, that they will develop a condition or other health condition.

Assessment of Self-Management capacity	Assessment using evidence-based tools, of a person's health beliefs, knowledge, attitudes, behaviours, strengths, barriers, readiness to change (motivation), confidence (self-efficacy) and the importance they place on their health (priority). This will be interpreted by the person through the lens of social, cultural, economic, political and spiritual influences. It may also include an assessment of the capacity of carers/family to support self-management.
Behaviour	The observable responses, actions or activities of an individual.
Behaviour Change – Theories and Models	A model is a framework which help us to understand human behaviour and how to change it. It involves theoretical understanding of the mechanisms involved in the choices people make in their lives and how to engage them in the process of change. Various models exist including: • The Health Belief Model (Pender, Murdaugh & Parsons, 2006) • Theory of Reasoned Action and Theory of Planned Behaviour (Pender, Murdaugh & Parsons, 2006) • Social Learning Theory (Bandura, 1977) • Transtheoretical (Stages of Change) Model (Prochaska & Di Clemente, 1983; Prochaska & Velicer, 1997) • Relapse Prevention Model (Miller and Rollnick, 1991) • Health Promotion Model (Pender, Murdaugh & Parsons, 2006) • The 5As Model (Glasgow,Davis, Funnell & Beck, 2003) • Cognitive Behavioural Therapy (BABCP, 2005).
Behaviour Change Interventions	These can be defined as coordinated sets of activities designed to change specified behaviour patterns. In general, these behaviour patterns are measured in terms of the prevalence or incidence of particular behaviours in specified populations (e.g., delivery of smoking cessation advice by general practitioners). Interventions are used to promote uptake and optimal use of effective clinical services, and to promote healthy lifestyles.
Behaviour System	A 'behaviour system' can have components of capability, opportunity, and motivation which interact to generate a behaviour (the 'COM-B' system, S.Michie). **Capability** is defined as the individual's psychological and physical capacity to engage in the activity concerned. It includes having the necessary knowledge and skills. **Motivation** is defined as all those brain processes that energize and direct behaviour, not just goals and conscious decision-making. It includes habitual

	processes, emotional responding, as well as analytical decision-making. **Opportunity** is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it.
Benchmark	A standard or point of reference for measuring quality or performance. They are used in accreditation processes. Benchmarking is a continuous process of measuring quality or performance against the highest standards. (AIHW)
Brief Interventions	'Brief interventions' refer to interactions that takes very little time and aim to change behaviour(s) . They are usually conducted in a one-on-one situation and can be implemented anywhere on the intervention continuum. The intervention can be brief and 'opportunistic', lasting as little as 30 seconds, or extending over a few sessions lasting 5-60 minutes. The aims of brief intervention are to: • engage with those not yet ready for change • increase a person's perception of real and potential risks • encourage change by helping a person to consider the reasons for change and the risks of not changing. Brief interventions utilise many skills such as motivational interviewing, problem solving, decisional-balancing and goal setting and requires an understanding of the process of change.
Burden of disease	Term referring to the quantified impact of a disease or condition on an individual or population, using the disability-adjusted life year (DALY) measure.
Capability	An integration of knowledge, skills, personal qualities and understanding used appropriately and effectively in response to new and changing circumstances. Capability embraces competence but is also forward-looking and concerned with the realisation of potential.
Capacity building	**Individual** level - the development of conditions that allow individual participants to build and enhance existing knowledge and skills and to engage in the "process of learning and adapting to change." **Community** level – the development of policies, structures and an environment within the community that contribute to the overall health and well environment being of that community.
Care Plan	A care plan records the outcomes from a care planning discussion, including any actions agreed for a person to manage their health or condition(s). It can be a written document, an electronic document or both. A Care Plan involves: • collaboration between the person and family or carer • setting goals that are meaningful and important to the person and family

	or carer • identifying service options, interventions, referrals and connections • identifying steps to reach the person's goals: specific, measurable, achievable, realistic and time orientated (SMART) • a timeframe with entry, exit points and review processes • care planning between agencies • shared responsibility to action • typically summarised in a document to be shared with the consumer. A consumer may have a number of plans and these should be reflected in a single overarching care plan. This overarching plan is typically managed by the person's primary care giver usually their GP.
Care Planning	The overarching aim of care planning is to improve the quality of care and outcomes for people with long term conditions by engaging them more in decisions about their care and supporting them to take control of their own health.
Carer	Under the Carers Recognition Act 2004, a carer is a person who provides ongoing care or assistance to another person who has a disability, a chronic illness or a mental illness, or who is frail and needs assistance in carrying out everyday tasks. Carers may be receiving income support such as the Carers Payment or Carers Allowance but are not employed to provide care. Carers are usually, but not necessarily, family members or relatives of the person they care for.
Caring	Caring can be considered the behaviours, actions, and attributes of providers of health care. Caring providers of health care listen to and are empathetic with the consumer's points of view. Generally, caring requires recognition of consumers as unique individuals whose goals providers of health care facilitate. Consumers' values and choices are of primary consideration when planning and providing care and the health care providers' own personal values should not interfere with consumers' right to receive care.
Change Management	Change in the structure of service delivery in order to impact on the way work is delivered to the population served. Various techniques are used within health care settings, each based on theories of organisational structure, culture and models of change, group behaviour and values. The Plan, Do, Study, Act (PDSA) cycle is one mechanism for mobilising staff for incremental organisational change (Johnson & Paton, 2007). Also refer Change Process Steps below.

Change Process Steps – (Kotter's 8 Step Process for Leading Change)	1. Establishing a Sense of Urgency 2. Creating the Guiding Coalition 3. Developing a Change Vision 4. Communicating the Vision for Buy-in 5. Empowering Broad-based Action 6. Generating Short-term Wins 7. Never Letting Up 8. Incorporating Changes into the Culture
Chronic	A process that begins and proceeds slowly, and lasts over a long period of time. Refer chronic condition.
Chronic Care Model	A model of care developed to provide a comprehensive strategy to address the growing burden of chronic disease. The Chronic Care Model identifies six critical elements to delivery best practice chronic condition care. 1. Community 2. Organisation of Health care 3. Self-Management Support 4. Delivery System Design 5. Decision Support 6. Clinical Information Systems  The CCM combines the principles of health promotion and community engagement with evidence based guidelines, decision tools for health professionals and self-management support for people and their families. The model identifies that patients need to be informed and activated to participate in their own health care. Prepared, activated health care teams need to adopt a partnership approach to supported support improvements in both health outcomes and quality of life. Developed by the MacColl Institute for Healthcare Innovation (USA) based on available literature about chronic condition management, it was refined by The Robert Wood Johnson Foundation, and tested across varied health care settings, creating the programme, Improving Chronic Illness Care (ICIC). Subsequently it has been implemented more broadly around the world, and further refinements include the ICCC Framework.
Chronic Condition	A chronic condition is typically 'any ongoing or recurring health issue that has a significant impact on the lives of a person and/or their family, or other carers. (World Health Organisation) These conditions include among others, chronic pain, asthma, arthritis, heart disease, cancer, anxiety, depression,

Chronic Condition continued	diabetes, alcohol and drug dependency. Although most chronic conditions lead to a gradual deterioration in health, some chronic conditions are associated with outcomes that are immediately life threatening, such as stroke or heart attack. Chronic conditions typically share the following characteristics: • multiple and complex causes and risk factors. • follow a pattern of recurrence or deterioration. • they are long lasting. They occur across the lifespan with increased prevalence in the aged. They can result in functional impairment or residual disability.
Chronic (Health) Condition	A broad term that can be applied to any ongoing or recurring health problem, including symptoms, diseases, and various risk factors, such as high blood cholesterol and obesity. Often used synonymously with disorder or problem. Characteristics of a chronic condition include: • complex causes • multiple risk factors • long latency periods • prolonged course of illness • functional impairment or disability.
Chronic Condition Management (CCM)	Chronic Condition Management (CCM) is a systematic approach to coordinating health care interventions across levels (individual, practice or service, organisational and system). Self-management support is a significant component of CCM. Evidence says that the CCM approach is more effective than single or uncoordinated strategies or interventions.
Chronic Condition Self-Management (CCSM)	Self-management is defined in the National Chronic Disease Strategy as “the active participation by people in their own health care”. CCSM involves consumers adopting attitudes and learning skills that facilitate a partnership with carers, general practitioners, and health providers in treating monitoring and managing their condition.
Chronic Condition Self-Management ***/*** **CONSUMER skills for Self-Management**	Self-Management for **Consumers** involves: 1. Having knowledge of the condition 2. Actively sharing in decision- making about health 3. Following an agreed care plan 4. Monitoring and managing the signs and symptoms of the condition 5. Managing the impacts of the condition on physical, emotional, social life 6. Actively adopting a healthy lifestyle and 7. Having confidence, access and the ability to use support services.

Chronic Condition Self-Management **SUPPORT**	Self-management support describes the techniques and strategies that health providers, carers, organisations and systems do to assist those living with chronic conditions to practice self-management. Also known as 'collaborative care strategies', these techniques are based on self-management principles.
Chronic Condition Self-Management **SUPPORT Principles**	For **Health Providers** (Organisations, Systems, Providers, the Community) 1. Person-centred approach 2. Consumer empowerment and enhanced capacity 3. Participation by consumer, family and carers 4. Partnership between consumer and health providers 5. Shared responsibility for health care outcomes 6. Coordination of support along the consumer journey 7. Appropriate information: accessible, timely and understandable 8. A holistic, lifelong approach to health and self-care.
Chronic Condition Self-Management **or Self-Management APPROACH**	The self-management approach emphasises the person's central role in managing their health. It includes strategies of assessment, goal setting, problem solving and follow-up; client empowerment and enhanced capacity, knowledge and skills; links them to personal and community resources; and employs a holistic, lifelong approach to health and self-care. A CCSM approach may be used in time-limited settings.
Chronic Condition Self-Management **PROGRAM**	Self-management programs offer people with chronic health conditions the knowledge, skills and resources to help them better manage their health. They are not educational programs or Cognitive Behaviour Therapy (CBT) or peer support groups on their own. WA defines self-management programs as programs (group, individual, online or other format) that: • Simultaneously address symptom and condition management, emotional consequences and daily life with a chronic condition (Corbin & Strauss 1988); • Provide opportunity for competence mastery, vicarious learning, social persuasion and re-interpretation of symptoms; • Teach problem solving and decision making (Bandura, 1997); and • Include instruction on developing partnerships, goal setting and action planning. Self-management programs or interventions aim to achieve one or more of the following outcomes for people with chronic conditions: • Improvements in health and other (eg. work) behaviours, • Improvements in health status (including physical functioning and

	psychological wellbeing), and • Reductions in unplanned health service utilisation eg. GP visits, emergency visits, hospital admissions. A program is differentiated from a service in that a service may run a number of programs and utilise other interventions and approaches.
Chronic Disease	Term applied to a diverse group of (diagnosed) diseases, such as heart disease, cancer and arthritis, which tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), the term is usually confined to non-communicable diseases. In WA consumer feedback has indicated a preference for the use of the term chronic 'condition' rather than 'disease' where practicable.
Clinical Practice Guidelines or	Systematically developed statements (based on best available evidence) to assist practitioner and patient decisions about appropriate health care for specific clinical (practice) circumstances Also known as **Best Practice Guidelines**
Clinician	A health care professional employed by a hospital/health service responsible for assessing and treating (potential) patients.
Coaching	See Health Coaching
Collaboration	Collaboration is the mutual sharing and working together to achieve common goals in such a way that all persons or groups are recognized and growth is enhanced.
Collaborative Care Planning	The process in which all those involved in the organising, provision and receipt of care for a given patient are actively involved in the planning and decision-making surrounding what that care involves over a given time period
Communic-ation	A two way exchange (includes verbal and non-verbal cues), in which a message sent is understood by the receiver. Effective communication involves the ability to establish and develop mutual understanding, trust, respect and cooperation.
Community-based resources	Available resources, supports, services and activities within the patient's community that would be useful in supporting them and their carers/family. This includes information about what the services involve, how to access them and their appropriateness in being able to meet the patient's and their carer's identified needs
Community of Practice	'Communities of practice (CoPs) are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.' There is a focus on situated learning through the lived experience of

<table>
<tr><td></td><td>interacting with other people in the real world with all its complexities and contradictions.
Whereas a network will disseminate information, lobby or collaborate on an issue or form an alliance between organisations, a community of practice is more concerned with individuals learning, refining and innovating in a particular area of activity or practice.</td></tr>
<tr><td>Co-morbidity</td><td>The co-occurrence of two or more health conditions in a person, such as heart disease with depressive disorder.</td></tr>
<tr><td>Competence mastery</td><td>The building of knowledge, skills and attitudes over time using a repetitive process.</td></tr>
<tr><td>Competency</td><td>The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served.</td></tr>
<tr><td>Confidence Ruler</td><td>A simple 1to 10 scale against which a person assesses their confidence of achieving a goal under discussion. The health provider uses open questioning to help patients set goals in which their confidence is at least 7 – a score that will also give the health provider confidence that the person will achieve their goal, becoming a better self-manager and more likely to achieve long-term stability or improvement in their chronic condition.
How READY are you to make this change? (1 = Low, 10 = High)
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<tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr>
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How IMPORTANT is this change to you?
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How CONFIDENT are you to make this change?
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<tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr>
</table></td></tr>
<tr><td>Confidentiality</td><td>Confidentiality is the right of an individual to have personal, identifiable medical information kept private.
All persons delivering healthcare have a duty to maintain the confidentiality of all information that comes to them in the course of their relationship with patients. The duty protects information created, disclosed or acquired directly or indirectly in the context of the patient and health care provider relationship. Patient confidentiality is protected by law.</td></tr>
<tr><td>Consensus</td><td>A process for making policy decisions (not a method for creating new knowledge). At its best, consensus development merely makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al, 1999).</td></tr>
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Consent	Consent is a patient's agreement for a health provider to provide treatment. In WA Health's Consent to Treatment Policy (2009), consent is described as involving a process of: 1. Informing the patient: to assist reach an informed decision including a description of the proposed treatment and any material risks and to ensure the patient understands the information given/discussed. 2. Gaining consent and 3. Recording consent.
Consumer	Also known as patient, client. Those who use, or are potential users, of health services.
Consumer Engagement	There are different levels of consumer engagement (from high to low engagement): • **Empowering** service users and the community, management is delegated to consumers, families and carers or the relevant community. • **Collaborating** with service users and the community through partnership mechanisms, such as participatory decision making and individual participation in care planning. • **Involving** service users and the community through consultation, such as forums, consumer representatives or advisory groups. • **Consulting** service users and the community whereby information is gathered, such as through utilising consumer feedback tools, surveys, focus groups. • **Informing** service users and the community about particular issues or services.
Consumer Participation	Consumer, family, carer and community participation is the process by which the needs, perspectives, concerns and values of clients and communities are incorporated into staff and organisational decision making and program planning, implementation and evaluation. A range of consumer participation activities can be ranked according to the degree of control that the consumer, carer or community has (Brager and Specht (1973): Has control; Has delegated control; Plans jointly; Advises; Is consulted; Received Information; None.
Consumer Representative	According to the Consumers' Health Forum of Australia a "consumer representative is someone who is a member of a government, professional body, industry or non-governmental organisation committee who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person is nominated by, and is accountable to, an organisation of consumers."
Consumer, Carer or	A reciprocal process of interaction that involves equitable consultation, participation and representation between health providers and consumers,

Community engagement	carers and members of the general community on matters relating to the impact of service delivery and client needs.
Continuous Improvement	Continuous and incremental improvements to clinical processes achieved by removing unnecessary activities and variations, so that each state is the starting point for the next step on the journey towards the ideal state.
Cultural Awareness	Cultural awareness entails an understanding of how a patient's culture may inform their values, behaviour, beliefs and basic assumptions (Centre for Cultural Diversity in Ageing, 2008). It involves understanding the local community and its needs, and specific communication skills that are culturally respectful. This may involve the effective use of interpreters to accurately relay and receive what is communicated between the worker and the patient and their carers/family.
Decision-Aids	A decision aid is an intervention designed to assist people make specific choices about different options for their healthcare by providing information on the clinical options and outcomes relevant to the person's health.
Demographic	A statistic characterising human populations (or segments of human populations) broken down by age or sex or income.
Depression	A mood disorder with prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts and self-blame. Depression has serious ramifications for treatment and self-management of other chronic conditions. Studies reveal that a high incidence of anxiety and depression occurs in people with chronic conditions.
Determinant	Any factor that can increase the chances of: • ill health (**risk** factors) or • good health (**protective** factors) in a population or individual. (AIHW)
Dignity	Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals. In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of the nursing team and others and by the way in which care activities are carried out. When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves. When dignity is absent people feel devalued, lacking control and comfort. They may lack confidence and be

	unable to make decisions for themselves. They may feel humiliated, embarrassed or ashamed. Dignity applies equally to those who have capacity and to those who lack it. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value. All people in all settings and of any health status should be treated with dignity, and dignified care should continue after death.
Disability	A concept of several dimensions relating to an impairment in body structure or function, a limitation in activities (such as mobility and communication), a restriction in participation (involvement in life situations such as work, social interaction and education), and the affected person's physical and social environment.
Disease	A physical or mental disturbance involving symptoms (such as pain or feeling unwell), dysfunction or tissue damage, especially if these symptoms and signs form a recognisable clinical pattern. (May or may not be chronic)
Embedding CCSM Support	Involves utilising a multi-level, multi- component approach to implement CCSM principles and practice at the organisational, service and individual levels of the health system and across the community. Refer CCSM Support Principles; Change Management
Emergency Department	The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care. An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition(s) and/or injury.
Empowerment	Empowerment is defined as "the participation of individuals and communities in a social action process that targets both individual and community change outcomes" (Wallerstein (1992)). A concept that is crucial to empowerment is that community workers and professionals must "start where the people are" (Nyswander, 1956). Initial and ongoing assessment of clients' values, feelings, and actions are integral to any community work.
Evaluation	• The systematic collection of information about the activities, characteristics and /or outcomes of programs to make judgements about the program, improve program effectiveness and /or inform decisions about future programming.' (Patton 1997) • The systematic acquisition and assessment of information to provide useful feedback about some object/subject. • The process of determining the worth merit or value of things …or the result of that process.' (Scriven 1991) • Evaluation determines the merit, worth, or value of things. The evaluation

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<tr><td></td><td>process identifies relevant values or standards that apply to what is being evaluated, performs empirical investigation (often) using techniques from the social sciences, and then integrates conclusions with the standards into an overall evaluation or set of evaluations. (Scriven, 1991)</td></tr>
<tr><td>Evaluation vs Research</td><td>
<table>
<tr><th>EVALUATION</th><th>versus RESEARCH</th></tr>
<tr><td>• Focus on programs</td><td>Focus on populations</td></tr>
<tr><td>• Improves</td><td>Proves</td></tr>
<tr><td>• Determines value</td><td>Stays value-free and</td></tr>
<tr><td>• Is it working?</td><td>Did it work?</td></tr>
<tr><td>• Happens in real time.</td><td></td></tr>
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</td></tr>
<tr><td>Evidence</td><td>An observation, fact, or organized body of information offered to support or justify inferences or beliefs in the demonstration of some proposition or matter at issue.</td></tr>
<tr><td>Evidence-based knowledge and practice</td><td>Evidence-based knowledge is an explicit approach to health care practice in which the health professional is aware of the evidence that bears on their practice, and the strength of that evidence, incorporating the risks and benefits of any intervention, including self-management support.
Evidence-based practice is the integration of best research evidence with clinical expertise and patient values, circumstances and preferences
Most evidence-based guidelines are condition specific. However, as an increasing number of people have co-morbidities, an important part of evidence-based knowledge and practice is to acknowledge this complexity.</td></tr>
<tr><td>Five A’s
(5 A’s)</td><td>The five A’s is a type of brief intervention that emphasises a conversation with the patient that elicits his or her problems in self-care and collaboratively develops goals and action plans to address the problems. The five steps are: Assess Advise Agree Assist Arrange.</td></tr>
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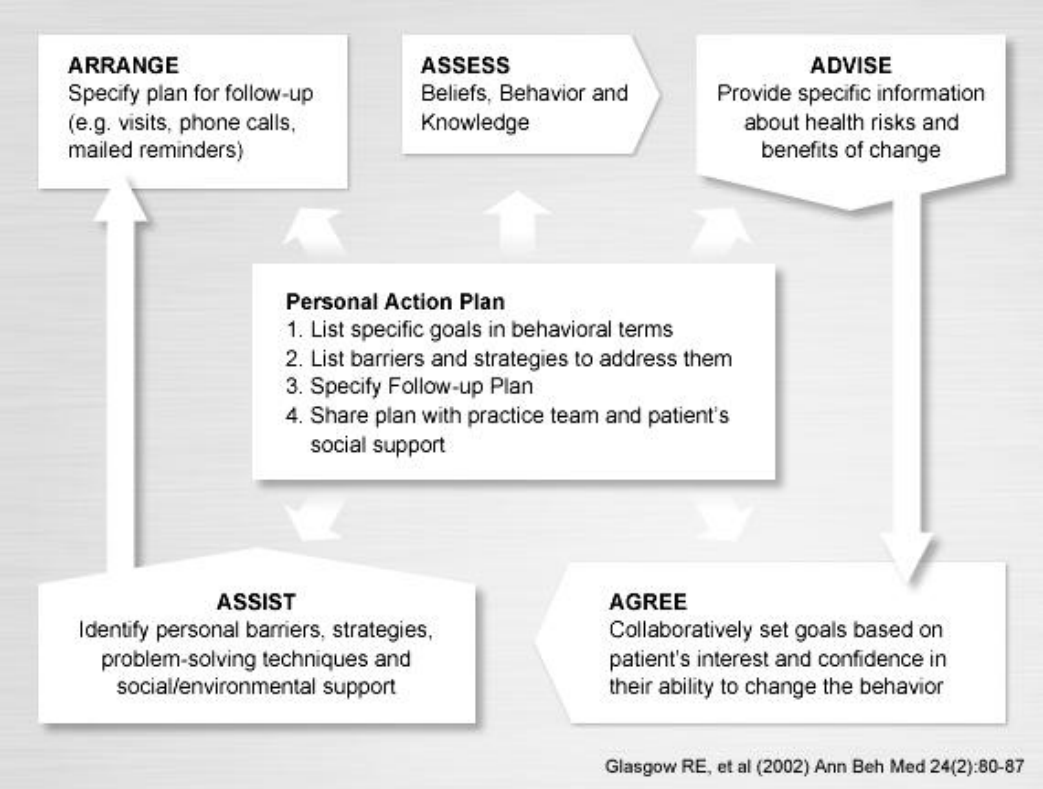
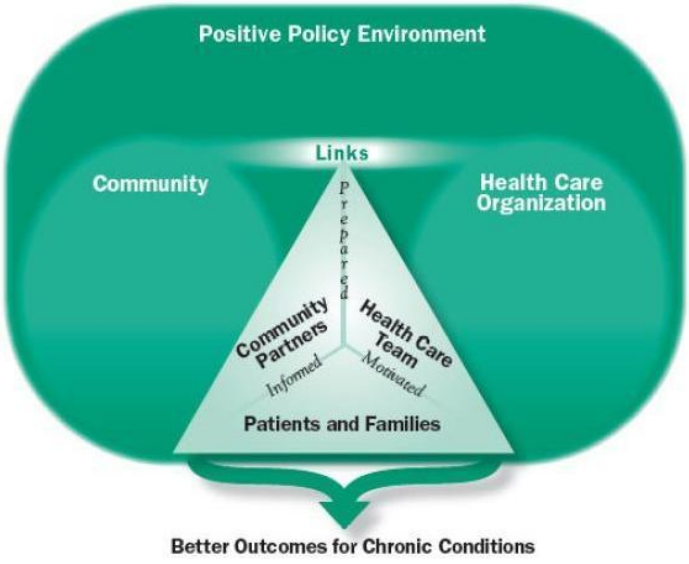
	 http://www.swselfmanagement.ca/smtoolkit/intro/index.aspx
(The) Flinders Model	The Flinders Program™ of Chronic Condition Self-Management, Flinders University Human Behaviour and Health Research Unit in South Australia. It identifies six characteristics of 'good' self-management and provides health providers with tools to assess self-management capability and to develop collaborative care plans with their clients. It utilises a number of standardised tools/forms: the Partners in Health Scale, Cue and Response Questionnaire, Problem and Goals, and Care Plan. Requires a two-day training program and submission and approval of three case studies for health professionals to become accredited to use the model in practice. For more information: http://www.flinders.edu.au/medicine/sites/fhbhru/self-management.cfm
Geriatric evaluation and management (GEM)	Care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management

	includes care provided: • in a geriatric evaluation and management unit • in a designated geriatric evaluation and management program • under the principal clinical management of a geriatric evaluation and management physician or, in the opinion of the treating medical officer, when the principal clinical intent of care is geriatric evaluation and management. (ARD TP)
Generic Programs	Self-management programs with content applicable to ALL chronic conditions
Goal setting and action planning	The process of deciding on what one wants, planning how to get it, and then working towards the objective of achieving it, usually by ensuring that it is SMART: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imely. In the health context, goal setting can be done by the patient alone or with the support of others to help formulate the goal and help the patient to remain motivated to achieve it, i.e. involving collaborative goal setting, problem-solving and other goal attainment skills (Locke & Latham, 1990).
Health	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO) Health is term relating to whether the body (which includes the mind) is in a good or bad state. With good health the state of the body and mind are such that a person feels and functions well, and can continue to do so for as long as possible. (AIHW)
Health behaviours	Personal behaviours that impact on a person's health and wellbeing. For example, nutrition and physical activity.
Health Care Providers	Many **health care providers** and health services are involved in supporting an individual with chronic condition. The term 'health care provider' is used as an inclusive, collective term for a range of health care workers. It includes medical practitioners and specialists, nurses and allied health professionals, pharmacists, health educators, community health workers, social workers, Aboriginal health workers. Reference to a specific type of provider, for example, a General Practitioner (GP) is made where appropriate.
Health Coaching	Health coaching can be defined as helping patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals. The familiar adage "Give a man a fish, and he eats for a day. Teach a man to fish, and he eats for a lifetime," demonstrates the difference between rescuing a patient and coaching a patient. In chronic care, patients need the

<table>
<tr><td></td><td>knowledge, skills and confidence to participate in their own care.
Coaching involves a paradigm shift from a directive to a collaborative model so that care teams and patients pursue an active partnership, instead of patients being passive recipients of care.</td></tr>
<tr><td>Health Indicator</td><td>A key statistic that indicates an aspect of population health status, health determinants, interventions, services or outcomes. Indicators are designed to help assess progress and performance, as a guide to decision making. They may have an indirect meaning as well as a direct one – for example, Australia’s overall death rate is a direct measure of mortality but is often used as a major indicator of population health.</td></tr>
<tr><td>Health Literacy</td><td>Health literacy is ‘the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health’ (USDHHS, 2000).
Of Australians aged 15–74 years in 2006–2007, less than half (41%) had an adequate or better level of health literacy.</td></tr>
<tr><td>Health Promotion</td><td>The process of enabling people to increase control over, and to improve, their health. This incorporates actions not only at the level of the individual, but also aimed at building healthy public policy, creating supportive environments, strengthening community action, developing person skills and reorienting health services. (4)</td></tr>
<tr><td>Health Promotion approaches</td><td>Any work which actively and positively supports people, groups, communities or entire populations to be healthy. It does not focus on sickness, but on building capacity.
It includes building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orientating health care services toward prevention of illness and promotion of health (WHO, 1986).
<table>
<tr><td rowspan="5">Individual focus
↕
Population focus</td><td>Screening, assessment, immunisation</td></tr>
<tr><td>Health education and skill development</td></tr>
<tr><td>Social marketing ; Health information</td></tr>
<tr><td>Community Action</td></tr>
<tr><td>Settings and supportive environment</td></tr>
</table>
It involves working with people and communities as they define their goals, mobilise resources and develop action plans for addressing problems they have collectively identified.</td></tr>
<tr><td>Health Register</td><td>A type of data collection that is specifically designed to collect information about individuals, usually for a single health topic.
Examples include the National Diabetes Register (for people with diabetes who are treated with insulin), the Australian Cancer Database (people</td></tr>
</table>

	diagnosed with cancer) and the Australian Childhood Immunisation Register (for children up to 7 who have received vaccinations). 'Health registry' may also refer to the office that manages the register.
Hospital in the Home (HITH)	Provision of care to hospital admitted patients in their place of residence as a **substitute** for traditional hospital accommodation. Under the Commonwealth definition, hospital in the home (HITH) is considered 'admitted patient care'. It is expected that these patient types will be seen at least daily by clinical staff providing inpatient care, and receive a minimum of five service events per week.
Hospital separations	Patients admitted to hospital separate in a number of ways, including to home, to another institution, against medical advice or by death
Humanistic Approach	A humanistic approach is based on knowing the consumer and the consumer's perspective through continuous dialogue. This allows a health provider to view the client as a whole, and recognise the interconnectedness and interrelationship between the client and the environment. This approach to care delivery focuses on restoring health, harmony and enhanced quality of life.
Impairment	Any loss or abnormality of psychological, physiological or anatomical structure or function.
Incidence	The rate at which new cases of a disease occur in a given place at a given time.
Information Management systems (for CCSM)	A systematic approach to proactive use of clinical data to screen, monitor and provide self-management support to patients. This may include use of electronic (or other) recall and reminder systems to enable health service providers to become pro-active in providing support to patients and alerting them to the need for a review of their health condition(s). Information system management also include use of systems for sharing of health records and coordination of communication and support between PHC service providers within the patient's community.

Innovative Care for Chronic Conditions Framework (ICCCF)	The ICCC Framework is an expansion of the Chronic Care Model (CCM), which was developed by researchers from the MacColl Institute for Healthcare Innovation in Seattle, USA. Both models present a "road map" for organizing health care for chronic conditions. To better suit the context of international health care, the ICCC Framework is expanded from the CCM and places emphasis on policy and community level components of good care for chronic conditions.  It recognises that a multi-level multi-component approach is required to deliver quality chronic care. The ICCCF was adopted to provide the basis for WA Health Models of Care.
Inter-professional education	'Inter-professional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care' (Jessop, 2007; Braithwaite & Travaglia, 2005).
Interprofession-al Learning (IPL)	Interprofessional learning is a philosophical stance, embracing life-long learning, adult learning principles and an ongoing, active learning process, between different cultures and healthcare disciplines. IPL philosophy supports health professionals working collaboratively in a health care setting, though a purposeful interaction with service users and carer, to produce quality client centred care. It acknowledges both formal and informal methods of learning which progress to develop service delivery.
Interprofession-al Collaborative Practice (IPCP)	All the members of the health service delivery team participate in the teams' activities and reply on one another to accomplish common goals and improve healthcare delivery thus improving the client's quality of care. IPCP refers to interactions between team members (Atwal and Caldwell, 2006). There is positive interdependence between health workers. IPCP is a term which encompasses the desirable behaviour resulting from the interprofessional learning and education. It is a term most easily understood by health workers from all disciplines. Teams of health workers who are able to practice collaboratively help service deliver through maximising the strengths and skills of all the individual team members.

	Also known as Interprofessional Practice (IPP) or Interprofessional Working (IPW) or Interprofessional Care (IPC) or Interprofessional Collaboration (IPC). These terms all relate to the healthcare setting and describe an ideal behaviour displayed by health workers.
Intervention	Any action taken by society or an individual which 'steps in' (intervenes) to improve health, such as medical treatment and preventive campaigns.
Lean thinking	A method that focuses on service provision in the most efficient manner by improving flow and eliminating waste from processes.
Living Well programs	Generic Self-Management programs based on the **Stanford Chronic Disease Self-Management Program**.
Medicare Local	Established in 2011 by the Australian Government, Medicare Locals plan and fund extra health services in communities across Australia. Services and programs include after-hours GP services, immunisation, mental health support, targeted and tailored services for those most in need, and eHealth.
Mental Illness	Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally. They include anxiety disorders, depression and schizophrenia. A diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Also referred to as mental disorder.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent that the criteria for a mental illness are met.
Model of Care	A 'model of care' is a multifaceted concept, which broadly defines the way health services are delivered (Queensland Health 2000). A model of care outlines best practice patient care delivery through the application of a set of service principles across identified clinical streams and patient flow continuums (Waikato Health Board 2004). WA Health's aim in developing their models of care are to ensure people get the right care, at the right time, by the right team and in the right place. They will ensure the best practice care and services within a health care system for a person or population group as they progress through the stages of a condition, injury or event.
Morbidity	Refers to ill health in an individual and to levels of ill health in a population or group.

Motivational Interviewing	Motivational interviewing is a therapeutic approach that was originally developed in the alcohol and other drug field by William Miller and Stephen Rollnick. The approach utilises the principles and practices of client-centred counselling to encourage the client to move through the stages of change and to make personal choices along the way. Client resistance is viewed as evidence of conflict or ambivalence and is met with reflection rather than a confrontational style. The process of Motivational Interviewing involves: • encouraging the person to talk • generating self-motivational statements, • dealing with resistance, • developing readiness to change and • negotiating a plan • developing determination and action. The 5 principles underlying the process are: 1. Expressing empathy. 2. Developing discrepancy. 3. Avoiding arguing. 4. Rolling with resistance. 5. Supporting self-efficacy.
Morbidity	Morbidity (from Latin morbidus, meaning "sick, unhealthy") is a diseased state, disability, or poor health due to any cause.[12] The term may be used to refer to the existence of any form of disease, or to the degree that the condition affects the patient.
Mortality	Mortality of a condition is the proportion of people dying during a given time interval.
Multi-disciplinary teams	The ability to establish working relations with others of a different profession or discipline, to interact effectively, and to promote productive cooperation, collaboration and coordination. It involves understanding and respecting the role and function of all members, and integrating care by recognising and actively engaging service providers across systems, sectors and agencies, not just within organisations. It involves communication skills together with the timeliness of those communications.
Occasion of Service	Occurs when a patient receives some form of service from a functional unit of a hospital, but is not admitted.
Non-Admitted	A patient who receives care from a recognised non-admitted patient

Patient	service/clinic of a hospital, including emergency departments and outpatient clinics.
Non-Government-Organisation	A non-governmental organisation (NGO) is a community-based not for profit association that operates independently of government. It may receive funding from government as well as other sources to deliver agreed outcomes. Examples include Medicare Locals and peak bodies for chronic conditions.
Palliative Care	Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive condition with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and grief and bereavement support service for the patient and their carers/family.
Partnering with Consumers	Partnering with consumers is a strategy to create a consumer-centred health system which includes consumers in the development and design of quality health care. [Refer Standard 2 of the National Safety and Quality Health Standards (NSQHA) for accreditation for health care organisations.]
Patient Journey	The primary focus in clinical process redesign to include all the sequential steps in providing a patient's clinical care.
Pathways	Pathways are standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of interventions, timeframes, milestones and expected outcomes for a patient group. Pathways may have a clinical, patient, population group, condition or site specific focus.
Peer	A person who has knowledge from their own experiences with a condition. A peer can provide support to complement, supplement and extend formal health care services. Peers once trained can deliver self-management and other support programs eg Stanford Lorig program.
Peak Body	A 'peak body' is a non-government organisation whose membership consists of groups of people or smaller organisations of allied interests. The peak body offers a strong voice in the areas of lobbying government, advocacy and promotion, community education, information sharing and networking between member groups and interested parties. eg Diabetes WA, Heart Foundation.
Peer Support	Peer support is provided by people with a 'lived experience' of effectively self-managing chronic conditions who can therefore act as positive role models for others with chronic conditions. Supportive cultural values held by the organisation or setting in which they are utilised are important (Solomon, 2004).

Peer Support Group	Groups of people who get together and share their experiences of a common concern, health or life issue. The power of a support group comes from the understanding that people within a group have for each other because as individuals they have dealt with or are still dealing with similar challenges. The strength of the group lies in their shared stories and their ability to provide empathetic support rather than sympathetic assistance. Support focusses on an individual's strengths not weaknesses, and works towards a common goal of the individual's wellbeing. Research indicates that in its various forms, peer support has widespread benefits for people with chronic conditions, dementia and with learning disabilities. The mutual support that peers offer improves the wellbeing of both the person receiving the support and the person giving it, increasing confidence and empowering people to take control of their lives.
Person-Centred Care (PCC)	PCC is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of person-centred care are: • respect • emotional support • physical comfort • information and communication • continuity and transition • care coordination • involvement of family and carers • access to care. Surveys measuring patients' experience of health care are typically based on these domains. PCC is an approach in which people are placed at the centre of their health care. It is not merely about delivering services where people are located. Person-centred care involves: • advocacy • empowerment • respecting a person's autonomy, voice, self-determination • participation in decision-making. Research demonstrates that person-centred care improves patient care experience and creates public value for services. When healthcare administrators, providers, patients and families work in partnership, the quality and safety of health care rise, costs decrease, and provider satisfaction increases and patient care experience improves. Person-centred care can also positively affect business metrics such as

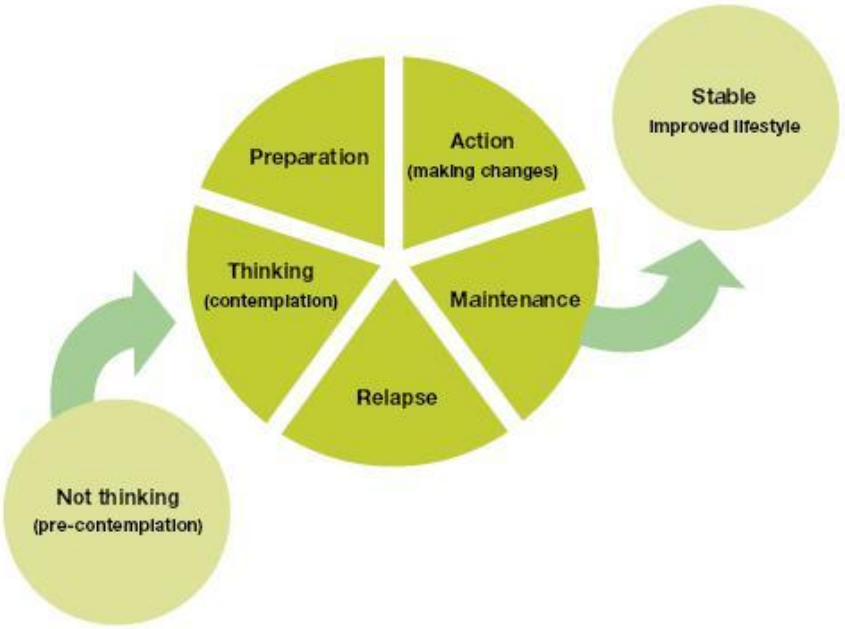
	finances, quality, safety, satisfaction and market share. (Also known as client-centred care, patient-centred care.)
Picker Principles	Picker Principles for person-centred care: • respect for patients' values, preferences and expressed needs • coordination and integration of care • information, communication and education • physical comfort • emotional support and alleviation of fear and anxiety • involvement of family and friends • transition and continuity • access to care. http://pickerinstitute.org/about/picker-principles/
PICO	PICO is an acronym for a process and technique used in evidence based medicine and healthcare to frame and answer a research or evaluation question. **P** - Population or patient problem **I** - Intervention **C** - Comparison, Control or Comparator **O** - Outcome(s)
Practice-based research	This involves undertaking practical research or evaluation in the field that can be used to inform everyday practice and improve the delivery of service to patients. Measures may include patient or health professional rated self-efficacy, self-management behaviours, patients' health-related quality of life, health service utilisation, patient/carer satisfaction with the service, service costs, or specific condition measures. This practice-based research provides services with a strategic overview of the key principles and practices necessary for the effective monitoring, management and improvement of their health services.
Plan-Do-Study-Act (PDSA) cycle	A quality improvement method consisting of the four continuous steps, plan, do, study and act, aiming to test a change by planning it, trying it, observing the results, and acting on what is discovered (also known as the Deming cycle or Plan-do-check-act cycle).
Population health	• The health of whole communities or populations including both a population's health status and the determinants of health. • The organised response by society to protect and promote health, and to prevent illness, injury and disability. Population health activities generally focus on prevention, promotion and protection rather than on treatment; on populations rather than on individuals; and on the factors and behaviours that cause illness. In this sense, often

	used synonymously with public health. Can also refer to the health of particular subpopulations, and comparisons of the health of different populations.
Prevalence	The total number of cases of a specific condition in existence in a given population at a certain time.
Prevention	In population health the following definitions apply to the stages at which prevention is undertaken across the continuum of a condition. **Primary** prevention - the goal of which is to limit the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departures from good health, control exposure to risk, and promote factors that are protective of health. **Secondary** prevention - aims to reduce progression of the condition through early detection, usually by screening at an asymptomatic stage, and early intervention. **Tertiary** prevention - to improve function and includes minimisation of the impact of established condition and prevention of complications and the establishment of chronic conditions through effective management and rehabilitation. (4)
Problem Definition - collaborative	Having an open dialogue with the patient about what they see as their main problem, what happens because of the problem, and how the problem makes them feel (Von Korff, et al. 1997).
Problem Solving - Structured	The ability to systematically assist a patient to learn the skill of problem solving including: • identify and analyse practical issues arising in a situation • determine options for a practical solution • making effective use of time and resources available. (Katon, et al., 2008)
Problem Solving	Problem solving is both: • a subset of skills that the patient uses to address barriers to goal attainment and • a process that health providers can employ to help patients identify and respond to barriers, particularly those barriers that are identified during the development of an action plan. The problem-solving process usually includes the following elements: – identifying strategies that have been successful in the past – brainstorming other possible strategies – sharing ideas that others have found useful – rating the attractiveness and potential effectiveness of strategies – choosing a strategy and tracking effectiveness over time –

Process mapping	Documenting the patient journey, not as the ideal, but as it is, and involves confirming it with data.
Primary Health Care (PHC)	Incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health.
Primary Care	Health care provided by a medical professional which is a client's first point of entry into the health system. Primary care is practised widely in nursing and allied health, but is predominantly in general practice.
Primary care networks	Networks of providers of primary health care for a region or geographical area.
Psychosocial	The interrelationship of social factors and individual thought and behaviour. It relates to a person's psychological development in, and interaction with, a social environment.
Psychosocial assessment	The ability of health professionals to identify, build and sustain positive aspects of psychosocial health such as resilience, strengths and coping skills with the patient and their carers. Psychosocial support by health professionals and others are 'interventions and methods that • enhance [patients'], families', and communities' ability to cope, in their own context, and to achieve personal and social well-being • enabling [them] to experience love, protection, and support that allow them to have a sense of self-worth and belonging' (Huni,'05).
Public health	Public health in Australia seeks to improve health and wellbeing by focusing on whole populations. It aims to reduce disparities in health status between social groups and to influence the underlying social, economic, physical and biological determinants of health. Public health practice informs and empowers individuals and communities, creating health environments through the use of evidence informed strategies, best practice and quality improvement approaches and effective governance and accountability mechanisms.
Quality Improvement	Quality Improvement is a formal approach to the analysis of performance and systematic efforts to improve it. Within health it is the process of continuous evaluation and improvement to ensure the safe, effective and efficient delivery of appropriate health care services. Quality Improvement Tools include:

	• **PDSA**: Plan > Do > Study > Act • **FADE**: Focus > Analyse > Develop > Execute / Evaluate • **Six Sigma**: DMAIC : Define > Measure > Analyse > Improve > Control • **RE-AIM**: Reach: Efficacy > Adoption > Implementation > Maintenance • **Q-SAF**: WA Health Quality Self-Management Assessment Framework
Quality Self-management Assessment Framework (Q-SAF)	The QSAF tool was developed in WA for use by providers, managers and researchers to assist in the quality improvement of self-management programs. It provides a generic framework to systematically examine self-management program strengths and weaknesses and is recommended for use in combination with an ongoing quality improvement cycle. The Q-SAF outlines quality components in four program domains: 1. Self-management Program Content and Delivery; 2. Program Reach, Consistency and Sustainability; 3. Workforce Skills; and 4. Organisational Support. For more information refer to WA CCSM website.
Readmission	An admission of a patient within 28 days to the same establishment for a condition either the same or related to one for which the patient has previously been admitted or hospitalised (unless clearly documented by the treating clinician at time of separation). Readmission can be planned, unplanned and unexpected. The distinction revolves principally around the intention to readmit, which must be clearly documented by the treating medical officer. (ARD TP)
Reflective Practice	An ongoing process utilised in order to review one's own practice, evaluate strengths, and identify ways of continually improving practice to meet client needs. Questions useful in framing the reflective process include: "What have I learned?"; "What has been most useful?"; "What else do I need?"; "What practices can I share with others?".
Rehabilitation in the Home (RITH)	Rehabilitation in the Home care is a substitute for inpatient rehabilitation, and may apply for part of, or the entire admission. RITH patients must therefore fulfil the same criteria for admission as any other admitted rehabilitation patients. Rehabilitation may be provided in the patient's home or place of residence. (ARD TP)
Re-interpretation of symptoms	A person with chronic conditions can experience many different symptoms and each symptom can have various causes and different impacts on daily life. By learning to better understand symptoms and different ways of managing them, this may bring some relief. (WA CCSM S/F 2006)
Research	• A detailed study of a subject, especially in order to discover (new) information or reach a (new) understanding.

	• The creation of new knowledge and/or the use of existing knowledge in a new and creative way so as to generate new concepts, methodologies and understandings. • The search for knowledge, or as any systematic investigation, to establish novel facts, solve new or existing problems, prove new ideas, or develop new theories, usually using a scientific method.
Resource	A resource is a source or supply from which benefit is produced. A resource can be used to provide support or help or to focus or leverage performance or outcomes.
Self-efficacy	In the context of health, self-efficacy is the belief in one's own ability to successfully perform a health behaviour. Self-efficacy is proposed as the most important prerequisite for behaviour change and will affect how much effort is put into a task and the outcome of that task.
Self-management	Refer Chronic Condition Self-Management. May be abbreviated to this in reference to consumers.
Signs (of a condition)	Signs are the physical manifestation of the illness, injury or condition. It is objective, which means that it can be seen and measured, usually by a doctor or a nurse. Symptoms, on the other hand, are things that can only be felt by the patient. In medicine a symptom is generally subjective (felt by the consumer) while a sign is objective (measureable or identifiable by a health provider) .
Silos (Clinical or Service)	Specialties, subspecialties or geographical locations within which care is provided without regard to other components of the overall patient journey through a medical facility.
Situational Awareness	The ability to maintain an awareness of what is happening around you, even when you are engaged in a task, Cultivating an awareness of the 'bigger picture' and understanding what that means for your work. Using this awareness to anticipate events enabling early intervention.
Simulation Learning	Simulation is a generic term that refers to an artificial representation of a real world process to achieve educational goals through experiential learning. Simulation based medical education is defined as any educational activity that utilizes simulation aides to replicate clinical scenarios. Medical simulation allows the acquisition of clinical skills through deliberate practice rather than an apprentice style of learning.
Situated Learning	Learning through the lived experience of interacting with other people in the real world with all its complexities and contradictions.
SMART goals	The process of deciding on what one wants, planning how to get it, and then working towards the objective of achieving it, usually by ensuring that it is SMART: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imely.

Specialist care	The health care provided by a health practitioner who is registered as a specialist under state or territory law; or holds a fellowship of a recognised specialist college; or is considered eligible for recognition as a specialist or consultant physician by a specialist recognition advisory committee.
Socio-economic status (SES)	A measure used to indicate a relative position in the community as determined by occupation, income and level of education.
Social persuasion	Social persuasion relates to encouragements/discouragements used that can have a strong influence on self-efficacy and self-confidence.
Stages of Change	The Stages of Change model recognises that different people are in different stages of readiness for change. It recognises that people are may r may not be ready for or want to make an immediate or permanent behaviour change. Adapted from the Prochaska and DiClemente model of change  By identifying a person's position in the change process, a worker can more appropriately match the intervention to the client's stage of readiness for change. The model forms part of a broader conceptual framework known as the Transtheoretical Model (Prochaska & DiClemente, 1982; 1986). The model shows that, for most people, a change in behaviour occurs gradually, with the patient moving from being uninterested, unaware or unwilling to make a change (precontemplation), to considering a change (contemplation), to deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behaviour occur. Relapses are almost inevitable and become part of the

	process of working toward lifelong change.
Stakeholder	A stakeholder is an individual, group or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al, 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. Stakeholders can be of various types, and can be divided into opponents, supporters and neutrals. (Ontario Public Health Association, 1996).
Stanford - Chronic Disease Self-Management Program	The Stanford model (sometimes called the Lorig model) developed at Stanford University, USA in the 1990s and has been translated into many languages and implemented throughout the world. • Six-week, group-based course for 10–15 participants. • Structured content. • Utilises two leaders, one a health professional and one a peer leader. • Requires a three-day training program for leaders to deliver the course.
Sub-Acute Care	Time limited, goal-orientated, individualised, multidisciplinary care that aims to help people who are disabled, frail, chronically ill or recovering from traumatic injury to regain and/or maintain optimal function to allow as many people as possible to maximise their independence and return to (or remain in) their usual place of residence. It is available to people of all ages on an admitted or ambulatory basis and may follow an admitted episode, ambulatory care or directly from the community.
Sustainability	Ability of activity or event to continue for a period of time.
Systematic Review	A systematic review synthesises the results from all available studies in a particular area and provides a thorough analysis of the results, strengths and weaknesses of the collated studies. 1. It addresses a focused, clearly formulated question. 2. It uses systematic and explicit methods: a. to identify, select and critically appraise relevant research b. to collect and analyse data from the studies that are included in the review Systematic reviews may or may not include a meta-analysis used to summarise and analyse the statistical results of included studies.
Symptoms (of a condition)	A symptom is a sensation or change in bodily function that is experienced by a patient and is associated with a particular condition eg Fatigue, Stress, Shortness of Breath, Pain, Anger, Depression, Changed Sleep Patterns. In medicine a symptom is generally subjective (felt by the consumer) while a sign is objective (measureable or identifiable by a health provider).

Symptom and condition management	(Chronic) condition management is a systematic approach to coordinating health care interventions across levels (individual, organisational, local and national) and evidence indicates that such coordination across care settings and providers is more effective than single or uncoordinated interventions. Australian Disease Management Association.
Tool	Any physical item that can be used to achieve a goal, especially if the item is not consumed in the process. It may also be used to describe a procedure or process with a specific purpose.
Vicarious learning	This is a type of learning that occurs as a function of observing, retaining and replicating novel behaviour executed by others. Also known as observational learning, social learning, or modelling.

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