Top tips for embedding chronic condition self-management support into practice

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Abstract.   Organisational change aimed at service improvement continues to be a challenging process for many health services, managers and teams. Current imperatives to develop service models responsive to the growing demands of chronic conditions on health systems suggest that reflection on core change principles is warranted.

Dominant themes for progress in embedding chronic condition self-management (CCSM) support into practice settings arose from content analyses of case studies from health professionals who have attempted to implement CCSM support into their health services after undertaking specific training (The Flinders Program of CCSM). This included in-depth interviews with 10 trainers accredited to deliver training in this CCSM care planning approach to the workforce, formal reflections from 47 postgraduate students (currently in the health workforce) enrolled in a dedicated CCSM program at Flinders University and a consensus forum with accredited trainers. Emergent themes were then considered in the context of existing organisational change and CCSM literature.

Long understood principles of effective change management continue to be important, including leadership support, clear vision, team cohesion, effective people management and shared values. However, interdependence of these and other factors seems to be most important. Organisational change that builds capacity for CCSM support is possible, given a clearer understanding of where efforts will have the most positive impact on change.

Background

Much has been written about organisational change, yet it continues to be a challenging process for many health services attempting to improve service delivery and effectiveness. Current intense pressures and imperatives to develop service models responsive to the growing demands of chronic conditions on health systems make reflection on core change principles warranted. Embedding CCMS support into practice is fundamentally about understanding organisational change. We all know how to prepare for change and how to make it happen. Meaningfully sustaining and embedding improvements arising from change processes in the long term is another matter altogether. Bate *et al.* (2008) argued that there remains little understanding of how these change processes interact and the contexts in which they occur.

Transformational change poses particular challenges because it likely involves broader change in mission and purpose, structure and culture (values, beliefs, behaviours) of organisations than other forms of organisational change (Kotter 1995). Embedding CCSM support requires a transformational change process to occur because it is attempting to shift the structure of how service is provided from an acute model of care to a chronic model of care (Newman *et al.* 2009). This involves knowledge, skills and attitudinal change at the individual, team and system level within organisations (Lawn and Battersby 2009). This

transformational change differs from transactional change, which is smaller scale and involves incremental steps and doesn't necessarily challenge overarching structures, though this series of steps can eventually bring about a transformational change.

Introduction

Kendrick (2006) stated that 'Change is a profoundly collective process…Change involves mobilising people to perceive their world differently and to eventually act in new ways. It is rarely achieved overnight…The process itself transcends even the most influential of people'. Bronfenbrenner (1979) made two significant and relevant points when devising his ecosystems framework. He stressed that:

(1) The best way to understand something is to try to change it; this will clarify the different levels of resistance to change and the degree of embeddedness of a particular behaviour or activity; and

(2) Change in one system is likely to promote change in other systems.

Any attempts at reform within our health settings would also benefit from an understanding of a range of sociological forces. Central to the notion of change is the need to understand why change does not occur. Schön's (1983) concept of 'dynamic conservatism' is relevant here; it recognises the inherent nature of organisational groups to be

conservative and protect themselves from constant change. Schön explored the need for what is now termed the 'learning organisation' and 'reflection-in-action', involving mapping the process by which this constant change can be coped with. Yet, we continue to struggle with translating many initiatives into practice and there is little implementation research to assist us (Greenhalgh *et al.* 2004), despite the extreme costs involved in translating change research into practice.

Many models of organisational change exist that build our understanding of what needs to be considered in order to embed CCSM support into practice. The Paton–Johnson Model (Johnson and Paton 2007) involves considering a range of processes when introducing new practices into organisations, such as undertaking conversations about change, diagnosis of current practice and identification of gaps, developing a vision, and planning for change using project methodology. Many initiatives follow this path. However, there is increasing realisation that change is complex. Greenhalgh *et al.* (2004) researched extensively the existing literature, scanning over 6000 sources, to determine how diffusion, dissemination and sustainability of innovations are achieved. They concluded that many existing models of organisational change contribute to our understanding of what is needed. Complexity Theory (McMillan 2004) acknowledges that change is dynamic as shown in Table 1. Organisations are not static entities that managers can act upon to cause a linear (cause and effect) change. Change involves many forces interacting.

McDaniel and Driebe (2001) made several salient points in the context of complexity theory that are pertinent to the implementation of change.

- No single agent can change an entire system on its own.
- Action should be focussed on small changes that can provide positive feedback to the system. Small inputs give room for learning and organisational development and are more predictable than large ones.
- When handling any surprises, meaning is derived from making sense of what is going on rather than just knowing what is going on. Hence collective dialogue is important.
- Connections and relationships are major components of action.

In a comparison of change facilitators and barriers, Hroscikoski *et al.* (2006) studied five group clinics in the USA

Table 1.   Comparing views of change

Traditional views of change	Dynamic views of change
Linear	Non-linear
An event	A process
Disruptive	Revolutionary and incremental
Cause and effect	Continuous
Incremental	About learning
Calamitous	Turbulent
Controllable	Uncontrollable/unpredictable
Abnormal	Creative
	Full of opportunity
	Normal

18–23 months after the implementation of the Chronic Care Model (Wagner *et al.* 2001) began. Some of the lessons drawn included understanding organisational and professional cultures, remaining flexible, providing leadership, allowing time for learning and reflection, and recognising the complexity of the change process. Emmons *et al.* (2008) explored factors that appear to facilitate effective and sustainable translation of chronic condition management research into practice and the role played by trans-disciplinary collaboration, which they saw as the foundation to effective translation. They cited institutional support, team selection, common goals and multidirectional communication as important factors within this. Kilbourne *et al.* (2008) studied 23 practices from across the USA that participated in a learning community meeting designed to identify barriers to integrated care and strategies for reducing such barriers. They identified administrative, financial and clinical considerations, strongly emphasising the importance of templates and clear processes for communication within and across services. All of these studies tell us that change is complex and involves many factors.

Green (2008) reminds us that how evidence is applied to the field is based on two significant fallacies: firstly that translation, dissemination and delivery of research to the field is a one-way 'pipeline', and secondly that practitioners are merely 'empty vessels' that receive evidence-based guidelines. Health policy continues to focus on outcomes, not processes which involve the context in which change is attempted. Yet, context here is all important if services are to translate evidence effectively. More participatory approaches and practice-based production of research evidence are suggested. The current study, though small, draws evidence from the field, from people who understand what actually works in practice.

Methods

The current study aims to draw evidence from the field, from people who have 'walked the talk' and 'learned a thing or two' about what actually works for them when attempting to embed CCSM support into practice. Participants were engaged through a process of realistic evaluation, which shifts from attempts to identify 'What works?' or 'Does this work?' to understanding 'What works where, for whom, and in what circumstances?' (Tilley 2000) thus taking into account the participants' local health service conditions in which changes are attempted.

Three participant groups were approached.

(1) Semi-structured qualitative interviews were conducted with a purposive sample of 10 experienced trainers recruited from across Australia and New Zealand, who were accredited to deliver the Flinders Program of CCSM two-day workshops, encompassing the teaching of self-management care planning processes (Flinders Human Behaviour and Health Research Unit 2009). All trainers had delivered the workshops and were mentoring health teams as part of workshop follow up and ongoing support.

They were believed therefore to have a good knowledge of the impact of the training on the field and of any challenges with embedding the approaches taught within the workshop.

(2) Written critiques were undertaken for assessment by 47 postgraduate students who had been enrolled in two core Graduate Certificate topics, four core Graduate Diploma topics, and/or an elective trainer accreditation topic as part of completing the Graduate Certificate in Health (Self-Management) and Graduate Diploma in Chronic Condition Management at Flinders University over the period 2005–08. All students were current health professionals working in the field and drawn from a broad range of nursing and allied health professions. Students' critiques described their attempts to build CCSM support initiatives into their health service practice and within their teams.

(3) Fifty accredited trainers who attended the Flinders Training Forum in late October 2008 discussed the findings from groups 1 and 2 in an open consensus.

All participants across the three groups had been involved in CCSM support change initiatives within their organisations, many as formal or informal change champions within specific projects. Organisations varied in size (from approx. 30 to 25 000 staff) and make-up (included community aged care, Aboriginal health service, general practice, mental health services, hospital-based allied health and rehabilitation services, community rehabilitation services, a range of primary health care community services).

Data collection

Accredited trainers, students and forum participants were asked what considerations were important when attempting to embed CCSM support initiatives into ongoing practice within their organisations. For accredited trainers, this related to their own experiences of attempting to teach CCSM support approaches within their organisations and feedback they received from clinician colleagues participating in workshops. Feedback included concerns raised with trainers both during the workshop and after training, when the clinicians had returned to their organisations and were attempting to implement approaches learned during the workshop. All accredited trainers also had experience of being change champions within past or present organisations where they were employed as clinicians. Each described the steps they had attempted in this role (case study). In their critiques, students mapped out the steps they had taken to build CCSM support initiatives into their health service practice.

At the conclusion of each in-depth interview with accredited trainers, the researcher and participant revisited the ideas expressed in the context of Kubina and Kelly's (2007, p. 3) 'navigation chart' and Ashford and Patkar's (2001) Development Strategy table as two examples of organisational frameworks for understanding change (Figs 1, 2). This enabled the researcher and participant to elicit further comments and understandings of the processes that unfolded in their organisations and check for any further issues of interest. Kubina and Kelly's (2007) 'navigation chart' (Fig. 1) is the centrepiece for their practical guide to implementing
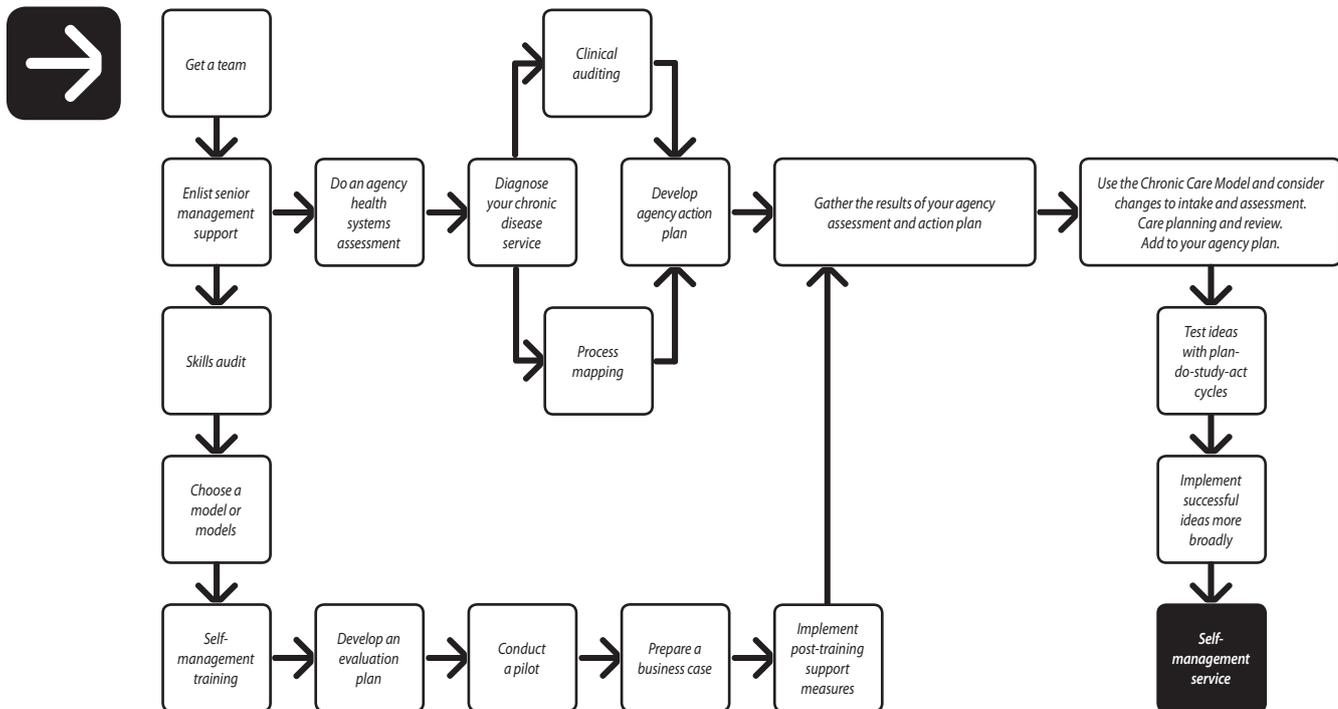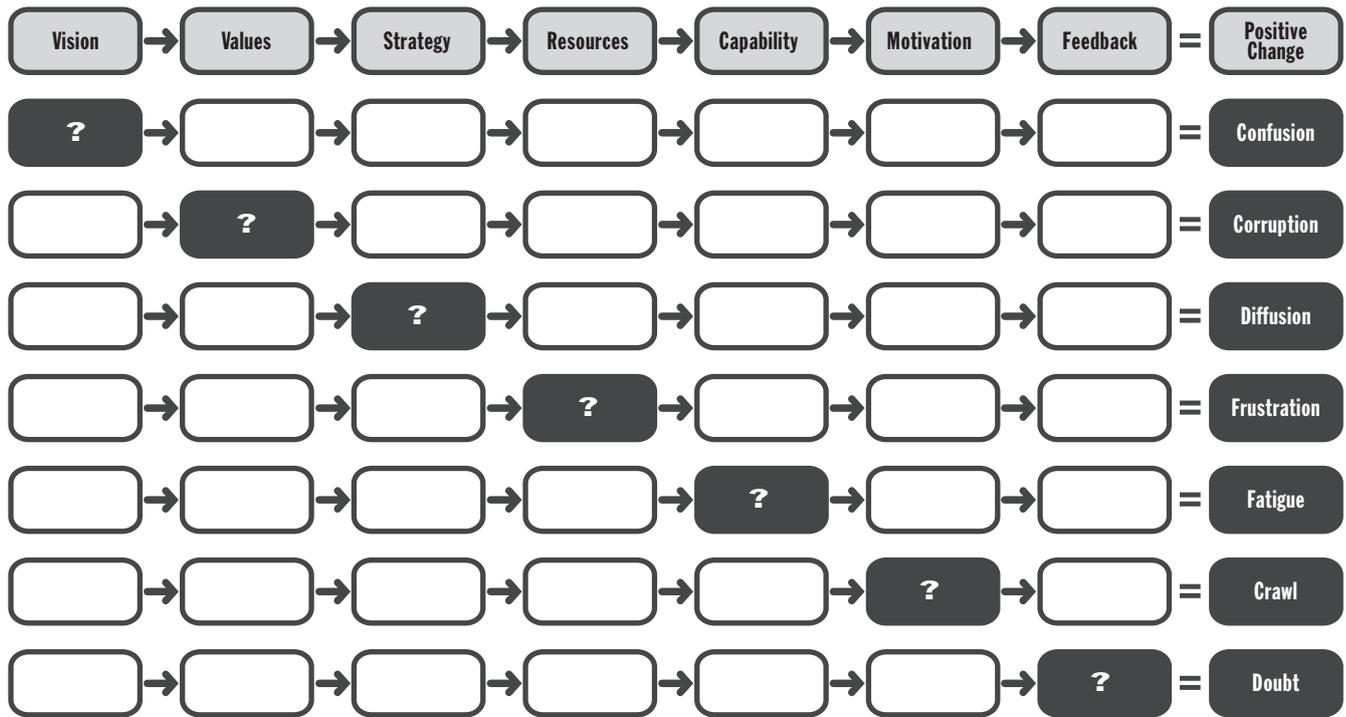

Fig. 1. Navigating self-management. (Republished from Kubina and Kelly (2007), with permission of the authors.)

Vision	→	Values	→	Strategy	→	Resources	→	Capability	→	Motivation	→	Feedback	=	Positive Change
?	→		→		→		→		→		→		=	Confusion
	→	?	→		→		→		→		→		=	Corruption
	→		→	?	→		→		→		→		=	Diffusion
	→		→		→	?	→		→		→		=	Frustration
	→		→		→		→	?	→		→		=	Fatigue
	→		→		→		→		→	?	→		=	Crawl
	→		→		→		→		→		→	?	=	Doubt

Fig. 2. Ashford and Patkar's (2001) development strategy. (Republished with permission of the International Institute for Sustainable Development, http://www.iisd.org.)

CCSM support into practice. It outlines a stepwise process of team building, undertaking skills and clinical audits and training staff in preparation for conducting plan-do-study-act (PDSA) cycles as part of implementing change into practice (NSW Health 2002). Ashford and Patkar's (2001) Development Strategy (Fig. 2) provides a useful framework for understanding the link between various factors that enable positive change, such as vision, values and resources. When one of the factors is absent, change may be difficult to sustain. It suggests possible outcomes when a particular factor is absent. For example, when a clear vision for the change is lacking, people can become confused as to its purpose. Similarly, when values are not shared the process can be corrupted.

Data analysis

In-depth interview transcripts and written student critiques were thematically analysed for dominant patterns using the constant comparative method of content analysis drawn from Grounded Theory methodology (Strauss and Corbin 1990). Following this methodology, each piece of data was open coded manually by the researcher who then applied a series of questioning to emergent patterns as part of the further stage of axial coding. This questioning was informed by the review of existing organisational change and CCSM-related literature. This 'analytic comparison' of content from each described change process, drawn from accredited trainer interviews and case studies, and student case studies and critiques of organisations, and critical reflections showed

what was common and different across their experience of attempting to embed CCSM support into practice (Neuman 2003, pp. 456–457). Participants in the Flinders Trainers Forum were then presented with the preliminary findings from these interviews and student critiques as a further test of face validity, to refine the analysis and conclusions drawn. This was done as an open consensus process in which participants were asked to what degree they agreed with the themes presented, whether any were not agreed with and whether any were missing.

All components of this study were approved by the Flinders Clinical Research Ethics Committee.

Results

A range of experiences were highlighted, with some participants describing a top-down approach to the embedding process and others describing a bottom-up approach or a combination of the two. Progress in embedding did not appear to be directly associated with either style; rather, several key qualities needed to be present regardless, and these were often interdependent, demonstrating the dynamic nature of the process. The following themes are not necessarily presented in order of their priority. This would require a more comprehensive analysis and methodology. Nine of the 10 themes arose during the analysis of interviews and student critiques and were confirmed by forum participants. A further theme (Demystify the process of change for staff) was added, based on the advice and consensus of forum participants. For

brevity of theme description, direct quotes from participants are not used.

Clear leadership

Participants spoke at length about the primary importance of leadership skills to ensure investment of time and resources, to 'set the example' for staff, to support modelling and mentoring, and lead a clear vision for the organisation. In one organisation, highly successful leaders portrayed a 'belief in people's capacity to change, fostered an environment where staff could openly discuss their concerns, not controlled completely by management'. The organisation possessed a CEO who openly talked of the values base for the organisation, fully believed in the work being undertaken, and who was clearly connected to staff and accessible. The service was able to pick good managers and was fundamentally an organisation with the philosophy of looking after and valuing its staff.

Where management were not fully on board from the initiative's beginning, participants described targeting and actively following up with senior clinicians and managers, persisting with them over time about the underlying need for CCSM. One participant described their organisation's struggle to translate initiatives into practice until the arrival of a highly collaborative and consultative manager who was more affirming of the team and good at connecting management and staff and who effectively mentored and developed change champions. This individual helped perpetuate a culture of innovation within the organisation, gaining staff trust and confidence to try new things. They also had the skills to manage any opposition, being politically 'savvy' with a strong and clear vision, which led to clear vision building within the staff group over time also. They had the skills to couch it in such a way that fitted with management's agenda and a business model that they could understand. This highlights the importance of leaders with clear vision and unity with each other in contrast to problems created by fragmented management.

The important role of workplace change champions

All participants described the important role played by change champions drawn from within the staff of organisations, often employed in dedicated roles and drawn from middle level health professionals, who were systems thinkers, persistent, visionary, energetic, motivational and trusted by and credible to broad groups of staff and who had the capacity and skills to walk the talk with both managers and staff groups, regardless of discipline or standing within the organisation. Change champions played a huge role in mentoring staff, actively demonstrating and role modelling what CCSM support looks like for staff and management. They had strong back-up by management who didn't just say 'go and do it'. They found ways to deliver the hard messages to staff by role modelling with staff. That is, they didn't just give the theory; they grounded it in practice to help staff translate the desired changes into practice. They provided individual and team

mentoring of staff and had skills in problem-solving the practical concerns of staff about implementation and the political savvy to do this at a range of levels.

A further important component was to identify several change champions (not just one) who could draw support, motivation and ideas from each other.

In some organisations where change champions were individually perceived as driving change, some had to step back or step out of this role in order for management to fully acknowledge the initiative as part of core business, commit funds and staffing, and embed the change across the service. This was especially so in organisations where leadership had been fragmented or detached.

Understanding and addressing values of and skills strengths and gaps in the organisation and staff

According to participants, organisations that were making progress with their CCSM support initiative had spent time 'sussing out' peoples' thoughts, beliefs and values about the client group. This allowed the organisation to be clearer about how and in whom training money should be invested. Participants saw the values of the organisation as central, including belief in peoples' capacity to change (staff and clients).

Undertaking a skills audit was seen as important not only for better targeting the use of resources but also in highlighting what each group within the organisation is doing, how collaboration can be improved, and how information and skills can be shared. Several participants reported that their organisation undertook process mapping using tools like the Assessment of Chronic Illness Care and the Patient Assessment of Chronic Illness Care (ICIC 2009) to gain a clear picture of the current state of play, strengths and gaps that would inform not only skills, but also overall vision and values. Participants stressed the role of managers in leading this process with the full collaboration of staff (and in some organisations, consumers).

Creating teamwork in the community and across services

Participants stated that this involved clearly knowing and networking with other organisations in the local community, understanding their agency's relationship to other organisations, and vice versa, and actively building a sense of 'team'. Participants spoke of organisations as not being insular, of drawing momentum and support from each other, sharing vision and purpose, values and processes, building understanding of inter-related programs and how they fit together, establishing memorandums of understanding. This applied equally to intra-agency teamwork process across disciplines, teams and departments as it did to inter-agency teamwork. Participants highlighted the importance of a shared commitment to a common vision, trust and rapport between staff. Responsibility for creating teamwork was seen as being led by managers and built and nurtured by all staff.

Participants consistently spoke of structural impediments to embedding CCSM support across sectors, especially with general practice and specialist acute services. An example of this was the time required to complete a CCSM care plan within general practice settings where staff were traditionally geared to shorter consultations with patients and were struggling to clear their often full waiting rooms. The growing pool of practice nurses and greater use of dedicated item numbers for shared management was perceived to have alleviated some of these impediments. However, the quality of networks and relationships between individuals across organisations remained an important precursor to this.

Demystify the process of change for staff

In organisations where change was perceived to be more successful, participants described change agents and leaders who:

- Took time to listen to and understand staff concerns about change;
- Clearly defined expected staff competencies;
- Clarified organisational change purpose and vision;
- Set clear targets with staff;
- Clearly defined what's in it for staff;
- Provided clear tools for change; and
- Provided support, support, support.

Adequately resource the process

Participants in organisations that were doing well with change also described a range of clear commitments and plans by the service that supported the process and sustainability of efforts. These included adequately matched and dedicated funds and time, effective management and resourcing of information systems, funding for initial training but also ongoing hands-on support post training and mentoring for staff, and attention to staff retention.

Actively involving consumers

All participants acknowledged consumer involvement as an essential part of embedding CCSM initiatives, though many acknowledged that the challenge was in ensuring that this was not perceived as token consultation. Hence, it was linked to the organisation's underlying values and beliefs.

Some participants reported that the client groups within their organisation were quite resistant to change initially because of their expectations about service delivery built up over time or their suspicion about the organisation's intentions. Service consumers were often an important yet politically neglected ally, whose value was well recognised in organisations that were prepared to listen and where meaningful consumer participation was apparent. Consumer involvement was viewed as fundamentally important as their feedback served to motivate staff to proceed with initiatives, and shift beliefs and values about the way they practice.

Have a toolkit of strategies for sustaining the distance

Several participants described a process of change that took months, and years in some cases, as management and staff built realisation, understanding and momentum, and as macro initiatives emerged to facilitate the systematic uptake of CCSM processes. In organisations where participants reported a process of change over several years, they described 'the stars lining up', fully recognising that a complex and dynamic range of factors needed to be present. 'We did a lot of presenting and even though the 3 years seemed to be a long haul, those people who became enthused but felt the service was not ready are now quickly launching into action with the recent activity i.e. it wasn't wasted effort.' This process allowed staff and management to progressively move in the desired direction and seize the opportunity to take on major structural steps towards CCSM embedding when new opportunities to do so arose. This of course, required managers with the skills to see the opportunities and to take them.

Participants described a range of interlinked strategies including:

(1) Looking clearly at paperwork systems and processes, and understanding the need for quality information systems to manage patient and practice data to inform the change process.
(2) Mapping the clients' journey through the service to clearly see duplications, opportunities, etc.
(3) Targeting senior clinicians and managers.
(4) Undertaking change strategies and evaluating them at clear and regular stages in order to maintain momentum and motivation and help staff to avoid going back to old practices.
(5) Undertaking PDSA cycles with a full range of staff, promoting ownership for the change and embedding this style of service development as part of ongoing quality improvement, not just a project activity. PDSA cycles also gave room for learning and organisational development.
(6) Recognising that orientation of new staff is an important component of sustaining initiatives.
(7) Developing peer review of work practices to foster greater consistency of practice across staff and team sharing of processes. This helped to address accountability issues, pockets of resistance to change, and isolation of practice apparent with some staff where more autonomous models of case management were the standard mode of practice.

These strategies also included developing productive responses to resistance. All participants in organisations where CCSM was successfully implemented described clear strategies for managing cultural and individual resisters to the change process. Many said they 'let them be' and didn't get caught up in the negativity. Others said they 'just kept going', cultivated champions and up-skilled others. All reported going first with enthusiastic staff who had capacity to take on changes 'NOW' and that could act as good role models for others, and thereby influence underlying values.

Effectively use evidence and training

Organisations where CCSM support was reported by participants to be working well were those that participants said had realised the importance of evidence in the first place,

collecting it in effective and meaningful ways, understanding the audience and how different types of evidence were needed to convince different groups. In their role as change champions, participants described clinical staff and managers needing different types of evidence for the change in order for each group to commit to the change in the longer term. Participants described clinical staff as needing clear evidence, such as the use of real case studies to provide a clear rationale compared with existing practice and to demonstrate effective CCSM translation to practice and quality outcomes for clients. Participants described managers as needing alternative evidence; how the change would address staffing issues, financial resource management and efficiency, accreditation needs of the service, service throughput and overall service quality.

Interestingly, some participants in the current study reported that they consciously chose to demonstrate the effectiveness of CCSM support with clients with more complex health and welfare needs. Success with these clients convinced even the most determined sceptics in their organisations. This was an example of the multidimensional approaches reported by participants as useful to provide the necessary evidence for change.

Several participants described the presentation of evidence for CCSM as part of staff training and the importance of using a combination of training leaders from within and external to the organisation. Experts from outside the organisation gave staff a broader context beyond an insular view of the service, built a sense that the service was part of something bigger, important and progressive and showed staff that management were serious about CCSM initiatives and quality support to staff to take them on. Also involving trainers from within the organisation helped to ground training material into the day-to-day practice experience for staff, support them to problem-solve how CCSM processes and goals could be translated to their specific organisation and client group and provide ongoing mentoring and support for embedding.

Another important aspect of this was actively involving staff in the collection of evidence and feedback, giving, not just creating, a situation where an individual or small project group could go away to collect evidence and let staff know at a distance what is going on. As one participant stated, this created an air of 'This is what WE are doing, not just me'. 'There needs to be more emphasis on measuring outcomes in day-to-day practice in order to increase its priority for the workforce. That is, it's them that need to hear this and in a style and mode that is meaningful to them and motivates them to keep going, balanced with what management also believe are good outcome measures.' Several participants spoke of running pilot projects that effectively satisfied the evidence needs of staff and managers, and which helped to problem-solve any implementation barriers.

The timing of training was also highlighted by participants and that training alone was not enough. Additionally, they reported that organisations needed to make sure training was not in conflict with their existing structures; it could be different but not so much so that workers had nowhere to go with translating it to practice due to existing structures. It needed to be timed and matched with the organisation's capacity for change at that time. This also involved ensuring people attending training had capacity to do it and translate what they had learned into practice, not just those who were interested but had little capacity once they returned to their service. One participant described a clearly layered strategy for the targeting and delivering training and therefore evidence for CCSM support, from the broader team to specific trainers and mentors.

Understand interdependent relationships between each component

Participants described organisations where they perceived CCSM support was being effectively embedded into practice as those organisations where the staff and managers clearly recognised that change was not a straightforward process, that it would be a challenge that required a level of commitment from all involved in the change process. Participants described organisations that they perceived to be making good progress in embedding CCSM support as those where there was a high level of flexibility within clear, strategically planned and interdependent steps to the change process, testing out multiple aspects of the process, broad and meaningful consultation and inclusion of the workforce and clear expectations by an engaged management towards the process. Persistence, patience and perseverance were clearly evident.

Discussion

The results show that general tenets for effective change management are relevant (for example clear leadership and effective teamwork) and that embedding CCSM support into practice is a 'process' that requires management support, team support and committed resources. Organisations described by participants as progressing well with embedding CCSM support into practice did not leave individual project staff members to lead the change on their own, only to become isolated and burnt out by the experience. Neither did such organisations assume that, if it was a good idea, the change would happen on its own. Transformational change will not occur without the active support of the most powerful people in organisations to guide and champion change and support others to also lead. As confirmed by participants, effective leadership provided direction and purpose; change without it created confusion, problems with sustainability and distrust. Resolution of competing claims will require leaders to form alliances and these alliances are stronger 'when the parties share common values, ideologies, purposes and vested interests' (Kendrick 2006). The culture of an organisation (assumptions, values, artefacts and symbols) is derived from these explicit and tacit values and beliefs about the way health care should be delivered and is often learned from wider society, from institutions where members of the organisation

initially trained to become health professionals, and expressed as legislation or organisational policy. It is therefore important for managers to reflect and role model the values they want for their organisation (Hatch 1993). These skills can be observed in good leaders who inspire shared vision, have credibility, exceed expectations and create an environment in which workers also strive to do this.

Collaboration and inclusiveness between managers and staff emerged as an important component of progressing and embedding this type of change. Distance created distrust, lack of involvement, lack of belief in change, splitting and other cultural problems. In such organisations, participants stated that staff often lacked opportunities to get together to talk about how they work as a team, to create a clear and shared purpose for their work. Schön (1983) stressed that creating such opportunities is good practice within learning organisations. If teams are to be effectively nurtured, such opportunities need to be part of core business, embedded into supervision, mentoring and ongoing staff interaction.

Additionally, focus on individual worker/client interactions runs the risk of creating inconsistent and parochial differences between staff, sites and regions, leading to long-term differences in service quality and delivery and fragmented approaches. In such organisations, knowledge and skill are often tied up within the subjective experience of individual workers, many who become frustrated with the culture or apparent inertia of their organisation. Inter-professional learning approaches may help overcome some of these issues. Leggat and Dwyer's (2005) conclusions provide a useful reminder when they argue that better people management is needed to improve teamwork, and reduce hierarchies and silos; that this is how service culture is best influenced to change. Staff members find it hard to change practice unless it makes sense within their daily practice (May 2006). They need a context for the change and practical tools to assist them. This requires good leadership and evidence-based tools that fit with practice realities. Bate *et al.* (2008) further reminded us to pay attention to the human dimensions of change and that, 'There are many different paths to sustained improvement, but successful efforts share two features: an ability to address multiple challenges simultaneously and skill in adapting solutions to the organisation's specific context' (p. 1).

Participants' descriptions also strongly suggest the need to stop thinking of CCSM support initiatives as finite projects undertaken by individual project officers. This has implications for funding, and longer term resource allocation both within the organisation and more widely, given existing funding structures in many organisations. As health services continually adjust to the growing demands within their community, and change becomes the norm, all staff will require an understanding of systems change and the context of their individual practice within it, as well as the place of their service within the network of services that comprise the 'team' providing support to consumers with chronic conditions. Champions working within and across staff who understand both the theory and practice of change and can effectively communicate among staff groups and with other 'team' members across services will need to become the norm if embedding is to be achieved. Greenhalgh *et al.* (2004) referred to these people as boundary spanners, bridgers and linkers.

Effective teamwork also emerged as central to embedding CCSM support into long-term practice. 'The mere existence of people working together in an agency does not automatically mean they are a team' (Kubina and Kelly 2007, p. 21). A systematic review of diffusion, dissemination and sustainability of innovations in health services confirmed the importance of leadership, teamwork, champion roles and networks as part of broader processes of effective communication and influence. Observable benefits to client outcomes found by other studies to be important to clinical staff, were also stated by participants to be important in the current study, as was congruence in values and meaning between clinical staff and management, and compatibility of innovations with the values and perceived needs of staff (Greenhalgh *et al.* 2004).

To help facilitate implementation of the Chronic Care Model, the US Agency for Healthcare Research and Quality (IHI 2008) has developed a toolkit for services. They highlight several key issues which are consistent with themes identified by participants here:

- Recognise what you are actually trying to do – i.e. a paradigm shift. Several participants demonstrate this recognition themselves and described it in leaders within organisations where CCSM support initiatives were progressing well.
- Recognise senior leaders, clinical champions and day-to-day champions, each with particular roles to play. Participants described their recognition of different skills of different members of staff within organisations.
- Teams need a vision of where they are trying to go and how they are going to get there. Participants readily described examples of organisations with clear vision for CCSM support and others where organisational values and culture continued to undermine such efforts.
- Use data to set priorities and guide decisions for improvement – know the evidence and compare your practice against it. The team can then problem-solve/use PDSA cycles to determine how it will fill these gaps. Use Patient Assessment of Chronic Illness Care and Assessment of Chronic Illness Care tools and map the person's journey to gather this data. Participants described processes where teams were actively undertaking such strategies.
- Build performance measurement capacity in the first place.
- Learn how to work as a team, to delegate tasks and roles, map who does what and in the process identify who needs what skills and training. Several participants described their organisation's attempts to do these processes.
- Involve service users – change doesn't happen in isolation from the patient. Several participants noted the importance of this strategy.

- Plan for challenge and expect plateaus given improvement is a journey not a destination. This was unanimously stated as understood by participants.

Participants stated that the Strategic Development tool (Ashford and Patkar 2001), used with participants in this study, provided a useful guide in capturing the complexity of change initiatives and that it would therefore be useful to plan and map the process of implementing CCSM support change into practice, in addition to understanding and addressing issues that arise through the process of embedding CCSM support in the longer term. Participants also reported the navigation chart developed by Kubina and Kelly (2007) as useful, though some participants stated that teams within their organisations did not really establish a real sense of being a 'team' until they undertook PDSA cycles together, an exercise that they stated made them act more collaboratively and focus off turf issues and other pressures.

Conclusions

Effective communication and connection between organisation leaders and workers is seen as one of the most important elements for progress in embedding CCSM support into practice. Change is not an event, rather it is a process in which the organisation is a living system that depends on the whole and cannot be divided into individual silos of interaction without incurring reactions in other parts of the system. Niklas Luhman (Seidl and Becker 2005) talked about this in his theory of social systems in which communication and how we behave towards each other, is central. More recently, May's Normalisation Process Theory has described a framework for how the implementation, embedding and integration of complex interventions (such as CCSM support) can be understood (May 2006). Recognising such theories may help organisations to overcome issues of sustainability after the initial flurry of project activity that often accompanies change initiatives.

This study examined the experiences of a range of health professionals who identified themselves as change champions attempting to embed CCSM support into their organisations. The study identified dominant processes that promote efforts to build CCSM support in practice. Long understood principles of effective change management continue to be important, including leadership support, clear vision, team cohesion, effective people management and shared values. However, the interdependence of these and related factors is what seems to be most important and is confirmed by other studies (Greenhalgh *et al.* 2004; May 2006; Litaker *et al.* 2008; May *et al.* 2009). Tackling service culture directly is fraught with challenges (Davies *et al.* 2000) and may undermine change efforts and lead to change champion burnout, heightened dissonance in teams and inertia. Organisational change that builds capacity for CCSM support is possible, given a clearer understanding of how it occurs, the roles, needs or motivations of the various players, and where our change efforts will have the most positive impact.

Limitations

This study was limited to participants who were familiar with and trained in the Flinders Program, with a small number of participants ($n = 3$) employed as trainers by Flinders Human Behaviour and Health Research Unit, the developer of the training program. Though not directly reflecting on this approach, their views may have shown bias in their understanding of what makes for effective chronic condition self-management support. The case studies relied on the reflections of individuals within organisations. This may not have reflected the full spectrum of views within their organisations. Likewise, students reflected their individual experiences within their organisations and had varying levels of skills in critically analysing systems issues as part of their learning. This study used frameworks to support reflection and analysis that show merit but that require more formal testing with a more rigorous methodology to explain the processes of implementing, embedding and integration of CCSM support practice. Use of a framework like Normalisation Process Theory (May 2006; May *et al.* 2009) may add further understanding of the processes at play here, in particular, the complexity of interacts within and between processes.

Conflicts of interest

The author is a member of staff of the Flinders Human Behaviour and Health Research Unit, which has led the development of the Flinders Program and CCSM.

References

Ashford G, Patkar S (2001) The positive path: using appreciative inquiry in rural Indian communities. Department of International Development, Bangalore. Available at http://www.iisd.org/pdf/2001/ai_the_positive_path.pdf [Verified 23 September 2010]

Bate P, Mendel P, Robert G (2008) 'Organizing for quality: the improvement journeys of leading hospitals in Europe and the United States.' (Radcliffe Publishing: Oxford, UK)

Bronfenbrenner U (1979) 'The ecology of human development: experiments by nature and design.' (Harvard University Press: Cambridge, MA)

Davies HTO, Nutley SM, Mannion R (2000) Organisational culture and quality of health care. *Quality in Health Care* **9**, 111–119. doi:10.1136/qhc.9.2.111

Emmons KM, Viswanath K, Colditz GA (2008) The role of transdisciplinary collaboration in translating and disseminating health research: lessons learned and exemplars of success. *American Journal of Preventive Medicine* **35**(2, Suppl.), S204–S210. doi:10.1016/j.amepre.2008.05.009

Flinders Human Behaviour and Health Research Unit (2009) The Flinders program for chronic condition management (incorporating self-management). Flinders University, Adelaide. Available at http://som.flinders.edu.au/FUSA/CCTU/self_management.htm [Verified 23 September 2010]

Green LW (2008) Making research relevant: if it is an evidence-based practice, where's the practice-based evidence? *Family Practice* **25**(Suppl.), i20–i24. doi:10.1093/fampra/cmn055

Greenhalgh T, Robert G, Bate P, Kyriakou O, Macfarlane F, Peacock R (2004) How to spread good ideas: a systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation. National Coordinating Centre for NHS Service Delivery and Organisation R&D, London. Available at http://www.sdo.nihr.ac.uk/files/project/38-final-report.pdf [Verified 23 September 2010]

Hatch MJ (1993) The dynamics of organizational culture. *Academy of Management Review* **18**(4), 657–693. doi:10.2307/258594

Health NSW (2002) 'Easy guide to clinical practice improvement: a guide for healthcare professionals.' (NSW Health: Sydney) Available at http://www.health.nsw.gov.au/resources/quality/cpi_easyguide_pdf.asp [Verified 23 September 2010]

Hroscikoski MC, Solberg LI, Sperl-Hillen JM, Harper PG, McGrail MP, Crabtree BF (2006) Challenges of change: a qualitative study of chronic care model implementation. *Annals of Family Medicine* **4**(4), 317–326. doi:10.1370/afm.570

Improving Chronic Illness Care (2009) Practice change. Available at http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35 [Verified 23 September 2010]

Institute Healthcare Improvement (2008) Integrating chronic care and business strategies in the safety net. Prepared by Group Health's MacColl Institute for Healthcare Innovation, in partnership with RAND and the California Health Care Safety Net Institute, under contract no./assignment no. HHSA2902006000171. AHRQ publication no. 08-0104-EF. Agency for Healthcare Research and Quality, Rockville, MD. Available at http://www.ahrq.gov/populations/businessstrategies/ [Verified 23 September 2010]

Johnson A, Paton K (2007) 'Health promotion and health services: management for change.' (Oxford University Press: Melbourne)

Kendrick M (2006) Leadership, alliances and change. *Interaction* **20**(2). Available at http://www.kendrickconsulting.org/pubs.asp?pid=0&ctid=15&cid=0&tr=SITEMENU [Verified 23 September 2010]

Kilbourne AM, Irmiter C, Capobianco J, Reynolds K, Milner K, Barry K, Blow FC (2008) Improving integrated general medical and mental health services in community-based practices. *Administration and Policy in Mental Health* **35**, 337–345. doi:10.1007/s10488-008-0177-8

Kotter JP (1995) Leading change: why transformation efforts fail. *Harvard Business Review* **73**(2), 59–68.

Kubina N, Kelly J (2007) 'Navigating self-management: a practical approach to implementation for Australian health care agencies.' (Whitehorse Division of General Practice: Melbourne)

Lawn S, Battersby M (2009) 'Capabilities for supporting prevention and chronic condition self-management: A resource for educators of primary health care professionals.' (Flinders University for the Australian Government Department of Health and Ageing: Adelaide) Available at http://som.flinders.edu.au/FUSA/CCTU/default.htm [Verified 23 September 2010]

Leggat SG, Dwyer J (2005) Improving hospital performance: culture change is not the answer. *Healthcare Quarterly* **8**(2), 60–68.

Litaker D, Ruhe M, Flocke S (2008) Making sense of primary care practices' capacity for change. *Translational Research; the Journal of Laboratory and Clinical Medicine* **152**(5), 245–253. doi:10.1016/j.trsl.2008.09.005

May C (2006) A rational model for assessing and evaluating complex interventions in health care. *BMC Health Services Research* **6**, 86. doi:10.1186/1472-6963-6-86

May CR, Mair F, Finch T, MacFarlane A, Dowrick C, *et al.* (2009) Development of a theory for implementation and integration: Normalization Process Theory. *Implementation Science* **4**, 29. doi:10.1186/1748-5908-4-29

McDaniel RR, Driebe DJ (2001) Complexity science and health care management. *Advances in Health Care Management* **2**, 11–36. doi:10.1016/S1474-8231(01)02021-3

McMillan E (2004) 'Complexity, organizations and change.' (Routledge: London)

Neuman WL (2003) 'Social research methods: Qualitative and quantitative approaches.' 5th edn. (Allyn & Bacon: Boston)

Newman S, Steed L, Mulligan K (2009) 'Chronic physical illness: Self-management and behavioural interventions.' (McGraw Hill/Open University Press: Berkshire, UK)

Schön D (1983) 'The reflective practitioner.' (Basic Books: New York)

Seidl D, Becker KH (2005) 'Niklas Luhmann and organization studies.' (Copenhagen Business School Press: Copenhagen)

Strauss A, Corbin J (1990) 'Basics of qualitative grounded research: grounded theory procedures and techniques.' (Sage: Thousand Oaks, CA)

Tilley N (2000) Realistic evaluation: an overview. Founding Conference of the Danish Evaluation Society. Denmark, September 2000. Available at http://evidence-basedmanagement.org/research_practice/articles/nick_tilley.pdf [Verified 23 September 2010]

Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A (2001) Improving chronic illness care: Translating evidence into action. *Health Affairs* **20**(6), 64–78.