

Capabilities for Supporting Prevention and Chronic Condition Self-Management

A Resource for Educators of
Primary Health Care Professionals

A Case Study



Australian Government

Department of Health and Ageing



Australian Better Health Initiative: A joint Australian, State and Territory government initiative

A CASE STUDY

Use of the core self-management support skills by Primary Health Care professionals: Through the lifecycle of wellness to chronic condition(s)

This case study is provided as a resource for educators who develop and deliver skills training for prevention and chronic condition self-management support to current and future Primary Health Care (PHC) professionals. It is intended to provide a working narrative of how the core capabilities identified in the **Capabilities for Supporting Prevention and Chronic Condition Self-Management resource** can be applied in practice. Educators are encouraged to adapt this case study to the learning needs and environments of their target audience.

Goal:

To illustrate the application of core PHC self-management support capabilities by a range of PHC

providers through the chronic condition lifecycle from wellness to diagnosed condition(s).

Outcomes:

After reading this case study educators will have a better understanding of:

- a. The chronic condition lifecycle and how the core self-management support capabilities relate to it;
- b. How the core self-management support capabilities can be demonstrated and translated into practice; and
- c. How PHC professionals can use these capabilities to work collaboratively with each other and the patient.

Core Capabilities for the PHC Workforce

General Person-Centred Capabilities	Behaviour Change Capabilities	Organisational/Systems Capabilities
<ol style="list-style-type: none"> 1. Health promotion approaches 2. Assessment of health risk factors 3. Communication skills 4. Assessment of self-management capacity (understanding strengths and barriers) 5. Collaborative care planning 6. Use of peer support 7. Cultural awareness 8. Psychosocial assessment and support skills 	<ol style="list-style-type: none"> 9. Models of health behaviour change 10. Motivational interviewing 11. Collaborative problem definition 12. Goal setting and goal achievement 13. Structured problem solving and action planning 	<ol style="list-style-type: none"> 14. Working in multidisciplinary teams / inter-professional learning and practice 15. Information, assessment and communication management systems 16. Organisational change techniques 17. Evidence-based knowledge 18. Conducting practice based research / quality improvement framework 19. Awareness of community resources

NB. Please refer to the accompanying Capabilities Resource for detailed definitions of these terms.

Case Study

This case study is about Julie through her lifecycle of:

- Wellness / absence of illness / awareness of lifestyle risk factors;
- Early detection and mitigation of condition conditions; and
- Management of established chronic conditions.

Each scenario depicts patients (Julie and her immediate family) at particular life stages and points on the continuum from wellness and early detection through to established chronic conditions. Each scenario offers opportunities for PHC professionals to provide self-management support at these various points. Beginning with childhood, the health issues depicted in the later scenarios of adulthood and senior years are not intended to be inevitable. Rather, they reflect situations where care has not been as proactive as it could have been, where the patient has not been engaged in her own care and where effective self-management has not been apparent to prevent further onset of chronic conditions and complications.

Opportunities for applying the core capabilities are discussed at the end of each scenario. Each described interaction between the patient and health professional, and between health professionals, is followed by the relevant core capabilities numbered in brackets.

Childhood

Social profile

Julie is the four year old child of a sole parent, Wendy (20 years old), who lives on the urban fringe of a capital city. Julie is the eldest of three children (siblings are two years old and three months old). The family live in Government-provided housing and their only income is a Government-provided Centrelink benefit, as Wendy does not work. Julie's mother left school at age 15 years after completing Year 9. The family lives in a low socio-economic neighbourhood. They do not own a car.

There are few local parks that are safe to play in and local community recreational facilities and public transport are limited. Julie attends the local preschool four mornings each week.

Family life

Julie's mother is obese (BMI 33) and predominantly buys takeaway food for the family. She also smokes 10–15 cigarettes a day and often smokes inside the house. Wendy takes little exercise and tends to spend most of her day inside. The children are left to play together and watch TV and DVDs for much of the day. Wendy often shouts at her children when they are fighting or get 'under her feet'.

Julie is a quiet, chubby girl who takes a little while to engage when she is confronted by new people. She is up to date with her immunisations and is not currently taking any medications. Her weight is at the 90th percentile for her age and her height is at the 50th percentile for her age. She tends to be a picky eater and prefers food like sausages and chips to fresh fruit and vegetables. She is rarely sick. Julie does little exercise or physical play and bullies her younger siblings. Julie's psychological/mental development is average for her age, although her vocabulary is fairly limited.

Health and health care

The nearest community health centre and GP clinic has a practice nurse and a dietitian and is within the local shopping area 1km away. The family's GP bulk bills for services. Julie and her siblings only visit the GP when there is significant need, such as an ear infection or injury. Access to the GP after hours is difficult and Wendy cannot afford to use the locum services. In addition to her GP service, Wendy occasionally uses health services such as the emergency department of the local hospital. She also attends the local swimming pool which employs an exercise physiologist. Julie's preschool centre recently ran an information session for parents on healthy eating. Julie's mother also visits a Community Health Nurse at the local early childhood clinic periodically to have the youngest child weighed and to check on their developmental progress. Julie's mother sometimes meets other mothers in the waiting area as part of this visit.

Opportunities for Applying the Core Capabilities

When the opportunity arises the Community Health Nurse (CHN) has an important role in engaging Julie's mother, Wendy, in thinking about

her own health and that of her children. This will require effective communication skills (3) to gain Wendy's trust and understanding of what Wendy is currently doing (4). The CHN is able to assess Wendy's knowledge, attitudes and behaviours to her risk factors. The CHN will also gain an understanding of her strengths, and barriers to self-management, including financial, social and education/literacy levels (4). It will also require knowledge and understanding of risk factors (2), and population health approaches (1), what influences Wendy's capacity and willingness to change her behaviour, and any relevant cultural influences (7), and how to support Wendy's behaviour change (9,10,11,12,13). The CHN will draw on evidence to support her understanding of risk factors and how best to work with this family (17). The CHN develops a self-management care plan collaboratively with Wendy in which they define her main issue as being isolated at home with three children (5). A collaboratively developed goal is for Wendy to access the local parenting support group run by the community health centre. As part of the care planned, the CHN will likely want to inform and link Wendy to community services, activities and resources (19), and this may involve other parents (6). The CHN will also link immunisation information and follow-up to the GP, and could begin the process of communication around improving this family's health as part of a collaborative approach with Wendy and the GP (14,15). The CHN will be using a system of immunisation record keeping and recall to assist both the centre and Wendy to follow up future immunisation and hearing test needs (15). At the community health centre level, the CHN will be part of a team involved in decisions about how best to

deliver services to the local population (18) and be involved in ongoing service improvement (16).

The GP also has an important opportunity and role in engaging Wendy about her smoking and about the various risk factors in her lifestyle that impact on her health and that of her children (2,3). This will require awareness and understanding of health promotion (1) and risk factor evidence (17), understanding of what currently influences Wendy's behaviour, cultural influences on her behaviour (7) and resources in the community that may be offered to Wendy (19). This assistance may include support to quit smoking and undertake risk screening for Wendy, and other supports for health promotion to her children (1). Reminders for screening appointments will assist Wendy. A trusting relationship is important in engaging this family, given that attendance at the clinic may be sporadic rather than planned. Good understanding of brief interventions that support behaviour change will also be important, given these limited opportunities (9,10,11,12,13). It will be important for the GP to work collaboratively with PHC staff within the practice team who can also engage with this family (14,15). Awareness of, collaboration with and involvement within the broader community of services will be important for the GP practice staff generally to coordinate efforts, improve communication between services and promote an environment of 'getting in early' for this family (5,14,16). The GP and practice staff, working as a coordinated team, have a significant opportunity in understanding Julie's needs and linking her with other services (3,16,19).

Role	Nature of patient contact *	Possible job functions *	Possible impacts of job functions on patient self-management *	Core capabilities
Community Health Nurse (CHN)	Direct short-term/ intermittent with Julie and Wendy	<ul style="list-style-type: none"> ■ Engagement prevention/health promotion ■ Identification of risk factors / early intervention ■ Supporting behaviour change ■ Referral to other services/resources/ supports including peer support ■ Collaborative planning with GP 	Likely to be high	<p>Actively using all 19 core capabilities.</p> <p>Particularly important will be communication (3), risk factor identification (2), assessment of self-management capacity (4), and health promotion (1).</p> <p>These skills highlight the importance of building engagement and trust, and understanding strengths and barriers within the home and community for this family.</p>
GP	Direct opportunistic planned potential with Julie and Wendy	<ul style="list-style-type: none"> ■ Engagement ■ Prevention/health promotion ■ Identification of risk factors / early intervention ■ Supporting behaviour change ■ Referral to other services/resources/ supports including peer support ■ Collaborative planning with CHN 	Likely to be restricted by time spent	<p>Actively using all 19 core capabilities.</p> <p>Particularly important will be communication (3), risk factor identification (2), assessment of self-management capacity (4), health promotion (1), and Evidence-based knowledge (17).</p> <p>As a significant regular, and likely long-term, health professional in the lives of this family, the GP has a real opportunity to support prevention and identify early risk factors for all family members.</p>
Dietitian	By referral only With Julie and Wendy	<ul style="list-style-type: none"> ■ Engagement ■ Supporting behaviour change ■ Communication/ care planning with other HPs 	Specific to diet	All 19 core capabilities are needed, though person-centred skills and behaviour change skills will likely be more important than organisational and systems skills.

* Adapted from Community Services and Health Industry Skills Council (CSHISC) (2007) *Incorporating Chronic Disease Self-Management Principles in Training Packages for CHC02 Community Services and HLT07 Health*. CSHISC, Strawberry Hills, NSW.

Others potentially involved in supporting this family's health and wellbeing are likely to include Government housing officers, Centrelink social workers, local council health promotion staff, kindergarten teachers, peers and the local pharmacy staff.

Adulthood (20 years later)

Further information

Julie is now in her mid-20s with a husband and two children (Tyler aged seven and Shannon aged five years). Julie became pregnant with her first child in her teens. Julie still lives in the area where she grew up. Her husband (of four years), is also a local whom she met when she was a teenager. At 17 years of age, Julie left school after completing Year 11, and worked for a short time in a local clothing shop. Julie stopped work when she became pregnant. Julie and her family live in private rental accommodation. In recent times, due to urban sprawl, the land values where Julie's family live have increased and rental housing has become more expensive. Julie's husband (Ted) works as a fitter and turner at a local vehicle component manufacturer plant; his job security is precarious because of the impact of globalisation of the car industry. Ted drives the family's car to work each day.

Lifestyle factors

Julie and Ted each smoke ~ 20 cigarettes a day each and each occasionally use marijuana (1–2 cones/2–3 times a week) to relax. Julie doesn't drink alcohol. She is overweight (BMI 30) and has asthma, which began when she was a child. The family's diet consists of white bread, sugary cereals and full cream milk, lots of processed and canned foods, take-away foods three times per week, ice cream, chocolate, biscuits, soft drinks, tea and coffee with two teaspoons of sugar per cup. Their diet contains little fresh fruit and vegetables, as these are expensive in Julie's area. Julie has little motivation to spend a lot of time preparing meals, preferring to watch TV and talk on the phone with friends or visit the local large shopping centre to get out of the house. She walks to local shops (~ ½ km) and to a part-time job at the local council offices (~1km) where she cleans three times a week in the evenings (5.30pm–8.30pm) once Ted arrives home from work. She does no other physical activity beyond this work and her daily living and care for her family.

Health care and health maintenance

Julie attends her local GP for reliever (Ventolin) and preventer (Pulmicort) medication prescriptions for her asthma and to obtain other prescriptions for other health needs (for example, oral contraceptive pill, antibiotics for the children's intermittent infections). Julie regularly visits her mother, who now is increasingly unwell with diabetes, hypertension and asthma. She also spends part of her week helping clean and shop for her mother. Ted has access to medical services through his workplace, where there has been a program to assess workers on health status, and offer a range of group programs for weight problems, quit smoking and other lifestyle health-risk factors. He reports that he has been assessed as overweight and is going to attend a program run by a dietitian, a physiotherapist, and a psychologist in a few weeks. Julie's children attend a school that runs parent information sessions on a range of topics, including some health topics. The local community health centre offers a range of fitness and other health-related programs in the centre and community, though Julie has not attended any of these in the past.

Aspirations

Julie's main concerns relate to her and Ted being able to buy a house of their own to establish a stable home for themselves and their children into the future. The safety of the current neighbourhood is mixed, with rising crime and drug problems among the young people, interspersed with working and pension supported families and elderly people. Julie and Ted's income is limited and Julie hasn't been able to find any other work now that the children are both at school. She has thought about going to TAFE. Julie is unhappy about her weight and is constantly dieting.

Opportunities for Applying the Core Capabilities

The CHN is in a less direct but no less important role; the focus of service will be pivotal at the broad local community level (1). Good communication skills (3) and relationships with other services at this level will be important. There are opportunities to be involved in health promotion and risk factor identification (2,17) initiatives with local school programs, delivering lifestyle groups to community members (e.g. fitness groups for young mums) (6), and to build

opportunities to engage people like Julie through advertising and information (3,14,17,19). The community health centre staff will be able to work as a team to determine their program of support to the community members and to evaluate whether they are meeting their needs (16,18). Group based support for behaviour change (9,10,11,12,13), and the opportunity for individual support plans with individuals like Julie may arise with the building of relationships and understanding her individual needs and capabilities (4). The CHN could provide ongoing motivation support for Julie to achieve her goal of losing weight and attending TAFE if the service was geared to this type of engagement. The GP could also make direct referrals or provide information on available options for Julie.

The GP has a significant opportunity to involve Julie in a process of more planned, proactive care (5,15) and to make referrals to other services (19) as part of a team approach to helping Julie improve her health. Having a clear understanding of the progress of her health, risk factors for her and her children (2,17) and the lifestyle of the family (4) will be important in understanding her motivation to change and supporting this change (9,10,11,12,13). A trusting relationship will also be important in helping Julie and her children over the years (3). Ted's workplace

health service may also communicate with the family GP and involve them in the communication loop and follow-up of any issues (14). Effective collaboration between the practice nurse, other allied health staff and the GP within the practice will enhance outcomes of care (14,17). These staff will all be important in support of any behaviour change being attempted as part of a team approach with Julie (9,10,11,12,13). Julie may represent a particular common population of users at the GP practice that warrant the delivery of more innovative programs at the practice level, targeting particular health conditions or risk factors (16,18).

The dietitian supporting Ted will be actively attempting to support his behaviour change, and there is much opportunity for him to then influence other family members (1,2,3,4,9,10,11,12,13). They could communicate with Ted's local GP clinic and liaise as needed regarding any follow-up support required.

Others that could potentially be involved in supporting this family's health and wellbeing could include school teachers, children's sports coaches, other community health and welfare staff, workplace occupational health, safety and welfare (OHSW) staff, dental services, peers, and pharmacy staff.

Role	Nature of patient contact *	Possible job functions *	Possible impacts of job functions on patient self-management *	Core capabilities
Community Health Nurse (CHN)	None unless through community and school health promotion programs with children and parents	<ul style="list-style-type: none"> ■ Prevention/ health promotion ■ Identification of risk factors/early intervention ■ Engagement 		Actively using all 19 core capabilities. Particularly important will be health promotion (1), communication (3), peer support (6), and behaviour change skills (9).
GP	Direct opportunistic planned potential with Julie and Ted	<ul style="list-style-type: none"> ■ Prevention/ health promotion ■ Identification of risk factors/early intervention ■ Engagement ■ Collaborative planning with CHN 	Likely to be high	Actively using all 19 core capabilities. Particularly important will be assessment of risk factors (2), information, assessment and management systems (15), evidence-based knowledge (17), awareness of community resources (19), behaviour change skills (9), and inter-professional practice links (14).
Dietitian	By referral only With Julie and Ted GP referral for Julie	<ul style="list-style-type: none"> ■ Engagement ■ Supporting behaviour change ■ Communication/ care planning with other HPs 	Specific to diet Opportunity to extend benefits to other family members through information and skills development	All 19 core capabilities needed. Particularly important will be behaviour change skills (9) including motivational interviewing (10) and related change skills. Also important will be communication skills (3) and linkage with other health professionals (5).

Senior Years

Further information

Julie is 63 years old and lives alone in a small public housing unit as part of a local aged care precinct in her suburb. Her husband died last year of a heart attack at age 64 years. Her two children are married with their own families, one living about 20kms away and the other interstate with little contact. Julie is also socially isolated, as many of her friends have

either moved away or are too busy to visit. She has not been motivated to go out since her husband died. Julie doesn't drive and rarely uses public transport.

Lifestyle risk factors

Julie continues to smoke, although she has tried to quit in the last 12 months. Her exercise tolerance is about 400 metres (she quickly gets out of breath). Her cooking repertoire remains fairly limited, despite

several visits to a dietitian and attendance at diabetes education sessions in the past, preferring mainly processed foods.

Health care and health maintenance

Julie has had Type 2 Diabetes for the past five years, although she has had intermittent elevated blood sugar levels for nearly 15 years. She also has asthma and is developing further respiratory illness, which restricts her capacity to walk beyond her immediate neighbourhood. She stays at home for much of the day. Her daughter Shannon visits once a week to take her shopping for groceries and to help pay bills.

Julie visits her local GP about every two months, when she needs scripts for her physical health conditions (including: Metformin, Budesonide and Ventolin inhaler, and an annual influenza injection), or when these conditions are exacerbated by infections (e.g. bronchitis). Apart from visits to her GP, Julie has had no support from other health professionals in recent years.

Julie's GP Practice has recently employed a practice nurse and has allied health professionals in attendance on a sessional basis a few days a week. Julie has recently noticed an advertisement in the GP's waiting room for low-cost practice-based group sessions on a range of health issues which she is thinking of attending.

Julie's daughter is socially and physically active, and supports her own children in after-school and weekend sporting activities. Shannon has taken on a coaching role for her daughter's netball team, and has asked Julie to help out, as she thinks it would be good for her mum to get out, meet people, and get some exercise as well.

Opportunities for Applying the Core Capabilities

With good working relationships and referral connections with local General Practices (14,15), the CHN could provide much of the direct follow-up support that Julie would need in her community. If Julie is admitted to hospital, or presents to an emergency department with an exacerbation of her chronic condition, or with complications, the CHM

may have contact as part of providing post-acute care or hospital avoidance support. There could also be a role here for Julie's daughter and grandchildren to support her and encourage behaviour change (6). Collaborative and team-based care planning could help Julie to manage her chronic conditions better (5,9,10,11,12,13), as well as alert the team to any complications and new risk factors (5,17). Effective recall and communication systems would facilitate an improved team approach and Julie's active involvement in the self-management of her own health (14,15). The CHN could visit her at home and liaise with the GP and practice staff about progress. Engagement with Julie by visiting her at home could be important (3) and provide the CHN with a better understanding of Julie's health behaviours (4,8). Otherwise, the CHN would be relying on her role in promoting health participation at the community level. This would involve understanding the needs of populations within the local community and evaluating the community health centre's effectiveness in meeting those needs (1,2,18). Again, how the community health centre is structured and how it undertakes advertising and information about services accessible to Julie at the community level will be important to Julie's capacity to access them (16,19).

The GP and practice staff working as a coordinated team (14,15) have a significant opportunity in understanding Julie's needs, taking a proactive role in supporting Julie to self-manage her health conditions (5,15,16, 9,10,11,12,13), identifying and alleviating any complications (2,17) and linking her to other community support services (6,19). This overall approach could improve her quality of life generally within her community (1).

The dietitian and diabetes educator will actively work with Julie to engage her (3), identify risk factors (2), support her motivation and action to change her health behaviours and manage her chronic conditions better (4,6,7,9,10,11,12,13,19). Their condition-specific knowledge about the management of diet and the management of diabetes respectively will be important. As members of the practice team are based within the local community health centre, their communication with the GP, practice nurse and

others as part of a shared approach to supporting Julie will be important. Information and referral to other supports will also be important (5,14,15,19). The capacity to support Julie will be dependent on the design of service delivery in the practice, systems to support this, including business model features (15,16), strength of collaborative links with other PHC services (14) and evaluation of outcomes and effectiveness (18).

Others potentially involved in supporting Julie's health and wellbeing are likely to include podiatrists, pharmacy staff, aged care service staff, community support service staff, Centrelink social workers and peers.

Role	Nature of patient contact	Possible job functions	Possible impacts of job functions on patient self-management	Core capabilities
Community Health Nurse (CHN)	None likely unless through community health promotion or self-management programs or referral from GP or as part of post-acute care or hospital avoidance contact	<ul style="list-style-type: none"> ■ Engagement ■ CCSM support to contribute to management of existing conditions and promote health and wellbeing in the community ■ CCSM skills enhancement 	Will rely on community involvement and linkages	Particularly important will be health promotion (1), group-based delivery (6), and linkage to other services (5).
GP	Direct opportunistic planned potential	<ul style="list-style-type: none"> ■ Engagement ■ CCSM support to coordinate management of existing conditions and avoid complications ■ Collaborative planning with CHN, dietitian and others ■ Referral to other services/resources/supports including peer support 	Likely to be high	Actively using all 19 core capabilities. Particularly important will be collaborative care planning (5) that includes linkage with a range of providers (14) and resources (19), and information, assessment and communication management systems (15) within the practice.
Dietitian and Diabetes Educator	By GP referral only	<ul style="list-style-type: none"> ■ Communication/ care planning with other HPs ■ Could be highly active in supporting behaviour change 	Specific to diet Specific to diabetes management	All 19 core capabilities needed. Particularly important will be collaborative care planning (5), support for behaviour change (9) and associated skills (10,11, 12,13).

Reference

Community Services and Health Industry Skills Council (CSHISC) (2007) *Incorporating chronic disease self-management principles in training packages for CHC02 Community Services and HLT07 Health*. CSHISC, Strawberry Hills, NSW.

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