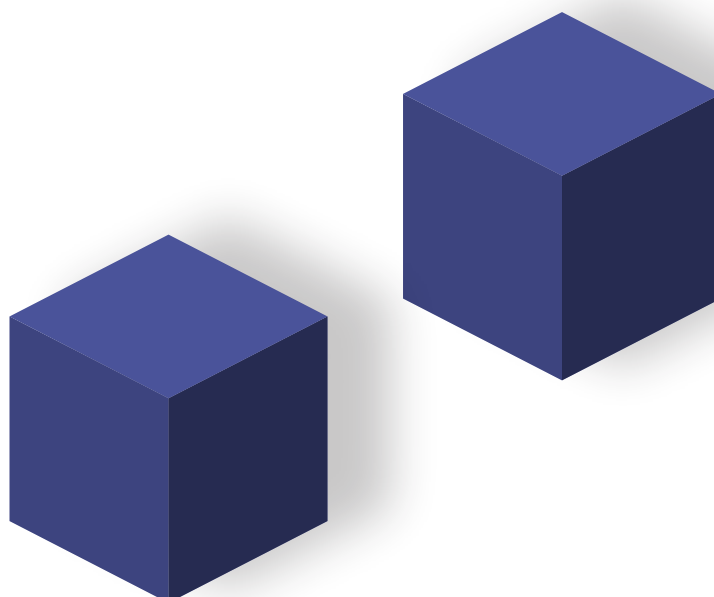
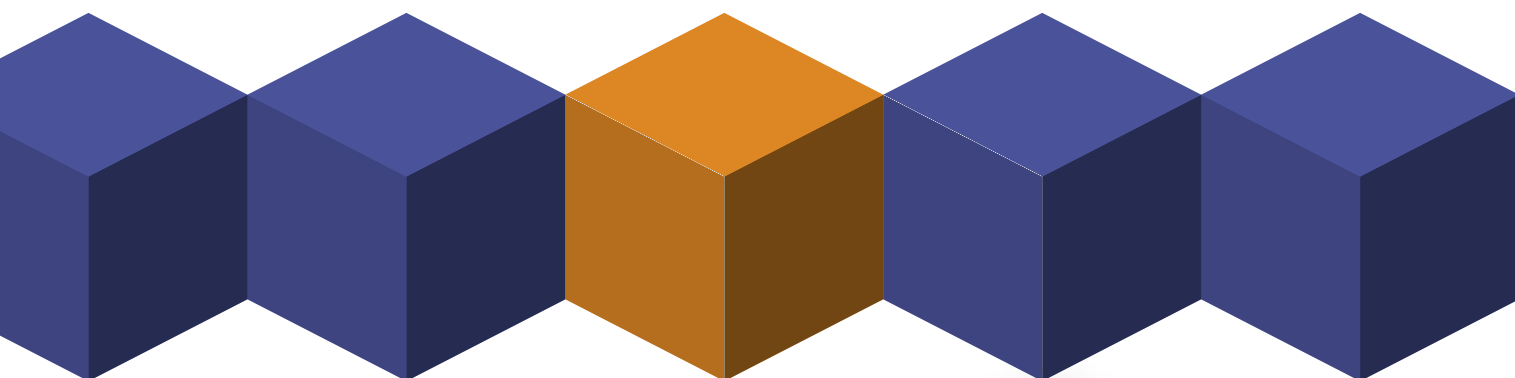
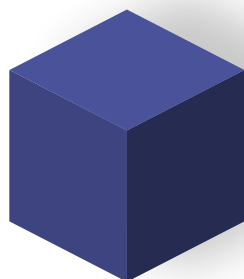


# Capabilities for Supporting Prevention and Chronic Condition Self-Management:

## A Resource for Educators of Primary Health Care Professionals



Australian Government

Department of Health and Ageing



Australian Better Health Initiative:

A joint Australian, State and Territory government initiative

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

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Any enquiries or comments on this publication should be directed to:

Professor Malcolm Battersby  
Flinders Human Behaviour and Health Research Unit  
Flinders University  
PO Box 2100  
Adelaide SA 5001  
Telephone: (08) 8404 2323  
Fax: (08) 8404 2101

Email: [HEALTH.Self-managementFMC@health.sa.gov.au](mailto:HEALTH.Self-managementFMC@health.sa.gov.au)

Website: <http://som.flinders.edu.au/FUSA/CCTU/default.htm>

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The contents of this resource plus a case study demonstrating the skills across the lifecycle and prevention/early risk factor/chronic condition continuum are available on the CD-ROM attached to this booklet.

## Acknowledgements

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*'A chronic disease self-management support curriculum framework for Australian undergraduate or entry level medical, nursing and allied health professional education';*

and

*'An analysis of training and information options to support chronic disease prevention and self-management in primary health care' (the PHC Workforce project).*

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## Capabilities for Supporting Prevention and Chronic Condition Self-Management Project Team

Flinders University

Professor Malcolm Battersby

Director (Project Leader)

Flinders Human Behaviour and Health Research Unit

Dr Sharon Lawn

Senior Lecturer (Senior Project Officer)

Flinders Human Behaviour and Health Research Unit

## Acronyms

|        |   |
|--------|---|
| ABHI   | Australian Better Health Initiative               |
| AGPN   | Australian General Practice Network               |
| APS    | Australian Psychological Society                  |
| CCM    | Chronic Care Model                                |
| CCSM   | Chronic Condition Self-Management                 |
| CDSM   | Chronic Disease Self-Management                   |
| FHBHRU | Flinders Human Behaviour and Health Research Unit |
| GP     | General Practitioner                              |
| ICCC   | Innovative Care for Chronic Conditions            |
| PHC    | Primary Health Care                               |
| RACGP  | Royal Australian College of General Practitioners |
| WHO    | World Health Organization                         |

# 1. Introduction

Chronic conditions pose significant burdens on health and wellbeing for individuals, families and communities (WHO, 2002). Their common co-morbidity adds to this burden. In Australia, chronic conditions such as asthma, diabetes, depression, arthritis and cardiovascular disease are the main cause of death and disability. The burden of chronic conditions is expected to reach 80% of healthcare expenditure by 2020 (National Health Priority Action Council, 2006). The term 'chronic condition' has been chosen instead of 'chronic disease' as it encompasses diseases, mental disorders and disabilities.

Chronic conditions are also among the most preventable health conditions. An estimated 6.8 million Australians currently have one or more chronic conditions (AIHW, 2004). Chronic condition management and self-management often involves the management of co-morbid health conditions and related complications. Early detection and treatment and active collaboration with the patient can delay complications and disability (Glasgow, Orleans, Wagner, Curry & Solberg, 2001). This approach is most effective within systems that are integrated and support self-management by the patient (Wagner, Austin & Von Korff, 1996a).

The skills of the primary health care (PHC) workforce are essential for effective chronic condition self-management support to patients across the lifespan. The World Health Organization has identified a number of competencies required by health professionals and healthcare systems to deliver effective care to those with, or at risk of developing, chronic conditions. These competencies include patient-centred care, partnering with the patient and other healthcare providers, and adopting a public health perspective. Empowering individuals towards adopting self-management strategies, where appropriate, feature significantly in these competencies (WHO, 2005).

## 2. Purpose and Outline of the Capabilities for Supporting Prevention and Chronic Condition Self-Management Resource

The Australian Government Department of Health and Ageing, through the Australian Better Health Initiative (ABHI), determined that education and training of the existing and future health workforce was a key element in assisting patients to better manage their chronic conditions. To begin to build an understanding of what this education and training might entail, two separate but related projects were conducted. These projects aimed to (a) develop a curriculum framework for *self-management support education* of the future workforce, and (b) determine the skills required for *prevention* and *self-management* support of chronic conditions by the current PHC workforce. Further detail about these two projects can be found in the Appendix to this resource.

This document represents a key resource developed from the findings of these two projects undertaken within the ABHI. It includes:

- Agreed definitions of chronic condition self-management (CCSM) related terms;
- A framework for delivery of self-management education to the future health professional workforce;
- Self-management support skills in the context of the Chronic Care Model (Wagner, et al., 2001); and
- Identification and definition of the knowledge, attitudes and skills required by the PHC workforce for prevention and CCSM support across the continuum of care from wellness, early detection and chronic condition management.

The document is intended to provide a resource for educators in universities and PHC service delivery settings, as well as regulatory and professional bodies. It will help guide the standards required by undergraduate and graduate programs for providing education and training in CCSM support to the existing and future PHC workforce.

This document may also provide guidance to:

- Educators undertaking curriculum design and evaluation;
- Teachers in academic and clinical settings in developing desired learning outcomes in relation to CCSM;
- Educators in the Vocational Education and Training (VET) sector;
- Students considering what capabilities required by them in practice;
- PHC workers in self-assessing their capabilities and up-skilling needs;
- Managers in assessing the quality of training offered to their employees;
- Administrators and policy makers in achieving CCSM outcomes;
- Government and non-government health care providers and workers; and
- Patients in the expected standards of care provided by the PHC workforce.

The term 'self-management' in this document applies across the continuum from prevention and early risk factor identification to existing chronic conditions.

The term 'patient' in this document refers to the person with risk factors for, or existing, chronic conditions. They receive self-management support from a range of health professionals and are also known as 'clients' or 'consumers' in some contexts. For consistency in this document, the term 'patient' is used.

The term 'chronic condition' rather than 'chronic disease' reflects the broad definition of persistent health problems espoused by the World Health Organization (WHO, 2002).

### 3. Definitions of Chronic Condition Self-Management and Related Terms

The following definitions of CCSM related terms were derived from literature reviews. They were developed further by the National Reference Groups for the two national projects mentioned previously. The definitions were then confirmed by broad consultations with organisations representing patients, carers, health professionals and educators as part of these two national projects.

**Table 1: Definitions of Self-Management related terms**

|  |   |
|--|---|
| <b>Chronic disease &amp; chronic condition</b>   | The term chronic condition encompasses disability and disease conditions that people may 'live with' over extended periods of time (i.e. more than 6 months). Chronic conditions are amenable to generic approaches based on the understanding that there are generic self-management tasks regardless of diagnosis. Chronic disease is a subset of chronic conditions and refers to a specific medical diagnosis. It may be more likely to have a progressively deteriorating path than other chronic conditions (WHO, 2002).  |
| <b>Chronic Condition Self-management</b>         | Chronic condition self-management is a process that includes a broad set of attitudes, behaviours and skills. It is directed toward managing the impact of the disease or condition on all aspects of living by the patient with a chronic condition. It includes, but is not limited to, self-care and it may also encompass prevention. The following are believed to contribute to this process: <ul style="list-style-type: none"> <li>■ Having knowledge of the condition and/or its management</li> <li>■ Adopting a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters</li> <li>■ Actively sharing in decision-making with health professionals, significant others and/or carers and other supporters</li> <li>■ Monitoring and managing signs and symptoms of the condition</li> <li>■ Managing the impact of the condition on physical, emotional, occupational and social functioning</li> <li>■ Adopting lifestyles that address risk factors and promote health by focusing on prevention and early intervention</li> <li>■ Having access to, and confidence in the ability to use support services.</li> </ul> (NHPAC, 2006) |
| <b>Chronic Condition Self-management support</b> | Chronic condition self-management support is what health professionals, carers and the health system do to assist the patient to manage their condition (NHPAC, 2006).  |
| <b>Care plan</b>                                 | This is a structured, comprehensive plan developed by the patient and their significant others, carers and health professional(s). It defines problems, goals, actions, time frames and accountability of all involved, to prevent complications and deterioration of chronic conditions (Battersby, et al., 2007).   |
| <b>Inter-professional education</b>              | Inter-professional education occurs when two or more professions learn with, from and about each other to improve collaboration, respect for each others' skills and the quality of care (Jessop, 2007; Braithwaite & Travaglia, 2005).   |
| <b>Patient-centred care</b>                      | Patient-centred care places the patient as the focus of any health care provision. The focus is on the needs, concerns, beliefs and goals of the patient rather than the needs of the systems or professionals. The patient feels understood, valued and involved in the management of their chronic condition. Patients are empowered by learning skills and abilities to gain effective control over their lives versus responsibility resting with others (Michie, Miles & Weinman, 2003).   |



|                        |  |
|------------------------|--|
| <b>Prevention</b>      | <p>Primary: The promotion of health and the prevention of illness</p> <p>Secondary: The early detection and prompt intervention to correct departures from good health or to treat the early signs of disease</p> <p>Tertiary: Reducing impairment and disabilities, minimising suffering caused by existing departures from good health or illness (RACGP, 2006, p. 1).</p>   |
| <b>Self-efficacy</b>   | Self-efficacy is the belief in one's ability to succeed at chosen tasks; to achieve set goals. It is the sense of confidence that one can effect change (Bandura, 1977).   |
| <b>Self-care</b>       | <p>'Self care is a part of daily living. It is the care taken by individuals towards their own health and well being ... whether in their homes, neighbourhoods, local communities, or elsewhere. Self care includes the actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital' (NHS, 2005, p.4).</p> <p>Self-management is a component of self-care that is informed by evidence-based health information.</p> |
| <b>Health Literacy</b> | 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).   |
| <b>Co-morbidity</b>    | Two or more diseases or conditions existing together in an individual (The Diabetes Monitor, 2008). They may be related causally, with the primary condition involving complications which have led to or influenced the onset of the second and further co-morbid health conditions. They may also be unrelated and merely co-exist in the one individual, and can include other disorders and disabilities such as mental illness, drug addiction, developmental and congenital conditions.  |

## 4. Prevention and Chronic Condition Self-Management Support Curriculum Framework

The following curriculum framework was developed after extensive auditing of existing courses within the tertiary education setting and consultation with these medical, nursing and allied health schools, and professional, accreditation and registration bodies. These tertiary education settings and bodies provided advice on course content and curriculum delivery issues involving the teaching of self-management support in the tertiary education setting in Australia. The vision, philosophy, core and operational principles were endorsed at a national workshop attended by representatives from:

- Tertiary education providers from the disciplines of medicine, nursing and allied health;
- The Medical Deans of Australia and New Zealand;
- The Council of Deans of Nursing and Midwifery;
- The Australian Council of Pro-Vice Chancellors and Deans of Health Science;
- The Australian Nursing and Midwifery Council;
- Allied Health Professions Australia;
- The Consumers Health Forum;
- Representatives with recognised relevant expertise in the application of a variety of self-management approaches in clinical and community settings in Australia; and
- Representatives from a range of States and Territories across Australia.

### 4.1 Vision and Philosophy

The National Reference Group developed a vision which was confirmed by the national consultation and consensus workshop. This consultation developed a vision and philosophy underpinning self-management capabilities of the future primary health care workforce. It emphasised that all Australians with chronic conditions and their carers receive care from health professionals competent in providing self-management support.

### 4.2 Core Principles

The core principles underpinning the development and delivery of a CCSM support curriculum are that:

1. All health professional graduates will be competent in supporting patients to self-manage their chronic condition(s).
2. Health professional education will ensure that graduates are equipped to:
  - Conduct their practice so that the patient with the chronic condition and their carers are central to the process of care, ensuring they feel understood, valued and involved in efforts to support their self-management;
  - Work in inter-professional teams that support CCSM; and
  - Understand and base their CCSM support on the biopsychosocial, cultural and economic context of the patient and their carers.

### 4.3 Operational Principles

This consultation also highlighted that CCSM curriculum for health professionals should display the following attributes in practice:

1. Patients are involved in the design, conduct and evaluation of CCSM support education;
2. The agreed national CCSM definitions and terms are used;
3. Students are exposed to a range of CCSM models of consumer education;
4. Students understand the influence of the health care system on CCSM;

5. CCSM support education incorporates inter-professional learning;
6. Students learn CCSM support in inter-professional practice settings;
7. There are identified individuals competent in CCSM support to champion development and delivery of CCSM support education;
8. CCSM support education is integrated across all years of the curriculum;
9. CCSM support competencies are explicitly assessed; and
10. The effectiveness of the CCSM support education is explicitly evaluated.

Further to these principles, students should understand contrasting health system orientations in terms of prevention, acute/episodic care or chronic condition care. Building capacity into the health system to better deliver prevention and better provide chronic condition management and self-management support must not be construed as a drive to reduce the existing effectiveness and efficiencies of acute/episodic care. There will always be a need for acute/episode care alongside CCSM support.

## 5. Best Practice for Delivering Prevention and Chronic Condition Self-Management Support

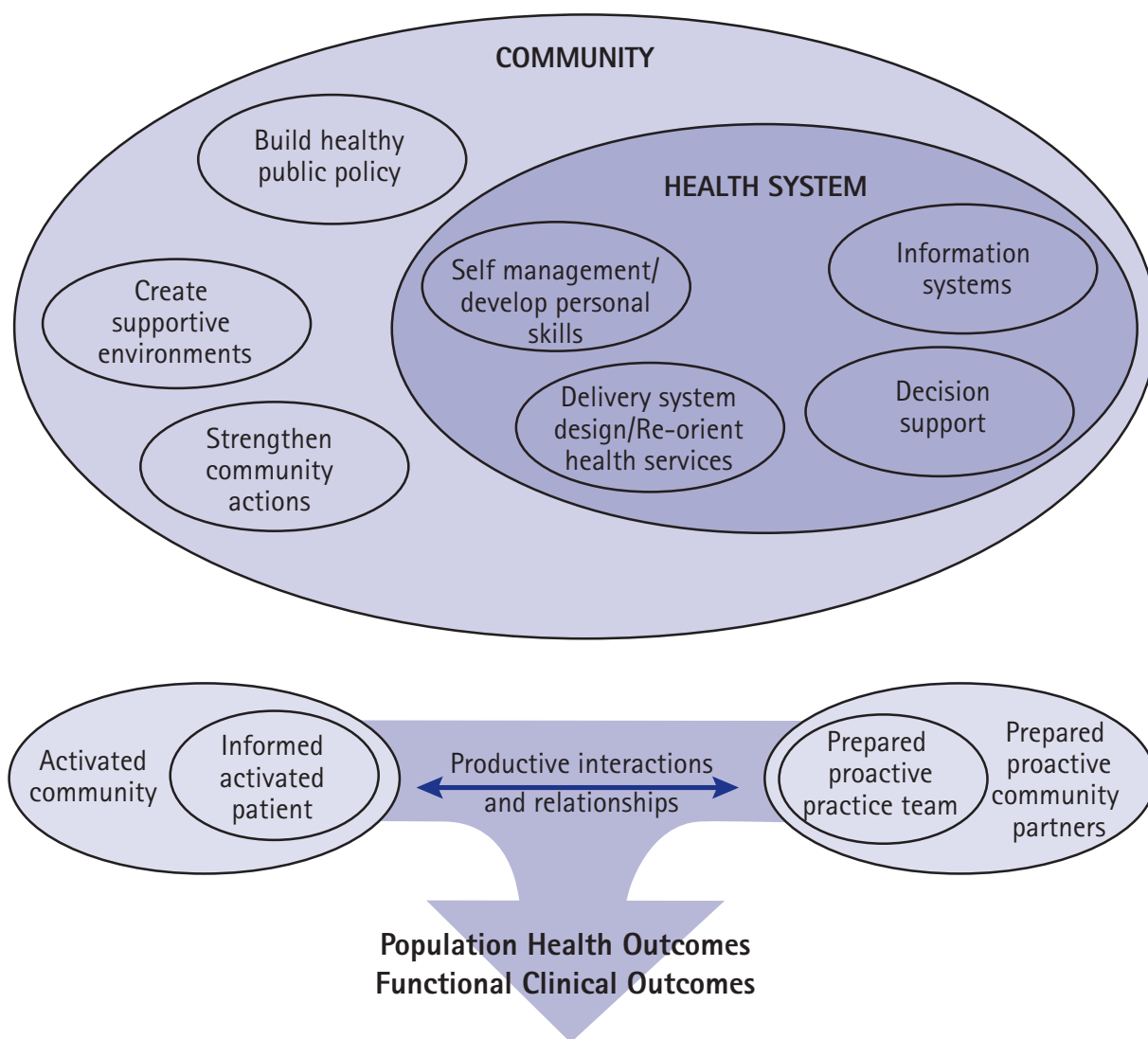
The Chronic Care Model is an internationally recognised, evidence-based guide to the comprehensive, integrated reorganisation of care delivery needed to support chronic condition self-management. The goal of the Chronic Care Model is to improve health outcomes by optimising the individual practice team's interaction with patients. The model also recognises that changes need to be made at all levels of the organisation and within the broader community and policy context to support this work (Wagner, et al., 2001). This model will continue to be refined and improved. Therefore, this summary should not be seen as the last word but rather as a means of conceptualising the various domains essential to good chronic condition care.

Each domain within the Chronic Care Model encompasses core skills required by the workforce for CCSM support to be successfully implemented into practice. Each domain also suggests specific structures and processes to be present within the health care setting in order to achieve this successful implementation. By taking this approach, this model proposes that workers require a full understanding of their interaction with patients at the individual, team and system level. This involves an understanding of the patient's health choices and behaviours at the interpersonal, community and population-wide level.

This model can be applied to PHC settings as part of implementing care across the prevention, early risk factor identification and CCSM support continuum (Hung, et al., 2007). It serves as a guide for education and training organisations to determine the education and training needs of the PHC workforce. The underlying skills and knowledge needed to action each of these domains include:

- Patient-centred skills for effective engagement and communication between patients, PHC workers and health systems;
- Skills to support behaviour change by patients (and staff);
- How to work collaboratively in teams and systems that actively use a range of technology and evidence-based practices to achieve optimal patient outcomes;
- How to plan care that accesses a range of skills and resources within and across disciplines and within the community; and
- An understanding of the social determinants of health and health promotion approaches to achieve population health outcomes.

The Chronic Care Model is outlined in the following diagram:



Created by: Victoria Barr, Sylvia Robinson, Brenda Narin-Link, Anita Dotts and Dariana Ravensdale (2002). Adapted from R. Glasgow, C. Orleans, E. Wagner, S. Curry and L. Solberg (2001). Does the Chronic Care Model also serve as a template for improving prevention? *The Millbank Quarterly*, 79(4), and World Health Organisation, Health and Welfare Canada and Canadian Public Health Association (1986). Ottawa Charter of Health Promotion. (This diagram may be found in Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale & Salivaras, 2003.)

## 6. Prevention and Chronic Condition Self-Management Support Capabilities

### 6.1 Core Knowledge, Attitudes and Skills for the PHC Workforce

The Chronic Care Model, supported by an extensive review of the prevention and chronic condition self-management support literature and research, provided the base for the development of a survey of the skills required by the national PHC workforce. Following this survey with the national PHC workforce and a survey of existing training organisations delivering chronic condition management and self-management education, national consultation with key stakeholders from across the PHC education, training, professional accreditation and clinical delivery sectors was undertaken. Nineteen core capabilities were defined and confirmed as necessary for the PHC workforce to successfully support patients and carers within the self-management continuum. Each of these skill areas assumes an underlying knowledge and values base.

The core capabilities are identified in Table 2 and further defined in Table 3.

**Table 2: Core Skills for the PHC Workforce**

| General Patient-Centred Capabilities  | Behaviour Change Capabilities  | Organisational/Systems Capabilities  |
|---|--|--|
| 1. Health promotion approaches<br>2. Assessment of health risk factors<br>3. Communication skills<br>4. Assessment of self-management capacity (understanding strengths and barriers)<br>5. Collaborative care planning<br>6. Use of peer support<br>7. Cultural awareness<br>8. Psychosocial assessment and support skills | 9. Models of health behaviour change<br>10. Motivational interviewing<br>11. Collaborative problem definition<br>12. Goal setting and goal achievement<br>13. Structured problem solving and action planning | 14. Working in multidisciplinary teams/interprofessional learning and practice<br>15. Information, assessment and communication management systems<br>16. Organisational change techniques<br>17. Evidence-based knowledge<br>18. Conducting practice based research/quality improvement framework<br>19. Awareness of community resources |

**Table 3: Definitions of Core Skills for Self-management Support**

| <b>Person-Centred Skills</b>  | <b>Definition</b>  |
|---|--|
| <b>(1) Health promotion approaches</b>  | 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). 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 (Dade Smith, 2005). |
| <b>(2) Assessment of health risk factors</b>                                    | Awareness and effective identification of predisposing factors (smoking, nutrition, alcohol, physical activity, stress) that may lead to future health problems for the patient. Further factors within the patient or part of their environment may increase their chances, or make it more likely, that they will develop a disease or other health condition (RACGP, 2006).   |
| <b>(3) Communication skills</b>   | Effective communication involves the ability to establish and develop mutual understanding, trust, respect and cooperation. It is the ability to express oneself clearly so the other person understands, and to listen and interpret effectively to understand what the other person is trying to express. In this context, it includes communication between patients and PHC workers, as well as communication between staff in PHC teams and with other service providers.   |
| <b>(4) Assessment of self-management capacity</b>                               | Assessment of the patient'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 patient 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 (Battersby, et al., 2003).   |
| <b>(5) Collaborative care planning</b>  | 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 (Battersby, et al., 2007).   |
| <b>(6) Use of peer support (within chronic disease self-management context)</b> | 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).  |
| <b>(7) Cultural awareness/ interpreter service utilisation</b>                  | 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.   |

|  |  |
|--|--|
| <b>(8) Psychosocial assessment and support skills/skills enhancement</b> | 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, 2005).  |
| <b>Behaviour Change Skills</b>   | <b>Definition</b>  |
| <b>(9) Models of health behaviour change</b>                             | <p>Frameworks which help us to understand human behaviour and how to change it. This 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:</p> <ul style="list-style-type: none"> <li>■ The Health Belief Model (Pender, Murdaugh &amp; Parsons, 2006)</li> <li>■ Theory of Reasoned Action and Theory of Planned Behaviour (Pender, Murdaugh &amp; Parsons, 2006);</li> <li>■ Social Learning Theory (Bandura, 1977)</li> <li>■ Transtheoretical (Stages of Change) Model (Prochaska &amp; Di Clemente, 1983; Prochaska &amp; Velicer, 1997)</li> <li>■ Relapse Prevention Model (Miller and Rollnick, 1991)</li> <li>■ Health Promotion Model (Pender, Murdaugh &amp; Parsons, 2006)</li> <li>■ The 5As Model (Glasgow, Davis, Funnell &amp; Beck, 2003)</li> <li>■ Cognitive Behavioural Therapy (BABCP, 2005).</li> </ul> |
| <b>(10) Motivational Interviewing</b>                                    | A process undertaken with a person to support their behaviour change. The sequence in Motivational Interviewing involves encouraging the person to talk, generate self-motivational statements, deal with resistance, develop readiness to change and negotiate a plan, developing determination and action. The 5 principles underlying the process are expressing empathy, developing discrepancy, avoiding arguing, rolling with resistance and supporting self-efficacy. Motivational Interviewing embodies cognitive change skills (Miller & Rollnick, 1991).   |
| <b>(11) Collaborative problem definition</b>                             | 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).   |
| <b>(12) Goal setting and action planning</b>                             | 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 (specific, measurable, achievable, realistic, and timely). 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).   |
| <b>(13) Structured problem solving</b>                                   | The ability to systematically assist a patient to learn the skill of problem solving, i.e. identify and analyse practical issues arising in a situation and to determine options for a practical solution, making effective use of time and resources available (Katon, et al., 2008).   |

| <b>Organisational/ Systems Skills</b>   | <b>Definition</b>   |
|---|---|
| <b>(14) Working in multi-disciplinary teams / Interprofessional learning and practice</b> | 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. '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). |
| <b>(15) Information, assessment and communication management systems</b>                  | 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). These information system management skills 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 (Wagner, Austin & Von Korff, 1996b).  |
| <b>(16) Organisational change techniques</b>  | 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).   |
| <b>(17) Use of evidence based knowledge</b>   | 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. This includes the risks and benefits of any intervention including self-management support. This approach to decision making involves the health professional using the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best (Muir Gray, 1997). Most evidence-based guidelines are disease specific. However, co-morbidity is common among people with chronic conditions. Therefore, it is important for evidence-based knowledge and practice to acknowledge this complexity.           |



|   |  |
|---|--|
| <p><b>(18) Conducting practice based research / quality improvement framework</b></p> | <p>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 disease 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. The Plan, Do, Study, Act (PDSA) cycle is one mechanism for undertaken this research in practice (Victorian Quality Council, 2005).</p> |
| <p><b>(19) Awareness of community resources</b></p>                                   | <p>Broad understanding of available resources, supports, services and activities within the patient's community that would be useful in supporting them and their carers/family. This involves an understanding of 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 (Wagner, et al., 2001).</p>  |

The core capabilities are further demonstrated in the case study attached to this resource (refer to CD-ROM).

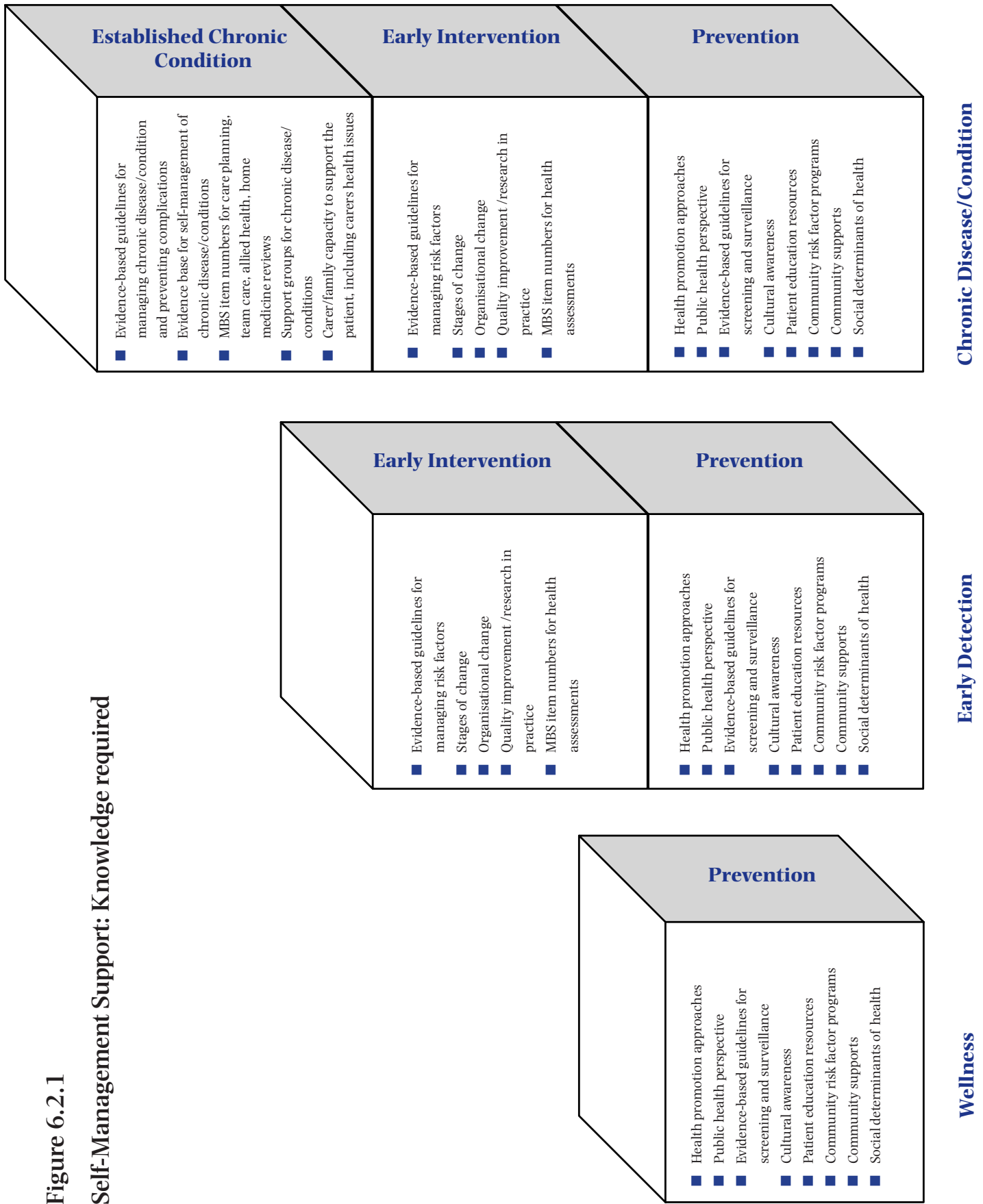
## **6.2 Prevention and Chronic Condition Self-Management Support Knowledge, Attitudes & Skills across the Continuum of Care**

The knowledge, attitudes and skills needed by the PHC workforce within the self-management continuum are linked and involve progressive capabilities that are important for working with patients to maintain wellness, detect and address risk factors early and to self-manage their existing chronic conditions. Prevention is seen to apply across the entire spectrum from wellness to someone who has early indicators of disease through to established chronic conditions. These capabilities are drawn from the extensive literature review and consultation undertaken for the PHC workforce project, and reflect the vision and philosophy, core and operational principles contained in this resource. The knowledge, attitudes and skills identified by the national PHC Workforce project are inherent within these capabilities.

Figures 6.2.1, 6.2.2 and 6.2.3 identify the baseline knowledge, attitudes and skills required by health professionals to support patients to self-manage their health through the lifespan from maintenance of wellness and prevention of illness, early detection and risk factor modification and self-management of established chronic conditions respectively.

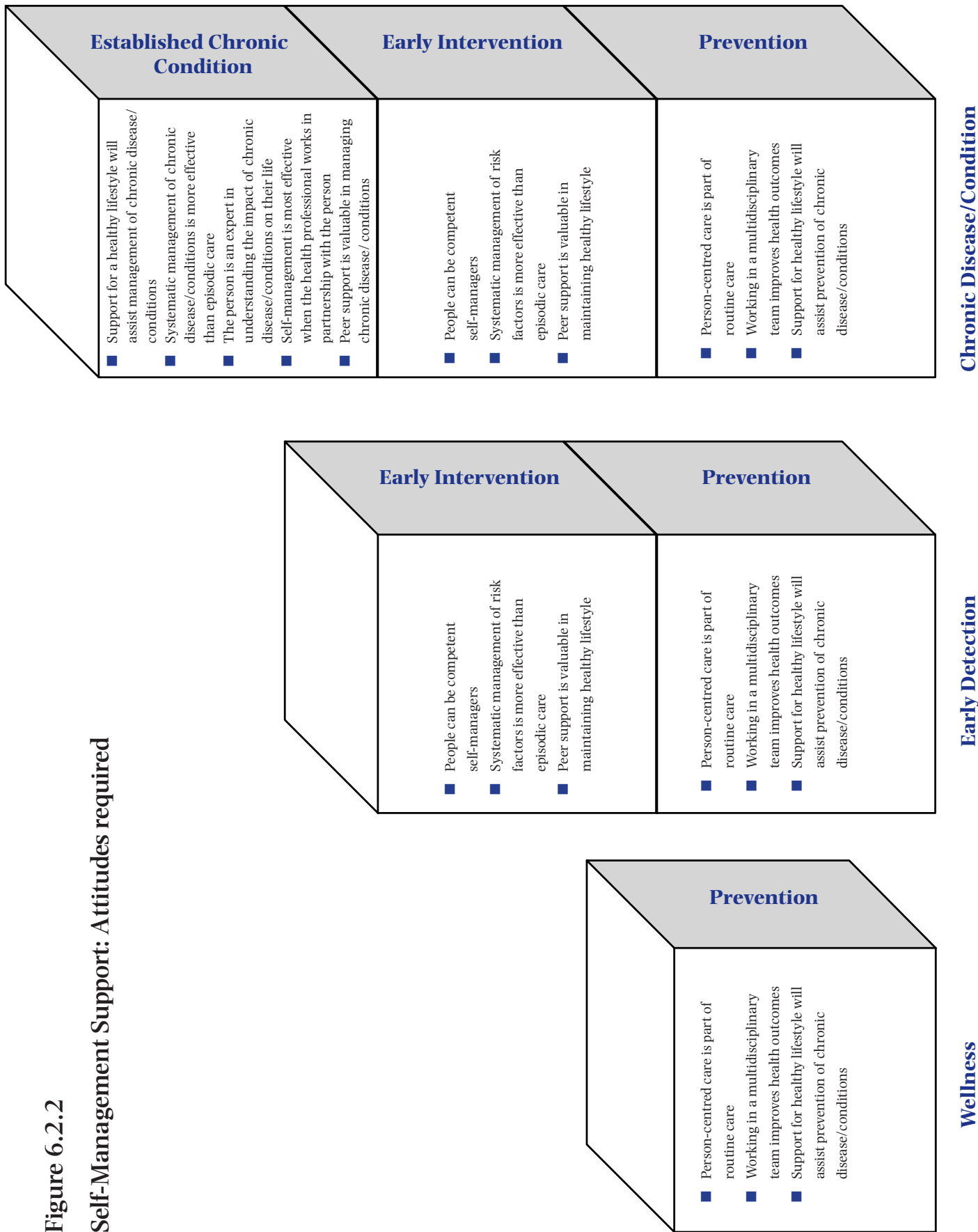
The three stages are separated to demonstrate a layering of interventions and associated skills. However, in reality an individual with established chronic conditions may undertake a range of activities that support wellness, have risk factors which increase the complications of the existing chronic condition, as well as risk factors for developing additional chronic condition co-morbidities. This staged model encourages the PHC worker to see the patient holistically on a continuum of wellness, risk and established chronic conditions, and not to focus solely on the established chronic condition.

**Figure 6.2.1**  
**Self-Management Support: Knowledge required**

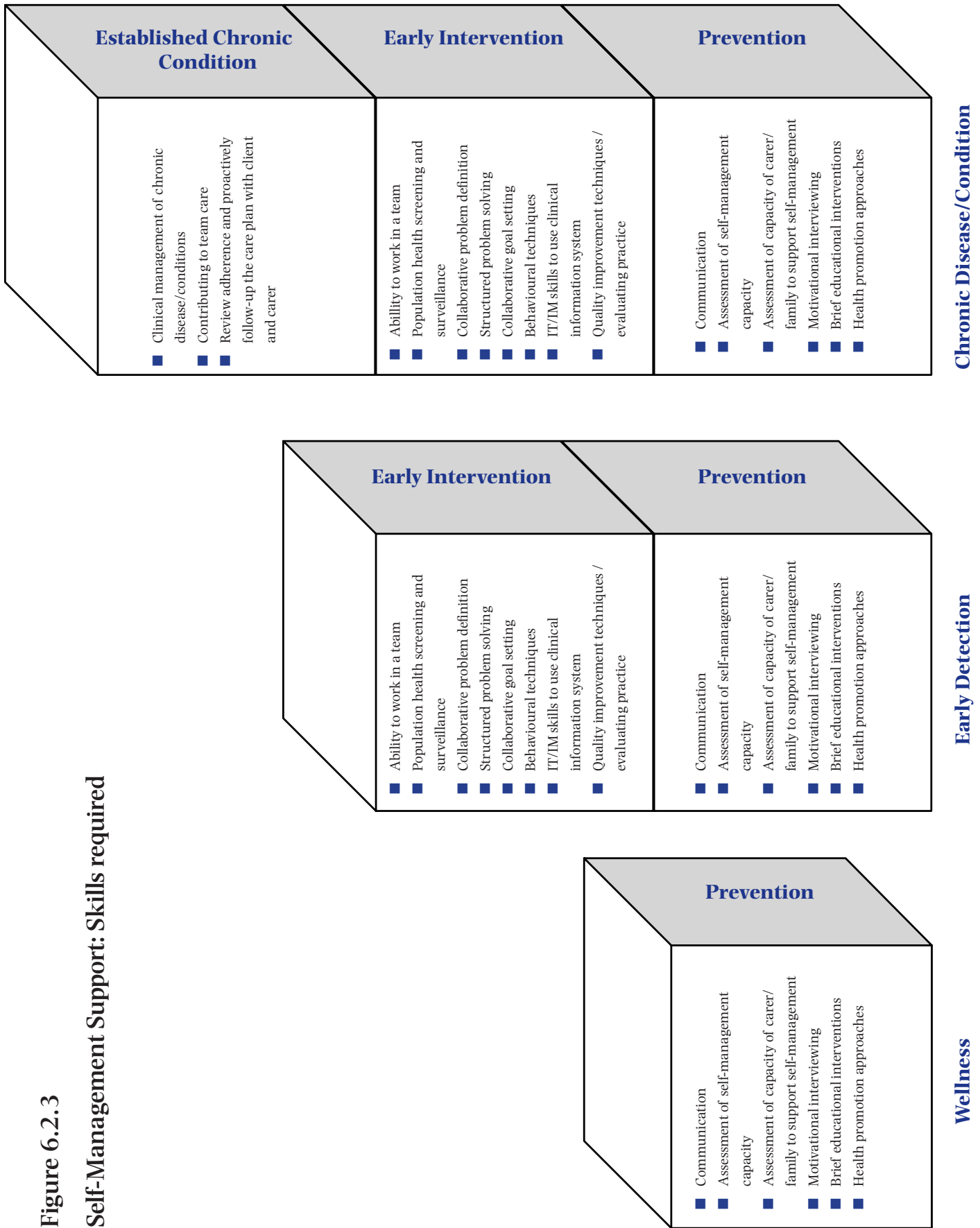


**Figure 6.2.2**

**Self-Management Support: Attitudes required**



**Figure 6.2.3**  
**Self-Management Support: Skills required**



## 7. Prevention and Chronic Condition Self-Management Care Planning

Self-management care planning is an example of how the PHC worker can demonstrate their use of the core capabilities in practice.

Within the Chronic Care Model framework, international evidence confirms that a best practice approach to self-management support is for each patient with a chronic condition or risk factors to have a self-management care plan. This plan should be collaboratively developed with health professionals and other supports (including carers), and should incorporate both medical management and self-management. The self-management care plan incorporates and integrates many of the underlying principles, values and core capabilities identified for the PHC workforce.

It should be derived from an assessment of self-management capacity and include:

- Knowledge;
- Behaviours;
- Attitudes;
- Impacts of the condition;
- Lifestyle risk factors;
- Barriers to self-management; and
- Strengths.

The care plan should contain:

- Patient defined problems;
- Patient defined goals;
- Medical management;
- A prioritised action plan based on the self-management needs of the patient and their carer;
- Community education programs or resources;
- Community support networks; and
- Time for review and follow-up. This includes the flexibility to acknowledge and anticipate unexpected emergent events arising from co-morbidity and/or increasing frailty and some direction as to what should be done in that circumstance.

The care plan should:

- Facilitate the patient's engagement in their own care and treatment;
- Enhance the patient-health provider relationship;
- Enhance the patient's belief that they can make changes to achieve improved self-management and health outcomes; and
- Enhance the patient's ability to maintain changes once improved self-management and health outcomes are achieved.

The care plan should incorporate condition-specific tasks to be carried out by the patient and condition-specific and generic education (knowledge and skills) required by the patient. This approach needs to consider the complexity that is brought to these tasks when co-morbid conditions are present. A balance between holistic and condition-specific approaches is needed.

These skills include:

- Problem definition and goal setting;
- Action planning;
- Problem solving;
- Emotional management;
- Pain management;
- Psychosocial skills;
- Cognitive change skills;
- Relapse prevention skills; and
- Goal attainment skills (i.e. monitoring, reinforcement, creating accountability, contingency planning).

The self-management care plan should occur within a health system that provides ready access to appropriate systems of self-management support that are:

- Based on a health promotion and population health view;
- Evidence-based;
- Adequately resourced; with
- Staff who are adequately trained, culturally sensitive to the patient's needs and who support the belief in the patient's ability to learn self-management skills.

A range of care planning item numbers is available to the PHC workforce through the national Medicare Benefits Scheme. These are designed to:

- Provide opportunities for the provision of planned preventive and chronic care to people at risk of or suffering from chronic and complex medical conditions;
- Enhance coordination of care and communication between the patient and their PHC providers;
- Build inter-disciplinary communication and working relationships between PHC providers; and
- Coordinate the various support services organised to support the patient's self-management of their health.

These care planning items include the General Practice Management Plan (GPMP) and Team Care Arrangements (TCA). Further item numbers are available for use by practice nurses or registered Aboriginal Health Workers on behalf of a General Practitioner. These may be further supported by allied health professionals (Australian Government Department of Health and Ageing, 2008).

The care planning items are complimented by a range of other items including:

- Health assessment;
- Prevention;
- Service Incentive Payments;
- Mental health;
- Quality use of medicines;
- Bulk billing incentives.

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## 9. Appendix

The Australian Better Health Initiative (ABHI) is a program of the Council of Australian Governments developed to refocus the health system to promote good health and reduce the burden of chronic disease across Australia. A key element of the ABHI is education and training of the current and future Australian primary health care (PHC) workforce to support health service users to better self-manage their chronic conditions.

In 2007, as part of the ABHI, the Flinders Human Behaviour and Health Research Unit (FHBHRU), in conjunction with its project partners, received funding from the Commonwealth Department of Health and Ageing to:

- Develop a chronic condition self-management support curriculum framework for Australian undergraduate or entry level medical, nursing and allied health professional education; and
- Investigate the training and information options to support chronic condition prevention and self-management in primary health care.

These projects built upon previous work by FHBHRU in the survey and development of recommendations for self-management support in undergraduate allied health curricula and an audit of Medical Schools' curricula assessing chronic condition self-management content. In addition, they recognise prevention and early risk factor identification as part of the continuum of self-management.

### 9.1 The Curriculum Framework Project: Key findings from consultative activities

The curriculum framework was developed after extensive auditing and consultation with medical, nursing and allied health schools, and professional, accreditation and registration bodies, on course content and curriculum delivery issues involving the teaching of self-management support in the tertiary education setting in Australia. The Project team was advised by members of the project's national reference group, which included representatives from:

- The Committee of Deans of Australian Medical Schools;
- The Council of Deans of Nursing and Midwifery;
- The Australian Council of Pro-Vice Chancellors and Deans of Health Science;
- The Australian Nursing and Midwifery Council;
- Allied Health Professions Australia;
- The Consumers Health Forum;
- Representatives with recognised relevant expertise in the application of a variety of self-management approaches in clinical and community settings in Australia; and
- Representatives from a range of States and Territories across Australia.

Results showed that whilst self-management support education was considered important by the vast majority of schools and the knowledge of theoretical elements of self-management support were usually being taught, very few schools were explicitly teaching or assessing the skills and attitudes that would ensure a new graduate was competent in providing self-management support in clinical practice.

## 9.2 The Primary Health Care Workforce Project: Key findings from consultative activities

Likewise, the objectives of the PHC workforce project were to identify and assess the gaps in the training and information options available to practising PHC professionals to assist them to support their patients to prevent chronic conditions through adoption of healthier lifestyles, early identification and management of risk factors and/or effective self-management of any existing chronic conditions. This was done through a needs assessment with the current primary health care workforce and an audit of current training options available to them.

The Project team was advised by members of the project's national reference group, which included representatives from:

- Key representatives from professional bodies and clinicians who represent the medical, allied health and nursing workforce in Australia;
- Recognised experts in self-management;
- Training organisation representatives;
- The Consumers Health Forum;
- The Chronic Illness Alliance;
- The Australian Chronic Disease Prevention Alliance;
- Health Consumers of Rural and Remote Australia Inc.;
- Carers Australia; and
- Representatives from a range of States and Territories across Australia.

The Needs Assessment found that:

- There is an overall lack of understanding, competence and practice of self-management support among PHC professionals;
- Translation of training into practice is a major problem, and more quality control of training programs is needed;
- The PHC workforce appears not to have the full set of skills needed to support patients' behaviour change. More psychosocial skills were also seen as needed; and
- A systemic approach is required to implement self-management training models, facilitated by organisational support, and accreditation from professional bodies.

The Needs Assessment also found that:

- Training and understanding vary between different professions;
- Training opportunities are more limited in rural and remote areas and in some states;
- Specific needs of the Indigenous health workforce continue to be compounded by social determinants of health and broader systems issues impacting on Indigenous populations; and
- Although a prescriptive approach to health care tends to dominate practice, the workforce are keen to develop more skills in behaviour change techniques and to undertake more multidisciplinary training and training that is translatable to practice.

Consumers and Carers reported that:

- Health professionals need more skills in order to listen and ask the patient their views and perspectives;
- Health professionals need more knowledge of community resources available to support the patient with chronic conditions and their carers;
- Health professionals need to work more from a position of identifying patients' strengths and current capacities than is currently the case;
- Health professionals need to be more collaborative with patients, carers and each other; and
- Patients need to be involved more in education and training of the PHC workforce, from development, delivery and evaluation, through to accreditation.

The Audit of existing training and resources found that:

- Universities provide the vast majority of training to the PHC workforce;
- There is little training targeting prevention;
- Integration of skills/components and translation of knowledge and skills into practice is uncertain;
- Evaluation of training needs improving;
- Urban areas have better access to training;
- Training is often expensive; and
- Workshops continue to be the main mode of delivery.