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9 Skills for person-centred care: health professionals supporting chronic condition prevention and self-management

Sharon Lawn and Malcolm Battersby

With the growing burden of chronic conditions and the sheer volume of expected demand for health services over the coming decades, it will become increasingly important for health service providers to work smarter and more collaboratively with one another and with service users. Building cooperative models of practice that overcome traditional turf sensitivities between professionals, and that overcome structural boundaries between services, will be challenging. Underpinning this, and arguably more important and elusive, is the challenge for health professionals to truly understand how their input impacts on service consumers. If we acknowledge the fact that many of us professionals do not adequately look after our own health or follow health professionals' advice (Vermeire et al. 2001) despite 'knowing what is good for us', there is clearly something else going on that we are failing to recognize about ourselves and the consumers we treat, who expect to follow our advice as part of our interaction with them. The central argument of this chapter is that solutions to these challenges can, in large part, be found through a return to placing the consumer voice at the centre of the process, a return to the core skills of engagement and person-centred care. Person-centred care regards the person receiving services as the focus of any healthcare provision. The focus is on the needs, concerns, beliefs and goals of the person rather than the needs of the systems or professionals. The person feels understood, valued and involved in the management of their chronic condition. People are empowered by learning skills and abilities to gain effective control over their lives versus responsibility resting with others (Michie et al. 2003). We will be examining the elements of knowledge in the practice of person-centred care as applied to supporting people to manage their chronic conditions. To help demonstrate this argument, we will summarize some of the findings of a recent national primary healthcare workforce project that determined the skills required to effectively support

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chronic condition prevention and self-management. The focus of this project specifically included interprofessional practice and education, that is, how each health profession engaged with consumers as well as each other.

In 2007, as part of joint Australian Government Department of Health and Ageing and State and Territory Government funding of the Australian Better Health Initiative (ABHI), the Flinders Human Behaviour and Health Research Unit (FHBHRU) in conjunction with its project partners, the Australian General Practice Network (AGPN), the Australian Psychological Society (APS) and the Flinders University Department of General Practice investigated training and information options to support chronic condition prevention and self-management in Australian primary health care (PHC). This project built upon previous work by FHBHRU in the development of an undergraduate curriculum framework in chronic condition self-management support for future medicine, nursing and allied health professionals. The ABHI was developed to improve chronic disease prevention and self-management across Australia. A key element of the strategy is education and training of the current and future PHC workforce in chronic condition prevention and self-management (CCSM) support principles (Australian Institute of Health and Welfare [AIHW] 2004). Justifications for the strategy include the ageing population, workforce pressures, a need for cultural change in clinician attitudes and practices, inequities in access to services, inadequate coordination and integration of services and the need to enhance the quality of services. Full ethics approval was granted for the work.

The objectives of the project were to investigate:

- What knowledge and skills primary health care professionals need to be able to provide effective support
- Their current knowledge and skills base, perceptions, practice, enablers and barriers
- What professional development opportunities are currently available to meet these needs
- Where the gaps are in professional development opportunities currently available and which gaps are of highest priority
- What options are available to address these gaps.

The PHC sector comprises health workers drawn from medicine, nursing and allied health, but often complemented by a broad range of semi-professional and community support and health promotion groups. What they all share is a commitment to promoting health and well-being and improving basic quality of life for people in their community. PHC professionals play a pivotal role at the primary, secondary and tertiary level, working closely with a full range of other services and sectors.

The efficacy of chronic condition prevention and self-management support depends on the quality of the collaboratively developed, integrated plan of care across these areas, the quality of their professional working relationships and, most importantly, the quality of the care relationship with consumers and carers. What enables health professionals to support the needs of people they serve together is effective training and knowledge, underpinned by person-centred attitudes to care that facilitate engagement with consumers and sustain it effectively over time.

Chronic condition self-management: the central underpinning notion

The term chronic condition self-management ('self-management') has emerged as a concept to describe the tasks, roles and responsibilities of individuals as they cope with their chronic conditions from diagnosis to long-term management. The Stanford model of chronic disease self-management, developed by Lorig and colleagues from the 1970s (Lorig 1993) has been prominent. It is based on patient-perceived problems. Its goal is to build the person's confidence (self-efficacy) to perform the three tasks of disease, role and emotional management, with the end goal of improved health status and appropriate utilization of healthcare. It draws heavily from the ideas of Corbin and Strauss (1988) in their earlier work with people with chronic conditions.

More recently, definitions of self-management have been informed by the Chronic Care Model (Wagner et al. 2001). Self-management control rests with the person, is often shared with peers, and acknowledges that the person is the 'expert' of their experience. It challenges the professional expert view of knowledge exchange/transfer. Central to self-management is the notion of rights and responsibilities and how these are shared. Self-management requires the person to hold the belief that they can effectively self-manage their condition, or learn to do so, to have improved self-efficacy or confidence in their ability to self-care, involving cognitive, perceptual, behavioural and lifestyle change.

The national consultation in the PHC self-management skills project led to an agreed definition of self-management (NHPAC 2006, Lawn and Battersby 2009, p. 7):

> Self-management is a process that includes a broad set of attitudes, behaviours and skills directed toward managing the impact of the disease or condition on all aspects of living by the person with a chronic condition. It includes, but is not limited to, self-care and it may also encompass prevention. The following are considered to contribute to this process:

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- Having knowledge of the condition and/or its management
- Adopting a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters
- Actively sharing in decision making with health professionals, significant others and/or carers and other supporters
- Monitoring and managing signs and symptoms of the condition
- Managing the impact of the condition on physical, emotional, occupational and social functioning
- Adopting lifestyles that address risk factors and promote health by focusing on prevention and early intervention
- Having access to, and confidence in, the ability to use support services. (Lawn et al. 2007)

Self-management support is what health professionals, carers and the health system do to assist the person to manage their disease or condition.

Justification for chronic condition self-management

Lifestyle is recognized internationally as the major remedial cause of ill health. Chronic conditions are recognized as being among the most common and costly to the health system and among the most preventable, with an estimated 6.8 million Australians who have a chronic condition (AIHW 2004). Early detection and treatment can delay complications and disability, but it is crucial that this occurs within an integrated system (Lawrence 2005, Best et al. 2003a) and supports self-management by the person. There is a growing body of evidence regarding the efficacy of CCSM and CCSM support for improving health outcomes for various conditions, and its use within various PHC professions (Department of Health Australia 2007). The World Health Organization (WHO) recently identified a range of competencies required to deliver effective care for those with chronic conditions, including patient-centred care and partnering and adopting a public health perspective. Empowering individuals towards adopting self-management strategies, where appropriate, features significantly in these competencies (World Health Organization 2005a). Yet, many health professionals continue to find it difficult to provide truly patient-centred care. Many claim to do so yet merely serve the rhetoric of their organizations, and others openly deny the person's collaborative involvement in the process. Paterson and Hopgood (Battersby et al. in press) discuss this phenomenon in the context of the rise of 'healthism', especially within Western neoliberal economies. Individual behaviour, attitudes and emotions are viewed as factors that need attention in order to realize health. Solutions to preventing or managing illness are perceived to lie in the realm of individual choice. Within this view,

personal responsibility is paramount. Behaviours, attitudes and emotions are medicalized and people become morally accountable for their health choices and are at risk of being blamed and stigmatized for their choices. The wholesale, arguably simplistic, adoption of the Stages of Change model (Prochaska and DiClemente 1983) by health professionals, in the absence of critical analysis, has done little to alleviate this problem. Our understanding of 'precontemplation' (that is, those not thinking of change at this stage) continues to be little understood and yet it is at the heart of understanding why people do not change despite often clearly displaying poor health choices. And people deemed to be in this group are not the minority of our clients; they often clog our health systems and disproportionately use service resources. The Stages of Change model has been criticized on a number of fronts (West 2005). Largely, it fails to acknowledge the social determinants of health that need to be understood in order to understand the problem from the person's perspective and why compliance and adherence to health professionals' advice is such a problem. We are repeatedly drawn back to asking whose agenda is ultimately being considered and is the person genuinely engaged in the first place.

Education and training of PHC professionals is influenced by many factors, including location, population profiles and contexts, government policies, healthcare trends, organizational needs and professional requirements. Opportunities and constraints for training arise from organizational factors such as their vision, values and strategic directions, which influence the structure and culture of the organization and its service objectives. These factors may encourage or inhibit changes in the overall practice of health professionals and expectations of consumers about the service. Informed, engaged, patients need proactive practice teams and agencies that together need collaborative social, economic and political systems to address the social determinants of health through effective education and training systems, resource management and social policy. Yet, arguably, the needs of service consumers are a common thread through all health service organizations regardless of how we may try to shape them to fit our service entry requirements, diagnostic criteria and boundaries. Consumers should not be made to navigate through each service receiving largely fragmented and superficial support and understanding of their needs. Rather, we professionals could do more to come together with the person and one another to know how we each contribute to the larger picture of care for the person. Much of this skill and knowledge can be seen implicitly in what we call practice experience.

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The primary health care workforce skills project

The work was undertaken in five stages from June 2007 to January 2008. The first two stages involved establishing a national reference group to guide the work and undertaking an extensive literature review to guide the construction and parameters for surveys and other data collection tools. The latter three stages produced the findings for the project. They included an electronic survey of the national PHC workforce to assess their training needs in this area, an audit of existing training programmes in this regard, focus groups across the PHC sector, and a gaps analysis, involving the national reference group and a national stakeholder workshop to test, refine and validate recommendations that emerged from data analysis. Reference group members and stakeholders included representatives of national peak bodies representing relevant primary healthcare professionals (such as nursing, physiotherapy, occupational therapy, dietetics, diabetes education, medicine, general practice, psychology, pharmacy, exercise physiology), experts in continuing professional development and delivery, experts in chronic condition prevention and self-management, consumer and carer peak organizations, and Department of Health and Ageing and state government representatives. Details of methods used can be found elsewhere (Lawn et al. 2009).

Based on a multifaceted research strategy of online and mailed surveys to the workforce and training organizations, focus groups and key informant interviews with a broad range of stakeholders, the PHC workforce project identified a broad range of training needs specific to CCPSM support. These are presented with a caveat. Of the more than 120,000 primary health professionals in Australia and of the 83,000 who were within the scope of the project, those who responded (1,168 to PHC workforce survey and 73 in focus groups) represent a limited and potentially biased sample, skewed towards those who are aware of and have participated in CCPSM support training. Survey respondents were also largely nurses and allied health professionals. General Practitioners (GPs) were engaged largely through focus groups, given their poor response to the online survey. However, given this bias towards those with some awareness of CCPSM support, the argument becomes even stronger for potential needs and gaps in knowledge and skills within the overall PHC workforce. That is, issues and needs that are identified for these participants will equally hold for others; arguably even more so.

The needs assessment and subsequent gaps analysis that considered all data sources from the project found that:

- There is an overall lack of understanding, competence and practice of CCPSM support among PHC professionals.
- Translation of training into practice is a major problem and more quality control of training programmes is needed.
- The PHC workforce appears not to have the full set of skills needed to support consumers' behaviour change and, in particular, the workforce needs more psychosocial skills and understanding.

The needs assessment also found that, although a prescriptive approach to healthcare delivery still tends to dominate practice, the workforce is keen to develop more skills in behaviour change techniques and to undertake more multidisciplinary training that is translatable to practice.

Interestingly, in their perception of receiving services, consumers and carers reported that health professionals:

- Often do not listen or ask the patient their views or perspectives
- Often have little knowledge of community resources available to support the person, largely because they continue to work within their own narrow frame of reference and service provision
- Rarely work from a position of identifying consumers' strengths and current capacities
- Need to be more collaborative with consumers, carers and particularly each other.

Consumer-driven training and more involvement overall was endorsed as needed, from accreditation through to development, delivery and evaluation of training and education.

What these broad findings tell us is that there is a significant discrepancy between the content and quality of what health service providers perceive they are providing and what service users experience as recipients of support from health services. Little wonder that we have such challenges with compliance and adherence to health professionals' advice.

The PHC workforce appears not to have the full set of skills needed to support consumers' behaviour change. This is perceived by their responses to the workforce training needs (see Table 9.1) survey in which they were asked to rate the usefulness of a range of core elements of training known to be essential for supporting behaviour change, as determined by an extensive literature review of existing evidence. Their responses indicate that there is still a substantial percentage of the PHC workforce that do not realize that these elements are essential to the process, despite the evidence. This was also reiterated in focus groups. It is also unclear if, how and in what context the PHC workforce integrates what it has learned and applies it effectively to the field, post training. An example of this is whether they are integrating motivational interviewing and stages of change by recognizing that one

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Table 9.1 The percentage of health professionals reporting on the usefulness of prevention and CCSM training topics

Topic area	Not useful				Very useful	Not useful				Very useful
Health promotion approaches	1.0	10.7	31.4	30.8	26.0	1.6	11.9	32.8	30.2	23.4
Communication skills	.9	7.2	18.3	34.7	39.0	.8	5.3	20.6	33.8	39.5
Stages of change	1.0	7.7	20.1	34.7	36.5	1.0	8.0	20.5	34.5	36.1
Motivational interviewing	2.2	7.4	19.2	29.5	41.7	2.2	6.5	16.9	31.4	43.1
Assessment of risk factors	.4	5.9	22.7	34.6	36.4	1.0	6.5	22.9	35.6	34.0
Assessment of self-management capacity	.9	7.8	23.5	33.6	34.1	1.1	4.7	21.5	33.5	39.3
Goal setting	.9	4.7	18.1	33.8	42.5	.5	4.2	19.2	31.3	44.7
Structured problem solving	.9	6.6	28.4	33.3	30.8	1.3	6.3	26.8	31.5	34.2
Behavioural techniques	1.1	9.1	27.5	34.8	27.5	1.3	8.5	25.8	33.9	30.5
Working in multidisciplinary teams	.8	5.4	20.1	32.7	41.0	.9	6.4	20.8	31.6	40.3
Electronic recall systems	8.0	17.2	31.9	26.4	16.6	7.5	19.0	39.1	18.4	16.1
Organizational change techniques	6.7	14.6	39.8	26.4	12.6	6.6	23.0	34.6	21.4	14.4
Health coaching	3.3	9.6	28.1	26.2	32.8	3.7	10.8	29.3	26.9	29.3
Evidence based guidelines	1.2	8.9	21.6	29.4	38.9	.2	9.9	26.0	29.4	34.5
Conducting practice based research	3.5	17.0	28.5	26.5	24.5	3.2	15.5	29.0	29.0	23.3
Use of peer support	1.8	12.2	25.0	34.7	26.3	1.2	11.0	26.4	35.4	25.9
Cultural awareness	1.8	12.3	25.9	32.1	27.9	1.5	13.2	26.2	32.3	26.7

facilitates the other, rather than learning about them in isolation from each other and therefore perceiving them as separate entities or skill sets. The quality of this integration of concepts is also not clear from the survey of training organizations.

Likewise, training organizations gave mixed and concerning responses when asked about the coverage of these important core elements of CCPSM support within their CCPSM training. For example, approximately one-third of training providers reported that assessment of self-management capacity is covered only some, minimally or none of the time. Likewise, 25.7 per cent of training in CCSM does not cover motivational interviewing at all and 79 per cent of training provides some, minimal or no coverage of health coaching.

Cultural awareness and competence in culturally sensitive practice appears to be largely neglected as a priority by both the workforce and training organizations. In focus groups it was only discussed when facilitators were proactive in raising it within the larger discussion.

In general, participants believed that it would be difficult to implement CCPSM support into their practice without support from professional bodies and requisite organizational change. Despite these barriers, the importance of an interdisciplinary approach to CCPSM support was recognized by participants. They stated that it would motivate them to participate in training programmes, enabling them to effectively implement CCPSM into their current practice.

Training content

There was an overall consensus that current training programmes were limited in their scope, focus and longevity. Although current programmes provide solid theoretical background and are effective for mainstream and well-functioning individuals, participants believed that they had limited suitability for other populations due to the lack of recognition of psychosocial factors and social determinants of health generally. Current training programmes appeared to have limited practitioner focus in that they lacked directive guidelines to inform professionals how to meet the specific needs of the patient in practice. Identified opportunities in current training models included emphasis on interdisciplinary support and shared respect between health professionals. The main areas of training requested by at least one-third of participants were structured problem solving, health promotion approaches, behaviour change techniques, assessment of self-management capacity, health coaching, and dealing with symptoms of anxiety and depression. These preferences were part of, and in addition to, a number of broader training needs identified as follows:

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- Interdisciplinary knowledge and collaboration. Health professionals need to be encouraged to 'break down the professional barriers'. They are perceived to be inflexible and territorial and often are not trained to consider issues that are beyond their primary focus.
- Flexibility to allow for patient-specific variables. This involves acknowledging that a spectrum of self-management support is needed that clearly matches the stage of self-management activation the person is at. Central to this is educating health professionals about assessment skills in order to ascertain the most important strategies for the client using 'a best practice guidelines pathway' focusing on the processes taken with the client.
- Review of professionally defined roles of health professions, with consumer engagement, self-management support and inter-professional practice expectations beginning at training, whether it is university or institution delivered.
- Consideration of language. The terminology used is very important and needs to be more positively framed. The word 'chronic' held negative connotations for many participants.

Training characteristics

A number of needs and recommendations arose from the data:

- Continued training is needed to enable effective and sustained transfer into practice, and to provide feedback to training providers so that programmes can regularly be modified and developed.
- Multimodal delivery is seen as particularly important for health professionals in rural or remote regions who face difficulties in accessing training programmes due to distance, limited resources and lack of commitment from organizational management (for example, more CD- or DVD-based resource systems and e-learning platforms).
- A systematic approach to training with some form of oversight by government would be preferred.
- Training programmes would most effectively be delivered through educational providers as they have 'the engine room to do this and do it all day long'.
- The lack of a central source of information that enables health professionals to locate other services.
- The development of networks in practice education and training, including an online database, online discussion forums, peer supervision groups, and libraries and community centres set up to support health professionals to access resources.

- The importance of interdisciplinary training opportunities as well as the need for discipline-specific groups that are tailored to each profession, including appropriateness for different levels of competencies and using discipline-specific examples.
- Training should be largely interactive and experiential, to assist with engaging the health professionals and to enhance transfer from training into practice.

Particular needs were identified for GP practices with recommendations that workforce training be:

- Directed at the whole of practice, with a particular focus on skills development for practice nurses and Aboriginal health workers and with information directed at General Practitioners (GPs) and community pharmacists to ensure their support and understanding
- Delivered locally, after hours, offered more than once, and with ongoing support to embed learning
- Scheduled to avoid clashing with other major training initiatives
- Free or of low cost
- Offered in alternative formats such as one-on-one, small group and online to account for different access requirements.

Audit of CCPSM training to the PHC workforce

A survey of training organizations was undertaken to complement the information received from other methodologies. This survey produced responses of 57 providers of training covering 76 different courses. Participants were asked whether the training they deliver covers various aspects of chronic condition prevention and self-management support, rating each on a scale of 1 (none) to 5 (extensive).

The overwhelming mode of delivery of training was by workshop and the majority of training was delivered over two days and away from the practice field. By contrast, this length and style of training may be a barrier to access, given the workforce have clearly indicated that they do not always have time, financial resources or management commitment for other staff to be available to backfill their positions whilst they attend training.

Goal setting and structured problem solving are relatively straightforward to teach. However, it is how they are incorporated and integrated into overall course objectives that is important. It is not possible to determine from survey responses whether these skills are integrated into training courses or are provided as an addition to training with little integration into the overall needs of people receiving support. Similar concerns exist for how the Stages

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of Change model is incorporated into training and whether it is taught as a distinct model in isolation or integrated with an understanding of other skills, such as motivational interviewing and an understanding of the social determinants of health that may influence if and how consumers engage with services in the first place.

The extent to which training is translated into practice is also unclear, given the overwhelming identification by the workforce and key informants of problems with this for most available training. These views contrast with the self-reported responses of training providers: 63.2 per cent selected a 4 or 5 when asked to what extent their prevention training covers 'translating training into practice' and 65.4 per cent selected a 4 or 5 for self-management training. Discussing translation into practice in a training session may well be different and less effective than giving people practical tools for implementation into practice.

Areas reported to be well covered included:

- Communication skills (contrary to the feedback from consumers and carers)
- Goal setting
- Structured problem solving
- Use of evidence-based guidelines
- Working in a multidisciplinary team
- Translation of training into practice.

Training in practice-based research was reported as receiving poor coverage by most providers, with approximately 75 per cent of providers covering this aspect between 'some' of the time and 'not at all'. Given the importance of innovation and uptake by the field, we suggest that this needs increased emphasis in view of the role the field plays in the development and then the translation of evidence-based guidelines into practice. Focus on multidisciplinary work was better for training in CCSM support than for prevention training; however, that it is arguably of greater importance for the management of complex and often multiple chronic conditions also suggests room for improvement in building this component of training.

A range of effective adult learning principles are being applied as part of the delivery of training to the PHC workforce. Small group learning is the dominant learning format. Other commonly reported approaches included:

- Didactic presentations
- Case studies
- Skills rehearsal/role plays
- Evidence for CCSM support

- Resources to assist implementation of training, for example, worksheets, tools.

Case studies are being used extensively in training. However, no information is available as to their relevance to the specific groups receiving training or whether there is any capacity for case studies to be tailored to different locations, professions, conditions or contexts, or special needs groups. Table 9.2 details training organizations' responses to a range of approaches determined to be important from a review of existing literature of the variables that constitute best practice in training for this area.

Table 9.2 Does your training use the following approaches?

Type of training approach	Responses		
Didactic presentations	Not at all – 1	2	4.1
	2	2	4.1
	Some – 3	23	46.9
	4	14	28.6
	Extensively – 5	8	16.3
Problem-based learning	Not at all – 1	1	1.9
	2	5	9.6
	Some – 3	18	34.6
	4	20	38.5
	Extensively – 5	8	15.4
Small group learning	Not at all – 1	2	4.0
	2	3	6.0
	Some – 3	13	26.0
	4	15	30.0
	Extensively – 5	17	34.0
Case studies	Not at all – 1	6	12.0
	2	4	8.0
	Some – 3	12	24.0
	4	17	34.0
	Extensively – 5	11	22.0
Skills rehearsal/role plays	Not at all – 1	8	15.7
	2	3	5.9
	Some – 3	12	23.5
	4	14	27.5
	Extensively – 5	14	27.5

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Table 9.2 cont'd

Type of training approach	Responses		
Workplace training	Not at all – 1	16	32.0
	2	7	14.0
	Some – 3	11	22.0
	4	10	20.0
	Extensively – 5	6	12.0
Academic detailing	Not at all – 1	24	52.2
	2	6	13.0
	Some – 3	5	10.9
	4	9	19.6
	Extensively – 5	2	4.3
Evidence for prevention	Not at all – 1	6	12.2
	2	4	8.2
	Some – 3	15	30.6
	4	15	30.6
	Extensively – 5	9	18.4
Evidence for CCSM	Not at all – 1	6	12.2
	2	4	8.2
	Some – 3	9	18.4
	4	16	32.7
	Extensively – 5	14	28.6
Follow-up by trainers	Not at all – 1	11	22.4
	2	6	12.2
	Some – 3	13	26.5
	4	15	30.6
	Extensively – 5	4	8.2
Resources to assist implementation of training e.g. worksheets, tools	Not at all – 1	6	12.8
	2	1	2.1
	Some – 3	21	44.7
	4	5	10.6
	Extensively – 5	14	29.8
Other e.g. manuals, DVDs, CDs, website, newsletter	Not at all – 1	5	55.6
	2	0	0.0
	Some – 3	0	0.0
	4	1	11.1
	Extensively – 5	3	33.3

National stakeholder workshop

The project consortium convened a national stakeholder workshop in Melbourne in December 2007 to test, refine and validate recommendations that emerged from the analysis of data collection undertaken with the PHC workforce and training organizations. The 40 workshop participants from nursing, allied health and medical professional organizations, training and accreditation organizations, consumer and carer advocacy groups, and Commonwealth, State and Territory governments were provided with a brief summary of findings from the data collection stages of the project and asked for their comments. This discussion document summarized the findings of the literature review and consultation process and the 19 recommended areas of knowledge and skills arising (see Table 9.3) from these processes. Workshop participants were then asked to consider the 19 core skills identified from the project as part of their group discussions. A series of case studies were also developed by the consortium and used to provide structure and context for the conversations. A variety of scenarios were deliberately chosen that could match the needs and interests of each discussion table, with a series of prompt questions used to support group discussions.

The skills deemed by consumers to be necessary core aspects of all training for health professionals, as determined by the existing literature, focus group and key informant interviews included:

- Interviewing skills
- Assessment of consumers' needs
- More person-centred approaches
- Communication skills
- Collaboration with consumers and acknowledging their self-management role
- Raising issues ('learn how to ask')
- Developing rapport
- Understanding stages of change
- Goal-setting
- Understanding how to use community resources more effectively
- Helping consumers navigate the system
- Identifying consumers' strengths and supporting self-efficacy
- Meeting culturally and linguistically diverse (CALD) groups' needs and delivering culturally appropriate practice.

Workshop participants supported all 19 core skills. They were unanimous that knowledge and values supporting CCPSM should be the same for all;

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however, it is the skill levels and emphases that may vary by profession, location and context. Examples of this are:

- Organizational change techniques that include business model skills will be important for GPs, practice nurses, and private providers, but may not be as important for PHC workers in other settings. However, understanding how to conduct and be part of Plan, Do, Study, Act (PDSA) cycles will be relevant to all as part of team approaches to organizational change.
- Personal trainers and others in the broader 'health and well-being' industry sector on the periphery of formal healthcare provision will also need skills in CCPSM, especially considering their role and opportunity in prevention. Concern that they generally target white collar groups in the community may mean that they need more skills in health promotion approaches and the social determinants of health that underlie them, with implications for improving access to their services by the lower socioeconomic groups in the community.

Table 9.3 Core skills for the PHC workforce

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

In summary, workshop participants confirmed that all health professionals need to:

- Communicate a clear assessment of the person's health risks and be able to perform a holistic assessment of needs, strengths, capacities, and goals
- Understand the pathology of disease and life stages and varying impacts on the person at different stages. This will include understanding influences on the person's capacity or willingness to change their behaviour and recognition that one size will not fit all, for example, CALD and Indigenous influences.
- Understand core principles of self-management and prevention, including the benefits of these and what they involve. This must include the need for a clear rationale for CCSM and the health professional's place within it, as well as what is in it for them.
- 'Walk the talk' as part of deconstructing the power relationship/differential between 'professional' and 'patient, that is, be aware that this relationship can be inherent in the process of help-seeking, and take active steps to acknowledge it and minimize its impact on the engagement and treatment process.
- Have effective communication skills and family and carer involvement skills that acknowledge the 'team' as also involving carers and other informal supports.
- Understand that multidisciplinary team skills mean understanding the role and function of all members. Multidisciplinary understanding also needs to be understood in the broader sense of being across systems, sectors and agencies, not just within organizations.

In order for these core skills to be acknowledged by health professionals, workshop participants concluded that:

- Endorsement of these skills will require the support and leadership of professional bodies
- Core skills will need to be integrated with each other as part of delivery of training
- Community education regarding self-management will be necessary to raise awareness among recipients of CCPSM support
- Core skills will need to be defined by consumer needs, that is, CCPSM core skills should not be considered by individual professions; it is role and context that determine what skills are needed
- Management will have a pivotal role in initiating, driving and sustaining change. An organizational response that covers structural aspects must also be included. Managers must clearly understand the benefits of CCPSM

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- Consumers are integral to the success of training and should be involved in the development, delivery, evaluation and accreditation of training.

Training delivery

In summary, workshop participants confirmed that training providers need to ensure:

- Multiple modes for delivery of training to ensure accessibility for the widest possible group of PHC professionals
- Training is delivered in modules, over time, in several sessions so that skills are delivered in a manageable manner, and with proper support mechanisms and follow-up to allow for reflection and practicing of skills during the training process
- Different levels of training are offered for different people both within and across different professions, some highly skilled, others with only basic skills and awareness
- Consideration about how training is joined up with existing programmes (otherwise a 'Rolls Royce' course that nobody comes to could eventuate)
- That they address issues for training delivery to GPs and allied health together, given that Divisions of General Practice are not funded to deliver to other professions
- Involvement by consumers to help drive training, with increased support given to consumer bodies and use of networks
- That they engage with employers and managers who need to be involved, convinced and committed to training delivery
- Consideration of specific PHC workforce groups, for example, Aboriginal Health Workers in remote areas who may not want to leave their communities to attend training and for whom online learning is problematic
- Accountability to the field, including greater scrutiny of the content of training via improved evaluation of its impact on the workforce in their attempts to translate what they learn in training to their practice. It also considers the need for a continuum of skills transfer from undergraduate training to practice to address organizational cultural barriers to CCPSM practice.

Recommendations

The National Reference Group confirmed the recommendations of an earlier consultation (Martin et al. 2007) undertaken in August 2007 with 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 recognized relevant expertise in the application of a variety of self-management approaches in clinical and community settings in Australia
- Representatives from a range of States and Territories across Australia.

These representatives developed a vision and philosophy to underpin self-management capabilities of the future and existing primary healthcare workforce. They emphasized that all Australians with chronic conditions and their carers should receive care from health professionals competent in providing self-management support.

Core principles

Adoption of the following principles is recommended by representatives from both national reference groups to ensure a seamless transition from the student experience of CCSM to practice by health professionals in the field and the culture of health organizations. The core principles are:

1. All PHC professionals will be competent in supporting people to maintain wellness and prevent the development of chronic conditions, identify and mitigate the effects of risk factors on the development of chronic conditions, and self-manage their existing chronic condition(s).
2. Health professional education will ensure that the workforce are equipped to:
   - Conduct their practice so that the person receiving support and their carers are central to the process of care, ensuring they feel

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understood, valued and involved in efforts to support their self-management
- Work in interprofessional teams that support chronic condition prevention and self-management
- Understand and base their chronic condition prevention and self-management support on the bio-psychosocial, cultural and economic context of the person and their carers.

Operational principles

The operational principles to develop strategies to achieve the above include:

1. Consumers' involvement in the design, conduct and evaluation of chronic condition prevention and self-management support training
2. Agreed national prevention and chronic condition self-management definitions and terms
3. Exposure of PHC workers to a range of self-management models that support consumer education and behaviour change
4. Understanding by workers of the influence of the healthcare system on CCPSM
5. CCPSM support training incorporating interprofessional learning
6. Worker learning of CCPSM support in interprofessional practice settings
7. Identified individuals competent in CCPSM support to champion development and delivery of CCPSM support training
8. CCPSM support training integrated across the career of PHC workers, with opportunities for further development of skills and specialization beyond the generic training offered to all PHC workers
9. Explicitly assessment of CCPSM support competencies
10. Evaluation of the effectiveness of CCPSM support training according to effectiveness of translation to practice and outcomes for patients/consumers and carers.

The following key areas are seen as priorities for improving the skills base of PHC health professionals in the area of CCPSM support:

- Shared/consistent definitions of prevention and CCSM and a conceptual framework to provide an overall vision for implementation (Royal Australian College of General Practitioners [RACGP] 2006, Greenhalgh et al. 2004, Zapka et al. 2003, Best et al. 2003b)
- Understanding the inherent relationship between prevention and CCSM as part of a population health/public health approach that recognizes and incorporates the social determinants of health (WHO 2005b, RACGP 2005, Fraser 2005, WHO 2003)
- Patient education and communication techniques and tools that more collaboratively involve the person in planning, decision making and activities to promote better self-management (Marshal et al. 2005, Lorig and Holman 2003, Martin et al. 2004, RACGP 2006)
- Training that supports a cultural, philosophical and organizational shift towards placing the person at the centre of the collaborative care process, with an emphasis on inclusion, participation, quality of life and well-being for the person (Hibbard 2003, Lewin et al. 2001)
- Effective techniques to support behaviour change by the person that incorporate an understanding of self-efficacy, motivation, stages of change, effective problem solving, reasons for non-compliance/adherence, goal setting, support systems and management of negative affect (Taylor and Bury 2007, Marks et al. 2005a, 2005b, Warsi et al. 2004)
- Recognition of the benefits of peer support (Copeland 2006, Deegan 2006, Glover 2005, Lawn et al. 2008)
- Understanding of organizational change and the need for a supportive organizational infrastructure to support implementation (Litt 2007, RACGP 2006)
- Multidisciplinary teamwork
- Maximizing information technology to underpin chronic disease prevention and self-management (Jimbo et al. 2006, Chaudhry et al. 2006, Wofford et al. 2005, Kawamoto et al. 2005, Bodenheimer and Grumbach 2003)
- Effective use of existing evidence-based guidelines and resources to support clinical decision making and planning of service delivery, including MBS items for prevention and CCSM (RACGP 2006, Buchan 2004, Grimshaw et al. 2004)
- Skills to support people with specific needs (for example, people with mental illness, young people, ATSI populations, and people with drug addictions) (Marmot 2005, Will et al. 2004, Health Inequalities Research Collaboration (HIRC) Primary Health Care Network 2004, Lawn et al. 2007)
- Effective use of other community resources, both formal and informal. (RACGP 2006, Flocke et al. 2006, Prilleltensky 2005, Glasgow et al. 2004, Bodenheimer et al. 2002).

This project has identified the core skills, knowledge and values underpinning health professional practice in general, not just in relation to CCPSM support. The process has also defined the core principles, components and practices of person-centred care. It also defined the issue in relation to training and integration of these skills into practice.

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Appendix: Definitions of core skills for self-management support

Person-centred skills	Definition
1. Health promotion approaches	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, mobilize resources and develop action plans for addressing problems they have collectively identified (Smith 2005).
2. Assessment of health risk factors	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 (Royal Australian College of General Practitioners 2006).
3. Communication skills	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.
4. Assessment of self-management capacity	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).

5. Collaborative care planning	The process in which all those involved in the organizing, 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).
6. Use of peer support (within chronic condition self-management context)	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 organization or setting in which they are utilized are important (Solomon 2004).
7. Cultural awareness/ interpreter service utilization	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.
8. Psychosocial assessment and support skills/ skills enhancement	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).

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Behaviour change skills	Definition
9. Models of health behaviour change	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: Health Belief Model (Pender et al. 2006); Theory of Reasoned Action and Theory of Planned Behaviour (Pender et al. 2006); Social Learning Theory (Bandura 1977); Transtheoretical (Stages of Change) Model (Prochaska and DiClemente 1983, Prochaska and Velicer 1997); Relapse Prevention Model (Miller and Rollnick 1991); Health Promotion Model (Pender et al. 2006); 5As Model (Glasgow et al. 2003); and Cognitive Behavioural Therapy (British Association of Behavioural and Cognitive Psychotherapies 2005).
10. Motivational Interviewing	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 five 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 and Rollnick 1991).
11. Collaborative problem definition	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).
12. Goal setting and action planning	The process of deciding on what one wants, planning how to get it, and then working towards the objective of achieving it, usually by ensuring that it is SMART (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 and Latham 1990).
13. Structured problem solving	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).

Organizational/ systems skills	Definition
14. Working in multidisciplinary teams/inter-professional learning and practice	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 recognizing and actively engaging service providers across systems, sectors and agencies, not just within organizations. 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' (Jessup 2007, Braithwaite and Travaglia 2005).
15. Information, assessment and communication management systems	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 et al. 1996).
16. Organizational change techniques	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 organizational structure, culture and models of change, group behaviour and values. The Plan, Do, Study, Act (PDSA) cycle is one mechanism for mobilizing staff for incremental organizational change (Johnson and Paton 2007).

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Organizational/ systems skills	Definition
17. Use of evidence-based knowledge	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 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.
18. Conducting practice based research/quality improvement framework	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 utilization, 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).
19. Awareness of community resources	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).

10 Knowledge and reasoning in practice: an example from physiotherapy and occupational therapy

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Introduction

In this chapter we describe the nature and sources of knowledge used by physiotherapists and occupational therapists in their daily clinical work. We have chosen to integrate our discussion of knowledge with a discussion of clinical reasoning reflecting the current understanding that knowledge and reasoning are inherently related in clinical practice (Higgs and Jones 2008). To illustrate the nature of knowledge and clinical reasoning used by these caring professions, we present an example of a client following a stroke. We conclude that the knowledge and reasoning processes used by these professions include shared and distinctive elements reflecting a close relationship between two professions that maintain defined and separate roles in health practice.

Physiotherapy (or physical therapy) is a healthcare profession which focuses on the restoration of movement. The World Confederation of Physical Therapists (WCPT) has defined physiotherapy in the following manner.

> Physical therapy provides services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. This includes providing services in circumstances where movement and function are threatened by ageing, injury, disease or environmental factors. Functional movement is central to what it means to be healthy.
>
> Physical therapy is concerned with identifying and maximising quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation. This encompasses physical, psychological, emotional, and social well being. Physical therapy involves the interaction between physical therapist, patients/clients, other health professionals, families, care givers, and communities in a process where