Chronic Condition Prevention & Self-management (CCPSM)

You may be familiar with the term 'chronic disease self-management' (CDSM). More recently the word 'disease' has become 'condition' to include disability (CCSM). Self-management is the day to day decisions a person with a chronic condition makes about their health. Ideally the 'patient' is the expert in their condition, accepts responsibility for their health, problem solves and works in a collaborative partnership with health professionals to optimise their health. Self-management is supported in a social, holistic model of health not the medical model of the acute care sector. A patient can learn skills to improve their self-management, often as part of a care planning process with goals set by the patient.

The need for CCSM is growing. At the moment 60 % of the global disease burden is attributed to chronic conditions and this is expected to rise to 80 % in 2020 as the world's population ages (WHO, 2002). This is placing pressure on health care systems that are not designed for long term care 'pos[ing] a threat to all countries from a health and economic standpoint' (WHO, 2002, p 6). To be economically viable health systems will need to change from an acute care model to one that supports self-management. In response to this Australia released a National Chronic Disease Strategy (NCDS) with key action areas to be implemented including self-management and condition prevention (NHPAC, 2006).

How prevention programs can help

Evidence shows that Chronic Condition Management is applicable to prevention of illness and 'can be used as a blueprint' in the delivery of preventative services (Glasgow et al, 2001, p 603). CCPSM support is defined as what is done to assist the person to manage their condition across a continuum covering prevention of illness, disease progression, and complications and disability from an existing chronic condition (Lawn et al, 2009, p 39).

Research in the USA to make the nation healthier has shown even small reductions in unhealthy behaviours can reduce health care costs (Woolf, Glasgow et al, 2005, S26). Research reviewing Australian projects supports this arguing the most effective management of chronic conditions is to

'manage the antecedents to it' and sees community based programs 'that help people to manage their lives before the lack of life management lands then in the acute sector' as a key solution to rising health costs (Harvey , 2003, p 106).

Does other research support CCPSM?

Glasgow et al (2001, p 602) state the 'community resources' component is 'especially important' as more preventative interventions happen 'outside of the clinical setting'.

In the World Health Organization's 'Innovative Care for Chronic Conditions' (ICCC) framework 'community partners' are one part of the centre triad alongside the 'health care team' and 'patient and family' (WHO, 2002, p 46). The community role includes mobilising and coordinating services and providing complementary services (WHO, 2002, p 46).

Evaluation of coordinated care trials in Australia has shown more action is needed for community based education and support programs particularly for addressing lifestyle issues for chronic condition prevention (Harvey, 2003, pp 106-107).) A review of Australian demonstration projects also noted that the most effective engagement with clients in self-management models occurred where there was a supportive community network (Francis, 2007).

Who can provide CCPSM support?

Self-management support can be provided in primary care by diverse providers including health professionals and well trained laypersons with clearly defined roles (Battersby et al, 2010, p 564). The steps to a healthier US cooperative agreement described 'working with faith communities to train lay educators in health promotion' as part of the comprehensive approach (Woolf et al, 2005, S26).

How does this fit with the AFCNA?

Faith community nursing 'is a model of care that uses nurses based within faith communities' (McGinnis and Zoske, 2008, p1). Their role is to provide culturally sensitive, wholistic health services to individuals, families and groups across the continuum of care from disease prevention to chronic disease management to end of life care including:

- health promotion
- referrals
- advocacy
- education
- case management
- facilitating support groups
- promoting healthy lifestyles
- helping with care management (McGinnis & Zoske, 2008; Van Loon, 2009).

The Australian Faith Community Nurses Association (AFCNA) says how '[m]any Australian faith communities/churches have the infrastructure and demographic spread to send important health messages and provide community based services that are culturally sensitive' (Van Loon, 2009).

CCPSM fits within the role of the FCN across the continuum of care from prevention to condition management. Faith Community Nursing happens outside of the clinic setting. FCNs can provide coordination of services. Faith communities can provide the supportive community network and

mobilise specifically trained volunteers. FCN and CCPSM. These acronyms have always belonged together, health research and literature are just catching on!

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