

# Care Plan Health Promotion Poster

## A Way of Reading and Learning Chronic Condition Self Management in Aboriginal Communities

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### Introduction

- Chronic Conditions (CC) are major health concerns
- Clinical and Self-Management is often difficult
- However, some clients are very successful
- Care Planning seems to be a key part

### Aim

- To develop health promotion posters that feature community members who successfully manage their CC.

### Working with Port Lincoln Aboriginal Health Service (PLAHS)

- With PLAHS staff we identified 3 clients with CC who are managing well ('self management stars').
- Each client has a care plan in which they set achievable goals.
- The Chronic Condition Management team at PLAHS help clients develop actions to meet their goals.
- Allied Health areas like dietetics, podiatry, smoking cessation, exercise and medication management are incorporated in care plans.
- We approached the 3 clients about putting their success stories on posters to encourage others to manage their CC better.

### Working with Self Management Stars

- Each client gave informed consent for use of their story and health data.
- Their goals were noted from the Care Plan.
- Quantitative data from clinical records were obtained and examined.
- Self Management Stars were interviewed to tell their story.
- We listened, read their transcribed interviews, matched clinical data (eg Point of Care test results) with the stories.



Isabel Richards



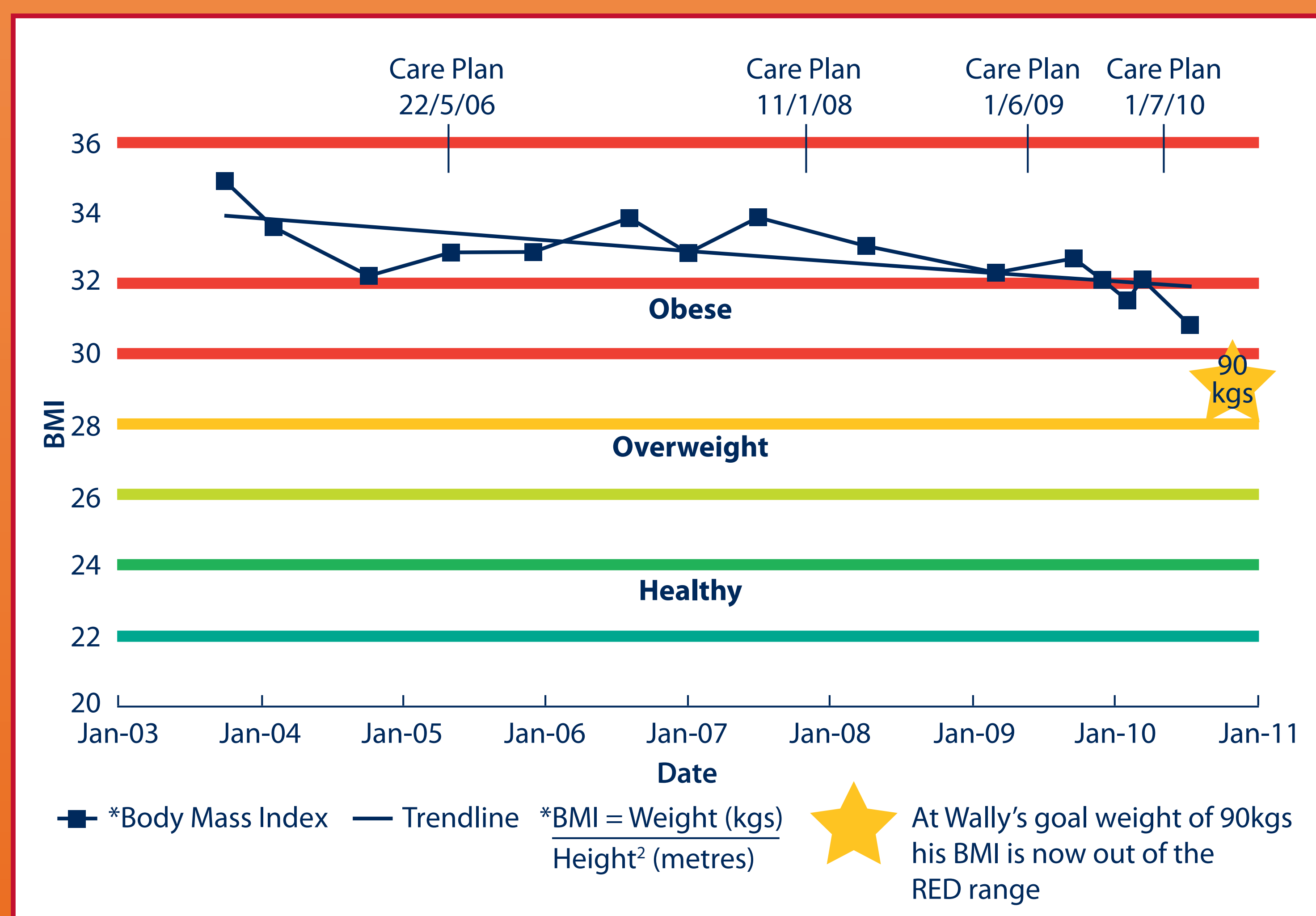
Wally Pickett



Jackie Stewart

### Developing meaningful charts

- The aim is to interpret individual client clinical data that are linked to their Care Plan goals so that they can understand the effect of their actions on health indicators (eg BMI).
- The example chart shows one client's clinical data (BMI) over time, and his goal. The chart uses a traffic light analogy on the background indicating progress against accepted BMI obesity risk levels.
- The chart was improved through crosschecks with the client and health worker.
- Further consultation with the client and health workers suggested charting other clinical indicators against the traffic light background also.
- These charts can help clients monitor progress towards their goal, and strengthen commitment to following their care plans.
- A range of health workers may also find the charts useful in engaging with clients
- All feedback received to date supports this innovative use of client health data.



### Developing the posters

- The voice of the client is what appeals; we started with their image and a quote.
- Underneath that we highlighted their main goals within a star shape.
- On the left side of the poster we outlined their CCs and goals.
- We used dot points to describe what the client said they had gained from their Care Plan.
- We included relevant facts to reinforce and offer another way of learning about the seriousness of CC.
- On the right of the poster we included a meaningful chart of clinical data over time.

**Chronic Condition Self Management Stars**  
Reaching for the stars through Care Planning with the PLAHS Chronic Condition Self Management Team

*'You can enjoy yourself even if you still got it, I'm a diabetic, and I can control it. I've got to look after myself, and Shirley looks after me. I look after her too'.*

**Wally's Story**  
Wally was diagnosed with Type II diabetes 10 years ago. His wife is also diabetic. They support each other to manage their chronic condition. His goals were to reach his target weight by the end of 2010 and to live better and longer. The support from Chronic Condition Self Management Team of Port Lincoln Aboriginal Health Service has helped him to achieve his goal.

**The care plan has helped Wally to:**

- Do things he couldn't do before
  - Travelling
  - Walking further
  - Sharing feelings
- Review his medication
- Organised and attend family gatherings
- Eat moderately - cut back on sweets
- Improve his circulation

**Wally's Goals are to:**

- Lose weight
- Live longer
- Be more active

**Wally's Achievements and Success**

- Insulin makes him feel better
- Can control weight
- Enjoys life more
- Has cut back on chocolate
- Feels blood circulation in feet

**Set Goals**  
**Feel Better**  
**Do More**

**Did you know that one third of Aboriginal people aged 55 and over live with high blood sugar levels or diabetes?**  
[http://www.healthinfocentre.sa.gov.au/health\\_facts/overweight](http://www.healthinfocentre.sa.gov.au/health_facts/overweight)

Background: portion of 'Journey', acrylic on canvas by Wally's daughter, Jenny Pickett. Image courtesy of Kuju Aboriginal Arts and Crafts, Port Lincoln

### Conclusion

- Care Plans appear to assist clients and health workers manage CC.
- We developed an innovative and meaningful way of charting clinical data to help clients and health workers manage CC.
- We developed health promotion posters to encourage Aboriginal people to get involved in managing their CC, based on real life success stories from community members.
- The posters will be placed in the waiting room and reception areas of Port Lincoln Aboriginal Health Service.

### Implications

This is an example of enhancing health literacy where people may be able to read and learn about health and wellbeing in several ways; their personal story, their improvement as evidenced in their clinical test results, in the translation of those aspects in an interpretive chart with a clearly understood analogy. The poster format can be adapted elsewhere in Australia and internationally, whether for this or almost any other topic for health promotion. As well as appealing to Aboriginal clients, this literacy approach may also be effective with migrant communities.



The research team

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