NURS2007 — CHRONIC DISEASE MANAGEMENT

# Nursing Management of Type 2 Diabetes Mellitus in the Australian Community Setting: Applying the Chronic Care Model

| WORD COUNT | ACADEMIC LEVEL | REFERENCING | CONTEXT |
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| ~1,500 Words | Distinction (70%+) | Harvard (Australian) | Australian Community Nursing |

INTRODUCTION

## Introduction

Chronic disease is the leading cause of death, disability, and preventable hospitalisation in Australia, accounting for approximately 87 per cent of all deaths and imposing a substantial burden on the health system and on individuals living with lifelong conditions (Australian Institute of Health and Welfare [AIHW], 2023). Type 2 diabetes mellitus (T2DM) is among the most prevalent of these conditions, affecting an estimated 1.3 million Australians and contributing to a cascade of serious complications including cardiovascular disease, chronic kidney disease, diabetic retinopathy, and lower-limb amputation (AIHW, 2023). The Australian Government's National Diabetes Strategy 2021–2030 (Australian Government Department of Health, 2021) identifies reducing the incidence, impact, and inequity of diabetes as a national health priority, recognising the registered nurse as a central figure in coordinating chronic disease management across community, primary, and hospital-based settings. Effective T2DM management is not achieved through episodic acute care but requires sustained, person-centred, evidence-based nursing support that addresses the clinical, behavioural, psychological, and social dimensions of living with a chronic condition. This essay examines the registered nurse's role in managing T2DM in the

Australian community setting through the fictitious case of Mr David Nguyen, applying the Chronic Care Model (CCM; Wagner et al., 2001), self-management support principles, motivational interviewing (Miller and Rollnick, 2013), and multidisciplinary collaboration, aligned with the Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (2016) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service Standards (NSQHS Standards; ACSQHC, 2023).

THEORETICAL FRAMEWORK

## The Chronic Care Model: A Framework for Community-Based Diabetes Nursing

The Chronic Care Model (CCM) provides the foundational conceptual framework for this analysis. Originally developed by Wagner and colleagues in response to the manifest limitations of acute-care-oriented health systems in addressing the complex, ongoing needs of people with chronic illness, the CCM identifies six interconnected elements essential to effective chronic disease management: self-management support, delivery system design, decision support, clinical information systems, health system organisation, and community resources and policies (Wagner et al., 2001). The model is predicated on achieving productive interactions between an informed, activated patient and a prepared, proactive practice team, with the ultimate aim of improved functional outcomes, reduced complications, and better quality of life (Bodenheimer et al., 2002). Critically, the CCM shifts clinical attention from disease management as something done to patients toward a collaborative partnership in which the patient's expertise in living with their condition is recognised and mobilised alongside the clinician's clinical knowledge.

In the Australian primary care context, the CCM directly underpins the architecture of the Medicare Benefits Schedule (MBS)-funded General Practitioner Management Plan (GPMP, MBS item 721) and Team Care Arrangement (TCA, MBS item 723), which formalise multidisciplinary care coordination for people with chronic conditions (Royal Australian College of General Practitioners [RACGP], 2022). Registered nurses working in community health, general practice nursing, and nurse practitioner roles are integral providers within this framework, contributing self-management education, care coordination, clinical monitoring, and health coaching, consistent with NMBA Standard 5 (develops, implements, and evaluates the plan for nursing practice; NMBA, 2016).

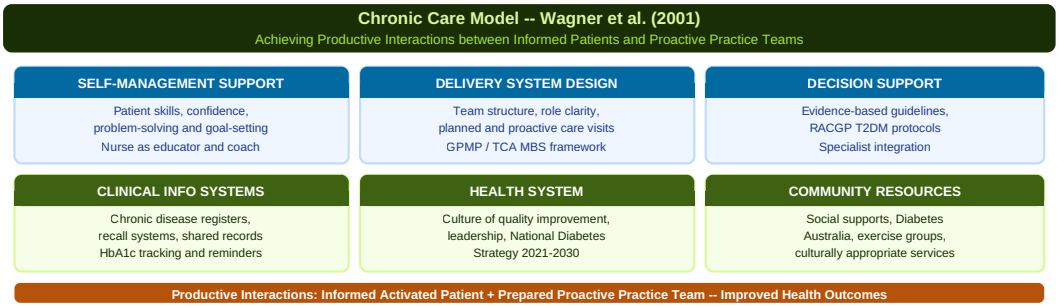


*Figure 1: Chronic Care Model (Wagner et al., 2001) applied to Type 2 Diabetes nursing in the Australian community setting. Six elements converge to enable productive interactions and improved outcomes.*

CLINICAL SCENARIO

## Clinical Scenario and Comprehensive Assessment: Mr David Nguyen

Mr David Nguyen (fictitious) is a 58-year-old Vietnamese-Australian male who was diagnosed with T2DM nine years ago. He is the owner-operator of a busy restaurant, regularly working in excess of 60 hours per week. He lives with his wife and two adult children and describes a diet rich in white rice, fried foods, and portion sizes reflecting his cultural food norms and the occupational temptations of working in hospitality. He reports minimal regular physical activity and acknowledges that he has "given up trying to manage" his blood glucose. His GP refers him to the community health nurse following persistently suboptimal glycaemic control and rising creatinine, with the goal of intensive self-management support.

### MR DAVID NGUYEN (FICTITIOUS) — REFERRAL ASSESSMENT PROFILE

The nurse notes Mr Nguyen describes feeling "overwhelmed and worn out" by his diabetes — consistent with **diabetes distress**, a clinically significant emotional burden distinct from clinical depression that affects up to 45 per cent of people with T2DM (RACGP, 2022). Key clinical and psychosocial parameters are summarised below.

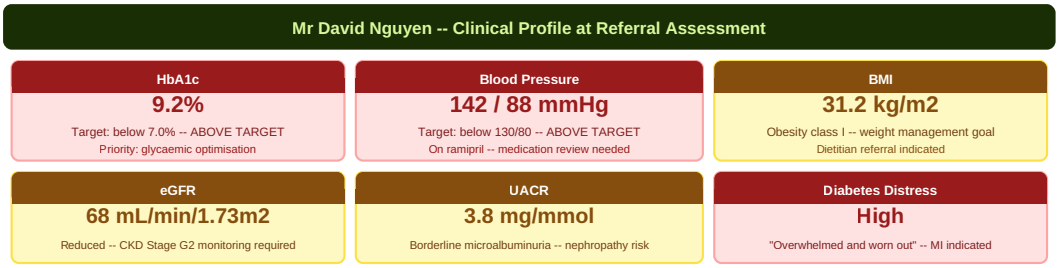


*Figure 2: Clinical assessment profile for Mr David Nguyen (fictitious) at community nurse referral. Red = above target / high priority; Amber = borderline / monitoring required. Guided by RACGP (2022) General Practice Management of Type 2 Diabetes.*

The community health nurse conducts a comprehensive biopsychosocial assessment aligned with NMBA Standard 4 (comprehensively assesses the needs of individuals; NMBA, 2016), examining not only clinical parameters but also the psychosocial, cultural, and structural determinants of Mr Nguyen's glycaemic control. The assessment confirms that Mr Nguyen's suboptimal HbA1c does not represent a knowledge deficit or deliberate non-adherence; rather, it reflects the complex interplay of long work hours reducing self-care time, culturally embedded food practices that are difficult to modify without family and social support, and diabetes distress that is eroding his motivation to engage with management. This distinction — between can't and won't, and between knowledge and capacity — is critical to designing effective nursing intervention and avoiding ineffective, repetitive disease education that does not address the actual barriers to self-management (Bodenheimer et al., 2002).

SELF-MANAGEMENT SUPPORT

## Self-Management Support and Motivational Interviewing

Self-management support is the first and most clinically impactful element of the CCM for people with T2DM in the community setting (Wagner et al., 2001). It encompasses far more than patient education: it involves equipping patients with the skills, self-efficacy, and practical strategies to manage the daily demands of their condition as informed and active participants in their own care (Bodenheimer et al., 2002). For Mr Nguyen, the nurse identifies three interrelated self-management domains requiring support: dietary behaviour (frequency of high-carbohydrate, calorie-dense foods given his restaurant context), physical activity (sedentary lifestyle compounded by exhausting work hours), and psychological self-management (diabetes distress reducing motivation and self-efficacy across all other domains).

Motivational Interviewing (MI) is the evidence-based communication approach that best addresses Mr Nguyen's presentation (Miller and Rollnick, 2013). MI is a collaborative, person-centred style of conversation designed to help people explore and resolve ambivalence about behaviour change. Rather than directing or advising the patient, MI invites the patient to articulate their own reasons for change, honours their autonomy, and recognises ambivalence as a normal rather than defiant response to the demands of chronic disease self-management (Miller and Rollnick, 2013). The nurse applies the four core MI micro-skills, collectively known as OARS: Open questions that invite reflection (“What worries you most about the direction your diabetes is heading?”); Affirmations that acknowledge the patient's strengths (“Despite working 60 hours a week, you've continued taking your medications consistently — that matters”); Reflective listening that demonstrates understanding without judgment; and Summarising that consolidates change talk and reinforces the patient's expressed motivations. Through this approach, Mr Nguyen articulates that his primary motivation for better diabetes management is fear of kidney failure affecting his ability to work, and that he feels most capable of change in the morning before the restaurant opens — information that directly shapes the SMART goal co-developed with the nurse.

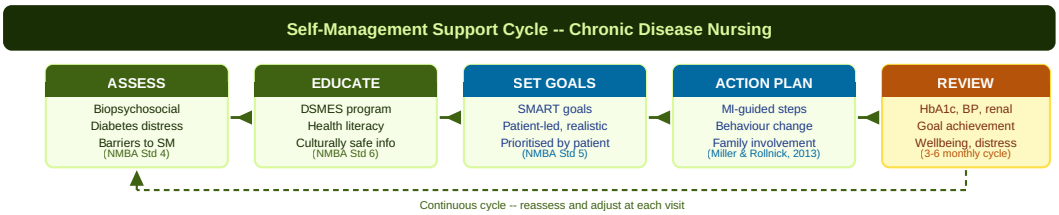


*Figure 3: Self-management support cycle for chronic disease nursing. Each phase is guided by the CCM (Wagner et al., 2001), motivational interviewing (Miller and Rollnick, 2013), and NMBA Standards for Practice (2016). The cycle repeats every 3-6 months aligned with the RACGP (2022) T2DM monitoring schedule.*

Using the MI process, the nurse and Mr Nguyen co-develop the first SMART goal: to walk for 30 minutes before the restaurant opens on three mornings per week for the next four weeks, leveraging the time he has identified as available and quiet. This modest, achievable starting point is deliberately calibrated to rebuild self-efficacy rather than imposing comprehensive lifestyle change simultaneously, consistent with the evidence base for SMART goal-setting in chronic disease self-management (Levett-Jones, 2023). Dietary change is deferred to the second nursing visit, at which time a credentialled dietitian's input will already be integrated. Health literacy is a critical cross-cutting consideration: the AIHW (2023) reports approximately 59 per cent of Australians have health literacy below that needed to navigate everyday health demands. For Mr Nguyen, whose primary language is Vietnamese, the nurse provides verbal information supported by diagrams, offers

Vietnamese-language diabetes resources, and confirms understanding at each interaction using the teach-back method, consistent with NMBA Standard 6 (provides safe, appropriate and responsive quality nursing practice; NMBA, 2016) and ACSQHC NSQHS Standard 2 (partnering with consumers; ACSQHC, 2023).

MULTIDISCIPLINARY CARE

## Multidisciplinary Care Coordination

The complexity of T2DM invariably requires coordinated input from multiple health professionals, and the community health nurse functions as both a direct care provider and a care coordinator within the GPMP/TCA framework (RACGP, 2022). For Mr Nguyen, the nurse collaborates with the GP to activate a TCA (MBS item 723), facilitating Medicare-subsidised referrals to a credentialled diabetes educator from the Australian Diabetes Educators Association (ADEA) for structured diabetes self-management education and support (DSMES); a dietitian for medical nutrition therapy informed by his cultural food preferences, including Vietnamese-appropriate carbohydrate alternatives and restaurant-specific strategies; a podiatrist for annual foot examination given the combined risk factors of elevated UACR, suboptimal glycaemic control, and nine years of T2DM duration; and an ophthalmologist for retinal screening, which RACGP (2022) guidelines recommend at least biennially or annually when retinopathy is at risk. The nurse also communicates with the GP regarding emerging evidence supporting SGLT-2 inhibitors, such as empagliflozin, for cardiorenal protection in patients with T2DM and early nephropathy, noting Mr Nguyen's borderline UACR of 3.8 mg/mmol as a potential indicator for medication optimisation (RACGP, 2022).

As the most frequent point of contact, the nurse ensures communication flows across the team, that the GPMP is reviewed at least annually, and that Mr Nguyen remains at the centre of care planning decisions rather than being a passive recipient of referrals. This care coordination function is directly articulated in NMBA Standard 5 and reinforced by ACSQHC NSQHS Standard 1 (clinical governance), which requires health service organisations to establish governance systems that ensure safe and effective care for people with complex chronic conditions (ACSQHC, 2023). Consistent with the National Diabetes Strategy 2021–2030 (Australian Government Department of Health, 2021), the nurse also screens for social determinants of health, including financial hardship related to the cost of diabetes consumables, and connects Mr Nguyen with Diabetes Australia's peer support and community programs that offer culturally appropriate resources for Vietnamese-Australian communities.

CONCLUSION

## Conclusion

Chronic disease management demands that registered nurses move beyond episodic, disease-focused care toward sustained, person-centred, team-based engagement with the full complexity of living with a long-term condition. This essay has demonstrated, through the fictitious case of Mr David Nguyen, how the Chronic Care Model (Wagner et al., 2001) provides a coherent framework for structuring community-based T2DM nursing, how comprehensive biopsychosocial assessment identifies the real barriers to self-management rather than assuming non-adherence, and how motivational interviewing (Miller and Rollnick, 2013) supports patient-led behaviour change in the context of diabetes distress, cultural food practices, and structural constraints. Coordination of multidisciplinary care through the GPMP/TCA framework, guided by RACGP (2022) clinical standards and the National Diabetes Strategy 2021–2030 (Australian Government Department of Health, 2021), ensures that the breadth of Mr Nguyen's clinical and psychosocial needs is systematically addressed. For the registered nurse, chronic disease management is a core and expanding professional domain, underpinned by NMBA Standards for Practice (2016), driven by evidence, and measured by the quality of outcomes achieved in partnership with patients.

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