HCA Client Case Study Template: Instructions

Section 1 – Clinician details

This section provides the reader (your peers) with a description of the clinical or other context in which you worked with your client. Please complete all details for this section.

Section 2 – Client demographic details

The client's demographic details must be de-identified but still give the reader a brief synopsis of the client's main health issues. Create a fictitious name. The client's age should be provided within a 5-year range (i.e. 40-45 years of age) rather than inserting the specific age. Gender must be accurately stated. In the section for 'other', record any relevant background information to help the reader to understand the client's circumstances. These may be co-morbidities or illnesses, and/or any prevailing life circumstances or psychosocial issues that may be affecting them currently. Do not include any information that may identify the client, such as number or names of family members or the client's profession.

Section 3 – Presenting issues and relevant lifestyle and treatment categories

State the referral issue, the referral source (or note if the client is self-referred), and any clinical issues or health concerns identified by the client. State the condition-relevant lifestyle and treatment categories discussed with the client.

Section 4 – Initial lifestyle or treatment category selected to work on

Write in the lifestyle or treatment category that the client chose to work on as a result of identifying and prioritizing the clinical issues and broad lifestyle or treatment categories in the consultation. Record the client's RICk levels relating to the chosen lifestyle or treatment category. RIC does NOT have to be scaled using numbers (categories or descriptions are fine). The 'k' in RICk does not require formal evaluation, but you may comment on the level of knowledge/understanding of the client if relevant (particularly if it represented a barrier to change that was addressed during decisional balance).

Section 5 – Client or other barriers to health behaviour change identified in consultation (BEST)

Record any barriers to health change identified by the client, or in conversation between you and the client, or from your own observation. For instance, the client may easily identify some barriers, such as not having the finances to purchase new shoes for walking, but there may be other barriers that the client is not aware of or does not readily accept. Examples are thinking barriers that may affect the client's perception of the importance of adequately following wound management procedures, or their confidence in their ability to reduce their alcohol intake. This section is for your synopsis of the factors that are responsible for the client's previous, current or anticipated non-adherence to health recommendations.

Section 6 – Client facilitators for health behaviour change identified in consultation (BEST)

This section is to record any client skills, strengths and resources that are, or could be, supportive of the client's health behaviour change. In particular, you should record the client's intrinsic motivators and other facilitators that could support the client to overcome their potential barriers to adopting new habits.

Section 7 – Techniques used by clinician to identify and address barriers and improve RICk

Provide details of any techniques used by you to identify and/or address the client's barriers. For example, these may be techniques used above the decision line to alleviate a client's sense of being overwhelmed and increase their confidence, or decisional balance to identify intrinsic motivators and increase a client's importance in making changes. They may be techniques used below the decision line, such as thinking strategies (ANNTs to PETs), or emotion management strategies etc. They may be patient-centred skills and techniques such as active listening, discussing trial and error or using the Client First technique to increase client engagement and avoid the negative perception that health practitioners are trying to 'force' them to change.

Section 8 – Outcome from initial consultation

Write the client's personal goal/s and the details of their action plan in this section. The personal goal/s should be written as a complete sentence or two that state exactly what the client intends to do and when. The client's own written action plan can be scanned and attached to this document, or you can write the details of the client's goal/s and plan/s in this section. The amount of detail required and components included in each action plan will vary between goals and from client to client. Ensure that you ask and record the client's RICk levels (particularly importance and confidence) after completing the action plan section.

Section 9 – Number, frequency and timeframe of consultations

Record the overall frequency and number of consultations that you had with the client. Also include separately any telephone, e-mail, text or other contact between consultations. Record the total timeframe between the first consultation and the last. Your contact with the client may be ongoing. If so, indicate what review consultations or other contact you have arranged with the client, or expect for the future.

Section 10 – Additional issues and personal goals and/or lifestyle and treatment categories addressed in review consultations

Document and discuss any significant or additional health issues, barriers, facilitators, goals and plans that were identified and/or addressed in your review consultation/s with the client.

Section 11 – Results over time

Record the client's health behaviour changes and outcomes since your first consultation. Provide figures where possible to highlight comparisons. These outcomes should be broken down into the following components:
Behavioural - changes in health behaviour (i.e. reduced from 40 to 15 cigarettes per day or increased from 50 to 210 minutes exercise per week), or changes in what the client is able to do (i.e. client now able to independently hang out the washing).
Physiological – changes in physiological indicators such as BMI, weight, BGLs, cholesterol levels, strength or fitness ability (e.g. VO2), etc. or changes in subjective indicators such as pain levels or energy levels.
Motivational – changes in the client's perception of importance in making changes (either regarding a broad lifestyle or treatment category or a specific behaviour), confidence (their perception of their ability to succeed with pursuing a personal health goal), or their general health beliefs and intrinsic motivators.
Psychological – changes in the client's moods, reactions, attitudes and self-reported well-being.

Section 12 – Spontaneous changes

Record in this section any changes that the client made spontaneously (unplanned in consultations) between the first and subsequent consultations. Make a note of what the client changed (the behaviour/s), how they did this (what skills/strategies they employed), and any outcomes that resulted.

Section 13 – Describe how you have adapted your professional practice to include health behaviour change principles and techniques

Describe how you have adapted your clinical practice to incorporate the HCA approach. Conversely, if you have adapted any HCA techniques or tools to suit your professional role, clients, programs or clinical contexts, we would love to hear about it and share your ideas with other practitioners and/or programs!

Section 14 – One paragraph summary of your case

Finally, write a one paragraph summary of your case, including key referral issues, barriers and facilitators, and outcomes. This paragraph will be used as a description to post your case on the HCA website for viewing by other clinicians.