



National Undergraduate Curriculum for Chronic Disease Prevention and Management

Part 2: Self-management Support for Chronic Conditions Facilitator Guide

A Collaboration between the Health Service Executive
and Higher Educational Institutions in Ireland



**Self-management
Support**



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Support for Chronic Conditions
Facilitator Guide

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Support**



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Seirbhís Sláinte
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á Forbairt

Building a
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Abbreviations

AHRQ	Agency for Health Research and Quality
BMI	Body Mass Index
CCM	Chronic Condition Management
CCSM	Chronic Condition Self-management
CDC	Centre for Disease Control
CDSMP	Chronic Disease Self-management Programme
CGM	Continuous Glucose Monitor
COM-B	Capability, Opportunity, Motivation and Behaviour Model
COPD	Chronic Obstructive Pulmonary Disease
CT	Computerised Tomography
CVD	Cardiovascular Disease
DAFNE	Dose Adjustment for Normal Eating
DESMOND	Diabetes Education and Self-management for Ongoing and Newly Diagnosed
ED	Emergency Department
GE	Graduate Entry
GP	General Practitioner
HBC	Health Behaviour Change
HCP	Healthcare Professional
HEI	Higher Education Institution
HEIQ	Health Education Impact Questionnaire
HIV	Human Immunodeficiency Virus
HLS-EU	European Health Literacy Survey
HSE	Health Service Executive
IOM	Institute of Medicine
MCQ	Multiple Choice Question
NALA	National Adult Literacy Agency
NICE	The National Institute for Health and Care Excellence
NUI	National University of Ireland
NWG	National Working Group
PIL	Patient Information Leaflet
PPT	PowerPoint
SM	Self-management
SSM	Specialist Study Module
UG	Undergraduate
WHO	World Health Organisation

Guide to Icons



Theory



Key theme



Activity



Read



PowerPoint



Pause for Reflection and Discussion



Watch



Website

Glossary of Terms

Chronic Conditions¹: chronic conditions are “long-term conditions, lasting more than six months, are non-communicable and involve some functional impairment or disability and are usually incurable” (Department of Health and Children, 2008, p. 9).

Carer: Where this term is used within this document it is intended to be inclusive of family members or any person that is significant to the individual with a chronic condition.

Individual: person living with a chronic condition.

Self-management: Self-management is the process where individuals with chronic conditions take control of their health and actively manage their chronic condition/s. Chronic conditions can result in considerable difficulties for individuals physically, psychologically, and socially. So, self-management is a process whereby individuals develop knowledge and skills in how to manage the consequences of their chronic conditions in their everyday lives.

Self-management Support²: “The systematic provision of education and supportive interventions, to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support” (Health Service Executive, 2017, p. 12). Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help individuals choose healthy behaviours; and as a fundamental transformation of the relationship between the individual with a chronic condition and their healthcare professional, to a collaborative partnership. The overall purpose of self-management support is to aid and inspire individuals to become informed about their chronic condition and take an active role in their treatment and management of the impact of a condition on their lives (Bodenheimer *et al.*, 2002).

Person-centred care: “Person centred co-ordinated care provides me with access to and continuity in the services I need when and where I need them. It is underpinned by a comprehensive assessment of my life and my world combined with the information and support I need. It demonstrates respect for my preferences, building care around me and those involved in my care” (Irish Platform for Patient Organisations Science & Industry (IPPOSI), 2019).

1 At all times we acknowledge that, while certain chronic conditions are preventable through lifestyle change, some chronic conditions such as type 1 diabetes, and many cases of asthma, are not preventable.

2 Permission was received to reproduce graphics and information contained in HSE documents referenced.

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Forewords

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Chair of National HEI/HSE Steering Group – Undergraduate Curriculum for Chronic Disease Prevention and Management

Every day people with long term conditions such as diabetes, COPD and heart failure, and their family members and carers, make decisions and take actions to manage their health. People are living longer, but many people particularly in older age groups have one or more chronic conditions. One million people in Ireland have long-term respiratory or cardiovascular disease, or diabetes. Supporting people with these and other long term conditions to self-manage means helping people to develop the knowledge, skills and confidence they need to make optimal decisions and take the best actions for their health. This improves outcomes for patients, while also helping to reduce healthcare utilisation, including hospital admissions.

Helping people to live well with chronic conditions is therefore key to provision of sustainable health services. Facilitating and training of current and future healthcare professionals to support self-management, is part of the whole system approach to self-management support, set out in '*Living Well with a Chronic Condition: Framework for Self-management Support*', published by the HSE in 2017.

This is reflected in the government's Slaintecare report and action plan, with its focus on integrated care and person centred services. The extension of the GP contract for chronic disease care which will come into effect in 2020 also includes explicit support for self-management.

There are many different types of self-management support; ranging from provision of high quality information and peer support, to multifaceted interventions tailored to specific conditions, such as pulmonary or cardiac rehabilitation. Effective self-management support, however, is underpinned by a collaborative relationship with a healthcare professional, within an organisation that actively promotes self-management.

While many healthcare professionals feel they already work in this way, evidence shows that patients actually need more support to self-manage. This involves a fundamental change in the relationship between patient and healthcare professional. Providing support to self-manage empowers patients, and enables them to move from being passive recipients of care, to being active partners in their healthcare. Self-management support is now regarded as inseparable from high quality care for people with long term conditions.

This curriculum is Part 2 of the National Undergraduate Curriculum for Chronic Disease Prevention and Management, and builds on the skills learned in Part 1: 'Making Every Contact Count for Health Behaviour Change'. It introduces students to the concept of self-management support for people with chronic conditions and provides them with the competencies required to deliver it. The curriculum is a timely resource for educators as they seek to prepare students for the changing landscape of healthcare as it transforms to meet the needs of our population. All healthcare professionals need to support patients to self manage, training our young professionals in these skills is essential for a sustainable service and building a team partnership with patients.

Professor Eileen Savage

Chair of the National Working Group, Professor of Nursing, Catherine McAuley School of Nursing and Midwifery, and Vice Dean of Graduate Studies and Interprofessional Learning College of Medicine and Health, Brookfield Health Sciences Complex, University College Cork.

The preparation of future healthcare professionals through higher education offers significant potential towards realising the potential of graduates to tackle the many challenges faced within the health system. The burden of chronic diseases is currently one of the most pressing challenges facing the healthcare system in Ireland and globally.

The national curriculum on *Self-management Support for Chronic Conditions* presented in this manual represents a collaboration between all healthcare disciplines across all Higher Education Institutes in Ireland (HEIs) and the Health Service Executive (HSE), specifically, the Health and Wellbeing Division. The manual provides an educational resource to facilitate future healthcare professionals develop the knowledge, skills and attitudes towards a person-centred approach to supporting individuals and families in the management of chronic conditions. These future healthcare professionals include graduates from dentistry, nursing, medicine, midwifery, occupational therapy, pharmacy, physiotherapy, public health, social work, and speech and language therapy. This critical mass of graduates will enter the workforce equipped with competencies and a sense of purpose to work in partnership with individuals and families in the self-management of their chronic conditions.

The collaborative alignment between the HSE and the HEIs in developing this curriculum is an exciting feature of the development of this national curriculum because it has brought educationalists and policy makers together with a shared goal for better healthcare in the management of chronic conditions.

Introduction

The Curriculum Manual on *Self-management Support for Chronic Conditions* is a comprehensive facilitator guide, providing educators with a set of resources, to assist in teaching self-management support for chronic conditions to undergraduate/graduate entry healthcare students in Ireland. The curriculum is designed to facilitate integration into existing undergraduate/graduate entry curricula within individual healthcare schools across the higher education sector; medicine, nursing, midwifery, dentistry, dietetics, pharmacy, physiotherapy, podiatry, public health, psychology, speech and language sciences, occupational science/occupational therapy and social care. While providing a recommended framework and educational resources, we encourage individual Schools to adapt the Curriculum to meet local or disciplinary needs. Therefore, the Curriculum, although standardised in terms of competencies and learning outcomes, has flexibility regarding implementation. Each individual School has scope to integrate components of the Curriculum into relevant existing modules where it is suited.

In response to the requirements set out by the Irish Government's *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025* (Department of Health, 2013), the HSE set an agenda to support self-management support for chronic conditions across the health services. The Health Service Executive (HSE) (2015) set out how the HSE would implement *Healthy Ireland*, the government Framework for improved Health and Wellbeing. As a result, '*Living Well with a Chronic Condition*', the national framework for self-management support for chronic conditions was launched in 2017 by the HSE. The national undergraduate/graduate entry curriculum for self-management support, fulfils a key priority of this framework. The main focus of the HSE framework is on four major chronic conditions; chronic obstructive pulmonary disease (COPD), asthma, diabetes and cardiovascular disease. In the development of this curriculum we have taken a broader view, inclusive of other long term health conditions and of the increase in mental health problems associated with physical conditions.

A collaborative statement was developed and agreed by all parties involved in curriculum development and four guiding principles were approved. The guiding principles to support collaborative relations are as follows:

Box 1: Guiding Principles to Support Collaborative Relations

1. Working together involves valuing a collective and national approach to curriculum development for a common purpose.
2. Meaningful collaboration is facilitated through a coordinated and cooperative exchange of ideas, information, knowledge, experiences, and teaching/learning resource materials relevant to developing a National Curriculum.
3. Mutual trust between all collaborators fosters a climate of reciprocity and greater opportunities for shared achievements.
4. Effective collaboration involves working together on all aspects of planning, implementing and evaluation of the National Curriculum.

This Curriculum Manual is divided into two sections;

Section 1: Lecturer/Facilitators Guide

In Section 1 we present details on all aspects of the Curriculum inclusive of the aims of the Curriculum and Curriculum Manual, the underlying philosophy, and development processes, including exploratory work to guide curriculum development; systematic review, professional competency review, national survey and consultation workshops. Sub-sections are presented dealing with implementing and integrating the Curriculum, assessment of learning, and curriculum evaluation.

Section 2: Curriculum Content

In Section 2 we present the learning content for self-management support for chronic conditions. There are five Units of Study:

- **Unit 1: Foundations for Self-management Support for Chronic Conditions**
- **Unit 2: Holistic Approach to Self-management Support**
- **Unit 3: Communication for Self-management Support**
- **Unit 4: Skills Building for Self-management**
- **Unit 5: Service Delivery and Organisation for Self-management Support**

For each unit we provide the learning content permitting easy interpretation and application across HEIs irrespective of local resources. A variety of teaching strategies including case studies, discussions and reflective exercises, readings and skills based learning are presented together with links to PowerPoint presentations. Each school can work with the learning materials as face-to-face lectures, upload the content online or adopt blended approaches to delivery.

Communication with Professional Bodies

The development of this Curriculum has been communicated to the following Regulatory Bodies to gain their support:

- Association of Occupational Therapists Ireland
- Dental Council of Ireland-Irish Dentist Associations
- Regulating Health and Social Care Professionals (CORU)
- Irish Association for Counselling and Psychotherapy
- Irish Association of Speech and Language Therapists
- Irish Association of Social Workers
- Irish Nutrition and Dietetic Institute
- Irish Society of Chartered Physiotherapists
- Medical Council of Ireland
- Nursing and Midwifery Board of Ireland
- Pharmaceutical Society of Ireland
- Psychological Society of Ireland
- Society for Chiropractors and Podiatrists of Ireland

Health Context: Background and Rationale

Every day, people with long-term health conditions, and their carers, make decisions, take actions and manage a broad range of activities and associated factors that contribute to their health. Self-management support acknowledges this and supports people to develop the knowledge, confidence and skills they need to make decisions and take actions to manage their health conditions.

People with chronic conditions are more likely to attend their GP, to present at Emergency Departments, to be admitted as inpatients and to spend more time in hospital, than people without such conditions, and utilise about 70% of health service resources (Department of Health, 2012).

Approximately one million people in Ireland have heart disease, diabetes or respiratory disease (Health Service Executive, 2016). For all chronic conditions the prevalence is significantly higher in people with lower levels of education and in lower socio-economic groups (Jennings, 2014). Those living in more deprived areas are more likely than those in more affluent areas to have a long-term health problem (33% and 24% respectively) (Department of Health, 2018).

The numbers of people living with diabetes, cardiovascular and respiratory disease will continue to rise in the coming years, due to our increasing older population and prevalence of risk factors (Health Service Executive, 2016).

Supporting people to self-manage improves outcomes for individuals – ranging from quality of life and clinical outcomes, to reduced healthcare utilisation including hospitalisation (Health Information and Quality Authority, 2015). The most effective self-management support interventions are multifaceted; tailored to the individual (their culture and beliefs) and tailored to specific conditions. Effective self-management interventions are underpinned by a collaborative relationship with a healthcare professional within a healthcare organisation that actively promotes self-management (Taylor *et al.*, 2014). Reported costs vary according to the intensity of the intervention, but are typically low relative to the overall cost of care for the chronic condition in question and in some instances, can result in cost savings through reductions or shifts in healthcare utilisation (Panagioti *et al.*, 2014; Health Information and Quality Authority, 2015).

Self-management support is considered critical by the World Health Organization (WHO) for countries where ageing populations and the growing burden of non-communicable disease means that there is ever greater demand for health services (World Health Organization, 2015).

The Chronic Care Model makes clear the role of self-management support in the management of chronic conditions (Wagner *et al.*, 2001). This model has broad international acceptance as a framework to provide guidance on shifting from our current model of care which is predominantly acute and episodic care, to a lifelong model of health promotion, prevention, early intervention and chronic care.

Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025 (Department of Health, 2013), recognised the need to implement a model for the prevention and management of chronic conditions, empowering people and communities, with an emphasis on partnership and cross-sectoral work to increase the proportion of people who are healthy at all stages of life. *Healthy Ireland in the Health Services – National Implementation Plan 2015-2017* (Health Service Executive, 2015) included, as a strategic priority, 'reducing the burden of chronic disease' and addressed this through specific actions. Such actions included development and implementation of services to support a national framework for self-care for the major cardiovascular conditions, respiratory diseases and diabetes; and to increase the proportion of individuals utilising self-care and self-management supports.

"Living Well with a Chronic Condition" (Health Service Executive, 2017), the national framework for self-management support for chronic conditions, which arose from the *Healthy Ireland Implementation Plan*, was launched in 2017 and specifically addresses COPD, asthma, diabetes and cardiovascular disease. It recommends the development of a curriculum for undergraduate/graduate entry healthcare professionals as part of overall training for healthcare professionals to support self-management of chronic conditions.

Self-management and self-management support are now recognised as core elements of high quality, evidence based care for people with chronic health conditions (Taylor *et al.*, 2014). The self-management support approach is considered key to delivering person-centred care, in which individuals are empowered to actively participate in the management of their condition (Health Service Executive, 2018).

The Department of Health has recently published a National framework and principles for the design of models of care as a deliverable under the Slaintecare Action plan 2019. Self-care and self-management is one of the nine key principles, further embedding support for self-management in future development of health services (Department of Health, 2019).

Underpinning the self-management support approach are informed and skilled healthcare professionals. This informed and skilled workforce are core to implementing the national framework for self-management support and provide motivation for this undergraduate/graduate entry curriculum. Graduates with self-management support competencies will enable the healthcare professionals of the future to play their part in what has been described as a fundamental transformation of the traditional individual and health professional/carer relationship into a collaborative ongoing partnership (Bodenheimer *et al.*, 2005).

Education Context: Background and Rationale

The adoption, promotion and overall recognition for the role of self-management support for chronic conditions is advocated for internationally [Ireland (2017), Australia (2005; 2011; 2012), Canada (2012), and Scotland(2007)]. This approach to chronic condition management is not new and people with chronic conditions manage their illness on a day-to-day basis. However, the extent to which healthcare professionals support this is an area that needs to be addressed. Alternative approaches to managing long term conditions require increased healthcare attention now, with a necessary shift in focus from responsive acute care provision, including community services and self-management support of chronic conditions.

Educating and supporting practicing healthcare professionals so that they incorporate the principles of self-management support in the care of individuals with chronic conditions is necessary. In order to sustain a culture of self-management support for chronic conditions it is necessary to target healthcare professional students. Creating an educational and clinical ethos, which embraces the principles of self-management support for chronic conditions, is a practical means of embedding the principles of self-management support in everyday care provision.

This idea has been embraced in Australia where Flinders University received funding to develop a curriculum framework for chronic condition self-management support (CCSMS) for undergraduate nursing, medicine and allied healthcare students (Flinders Human Behaviour and Health Research Unit, 2007a). The overall aim was to develop a framework to guide CCSMS education in the Australian health education system. Of note, the project team recommended a three-year plan for integrating the CCSMS curriculum framework in Australian universities inclusive of curriculum development and implementation. A three-stage approach was adopted in the development and integration plan for the curriculum framework; 1) Scoping and Consultation, 2) Stakeholder Workshop and 3) Curriculum Framework and Integration Plan- validation and publication (Flinders Human Behaviour and Health Research Unit, 2007b).

Pols *et al.* (2009) presented an account of a national workshop consisting of representatives from eight medical schools convened to explore content for both chronic condition management (CCM) and chronic condition self-management (CCSM) resulting in the identification of core competencies for CCSM for medical education. A recommendation followed to incorporate learning of self-management for chronic conditions for all medical students and these competencies supported the development of Flinder's framework (Pols *et al.*, 2009). Recommendations exist to develop and incorporate self-management support competencies at undergraduate level advocated for by the Institute of Medicine (2003) and supported by policy documents in Ireland (2017), Australia (2011) and Scotland (2007).

Project Processes

The Project Team

The structure and purpose of the collaborative:

1) A Steering Group to oversee the collaboration and the development of the curriculum.

Purpose: To govern the development of a standardised undergraduate curriculum for health behaviour change, self-management support and chronic condition prevention and management for healthcare professionals.

Terms of Reference Steering Group

- Facilitate the establishment of the collaborative on behalf of the institutes and universities.
- Review and approve the curriculum developed by a Working Group on behalf of all the healthcare professional schools in their institute and university.
- Promote the implementation of the agreed standard curriculum within their own institution.
- Work with the HSE to evaluate the outcome of the collaborative.

- 2) A Working Group** to develop this curriculum consisting of an agreed representative from each university and institution and patient representation to contribute to the self-management support for chronic conditions curriculum development.

Purpose: To develop a standard undergraduate/graduate entry curriculum for self-management support for chronic conditions for healthcare professionals.

Terms of Reference National Working Group

- To develop and agree a standard undergraduate/graduate entry curriculum on self-management support for chronic conditions identifying minimum core components for all students within health sciences professions.
- To develop and agree a standard undergraduate/graduate entry curriculum for selected healthcare professionals with a heightened emphasis on self-management support skills and person-centred care.
- To recommend and agree the content, pedagogical approaches, assessment and evaluation of the above curriculum which should be undertaken by different healthcare professionals.
- To identify additional modules required for training in chronic condition prevention for selected disciplines.
- To develop and agree the curriculum for these additional chronic condition prevention modules and identify the disciplines to which these should be taught.
- Members to consult within relevant colleagues/disciplines in their respective HEIs in order to develop and agree the curriculum outlined.
- To chair Local Working Group meetings to progress the development of the curriculum and promote implementation.
- To make recommendations regarding the implementation and evaluation of the curriculum for self-management support for chronic conditions.
- To attend, contribute and report at monthly meetings to progress the development of the curriculum.
- To report to the Steering Group each quarter.

- 3) Local Working Groups** in each HEI – consisting of representatives of the individual healthcare disciplines/schools within the HEIs.

Purpose: To contribute to the development of a standard undergraduate curriculum for self-management support for chronic conditions for healthcare professionals.

Terms of Reference

- To represent their healthcare school locally
- To provide key information to inform the development of the curriculum.
- To attend regular Local Working Group meetings.
- To contribute to the development of the content, pedagogical approaches, assessment and evaluation of the standard undergraduate curriculum on self-management support for chronic conditions
- To support and monitor curriculum implementation

Exploratory Work to Guide Curriculum Development

Systematic Review

A systematic review was conducted to explore current research on the provision of education to undergraduate/graduate entry healthcare students on self-management support for chronic conditions as a reference point for the development of this national curriculum. The review provides key information on current trends in self-management support for chronic conditions education. Some key findings, which were instrumental in the development of this curriculum, included the following information.

A total of thirteen papers reviewed integrated self-management support courses into pharmacy curricula (n=6), nursing curricula (n=3), medical curricula (n=3) or graduate entry physiotherapy and medical curriculum (n=1). The courses introduced in the studies were developed not with the context of a national curriculum, but by faculty alone, faculty with supporting people or project teams. The majority of interventions targeted individuals with diabetes (n=8). Four studies reported competencies and the main focus were 'patient education/care' and 'service delivery and organisation.' Examples of competencies included effective delivery of patient-centred care, to provide self-management support to individuals in partnership with them, to communicate and collaborate with individuals and carers, to demonstrate problem-solving skills through active learning, to collaborate with other healthcare professionals, etc.

The core learning areas of the curricula were reviewed in terms of knowledge, skills and attitudes. All thirteen studies addressed knowledge content, mostly related to management and treatment of a chronic condition and foundations for self-management support. For skills, communication skills were predominant in most of the studies. Developing of skills for goal setting, action planning, care plan reviews and problem-solving was also reported in seven studies. Attitudes towards self-management support were reported the least (n=9). Appreciation, understanding and empathy for individuals with chronic conditions and their challenges were mainly included.

The teaching and learning strategies were reported in all studies. The most common approach to knowledge was lectures and discussion in class room settings, followed by multi-media and online learning. Most teaching and learning of skills were facilitated through simulation exercises and role-play activities either in laboratory or in everyday life. Service learning with allocated patients was also used for training skills. The approach to attitudes component showed similar pattern to facilitating skills as simulating a patient's experience and service learning were used the most. Student assessment was addressed in five papers. The strategies included multiple choice questions, quizzes, group presentation, log books on self-care tasks, reflective papers, competency assessment and completion of care plan. Curriculum evaluations are conducted by quantitative and qualitative student surveys, focus groups, analyses of patient clinical data, faculty rubric scoring and analysis of students' action plan data. It is evident from the studies reviewed that students' confidence in implementing skills for self-management support and their knowledge level were increased after courses. The findings from the systematic review indicated that the overall impact of self-management support education is positive and future curriculum should be developed more systematically in terms of content, delivery methods and assessment and evaluation strategies.

Professional Competency Review Process (Appendix 1)

Nineteen regulatory body frameworks were reviewed for any elements of content or competencies that related to the principles of self-management support for chronic conditions. Accreditation standards were reviewed from several healthcare disciplines including nursing and midwifery, medicine, occupational therapy, dentistry, pharmacy, social care, and physiotherapy, within five countries, encapsulating healthcare programmes in the UK, Australia, Canada, South Africa, and Ireland. Additionally, a number of healthcare policies from the World Health Organisation were also reviewed.

Competencies and Standards were comprehensively and efficiently reviewed for:

- Learning outcomes explicitly referring to self-management support for chronic conditions.
- References to terms relevant to self-management support for chronic conditions, such as "chronic disease", "chronic condition", "self-management", "self-management support", "management" and "self-care".

- Standards evoking the principles of self-management support, including patient education, shared decision-making, health promotion and health advocacy.

Of note while self-management support has strongly featured in regulatory frameworks as a critical competency, in most instances it has not been explicitly cited in relation to chronic condition management (Health Service Executive, 2008; General Medical Council, 2009; Occupational Therapists Registration Board, 2014; Nursing and Midwifery Board of Ireland, 2016). The *'Future Pharmacy Practice in Ireland: Meeting Patients' Needs'* framework (The Pharmaceutical Society of Ireland, 2016) clearly identifies 'the need to support self-care, particularly in the prevention and management of chronic diseases' (p. 27), and this competency proliferates in the framework, where self-management support for chronic conditions features a significant role in the future education of pharmacy healthcare professionals.

Coincidentally, it has been argued that healthcare 'curricular content should keep pace with the strategic health policy move towards the management of chronic ill health and life-limiting conditions' (Nursing and Midwifery Board of Ireland, 2016, p. 11); however, this fundamental philosophy has yet to be realised in curriculum development, and regulatory standards and requirements. See Appendix 1 for more detailed information on self-management support for chronic conditions in regulatory body guideline documents.

National Survey (Appendix 2)

A survey developed and piloted by members of the NWG was carried out to explore what self-management support education for chronic conditions is currently addressed in undergraduate/graduate entry healthcare programmes across HEIs in Ireland. There is currently a lack of baseline data on the provision, practice and variation of self-management support for chronic conditions education in healthcare programmes in HEIs in Ireland. The collation and analysis of the data generated was a preliminary step to informing the development of this standardised national curriculum on self-management support for chronic conditions while providing a situational analysis on the current educational provision of self-management support for chronic conditions. The guiding question of the survey was "what is the current practice and provision of self-management support for chronic conditions in curricula of undergraduate/graduate entry healthcare students attending HEIs in Ireland?" Ethical approval was granted from the Social Research Ethics Committee in University College Cork. Emails with invitation, information leaflet and web link to the online survey were circulated to the heads of schools and programme leads for each UG/GE healthcare discipline requesting module leads/academics involved in teaching self-management support for chronic conditions related content complete the survey within the Republic of Ireland. The results of this survey indicate that elements of self-management support for chronic conditions are taught to future healthcare professional students with over half of respondents indicating so. However, there were no explicit competencies on self-management support for chronic conditions provided for any of the programmes reported on. Content that is taught is delivered within the context of other related modules in a disparate manner.

For the most part traditional approaches to both teaching and assessment of self-management support for chronic conditions are adopted which occurs predominantly in years 3 and 4.

The numbers reporting were small overall and unevenly distributed across programmes therefore no inferential analyses were carried out. However, for the purpose of discussion the variations in results between programmes are acknowledged.

While the overall survey response rate was 65, not all respondents completed Section 2, which dealt with content. Consistently, allied health programmes (n=17) followed by nursing and midwifery programmes (n=20) demonstrated overall highest level of agreement that elements from the eight learning areas identified are taught. This was followed to a lesser extent with agreement by those reporting for medicine (n=4) and dentistry (n=1). Overall respondents reporting on behalf of pharmacy (n=3-4) indicated the least level of agreement that the elements provided were taught in their programmes. See Appendix 2 for more information on this survey.

Workshop

A workshop on self-management support was scheduled as part of the *2017 International Conference of the Diabetes Self-management & Prevention Alliance* (10th November), hosted by National University of Ireland, Galway. The facilitators were Professor Eileen Savage and Dr Peter Cantillon, both of whom are on the National Working Group in relation to the national curriculum for self-management support for chronic conditions. Participants attending the workshop were conference delegates comprising mostly of researchers and clinicians and to a lesser extent academics involved in teaching undergraduate healthcare students. The workshop was 1.5 hours in duration.

The learning outcomes set for the workshop are presented in Box 2.

Box 2: Workshop Learning Outcomes

By the end of this workshop, the participants will be able to:

- Outline a set of competencies for self-management support required of graduates of health professional programmes specific to chronic condition management
- Describe appropriate teaching and learning strategies to facilitate undergraduate students apply self-management support chronic condition management in clinical practice
- Identify appropriate approaches to assessment regarding self-management support
- Describe common enablers and barriers to integrating self-management support into undergraduate education for future health professionals

The workshop was interactive involving small group work and with each purposely mixed to include a combination of researchers, clinicians and educators in as far as was possible. Each group was asked to identify what they perceived to be the principal competencies, learning areas, teaching strategies, and assessment strategies needed within an undergraduate curriculum to prepare future healthcare professionals for self-management support in clinical practice.

Collectively, a total of 10 competencies were identified by the groups and which can be categorised into the following broad overlapping areas:

- Philosophical/affective orientation: person-centred care; empowerment; positive beliefs and attitudes towards self-management; building confidence
- Communication: initiating self-management conversation
- Relationship with individuals: working in partnership
- Self-management specific skills: collaborative goal setting; interdisciplinary goal setting with individuals; supporting decision-making; motivational interviewing.

Key areas of learning for self-management support practice among undergraduate students related to communication skills, knowledge and skills relating to self-management support including barriers and enablers, and appreciation of living with a chronic condition. Communication for self-management support included skills such as listening, empowering and motivating as well as handling conflict. Some groups noted the need for motivational interviewing as a basis for self-management support practice. Developing the skill of communicating professional and technical knowledge into everyday lay language was also noted, as was the skill of interacting with individuals who have 'literacy problems'. Knowledge and skills relating to self-management support were identified as relating to understanding the role of self-management in effectively managing a chronic condition and integrating its impact into one's everyday life. The groups indicated that students should acquire knowledge on lifestyle issues and develop competence in supporting behavioural change. Specific skills identified included goal setting and problem-solving, verbal persuasion, and supporting individuals to manage the emotional aspects of living with a chronic condition. Person-centredness was viewed as a core aspect of self-management support. There was a strong emphasis on the need for undergraduate students to appreciate what it might be like to live with a chronic condition. To this end, they placed particular emphasis on experiential learning activities as detailed further below.

A range of teaching and learning strategies were proposed across the groups but experiential learning dominated as the most important strategy. Simulation was seen as a way of facilitating learning about living with a chronic condition with reference to students taking on individuals' roles over a period of time or role playing with actors. Clinical learning experiences considered important were home visits so that students can meet individuals with chronic conditions in their own environments, listen to them, and record their stories. Shadowing experienced staff as well as high quality supervision that incorporated feedback to students was reported as integral to students' clinical learning. Individuals with chronic conditions were seen to have an active role in facilitating student learning such as being 'teachers' providing feedback to students and being involved in assessing their learning. Other teaching and learning strategies identified during the workshop included small group work, case study analysis, analysis of blogs and wikis, and videos with positive and negative examples of self-management support. Throughout the learning experience, it was noted that students need to be facilitated to be reflective and cognisant of their own beliefs, values, and attitudes concerning self-management support and the role of individuals with chronic conditions in actively managing their conditions.

A diverse range of assessment of learning strategies were articulated, most of which related to demonstrating competence in self-management support practice. These included videoing of student-individual with a chronic condition, encounters with self-reflections built in, reflective logs/ essays/diaries, photo voice, and oral assessments. Some groups indicated the need to assess student self-management support performance against pre-determined criteria of behaviours which could include peer assessment, self-assessment, and healthcare user assessment in addition to assessment by clinicians. Other assessment strategies included online e-tivities, MCQs, written essays, and written projects.

Overall, workshop participants were positive about introducing self-management support education into the undergraduate curricula. The potential of this initiative was seen as important to developing a critical mass of future healthcare professionals with competence to engage in self-management support in their practice. Furthermore, they viewed it as an opportunity to foster an interdisciplinary approach to self-management support but noted that undergraduate education needs to strengthen interdisciplinary learning. Another points of caution based on perceived barriers to self-management support education included negative attitudes of students and clinicians in terms of seeing self-management and motivational interviewing as 'soft' knowledge and skills in healthcare and therefore less important to objective clinical knowledge concerning health outcomes. Participants also expressed concerns about overcrowded curricula in accommodating new content in relation to self-management support.

Self-management Support-Chronic Conditions – Curriculum Consultation Workshops

A number of consultation workshops on the competencies and learning outcomes to be addressed in the curriculum, were held nationwide in Cork, Dublin and Limerick. The workshops were open to all academics in health science disciplines of HEIs, and we were particularly interested to speak with those involved in teaching on chronic conditions, programme leads and chairs of teaching and curriculum committees. The workshops were led by Professor Eileen Savage with the support of Dr Carmel Mullaney, Dawn Sinclair and Eunjin Selena Han. We presented a draft competency framework with a broad outline of the proposed content and asked attendees to reflect on the competencies and content in terms of; 1. Relevance for self-management support, 2. Any Omissions 3. Validity of Learning Outcomes and 4. In what year of UG programmes are learning outcomes best placed.

The core editing group reviewed the notes from the workshops and extracted key points and themes and made amendments where possible based on review of the feedback sourced and consultation with NWG members. All sources of evidence and contributions were considered. Some areas identified are already covered in the *Making Every Contact Count* curriculum, and as such were not considered for inclusion in the *Self-Management Support for Chronic Conditions* curriculum, however we have directed to the relevant sections of *Making Every Contact Count* curriculum in those instances.

Section 1: Lecturer/Facilitator Guide

Aims of the Curriculum and Curriculum Manual

This standard National Undergraduate/Graduate Entry Curriculum on Self-management Support for Chronic Conditions was introduced in recognition of, and response to, the growing burden of chronic conditions in our society and the increasing need for people living with chronic conditions to be supported in their self-management. In Ireland, the development of the *Framework for Self-management Support* (Health Service Executive, 2017) highlights a number of key actions to promote and provide self-management support for four major chronic conditions – chronic obstructive pulmonary disease (COPD), asthma, diabetes and cardiovascular disease. One of the actions set out in the Framework is to;

“Collaborate with Higher Education Institutions in Ireland to include self-management support education and skills training in the Standard Curriculum for Chronic disease prevention and management for relevant undergraduate and training and development for Health and Social Care Professionals” (Health Service Executive, 2017, p. 35).

The introduction of self-management support for chronic conditions to undergraduate/graduate entry curricula, which incorporates the learning and skills necessary for self-management support for chronic conditions, is a way of instilling the principles and culture of self-management support in the early stages of healthcare careers.

The Aims of the Curriculum are:

- To introduce self-management support for chronic conditions education and training in all healthcare professional education settings nationwide as part of the implementation of the ‘*Living Well with a Chronic Condition*’ the National Framework for Self-management Support for Chronic Conditions: COPD, Asthma, Diabetes and Cardiovascular disease (Health Service Executive, 2017).
- To provide a national standardised approach to teaching self-management support for chronic conditions.
- To provide undergraduate/graduate entry healthcare students with basic self-management support skills, knowledge and attitudes in preparation for clinical practice.
- To foster national collaboration on self-management support for chronic conditions training and education across the Higher Education Sector.

This manual provides healthcare educators with a comprehensive resource to facilitate the teaching and learning of self-management support for chronic conditions. The manual is designed to provide guidance to educators on the provision of the curriculum, including underpinning philosophies, course content, teaching strategies, assessments and evaluation.

A key aim of this manual is to inform HEI educators of the topics and learner content for self-management support for chronic conditions. The curriculum contains five units of study and each unit contains the lessons with learning content required for integration into existing curricula across HEIs. A variety of teaching strategies are presented including case studies, discussions, learner activities and reflective exercises. There is an option of developing online material and delivering the content online, other options include delivering the curriculum face-to-face, through interprofessional teaching, online or in blended format. The context in which the curriculum was developed is presented incorporating the background rationale and competency framework.

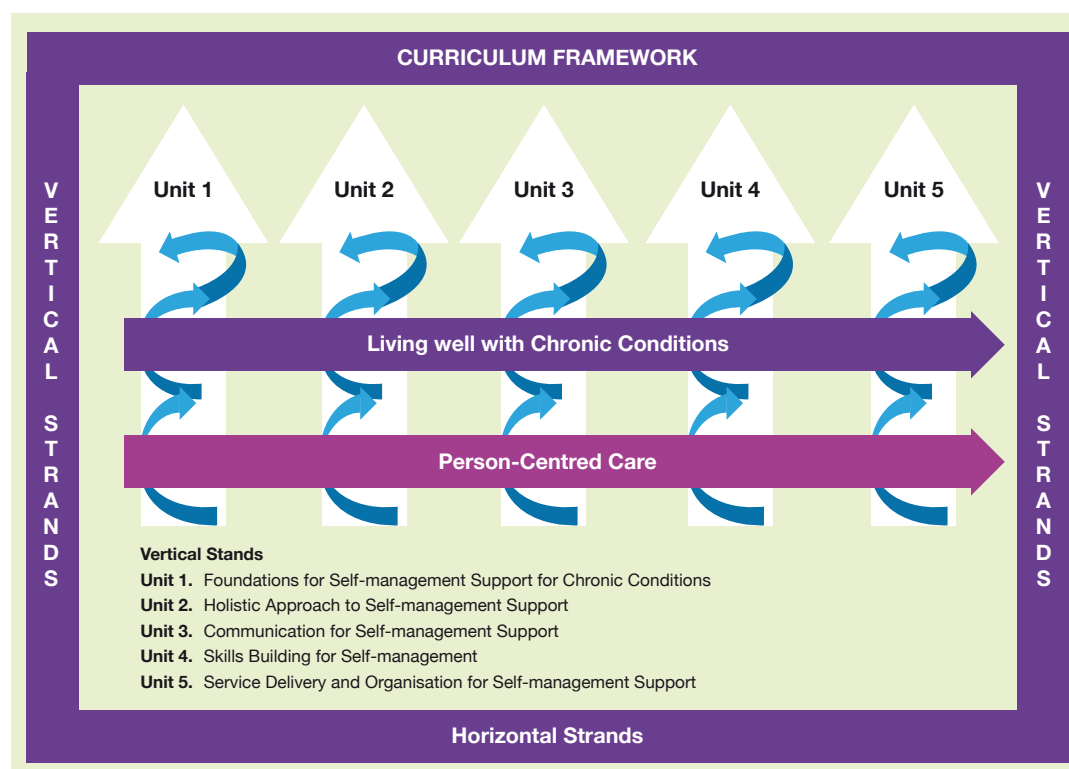
The aim of the Curriculum Manual is

to provide educators with a national standardised educational resource on self-management support for chronic conditions targeting all undergraduate healthcare students.

Curriculum Philosophy and Design

This is a competency based curriculum designed around five vertical and two horizontal strands (Figure 1.0). The curriculum framework was developed following in-depth scoping exercises including literature reviews, professional competency review, a national survey, a stakeholder workshop, consultation workshops and national working group review and consultation. Drafting of the initial framework was followed by review and amendment by the project team including national and local working groups. The framework offers theoretical underpinnings and philosophical assumptions to create a common understanding of the principles of self-management support for chronic conditions. It also provides an educational structure for integration and delivery of standardised curriculum content on self-management support for chronic conditions.

Figure 1.0: Curriculum Framework



The core philosophy underpinning the National Undergraduate Curriculum for Chronic Disease Prevention and Management Part 1: *Making Every Contact Count* for Health Behaviour Change was subject-centred learning (Morrison-Saunders and Hobson, 2013). Adopting the same philosophy for this Curriculum, subject-centred learning involves interactive learning “where space is created for the students to enter into their own engagement with the subject in a shared pursuit with the teacher, resulting in more effective teaching and learning” (Morrison-Saunders and Hobson, 2013, p. 212). The subject unites the educator and student, where the educator engages with the subject in ways that inspire students to enter into a relationship with that subject.

This National Curriculum is designed around five vertical and two horizontal strands as shown in Figure 1.0.

Vertical strands refer to subject matter that builds on previous course work such that there is a sequence to learning (Torres and Stanton, 1982). Five vertical strands informed by a literature review and stakeholder consultation for this Curriculum are:

- **Unit 1: Foundations for Self-management Support for Chronic Conditions**
- **Unit 2: Holistic Approach to Self-management Support**
- **Unit 3: Communication for Self-management Support**
- **Unit 4: Skills Building for Self-management**
- **Unit 5: Service Delivery and Organisation for Self-management Support**

Horizontal strands refer to basic concepts that are integrated from one subject area to another and therefore offer continuity to learning in the curriculum (Torres and Stanton, 1982). This Curriculum has two horizontal strands. These are:

- **Living Well with Chronic Conditions**
- **Person-centred Care**

The horizontal strands of Living Well with Chronic Conditions and Person-centred Care in this Curriculum emphasise the pivotal role of the person in self-management support for chronic conditions education for healthcare students and reflects the national framework for self-management support for chronic conditions in Ireland, “*Living Well with a Chronic Condition*” (Health Service Executive, 2017). “The concept of living well reflects the best achievable state of health that encompasses all dimensions of physical, mental, and social well-being” (Institute of Medicine, 2015, p. 486). Ultimately, chronic conditions have the capacity to limit an individual's ability to live well (Institute of Medicine, 2015). Living well with chronic conditions incorporates preventive strategies and services recommended for those without chronic conditions in addition to management of the chronic condition (Harris and Wallace, 2012). For most individuals living well is about achieving one's optimal physical, psychological and social level of functioning. Living well is dependent on a multitude of interacting factors therefore including families, friends and societies working in union to positively influence quality of life for individuals with chronic conditions (Institute of Medicine, 2003). Healthcare professionals should be encouraged to explore and become responsive to a person's wishes and values in an effort to promote living well (Entwistle *et al.*, 2018). Promoting the concept of living well requires an enabling approach to self-management support from healthcare professionals (Entwistle *et al.*, 2018). There are many fundamental underpinnings to self-management support including collaborative working and partnership building (Thom *et al.*, 2015; Dures *et al.*, 2016; Figueiredo *et al.*, 2017). All of which, when embraced by healthcare professionals, support a living well philosophy.

Person-centred care infiltrates all aspects of self-management support learning presented here, and is recognised as a core attribute of successful chronic condition care in general (Pulvirenti *et al.*, 2011). It is a concept that was also presented as a horizontal strand in the *National Undergraduate Curriculum for Chronic Disease Prevention and Management Part 1: Making Every Contact Count for Health Behaviour Change* (National Undergraduate Curriculum Working Group, 2017). A comprehensive collection of person-centred care definitions were prepared previously and are replicated here (Appendix 3). “Person-centred care and, in particular, approaches such as collaborative care and support planning and self-management support can also help services respond to the needs of the growing number of people living with long-term conditions” (The Health Foundation (UK), 2014, p. 12). In Ireland, patients have indicated that “person centred co-ordinated care provides me with access to and continuity in the services I need when and where I need them. It is underpinned by a comprehensive assessment of my life and my world combined with the information and support I need. It demonstrates respect for my preferences, building care around me and those involved in my care” (Irish Platform for Patient Organisations Science & Industry (IPPOSI), 2019).

A person-centred approach is an important aspect of self-management support, one which endorses consideration of preference in conjunction with capabilities, resources and circumstances. Equally, a person-centred approach acknowledges the varying levels of eagerness to engage with self-management and what individuals perceive to be important supports (Havas *et al.*, 2017). Like self-management support, the concept of person-centred care is widely endorsed by healthcare professionals in general. For the most part healthcare professionals also agree that chronic condition care requires a self-management support component and that person-centred care is instrumental to successful self-management. The challenge that presents is embedding this approach in healthcare provision. Within the framework of this curriculum, we embrace the concepts of *Living Well with Chronic Conditions* and *Person Centred Care* and recognise their pivotal role across self-management support for chronic conditions learning in undergraduate healthcare education.

Competency Framework

The term “competency” has become significant in undergraduate/graduate entry healthcare courses, it is required that on completion of healthcare courses, students are competent healthcare professionals. Identifying competencies to frame curricula fosters knowledge, attitudes, values and skills which are considered to be core curricular requirements (Madsen and Bell, 2012). Competencies are overarching requirements from where a number of measurable or observable learning outcomes/behaviours stem. Competency-based education is described as “a framework for designing and implementing education that focuses on the desired performance characteristics of healthcare professionals” (Gruppen *et al.*, 2012, p. 1).

Competencies need to be integrated across an entire curriculum and be reflected in the structure, content and assessment processes of the curriculum.

The national curriculum detailed in this manual comprises of five units, building towards the development of competencies for professionals in delivery of self-management support for chronic conditions. Each unit focuses on development of specific competencies with learning outcomes identified. This national curriculum is intended for undergraduate/graduate entry healthcare professional educational programmes and contains common content across healthcare disciplines, while also permitting for inclusion of unique content within professions, in accordance with the specific requirements of individual courses. We present a competency framework to guide the development of this national undergraduate curriculum for *Self-management Support for Chronic Conditions* (Table 1).

Table 1: Competency Framework

Competencies	Learning Outcomes	Unit of Study
1. Demonstrate knowledge and understanding of self-management of chronic conditions and self-management support from an individual/carer and healthcare perspective.	1.1 Understand what is meant by self-management and self-management support and its fundamental theoretical principles. 1.2 Understand the tasks that individuals must undertake in order to be effective self-managers of their chronic condition. 1.3 Identify the core skills required for individuals ³ to become effective self-managers. 1.4 Identify the core skills required by the healthcare professional to support self-management. 1.5 Understand different approaches for providing self-management support.	1. Foundations for Self-management Support for Chronic Conditions
2. Apply a person-centred approach to holistically supporting individuals/carer, that integrates the biological-physical, psychological, social and cultural aspects of individuals' lives in self-managing a chronic condition.	2.1 Recognise individuals with chronic conditions as whole persons with interacting and interdependent biological-physical, psychological, social and cultural aspects of self. 2.2 Appreciate how an individual's physical, psychological, social and/or cultural responses to a chronic condition may affect abilities to self-manage. 2.3 Critically reflect and examine clinical practice to apply a holistic approach to supporting self-management of individuals with chronic conditions. 2.4 Understand individuals' needs for information in different formats and at different stages of a chronic condition to support self-management. 2.5 Describe the concept of health literacy, assess information needs and provide information tailored to individual needs. 2.6 Identify the health consequences of limited health literacy, its relevance to self-management and the practical ways that healthcare professionals can contribute to mitigating the effects of limited health literacy.	2. Holistic Approach to Self-management Support
3. Engage in collaborative-partnership communication with individuals/carer to support self-management of chronic conditions	3.1 Understand how to gain an individual's perspective on the impact of a chronic condition on daily life. 3.2 Understand the importance of individual/healthcare professional/ family partnerships in chronic condition management. 3.3 Understand the importance of trust and collaboration in relationships with individuals. 3.4 Understand the importance of discussing treatment options with individuals and the concept of shared decision-making. 3.5 Critically evaluate communication between healthcare professionals and individuals for collaborative-partnership and relationships.	3. Communication for Self-management Support

³ Where "Individual" is mentioned in the learning outcomes we imply "carer" as per competencies. Carer is inclusive of family or any person that is significant to the individual with a chronic condition.

Competencies	Learning Outcomes	Unit of Study
4. Assist individuals/carer in skills building to effectively self-manage a chronic condition in their daily lives.	4.1 Build individuals' confidence by supporting them to develop problem-solving and decision-making skills to support self-management of a chronic condition. 4.2 Demonstrate ability to support individuals to develop self-monitoring skills and interpret changes in health status indicating improvement, maintenance or deterioration. 4.3 Develop ability to support individuals to utilise resources and form partnerships to effectively manage their chronic condition. 4.4 Demonstrate ability to actively engage individuals in setting goals, planning actions and re-evaluating according to their needs.	4. Skills Building for Self-management
5. Demonstrate knowledge and understanding of co-ordinating and managing care delivery relevant to day to day practice that supports self-management by healthcare professionals.	5.1 Critically evaluate examples of current health service organisation and delivery reforms relevant to self-management support for chronic conditions. 5.2 Appreciate the importance of co-ordinating care across relevant health and social service boundaries and community supports to ensure appropriate pathways of care based on need. 5.3 Recognise and appreciate the role of individual healthcare team members in self-management support. 5.4 Appreciate the ability to work as a member of a multi-disciplinary/inter-professional team for collaborative care planning in self-management support. 5.5 Assist individuals/families to access relevant community resources, education and support groups for self-management of a chronic condition.	5. Service Delivery and Organisation for Self-management Support

Curriculum Implementation and Integration

In this part of the Manual, guidance is offered on the implementation and integration of self-management support for chronic conditions in programmes. Although this is a national, standardised curriculum in terms of competencies and learning outcomes, we encourage the use of flexibility in delivery options and encourage professional specific literature to provide relevance and application to support student learning. We also encourage modifying of case studies to reflect the professional curriculum under study. We promote innovative methods to deliver the curriculum, or components of it, for example, interdisciplinary learning may be an option in some HEIs.

A new national curriculum for all undergraduate/graduate entry healthcare programmes generates questions from educators such as;

- Who will deliver the curriculum?
- How will we deliver it?
- Is there support for educators?
- How will it be assessed?
- How can it be integrated into existing curricula?

Undergraduate/graduate healthcare curricula are already reaching content capacity and we are mindful of the challenges of integrating new material into existing programmes. This section of the manual looks at some of the possible ways of integrating the curriculum for self-management support for chronic conditions into established healthcare programmes.

Many of the theories and skills embedded in the curriculum for self-management support for chronic conditions are not new and are already delivered in existing teaching. It is likely that there will be many opportunities in your programmes to incorporate content for self-management support for chronic conditions into existing modules. However, some components of the curriculum may be new and these topics may require specific curriculum time. The duration of the curriculum is 12 hours, distributed across 5 units. The recommended timeframe for each unit is provided in Section 2. The content of the curriculum may be delivered over the entire programme or in block times at the discretion of each school.

In order to integrate the national curriculum in schools and courses in HEIs nationally the competency framework of the curriculum on self-management support for chronic conditions should be mapped at course level and existing curriculum content identified to establish what is already being covered in a given curriculum. There is scope to integrate the topics that are to be covered in this curriculum into a number of existing subject areas.

Preparing for Implementation

We suggest that one member of academic staff, in each institution/school where possible, is identified to lead the implementation of this curriculum. The following questions should be considered in preparation for this:

- What content from this new curriculum is already taught as part of the existing undergraduate curriculum?
- Who teaches it?
- Who could potentially teach content of this new curriculum for self-management support for chronic conditions?
- Where in the programme can we implement self-management support for chronic conditions?
- What resources do we have?
- What support or training is needed to implement this curriculum for self-management support for chronic conditions?

Implementation Exercise

It is necessary to map the competencies of this curriculum with each Regulatory Body's requirements to demonstrate alignment of the self-management support for chronic conditions curriculum with existing frameworks.

We recommend that a mapping exercise is also carried out at course level to identify where the learning outcomes and competencies of this curriculum are already addressed within existing curricula. Once it is evident where content already exists it is important to consider the timing or placement of this curriculum content in the overall undergraduate/graduate entry curriculum.

We offer recommendations on content location within undergraduate curricula (Section 2). However, we advise that final decisions regarding content location be reached at local level. This is of particular relevance in graduate entry programmes, which are often delivered in a more intensive manner than undergraduate curricula.

For self-management support for chronic conditions, once it is known what components of this curriculum are already in place it must then be decided whether any changes are required to ensure that content meets self-management support for chronic conditions learning outcome requirements. Also, consideration must be given to whether or not the new material should replace any existing content.

Building Capacity

This is a new curriculum and therefore it is necessary to raise awareness and ensure that lecturers are familiar with it and have insight into its potential impact on service delivery. Gaining the support of lecturers and students is paramount to its successful implementation. Supporting staff to ensure that they are prepared to successfully deliver the curriculum is also important. It is worth identifying available resources/personnel who already have a vested interest in the area of self-management support for chronic conditions to help raise awareness and support for the curriculum.

Assessing Student Learning

There are a number of competencies and learning outcomes in this curriculum with a number of suggested student assessment methods possible.

Options for assessment include assessing each unit independently or assessing units in a combined way. In addition an online assessment strategy, such as developing multiple choice questions, is another option for assessment. For some schools the competencies and learning outcomes of the curriculum could be placed in a clinical log book for signoff in the clinical setting.

Another assessment suggestion for this curriculum is to adopt an interprofessional approach to assessment. This could be regarded as a group type assessment. A case study could be provided to the various healthcare discipline students. The leading assessment question asking each discipline what they feel their role would be in supporting that individual to self-manage their condition. An opportunity would be provided for each group to return and present their work.

Evaluation

It is beyond the scope of the current project and collaborative to evaluate the overall development and implementation of the curriculum. We make a recommendation to the HSE for a future national evaluation of the project specifically looking at, yet not limited to, the following elements;

- Structure; including group membership, terms of reference, collaborative.
- Curriculum; development, content, delivery methods, assessments, resources.
- Curriculum implementation.

Once the curriculum is implemented and integrated into HEIs, we suggest that evaluation of the learning content is carried out within schools in keeping with local evaluation methods at unit level and whole curriculum level within programmes. We also recommend sustaining a collaboration across HEIs to provide a forum for ongoing support around implementation.

A number of local working group visits to each HEI will be facilitated in the first year of roll out to gather feedback on implementation of the curriculum.

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Section 2: Curriculum Content

Introduction

There are five units of study or content areas identified for this Curriculum. The content is presented as interactive discussions with the objective that dialogue will encourage students to reflect on the topics and examine their own attitudes to self-management of chronic conditions and the support that they will, as healthcare professionals, offer individuals with chronic conditions. Each unit is evidence based and written to facilitate face-to-face or to facilitate further development as part of an online blended learning initiative. Accompanying each unit is a PowerPoint slide pack where the key discussion areas are outlined. Lessons include three key approaches to assist you as a lecturer to facilitate students to contextualise the material within each of the lessons. The three components include assimilative activity which requires you to read and understand the learning material presented; productive activities which require you to create material to demonstrate and link core concepts which you have assimilated; and finally, interactive and adaptive approaches which will enable you to acquire core competencies in recognising self-management support requirements in your practice domain.

Unit 1: Foundations for Self-management Support for Chronic Conditions

The core purpose of Unit 1 is to introduce students to the concept of self-management and self-management support. The unit is concerned with the exploration of the definitions, foundations and principles underpinning both self-management and self-management support. Here, students are introduced to the core tasks and skills which individuals with chronic conditions require to be effective self-managers. In addition, students are encouraged to reflect and explore the skills that are required of the healthcare professional in supporting individuals to develop the skills which they need to self-manage their chronic condition.

Unit 2: Holistic Approach to Self-management Support

In Unit 2, the concept of person-centred holistic care in the context of self-management support is addressed. In this unit there is opportunity to gain a deeper understanding of how to support individuals in the medical, role and emotional self-management of their chronic condition. There will be discussions on the ways in which healthcare professionals, communities and families can support self-management in a holistic way. There is a lesson on health literacy, again highlighting the importance of individual preferences and abilities in keeping with person-centred holistic care. Case studies are presented to facilitate learning.

Unit 3: Communication for Self-management Support

In Unit 3 students will have an opportunity to learn about the importance of effective collaborative-partnership communication for self-management support. They will explore the engagement between healthcare professionals and individuals to support self-management of chronic conditions. Key learning outcomes in this unit focus on gaining an individual's perspective on the impact of a chronic condition on their daily life through appropriate listening and questioning. Understanding the importance of trust and collaboration in relationships and the importance of discussing treatment options with individuals as well as the concept of shared decision-making are addressed in this unit.

Unit 4: Skills Building for Self-management

In Unit 4 the emphasis is on assisting individuals to build skills to effectively manage a chronic condition in their daily lives: problem-solving, decision-making, resource utilisation, forming partnerships and action planning. Discussions will focus on building individuals' confidence by supporting the development of problem-solving and decision-making skills. In addition, students will explore how to support the development of an individual's self-monitoring skills and their ability to interpret changes in their health status indicating improvement, maintenance or deterioration.

Unit 5: Service Delivery and Organisation for Self-management Support

In Unit 5 students will develop a knowledge and understanding of co-ordinating and managing care delivery relevant in the context of health service delivery and organisation. A critical perspective on current health service organisation and delivery for self-management support will be considered. The relevance of broadening perspectives on self-management support beyond health services to include social services and community support groups will be examined. Students will explore the role of inter-professional team approaches to self-management support including critical examination of current practices. They will also have opportunity to review the impact of self-management support on service provision and delivery, and on patient outcomes.

The accompanying slide packs for each unit can be accessed and downloaded from
<https://www.hse.ie/sms-undergradcurriculum/>

Unit 1: Foundations for Self-management Support for Chronic Conditions

Duration: **2 hours**

Recommended Programme Placement: **Year 2 or 3**

Lesson Plan

Unit 1: Learning Outcomes	<p>Competency: Demonstrate knowledge and understanding of self-management of chronic conditions and self-management support from an individual/carer and healthcare perspective.</p> <p>Learning Outcomes:</p> <ol style="list-style-type: none"> 1.1 Understand what is meant by self-management and self-management support and its fundamental theoretical principles. 1.2 Understand the tasks that individuals must undertake in order to be effective self-managers of their chronic condition. 1.3 Identify the core skills required for individuals to become effective self-managers. 1.4 Identify the core skills required by the healthcare professional to support self-management. 1.5 Understand different approaches for providing self-management support. 	
Lesson 1: Introduction to Self-management Support 1 Hour	<ul style="list-style-type: none"> • Introduction to Unit 1 • Introduction to Lesson 1 • Living Well with Chronic Conditions • Self-management • Self-management Support • Social Cognitive Theory Applied to Self-management Support • Components of Self-management 	<p>Activity 1.1: Self-management Definitions</p> <p>Activity 1.2: Self-management Support Definitions</p> <p>Activity 1.3: Self-management Components</p>
Lesson 2: Self-management Skills, Approaches, Outcomes 1 Hour	<ul style="list-style-type: none"> • Introduction to Lesson 2 • Brief Recap Unit 1 Lesson 1 • Self-management Skills and Tasks • HCP Skills to Support Self-management • Approaches to Self-management Support • Health Behaviour Change Theories • Measuring the Effectiveness of Self-management Support 	<p>Activity 1.4: Approaches to Self-management Support</p> <p>Activity 1.5: Health Behaviour Change</p> <p>Activity 1.6: Self-management Support Outcomes</p> <p>Activity 1.7: Read and Reflect</p>
Core Reading	<p>Charmaz, K. (1997). <i>Good days, bad days: the self in chronic illness and time</i>. New Brunswick, N.J., Rutgers University Press.</p> <p>Lorig K. and Holman H. (2003). Self-management education: History, definition, outcomes, and mechanisms. <i>Annals of Behavioural Medicine</i>, 26(1): 1-7.</p>	
Accompanying Slide Pack for Unit 1	https://www.hse.ie/sms-undergradcurriculum/	

Unit 1: Foundations for Self-management Support for Chronic Conditions

Introduction to Unit 1

In Unit 1 you will be introduced to the concept of self-management support through exploration of the definitions, foundations and principles underpinning both self-management and self-management support. Here, you will explore the core tasks and skills which individuals with chronic conditions require to be effective self-managers. In addition, you are encouraged to explore the skills that are required of the healthcare professional in supporting individuals to develop the skills which they need to self-manage their chronic condition.

Lesson 1: Introduction to Self-management Support

Duration: 1 Hour



**PPT Title – Unit 1 Lesson 1:
Introduction to Self-management Support**

Introduction to Lesson 1

In Lesson 1 you will be introduced to the concept of self-management and self-management support. Discussions will focus on the definitions and principles of both concepts. As the focus of self-management support is on individuals with a chronic condition you will have an opportunity to recap on some facts and policy documents on the determinants and incidence of chronic conditions. You will reflect on person-centred care, social cognitive theory and empowerment as they apply to self-management. We will explore the core components of self-management- medical, role and emotional, and corresponding tasks. You will also be introduced to the skills of self-management.



Some Background

The Department of Health and Children (2008) in Ireland, in the policy *Tackling Chronic Disease*, indicate that chronic conditions are “long-term conditions, lasting more than six months, are non-communicable and involve some functional impairment or disability and are usually incurable” (p. 9). Multimorbidity is described as “The coexistence of two or more chronic conditions in the same individual” (World Health Organisation, 2016, p. 3).

Living well with Chronic Conditions

“The concept of living well reflects the best achievable state of health that encompasses all dimensions of physical, mental, and social well-being” (Institute of Medicine, 2015, p. 486). However, there may be some differences between individuals about what ‘living well’ means, this may be more evident in individuals with a chronic condition.



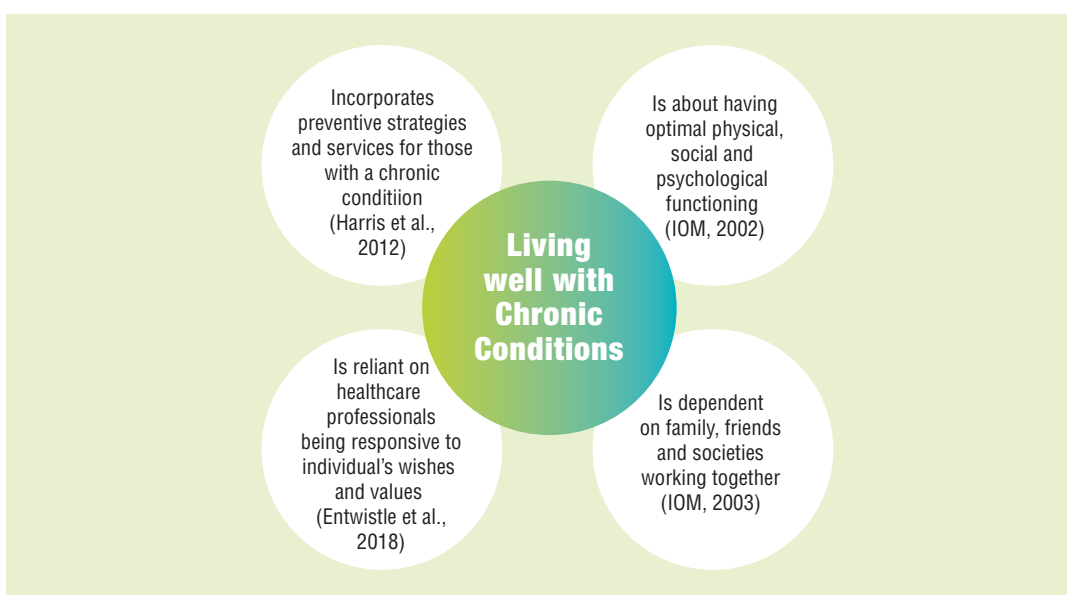
Pause for Reflection and Discussion

What does living well mean to you?

What do you think living well means to a person with a chronic condition?

Do you think it is any different to how a person without a chronic condition feels?

Figure 1.1: Key Components of Living Well with Chronic Conditions



Write a definition of what you believe a chronic condition is. Now, write 3 sentences on what you think it would be like to live well with a chronic condition.



Read Fact-sheet 1 accompanying this lesson which offers some definitions on chronic conditions, compare your definition to the definitions provided and discuss in groups.



Read Fact-sheet 2 accompanying this Lesson on the causes and determinants of chronic conditions (you may have previously studied these topics in other modules and specifically in the 'Making Every Contact Count' module).



Some Background

Healthy Ireland in the Health Services – National Implementation Plan (Health Service Executive, 2015) included as a strategic priority, 'reducing the burden of chronic disease' and addresses this through specific actions. Such actions include development and implementation of services to support a national framework for self-management for the major cardiovascular, respiratory diseases and diabetes; and to increase the proportion of individuals utilising self-management supports.

"Living Well with a Chronic Condition" (Health Service Executive, 2017), the national framework for self-management support for chronic conditions, which arose from the Healthy Ireland Implementation plan, was launched in 2017 and specifically addresses COPD, asthma, diabetes and cardiovascular disease (<https://www.hse.ie/eng/health/hl/selfmanagement/hse-self-management-support-final-document1.pdf>).



Read “*Healthy Ireland in the Health Services – National Implementation Plan*” (Health Service Executive, 2015) and “*Living Well with a Chronic Condition*” (Health Service Executive, 2017) for background context.

We will now explore the concept of self-management for chronic conditions.



Pause for Reflection and Discussion

What are your thoughts on self-management?
What do you think self-management involves?

Let us start by focusing on the principles and definitions of self-management.

What is Self-management?

Self-management is the process where individuals with chronic conditions take control of their health and actively manage their chronic condition/s to the best of their ability. Chronic conditions can result in considerable difficulties for individuals physically, psychologically, and socially. So, self-management is a process whereby individuals develop knowledge and skills in how to manage the impact of their chronic conditions in their everyday lives.



Activity 1.1: Self-management definitions

Take a look at the following two definitions.

“The day-to-day tasks an individual must undertake to control or reduce the impact of disease on physical health status. At-home management tasks and strategies are undertaken with the collaboration and guidance of the individual’s physician and health care providers”

(Clark *et al.*, 1991, p. 5).

“The ability of the individual, in conjunction with family, community and healthcare providers to manage symptoms, treatments, lifestyle changes, and psychosocial, cultural, and spiritual consequences of health conditions”

(Richard and Shea, 2011, p. 261).

How do they compare and contrast?

Which of the two definitions do you think best captures what is required of individuals in order to ‘live well’ in managing their chronic condition?

How have these definitions changed over time?

What do they mean for you as a healthcare professional?

Discuss in groups

What is Self-management Support?

Self-management Support is...

Holistic interventions aimed at maximising physical and psychosocial functioning by providing individuals with skills to manage symptoms, treatments and the psychosocial consequences of living with a chronic condition (Lorig and Holman, 2003).

“The systematic provision of education and supportive interventions, to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support” (Health Service Executive, 2017, p. 12)



Activity 1.2: Self-management support definitions

How have these definitions changed over time?

What do they mean for you as a healthcare professional?

Discuss in groups

Self-management support is the assistance health professionals and others give to individuals with chronic conditions to maintain active management of their condition and to encourage daily decisions that improve health-related behaviours and clinical outcomes. Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help individuals choose healthy behaviours; and as a fundamental transformation of the relationship between the individual with a chronic condition and their healthcare professional, to a collaborative partnership. The overall purpose of self-management support is to aid and inspire individuals to become informed about their chronic condition and take an active role in their treatment and management of the impact of a condition on their lives (Bodenheimer *et al.*, 2005).

Self-management support is an intervention at the individual level with potential for positive impacts on health and health behaviours. Self-management support, tailored to various chronic conditions including diabetes, asthma, COPD and cardiovascular disease, has potential to be effective across the preventative spectrum of primary, secondary and tertiary disease prevention (Grady and Gough, 2014).

The person who is able to self-manage their long term condition:

- 1) Knows about their condition.
 - 2) Follows a treatment plan (care plan) agreed upon with shared decision making with their healthcare professionals.
 - 3) Monitors and manages signs and symptoms of their conditions.
 - 4) Knows how to respond to a deterioration in their condition.
 - 5) Manages the impact of the condition on their physical, emotional and social life.
 - 6) Adopts lifestyles that promote health.
 - 7) Has access to support services and has the confidence and ability to use them
- (Health Service Executive, 2017, p. 12, adapted from Flinders University, 2017).

Figure 1.2 demonstrates the actions recommended in the '*Living Well with a Chronic Condition*' framework at four levels, to support the person in their management of their long-term condition: Individual level, Healthcare professionals, Organisation, and Wider system.

The actions recommended are at the levels of the individual, the healthcare professional, the organisation and the wider system.

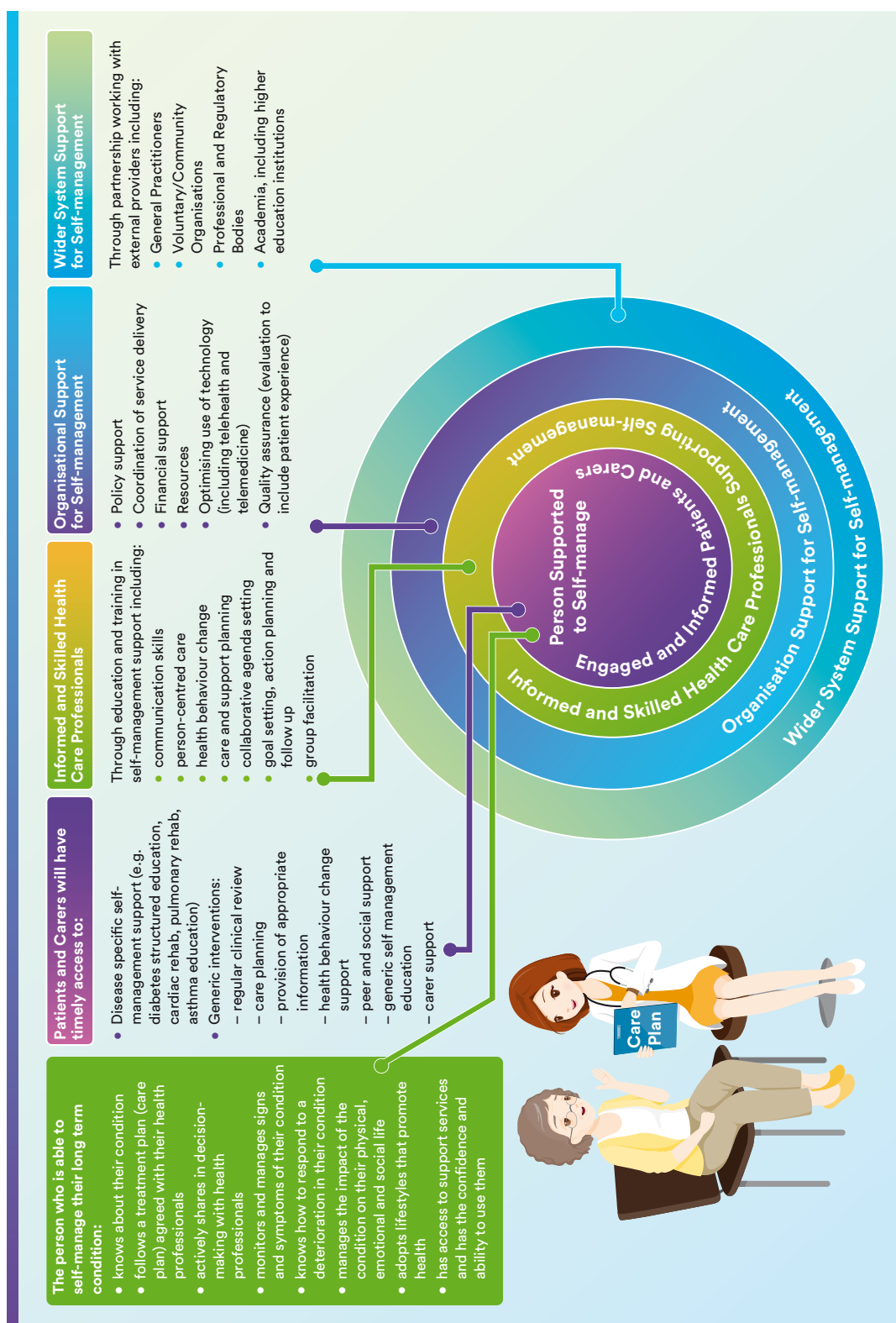
Individual level – Individuals should have access to disease specific interventions which support their self-management e.g. cardiac and pulmonary rehabilitation, diabetes structured patient education, provision of asthma action plans. Generic interventions should also be provided including regular clinical review, care and support planning, provision of information, health behaviour change support, peer and social support, generic self-management education, and carer support.

Healthcare professionals – Healthcare professionals should be provided with the skills and information they need in supporting self-management, including adopting a person-centred approach and encouraging individuals' engagement.

Organisation – The healthcare organisation should provide disease specific and generic interventions which support self-management; policy support; financial support and resources; coordination of delivery; technology supports; quality assurance and evaluation.

Wider system – Wider system support is provided through partnership with non-HSE healthcare staff such as general practitioners, practice nurses and pharmacists; voluntary organisations and service users; community organisations; peer support; and academia.

Figure 1.2: Whole System Model for Self-management Support (Reproduced with permission from Health Service Executive, 2017, p. 18)



Self-management support and disease specific education

Most individuals with diabetes, asthma, COPD and cardiovascular disease need disease-specific education regarding their chronic condition. This usually includes information related to the causes, sign and symptoms, and treatments of a specific condition. It may also include information and demonstration of technical skills related to the treatment of the specific chronic condition. For example, disease specific education related to diabetes may include information on causes and risk factors for diabetes, and factors that may impact on disease progression; development of complications; or risk of exacerbation; medication management, and technical skills involved e.g. monitoring blood glucose levels if required. The person delivering the education is considered a specialist in the specific chronic condition (Bodenheimer *et al.*, 2002).

Table 1.1 illustrates how self-management support has built on and improves on traditional disease specific education through the development of skills and confidence in the medical, role and emotional management of their condition. Self-management support includes the provision of disease-specific education as well as the development of core self-management skills, which we will discuss in more detail in Unit 4.

Table 1.1: Traditional Disease Specific Education and Self-management Support

	Traditional Disease Specific Education	Self-management Support
What is the focus?	Information and technical skills related to the disease	Problem-solving skills
Problem-identification	Problems are pre-defined as related to clinical understanding of disease and disease management	Problems are identified collaboratively by individual and healthcare professional reflecting individual priorities while acknowledging problems can arise even when chronic conditions are being managed well.
Relationship between the educational content and the specific chronic condition	Content focuses on information and technical skills required to manage the symptoms of a specific chronic condition	Content focuses on development of knowledge and skills required to manage symptoms of disease and the impact of disease on everyday activities
Underlying assumption/s of education	Disease specific education may improve clinical outcomes through effective symptom management	Development of an individual's confidence in their knowledge and skills of their chronic condition, and its consequences on daily life, may result in better clinical and individual-reported outcomes
Overall goal	Adoption of behaviours required for symptom management and treatment, with the aim of improving clinical outcomes	Increased confidence in medical, role and emotional management to improve clinical outcomes and other outcomes
Education provider	Healthcare professionals	Healthcare professionals <i>and</i> individuals with a chronic condition

Did You Know?

A person-centred approach is fundamental to both self-management and self-management support.

For centuries, the medical model largely ignored the expertise of the individuals being treated. Individuals were positioned as passive clients whose role was to be investigated, diagnosed and to take their treatment as prescribed. However, healthcare professionals need to recognise that it is the individual who decides to attend the healthcare professional, it is the individual who understands how the illness is affecting his or her life and it is the individual whose motivation,

self-efficacy and social circumstances will dictate considerably the outcomes of any therapeutic plan or strategy. Thus, if the healthcare professional, comes to regard every encounter with the individual as a meeting with another expert, they are unlikely to undervalue the individual's perspective, their know-how, and their insights.



View this web link to access a “toolbox” on Person-centred Care and Support: <https://www.hse.ie/eng/about/who/qid/resourcespublications/patientsafetytoolboxtalks.html>

Taking a person-centred approach when providing self-management support, facilitates a collaborative relationship and shared decision-making between healthcare professionals and individuals with chronic conditions. This approach recognises that the healthcare professional and the individual both bring different types of expertise to the management of the individual's chronic condition. This collaborative approach facilitates effective self-management support.

“Person centred co-ordinated care provides me with access to and continuity in the services I need when and where I need them. It is underpinned by a comprehensive assessment of my life and my world combined with the information and support I need. It demonstrates respect for my preferences, building care around me and those involved in my care” (adapted from Irish Platform for Patient Organisations Science & Industry (IPPOSI), 2019).

Table 1.2: Person-centred Approach

A Person-centred Approach recognises the healthcare professional is knowledgeable in:	A Person-centred Approach recognises an individual with a chronic condition is expert in:
Making diagnoses	Personal experience of the illness
Disease monitoring	Personal social circumstances and network
Disease aetiology	Personal attitudes to risk
Estimating prognosis	Personal values
Therapeutic options	Personal preferences
	Personal goals

Social cognitive theory applied to self-management support

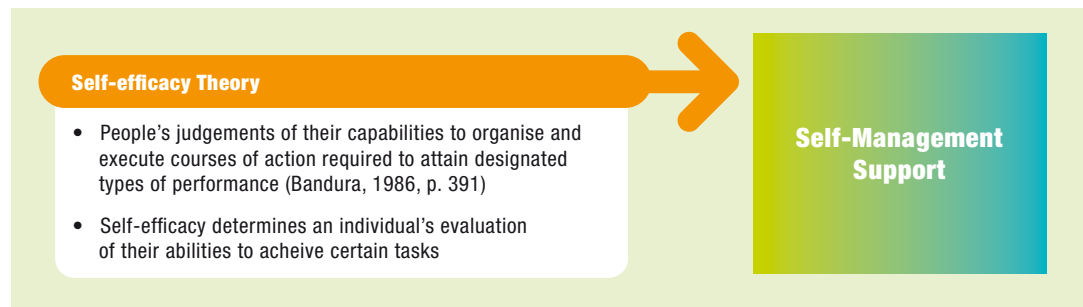


Some Theory

Social cognitive theory holds that an individual's knowledge acquisition is related to observing others within the context of social interactions, experiences, and outside media influences. It includes four elements: self-evaluation, self-observation, self-regulation and self-efficacy. Although all four elements contribute to development of self-management, self-efficacy is what helps people believe in their abilities to change and to take the necessary actions to make those changes. Therefore promotion of self-efficacy is considered a cornerstone of self-management support.

Self-efficacy is defined as “People’s judgements of their capabilities to organise and execute courses of action required to attain designated types of performance. It is concerned not with the skills one has but with the judgements of what one can do with whatever skills one possesses” (Bandura, 1986, p. 391). Individuals need to develop confidence in their knowledge and skills in order to manage their current health status and any future changes or fluctuations to their health. You will revisit self-efficacy theory in Unit 4.

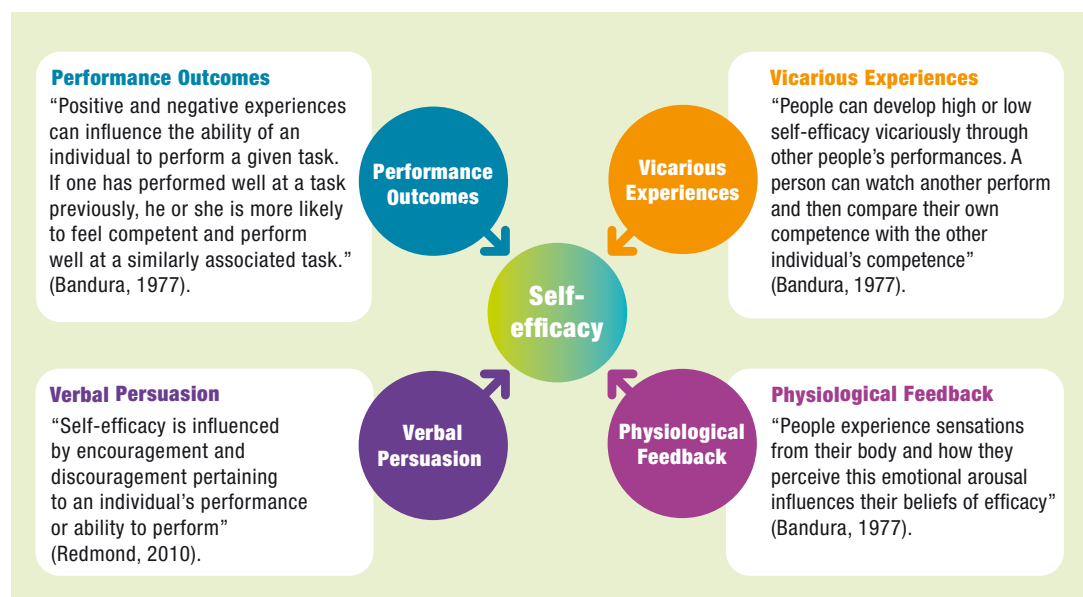
Figure 1.3: Self-efficacy Theory and Self-management Support



Did You Know?

There are four different ways in which a healthcare professional can help individuals to be more confident in self-management of chronic conditions: 1) Performance mastery, 2) Vicarious experience, 3) Social and verbal persuasion, and 4) Physiological and emotional responses.

Figure 1.4: Determining Efficacy Judgements (adapted from Redmond, 2009)



Healthcare professionals must provide individuals with opportunities to maximise the impact of these four influences on self-efficacy in order to develop individuals’ confidence for self-management. Examples of this include:

Performance mastery:

- Ask the individual to discuss past positive accomplishments in undertaking self-management tasks and to identify factors that led to success in these tasks.
- Facilitate opportunities for the individual to acquire and practice successful self-management skills by setting achievable goals.

Vicarious Experience:

- Provide opportunities for individuals to compare their abilities to cope with the emotional and physical impacts of their chronic condition with others with similar chronic conditions.

Social and verbal persuasion:

- Provide encouragement, coaching and feedback.

Physiological and emotional responses:

- When reviewing self-management goals ask the individual how they felt when approaching and working on their goals.
- Provide individuals with strategies to manage any anxieties when working on their goals.

The role of empowerment in self-management

If individuals have relevant knowledge and skills, they are more likely to accept responsibility for and have confidence managing their own health and for solving future health problems with evidence based information. Empowerment is facilitated by knowing where to find reliable information and resources (carer and community) that can support individuals to be effective self-managers (Bodenheimer *et al.*, 2002).



What does effective self-management involve?

Components of Self-management

Effective self-management involves successfully managing three components of living with a chronic condition: medical, role and emotional self-management.

Medical management:

The tasks an individual needs to carry out in relation to managing the medical aspects of their chronic condition. This includes taking medications; using appropriate medical devices, and following a recommended diet and prescribed exercise programmes (Lorig and Holman, 2003).

Examples of self-management tasks required for medical management include:

- Monitoring of symptoms and signs associated with the condition. Examples of these might include daily weighing for a person with heart failure, monitoring of blood glucose levels in type 1 diabetes and knowing when to seek help and healthcare professional input.
- Agreeing a care plan with healthcare professional.
- Working on changing health behaviours such as exercise, healthy eating, etc.

Role management:

The activities and tasks involved in carrying out their usual roles for example as a student, worker, parent, friend, etc., while accommodating their chronic condition and any restrictions they experience as a result of their chronic condition (Lorig and Holman, 2003).

Examples of self-management tasks required for role management include:

Recognising and addressing the effects of particular symptoms of the chronic condition on aspects of daily living. For example, fatigue is a common symptom experienced by individuals with many different types of chronic conditions. So, individuals need to understand fatigue and use effective fatigue management strategies to enable them to participate effectively in daily activities. A person with heart disease might substitute swimming for hillwalking. Can you think of any other examples?

Emotional management:

Living with a chronic condition can result in a wide range of emotional issues for individuals such as feeling frustrated, worried, depressed or angry. These emotions can impact on daily activities and can also influence the severity of symptoms associated with chronic conditions. Therefore emotional self-management of chronic conditions involves recognising and addressing the social and emotional effects of the chronic condition on oneself, one's carers and community (Lorig and Holman, 2003).

Examples of the tasks required for emotional self-management include:

Recognising and addressing the emotional effects of chronic conditions on one's life and exploring ways to manage emotions. Communicating effectively with carers and a wider social network to maintain effective relationships; identifying and learning how to use stress management strategies and knowing when to seek healthcare professional help when needed. Of note people with chronic physical illness have a higher risk of depression and anxiety (see Unit 2 for more details).

Self-management Skills

There are core interpersonal skills that are required to carry out the tasks of medical, role and emotional self-management including; problem-solving, decision-making, resource utilisation, forming partnerships and action planning (Lorig and Holman, 2003). These skills will be explored in detail in Unit 4.

Figure 1.5: Elements and Skills of Self-management Support





Activity 1.3: Self-management components

Think of a time that you have worked with an individual with a chronic condition
Can you identify aspects of 1) medical, 2) role and 3) emotional self-management?

Discuss in groups.

Note for instructors: If a student has not had clinical experience they could consider someone they know, e.g. family member or friend

Summary of the Lesson

In Lesson 1, you were asked to discuss the concept of living well and living well with a chronic condition. You explored the definitions and principles of self-management and self-management support and the differences between traditional disease-specific education and self-management support. You explored the core components and tasks of self-management; medical, role and emotional self-management, and you identified the skills an individual needs to self-manage.

In Lesson 2, you will have the opportunity to further explore the concepts of self-management and self-management support. There will be some discussion on the skills that a healthcare professional requires to support self-management. You will be provided with a fact-sheet which offers information on approaches to self-management and on self-management support programmes including the Flinders Chronic Condition Management Programme and the Stanford Chronic Disease Self-management Programme. There will be opportunity to identify some of the methods used to assess the effectiveness of self-management support. Lastly, you will be asked to read some relevant papers and respond to guided questions on self-management support criteria.

Factsheet 1: Chronic Conditions in Ireland

What is a Chronic Condition? Definitions of chronic conditions vary. The US Centre for National statistics defines a chronic condition as a condition that lasts for three months or more. This rather inclusive definition could arguably include a presentation of infectious mononucleosis followed by a prolonged period of post viral fatigue. The Irish Department of Health and Children (2008), in the policy *Tackling Chronic Disease*, define chronic conditions as "long-term conditions, lasting more than six months, are non-communicable and involve some functional impairment or disability and are usually incurable" (p. 9).

What are the Components of Chronic Conditions?

Chronic conditions are long-term, and often lifelong. They are non-communicable (albeit they may have communicable antecedents and aetiological factors). They always involve some degree of functional impairment, social impairment or disability and, given that they are chronic, they are not curable. Thus you need to think about a chronic condition as something established that you are attempting to mitigate and manage rather than cure. Typical chronic conditions include cardiovascular disease, diabetes, asthma, chronic obstructive airways disease, rheumatoid arthritis, etc. Many chronic conditions have a genetic and or familial component. However, lifestyle factors may contribute to the onset of chronic conditions, its severity and its prognosis. The well-known lifestyle factors include smoking, alcohol consumption, unhealthy diet, inadequate physical activity, and obesity.

IRISH CHRONIC CONDITION FACTS

- 38% of Irish people over the age of 50 years have one chronic condition.
- By the age of 65, 65% of adults have two or more chronic conditions.
- Ireland has a population of 4.6 million people; 1 million adults in this country have either cardiovascular disease, respiratory disease or diabetes.
- People with chronic conditions utilise about 70% of health service resources. They are much more likely to require general practice services, they are more likely to present to an emergency department and they are more likely to be admitted than sent home.
- It has been estimated that up to 80% of general practice consultations and 76% of hospital bed days relate to chronic condition and its complications.

CHRONIC CONDITION MANAGEMENT

The management of chronic conditions and multi-morbidity is complex and challenging. Clinical care is often fragmented between primary and secondary care and between state-run health services and the voluntary sector. Tackling chronic conditions requires integration between government, health services, service providers, non-government organisations, community organisations and individuals. At a government level the focus is on creating policy documents, setting targets, agreeing how to distribute resources and monitoring outcomes. At a regional and local level, the focus is on the integration of formal and non-government organisational activities and the implementation of best evidence practice at secondary and primary care levels. At sites of healthcare provision such as primary care or specialist clinics and hospitals, the focus is on applying the best possible care customised to the needs of each individual.

In Ireland, there have been several policy initiatives that inform how Ireland intends to address its growing chronic condition problem:

- Tackling Chronic Disease (2009) <https://www.lenus.ie/bitstream/handle/10147/45895/9558.pdf?sequence=1&isAllowed=y>
- Healthy Ireland (2013) <http://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf>
- As an action from the "healthy Ireland in the health services" implementation plan, two important framework documents were developed:
- Making Every Contact Count (2016) <https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/making-every-contact-count-framework.pdf>

- Living Well with a Chronic Condition (Health Service Executive, 2017) <https://www.hse.ie/eng/health/hl/selfmanagement/hse-self-management-support-final-document1.pdf>

Common themes emerging from these policies consider:

- That chronic conditions need to be prevented, where possible (not all chronic conditions are preventable e.g. type 1 diabetes), as well as managed, and that individuals can play a large part in preventing or mitigating the effects of disease by taking responsibility for their own lifestyle choices, eating properly, stopping smoking and other addictive substances, reducing alcohol intake, taking exercise and keeping weight under control.
- The importance of self-management as a concept in managing established a chronic condition.

Reference

Department of Health and Children. (2008). *Tackling Chronic Disease – A Policy Framework for the Management of Chronic Disease*. Department of Health and Children. Available at: <https://www.lenus.ie/bitstream/handle/10147/45895/9558.pdf?sequence=1&isAllowed=y>

Factsheet 2: Causes of Chronic Conditions



SOCIAL DETERMINANTS

The social determinants of health play an enormous part in the quality of health, longevity and the prevalence of chronic conditions in any society. Health is much more strongly associated with adequate housing and access to clean water than it is with the availability of antihypertensive or lipid-lowering medications. Thus, as healthcare professionals, we must recognise the relatively small part that we play in contributing to the overall health of the population. An individual's health is more likely to be determined by his/her socio-economic status, for example, than it is by the quality of his healthcare. Critical social determinants of health include:

- Income
- Educational attainment
- Employment status and job security
- Working conditions
- Early childhood development
- Food security
- Housing
- Social exclusion
- Social networks and social capital
- Sex
- Race
- Disability

The rising burden of chronic conditions is due mainly to behavioural factors. Many chronic conditions such as cancer, CVD, COPD and diabetes are amenable to prevention.

The main risk factors are tobacco and alcohol use, overweight and obesity, and low levels of physical activity. Associated risk factors such as hypertension and hyperlipidaemia are also major contributors. However, the aetiology of chronic conditions is complex. Whilst lifestyle and risk factors are modifiable through changes in diet, behaviour and medication, many factors are even more difficult to address. Poorer people are more likely to smoke, to be overweight or obese as children and adults, and be less physically active. Notably, smoking is the greatest contributor to health inequalities between the richest and poorest sections of society.

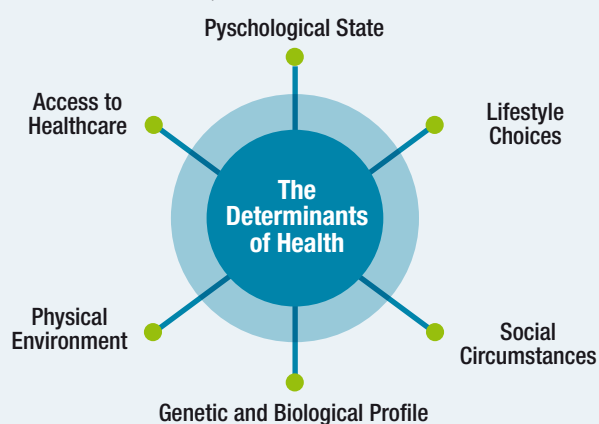
Smoking is also a significant factor in gender-based mortality differences. Members of the travelling community, both men and women, have especially high smoking rates. Raised blood pressure shows a social class differential, with the poorer sections having higher levels of raised blood pressure. No differential is shown for raised cholesterol (Jennings, 2014).

WHAT DETERMINES YOUR HEALTH?

What determines your health? The first thing that might spring to mind is the quality of your diet, whether you take exercise or perhaps your stress levels. However, these factors are only a very small part of the picture.

There are many factors that impact upon health and wellbeing. These include the circumstances in which people are born, grow up, live, work and age. These factors are not usually the direct causes of illness but are described as “the causes of the causes”. While smoking is the cause of illnesses such as COPD, heart disease and lung cancer, it is the social factors, including cultural and environmental factors, which largely determine whether an individual is more or less likely to smoke, and if they do start whether they are likely to quit successfully.

Factors such as where we live (e.g. damp, poorly insulated accommodation), the state of our environment (e.g. working in a noisy or toxic environment), genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.



The determinants of health (Department of Health, 2013)

Reference

Jennings, S. M. (2014). *Preventing chronic disease: defining the problem*. Dublin: Health Service Executive. Available at: https://www.lenus.ie/bitstream/handle/10147/338212/PreventingChronicDisease_DefiningtheProblem.pdf?sequence=3&isAllowed=y

Department of Health. (2013). *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025*. Dublin: Department of Health. Available at: <https://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf>

Lesson 2: Self-management Skills, Approaches and Outcomes

Duration: 1 Hour



**PPT Title – Unit 1 Lesson 2:
Self-management Skills, Approaches and Outcomes**

Introduction to Lesson 2

In Lesson 2 you will have the opportunity to gain a deeper understanding of the concepts of self-management and self-management support. You will discuss the skills that a healthcare professional requires to support self-management. You will review a fact-sheet, which offers information on approaches to self-management and on self-management support programmes including the Flinders Chronic Condition Management Programme and the Stanford Chronic Disease Self-management Programme. This is followed by discussions around facilitating individuals to become effective self-managers. You will take time to consider some of the methods used to assess the effectiveness of self-management support. Lastly, you will be asked to read some relevant papers and respond to guided questions on self-management support criteria.

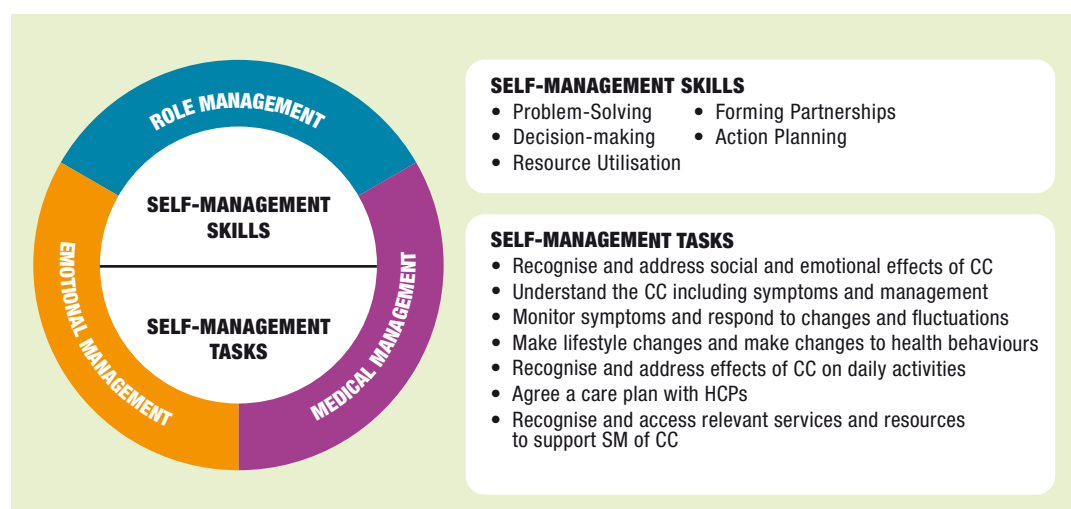
Recap Unit 1 Lesson 1

In Lesson 1 you explored the concept of living well with a chronic condition and you discussed the incidence and determinants of chronic conditions. The role of self-management to living well with a chronic condition was acknowledged and you were introduced to definitions and principles of self-management and self-management support. You explored the core components and tasks of self-management: medical, role and emotional self-management, and you identified the skills an individual needs to self-manage.

Self-management Skills and Tasks

In Unit 1 we identified three components of self-management, medical, role and emotional self-management. In order to self-manage, the person needs to undertake several tasks, and attain a number of skills. The components, tasks and core skills that an individual needs for effective self-management are presented in Figure 1.6.

Figure 1.6: Self-management Components, Skills and Tasks





Pause for Reflection and Discussion

An individual with a chronic condition has to develop skills to carry out the tasks of effective self-management. What skills do you think a healthcare professional requires to support self-management?

Healthcare Professional Skills to Support Self-management

The healthcare professional needs to possess core skills in order to collaborate with individuals with chronic conditions, these include the ability to:

- Assess the individual's level of knowledge and existing engagement.
- Assess readiness to change (Unit 1 and *Making Every Contact Count* Curriculum).
- Promote healthy lifestyles and educating people about their chronic condition (Unit 1 and *Making Every Contact Count* Curriculum).
- Facilitate development of core self-management skills in individuals with chronic conditions: problem-solving, decision-making, resource utilisation, forming partnerships and action planning (Unit 4 and Unit 5).
- Provide individuals with information on their chronic condition to enable them to monitor their symptoms and know when and how to take appropriate action (Unit 2 and Unit 4).
- Identify and utilise relevant state, community and voluntary/charitable support services. Provide or signpost to opportunities to share and learn from other individuals with similar chronic conditions (such as peer support groups Unit 2, 4 and 5).
- Communication and negotiation skills required to support and work in partnership with individuals with chronic conditions (Unit 3).
- Motivational interviewing skills (Brief intervention skills, based on motivational interviewing, are addressed in the *Making Every Contact Count* curriculum. Motivational interviewing is not dealt with further here. It is not dealt with here as more specialised training would be required).

Thus, effective self-management requires a lot of commitment from the persons experiencing the conditions as well as the health professionals involved.



Approaches to Self-management Support

There are two commonly used approaches to providing self-management support: individually delivered self-management support and group-based self-management support. **Factsheet 3** provides an overview of the approaches to self-management support.



Activity 1.4: Approaches to self-management support

Why do you think someone might be more suited to an individual or group approach to self-management support? Discuss in groups

Individual approach to self-management support

“Supporting self-management is inseparable from high-quality care for people with long term conditions” (Health Service Executive, 2017, p. 14). An individual approach to self-management support involves development of a self-management care plan negotiated between healthcare professionals, the person, and their carer. The aims of a self-management care plan are:

- To facilitate the person's engagement in assuming responsibility for their own healthcare.
- To enhance the relationship between the person and the healthcare professional.
- To enhance the person's self-efficacy for managing their health and achieving optimal health outcomes.
- To support the person to make and maintain health behaviour change relevant to their chronic condition/s.
- To facilitate disease-specific skill acquisition.
- To create an opportunity for healthcare professionals to provide feedback on self-management outcomes.

Two internationally recognised self-management support programmes are the **Flinders Chronic Condition Management Programme** (Battersby *et al.*, 2007) and the **Stanford Chronic Disease Self-management Program** (Lorig *et al.*, 2001). Both are licensed programmes and require specialised training by registered trainers in order to be licensed to deliver either programme.



Before deciding on which approach to use, the ability of an individual to assume responsibility for managing their chronic condition needs to be assessed in order to identify the most appropriate approach to take to provide self-management support.

Some individuals may require minimal support while others with more complex health issues may require more intensive support (Lawn and Schoo, 2010).

Group-based self-management support

Group-based self-management approaches are typically delivered over a 6-week period and usually consist of between 6-12 individuals. They are often supplemented with written materials so that participants have a resource after completion of the programme to which they can refer as a reminder of self-management strategies. The weekly sessions consist of presentation of disease related information by a healthcare professional followed by group discussion where individuals have an opportunity to share their experiences and to ask questions related to disease management (Barlow *et al.*, 2002).

Due to the group nature of this approach, it is not possible to tailor the content to each individual's needs. Therefore, many group programmes cover generic issues related to living with a chronic condition including:

- healthy eating
- the role of physical activity on chronic condition management
- pain management
- strategies for managing the psychosocial impact of living with a chronic condition
- communication strategies for developing an effective partnership with healthcare professionals

Facilitating individuals to become effective self-managers

To become an effective self-manager an individual has to firstly be motivated to want to change how s/he manages his/her health and secondly, have the self-belief that they are capable of managing the day to day aspects of their chronic condition. The '*Making Every Contact Count*' module discussed theories that are used to understand what motivates individuals to make changes to their health behaviours.

Health Behaviour Change Theories Underpinning Self-management of Chronic Conditions

Behaviour change models help to understand why people behave the way that they do so that they can be encouraged and supported to make and maintain healthy lifestyle choices. Behaviour change can be very complex, particularly encouraging individuals to adopt healthy behaviours.

Did You Know?

Health behaviour change theories are covered in Making Every Contact Count curriculum (Unit 2, lesson 4).

- Trans-theoretical Model of Health Behaviour
- The Health Belief Model
- The Behaviour Change Wheel (COM-B)



Activity 1.5: Health Behaviour Change

Revise the Trans-theoretical Model of Health Behaviour, The Health Belief Model and The Behaviour Change Wheel (COM-B), especially the principles of each model (Revision from *Making Every Contact Count* curriculum).



Pause for Reflection and Discussion

How do you think “health behaviour change theories” apply to self-management? Discuss in groups

For behaviour change to take place the individual must want to make changes to how they are currently managing their chronic condition (be motivated) and secondly feel capable of making necessary changes (be confident in their ability to make changes: i.e. self-efficacy).

Therefore, the process begins by assessing an individual's self-management behaviours, identifying any barriers to self-management and/or psycho-social difficulties that could interfere with self-management ability.

Two simple questions can guide healthcare professionals in identifying this

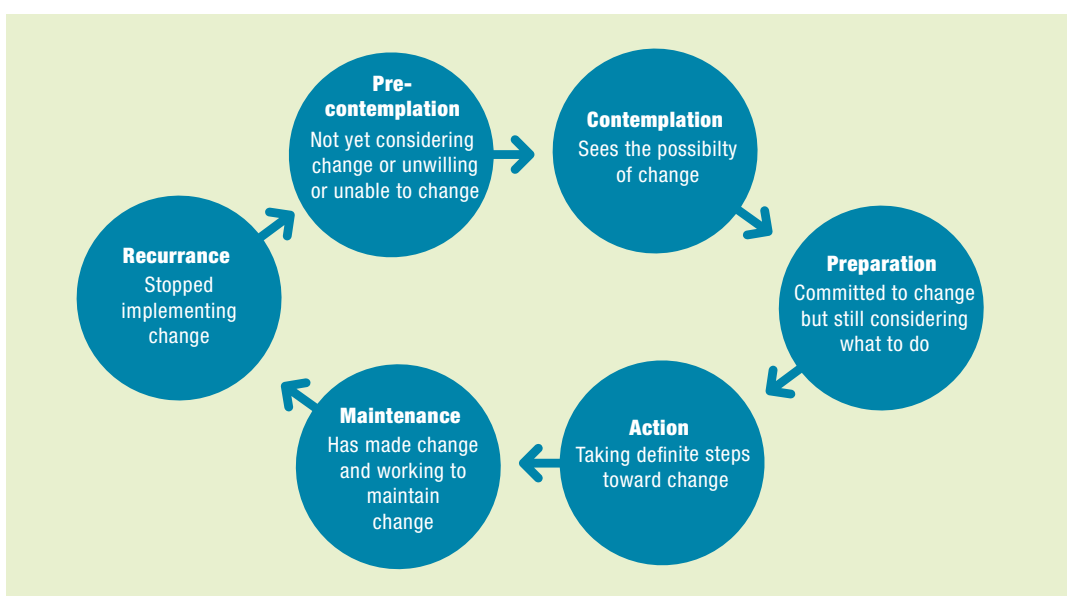


1. "On a scale of 1-10 how important do you think it is for you to change how you currently manage your chronic condition?"

2. "On a scale of 1-10 how confident are you that you can make changes to how you currently manage your chronic condition?"



Figure 1.7: Trans-theoretical Stages of Change Model (adapted from Prochaska and DiClemente, 1992)



Pause for Reflection and Discussion

At what stage in the Trans-theoretical stages of change model do you think a healthcare professional can provide self-management support?

Measuring the Effectiveness of Self-management Support

It is hoped that by providing support to individuals to self-manage that we will, in the longer term, be able to observe changes for the better, for individuals, healthcare professionals and health service providers. Here is a short activity to explore this idea further;



Activity 1.6: Self-management support outcomes

Indicate the outcomes you would hope to see, as a result of self-management support, in relation to individuals with diabetes, healthcare professionals and health service providers' outcomes. One option for this activity is to use a platform such as Mentimeter to log feedback.

Individuals

Focused Outcomes



TEXT

Healthcare professional

Focused Outcomes



TEXT

Health Service Provider

Focused Outcomes



TEXT

Typical outcome measures used to evaluate the effectiveness of self-management support include:

Category	Outcomes for evaluation
Physical health	Blood pressure, weight, physical activity, physical endurance, peak expiratory flow rate, fatigue, pain, functional abilities
Self-management behaviours	Increased physical activity, improved diet, smoking and alcohol use, adherence to medication and treatment, attendance at appointments. Patient activation measures
Psychological health	Self-efficacy, anxiety, depression, problem-solving ability
Social health	Accessing support services, participation in social activities, quality of life
Laboratory tests	HbA1c, cholesterol
Medication	Medication management (including technique such as inhalers)
Cost	Cost of delivery of intervention (direct and indirect) to include facilitators time (healthcare professional and/or lay leaders); resources required to deliver self-management support such as space, refreshments, design and printing of manual, resources for participants such as relaxation tapes; costs offset due to fewer complications; successful prevention
Healthcare utilisation	Change in frequency of GP or practice nurse visits; ED visits; number of hospital admissions and length of stay; days lost from work or education, appropriateness of healthcare utilisation (e.g. regular GP review visits v. emergency presentations)
Process evaluation	Acceptability of self-management support to service users and healthcare professionals, health education questionnaire (HEIQ)



Activity 1.7: Read and Reflect

Read these papers on involving individuals with chronic conditions in chronic condition self-management:

Entwistle, V.A., Cribb, A., and Owens, J. (2018). Why Health and Social Care Support for People with Long-Term Conditions Should Be Oriented Towards Enabling Them to Live Well. *Health Care Analysis*, 26(1): 48-65.

Phillips, R.L., Short, A., Dugdale, P., Nugus, P., and Greenfield, D. (2014). Supporting patients to self-manage chronic disease: clinicians' perspectives and current practices. *Australian Journal of Primary Health*, 20(3): 257-265.

After reading the papers on self-management support for individuals with chronic conditions, consider the following questions;

- What is meant by the term self-management support, and what is its purpose?
- What are some of the key components of self-management support for individuals with a chronic condition?
- How important is the individual with a chronic condition in self-managing their condition, and what factors can influence a person's adoption of more effective self-management behaviour?
- How can healthcare professionals support individuals with a chronic condition to self-manage?
- What supports are needed to enable healthcare professionals to allow individuals with a chronic condition to 'Live Well'?

Summary of the Lesson

In Lesson 2 you explored tasks and skills needed for effective self-management and also the skills that a healthcare professional requires to support self-management. You were provided with fact-sheets which offer information on approaches to self-management and on self-management support programmes including the Flinders Chronic Condition Management Programme and the Stanford Chronic Disease Self-management Programme. You also highlighted the outcomes, which you would expect to see as a result of self-management support. Lastly, you were asked to review relevant papers and to respond to questions on self-management support criteria.

Factsheet 3: Approaches to Self-management Support

Individual approach to self-management

An individual approach to self-management involves development of a **self-management care plan** negotiated between healthcare professionals, the individual/carer. This will be addressed again in Unit 4.



The aims of a Self-management Care Plan

Group Based Self-management Support

Group-based self-management approaches are typically delivered over a 6-week period and usually consist of between 6-12 individuals. They are often supplemented with written materials so that participants have a resource after completion of the programme to which they can refer as a reminder of self-management strategies. The weekly sessions consist of presentation of disease related information by a health professional followed by group discussion where individuals have an opportunity to share their experiences and to ask questions related to disease management (Barlow *et al.*, 2002). Due to the group nature of this approach, it is not possible to tailor the content to each individual's needs. Therefore, many group programmes cover generic issues related to living with a chronic condition including:

- healthy eating
- the role of physical activity on chronic condition management
- pain management
- strategies for managing the psychosocial impact of living with a chronic condition
- communication strategies for developing an effective partnership with healthcare professionals

Self-management Support for Multimorbidity

As individuals age, there is an increasing likelihood that they will develop more than one chronic condition. This is known as multimorbidity and now we will take a moment to discuss multimorbidity in the context of self-management support.

Multimorbidity is defined as the co-existence of two or more chronic conditions (Van den Akker, 1996). Risk factors for multimorbidity are similar to those for single chronic condition and as people are now living longer, the incidence of multimorbidity is increasing globally. Multimorbidity is associated with reduced functional abilities, psychological distress and poorer quality of life. People with multimorbidity have reported that they have greater difficulty managing the impact of multimorbidity on their daily activities than managing their various chronic conditions. A Cochrane review of effective interventions for multimorbidity recommended providing support for individuals to maintain their functional abilities. Self-management support therefore focuses on developing broad-based knowledge and skills for individuals to manage their daily activities.

OPTIMAL, is a group-based self-management programme for individuals with multimorbidity (O'Toole *et al.*, 2013, Garvey *et al.*, 2015). It is delivered by a multi-disciplinary team over a 6-week period. The content of OPTIMAL includes fatigue and stress management, diet and physical activity, medication management and effective communication with carers, healthcare professionals and employers. Goal setting and problem-solving skills are embedded into each weekly session. Studies on the effectiveness of OPTIMAL demonstrate significant improvements in activity participation, self-efficacy and quality of life (Garvey *et al.*, 2015).

Self-management Support Programmes

Two internationally recognised self-management support programmes are **the Flinders Chronic Condition Management Programme** (Battersby *et al.*, 2007) and **the Stanford Chronic Disease Self-management Program** (Lorig *et al.*, 2001). Both are licensed programmes and require specialised training by registered trainers to in order to be licensed to deliver either programme.

The Flinders Chronic Condition Management Programme

The Flinders Chronic Condition Management Programme (Battersby *et al.*, 2007) is probably the most widely-known individual approach for providing self-management support. It is based on health behaviour change theory and provides structured opportunities for developing positive health behaviours to improve self-management abilities. The Flinders programme was developed following a considerable investment from the Australian government to promote self-management in individuals with chronic conditions. This was in recognition of the increasing burden of chronic conditions for individuals, their families and Australian health services. The Flinders programme uses a person-centred care planning process to set lifestyle-related goals for the management of an individual's chronic condition. It consists of a generic set of tools from which health professionals can choose in order to provide tailored self-management support based on individual's needs and readiness to engage in self-management.

The Stanford Chronic Disease Self-management Programme (CDSMP)

The Stanford Chronic Disease Self-management Program (CDSMP) is a group-based self-management programme developed by Kate Lorig and colleagues in Stanford University (Lorig *et al.*, 2001). The CDSMP was initially designed for people with arthritis to develop knowledge and skills to manage the medical, physical and psychological impact of their arthritis. It provides disease specific information, medication management, symptom management, strategies for dealing with the emotional aspects of living with chronic conditions and communicating effectively with healthcare professionals.

Internet-based self-management support

Various internet-based self-management support programmes have been developed over the past decade. The impetus for this development is related to a number of factors including:

- Less resource intensive to deliver
- Suits those who are unable to travel to receive self-management support
- Is more appealing to those who do not wish to participate in group-based self-management support
- More relevant to younger people who generally fulfil their information needs through online resources

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Unit 2: Holistic Approach to Self-management Support

Duration: **2 hours**

Recommended Programme Placement: **Year 2 or 3**

Lesson Plan

Unit 2: Learning Outcomes	<p>Competency: Apply a person-centred approach to holistically supporting individuals/ carers that integrates the biological-physical, psychological, social and cultural aspects of individuals' lives in self-managing a chronic condition</p> <p>Learning Outcomes:</p> <ul style="list-style-type: none"> 2.1 Recognise individuals with chronic conditions as whole persons with interacting and interdependent biological-physical, psychological, social and cultural aspects of self. 2.2 Appreciate how an individual's physical, psychological, social and/or cultural responses to a chronic condition may affect abilities to self-manage. 2.3 Critically reflect and examine clinical practice to apply a holistic approach to supporting self-management of individuals with chronic conditions. 2.4 Understand individuals' needs for information in different formats and at different stages of a chronic condition to support self-management. 2.5 Describe the concept of health literacy, assess information needs and provide information tailored to individual needs. 2.6 Identify the health consequences of limited health literacy, its relevance to self-management and the practical ways that healthcare professionals can contribute to mitigating the effects of limited health literacy. 	
Lesson 1: Good Days Bad Days 1 Hour	<ul style="list-style-type: none"> • Introduction to Unit 2 • Brief Recap Unit 1 • Introduction to Lesson 1 • Good Days Bad Days • Providing Holistic Support for SM • Simulation Exercise 	<p>Activity 2.1: Mental and Physical Health</p> <p>Activity 2.2: Triggers for Discussion</p> <p>Activity 2.3: Holistic Elements and Self-management</p> <p>Activity 2.4: Case Studies</p>
Lesson 2: Health Literacy 1 Hour	<ul style="list-style-type: none"> • Introduction to Lesson 2 • Brief Recap Unit 2 Lesson 1 • Provision of Information to Support SM • What is Health Literacy • Why Health Literacy Matters • Communication Skills for Health Literacy 	<p>Activity 2.5: Patient's Information Need</p> <p>Activity 2.6: HLS-EU The Movie</p> <p>Activity 2.7: Health Literacy Demands</p> <p>Activity 2.8: Teach-back</p> <p>Activity 2.9: Written Information</p>
Core Reading	<p>charmaz, K. (1997). <i>Good days, bad days: the self in chronic illness and time</i>. New Brunswick, N.J., Rutgers University Press.</p>	
Accompanying Slide Pack for Unit 2	<p>https://www.hse.ie/sms-undergradcurriculum/</p>	

Unit 2: Holistic Approach to Self-management Support

Introduction to Unit 2

In Unit 2, you will study the concept of holistic care in the context of self-management support. There will be opportunity to gain a deeper understanding of how to support individuals in the medical, role and emotional self-management of their chronic condition. There will be discussions on the ways in which healthcare professionals, communities and families can support self-management in a holistic way. There is a lesson on health literacy, again highlighting the importance of individual preferences and abilities in keeping with person-centred holistic care. Case studies are presented to facilitate learning.

Recap Unit 1

In Unit 1 you were introduced to the concept of self-management support through exploration of the definitions, foundations and principles underpinning both self-management and self-management support. You explored the core tasks and skills which individuals with chronic conditions require to be effective self-managers. In addition, you were encouraged to explore the skills that are required of the healthcare professional in supporting individuals to develop the skills that they need to self-manage their chronic condition.

Lesson 1: Good days Bad days

Duration: 1 Hour



PPT Title – Unit 2 Lesson 1:
Good days Bad days

Introduction to Lesson 1

In Lesson 1 you will be asked to reflect on what good days and bad days might feel like when living with a chronic condition. The interrelationship between physical and psychological health problems will be addressed. You will take time to consider how healthcare professionals can provide holistic care to individuals with chronic conditions, which supports self-management. Holistic care incorporates community and family support. In this Lesson, you will have an opportunity to reflect on a number of case studies and read about a home simulation exercise which describes how students may “live a week” as a person with diabetes.

Good Days Bad Days: A Holistic Approach



Living with a chronic condition entails managing the effects on physical, psychological and social functioning. As addressed in Unit 1, self-management includes having the confidence to deal with the medical, role and emotional self-management of long-term health conditions. All are elements that play a unique yet interrelated role. Everyone experiences good days and bad days, this is no different from living with a chronic condition. Have you ever thought about what it is that makes you feel well or healthy? Have you considered why you are having a good day or a bad day? Have you thought about how one aspect of your life can influence another? Let's take some time to think about these simple yet extremely significant factors.



Pause for Reflection and Discussion

What does having a good day mean to you?

What do you consider a bad day?

Would having a chronic condition alter your perception on having good or bad days?

It is possible to agree that living well with chronic conditions is reliant on managing a combination of inter-related holistic factors; including medical, role and emotional elements. In Unit 1, we identified that adopting a holistic person-centred approach in healthcare provision is key to successful self-management. The literature on chronic condition management frequently refers to a holistic approach as an integral part of optimal care.



Pause for Reflection and Discussion

What do you understand about the term 'holistic' in the context of chronic condition self-management?

The interrelationship between physical and psychological health problems

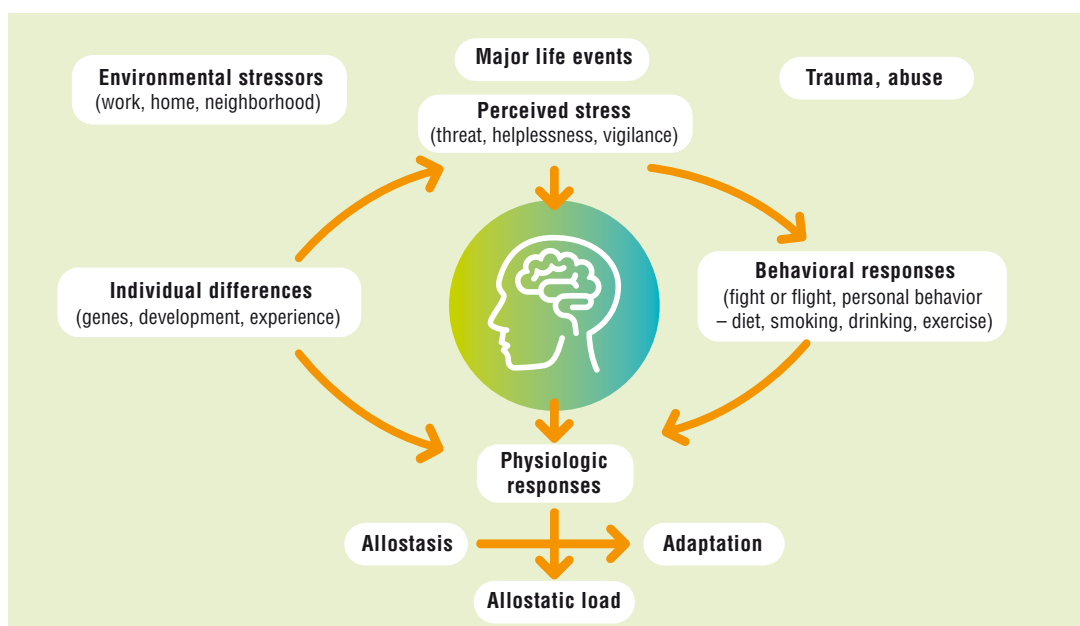
People with chronic physical illness have a higher risk of depression and anxiety. Both are very common co-morbidities for people with chronic physical illness (Naylor *et al.*, 2012). Depression and anxiety are also amongst the most common recurrent or long-term conditions people now face (World Health Organisation, 2017). It is important to recognise that mental disorders of all kinds are associated with an increased risk of onset of a wide range of chronic physical conditions (Scott *et al.*, 2016).



Activity 2.1: Mental and physical health

Write down 3 ways in which poor mental health might impact on physical health. Write down 3 ways in which poor physical health might impact on mental health. Discuss your responses in groups.

Figure 2.1: The stress response and development of allostatic load (adapted from McEwen, 2000, p. 114)





Discussing holistic care also provides opportunity to think about some of the instances that may support or impede an individual's ability to self-manage.

Did You Know?

Individuals with serious mental illness may face a series of barriers firstly in accessing healthcare provided self-management support; and secondly in effectively engaging in self-management of their illness. Persons with serious mental illness experience greater social challenges that may include unemployment, homelessness, incarcerations, victimization/trauma, poverty, and social exclusion. Consequently, it is particularly important for these persons to acquire the skills to self-manage both their chronic medical conditions and their mental illness.



Pause for Reflection and Discussion

Can you think of other instances where self-management is more challenging for individuals?



Activity 2.2: Triggers for discussion

Do you think that being deaf or blind would challenge a person's ability to self-manage?

Do you think being homeless would challenge self-management?



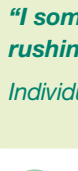
Activity 2.3: Holistic elements and self-management

Take a moment to read these quotes provided from individuals with chronic conditions. Can you see examples of how holistic elements influence self-management? Discuss in groups.



“My hospital is a teaching hospital, so my care team came with an army of medical students, and discussions about my situation and my care were had while I was sitting in the room with them, only they did not actively acknowledge my presence, so I felt like an animal at the zoo.”

Individual with a chronic disease (Benham-Hutchins et al., 2017, p. 6)



“I sometimes forget to take my medication, like if I’m in hurry, rushing to the mall, I forget and then take it after sometime.”

Individual with a chronic condition (Dube et al., 2017, p. 26)



“I can’t go to a public place.”

“I wish I could be normal like everybody else.”

“It means growing away from the pleasures of life.”

Individuals with Asthma (Pickles et al., 2018, p. 29)



“I literally told my professor that I had diabetes and that I need fast-acting sugar...she understood.”

Student Type 1 Diabetes (Hill et al., 2013, p. 239)

“I was alone with no family or friends available to act as advocates.”

Individual with a chronic disease (Benham-Hutchins et al., 2017, p. 5)



“I find it very hard to get an appointment. It’s over a year since I’ve seen the specialist in X hospital.”

Individual with chronic lung condition (Hudson and McMurray, 2017, p. 32)

There are lots of different ways of trying to get some appreciation of what it is like to have to live with a chronic condition.



Watch this video about a man who has COPD: <https://www.blf.org.uk/your-stories/copd-affects-every-part-of-my-daily-living> (Permission to use for educational purposes received from the British Lung Foundation (Helpline@blf.org.uk)).

Poetry also provides another way to connect with the experiences and feelings of others. Northern Irish poet Leontia Flynn, wrote a powerful poem about her father's dementia, entitled "*Alzheimer's Villanelle*." She uses the writer Jonathan Franzen's extraordinary book on his own father's death, "*My father's brain*" as a point of departure.



Excerpt from *Alzheimer's Villanelle*

'I wish he'd had a heart attack instead'
Jonathan Franzen wrote about his father
of the slow, quick-slow disease that left him dead...

Imagine a train delayed... delayed... delayed
that pulls up without passenger or driver
I wish he'd had a heart attack instead...

Amongst other things this poem gives you some sense of the flight of personality, the sense of loss associated with Alzheimer's disease whilst at the same time hinting at how difficult it is for those who stand around the individual's metaphorical bed.



Watch this video clip on an individual with diabetes and arthritis' perspective of self-management support: <https://youtu.be/x7Zu4P1qK48> (Permission to use for educational purposes received from The Health Foundation (info@health.org.uk))



Read this diary entry which touches on living a day in Anna's life with asthma (adapted from: <https://www.healthline.com/health/asthma/day-in-the-life-asthma#1>).

Date: 27th April. Weather: Sunny

I woke up at 8 a.m. and thought 'Thank goodness, last night was such a (rare) good night because my nights are usually filled with insomnia, pains and sometimes an asthma attack. First thing in the morning, I checked the weather and it seemed not that bad today. So, I omitted my nasal spray, opened the windows in my apartment and I went shopping.

As I left the shop, there was a man smoking outside near the exit. I tried to hold my breath until I got far enough away from him and the smoke. This was short but made me very tired physically. When I got home, I went up the stairs very slowly as I struggled with the stairs and felt like I was climbing a mountain. I closed all the windows and turned on the air conditioning system to help control my breathing.

After having dinner with John (husband), we watched a TV comedy to enjoy the rest of our evening. I've always laughed deeply and loudly, but unfortunately it sometimes upsets my asthma. Tonight, I couldn't catch my breath while laughing. I sat up and John rubbed my back. I took out my inhaler and administered a double dose. I felt scared because I started thinking that one of my former colleagues lost her son due to an Asthma attack. I drank some water and nothing worse happened to me tonight.

John fell asleep at around 10:40 p.m. but I found it too difficult to sleep. I tried to read a book or play some mobile games, but it was no use at all. At around midnight, I moved out to our couch in the living room to try to get some sleep.



Pause for Reflection and Discussion

Is there evidence of medical, role and emotional elements influencing Anna's day?

What aspect of Anna's day stands out for you and why?

Providing Holistic Support for Self-management

We are starting to get a sense of the multiple factors involved in living with a chronic condition and of how they can influence a person's ability to self-manage. It is also clear that chronic condition management is dependent on a number of key players.



Pause for Reflection and Discussion

Who do you think the key players are in supporting self-management of chronic conditions?

Take a few minutes to read some of the ways that carers, communities and healthcare professionals contribute to supporting individuals and to self-manage their chronic condition, and to live fulfilling lives.

Family and community support to individuals with chronic conditions



"I was amazingly surprised to see my husband on the same diet as me! He said that this is also his part sacrifice to have a healthy baby. Since I am enduring so much pain and health complications, he can do this small effort for me."

A pregnant diabetes patient (Nishaat, 2017, p. 28)

"I am always late as I just explained. So it's usually my husband who tells me 'If you don't go now, I will take care of it'. You know, like, then I will make the call."

A COPD patient (Korpershoek et al., 2018, p. 6)



"At school there's a nurse and I find school very helpful with him, they keep an eye on it, they're very aware of it. You know, there's obviously several other children with inhalers and they're very up to date, give it back to you if it's out of date, they listen to him if he asks for it, there's never a problem like that. I feel he's safe in their hands...I do think the school are quite reassuring, to know that they keep an eye on him for me, even if it was a false alarm, I do think the school are very good."

An asthma patient's parent (Kendall et al., 2010, p. 91)

"[When I learned I had diabetes] I was worried that I would die, and my father would tell me that I was not going to die. "Look at me, I've had diabetes for so long and I haven't died yet." So now I have my psychologist, my children, my husband telling me to stay calm."

A diabetes patient (Pesantes et al., 2018, p. 1874)



"The greatest source of happiness in our lives was everything we did together. Like being out in the forests picking wild mushrooms and travelling with our caravan. But I finally had to stop him from driving the car and caravan. 'But maybe we can buy a camper?' So I organized this and now we have bought a camper... so now we have been out with it."

A spouse (Eriksson and Svedlund, 2006, p. 329)

"If I didn't wake her up, I think that she could sleep all through, without taking medication and that. I have to wake her up to give her medication."

A family carer of a COPD patient (Schafheutle et al., 2018, p. 1024)



How can healthcare professionals provide holistic care to promote and support self-management?



“Sometimes I contacted the company physician at the patients’ workplace. If a patient is shift working, I asked, for example, to change the workplace because the meal time of this patient is irregular or something like that.”

A GP (Goetz et al., 2012, p. 4)

“You want the patient to do it himself. You practice together if it is necessary and you then inform him once again.”

A nurse (van Hooft et al., 2015, p. 163)



“Yes to the dietician, because she explained everything to us and she asked me what we were eating and to cut out certain things and with cholesterol as well.”

A stroke patients’ wife (Kendall et al., 2010, p. 114)

“I will try to establish a sports group particular for multimorbid patients not just for diabetes or coronary patients.”

A GP (Goetz et al., 2012, p. 6)



“Good self-management support is only possible if you look at the holistic person, if you open up all your senses and look at what this person needs.”

A nurse (van Hooft et al., 2015, p. 162)

“Sometimes, ignorance plays a part. As a health professional it is my duty to support patients and especially to give information, even when the patient does not ask for it.”

A nurse (van Hooft et al., 2015, p. 163)



There is broad consensus that to realistically promote optimal engagement and self-management in chronic condition management, healthcare professionals must take a person-centered, holistic approach. But what does this mean? Do all individuals with diabetes; or cardiovascular disease or respiratory disease not receive the same standard of guideline-driven care; the same clinical tests; the same medications?



Pause for Reflection and Discussion

What is meant by person-centred care?

Think of an example of how two persons, the same age, both with stage 2 COPD, on the same medications might require different supports.

Now think of an example of how two persons, the same age, both with type 1 diabetes might require different supports.



Read this definition person-centred care.

“Person centred co-ordinated care provides me with access to and continuity in the services I need when and where I need them. It is underpinned by a comprehensive assessment of my life and my world combined with the information and support I need. It demonstrates respect for my preferences, building care around me and those involved in my care” (Adapted from Irish Platform for Patient Organisations Science & Industry (IPPOSI), 2019).

With the abundance of ‘diagnostic algorithms’, ‘care pathways’, ‘policies’, ‘clinical guidelines’, etc., that must be considered in clinical practice, it is easy for novice healthcare professionals to lose sight of the individuality of the person with a chronic condition. Expansion of care and support beyond the medical management, and to include community and social resources and networks, is an important element of person-centred holistic care provision.

This leads to the important topic of social prescribing. Social prescribing is a non-clinical, community-based service that supports individuals with chronic mental and/or physical health conditions to participate in activities in their local communities that interest them and that can improve their health (Moffatt *et al.*, 2017). This topic is further addressed in Unit 4.

Having explored the myriad of factors involved in the day-to-day self-management of chronic conditions and the importance of adopting a holistic approach in supporting individuals to self-manage, we will take time to reflect on some case studies to strengthen your appreciation of living with a chronic condition.



Activity 2.4: Case studies

In groups read one of the following case studies and respond to the questions provided. Feedback to the class on the case study and on your responses.

Case Study 1

Living with diabetes: Seeking support to live life to the full

Eliza is a 90-year-old woman, who enjoys life and always wants to live it to the full. A typical day for Eliza is that she rises at 8 a.m., has a shower, and then breakfast. She drives to church every morning which is an important spiritual and social event in her life. She has lunch at 1 p.m. and dinner at 6 p.m. In between meals and weather permitting, she likes to get outdoors, and enjoys to spend time gardening, especially growing and tending to her vegetables, fruit trees and shrubs, and lots of flowering plants. In the afternoon, she almost always has a visitor calling on her for a cup of tea and a chat.

Being 90, Eliza has many stories to share. As the evening closes, Eliza likes to read and she has a wide range of interests in both fiction and non-fiction. On Thursday mornings she drives to her local town for her weekly appointment at the hairdressers, then goes to the bank, then does her shopping, and is usually home by 1pm for her lunch. Occasionally, she might arrive home later if shopping takes longer than usual or if she bumps into people she knows in which case she spends time chatting with them or might go for a coffee with them. On Friday morning, Eliza goes to the 'Young at Heart' club which is a social event for older adults in her community.

In order to live life to the full, Eliza is keen to manage her diabetes which she has for the past 6 years. She has latent autoimmune diabetes requiring insulin injections (short and long acting) in the morning and evenings. In addition, she has a suprapubic catheter and knows that if she 'breaks out' on sweet foods, her urine bag will become fuller more often in the day. Eliza's daughter-in-law who lives close by likes to keep an eye of Eliza's diabetes and feels she needs to slow down in her life and be strict with herself in taking the prescribed amount of insulin so that her blood sugars stay stable and do not drop because of being too active. With a twinkle in her eye, Eliza pretends to agree with her but she has figured out how best to manage her insulin. For example, on Thursday, because she is going to town and more active than a typical day, she takes 2 units less of the fast acting insulin at breakfast time. She has found that this works well for the most part (although not always) such that her blood sugar does not drop to the point of having a 'hypo'. Eliza believes that managing her insulin dosage around her activities means she can continue to live her life to the full. However, at times, she does wonder if she should be more rigid about her insulin even if it does mean being less active and withdrawing from some of her hobbies. This is something she plans to raise with the diabetes team the next time she goes to the clinic.

Questions for Reflection and Discussion

Note for instructors: Consider the extent to which students pick up on the fullness of health and well-being – physically active, enjoyment at a psychological level, and social interactions. Daily activities and living life to the full are at the foreground whereas diabetes and living with a suprapubic catheter are at the background. Note that Eliza was not introduced as a diabetic at the outset, and so diabetes does not define who she is and how she wants to live her life.

1. What strikes you about this case study on Eliza in terms of having a holistic perspective on life and where is diabetes situated within this?
2. What are your views about the disparities between Eliza's approach to managing her insulin and her daughter-in-law's desire that she be compliant with prescribed insulin dosages?
3. If Eliza raises her approach to managing her insulin with you as a member of the diabetic team, what would your priorities be for Eliza in her life and why?

Case Study 2

New Diagnosis of Heart Failure

Claire is 72 and lives with her husband Jim to whom she is married to for 46 years. Claire and Jim have 3 daughters, Clodagh (42), Amy (40) and Claire (36) and 8 grandchildren. They all live within 10 miles of the family home. They visit her frequently and are a great support to herself and Jim. Jim is 75 and in excellent health. Claire does not drive but Jim does and he is always happy and available to drive her anywhere. Typically Claire walks to meet her friend for coffee daily. The walk is just about 800 meters. She enjoys her game of 25s cards every Sunday night and goes to bingo every Thursday night. She finds these events great fun and she particularly enjoys the social aspect of it. She is an avid reader, always has a novel on the go and reads the 3 regional newspapers weekly. She minds Amy's two children after school on Mondays and Fridays. She cooks their dinners and helps them with their reading. She really looks forward to these days with her grandchildren.

Claire was diagnosed with left ventricular systolic dysfunction heart failure 3 months ago. Apart from when she delivered her children, it was her first ever time in hospital as a patient. Prior to that, she was only on one little tablet (calcium channel blocker) for 12 years to treat her blood pressure. She is now on three tablets (loop diuretic, beta-blocker and ACE inhibitor). From a clinical perspective, since her diagnosis, Claire has been doing very well. Her daily weights and symptoms have been very stable. She eats healthily, has a healthy BMI and a reasonable physical activity level.

Claire's hospitalisation and diagnosis really came out of the blue and have given quite a knock to both herself and Jim. Jim has noticed a significant drop in her energy and motivation levels, particularly in the mornings. In fact some days she has even asked Jim to drive up to the church for mass. She has also skipped a few of the Wednesday morning catch-ups with her friends. Claire herself has also noticed that her concentration levels are not quite as good as they used to be. This has particularly affected her enjoyment of reading. Staff at the heart failure clinic have advised her that the low energy levels she is experiencing are to be expected and that over time and on the right medication her energy levels should improve. However, Claire is not convinced. In fact she believes the new medication regimen is making her worse rather than better.

Amy has noticed and commented on the fact that Claire is a little down in herself. Deep down, Claire's greatest concern is that Amy will consider alternative childcare arrangements to the Monday and Friday visits to her house. It would upset Claire greatly if the children did not come over on those days. They are her greatest motivation and the highlight of her and Jim's week.

Questions for Reflection and Discussion

1. In taking a holistic approach to Claire's situation, consider what may be contributing to Claire's low energy and low motivation levels? Consider this from a medical, role and emotional perspective.
2. Consider what are the potential consequences of Claire's inclination to withdraw from her social groups?
3. Claire is concerned about not being able to look after her grandchildren. Consider how realistic these concerns are? How might these concerns be addressed?
4. Upon reading Claire's story, what elements if any may indicate a challenge in terms of her ability to self-manage her condition?

Case Study 3

Chronic Obstructive Airways Disease

Mark is 49 and works as a senior partner for a leading international accountancy firm. He is very dedicated to his work. It is a very fast-paced and competitive environment and this is what he loves about it – ‘it is his life’ by his own admission. He works very long hours including being in the office most Saturdays and sometimes Sundays as deadlines approach. He travels on short international trips at least three times per month. He has an annual gym membership and is a member of the local yacht club. He does not go out socialising with friends frequently because he is so busy. He experiences a lot of stress in his work but he believes this is par for the course and once deadlines pass things settle down for a while again.

Mark was a chronic smoker for 25 years – smoking 20-30 cigarettes a day. He was diagnosed with hypertension in his early 40s and was diagnosed with moderate COPD two years ago. He gave up smoking after being diagnosed with COPD and in his mind, he has dealt with it. He is prescribed inhalers but regularly forgets to take them.

Despite having gym membership he has only been once this year and the yacht club activity is no different. He is just too busy and by the end of the week he is exhausted. Although he does not socialise with his friends much, he has a very hectic social life through his work with office dinners and client dinners as many of his most important client dealings are conducted in these environments. Although he does not identify with having a high alcohol intake, on many weeks his alcohol intake significantly exceeds the recommended maximum of 21 units. He is not inclined to have breakfast and eats out on a daily basis or grabs a roll for lunch on the go. Since ceasing to smoke he has gained almost 11 kg over the past two years. He works late into the night on email and gets a maximum of 5 hours sleep per night. He has noticed his energy levels have reduced significantly and plans to discuss this with the COPD team at his next health visit – although he must reschedule that again and push it out for another month or two until after his next deadline at work. He has already had to take a few extra days out of work at Christmas because of a severe chest infection and cannot afford take another day out just to attend an appointment.

Questions for Reflection and Discussion

1. In taking a holistic approach to Marks' situation, consider what may be contributing to Mark's low energy levels? Consider this from a medical, role and emotional perspective.
2. Consider and discuss how Mark has addressed his diagnosis of COPD? Is Mark optimising his capacity to self-manage his condition?
3. When Mark next attends the COPD clinic, what are the priorities that need to be addressed? How should these be approached from a holistic perspective?



Read the following two papers and respond to the questions provided.

Hill, S., Gingras, J., & Gucciardi, E. (2013). The Lived Experience of Canadian University Students with Type 1 Diabetes Mellitus. *Canadian Journal of Diabetes*. 37: 237-242.

Pickles, K., Eassey, D., Reddel, H., Locock, L., Kirkpatrick, S., & Smith, L. (2018) "This illness diminishes me. What it does is like theft," A qualitative meta-synthesis of people's experiences of living with asthma. *Health Expectations*. 21: 23-40.

When reading the papers, please consider the following questions, which you will discuss with your classmates.

1. What is your first impression here of the lived experience of chronic condition?
2. How much does the paper bring out the medical, role and emotional aspects of living with a chronic condition?
3. Is there any discussion in the papers around key supports for the individual?

Note for instructors: There is opportunity here for students to discuss their own personal experiences of living with a chronic condition or living with a family member with a chronic condition. Also, these papers are options and may be substituted.

Simulation Exercise

Note for instructors: The following exercise is provided as an example, and facilitators may wish to incorporate or develop a similar exercise

As a healthcare professional, gaining a better understanding of what it is like to live with a chronic condition may help you in providing holistic self-management support. In some programmes, educators have developed simulation exercises to help achieve this deeper understanding. The following descriptor is a sample of a 'simulation' assignment from a module on 'Diabetes Self-management' in the School of Medicine at NUI Galway. The aims of the module are outlined below but can summarised in the module tagline: "You can't judge a man until you walk a mile in his shoes". The module was developed by Prof Séan Dinneen (School of Medicine, NUI Galway) with colleagues in the Diabetes Day Centre at University College Hospital Galway.

Sample 'Simulation' Assignment: Learnings from a Specialist Study Module (SSM) in Diabetes Self-management⁴

Module Title:

Self-management of diabetes mellitus: what does it really mean?

Module Learning Objectives:

By the end of this module, students are expected to be able to:

1. Describe the main differences (including the lived experience) between type 1 and type 2 diabetes.
2. Describe the principles underlying self-management education.
3. Appreciate the impact that living with diabetes has on a person's life through experiential learning.
4. Describe the components of a Structured Education Programme such as 'Dose Adjustment for Normal Eating (DAFNE)' or 'Diabetes Education and Self-management for Ongoing and Newly Diagnosed (DESMOND)' for people living with Diabetes.
5. Discuss the term Patient Empowerment and what it means.
6. Describe what is meant by goal setting and personalized care planning.

Module Content (relevant to the above assignments):

1. Introduction to qualitative methodology, including PhotoVoice.

Students are introduced to qualitative research and in particular, PhotoVoice. PhotoVoice is a research methodology that provides participants an opportunity to take photographs that address a salient concern (Wang and Burris, 1997).

Students are then asked to use PhotoVoice methods for the duration of the module to capture their experience of 'Living with' type 1 and 2 Diabetes (discussed below).

2. Living with type 2 Diabetes

In this module, students are given the opportunity to meet someone living with type 2 Diabetes, ask questions and reflect on the same. In addition, students experience a 'Supermarket Tour' facilitated by a Diabetes Specialist Dietician which enables them to reflect on packaging/marketing of foods, reading food labels, meal planning, healthy 'on-the-go' options and interpret health claims. A lecture on physical activity and behaviour change is also provided by an expert in that field. Key reading is provided throughout the module.

Students are then asked to complete the following simulation exercise for a 1 week period:

- Complete a food diary
- Log their physical activity
- (e.g. step count using an accessible device or self-report activity log)

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2. Diabetes Day Centre, University College Hospital Galway, Saoilta Hospital Group.

3. Research and Development, Strategic Planning and Transformation, HSE.

4. School of Medicine, NUI Galway.

3. Living with Type 1 Diabetes

Similar to the 'living with type 2 Diabetes' content of this module, students are given the opportunity to meet someone living with type 1 Diabetes, ask questions and reflect. They meet a pump wearer and also a parent and child (who lives with type 1). A Diabetes Specialist nurse facilitates sessions on the background and management of type 1 Diabetes and provides key reading in the area.

Students are then asked to complete the following simulation exercise for a 1 week period:

- Wear an insulin pump
- Carbohydrate counting
- Monitor blood glucose
- Complete a blood glucose diary
- Reflect on how to adjust insulin dose
- Reflect on how to manage, anticipate and prevent episodes of hypo- and hyper-glycaemia
- Reflect on how to manage ketones and sick days

Assignment Details:

Students are given the following two assignments in relation to the 'living with Diabetes' part of the module. These include a written reflective piece and an oral presentation as follows:

Reflective Assignment (80%):

- Based on your experiences of participating in this Special Study Module and 'living' as someone with type 1 and type 2 diabetes, reflect on the burden of diabetes self-management. You are required to use PhotoVoice to aid reflection. (500 words)

Oral Presentation (20%):

- Students must prepare a 5-minute PowerPoint presentation addressing the title below. As a guide, you should have between 5 and 10 slides maximum and use your experience of PhotoVoice.

"Self-management of diabetes: what does it really mean?"
A reflection of my experience living with diabetes

Reference:

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health education & behavior*, 24(3), 369-387.

Summary of the Lesson

This completes Lesson 1 where you looked at the interrelationship between medical, role and emotional elements. You also explored some of the ways in which healthcare professionals can provide holistic care to individuals with chronic conditions, facilitating self-management support. Holistic care incorporates community, family and carer support in addition to direct healthcare provision. In Lesson 2, you will learn that *health literacy* is an important aspect in holistically supporting individuals to self-manage.

Lesson 2: Health Literacy

Duration: 1 Hour



PPT Title – Unit 2 Lesson 2:
Health Literacy

Introduction to Lesson 2

In Lesson 2 you have opportunity to explore health literacy in the context of holistically supporting individuals to self-manage to the best of their ability. This lesson emphasises the importance of each individuals' capabilities in terms of accessing and interpreting health information while acknowledging the implications of how health literacy impacts on the way in which individuals ultimately manage their condition.

Recap Unit 2 Lesson 1

In Lesson 1 you explored the interrelationship between medical, role and emotional elements. You also discussed some of the ways in which healthcare professionals can provide holistic care to individuals with chronic conditions, facilitating self-management support while acknowledging that holistic care includes community, family and carer support in addition to direct healthcare provision. You were also introduced to *social prescribing* in the context of self-management.

Provision of Information to Support Self-management

Being able to effectively obtain and use health information is an essential element of empowering and supporting patients to self-manage their chronic conditions. People with chronic conditions, and their carers, need a variety of information at different times, depending on their personal situation and the stage of their condition. However, there are a number of key stages where people need specific health information and advice:

- *Diagnosis*: understanding the condition (impact and prognosis), medication and treatment options, and contact details of relevant support services and networks.
- *Living with the condition*: adapting to the impact of the condition on social roles and daily activities, learning how to manage the condition, using their medication, accessing appropriate vaccination and understanding when and how to access further help and support.
- *Progression of the condition and changes in life circumstances*.
- *Transitions in the condition and care*: moving between care settings.
- *End of life*.

Information can be either disease specific, or generic (e.g. how to most effectively liaise with healthcare professionals, or information on relaxation techniques).

Since people with chronic conditions, and their carers, learn in different ways, information should be available in a variety of formats that can be personalised to meet individual's needs and understanding. **The impact of information provided is greater when written information is targeted, personalised and reinforced by verbal communication from healthcare staff.** It is important to identify patients and carers with poor levels of **health literacy** and this needs to be taken into account when designing and imparting information and care planning for best use of resources.

Healthcare professionals, and organisations, should promote the development and co-ordination of consistent information resources, informed by patients and carers needs and preferences, across care settings – See Unit 5: Service Delivery and Organisation for Self-management Support – (Health Service Executive, 2017).



Activity 2.5: Patient's information needs

Consider what the information needs of a person at the different stages above would be?

How might you help the person to access the information they need?

What is Health Literacy?

There is no one universal definition of health literacy. Multiple definitions have evolved over time (Sørensen *et al.*, 2012; Pleasant, 2014; Batterham *et al.*, 2016).

Health literacy concerns the capacities of people to meet the complex demands of health in modern society. It is viewed as an increasingly important component in the self-management of illness and the ability to effectively engage in health promotion activities (Sørensen *et al.*, 2015).

Institute of Medicine Committee on Health Literacy (2004) have defined health literacy as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Health literacy is understood to be linked to literacy and encompasses people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course (Sørensen *et al.*, 2012).

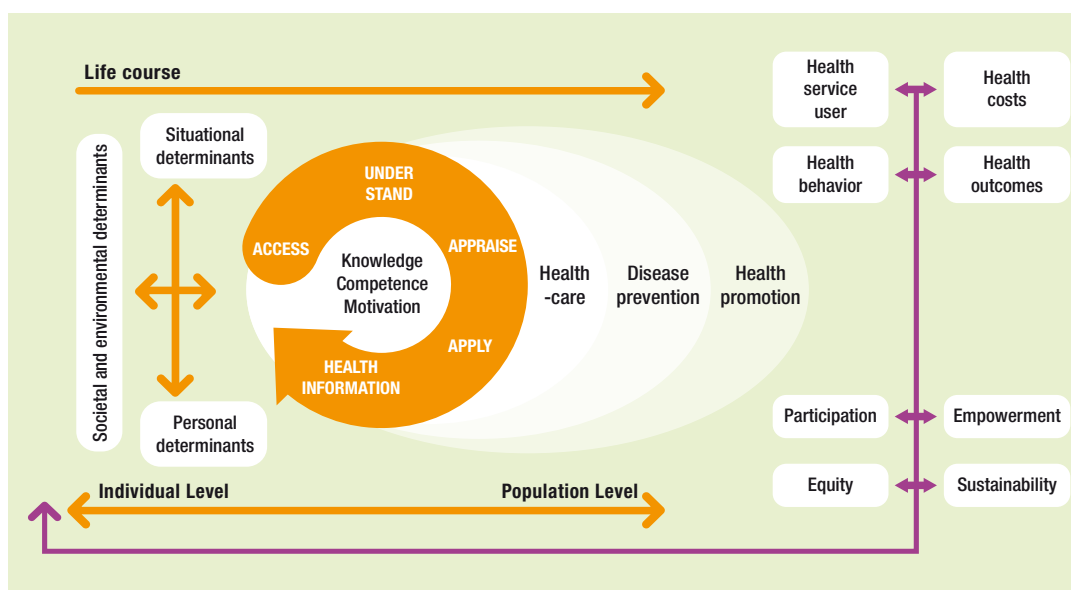
Sørensen *et al.* (2012) undertook a systematic review to develop an integrated definition and conceptual model of health literacy. They identified three domains and four dimensions of health literacy set out below which illustrates the breadth of the health literacy concept:

Table 2.1: Three Domains of Health and Four Dimensions of Health Literacy (Sørensen *et al.*, 2012, p. 10)

	Access/obtain information relevant to health	Understand information relevant to health	Process/appraise information relevant to health	Apply/use information relevant to health
Healthcare	Ability to access information on medical or clinical issues	Ability to understand medical information and derive meaning	Ability to interpret and evaluate medical information	Ability to make informed decisions on medical issue
Disease Prevention	Ability to access information on risk factors for health	Ability to understand information on risk factors and derive meaning	Ability to interpret and evaluate information on risk factors for health	Ability to make informed decisions on risk factors for health
Health Promotion	Ability to update oneself on determinants of health in the social and physical environment	Ability to understand information on determinants of health in the social and physical environment and derive meaning	Ability to interpret and evaluate information on health determinants in the social and physical environment	Ability to make informed decisions on health determinants in the social and physical environment

These aspects of the health literacy concept informed the development of a model of health literacy which is set out below:

Figure 2.2: Conceptual Model of Health Literacy (adapted from Sørensen *et al.*, 2012)

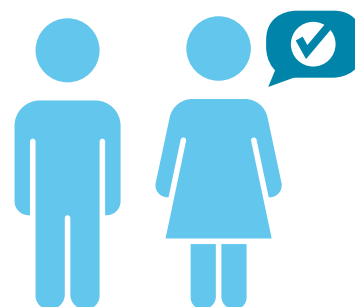


Read For more information on this model please read the article by Sørensen *et al.* (2012), which can be found at <http://www.biomedcentral.com/1471-2458/12/80>.

It is important to recognise that health literacy has two elements as illustrated by National Adult Literacy Agency (NALA)



Health services communicate clearly and take account of possible health literacy and numeracy needs.



People understand health and information correctly and can make an informed decision

Health literacy is about the discrepancy between an individual's health literacy skills and the demands and expectations placed on them by the increasingly complex environments of health and social service provision (Rudd, 2016). This is depicted in figure 2.3 below:

Figure 2.3: Health Literacy (adapted from Institute of Medicine, 2009)



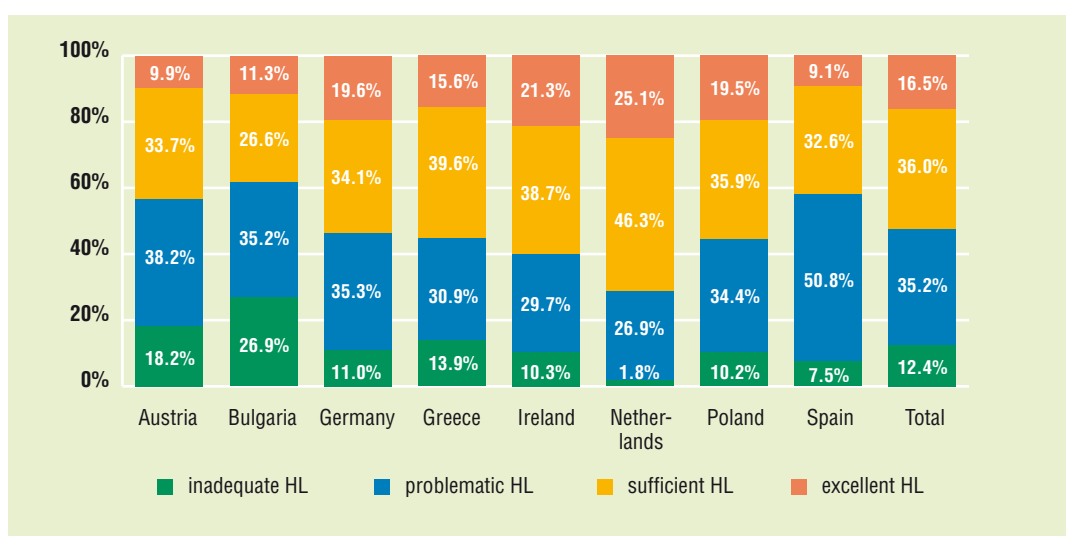
The level of skills and abilities an individual needs to successfully make informed decisions and take and sustain actions that promote their health, prevent ill health and manage chronic conditions, are dependent on the way information is made available and presented. It is also dependant on an environment in which individuals health actions are supported. Health literacy skills can be classified into three categories of functional, interactive and critical health literacy (Nutbeam, 2000) and these are described below:

- **Functional health literacy:** which is the basic skills of reading, writing and numeracy necessary to function effectively in a health context.
- **Interactive health literacy:** which refers to more advanced cognitive literacy skills that with social skills, can be used to actively participate in everyday situations, extract information and derive meaning from different forms of communication, and apply this to changing circumstance.
- **Critical health literacy:** is the ability to critically analyse information and use this to exert greater control over life events and situations.

Why is it relevant?

The work of Sørensen *et al.* (2012) outlined above informed the development of the European Health Literacy Survey (HLS-EU Consortium, 2012) which was conducted during the summer of 2011 across eight European countries (Austria, Bulgaria, Germany, Greece, Ireland, The Netherlands, Poland, and Spain) in a total sample of approximately 8000 respondents. Scores were divided into 4 categories: 'inadequate', 'problematic', 'sufficient' and 'excellent' health literacy. In the general sample about 12% of respondents were found to have inadequate general health literacy, and more than one third (35%) problematic health literacy. This means that nearly one out of two respondents in this survey has limited health literacy. While this is the overall result this pattern differs by country which can be seen in figure 2.4 below (Sørensen *et al.*, 2015).

Figure 2.4: General Health Index (adapted from Sørensen *et al.*, 2015)



When we look at the distribution of health literacy levels across the European countries we see that these differed substantially across countries (29-62%). The survey findings also indicated that there were a higher proportion of people with limited health literacy in subgroups within the population. This suggests a social gradient and inequality (Sørensen *et al.*, 2015).

These subgroups included those with:

- financial deprivation
- lower social status
- lower educational attainment
- older age.



Activity 2.6: HLS-EU The Movie

Watch Health Literacy: 'HLS-EU The Movie' for an overview of survey findings and the implications for population health: <https://www.healthliteracyeurope.net/hls-eu> (Permission to use for educational purposes received from Health Literacy Europe (healthliteracyeurope@gmail.com)). In groups discuss the implications for people in Ireland.

Why Health Literacy Matters (adapted from Mitic and Rootman, 2012)

Health Literacy affects a lot of people

Every one experiences situations that require accessing, understanding, appraising and applying information to make informed appropriate health-related decisions. However, nearly 50% of people surveyed across eight European countries lack the capacity to do just that (HLS-EU Consortium, 2012).

Limited health literacy negatively impacts on health

Research has consistently found that individuals with low health literacy experience poorer health outcomes across a wide range of areas and poorer use of the health services. Berkman *et al.* (2011) undertook a systematic review that identified that this was the case across the three domains of health with regard to; the use of preventive services, the self-management of illness such as adherence to medication and increased admission to hospital and longer hospital stays for those with limited health literacy.

Reducing the burden of chronic conditions

There are increasing rates of chronic condition across the EU which will place ever increasing demands on health systems (Busse *et al.*, 2010). One way to ameliorate the effects of this is to engage patients in more effective self-management (Heneghan *et al.*, 2009). Health Literacy is central to this approach.

Equity and the promotion of fairness

Equity in health implies that the needs of people guide the availability of opportunities for well-being (World Health Organisation, 1996). Improving the health literacy of those with the poorest health outcomes is an important way to reduce health inequalities (Department of Health, 2009).



Read the paper: Health literacy and cardiovascular disease: fundamental relevance to primary and secondary prevention by Magnani *et al.* (2018), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6380187/pdf/nihms-983939.pdf>

What does this mean for healthcare professionals?

Health literacy is central to effective health promotion, disease prevention and healthcare. Healthcare professionals need to have a knowledge and understanding of health literacy and its importance in relation to patient/clients health and health outcomes. Healthcare professionals often underestimate patients/clients health literacy abilities (Kelly and Haidet, 2007) and at the same time patients/clients often over report their level of ability in relation to health literacy (Kirsch *et al.*, 2005). It has been found that many people with limited health literacy have a sense of shame and/or embarrassment of their lack of ability and as a result hide it (Parikh *et al.*, 1996). As limited health literacy has such an impact on health outcomes it is important that healthcare professionals are able to identify people with limited health literacy. In addition healthcare professionals need the communication skills to mitigate the increasing health literacy demands placed on patients/clients, particularly those with limited health literacy.

Health literacy is crucial to enable people to manage their health. Much of the self-management of chronic conditions is performed by individual patients outside of the medical or healthcare setting. Often this care is quite complex. For example if we consider an individual with newly diagnosed type 2 diabetes we can identify a number of different activities that people are responsible for when self-managing that can be particularly challenging, especially when limited health literacy is an issue. These activities may include:

- Taking medication.
- Eating a healthy diet.

- Reduction of risks.
- Managing weight if relevant.
- Organising medical appointments.

Persons with diabetes who have multiple complications or experience repeated hospitalisations might have some of these problems because of unrecognised low health literacy (Boren, 2009).



Activity 2.7: Health Literacy Demands

In groups brainstorm the health literacy demands for an individual with a chronic condition (COPD/asthma/CVD). Think through all aspects of their engagement with the health system and the lifestyle adjustment that need to be made.

How to recognise persons with low health literacy? (adapted from Agency for Healthcare Research and Quality, 2015)

There are no perfect indicators of low health literacy. The following are warning signs for low health literacy.

- Frequently missed appointments.
- Incomplete registration forms.
- Non-compliance with medication.
- Unable to name medications, explain purpose or dosing.
- Identifies pills by looking at them, not reading label.
- Unable to give coherent, sequential history.
- Ask fewer questions.
- Lack of follow-through on tests or referrals.



A systematic review by Sheridan *et al.* (2011) of health literacy interventions for people with low health literacy found evidence that intensive self-management interventions reduced emergency department visits and hospitalizations; and intensive self- and disease-management interventions reduced disease severity. The findings of this systematic review demonstrates that poor health outcomes for people with low health literacy can be mitigated. This is supported in relation to health literacy interventions promoting adherence with medical treatment in patients with cardiovascular disease (Miller, 2016) and demonstrated in interventions shown to increase medication adherence by people living with HIV (Perazzo *et al.*, 2017). In relation to older people, Brainard *et al.* (2016) found that health literacy interventions can increase patient satisfaction and improve chronic condition management.

Communication Skills to Mitigate Health Literacy Demands

The universal precautions approach advocates for standardised communication accessible at any level of healthcare. In the United States The Agency for Health Research and Quality (AHRQ) has promoted the *Universal Precautions Toolkit* to improve communication and implementation of healthcare (Brega *et al.*, 2015). The objective of the toolkit is to develop and maintain a best practices approach (universal precautions) in the provision of practical approaches for clear oral and written communication to help patients better understand their health information. See www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf for more information on this.

What health literacy techniques can be used in practice?



- Use pictures
- Identify people with low health literacy
- Chunk and check ('Reinforcing information is key for retention. Stop after giving each key point to solicit questions and have patients repeat the material back to you. This technique is called 'chunk and check' (Cornett, 2009, p. 5) (link: <https://www.who.int/global-coordination-mechanism/activities/working-groups/Assessing-and-Adressing-Health-Literacy.pdf>)).
- Offer help with forms
- Teach-back
- Use simple language

(adapted from: The Health Literacy Place, available at: <http://www.healthliteracyplace.org.uk/tools-and-techniques/techniques/>)

Use simple language/plain English

Example of simple language:

Instead of	Use
Cellulitis	Skin Infection
Acute	Sudden/severe
Catheter	Tube
Intravenous	Through a vein

For more examples see pages 11-13 of 'Guidelines for Communicating Clearly using plain English with our Patients and Service Users: A resource to improve the quality and consistency of our communications' (HSE Communications Division, 2017). Available at: <https://www.hse.ie/eng/about/who/communications/communicatingclearly/guidelines-for-communicating-clearly-using-plain-english.pdf>

Teach-back

The teach-back method is a useful way to confirm that the information you provide is being understood by getting people to 'teach-back' what has been discussed and what instruction has been given. This is more than saying 'do you understand?' and is more a check of how you have explained things than a test of how well the patient has understood you.

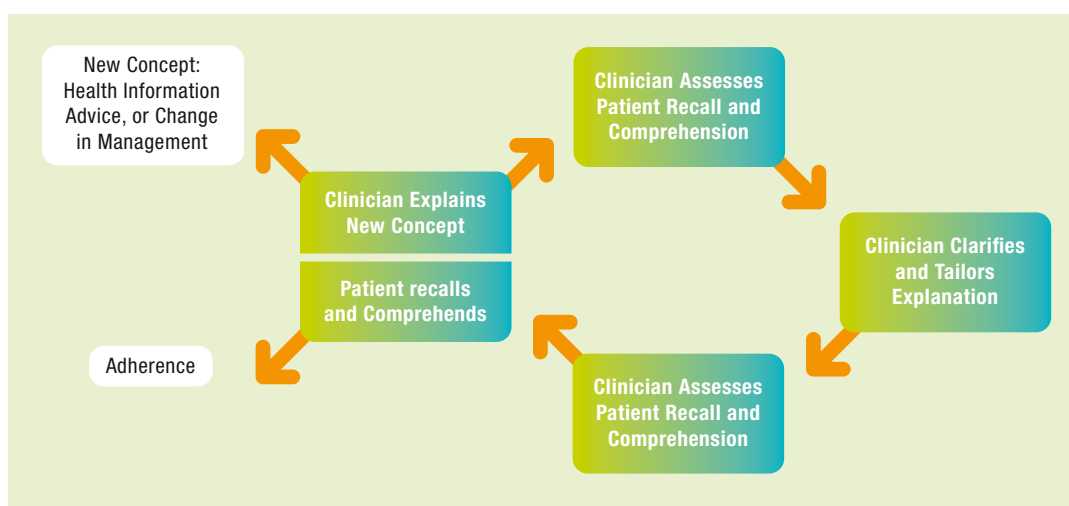
A similar tool can be used when showing people how to carry out actions, such as how to use an inhaler. This is called 'show me'.

The responsibility for effective communication is on you as the person giving the information. Some example of how to use teach-back are below:

- 'We have talked about a lot of things today, I want to check I have been clear. Can you tell me what is going to happen next and what you are going to do?'
- 'I want to check I have been clear. What are you going to tell your family when you get home?'
- 'Just to be sure I haven't missed something, can you tell me what I have told you about this x-ray.'
- 'I want to check I have been clear, so can you tell me what you have to do and I will listen to make sure I explained it properly.'

If the person can't explain or demonstrate what they need to do then you have to start again by checking what the person does understand, re-explaining the missing information again in a different way and then using Teach-back again. This is illustrated in the diagram below:

Figure 2.5: Teach-back Closing the Loop (adapted from Schillinger *et al.*, 2003)



Activity 2.8: Teach-back

Watch the YouTube clip on the teach-back method: https://www.youtube.com/watch?v=bzpJJYF_tKY (Permission to use for educational purposes received from IHI Open School (info@ihi.org))

In groups of two practice the technique with one person acting as the patient and the other acting as the healthcare professional.

Some more tips for the teach-back method:

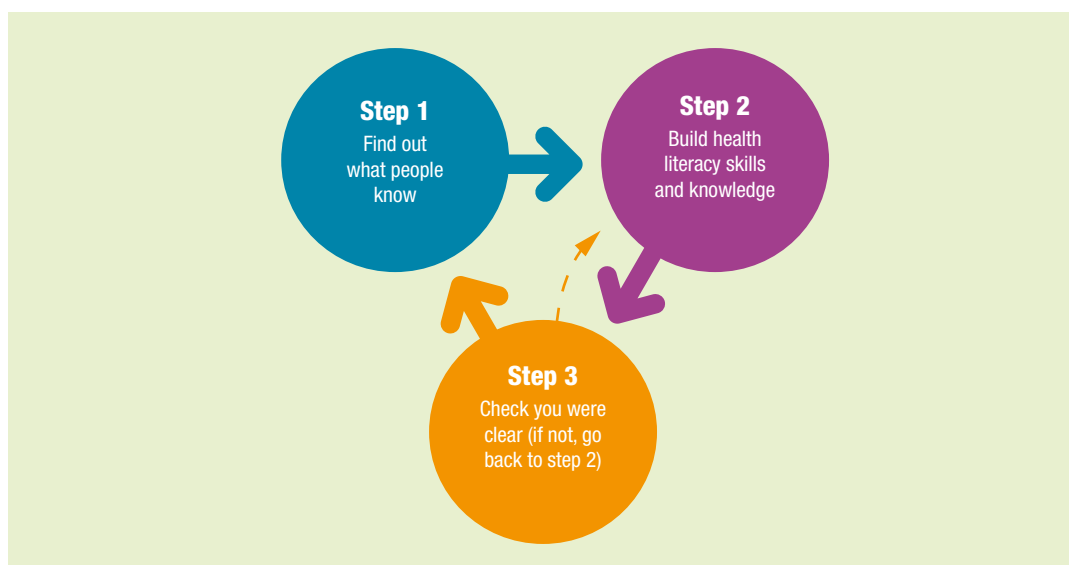
Don't say "Have you got any questions?" or "Do you understand?" Most people will not tell you they don't understand.

Instead use 'We have talked about a lot of things today. Most people have questions. What are your questions?'

For more information, see Tool 5, page 28 and pages 138 to 160 of the Universal Precautions Toolkit: www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf

The Health Quality and Safety Commission New Zealand (2015) has developed useful three-step model for better health literacy which incorporates these techniques and which is depicted below:

Figure 2.6: The Three-step Model (adapted from Health Quality and Safety Commission New Zealand, 2015)



Step 1: Find out what people know

This step is important as everyone who comes into the healthcare setting has existing knowledge even if it is incorrect. This step helps

- you uncover what people already know
- you plan how much information you will give people and in what order (step 2)
- people recall what they already know so they can make connections to the new information you give them

Tips for finding out what people know:

Ask these questions at the beginning in a conversational, friendly tone. The tone you use is important.

Try putting the words “Tell me” in front of any questions you ask, e.g., “Tell me what you know about what could happen next”.

“Tell me what you know about your diabetes”.

Step 2: Build people’s health literacy (knowledge and skills) to meet their needs

- Link all new information back to what the person knows (Step 1).
- Use the words the person used and build on these words.
- Give information in logical steps as people are more likely to understand and remember information if you give it in a logical sequence and explain why someone has to do something.

Tips for giving information in logical steps:

1. Condition (this is your condition)
2. Action (this is what needs to be done about it)
3. Rationale (this is the reason why)

For example:

“You know aspirin can upset the stomach. So take aspirin in the morning with breakfast and then wait one hour before you take your indigestion medicine. You need to wait one hour because your indigestion medicine works best on an empty stomach”

People can only take in so much information before their short-term memory is overloaded. So, be careful not to overwhelm the person with too much information. If you think the person needs more information at a later stage, agree with them how you will do this – a follow-up phone call, another appointment, text message, email, a website link and so on.

Tips for giving information in manageable chunks: (similar to chunk and check)

- Make sure you link new information to what people already know.
- Try and limit the information you are giving to 3-5 pieces of information.
- If the information is complex, check you have been clear after each chunk (step 3) before going on to the next chunk.
- Use visuals and diagrams to reinforce new information.
- Make sure you don't speak too quickly, especially if people don't have English as their first language.

- Explain technical words
- Use visuals
- Use written materials

People are often given a lot of written information to read 'when they get home'. Discussing the materials with the person beforehand means they are more likely to read the information.

- Help people anticipate the next steps

Explaining the next steps helps people better navigate the system, ask and answer questions, understand how long it could take for their condition or disability to improve and be better prepared for any changes they could experience.

Example: *'Now you have started your warfarin you will need to have regular blood tests in case we need to adjust your dose. So I need you to come back for another blood test in two weeks.'*

- Medicine reviews
- Reinforce and emphasise

Step 3: Check you were clear

If you do not check you have been clear, the only indication that the person did not understand may be a medicine error or failure to follow up. Relying on spoken, non-spoken and non-verbal cues such as the person saying 'yes' or nodding is not accurate.

Check understanding using the teach-back method

Studies show that when done effectively, Teach-back doesn't take any longer and actually improves understanding and outcomes. The results of a systematic review conducted by Dinh *et al.* (2016) found evidence to support the use of the teach-back method in educating people with chronic condition to maximize their disease understanding and promote knowledge, adherence, self-efficacy and self-care skills.



Read the 'Three steps to better health literacy-a guide for healthcare professionals' available at: <http://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf>

Interpersonal communication can be supported by written material. However written information on its own is not very useful.

Written information

It is important that written information is clear. You can ensure this by regularly reviewing written information and by following certain steps if you are developing materials. The Health Literacy committee of Galway University Hospital has developed a guide for the format and layout of patient information material which is a useful resource.

Table 2.2: Format and Layout Guide – Dos and Don'ts (reproduced with permission from Saolta, 2017)

Do	Don't
Use the Active Voice – use personal pronouns – 'we' and 'you' - this helps to build a relationship of trust. For example: 'We will call you'	Don't use the Passive Voice – For example: 'You will be called'. Don't be afraid to use 'we' for your organisation and 'you' for the reader.
Limit Jargon – Use everyday words if possible. For example: require > need administer > give facilitate > help	Don't use too many words that could confuse the reader. If you cannot avoid specialised terms then explain them in plain English immediately afterwards and use the same term consistently.
Use headings that are statements or questions . Questions and answers are a great way to get information across.	Avoid using one-word headings such as 'Introduction'. Instead use something like: 'About Our Services' or 'What is a CT Scan?'
12 Font – minimum size 12	Avoid small text which may be difficult to read.
Font – use ' sans serif ' such as Arial or Calibri – Calibri is useful when there is more text content.	Avoid using fonts like Times New Roman – they are difficult to read
Use bold when you want to emphasise a heading or paragraph or text. Use a bigger size for emphasis.	Don't use italics or underlining to create emphasis. It makes them harder to read. Keep CAPITAL letters to a minimum: when words are in capitals, THEY ALL LOOK THE SAME.
Spell out/explain acronyms the first time you use them, for example: ED (Emergency Department)	Avoid using symbols such as '&', '/' and ';' Avoid using abbreviations such as e.g., i.e., etc., dept. These can confuse the reader
Left align and create a path for the eye to follow: most readers start at the top left hand corner, use this to your advantage, placing important information in that quadrant.	Avoid using 'justified text' . It changes the spacing between words which can be hard to read.
Paragraphs – Headings and lists are a good way to break up paragraphs and add white space. Leave space between sections.	Don't be afraid of 'white space'- don't clutter your PIL with lots of writing. Blank areas create balance, attract the eye to important messages and make it easier to read.
Sentence length – Use short sentences – 15 to 20 words maximum.	A paragraph should never be longer than its width!
Include images that support the text and facilitate understanding. People are more likely to retain and understand content when it is reinforced with a picture.	Avoid background images and watermarks – Images behind text can make text hard to read.
Bullet points – Bulleted or numbered lists are easier to scan and break up text.	Don't put more than 7 points/items in a list.
Numbers should be presented as digits rather than spelt out.	Don't express figures as a percentage %, use a simpler format, for example: 1 in 20 people, instead of 5%

The Centers for Disease Control and Prevention (2015) have developed a clear communication index which is based on the research evidence (available at: <https://www.cdc.gov/ccindex/index.html#>). It promotes the principles of plain English and also goes beyond the words that are written to include aspects of presentation and layout. The health literacy committee at University College Hospital Galway have adapted this to develop a checklist to assist healthcare staff to produce clear, accessible patient information in practice. An adaption of the checklist can be found in the 'Guidelines for Communicating Clearly using plain English with our Patients and Service Users: A resource to improve the quality and consistency of our communications (HSE Communications Division, 2017)' and available at: <https://www.hse.ie/eng/about/who/communications/communicatingclearly/guidelines-for-communicating-clearly-using-plain-english.pdf>



Activity 2.9: Written information

In groups use the CDC Clear communication index and the dos and don'ts list to examine a patient information leaflet or brochure. What improvements do you think could be made?

Summary of the Lesson

In Lesson 2 you discussed health literacy as an important consideration of holistic self-management support. You explored what health literacy means and discussed its relevance and importance in self-management. Useful tips were provided to help you as a healthcare professional to support individuals while taking their health literacy into account.

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Unit 3: Communication for Self-management Support

Duration: **2 hours**

Recommended Programme Placement: **Year 2 or 3**

Lesson Plan

Unit 3: Learning Outcomes	<p>Competency: Engage in collaborative-partnership communication with individuals/carer to support self-management of chronic conditions.</p> <p>Learning Outcomes:</p> <ul style="list-style-type: none"> 3.1 Understand how to gain an individual's perspective on the impact of a chronic condition on daily life. 3.2 Understand the importance of individual/healthcare professional/family partnerships in chronic condition management. 3.3 Understand the importance of trust and collaboration in relationships with individuals. 3.4 Understand the importance of discussing treatment options with individuals and the concept of shared decision-making. 3.5 Critically evaluate communication between healthcare professionals and individuals for collaborative-partnership and relationships. 	
Lesson 1: Communication Skills for a Person-centred Approach 1 Hour	<ul style="list-style-type: none"> • Introduction to Unit 3 • Recap Unit 1 and 2 • Introduction to Lesson 1 • Communication Skills for a Person-centred Approach • Non-judgemental Approach 	<p>Activity 3.1: Just Listen</p> <p>Activity 3.2: Role-play for Communication Skills</p> <p>Activity 3.3: Non-judgmental Communication</p> <p>Activity 3.4: Making Judgements</p>
Lesson 2: Communication for Trust, Collaboration and Shared Decision- making 1 Hour	<ul style="list-style-type: none"> • Introduction to Lesson 2 • Recap Unit 3 Lesson 1 • Recognising Individuals/Families as Partners • Building Trust and Collaboration with Individuals • Shared Decision-making • Use of Decision Aids 	<p>Activity 3.5: Trust and Collaboration</p> <p>Activity 3.6: Shared Decision-making</p> <p>Activity 3.7: Partnership & Person-centredness</p> <p>Activity 3.8: Role-play: Asthma</p>
Core Reading		
Accompanying Slide Pack for Unit 3	https://www.hse.ie/sms-undergradcurriculum/	

Unit 3: Communication for Self-management Support

Introduction to Unit 3

In Unit 3 you will have an opportunity to learn about the importance of effective collaborative-partnership communication for self-management support. You will explore the engagement between healthcare professionals and individuals to support self-management of chronic conditions. Key learning outcomes in this Unit focus on gaining an individual's perspective on the impact of a chronic condition on their daily life through the use of appropriate listening and questioning. Understanding the importance of trust and collaboration and being non-judgemental in relationships, discussing treatment options with individuals as well as the concept of shared decision-making are addressed in this unit.

Recap Unit 1 and 2

In Unit 1 you were introduced to the concept of self-management support through exploration of the definitions, foundations and principles underpinning both self-management and self-management support. You explored the core tasks and skills which individuals with chronic conditions require to be effective self-managers. In addition, you were encouraged to explore the skills that are required of the healthcare professional in supporting individuals to develop the skills that they need to self-manage their chronic condition. In Unit 2, you studied the concept of holistic care in the context of self-management support. You had the opportunity to gain a deeper understanding of how to support individuals in the medical, role and emotional self-management of their chronic condition. You discussed the ways in which healthcare providers, communities and families can support self-management in a holistic way. You had opportunity to gain an understanding of health literacy and how important it is in supporting self-management, again highlighting the importance of individual preferences and abilities in keeping with person-centred holistic care.

Lesson 1: Communication Skills for a Person-centred Approach

Duration: 1 Hour



**PPT Title – Unit 3 Lesson 1:
Communication skills for a person-centred approach**

Introduction to Lesson 1

In Lesson 1 you will be introduced to the communication skills required in adopting a person-centred approach to supporting self-management. These skills are important as they will help you in understanding an individual's perspective on the impact of chronic conditions on their daily life.

Communication Skills for a Person-centred Approach

Person-centred care is the practice of caring for individuals (and their families) in ways that are meaningful and valuable to the individual. Helping individuals with chronic conditions to be more active in consultations and training healthcare professionals to be more mindful, informative, and empathic leads to more partnership, solidarity, empathy, and collaboration in the management of chronic conditions (Epstein and Street, 2011). Person-centred care in chronic condition management is very important; see the link below to this World Health Organisation video on person-centred care;

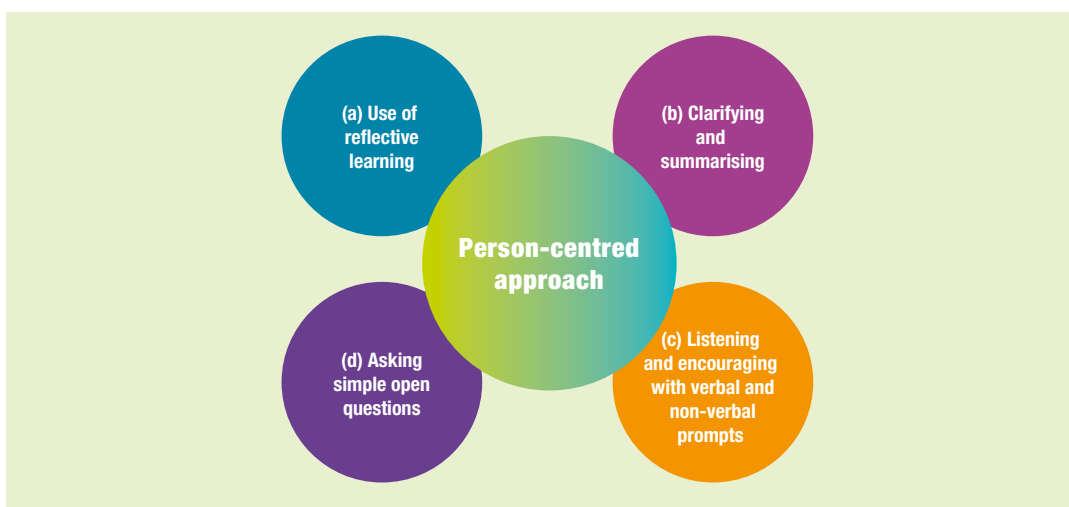


Watch WHO: What is people-centred care? (<https://www.youtube.com/watch?v=pj-AvTOdk2Q>) (Permission to use for educational purposes received from WHO (permissions@who.int))

Key communication skills to help you develop a person-centred approach are:

- a) Use of reflective listening
- b) Clarifying and summarising
- c) Listening and encouraging with verbal and non-verbal prompts
- d) Asking simple open questions

Figure 3.1: Communication Skills for a Person-centred Approach (Reproduced with permission from National Undergraduate Curriculum Working Group, 2017, p. 87, adapted from Rollnick *et al.*, 1999)



a) Reflective Listening

The use of Reflective listening focuses on the emotional overtones of a message (looking for relationship between content and emotional aspect of the message).

Consciously pick up on some key words/phrases the individual used and introduce them into your own side of conversation

'You sound really frustrated that you are having difficulties dressing yourself in the morning'

b) Clarifying and summarising

Clarifying and Summarising: every so often sum up in a few succinct sentences what has been discussed.

Clarification: seeking to understand the message by asking for more information

'I'm not sure I understand what you mean; can you give me an example?'

Summaries can help to bring focus to a session (drawing the strands together)

'Before moving on I would like to go over with you what I think we have accomplished so far...'

c) Active Listening and encouraging with verbal and non-verbal prompts

Figure 3.2: Active Listening (Reproduced with permission from National Undergraduate Curriculum Working Group, 2017, p. 89)



You need to be sincerely attentive and find ways to demonstrate that you have taken in what has been said to you and show that you value the speaker and their opinion e.g. nod of the head, sitting forward and interested.

Verbal and Non-verbal prompts: Listening involves not only hearing but also understanding linguistic, paralinguistic (e.g. tone of voice) and nonverbal aspects of the message (remember non-verbal makes up most of an interaction).



Activity 3.1: Just Listen

Note for instructors: This is an activity that encourages participants to communicate how they feel about a subject. People get into pairs and one member talks about their opinions. Each partner listens without speaking, and then, without rebuttal, recaps on what has been said.

Uses

This activity strengthens your students' listening skills. Listening is an incredibly important part of good communication, and it's a skill that people often ignore in team activities. This activity also shows you how to listen with an open mind.

People and Materials

- An even number of students, ideally.
- Eight index cards for each team of two. Each card should list one topic. The topics should be interesting, but not too controversial. You don't want the listeners disliking the speakers just because they disagree with their viewpoint.
- A private room.

Instructions

1. Have your students sit down in pairs.
2. Give each pair eight index cards.
3. One partner will blindly choose a card and then speak for three minutes on how she feels about the topic. As she talks, the other person cannot speak – his goal is to listen.
4. After three minutes, the listener has one minute to recap on what his partner has said. He cannot debate, agree or disagree – only summarise.
5. Next, the roles switch, and the process starts again.

Advice for facilitator

Talk with your students about how they felt about this exercise. Discuss these questions:

- How did speakers feel about their partners' ability to listen with an open mind? Did their partners' body language communicate how they felt about what was being said?
- How did listeners feel about not being able to speak about their own views on the topic? How well were they able to keep an open mind? How well did they listen?
- How well did the listening partners summarize the speakers' opinions? Did they get better as the exercise progressed?
- How can they use the lessons from this exercise at work?

d) Asking simple open-ended questions

Questions should be kept simple and encourage the individual to tell more of their story rather than elicit yes/no responses

'Tell me about how your condition presented?'

'How did you feel when you got your diagnosis?'

'How does your condition affect you now?'

'Looking back, what do you think would have helped you when you got your diagnosis?'



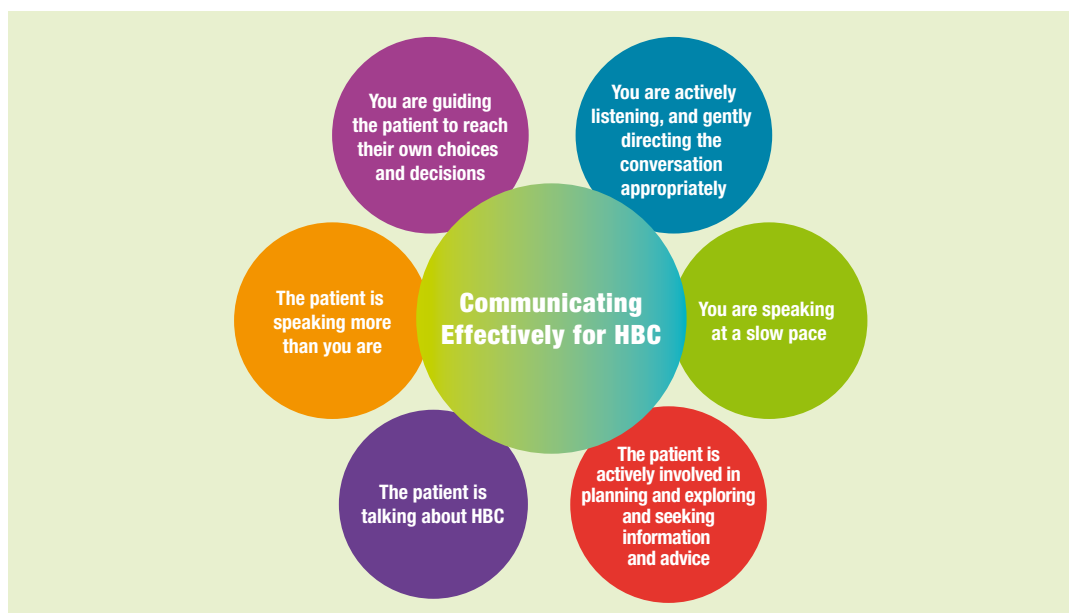
A quick note on the importance of the awareness of the concept of multimorbidity.

Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual. Individuals with multimorbidity have a high treatment burden in terms of understanding and self-managing the conditions, attending multiple appointments, and managing complex drug regimens (Gallacher *et al.*, 2011). There is an increasing prevalence of multimorbidity, particularly in the over 65s. From a communication point of view, asking individuals with several chronic conditions at the outset of a consultation "What is bothering you the most today?" or "What would you like to focus on today?" can help prioritise management to those aspects of care that will have the most impact on individuals (Wallace *et al.*, 2015).

"What is bothering you the most today?"

"What would you like to focus on today?"

Figure 3.3: Communicating Effectively for Health Behaviour Change (Reproduced with permission from National Undergraduate Curriculum Working Group, 2017, p. 101, adapted from Rollnick *et al.*, 1999, p. 34)



Activity 3.2: Role-play for communication skills

Note for instructors: Students to role play talking to an individual about their chronic conditions focussing on the impact of the chronic conditions on the individual's life from the onset of symptoms, to diagnosis and finally to how they are managing now.

Options for role play include:

1. Groups of 2

Breaking into pairs with one student role playing being an individual with chronic fatigue associated with heart failure and the other student role playing being the healthcare professional.

Students then reverse roles. This time the student playing the healthcare professional is to explore with the student playing the individual's role, the impact of how living with chronic fatigue affects their life.

2. Groups of 3

As per 'groups of 2', but this time each student alternates taking on the role of being an observer. The observer role is to watch the interaction between the 'individual' and 'the healthcare professional' focussing on the 4 key communication skills listed below. The observer then gives constructive feedback to the other two students.

Use the four key communication skills for person-centred care that you have been learning about.

- Use of reflective listening
- Clarifying and summarising
- Listening and encouraging with verbal and non-verbal prompts
- Asking simple open questions (consider using the 4 examples of open questions as a guide in the 'coloured bubbles' in the 'asking simple open questions section' above)

Do you think being homeless would challenge self-management?

Non-judgemental approach

Adopting a non-judgemental approach is a key factor in person-centred communication. Carry out the following activities to help you develop an awareness around non-judgemental behaviour.



Pause for Reflection and Discussion

Take a minute to think about the following:

Are you aware of ways in which you make judgments about others?

Do you think that making judgements impact on partnership formation?



Activity 3.3: Non-judgmental Communication

Experiential Exercise on Non-judgmental communication

Note for instructors

Purpose: to objectively make observations, state those observations based on fact and without judgement/making interpretations.

Structure: Triads i.e. three people. Individual #1 observes Individual #2 and the 3rd individual observes what is said by Individual #1. Then rotate the individuals so that all take on the role of (i) factual observing, (ii) being observed, (ii) observing what is said by Individual #1 in stating factual observation.

Exercise

Individual 1: State what is seen in describing Individual #2 – factual and without judgement/interpretation

Individual 2: Be observed without making any comments

Individual 3: Take note of what is said by Individual #1 about Individual #2 in terms of factual observation and also judgemental observation. Give feedback on what is heard about factual/judgemental observations of Individual #1

Then Rerate the 3 individuals and continue with the same exercise so that each plays Individual #1, #2 and #3.

Example of difference between judgemental and non-judgemental

Judgemental	Non-judgemental
I see a lady	I see a woman
He is bad at taking his inhaler regularly	He is not taking his inhaler regularly
She is really good for attending her follow-up clinic appointments	She attends her follow-up clinic appointments.
etc...	

Note: 'lady', 'bad', 'really good' are judgements.



Activity 3.4: Making Judgements

Note for instructors: Ask students to close their eyes and listen to the following short story. Once you have finished reading, ask the students to open their eyes and ask them to offer any feedback, prompt them to think about whether they had made any judgements as you read the story.

Billie ran to the front gate clutching a lunchbox in one hand and a toy bear in the other just as the school bus turned out of sight.

She looked back to the house, sighed and started to walk along the footpath, holding tightly to the lunchbox and bear.

If she hurried she might make it before school started. Cars sped along the busy road next to the narrow footpath.

With a few minutes to spare, Billie entered the school doors and walked up to the reception where she asked if it would be okay to go to Ms O'Flynn's junior class because her son Adam had forgotten his lunch.

Note for instructors: After students have provided feedback ask them to reflect once more on how easy and natural it can be to make judgments. Then ask the students to think about the ways in which healthcare professionals might make judgements about individuals with chronic conditions



Pause for Reflection and Discussion

Do you know anyone in your family or neighbourhood with a chronic condition?

Are you aware of any lifestyle factors that might have contributed to that person's chronic condition?

If so, how does the fact that that person's health behaviour may have contributed to the development of a chronic condition make you feel about that person?

It is worth reflecting on this, because there is a danger that healthcare professionals, (particularly younger healthcare professionals who do not have chronic conditions), might bear some negative stereotypes or prejudices about individuals with chronic conditions. It is necessary to become aware of those prejudices, which we are all prone to at this early stage of your training.

Summary of the Lesson

In Lesson 1, you discussed and practised core communication skills to assist you in supporting individuals in the self-management of their chronic condition. In particular the importance of listening, the use of simple open questions and non-judgemental person-centred approaches were highlighted. In Lesson 2 you will have an opportunity to discuss building trust and collaboration and the importance of shared decision-making in effective partnerships.

Lesson 2: Communication for Trust, Collaboration and Shared Decision-making

Duration: 1 Hour



**PPT Title – Unit 3 Lesson 2:
Communication for Trust, Collaboration
and Shared Decision-making**

Introduction to Lesson 2

In Lesson 2, you will be introduced to the importance of building trust and collaboration and shared decision-making in developing effective partnerships with individuals with chronic conditions. There are a number of videos and activities to assist you.

Recap Unit 3 Lesson 1

In Lesson 1, you discussed and practised core communication skills to assist you in supporting individuals in the self-management of their chronic condition. In particular the importance of listening and the use of simple open questions were highlighted. Becoming aware of ways in which we make judgements about others was also addressed in Lesson 1.

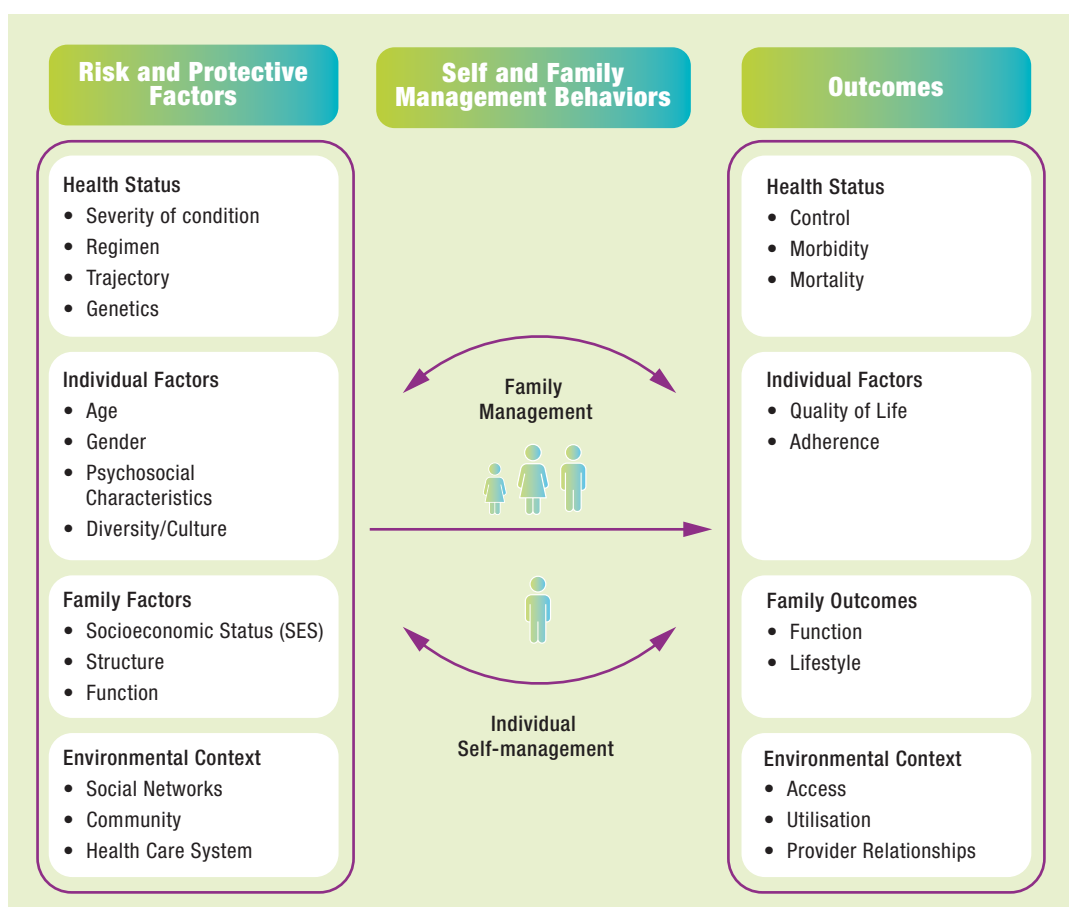
Recognising Individuals/Families as Partners

Individuals with chronic conditions make day-to-day decisions about self-managing their conditions. Each day, individuals decide what they are going to eat, whether they will exercise, and to what extent they will consume prescribed medications. The partnership paradigm credits individuals with an expertise similar in importance to the expertise of professionals. This paradigm implies that while professionals are experts about diseases, individuals are experts about their own lives (further addressed in Unit 4). Sometimes called “patient empowerment,” this concept holds that individuals accept responsibility to manage their own conditions and are encouraged to solve their own problems with information, but not orders, from professionals. The ideas of individuals and physicians interact, building upon each other to create a better outcome (Bodenheimer *et al.*, 2002).

Family involvement

The concept of *family* is highly relevant to self-care, and a framework published by Grey and colleagues outlines the relationships among family factors, individual, and family self-management of chronic conditions (Grey *et al.*, 2006).

Figure 3.4: Self and Family Management Framework (adapted from Grey *et al.*, 2006, p. 282)



It is important to remember that individuals without family and those who live alone may be more socially isolated and vulnerable for poor self-care and should receive focused attention if appropriate (Dunbar *et al.*, 2008).

Building trust and collaboration with individuals



Theory

Trust

As discussed earlier in this unit, aspects of the individuals and healthcare professional relationship such as communication and empathy have been shown to be important to individuals' adherence and ability to complete self-care tasks (Bonds *et al.*, 2004). Individuals trust is another component essential to the individual-healthcare worker relationship (Pearson and Raeke, 2000).

Collaboration

As indicated in Lesson 1 and also in Unit 1 the partnership paradigm acknowledges individual's expertise of their chronic condition experience similar in importance to the expertise of professionals. This "patient empowerment," holds that individuals accept responsibility to self-manage their own conditions and are encouraged to problem-solve with information, but not orders, from professionals (Bodenheimer *et al.*, 2002).



Activity 3.5: Trust and collaboration

Class Activity 1

What ways do you think trust can be developed in relationships? Discuss in groups

Class Activity 2 Role Play

A classmate of yours who you do not know well comes to you for advice about how to manage some exam stress they are having. How will you manage this?

Note to Instructors: Remind the class about the active listening skills/open questions they learnt about in Lesson 1 (i.e. ask about how exam stress is affecting the classmate's life?)

- Get the class to consider what advice options they could give their classmate
- How can they work on building trust/collaboration with the classmate?

Shared Decision-making



Theory

Shared decision-making

A very important part of person-centred care is the active engagement of individuals in healthcare decision-making. The following excerpts from a paper by Barry *et al*, outline some of the important features of shared decision-making (Barry and Edgman-Levitan, 2012). For some decisions, there is one clearly superior path, and individual preferences play little or no role – a fractured hip needs repair, acute appendicitis necessitates surgery, and bacterial meningitis requires antibiotics. For most medical decisions, however, more than one reasonable path forward exists (including the option of doing nothing, when appropriate), and different paths entail different combinations of possible therapeutic effects and side effects.

The process by which the optimal decision may be reached for an individual is called shared decision-making and involves, at minimum, a healthcare professional and the individual, although other members of the healthcare team or friends and carers may be invited to participate. In shared decision-making, both parties share information: the healthcare professional offers options and describes their risks and benefits, and the individual expresses his or her preferences and values. Each participant is thus armed with a better understanding of the relevant factors and shares responsibility in the decision about how to proceed.

You mentioned you would like to discuss Nicotine Replacement Therapy options to help you stop smoking. Nicotine replacement can come in chewing gum, patch, spray or inhaler formats. Would you like me to tell you more about each of the options?





Trigger Video

Watch this video clip of an individual with diabetes' views on shared decision-making and on the importance of being offered choices.

- Individual's perspective only – Diabetes: https://www.youtube.com/watch?time_continue=34&v=QR3OD0SJQ38 (Permission to use for educational purposes received from Mayo Clinic (mayoclinicsupport@mayoclinic.com))
- Here is a video describing shared decision-making with some interaction between a GP and individual with a chronic condition: <https://www.youtube.com/watch?v=fhiwftNLtyc> (Permission to use for educational purposes received from The Health Foundation (info@health.org.uk))



Activity 3.6: Shared decision-making

Having watched these video clips, discuss in group:

- What are your views on shared decision-making?
- Can you think of a time that you observed shared decision-making in practice?



Trigger Video

Person-centred care – GP perspective: https://www.youtube.com/watch?v=y43TLRzal44&list=PLjsZ-3xunlyt_I_DrG20TCWCyfsx7T9v&index=4 (Permission to use for educational purposes received from The Health Foundation (info@health.org.uk))

Person-centred care – pharmacist viewpoint: https://www.youtube.com/watch?v=POwThWDPZQ&index=3&list=PLjsZ-3xunlyt_I_DrG20TCWCyfsx7T9v (Permission to use for educational purposes received from The Health Foundation (info@health.org.uk))

Use of Decision Aids

Decision aids, which can be delivered online, on paper, or on video, can efficiently help individuals absorb relevant clinical evidence and aid them in developing and communicating informed preferences, particularly for possible outcomes that they have not yet experienced.

Here is a good example of how you, as a healthcare professional, can ensure that you are enabling choice in decision-making processes. In Unit 4 you will have opportunity to explore how to support individuals in developing decision-making skills.

Example: Reminder Pocket Card (Braddock *et al.*, 2008)

Pocket Card (FRONT)

CHECKLIST:

YES	NO	
		Did you discuss the individual's role in the decision-making process? (Role)
		Did you discuss how the decision would impact the individual's daily life? (Context)
		Did you discuss the essential clinical issues? (Nature)
		Did you discuss reasonable alternatives? (Alternatives)
		Did you discuss the relevant risks and benefits? (Pros & cons)
		Did you discuss the likelihood that surgery would/would not succeed? (Uncertainty)
		Did the individual understand the decision? (Understanding)
		Did you discuss whether the individual would like to consult others? (Input)
		Did you discuss what the individual preferred? (Preference)
		Did you ask the individual to teach-back what was discussed? (Teach-back)

Pocket Card (BACK)

EXEMPLAR:

DIMENSION	ELEMENTS
Provide information	NATURE – What are the health concerns we are addressing? ALTERNATIVES – What are the treatment options? PROS & CONS – What are the relevant risks and benefits? UNCERTAINTY – What is the chance that the treatment will help/fail?
Foster involvement	ROLE – What role do you want to play in the decisions? CONTEXT – How will the decision impact your daily life? UNDERSTANDING – What questions do you have? INPUT – Would you like to talk to anyone else before you make your final decision? PREFERENCES – Does that sound reasonable? What do you think?
Check for understanding	TEACH-BACK – Did you ask the individual to teach back what was discussed?

Did You Know?

“Self-management support can be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviours; and a fundamental transformation of the patient-caregiver relationship into a collaborative partnership” (Bodenheimer *et al.*, 2005, p. 4).

Note to Instructors regarding learning outcome 3.5: Effective communication and partnership formation for self-management support requires a fundamental culture shift which takes Bodenheimer's definition into account. Ask students to critically evaluate communication between healthcare professionals and individuals for collaborative-partnership and relationships. It is recommended to stress here the importance of transforming from a paternalistic approach to an equal partnership and recognition for expertise in the individual's experience of their chronic condition.



Trigger Video

Watch this video where a diabetes nurse specialist explains how the focus of healthcare interactions have changed in her clinic in support of collaborative relationships.

Co-creating health – a nurses perspective: https://www.youtube.com/watch?v=oyg89oVnVuY&list=PLjsZ3xunlyt_I__DrG20TCWCyfsx7T9v&index=15
(Permission to use for educational purposes received from The Health Foundation (info@health.org.uk))



Activity 3.7: Partnership and person-centredness

Following on from this trigger video, in groups, discuss your views on partnership and person-centredness.

Can you think of three key communication skills that are needed for effective partnership building?

Partnership facilitates personalised care planning in the context of regular clinical review.

“Personalised care planning encourages healthcare professionals and people with chronic conditions, and their carers, to work together to clarify and understand what is important to that individual. They agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a planned and continuous process, not a one-off event. The plan should identify the patient’s particular self-management support needs – for instance, these may include help with health behaviour change; need for social support or peer support or support for (or from) a family member; or with disease specific education or training... The self-management plan should be reviewed regularly in a structured way along with the patient’s overall care plan as their need for support changes. It should be integrated into the patient’s care over time and across care settings. Training and support for frontline health professionals to provide self-management support is essential” (Health Service Executive, 2017, p. 19).

As part of self-management care, it may be appropriate to plan for deterioration, such as using the asthma action plan. The following will demonstrate an example of this:

Example: Asthma Action Plan

Effective asthma management requires the development of a partnership between the individual who has asthma and a healthcare professional. This partnership can enable the individual to gain the knowledge, confidence and skills to self-manage their condition (Global Initiative for Asthma, 2017). Self-management support plan for a person with asthma should include the development with the individual of an Asthma Action Plan. This is based on the individual’s own experience (e.g. the individual’s asthma triggers and other history) together with disease education, and inhaler technique training (Health Service Executive, 2017). It is designed to support individuals who have asthma to monitor their symptoms and signs (self-monitoring) and to make decisions based on these signs. It also supports them to plan for deterioration of their condition and provides them with the information they need on when and where to seek medical attention. The Asthma Action Plan is a prime example of self-management, encapsulating and supporting the core skills of problem-solving, decision-making, resource utilisation, forming of an individual/healthcare professional partnership, and taking action. These skills will be addressed further in Unit 4.



Activity 3.8: Role-play: Asthma

Read the case study. One person to be Jane and one to be the healthcare professional. Imagine that Jane is attending your clinic for a review. Complete the Asthma Action Plan with Jane. This may include seeking out additional information from Jane to complete the Action Plan. After role play and completion of Action Plan – Group discussion on role play, developing the partnership and forming the action plan.

Note for instructors: In the case study, the healthcare professional is a practice nurse. This may be altered to suit your professional area of study. This example would best be used with students who already have basic knowledge of the diagnosis and treatment of asthma and the use of preventer and reliever inhalers. You may decide to develop an alternative case study to meet your requirements.

Case Study: Asthma Action Plan

Jane is a 27 year old female. Jane was diagnosed with asthma when she was 10 years old. Her asthma triggers are smoke and dust. Jane works in a sedentary job in an office five days per week. Jane goes for a walk three times a week for 20 minutes. Jane considers her eating habits to be healthy but does treat herself to a takeaway every Saturday and Sunday night. Sometimes if Jane has to work late she gets fast food for her dinner. Jane is a non-smoker, she has an active social life and enjoys meeting friends at the weekend to attend concerts or to meet in the local pub. Jane lives with three housemates, whom she only met when she moved in with them four months ago.

Jane describes herself as a disorganised person and frequently forgets to bring her inhaler with her on nights out. Jane uses a Beclomethasone controller inhaler and a Salbutamol reliever inhaler. Jane doesn't worry when she forgets her inhaler. At a concert a few months ago Jane got an asthma attack. The attack was managed with the help of paramedics at the concert however she was transferred to hospital, monitored for 24 hours and discharged. She was advised to attend her GP for a follow-up review within the next few days. Jane attended her GP and her inhaler technique was observed and her medications were reviewed.

Jane then met with her practice nurse and once it was established that Jane's asthma was controlled they worked through and completed the asthma action plan together. To Jane's surprise, sitting down with the nurse, and working in partnership to create a plan, that was just about her and her needs, felt very reassuring. She felt prepared, confident and equipped to deal with whatever might come her way with regards to her asthma. She also felt that she had been a bit dismissive and if she were being honest a little irresponsible in the past. Jane did not sense any judgment about this from the nurse, instead she felt understood, reassured and supported to be able to manage her asthma going forward.

Summary of the lesson

In Lesson 2, you had the opportunity to explore the concepts of trust and collaboration and shared decision-making in partnership between healthcare professionals and individuals with chronic conditions and how you as a healthcare professional develop the skills you need to communicate effectively to support self-management. In the next unit you will explore ways in which you can support individuals to develop these skills also.

Self-Care Plan | Asthma



This is a guide to managing your symptoms. It's important to look after your own health and wellbeing, with support from your team of health professionals.

Figure 3.5: Asthma Action Plan
(M. Owens, personal communication, November 4, 2019)

<p>ASSESSMENT</p>	<div data-bbox="450 1809 526 1892"> </div> <div data-bbox="461 1592 520 1792"> <p>FEELING WELL Everyday asthma care</p> </div> <div data-bbox="547 1626 574 1883"> <p>My asthma is controlled:</p> </div> <ul data-bbox="574 1393 842 1883" style="list-style-type: none"> • I have no cough, wheeze, shortness of breath or chest tightness • I can exercise without asthma symptoms • My asthma symptoms do not wake me at night • I do not need to take days off school, college or work • I use my reliever inhaler twice a week or less (over the age of 6 years) • I use my reliever inhaler once a week or less (under the age 6 years) <div data-bbox="847 1393 908 1883"> <p>My peak flow is between: _____ and _____ (80–100%) of my personal best</p> </div>	<div data-bbox="450 1276 526 1359"> </div> <div data-bbox="461 1028 520 1261"> <p>FEELING UNWELL When I am feeling unwell</p> </div> <div data-bbox="547 862 574 1352"> <p>• My asthma symptoms include one or all of the following: cough, wheeze, shortness of breath or chest tightness</p> </div> <ul data-bbox="574 878 924 1352" style="list-style-type: none"> • I have symptoms with exercise • My asthma symptoms wake me at night • I need to take days off school, college or work due to asthma symptoms • I am taking my reliever inhaler more than twice a week (over the age of 6 years) • I am taking my reliever inhaler more than once a week (under the age of 6 years) • My peak flow is dropping • I feel like I have a cold or flu 	<div data-bbox="450 712 526 828"> </div> <div data-bbox="461 445 520 728"> <p>VERY UNWELL I am having an asthma attack</p> </div> <div data-bbox="547 362 574 819"> <p>• My asthma symptoms are getting worse and I have increased: cough, wheeze, shortness of breath or chest tightness</p> </div> <ul data-bbox="574 371 869 819" style="list-style-type: none"> • My reliever inhaler gives little or no relief • I find it difficult to talk or walk • I find it difficult to breathe • I have blue lips or fingernails • My peak flow is dropping further • The attack came on suddenly • I am breathing fast and using my tummy and neck muscles
<p>ACTION</p>	<div data-bbox="957 1635 984 1883"> <p>CONTROLLER INHALER</p> </div> <ul data-bbox="984 1393 1152 1883" style="list-style-type: none"> • When my asthma is controlled I take my controller medication everyday like this: Name _____ Colour _____ Number of puffs in the morning _____ at night _____ • I always rinse my mouth after I take my controller inhaler <div data-bbox="1169 1675 1197 1883"> <p>RELIEVER INHALER</p> </div> <ul data-bbox="1197 1393 1463 1883" style="list-style-type: none"> • I take my reliever inhaler if I wheeze, cough, have chest tightness or I am finding it difficult to breathe Name _____ Colour _____ Number of puffs _____ • I should always carry my reliever inhaler • I take two puffs of my reliever inhaler before exercise if needed <div data-bbox="1431 1393 1458 1883"> <p>When I am well, I also take my other medication</p> </div>	<div data-bbox="957 1095 984 1352"> <p>CONTROLLER INHALER</p> </div> <p data-bbox="984 862 1032 1352">When I am feeling unwell I take my medication like this:</p> <p data-bbox="1038 862 1098 1352">Name _____ Colour _____ Number of puffs in the morning _____ at night _____</p> <div data-bbox="1115 1135 1142 1352"> <p>RELIEVER INHALER</p> </div> <p data-bbox="1142 862 1197 1352">Name _____ Colour _____ Number of puffs _____</p> <ul data-bbox="1197 862 1463 1352" style="list-style-type: none"> • If I am not improving and I have been prescribed Prednisolone tablets (steroid tablets) to keep at home, I should start taking them: Yes _____ No _____ • If I continue to feel unwell and I am not improving, or I am concerned, I contact the GP/Nurse/Out-of-Hours Doctor/Emergency Department 	<div data-bbox="957 430 984 819"> <p>THIS IS AN EMERGENCY – ACT NOW</p> </div> <p data-bbox="984 338 1038 819">Follow the 5 steps below. If you are worried or not improving at any stage, CALL 999 or 112.</p> <ol data-bbox="1059 329 1463 819" style="list-style-type: none"> 1. Stay calm. Sit up straight – do not lie down. 2. Take slow steady breaths 3. Take one puff of your reliever inhaler (blue) every minute. Use a spacer if available. <ul data-bbox="1174 329 1294 819" style="list-style-type: none"> • People over 6 years can take up to 10 puffs in 10 minutes • Children under 6 years can take up to 6 puffs in 10 minutes 4. Call 112 or 999 if your symptoms do not improve after 10 minutes 5. Repeat step 3 if an ambulance has not arrived in 10 minutes <p data-bbox="1404 396 1463 819">It is safe to take additional puffs of your blue inhaler during an acute asthma attack</p> <p data-bbox="1485 362 1513 819">I always use a spacer with my inhaler if I have one</p>

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Unit 4: Skills Building for Self-management

Duration: **2 hours**

Recommended Programme Placement: **Year 2 or 3**

Lesson Plan		
Unit 4: Learning Outcomes	<p>Competency: Assist individuals/carer in skills building to effectively self-manage a chronic condition in their daily lives.</p> <p>Learning Outcomes:</p> <ul style="list-style-type: none"> 4.1 Build individuals' confidence by supporting them to develop problem-solving and decision-making skills to support self-management of a chronic condition. 4.2 Demonstrate ability to support individuals to develop self-monitoring skills and interpret changes in health status indicating improvement, maintenance or deterioration. 4.3 Develop ability to support individuals to utilise resources and form partnerships to effectively manage their chronic condition. 4.4 Demonstrate ability to actively engage individuals in setting goals, planning actions and re-evaluating according to their needs. 	
Lesson 1: Problem-solving and Decision- making 1 Hour	<ul style="list-style-type: none"> • Introduction to Unit 4 • Recap Unit 1 to 3 • Introduction to Lesson 1 • Core Self-management Skills • Problem-solving and Decision-making • Problem-solving for Self-management • Decision-making for Self-management 	<p>ACTIVITY 4.1 Ottawa Personal Decision Guide</p> <p>ACTIVITY 4.2 Case studies</p>
Lesson 2: Resource Utilisation and Forming Partnership 1 Hour	<ul style="list-style-type: none"> • Introduction to Lesson 2 • Brief recap Unit 4 Lesson 1 • Resource Utilisation • Social Prescribing • Forming Partnerships • Effective Communication for Forming Partnerships 	<p>ACTIVITY 4.3 Case study for communication</p>
Lesson 3: Action planning 1 Hour	<ul style="list-style-type: none"> • Introduction to Lesson 3 • Brief recap Unit 4 Lesson 1 and 2 • Action Planning • Self-management Support Care Planning 	<p>ACTIVITY 4.4 SMART goal</p> <p>ACTIVITY 4.5 Addressing barriers and enablers to achieving goals</p> <p>ACTIVITY 4.6 Clinical activity</p> <p>ACTIVITY 4.7 Case study</p>
Core Reading	<p>Charmaz, K. (1997). <i>Good days, bad days: the self in chronic illness and time</i>. New Brunswick, N.J., Rutgers University Press.</p> <p>Lorig K. and Holman H. (2003) Self-management education: History, definition, outcomes, and mechanisms. <i>Annals of Behavioral Medicine</i> 26(1): 1-7.</p>	
Accompanying Slide Pack for Unit 4	<p>https://www.hse.ie/sms-undergradcurriculum/</p>	

Unit 4: Skills Building for Self-management

Introduction to Unit 4

In Unit 4 the emphasis is on assisting individuals to build skills to effectively manage a chronic condition in their daily lives: problem-solving, decision-making, resource utilisation, forming partnerships and action planning. Discussions will focus on building individuals' confidence by supporting the development of problem-solving and decision-making skills. In addition you will explore how to support the development of individuals' self-monitoring skills and their ability to interpret changes in their health status indicating improvement, maintenance or deterioration.

Recap Unit 1, 2 and 3

In Unit 1 you were introduced to the concept of self-management support through exploration of the definitions, foundations and principles underpinning both self-management and self-management support. You explored the core tasks and skills which individuals with chronic conditions require to be effective self-managers. In addition, you were encouraged to explore the skills which are required of the healthcare professional in supporting individuals to develop the skills that they need to self-manage their chronic condition.

In Unit 2, you studied the concept of holistic care in the context of self-management support. You had the opportunity to gain a deeper understanding of how to support individuals in the medical, role and emotional self-management of their chronic condition. You discussed the ways in which healthcare professionals, communities and families can support self-management in a holistic way. Health literacy was introduced, again highlighting the importance of individual preferences and abilities in keeping with person-centred holistic care.

In Unit 3 you had the opportunity to learn about the importance of effective collaborative-partnership communication for self-management support. You explored the engagement between healthcare professionals and individuals to support self-management of chronic conditions. Key learning outcomes in Unit 3 focused on gaining an individual's perspective on the impact of a chronic condition on their daily life. Understanding the importance of trust and collaboration in relationships and the importance of discussing treatment options with individuals and the concept of shared decision-making were also addressed in Unit 3.

Lesson 1: Problem-solving and decision-making

Duration: 1 Hour



**PPT Title – Unit 4 Lesson 1:
Problem-solving and decision-making**

Introduction to Lesson 1

In Lesson 1 you will have opportunity to explore, reflect and understand the skills of problem-solving and decision-making for self-management. Self-efficacy theory is briefly discussed before moving on to look at each of these two skills individually. Case studies are provided to demonstrate the importance of both problem-solving and decision-making in the day-to-day self-management of chronic conditions. Your role, as a future healthcare professional, in supporting skill acquisition in individuals with a chronic condition, is a core consideration throughout the lesson.

Core Self-management Skills

There are many frameworks and theories related to self-management, including that proposed by Lorig and Holman (2003). Lorig and Holman (2003) described five core self-management skills – problem-solving, decision-making, resource utilisation, forming of an individual/healthcare professional partnership, and taking action. The skills described are foundational to assisting individuals to self-manage their chronic condition. Self-management skills and knowledge need to be individually tailored and broader consideration of factors is essential in supporting individuals, including wider determinants of health, such as those described in the “Social Determinants of Health Model” (Dahlgren and Whitehead, 1991) in the *Making Every Contact Count for Health Behaviour Change Curriculum Manual Part 1; Unit 2 Lesson 1*.

Table 4.1: Core Self-management Skills (Lorig and Holman, 2003)

Skill	Description
Problem-solving	Skills including problem definition, generation of possible solutions including the solicitation of suggestions from friends and healthcare professionals, solution implementation, and evaluation of results
Decision-making	Making day-to-day decisions in response to changes in conditions, and may be part of problem-solving. Decision-making is based on having enough and appropriate information.
Resource utilisation	Developing ability to seek out and utilise resources which may help in managing their health conditions.
Forming partnerships	Helping people to form partnerships with their healthcare professionals, including ability to report accurately the trends and tempo of the disease, make informed choices about treatment, and discuss these with the healthcare professional.
Action planning	Developing skills to plan action and to implement self-management plans.

Problem-solving and Decision-making

This lesson focuses on exploring and understanding the importance of problem-solving and decision-making skills as fundamental elements of self-management, and also on assisting individuals to develop these skills, as a key element of self-management support. In chronic conditions this often occurs in self-monitoring of the person's own health status. Interpreting changes in health status is a vital element of problem-solving and decision-making as this is an indication of improvement, maintenance or deterioration. Both problem-solving and decision-making therefore require appropriate knowledge regarding the chronic condition. Self-management support involves offering assistance in developing problem-solving and decision-making skills to individuals with a chronic condition and providing education and training, to enable individuals to self-monitor and make decisions based on their interpretations. There are disease specific programmes which provide disease specific education, such as the DESMOND (Diabetes Education and Self-management for Ongoing and Newly Diagnosed) and DAFNE (Dose Adjustment for Normal Eating) programme for diabetes. There are also certain programmes which enable individuals to develop generic self-management skills, for example; the Chronic Disease Self-management Programme (CDSMP) (Lorig *et al.*, 2001).

Before looking closer at problem-solving and decision-making we will focus on the concept of self-efficacy. In Unit 1 we mentioned self-efficacy. Self-efficacy is seen as individuals' confidence that they can effectively manage their health and has been recognised as a powerful factor in inducing new behaviours (Bandura, 1977; Lorig and Holman, 2003; Bourbeau *et al.*, 2004). The self-efficacy theory proposed by Bandura (1977) states that expectations of personal efficacy determine whether coping behaviour will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences. Skills mastery, modelling, interpretation of symptoms and social persuasion are believed to contribute to enhanced self-efficacy (Lorig and Holman, 2003). The development of self-efficacy provides individuals with the confidence they need to problem-solve and make decisions regarding the self-management of their chronic condition.

Self-efficacy for Problem-solving and Decision-making

Healthcare professionals can use numerous strategies to enhance self-efficacy in individuals who have a chronic condition, which are explained below. These include:

1. Practice
2. Feedback
3. Reattribution of the perceived causes of failure when the individual has negative experiences
4. Sharing experience (role model) (Bourbeau *et al.*, 2004)

Bourbeau *et al.* (2004) described how self-efficacy can be enhanced in people who have COPD.

Table 4.2: Self-efficacy Strategies

Strategy	Description
Practice	Self-management skills must be practiced by the person who has a chronic condition. Coaching from their healthcare professional is an important element of this as is the opportunity to practice skills in different environments.
Feedback	Feedback on self-management skills is important to allow for refinement of skills. This feedback can be provided in numerous forms, e.g. verbal/non-verbal, in person, via phone, or web-based. Regular clinical review facilitates this.
Reattribution of the perceived causes of failure when the individual has negative experiences	Prior (negative) experiences of individuals in carrying out the behaviours need to be addressed as failures experienced in the past may need to reattribute the perceived causes of this failure. Bourbeau <i>et al.</i> (2004) provide an example of this "I was not adequately prepared then, but now I know exactly how to..."
Sharing experience (role model)	Learning from a peer that succeeded in changing the behaviour(s) enhances self-efficacy expectations of an individual. Groups (such as community peer support groups) can be useful in helping individuals learn vicariously through a sharing of experiences, reinforce learning, change self-image and discourage passivity.

Problem-solving for Self-management



Reminder: What is problem-solving for self-management? It is about problem definition, generation of possible solutions including the solicitation of suggestions from friends and healthcare professionals, solution implementation, and evaluation of results (Lorig and Holman, 2003).

Healthcare professionals, in supporting self-management, teach basic problem-solving skills as opposed to providing all of the solutions (Lorig and Holman, 2003). Flinder's University have described problem-solving as;

"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"
(Lawn and Battersby, 2009, p. 14, adapted from Von Korff *et al.*, 1997).

and as

"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"
(Lawn and Battersby, 2009, p. 14, adapted from Katon *et al.*, 2008).



Pause for Reflection and Discussion

Think of a time you had a problem to solve?

Now think about the process you underwent to address that problem? Was it a successful process? Would you change anything about the way you addressed the problem?

Apply the criteria for problem-solving to the identified problem:

1. Define the problem
2. Generation of possible solutions
3. Solution implementation
4. Evaluation of results

Now let us take that a step further and think of a time that you supported someone else to solve a problem.

What did that feel like for you?

What do you think helped you in offering support with problem-solving?

Take some time to reflect on what this problem-solving strategy might look like for a person with a chronic condition:

Mary is a 60 year old woman and is suffering from heart failure. On a recent visit to her GP, Mary admitted to feeling increasingly down because she feels that she is unable to do the things she enjoyed most, including working outside in the garden and walking to the shopping centre in the mornings. This was a great social outlet for Mary where she regularly met friends for coffee. Clinical examination indicates that there is no deterioration in Mary's physical condition.

1. *Define the problem* - Mary is starting to feel isolated and depressed and she admits that this is because she is not keeping busy and has stopped going out to meet her friends. On further investigation the GP discovers that Mary is fearful about doing the activities that she used to do in case it will exacerbate her symptoms.
2. *Generation of possible solutions* - The GP asked Mary if she would like information to help better understand her condition and the things that are safe for her to do. Mary was very keen to receive this information and her GP explained that "Keeping active helps the symptoms of heart failure by improving the body's circulation and use of oxygen" as detailed in the website he provided; (<https://irishheart.ie/news/heart-failure-and-physical-activity/>).
He explained to Mary that the Irish Heart Foundation provides people with information and advice on heart conditions and their website offers lots of resources including real life stories, booklets and useful contacts. The organisation runs local support groups, where people with heart conditions share experiences and advice through their regular meetings. Mary indicated that she didn't use computers but that her daughter did and that she would look at it with her. In the meantime the GP printed out some useful information which Mary could take away and read at home including the signs and symptoms which Mary should watch out for when exercising. They also explored other possible exercise options, such as a seated yoga class held in the local community which Mary had heard about from a friend.
3. *Solution Implementation* - Mary and her daughter accessed the Irish Heart Foundations' website. Mary decided that she would start walking to the shopping centre again now that she understands it is safe for her to do so. She is also happy to attend the local support group run by the Irish Heart Foundation and has booked into the next seated yoga class.
4. *Evaluation of results* - The next time that Mary went to visit her GP she was feeling much better. She was more optimistic about her future and was feeling happier now that she was participating in gentle exercises and socialising more as a result of this. The resources that the GP offered were very useful and having the correct information gave Mary the confidence that she needed to remain active.

The ability to problem-solve is a vital skill when self-managing a chronic condition. It is a skill that will be used over and over on a daily basis. Problem-solving will ultimately help inform the decisions that individuals make and is therefore closely linked to the next skill that we will explore: decision-making.

Decision-making for Self-management



Reminder: What is decision-making for self-management of chronic condition? It is about making day-to-day decisions in response to changes in disease condition, and may be part of problem-solving. Decision-making is based on having enough and appropriate information (Lorig and Holman, 2003).

The healthcare professional plays a key role in education and information provision, which ultimately supports an individual's decision-making skills required for effective medical, role and emotional self-management of their condition. Oftentimes, a person with a chronic condition may ask for information, for example; *how much exercise can I participate in? Is it safe to drive? Can I carry on working shifts? Should I increase my salbutamol inhaler if I get the flu?*



Pause for Reflection and Discussion

Think about the decisions that you make on a daily basis.

Think about the outcome of the decisions. What factors inform the decisions you make?

Have you ever supported someone to make a decision?

How did you support them? What did that feel like?

As a healthcare professional how do you think you could support an individual to develop decision-making skills to self-manage their chronic condition?



Activity 4.1: Ottawa Personal Decision Guide

Ottawa Hospital Research Institute (2015) developed a decision guide to help people identify their decision-making needs, plan the steps, track their progress, and share their views about the decision. Think about a decision you face now and use this guide to make your choice. This guide can be used by healthcare professionals to facilitate any health-related and social decision-making.

- PDF Link: <https://decisionaid.ohri.ca/docs/das/OPDG.pdf>
- A completed example by a student:
<https://decisionaid.ohri.ca/docs/opdg-video/opdg-example.pdf>

Figure 4.1: Ottawa Personal Decision Guide (reproduced with permission from Ottawa Hospital Research Institute, 2015)

Ottawa Personal Decision Guide

For People Making Health or Social Decisions



1 Clarify your decision.

What decision do you face?

What are your reasons for making this decision?

When do you need to make a choice?

How far along are you with making a choice?

☐ Not thought about it
☐ Thinking about it

☐ Close to choosing
☐ Made a choice

2 Explore your decision.



Knowledge

List the options and benefits and risks you know.



Values

Rate each benefit and risk using stars (★) to show how much each one matters to you.



Certainty

Choose the option with the benefits that matter most to you. Avoid the options with the risks that matter most to you.

	Reasons to Choose this Option Benefits / Advantages / Pros	How much it matters to you: 0 ★ not at all 5 ★ a great deal	Reasons to Avoid this Option Risks / Disadvantages / Cons	How much it matters to you: 0 ★ not at all 5 ★ a great deal
Option #1				
Option #2				
Option #3				

Which option do you prefer?

☐ Option #1

☐ Option #2

☐ Option #3

☐ Unsure



Support

Who else is involved?

Which option do they prefer?

Is this person pressuring you?

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

How can they support you?

What role do you prefer in making the choice?





☐ Share the decision with...



☐ Decide myself after hearing views of...

☐ Someone else decides...

3 Identify your decision making needs.








Adapted from The SURE Test © 2008 O'Connor & Légaré.


	Knowledge	Do you know the benefits and risks of each option?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Values	Are you clear about which benefits and risks matter most to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Support	Do you have enough support and advice to make a choice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Certainty	Do you feel sure about the best choice for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answer 'no' to any question, you can work through steps two  and four , focusing on your needs.

People who answer "No" to one or more of these questions are more likely to delay their decision, change their mind, feel regret about their choice or blame others for bad outcomes.

4 Plan the next steps based on your needs.

Decision making needs	Things you could try
 Knowledge If you feel you do NOT have enough facts	<input type="checkbox"/> Find out more about the options and the chances of the benefits and risks. <input type="checkbox"/> List your questions. <input type="checkbox"/> List where to find the answers (e.g. library, health professionals, counsellors): <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
 Values If you are NOT sure which benefits and risks matter most to you	<input type="checkbox"/> Review the stars in step two  to see what matters most to you. <input type="checkbox"/> Find people who know what it is like to experience the benefits and risks. <input type="checkbox"/> Talk to others who have made the decision. <input type="checkbox"/> Read stories of what mattered most to others. <input type="checkbox"/> Discuss with others what matters most to you.
 Support If you feel you do NOT have enough support If you feel PRESSURE from others to make a specific choice	<input type="checkbox"/> Discuss your options with a trusted person (e.g. health professional, counsellor, family, friends). <input type="checkbox"/> Find help to support your choice (e.g. funds, transport, child care). <input type="checkbox"/> Focus on the views of others who matter most. <input type="checkbox"/> Share your guide with others. <input type="checkbox"/> Ask others to fill in this guide. (See where you agree. If you disagree on facts, get more information. If you disagree on what matters most, consider the other person's views. Take turns to listen to what the other person says matters most to them.) <input type="checkbox"/> Find a person to help you and others involved.
 Certainty If you feel UNSURE about the best choice for you	<input type="checkbox"/> Work through steps two  and four  , focusing on your needs.
Other factors making the decision DIFFICULT <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	List anything else you could try: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>



In order to further understand the importance of problem-solving and decision-making processes in the self-management of a chronic condition, a number of case studies are presented in Activity 4.2.

These case studies have been written by people living with a chronic condition to demonstrate how daily life can impact on their chronic condition and how they use their self-monitoring skills to interpret changes in health status, problem solve and make decisions.



Activity 4.2: Case studies

Select one of the case studies.

In groups:

- Identify the problem for the person in your scenario
- Discuss the decision made by the person, and the factors that influenced the decision
- What strategies might have helped in developing the problem-solving and decision-making skills used to manage their condition, *Consider self-efficacy strategies*
- Feed back to the wider group on the points above

Case study 1: Airport Security Hypoglycaemia (Type 1 Diabetes)

If you live with type 1 diabetes and travel, those three words “Airport Security Hypo” probably strike fear into your heart. Airport security is stressful enough with type 1 diabetes, even when it goes smoothly but if you throw in a hypo it’s nerve wrecking.

Last Saturday, I flew to London on my own (I live in Ireland). This incident happened on my return journey. I was in line at the metal detector, and had put my personal belongings on the security belt and that’s when my CGM (Continuous Glucose Monitor) alarm went off, telling me that my glucose levels were 4.4mmols and dropping. Emmm, what do I do??? I need to manage my hypo. Do I jump the person behind me to grab my bag off the belt and risk the security agents responding as I would expect? Or do I wait and see if a more opportunistic moment presents itself? I knew I was going to have to volunteer for a pat down anyway.

I choose this option, “Well, it’s only going to take a few minutes and feel fine so let’s assume my CGM is telling a bit of a fib for right now” combined with the “wait and see” approach. I went through the metal detector and it beeped. I was directed to the body scanner which I declined because of the manufacturer’s recommendations about my CGM and opted for the manual check by a security person. The manual checks in this airport are conducted in a private room which requires two female security officers to be available. And so I took a seat and waited for the manual check. And waited some more. Thankfully the security officer directing the other people through the metal detector kept checking that someone was coming to me. Thankfully, I was at the airport way too early for my flight so apart from the threatened hypo I was relaxed.

Another five minutes went by and I could start to feel the heat of my body increase but I was still functioning and calm. By the time the female security officers came to usher me to the screening room I could feel the heat turn into perspiration. I thought about asking if I could grab my glucose out of my personal belongings, but I really wanted to get this stress over with so I could relax and so I didn’t ask for it. Additionally, I didn’t know how it would be perceived if I asked for my belongings. The security officers seemed like really nice, jolly ladies but I did not want to push it. I want to reiterate that this was the choice I made and take full responsibility for. I did feel that I could ask for help at any stage help.









Case study 2: COPD

Arjun is a 56 year old male, he has been an ex-smoker for 6 years, and was diagnosed with COPD two years ago. He has had a number of admissions to hospital with exacerbations, but he feels well most of the time, and works with his GP and practice nurse to stay well. Six months ago Arjun and his GP took some time during a clinical review to become familiar with a COPD self-management plan as an additional support to him in managing his condition and staying well.

On this particular occasion Arjun woke up early with a funny sensation in his throat. He had some water to see if that would help. He continued with his normal morning routine which included taking his regular medications and inhalers, and keeping as active as possible. Arjuns's morning activity is to walk to the nearby shop for the newspaper before returning home to work in his office. On his walk back from the shop Arjun noticed that he was becoming a little more short of breath than usual. On his return home, he consulted his self-management plan, and started to use his breathing control exercises and took a dose of his reliever inhaler. The following day, he felt that he was getting more tired than usual and was also feeling hot. Later that day Arjun noticed that he was now coughing up sputum, which was yellow in colour instead of his normal clear colour. He also noticed that he was starting to get wheezy. He decided that it was time to follow the steps that were indicated for "feeling unwell" in his COPD self-management plan. He started to take his reliever inhaler every 4 hours. He also contacted his GP for advice. His GP advised Arjun to come into the surgery the following morning so that he could examine him and determine if he needed to commence on antibiotics and/steroids.

COPD Self-management Plan

(M. Owens, personal communication, November 4, 2019)

SYMPTOMS		ADVICE
FEELING WELL 	<ul style="list-style-type: none"> I am able to carry out my usual activities My phlegm is a normal colour and amount for me 	<ul style="list-style-type: none"> Continue with my medication as prescribed and continue my day as normal Keep as active as possible 
BAD DAY 	<ul style="list-style-type: none"> My COPD may be bothering me. For example, I am more breathless than usual. 	<ul style="list-style-type: none"> Use chest clearance techniques Use my reliever inhaler Use breathing control exercises If no relief I may be unwell. Move on to 'Feeling Unwell' section for guidance. 
FEELING UNWELL 	<ul style="list-style-type: none"> I am more wheezy, breathless I have more phlegm, which is yellow or green in colour 	<ul style="list-style-type: none"> Take my normal medications and inhalers Take my reliever medication every 4 to 6 hours Start rescue antibiotics and steroids Call GP or GP Out-of-Hours GP service for advice Call my COPD Outreach Team or COPD Support Ireland advice line 
VERY UNWELL 	<ul style="list-style-type: none"> My reliever and rescue prescription are not helpful or I feel worse 	<ul style="list-style-type: none"> I should urgently contact my GP or Out-of-Hours GP service. Go to the hospital Emergency Department if GP is not available. If I am short of breath at rest, have chest pain or confusion this is an emergency. CALL 112 or 999 and ask for an ambulance. 

Note for instructors: Possible discussion points:

- What does Arjun do to self-manage his condition on a daily basis?
- What else could Arjun do to that would help him to manage his condition?
- What else could his GP do when Arjun is well again, to support him to self-manage?

Case study 3: Thanksgiving Blood Sugar Battle (Type 1 Diabetes)

Thanksgiving features strongly in our household because my husband is American. As a person with type 1 diabetes dealing with celebrations feasts are a huge challenge. This one turned into a 24-hour challenge, in that the high blood glucose levels wiped me out the next day. Maybe, this is why the Americans make thanksgiving a four-day weekend?

My approach to big meals, is to have a little of what I love, a very small amount of what I don't consider worth the insulin, just to be polite, and maybe even skip the potato, because, well, I'm Irish and we had them every single day growing up.

My blood sugars did reasonably well, considering what I ate. But this year, about four hours after pie, when I thought I was a little in the clear, my blood sugars started to climb and climb and hover. It was 2am when my CGM alarmed for the last time and I finally got to sleep. I woke the next morning as if I had been out all night.

The next morning, I had planned to treat myself to a morning of retail therapy in the city and to finish off the last of my Christmas shopping. I thought about not going because I was too tired. Then, made myself go because it would do me good and maybe I'd feel better for it.

It did not work! I persevered because I had driven all the way there, but when the toy shop told me after waiting in line for about eight minutes, that their computers were down and could not issue a gift card, I decided It was time to go home.

Had this been any other day and had I not been battling high blood glucose numbers the night before, I would have been productive on a superhuman level. My daughter finished early from school and so I only had one school pick up in the afternoon. I thought to myself "Great! I'll have at least an hour or more to do some writing this afternoon". That didn't work either. I could even concentrate on scrolling through my Facebook feed. And that doesn't require any concentration but I still couldn't do it.

I gave up! I put the iPad down, the phone down and put my head down on the couch with lots of blankets and took a nap! And actually, in between the "Mom, where is the..." and the "Mom, can I..." I did actually nap.

Sometimes, you have to give diabetes a win so that you can prepare yourself to fight the battle again another day. Compared to most hypos this one rebounded quite quickly and not too high. However, I did spend most of the day with glucose levels that were more elevated than my usual. And there you have it, diabetes the spontaneity killer.

Case study 4: Medication Management (Chronic Atrial Fibrillation)

As a practicing nurse for many years the process of dispensing medication to patients was an activity that I did daily. Other than considering this activity from a patient safety perspective, I thought little about the impact of long term medication use from an individuals' psycho social perspective. In more recent times my current role as a researcher placed other demands on me. For example, it required that I sit for long periods of time reviewing, analysing, and processing research data. Combining my work life balance with aging parents and their associated care needs I failed to recognise the little time this left for me to focus on personal healthy lifestyle choices. In 2015 after a series of trips presenting my work overseas, I developed bilateral pneumonia and shortly after chronic atrial fibrillation.

Initially I considered this bout of illness as a disruption to my busy life which I was keen to return to. I love what I do. Although there was a family history of atrial fibrillation it never occurred to me that this health issue was anything other than a temporary setback. I have never been ill or in hospital other than to have my two children. As someone who had recently turned 50 my firm belief was that these health issues would be something I would need to face much later in life.

So while I maintained a strong focus on taking medications and health seeking behaviours it was a great disappointment to me after a year when I realised there was no ability for me to return to my former health state. With consultants support and approval, I trialled a period weaning myself off the medications which I was now having to take twice a day. Within a month I was back in hospital and required cardio version for a third time.

My dilemma was this... what am I supposed to do? These medications carry serious side effects, and need to be taken regardless of their associated side effects and dietary restrictions which I now needed to manage. If I stop taking the medication... well two failed attempts already would suggest that this path would lead to additional cardio version. So where am I now three years later?... Following consultation with a cardiologist, I am considering ablation but again there is no indication that this approach is 100% successful as this procedure doesn't always work for everyone.

Summary of the Lesson

In this lesson you discussed the skills of problem-solving and decision-making for self-management. You had an opportunity to explore the importance of your role as a healthcare professional in supporting the development of these skills in individuals with chronic conditions. A number of case studies demonstrating the use of problem-solving and decision-making in day-to-day self-management of chronic conditions were presented. In the next lesson you will have the opportunity to explore the skills of resource utilisation and forming partnerships.

Lesson 2: Resource Utilisation and Forming Partnerships

Duration: 1 Hour



**PPT Title – Unit 4 Lesson 2:
Resource Utilisation and Forming Partnerships**

Introduction to Lesson 2

In this lesson we are going to talk about the skills of resource utilisation and forming partnerships for effective self-management. This will include strategies that can help an individual cope with self-management of a chronic condition and with regard to forming partnerships the focus will be on effective communication.

Recap Unit 4 Lesson 1

In Lesson 1 you explored the skills of problem-solving and decision-making. You revised the theory of self-efficacy and you were presented with case studies demonstrating the importance of these skills in the day-to-day self-management of chronic conditions.

Resource Utilisation



Reminder: What is resource utilisation for self-management?

It is about developing ability to seek out and utilise resources which may help in managing health conditions. Self-management support therefore not alone involves educating the individual on how to utilise resources, but on how to seek them out and access them (Lorig and Holman, 2003).

Flinder's University highlight that resource utilisation is about having a;

“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”

(Lawn and Battersby, 2009, p. 16, adapted from Wagner *et al.*, 2001).



Pause for Reflection and Discussion

Have you ever considered what resources are available to individuals with a chronic condition?

Have you ever thought how individuals with a chronic condition receive information about the resources available to them?

What factors do you think influence an individual's ability to utilise resources?

How do you think a healthcare professional could support an individual in utilising resources? How would you identify resources that you would direct individuals to?

Signposting is an important strategy for resource utilisation:

“This acts as a bridge between health care professionals and the social activities available, and can be done by a variety of people including health trainers, wellbeing coaches, navigators, and voluntary community services networks... Much of this support might be provided outside of a traditional consultation between a health care professional and someone with a long-term health condition. However, all of these types of support are strengthened when backed up by professionals using skills such as motivational interviewing, goal setting and problem solving in consultations”
(The Health Foundation (UK), 2015, p. 32).

Some examples of local directories of services that support self-management can be accessed at <https://www.hse.ie/eng/health/hl/selfmanagement/>

Social Prescribing is another way of helping individuals to access resources.

Did You Know?

The national framework document '*Living Well with Chronic Conditions*' highlights that social prescribing;

“... is a mechanism for linking people with non-medical sources of support within the community to improve physical, emotional and mental wellbeing” (Health Service Executive, 2015, p. 2).

“The healthcare professional and person identify together the type of activities that will be of benefit, with the professional writing a ‘prescription’ directly to a service or ‘referring’ the individual to an intermediary, such as a link worker, with whom a package of services can be constructed” (The Health Foundation (UK), 2015, p. 32).

“This approach has recently been tested and evaluated successfully in a social prescribing programme in Donegal where the various options taken up by participants include books for health, exercise initiatives, stress control workshops, creative and green activities, and volunteering” (Health Service Executive, 2017, pp. 26-27).

Social Prescribing



How is social prescribing related to self-management support?

Self-management support provides individuals with knowledge and skills to manage the medical, role and emotional tasks needed for effective self-management. Social prescribing services are therefore a resource that healthcare professionals can avail of to facilitate individuals to improve their health and well-being. It provides a link between health services and the community sector.

What does social prescribing involve?

There are many health related activities available in people's local communities. These activities range from exercise-related activities such as the local gym, walking groups, gardening groups etc. to art-based activities and self-help programmes. Research has shown how participation in activities can improve mental and physical health. However, some individuals with chronic conditions may not be aware of what activities are available in their local community and how to access them. Social prescribing will assist individuals to do this.

How does it work?

Social prescribing can be provided by a community link worker who will meet with an individual to identify activities in which they are interested in participating. Following this initial meeting, the community link worker will locate where in the person's community this activity is provided and get details such as how often it runs etc. They will then either pass on the information to the individual or they will accompany the person the first time they attend the activity or programme.



Watch this video on a social prescribing for people recovering from cancer treatment

<https://vimeo.com/176618952>



Visit the following links to find out about some of the social prescribing services in Ireland:

Sligo: <http://www.alive2thrive.ie/social-prescribing/>

Waterford: <http://www.healthywaterford.ie/projects/social-prescribing/>

Donegal: <https://www.hse.ie/eng/health/hl/selfmanagement/donegal/programmes-services/social-prescribing/social-prescribing-brochure.pdf>

Peer and social support are also very important to individuals with chronic conditions.

As discussed in Lesson 1 of this Unit, learning from peers can assist in the development of self-efficacy. Peer support is defined as:

“support from a person who has experiential knowledge of a specific behaviour, condition or situation” (Health Service Executive, 2017, p. 26, adapted from Dennis, 2003).

Peer support includes the following (Health Service Executive, 2017, p. 26):

- Health professional-led groups which facilitate the exchange of peer-support
- Peer-led face-to-face self-management programmes e.g. Stanford programme
- Peer coaches
- Community health workers e.g. within the traveller community
- Support groups e.g. stroke support groups, COPD Ireland support groups
- Telephone-based peer support
- Internet and email based support
- Joint peer and healthcare professional led programmes

Let's take a closer look at an example of peer support: **The Chronic Disease Self-management Programme (formally known as the Stanford Programme)**

“This is based on the concept of self-efficacy within social learning theory. It was originally developed by Stanford University in the US. It uses peer educators to build self-efficacy in a group setting. The Stanford chronic disease self-management programme is a generic programme, that is, it can be used for patients with a range of chronic diseases. It is based on the fact that people with chronic disease have similar concerns and, with specific skills and training, can effectively manage aspects of their own conditions. The programme consists of two and a half hour workshops once a week for six weeks, and while generally administered in community settings, is also available online.” (Health Service Executive, 2017, p. 26, adapted from Health Information and Quality Authority, 2015).

Now that you have explored the importance of supporting effective resource utilisation, we will look at forming partnerships as another core self-management skill.

Forming Partnerships



Reminder: forming partnerships is an important skill in self-management of chronic conditions. It involves: helping people to form partnerships with their healthcare professionals, including ability to report accurately the trends and tempo of the disease, make informed choices about treatment, and discuss these with the healthcare professional (Lorig and Holman, 2003).



Pause for Reflection and Discussion

Do you think that forming partnerships between individuals and healthcare professionals is important in self-management of chronic conditions?

What do you think are the key elements of a “good” partnership?

How can you as a healthcare professional support the formation of partnerships?

What do you think the individual brings to the partnership?

What do you think the healthcare professional brings to the partnership?

Did You Know?

Traditional models of acute healthcare delivery, resulted in the healthcare professional regarded as the expert and the individual as a passive recipient of diagnoses and treatment. Lorig and Holman (2003) highlighted the reorganisation of healthcare delivery to meet the demands of chronic conditions has resulted in a change in the relationship between the healthcare professional and individual with a chronic condition. Similarly the *Living Well with a Chronic Condition: Framework for Self-management Support* reports “For health professionals it means not only providing clinical care, but helping people to think about their strengths and abilities, identifying their information needs and goals, and the changes they can make in their lives to take control, reach their goals and maintain their physical and mental health and wellbeing” (Health Service Executive, 2017, p. 28).

Bodenheimer *et al.* (2005) stated that “rather than having caregivers, particularly physicians, tell patients what to do to improve their health, the new model is designed to build a partnership between caregiver and patient, with a shared responsibility for making and carrying out health related decisions” (p. 7). They have also indicated that; “Self-management support can be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviours; and a fundamental transformation of the patient-caregiver relationship into a collaborative partnership” (p. 4).

In Unit 1 we looked at the elements both the healthcare professional and the individual bring to the partnership: Here is a recap:

Table 4.3: Qualities for Partnerships

A Person-centred Approach recognises The healthcare professional may be expert in:	A Person-centred Approach recognises an individual with a chronic condition is expert in:
Making diagnoses	Personal experience of the illness
Disease monitoring	Personal social circumstances and network
Disease aetiology	Personal attitudes to risk
Estimating prognosis	Personal values
Therapeutic options	Personal preferences
Personal goals	

Effective communication is a vital component of forming partnerships!

What elements of good communication should be fostered to help develop partnerships?



Effective Communication for Forming Partnerships

Communication is a core component in fostering confidence in individuals who have a chronic condition, and is vital in forming healthcare partnerships. There is a responsibility on the healthcare professional to be empathetic and informative in their communication, whilst the individual who has a chronic condition should give information clearly, seek information and seek clarity when necessary (Global Initiative for Asthma, 2017). It is understood that individuals are partners in their own care and as a result need the skills and know how to communicate effectively with their care providers, this is especially true for the facilitation of self-management (Dures *et al.*, 2016). Indeed, effective communication has many desirable outcomes for self-management such as increased satisfaction, treatment success and improved health outcomes (Schmidt *et al.*, 2017). While Table 4.4 gives an outline for considerations in effective partnerships, communication interactions should be tailored according to individual needs e.g. complex needs, gender, deprivation levels, disability, health literacy levels, access.

Table 4.4: Considerations for Effective Partnerships

Based on guidelines and evidence from individuals and healthcare professionals perspectives.

Individual's Role in Forming Effective Partnership	Action	Resource
Individuals as active, accountable partners in their own care	Dependent upon confidence building and self-efficacy. Have the confidence and skills to report on own care and forward any concerns.	2010 Patient Charter – What you can expect from your health service. Available https://www.hse.ie NICE guidelines
Knowledge of own care needs	Development of a self- management plan in conjunction with their named healthcare professional/s e.g. community dietician. The use of decision aids may be useful at this juncture.	Living Well with a Chronic Condition: Framework for Self-management Support (2017) available from www.lenus.ie Stacey <i>et al</i> (2017) Decision aids for people facing health treatment or screening decisions
Getting ready for an appointment	What questions should I ask? Make a list of questions and concerns (May base questions on activity recommendations, lifestyle changes, medication regime or side effects of treatment). Prepare clear concise list of symptoms, changes and concerns May want to bring somebody to support	My choices: my autonomy available at www.hiqa.ie Ask me Three http://www.ihl.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Healthcare Professional's Role in Forming Effective Partnerships		
Healthcare Professional's Role in Forming Effective Partnerships	Action:	Resource:
Supporting autonomy	Respect the person's right to autonomy Avoid pre-judging Communicate appropriately Balance rights, risks & responsibilities Agree person-centred supports Implement & evaluate supportive actions	My choices: my autonomy available at www.hiqa.ie Larger document also available entitled 'Supporting people's autonomy: a guidance document'.
Support for making appointments	It is imperative that each healthcare professional is familiar with precise access routes, therefore offering the individual information with which to navigate the system. Mechanism to be in place to allow this.	NICE guidelines.
Support for accessing information	Both oral and written information in the form of leaflets are essential, leaflets available in health centres and hospitals, also online information, individuals encouraged to use HSE information sites and/or equivalent.	Individual with diabetes and driving, information available at http://www.rsa.ie
Support person-centred holistic care	The individual's autonomy is supported by the healthcare professional.	Living Well with a Chronic Condition: Framework for Self-management Support (2017) available from www.lenus.ie
Have Knowledge of patient/human rights	Be familiar with patient and human rights.	European patient's charter for Ireland (2005) and the United Nations Universal Declaration of human rights.
Effectively communicates sensitive information to others	Guided by a suitable model. Use a person-centred approach Communicated effectively in challenging situations. E.g workplace disclosure.	e.g. Disclosure processes model (2010) Chaudoir and Fisher Guidance may be sought from Vickers 'Stigma, Work, and "Unseen" Illness: A Case and Notes to Enhance Understanding'



Activity 4.3: Case Study for Communication

Read the case study. Identify the challenges to Joe's communication in this case study.

Joe is 59 years old and has a history of depression and type 1 diabetes. Currently he is experiencing depressive symptoms and his blood glucose levels are quite erratic. He has lost one toe and has a diagnosis of diabetic retinopathy.

Over the last 10 years Joe has lived between group homes and sheltered accommodation, more recently preferring the security of the group homes. Joe frequently misses appointments with his GP and continues to smoke up to 40 cigarettes a day, however he always remembers to take his insulin and keeps a log of his blood glucose levels. He recently received a cigarette burn to his left calf which isn't healing very well.

Imagine you are a pharmacist (or other healthcare professional) and that you meet Joe on a regular basis. You and Joe have formed a partnership.

Based on the information presented in this lesson on partnership formation;

1. What do you as the healthcare professional bring to this partnership?
2. What are the main contributions that Joe brings to the partnership?
3. How might you support Joe in forming future partnerships with other healthcare professionals?

Summary of the lesson

In this lesson you looked at resource utilisation, including, consideration of what resources are available, how to identify what is available and on how to support individuals to access and avail of resources. We also looked at the importance of forming partnerships between healthcare professionals and individuals and at how effective communication is a fundamental element of this. In the next lesson you will be introduced to the skill of action planning.

Lesson 3: Action Planning

Duration: 1 Hour



PPT Title – Unit 4 Lesson 3:
Action Planning

Introduction to Lesson 3

This lesson focuses on actively engaging individuals/families in setting goals, developing action plans, and continuously re-evaluating and revising goals and action plans according to their needs.

Recap Unit 4 Lesson 1 and 2

In Lessons 1 and 2 you explored the skills of problem-solving, decision-making, resource utilisation and forming partnerships as core skills of self-management for individuals with chronic conditions.

Action Planning



Reminder: what is action planning? It is about developing skills to plan action and to implement self-management plans (Lorig and Holman, 2003).

Let's start by looking at action planning:

Begin with identifying a **SMART** goal:

- **Specific:** identify a specific personal goal.
- **Measurable:** How will you measure achievement of your goal?
- **Achievable:** Outline the steps you need to take to achieve your goal.
- **Realistic:** Be realistic about how long it could take to achieve your goal.
- **Timed:** What is the timeframe for goal achievement?



Activity 4.4: SMART goal

Consider your own personal health and identify a SMART goal and complete the Accomplishing Goals Template.

When identifying your personal goal, remember to plan small steps that will assist you in the achievement of your goal.

Accomplishing Self-management Goals Template

- **Identify your goal?**
- **Describe your goal:**

How:

What:

When:

Where:

How often:

- **Identify any potential barriers to achieving your goal:**
- **How will you manage these barriers:**
- **What is your level of commitment/motivation to achieving your goal?
Circle as appropriate: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10**

(1 being not committed/motivated and 10 being very committed/motivated)

- **What is your follow-up plan?**

Group Feedback and Discussion: Provide feedback to your facilitator on your SMART goal and plan for accomplishing your goal and discuss your plan with class colleagues.



Activity 4.5: Addressing barriers and enablers to achieving goals

Consider why you circled a particular number in the commitment/motivation scale on the Accomplishing Goals Template?

Consider the following examples:

- If you circled the number 7; consider what might help you to get to the number 8 or 9.
- If you circled the number 3; consider what might help you to get to the number 4 or 5.

Consider the following questions:

- What could stop you achieving your goal?
- What might help you overcome this barrier?
- What have you tried in the past to overcome this barrier, did it work, if yes (*could you try this again*), if no (*why do you think it did not work*).

Consider suggestions provided during **Activity 4.6** as to what has helped other people achieve their goal.

Think about other options to goal accomplishment.

Consider all the options and devise a plan and remember to follow-up.

Group Feedback and Discussion: Provide feedback to your facilitator on addressing barriers.



Activity 4.6: Clinical Activity

Identify a person with a chronic condition (Diabetes, Asthma, COPD and Cardiovascular Disease) and have a discussion with them about identifying their goals related to self-management, and setting a SMART goal. In a collaborative process with the person complete the Accomplishing Goals Template.

Feedback and Discussion (*potential feedback platform – online discussion board*): Reflect on any barriers/challenges you experienced (if any) and how you managed these. Were you happy with the experience? If you were to complete this activity again, would you do anything differently, if yes, please explain.

Self-management support care planning

Self-management support emphasises the central role of the individual living with a chronic condition in the management of their condition within their daily lives. It involves assessing an individual's personal beliefs, health behaviours and health knowledge, as well as providing advice by giving specific information about the trajectory of living with a chronic condition and the associated health benefits of understanding and managing the condition. For this to happen, it is important to problem solve collaboratively (individual living with a chronic condition and healthcare professional).

This collaborative process is used to:

- Identify and set personal goals related to self-management
- Examine current health behaviours that could potentially change
- Understand barriers to change and how to manage them

It is important to understand that self-management support is not lecturing, saying “you should do this or that”, didactic patient education, shaming a person or waiting for the person living with a chronic condition to ask a question. Remember, that assessing individual’s knowledge is important, but this alone will not change the health outcomes of chronic conditions. To enact health outcome change, one must involve the person with a chronic condition in the decision-making process. This involves assessment of personal health needs and barriers, goal setting, skills development, problem-solving and most importantly a follow-up action plan. Following this, the person with a chronic condition will be more aware and informed about their health, empowered and confident that they can self-manage, and importantly understand that they are decision-making partners with their healthcare professional. This can be facilitated by personalised care planning including self-management planning process. In Unit 3, you had the opportunity to explore an example of planning for deterioration with the individual who has asthma by working through the *Asthma Action Plan*.

Remember, that the person living with a chronic condition is an expert about their own life living with the condition. The healthcare professional is perceived only an expert on the condition. Self-management support is about the relationship/marriage between chronic conditions and living the best possible healthy life.

Figure 4.2: Aims of a Self-management Care Plan





Activity 4.7: Case Study

Read the case study and answer the following questions. This activity encompasses information from Unit 2 – addressing holistic approaches to self-management support and health literacy, and it also incorporates the five skills that we have addressed in Unit 4.

Jack is 68 years old and has chronic obstructive pulmonary disease (COPD). His COPD was diagnosed 15 years ago. Jack is often out of breath and fatigues easily. Jack currently has which is likely to be an exacerbation of his COPD.

Jack lives alone. He is independent with all activities of daily living, for example, shopping, cooking, cleaning, washing, and dressing. However, Jack is finding it increasingly difficult to complete these activities. Jack likes to walk to mass and goes to bingo once per week. Jack has two sons who live nearby, but Jack does not have much contact with either of them. Jack takes a lot of medication to manage his COPD. He finds winter time very difficult as he usually experiences an exacerbation of his COPD.

Jack visits his GP for a repeat prescription. When he attends he is reviewed by his GP and practice nurse and through discussion with Jack his self-management support needs were identified. These included:

- He did not know how to use the inhalers prescribed for him (need = education, information, training)
- He was worried that he might become dependent on his inhalers if he used them regularly (need= education)
- His confidence had suffered since his recent exacerbation, and he was anxious about walking to local shops due to fear of becoming breathless (need= confidence building particularly around exercise)
- He still smoked, and although he recognised it was bad for his health and wanted to quit, he didn't feel he could do this alone (need=advice on smoking cessation)
- He was lonely and becoming more isolated because of his condition, and was at risk of developing depression (need= social and emotional support)

Questions

- What self-management skills would help Jack with these issues?
- How could you as a healthcare professional support Jack in self-managing his chronic condition?

Support from the healthcare professionals might include: regular clinical review will help with developing partnership, joint goal setting and action planning; education and information about his condition, and training in inhaler technique; smoking cessation support; signposting him to COPD support groups locally – or directing him to COPD Support Ireland helpline – this may help provide social interaction and help him to adapt to living with a long term condition through seeing and hearing how others have coped.

Pulmonary rehabilitation is recommended for patients who have experienced an exacerbation of COPD. It includes exercising (building confidence to do more in daily life), education about disease, inhaler technique; self-monitoring, ongoing self-management.

Before moving on to Unit 5 it is important to consider the challenge faced by individuals who have a chronic condition in juggling the management of their condition, when they are engaged in various services. For example a person living with COPD, like Jack as in Lesson 3 may attend the GP for medical management on a regular basis, a respiratory consultant when required, a physiotherapist for respiratory management and general physical conditioning, an occupational therapist for energy conservation and a social worker for support. Each healthcare professional will likely set discipline-specific goals and action plans with the individual. Thus, the individual living with the chronic condition may have numerous goals to meet, which conflict with each other. Healthcare professionals and individuals living with chronic conditions should consider the management of the condition holistically, to ensure that management strategies are feasible for the individual. In some cases it may be appropriate to have a designated key worker, i.e. a healthcare professional who has oversight of all services and supports that the individual living with the chronic condition is engaged with.

However, in most cases the individual living with the chronic condition will have responsibility and oversight of the services they are utilising. Healthcare professionals should support the individual to navigate and manage the requirements from varying services.

Summary of the lesson

In this lesson you focused on the skill of action planning. You had the opportunity to set a goal for yourself and to consider a plan of action to achieve that goal.

You then explored the importance of self-management action planning to individuals with a chronic condition and reflected on your role as a healthcare professional in supporting individuals to develop this skill.

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Unit 5: Service Delivery and Organisation for Self-management Support

Duration: **3 hours**

Recommended Programme Placement: **Year 3, 4 or Final year**

Lesson Plan

Unit 5: Learning Outcomes	<p>Competency: Demonstrate knowledge and understanding of co-ordinating and managing care delivery relevant to day to day practice that supports self-management by healthcare professionals.</p> <p>Learning Outcomes:</p> <ul style="list-style-type: none"> 5.1 Critically evaluate examples of current health service organisation and delivery reforms relevant to self-management support for chronic conditions. 5.2 Appreciate the importance of co-ordinating care across relevant health and social service boundaries and community supports to ensure appropriate pathways of care based on need. 5.3 Recognise and appreciate the role of individual healthcare team members in self-management support. 5.4 Appreciate the ability to work as a member of a multi-disciplinary/inter-professional team for collaborative care planning in self-management support. 5.5 Assist individuals/families to access relevant community resources, education and support groups for self-management of a chronic condition. 	
Lesson 1: Self-management Support within the Context of Healthcare Reforms: Whole System Perspectives 1 Hour	<ul style="list-style-type: none"> • Prior Learning Units 1 to 4 • Introduction to Unit 5 • Introduction to Lesson 1 • Whole Systems Approaches to Healthcare Organization and Delivery • Whole Systems Approach to Healthcare and Self-management Support • Current provision of Self-management Support in the Irish Healthcare System 	<p>ACTIVITY 5.1 Recap on Units 1 to 4</p> <p>ACTIVITY 5.2 In-class Warm-up Brainstorm</p> <p>ACTIVITY 5.3 Preparing a Statement for Submission to the Minister for Health</p>
Lesson 2: Co-ordinating Care and Health Services for Self-management 1 Hour	<ul style="list-style-type: none"> • Introduction to Lesson 2 • Keeping the Focus on Person/people-centred Care • Integrated Care for self-management support • Mobilising Resources for self-management support 	<p>ACTIVITY 5.4 People-centred Care</p> <p>ACTIVITY 5.5 Pause and Think</p> <p>ACTIVITY 5.6 Integrated Care</p> <p>ACTIVITY 5.7 e-Health</p>
Core Reading	Health Service Executive. (2017). <i>Living well with a chronic condition: Framework for Self-management support</i> , Dublin: Health Service Executive	
Accompanying Slide Pack for Unit 5	https://www.hse.ie/sms-undergradcurriculum/	

Unit 5: Service Delivery and Organisation for Self-management Support

Prior Learning on Self-management Support – Flipped Classroom Approach⁵

For Unit 5, students are required to recap on learning to date from Unit 1 through to Unit 4 of self-management support curriculum. This learning recap must be completed in advance of Lesson 1 for Unit 5, and so students need to be instructed through virtual learning platform approximately one week in advance of scheduled time for Lesson 1.



Activity 5.1: Recap on Units 1-4 of Self-management Support for Chronic Conditions Curriculum

Note to Instructors: Students are asked to take responsibility for completing this activity. There is no requirement to hand it up to lecturers in advance of commencing Unit 5. However, some recall discussion will take place in Lesson 1.

Recall and revise key learning points from Units 1 to 4 on the self-management support curriculum prior to the first lesson for Unit 5. This activity requires you to revisit your notes. Before looking at your notes however, try to recall as much as you can. Use the prompts below on the worksheet.

As a prerequisite to Unit 5, you are also required to read:

“Living Well with a Chronic Condition” (Health Service Executive, 2017), the national framework for self-management support for chronic conditions, which arose from the Healthy Ireland Implementation plan, was launched in 2017 and focuses on COPD, asthma, diabetes and cardiovascular disease.

⁵ Flipped classroom is an instructional approach to blended learning which can involve students being set learning activities outside the classroom and which then become the focus of discussion during class time. For Activity 5.1, students are set a recap exercise in advance of commencing Unit 5. For further reading on Flipped Classrooms, consider these articles:

- Sharma N., Lau C. S., Doherty I. and Harbutt D. (2015) How we flipped the medical classroom, *Medical Teacher*, 37(4): 327-330, available at: <https://www.tandfonline.com/doi/pdf/10.3109/0142159X.2014.923821?needAccess=true>
- Gilboy M. B., Heinerichs S. and Pazzaglia G. (2015) Enhancing student engagement using the flipped classroom, *Journal of Nutrition Education and Behaviour*, 47(1): 109-114, available at: <https://reader.elsevier.com/reader/sd/pii/S1499404614006381?token=056D6C42B77E5667497A926992FADAE42D7FF43335D9FF-DA29EB25F2F8E89CACF41C27FF5D2C3AD8EA16F05855EC0355>
- Abeysekera L. and Dawson P. (2015) Motivation and cognitive load in the flipped classroom: definition, rationale and a call for research, *Higher Education Research & Development*, 34(1): 1-14, available at: <https://www.tandfonline.com/doi/pdf/10.1080/07294360.2014.934336?needAccess=true>

Table 5.1: Revision Worksheet on Prior Learning for Units 1 to 4 of Self-management Support Curriculum (using flipped classroom approach)

Prompt Questions	Your recall and revision notes
UNIT 1 Foundations for Self-management Support for Chronic Conditions	
What is self-management?	
What is self-management support?	
What skills does a healthcare professional require to support self-management?	
UNIT 2 Holistic Approach to Self-management Support	
"Adopting a person-centred holistic approach is key to effective self-management support". What do you think this approach involves?	
What factors might make it more difficult for an individual to self-manage the medical, role and emotional elements of their chronic condition?	
UNIT 3 Communication for Self-management Support	
What core communication skills are needed to support self-management?	
How can healthcare professionals facilitate shared decision-making?	
UNIT 4 Skills Building for Self-management	
Can you identify the five core skills that an individual needs to effectively self-manage their chronic condition?	
Choose one of the core skills and describe how a healthcare professional can support an individual in developing that skill.	

Introduction to Unit 5

In Unit 5 you will develop a knowledge and understanding of co-ordinating and managing care delivery relevant to day to day professional practice that supports self-management by healthcare professionals. A critical perspective on current health service organisation and delivery for self-management support will be considered. The relevance of broadening perspectives on self-management support beyond health services to include social services and community support groups will be examined. The role of inter-professional team approaches to self-management support will be explored including critical examination of current practices. The impact of self-management support on service provision and delivery, and on patient outcomes will be reviewed. There are two lessons in total in this unit each one builds on the previous lesson.

Lesson 1: Self-management Support within the Context of Healthcare Reforms: Whole Systems Perspectives

Duration: 1 Hour



**PPT Title – Unit 5 Lesson 1:
Self-management Support within the Context
of Healthcare Reforms: Whole Systems Perspectives**

Introduction to Lesson 1

In this lesson we will do an initial recall of your learning from Units 1 to 4 and consider the relevance of the knowledge gleaned from these prior units to exploring self-management support within the context of healthcare reforms in Ireland. We will then take a critical review of how current national reforms in healthcare are relevant to promoting self-management support for chronic conditions drawing on your experiences of learning in practice/health services in your programme to date. We will examine the strengths and weaknesses of current healthcare organisation and delivery specific to its implications for self-management support for individuals with chronic conditions. In this lesson we consider why supporting self-management through service delivery and organisation is important to managing the burden of chronic conditions on our health system.

Let's begin this lesson with an activity, drawing on the recall activity requested of you as a prerequisite for this Unit.



Activity 5.2: In-class Warm-up Brainstorm

In dyad/triad groups, ask students to jot down their thoughts on the following questions:

1. What is the relevance of self-management support to managing the burden of conditions?
2. What is your responsibility as a healthcare professional in providing self-management support within the context of healthcare delivery and day to day practice?

Take feedback

Note to Instructors: During feedback, take note of students' responses and whether some key points are raised:

Q1: e.g. prevalence of chronic conditions including multimorbidity; burden on the health services such as accessibility, utilisation, costs, etc.

Q2: e.g. skilled and competent for self-management support delivery, working in partnership with individuals, coordinating care across service boundaries, advocating for service improvements, other etc.

This is intended to be a quick feedback rather than detailed discussion.

Whole Systems Approaches to Healthcare Organization and Delivery

In everyday practice, it is common for many frontline healthcare practitioners to get caught up in very busy workloads focusing mostly on their immediate practice rather than seeing the bigger picture at a health system level. This raises a question of whether a 'big picture' in terms of having a 'whole system' perspective on healthcare is relevant to frontline staff.



Pause for Reflection and Discussion

What is your understanding of a 'whole system' approach to healthcare organization and delivery?

What are the benefits of taking a 'whole system' perspective on healthcare organization and delivery in supporting individuals with chronic conditions?

Note to Instructors: To facilitate discussion on the above questions, papers that may be helpful to as a resource on systems thinking specific to health are:

The application of systems thinking in health: why use systems thinking? (Peters, 2014) and, *embracing uncertainty, managing complexity: applying complexity thinking principles to transformation efforts in healthcare systems* (Khan *et al.*, 2018).

These papers are to serve as background reading for instructors to raise awareness about whole systems thinking for self-management support in healthcare among students, rather than any in-depth theoretic/conceptual/empirical discussion around health system transformation in general. That said, these papers could be included in student reading list as resourceful reading.

Following on from this discussion around 'whole systems' perspectives on healthcare organization and delivery, let's briefly capture what this means. Peters (2014) refers to the origin of the word system:

"The word system is derived from the Greek *sunístánai* meaning 'to cause to stand together' (Peters, 2014, p. 1).

Peters goes on to explain that:

"A system is a perceived whole, made up of parts that interact toward a common purpose... Systems thinking [takes account]...of the whole, its parts, and the interactions within and between levels" (Peters, 2014, p. 1).

Over time there has been increasing efforts to rank the performance of health systems around the world, and while there is no gold standard for this ranking (Schütte *et al.*, 2018), a whole systems approach is considered critical to tackling complex public health problems including chronic conditions (Greenhalgh, 2009; Pinnock *et al.*, 2016; Bagnall *et al.*, 2019). Greenhalgh (2009) offers a useful differentiation between the micro level of managing chronic conditions in healthcare with a focus on patient self-management and the macro level of healthcare with a focus on whole systems approaches. Take a look at this difference in the following table.

Table 5.2: Micro-and Macro Level Healthcare in Managing Chronic Conditions

Approach	Patient Role	HCP Role	Definition of Success
At micro-level: SM with gains in knowledge, skills, motivations, attitudes	e.g. working with SM plan requiring psychological resources (e.g. self-efficacy) and skills (e.g. setting goals & action planning,* taking inhaler*)	e.g. educator,* trainer, advisor, establishing partnership/collaborative relationships with patients	Implementation a SM plan with positive outcomes* e.g. increased self-efficacy, improved health status
At macro-level: Whole Systems approaches involving multiple sectors* e.g. primary, community, acute care, voluntary, social care and service user sectors	"Developing and achieving a holistic, personalised care plan, drawing on available resources in the community" (p. 629) and other resources such as support from HCPs	e.g. educator,* advocate,* partnering with patients to support social learning and participatory change	"Emergence of new structures and opportunities for supporting healthy living and managing illness" (p. 629) Others* e.g. improved accessibility to healthcare, improved quality of healthcare delivery, & reduced health costs

HCP = healthcare professional; SM=self-management

Source: abbreviated and adapted from Greenhalgh (2009, p. 629) to include points addressed in previous units of this curriculum.

Note to Instructors: Consider drawing on points raised by students in the 'Pause for Reflection and Discussion' exercise above as a way of linking their understandings of whole systems approaches to that offered in the above table.

Whole Systems Approach to Healthcare and Self-management Support

In Ireland's national framework for self-management support – "*Living Well with a Chronic Condition*" (Health Service Executive, 2017), there is a commitment to a whole system approach to supporting patient self-management for better healthcare in managing chronic conditions taking account of different levels of the system. The following diagram extracted from the framework captures a whole systems approach for self-management support:

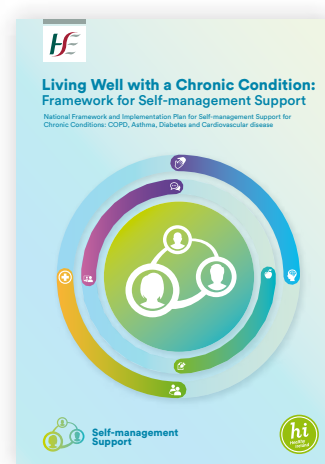
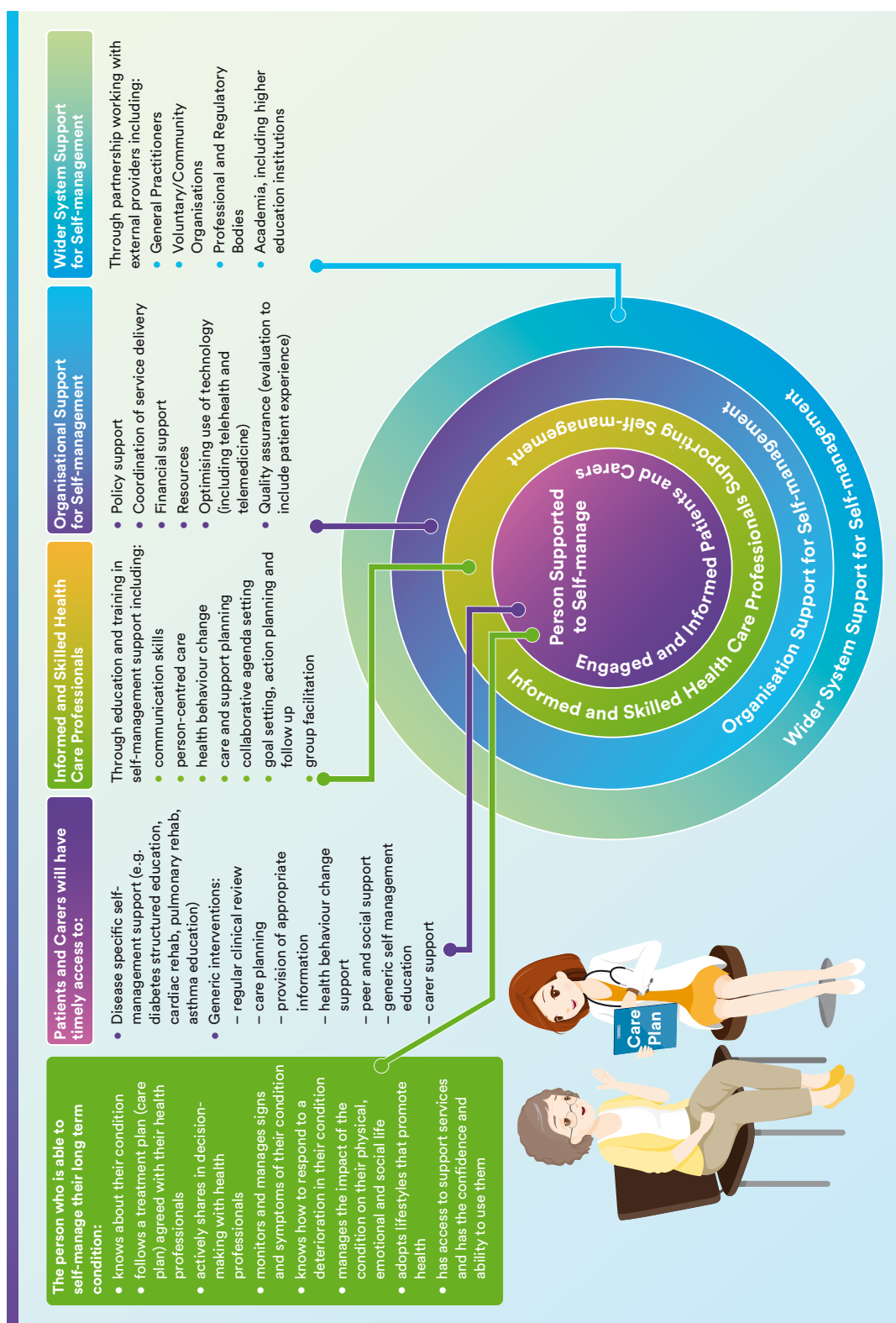


Figure 5.1: Whole System Model for Self-management Support for Chronic Conditions (reproduced with permission from Health Service Executive, 2017, p. 18)



Note to Instructors It is worth taking students through this diagram to illustrate the complexity of whole systems approach and the need to link each component i.e. individual and healthcare professionals (micro-level), organisation of services e.g. interventions, technology support (meso-level) and then wider system support (working with voluntary sector, developing the role of HCPs).

This overview will inform students' knowledge and understanding of how self-management support sits within the wider organization and delivery of healthcare (see below the Chronic Care Model).

Although self-management support requires a whole systems approach for successful management of chronic conditions, self-management support is a component within a broader model of healthcare for chronic conditions. The *Chronic Care Model* illustrates this very well.



Pause to examine and discuss self-management support within the *Chronic Care Model*

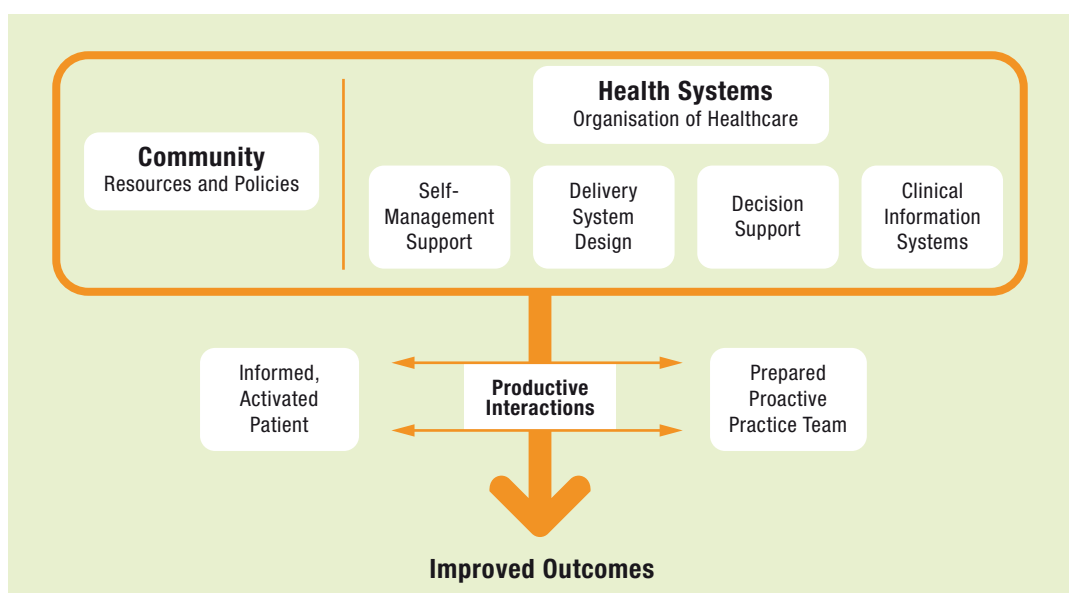
Take a look at the *Chronic Care Model* (presented on slide).

When you look at this diagram, what comes to mind about the 'bigger picture' of chronic care?

How would you describe what this model means in terms of managing chronic conditions in your own words?

Note: this is intended to be a 'warm-up' exercise for students. More detailed prompt and probe questions are detailed below in notes to instructors.

Figure 5.2: The Chronic Care Model (Wagner *et al.*, 1996)



Note to Instructors: Use prompt and probe questions to facilitate students share their observations and thoughts e.g. What sector of the healthcare system is given prominence and why (Explore community & relevance to self-management support)? What resources need to be mobilised to support individuals' needs for self-management? What is needed in a health system to promote safe, high quality care in providing self-management support? What is required of a delivery design system to assure effective, efficient self-management support? What is needed to support healthcare professionals' clinical decision-making for self-management support? What is the relevance of clinical information systems to organising individuals and population data for efficient and effective care? What does the Chronic Care model depict in terms of an individual and a healthcare professional working relationships?

The approach to this exercise may vary depending of student group learning styles and also factors such as class sizes, time etc. a lean way to capture breadth and depth of information from students is to divide them into groups and allocate questions accordingly.

As a resource for this discussion, it is recommended that instructors orientate themselves to the *Chronic Care Model* website http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2. From here links to each of the model's components can be accessed. This link can also be provided to students who wish to explore the model further.

Although the *Chronic Care Model* is not formally used in Ireland, all of its components are relevant as various aspects of healthcare reform including the implementation of self-management support. The *Chronic Care Model* originally developed and implemented by (Wagner *et al.*, 1996) in the USA, to tackle the rising burden of chronic conditions and the need for effective healthcare organization and delivery, is the most prominent and widely used chronic condition management approach worldwide. Support for the *Chronic Care Model* is evident in Ireland's national framework for self-management support – "*Living Well with a Chronic Condition*".

“This model has broad international acceptance as a framework to provide guidance on shifting from our current model of care which is predominantly acute and episodic care, to a lifelong model of health promotion, prevention, early intervention and chronic care” (Health Service Executive, 2017, p. 13).

Current provision of Self-management Support in the Irish Healthcare System – Your Perspectives and Experiences

The perspectives and experiences of frontline healthcare professionals and individuals are important to shaping healthcare system reforms and also to evaluating current provision of services arising out of national health policy. Take for example, the national framework for self-management support – “*Living Well with a Chronic Condition*”, healthcare professionals were consulted through focus groups, and their views along with the views of other groups including individuals helped develop the framework. The framework states the following:

“An initial draft of the framework was further refined through a national consultation in 2016. This consultation included focus groups with healthcare professionals both within and outside the HSE, patients and representatives of patient organisations; and interviews with HSE senior management, and ICGP and Department of Health representatives” (Health Service Executive, 2017, p. 12).

Although current students as future healthcare professionals were not involved in the consultation process around developing the framework for self-management support, that does not preclude students from having a view on the framework, specifically on its implementation and future direction. As future healthcare professionals, you already have experienced clinical practice/health service delivery as students during scheduled clinical placements. Therefore, you are in a position to comment on how self-management support is working in practice. Your view matters, because as future frontline healthcare professionals your critical reflections on current practices can be an important springboard for continuing improvement of the healthcare of individuals with chronic conditions through self-management support (i.e. micro-system level). Your view also matters at a policy and system level (i.e. macro-system level) such that any reforms at national level needs to be informed by frontline staff.

The Chronic Care Model represents a comprehensive approach to addressing the challenges of chronic conditions. In the Chronic Care Model, Wagner *et al.* (1996) emphasises the importance of self-management support linked with adequate record systems, readily available evidence and well-designed care delivery systems in leading to improved outcomes.

The model also highlights how essential it is that individuals play an active and informed part in the continuing care of their own diseases in a partnership with their healthcare professionals.

Let's return for a moment to the earlier point about the daily 'busy' lives of frontline healthcare, and not seeing the bigger picture at a health system level. This raises a question of whether a 'big picture' in terms of having a 'whole system perspective' on healthcare is relevant to frontline staff. Just imagine as frontline healthcare professionals, an opportunity arises to step back from the business of everyday practice to critically reflect on how the organisation and delivery of healthcare through the current healthcare system in Ireland impacts on your work and efforts to support individuals in the self-management of their chronic conditions.

Let us now explore your experiences and hear your views through the following activity.



Activity 5.3:

Preparing a Statement about Self-management Support for Chronic Conditions for submission to the Minister for Health (Worksheet 1)

As frontline healthcare professionals, you are invited to make a submission to the Minister for Health on the current health services towards self-management support for individuals with chronic conditions. For this submission, draw on your experiences in practice to date to inform your views.

In your submission, address the following:

- Current strengths of the health services towards self-management support implementation
- Current weaknesses/limitations of the health services towards self-management support implementation
- Recommendations for future direction towards enhancing self-management support implementation in healthcare organization and delivery

A template is provided for this exercise including various areas of services based on Chronic Care Model that students can comment on. The total number of students in the class can be divided into small groups (and may need to comprise clusters of triads if groups are large) and allocated a subset of topics from those listed below. This is to ensure that all topics are addressed within a limited time frame. Prompt students to reflect on earlier discussion on Chronic Care Model.

Allow Students approximately 15-20 minutes for this Activity following which open class discussion takes place.

Note to Instructors: Student are not expected to write a full submission but rather to jot down their thoughts.

At the end of this exercise, explore some key points from students to generate discussion. The following resources can serve as information for integration into the discussion and for raising awareness to the students that these are available, although not necessarily directly relating to self-management support.

Slainte Care Implementation Strategy at <https://health.gov.ie/wp-content/uploads/2018/08/Sl%C3%A1intecare-Implementation-Strategy-FINAL.pdf>

eHealth strategy Ireland at <https://www.ehealthireland.ie/Knowledge-Information-Plan/eHealth-Strategy-for-Ireland.pdf>

Specifics in relation to chronic condition management such as clinical care programmes, directories of community resources will be addressed in Lesson 2.

Summary of the lesson

As a way of summarising and concluding Lesson 1, using a 'speeding' exercise, ask each student to highlight one piece of new learning from the Lesson, noting that a student cannot repeat what was already said. If the class is very large, a sample of the class only can be asked to respond.

Worksheet 1: Views and Experiences Worksheet for Submission to Minister Exercise

Health System Area	Strengths of System Area & impact on my practice for self- management support	Weakness of System Area & impact on my practice for self- management support	Key recommendations (at least 2) to the Minister to improve this area of healthcare system for self- management support of chronic conditions in practice
Community Resources			
Delivery Design System i.e. provision of effective and efficient safe quality healthcare			
Decision support e.g. clinical guidelines/ Standards for clinical decision-making			
Clinical Information systems e.g. electronic records telehealth/ medicine, shared IT systems across healthcare sectors			

Lesson 2: Co-ordinating Care and Health Services for Self-management

Duration: 1 Hour



**PPT Title – Unit 5 Lesson 2:
Co-ordinating Care and Health Services for Self-management**

Introduction to Lesson 2

To date, much of the learning in previous units of this national curriculum on self-management support has been on the knowledge and skills required of healthcare professionals in their daily practice of working with individuals with chronic conditions. While this is important, educating healthcare professionals alone is not sufficient to make significant gains in realising a culture of self-management support in the health system. A health system committed to self-management support requires a coordinated approach such that services are integrated between acute, primary care and community services and resources. In this lesson, we examine what is meant by co-ordinating person-centred care and health services within an integrated health system, and how resources can be mobilised to support this.

Keeping the Focus on Person/People-centred Care

From the very first unit of this curriculum (Unit 1: Foundation of Self-management Support for Chronic Conditions) and throughout the curriculum on self-management support as a whole, person-centred care has been presented as a core concept. Often times, healthcare professionals may focus on person-centred care only within the context of their day to day encounters with individuals. However, person-centred care also needs to be a core focus at the level of organising service delivery.

The intention here is not to consider person-centred care in depth since by now in the curriculum, as future healthcare professionals, you will be familiar with this concept. However, it is useful to remind ourselves of this concept within the specific context of organisation and delivery of healthcare for people with chronic conditions. Let's now watch a brief video as a reminder, which refers to people-centred care.



Activity 5.4: People-centred Care

People-centered care is concerned with moving a healthcare service from what is the matter with you to what matters to you. Watch the video on the link provided which summarises what person-centered care is.



Watch this video on people-centered care (2m 35s): www.youtube.com/watch?v=pj-AvTOdk2Q (Permission to use for educational purposes received from WHO (permissions@who.int))



Pause for Reflection and Discussion

Prompt Question: How people-centredness is our current healthcare system in Ireland in terms of service organisation and delivery?

Integrated Care for self-management support: What Does This Mean?

The organisation and delivery of healthcare services is complex and multifaceted involving multiple service areas. The need for these services to be integrated towards a seamless continuum of care is paramount if individuals are to be supported to manage their chronic conditions in their homes.



Activity 5.5: Pause and Think

Discuss these questions in groups.

- What does integrated care and health services mean within the context of self-management support?
- How do you think integrated care can support self-management support service delivery and organisation?



Activity 5.6: Integrated Care

Watch this video on Sam's story regarding integrated care. As you watch this, reflect on your experiences of working in the Irish healthcare system taking note of the strengths and weaknesses of the organization and delivery of health services specific to the context of self-management support for people with chronic conditions.

Link: <https://www.kingsfund.org.uk/audio-video/joined-care-sams-story>
(permission to use under Creative Commons)

Note to Instructors: The following short animation is designed to bring integrated care to life with a focus on improving patient care in managing a chronic condition. The video focuses on the NHS in the UK. However, with consideration to the Irish healthcare services while watching this video, consider the following activity.

Mobilising Resources for Self-management Support

Based on the video on Sam, it was apparent that a number of resources were available to him.



Pause for Reflection and Discussion

Recall what the resources were in Sam's story

Apart from the resources identified in the video on Sam, other community resources are available. Consider the directory of services available to facilitate discussion, accessible at www.hse.ie/selfmanagementsupport.

Mobilising resources requires a critical review of how these can be accessed and optimised for self-management support when working with individuals with chronic conditions. Consideration needs to be given to current developments in healthcare services and reforms that are taking place. At the time of writing this curriculum, the following are some of the changes or ongoing developments taking place that potentially could impact on the organisation and delivery of services in terms of resources available for self-management support. These include but are not limited to:

- GP contracts
- Clinical Care Programmes
- Demonstrator Projects for chronic condition management
- Growth in Advanced Nurse Practitioners
- Recognition of role of voluntary sector
- Service user involvement

Drawing on the above examples, facilitate discussion with students on how resources can be mobilised to facilitate self-management support for individuals with chronic conditions.

Following on from the above discussion, move towards consolidating learning at the macro and meso level of providing self-management support focusing on the following activity.



Activity 5.7: e-Health

Read the following case study in the link and consider giving this as a handout or posting on VLE for students to print out prior to this Lesson. Take note that at the core of this case study is the potential of e-Health in the organisation and delivery of health services.

<https://www.ehealthireland.ie/Strategic-Programmes/Electronic-Health-Record-EHR-/Final-Persona-Scenario-files/Community-Care-Persona-John-Malone-Scenario-1-v1-0.pdf>

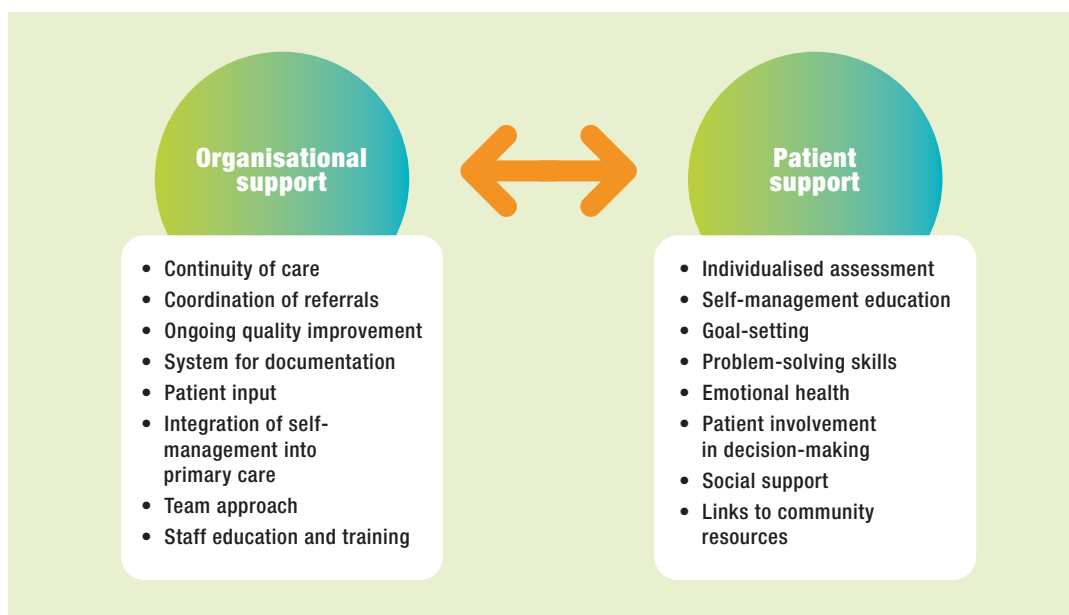
Follow on from this case study, explore other resources that may be relevant to optimising self-management support.

Note to Instructors: Lecturers/Instructors to probe and prompt based on current knowledge of resources available to people with chronic conditions.

Summary of the lesson

In drawing a conclusion to this final unit of the Self-management Support for Chronic Conditions curriculum, let's recap on the curriculum as a whole. For this, consider how the health service organisation and delivery connects with the micro-level involving direct patient. Take a look at the following diagram and explore how it brings together all of your learning on self-management support for chronic conditions.

Figure 5.3: Resources and supports for self-management support in primary care (adapted from McGowan, 2013)



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Appendix 1: Self-management support for chronic conditions in regulatory body guideline documents

Policy	Organisation	References to Self-management Support	Comments
Nurse Registration Programmes Standards and Requirements	Nursing and Midwifery Board of Ireland (2016)	<p>Competence to assist individuals, families and groups towards healthy lifestyles and self-care on the basis of the knowledge and skills acquired (p. 15); EU Directive 2013/55/EC amending Directive 2005/36/EC</p> <p>Support and facilitate the person to promote his/her physical and emotional well-being (p. 31); year 2 competency (all divisions)</p> <p>Use appropriate skills and knowledge to teach/facilitate a person or family member in an aspect of self-management (p. 33); year 2 competency (all divisions)</p> <p>Empower a person to make a plan to change an aspect of their lifestyle to promote health, recovery, resilience or self-management of a condition, or to improve his/her wellbeing or social inclusion (p. 37); year 3 competency (all divisions)</p> <p>Ensure that a person receives all necessary information to make an informed choice regarding their healthcare (p. 40); year 3 competency (all divisions)</p> <p>Support and empower the person, through the provision of accurate and relevant information, to make health and life choices for health promotion and screening, recovery, resilience, self-management, wellbeing and social inclusion (p. 45); year 4 competency (all divisions)</p> <p>Support a safe and comfortable environment to facilitate the person to promote health, self-management and physical and emotional well-being (p. 45); year 4 competency (all divisions)</p> <p>Empower the person and primary carer to follow appropriate policies to express concerns about their experience of nursing and health procedures/interventions (p. 47); year 4 competency (all divisions)</p> <p>General Nurses promote wellness, health education and self-management to empower people to achieve their maximum health potential across the health continuum and lifespan (p. 64)</p> <p>Principles of shared decision-making, facilitation and promotion of recovery and empowering people and their primary carer(s) on health lifestyles as they pertain to general nursing (p. 68); Domain 4 (Gen)</p> <p>Children's nurses work in partnership with children and young people and their families to facilitate child and family empowerment (p. 73); (Children's)</p>	

Policy	Organisation	References to Self-management Support	Comments
		<p>Support of the child, young person and family for autonomy and self-management of health for recovery, health maintenance and promotion of optimal health and functioning (p. 74); Domain 2 (Children's)</p> <p>Empowering and helping children and young people to achieve, maintain or recover optimal health, self-management of long-term health issues and living as part of a positive network of family and local support (p. 75); Domain 2 (Children's)</p> <p>Empowering the person to access primary, secondary and tertiary health services (p. 85); Domain 2 (ID)</p> <p>Activities of living support; enhancing personal safety; promoting self-care; addressing oral and dental health; promoting personal health and healthy lifestyles (p. 87); Domain 3 (ID)</p> <p>Empowering the person to reside within the community, to receive services necessary to meet his/her specialised and changing needs and to live as independently as possible (p. 87); Domain 3 (ID)</p> <p>Understanding the empowerment of people with mental health difficulties who use mental health services (p. 96); Domain 1 (Psych)</p> <p>Empowering through partnership in 'own' care (p. 98); Domain 2 (Psych)</p>	
Social Work in Medical School: Competencies Framework	National Head Medical Social Worker's Forum (2014)	<p>Can also work with clients to encourage them to advocate for themselves as appropriate (p. 11); indicator for effective performance (IEP) 5 (Main Grade Social Worker)</p> <p>Makes decisions in a transparent manner by involving and empowering others where appropriate (p. 50); IEP 3 (Head Medical Social Worker)</p>	Not relevant
Core Competency Framework for Pharmacists	The Pharmaceutical Society of Ireland (2013)	<p>Self-management skills (p. 10); Domain 6 aspect</p> <p>Educates and empowers the patient to manage their own health and medicines (p. 11); Domain 1</p> <p>Uses patient counselling skills to educate the patient and provide all the required information to ensure safe and rational use of the medicines (p. 17); Domain 3</p> <p>Assesses patients' understanding and knowledge of the medicines and provides appropriate information and education (p. 19); Domain 4</p> <p>Encourages patients to be knowledgeable about their medication (p. 20); Domain 4</p>	With reference to HCP

Policy	Organisation	References to Self-management Support	Comments
		Provides information, advice and education for patients and the public on health awareness, disease prevention and control, and healthy lifestyle and wellness (p. 20); Domain 5	
Medical Education, Training, and Practice in Ireland 2008-2013: A Progress Report	The Medical Council (2013)	Management (including self-management) (p. 11); 8 Domains of good professional practice	Focused on HCP
		Management (including self-management): A medical practitioner must understand how working in the healthcare system, delivering patient care and other professional and personal activities affect other healthcare professionals, the healthcare system and wider society as a whole (p. 12)	Focused on HCP
Tomorrow's Doctors: Outcomes and standards for undergraduate medical education	General Medical Council (UK) (2009)	Support patients in caring for themselves to improve and maintain their health (p. 0)	
		Determine the extent to which patients want to be involved in decision-making about their care and treatment (p. 19); graduate outcome 2	
		Support patients in caring for themselves (p. 20); graduate outcome 2	
		Recognise the principles of patient centred care, including self-care , and deal with patients' healthcare needs in consultation with them and, where appropriate, their relatives or carers (p. 25); graduate outcome 3	
CanMEDS 2015 Physician Competency Framework	Royal College of Physicians and Surgeons of Canada (2015)	Assist patients and their families to identify, access, and make use of information and communication technologies to support their care and manage their health (p. 18); Communicator Competency 4 (Physician)	
Basic Medical Education: WFME Global Standards for Quality Improvement: The 2015 Revision	World Federation for Medical Education (2015)	N/A	

Policy	Organisation	References to Self-management Support	Comments
Australian Minimum Competency Standards for New Graduate Occupational Therapists 2010	Occupational Therapy Australia (2010)	<p>Occupational therapy intervention enables and empowers clients through enhancing their participation in meaningful occupation(s) and life-roles (p. 19); Unit 1</p> <p>Work with individuals, organisations and communities by the occupational therapist utilises skills that promote culturally safe services that empower clients cultural identity and well-being (p. 21); Unit 1</p> <p>Education of clients is a major area of practice and should be informed by educational/adult learning theories and appropriate educational content and delivery format in all areas of practice (p. 29); Unit 3</p> <p>Community-based resources, facilities and services that can enable occupational performance and engagement and are accessible to the client, are identified (p. 34); Unit 3</p> <p>Client access and connection with appropriate community-based resources, facilities and services that can enable occupational performance and occupational participation, is advocated and supported (p. 34); Unit 3</p>	No specific mention of self-management but implied throughout Unit 3
Therapy Project Office 2008 Occupational Therapy Competencies	HSE (2008)	<p>Analyse the use and adaptation of occupations related to self care, productivity and leisure (p. 8); A] Entry Level</p> <p>Select appropriate standardised and non-standardised assessment tools to identify occupational and functional needs in the areas of self care, productivity and leisure (p. 9); A] Entry Level</p> <p>Skilfully analyse the use and adaptation of occupations related to self care, productivity and leisure (p. 11); A] Senior Therapist</p> <p>Select, implement and analyse the outcomes of standardised and non-standardised assessments that identify occupational and functional needs in the areas of self care, productivity and leisure, including in complex situations (p. 12); A] Senior Therapist</p> <p>Skilfully analyse the use and adaptation of occupations related to self care, productivity and leisure (p. 16); A] Clinical Specialist</p> <p>Select, implement and synthesise the outcomes of standardised and non-standardised assessments that identify occupational and functional needs in the areas of self care, productivity and leisure, in complex situations (p. 17); A] Clinical Specialist</p>	

Policy	Organisation	References to Self-management Support	Comments
Occupational Therapists Registration Board Code of Professional Conduct and Ethics	The Occupational Therapists Registration Board (2014)	N/A	
Standards of Proficiency for Social Care Workers	CORU: Health and Social Care Professionals Council (2016)	Recognise service users as active participants in their health and social care and be able to support service users in communicating their health and/or social care needs, choices and concerns (p. 7); domain 2	
		Understand the need to empower service users to manage their well-being where possible and recognise the need to provide advice to the service user on self-treatment, where appropriate (p. 7); domain 2	
		Understand the need to work in partnership with service users, their relatives/carers and other professionals in planning and evaluating goals and interventions, as part of care planning and be aware of the concepts of power and authority in relationships with service users (p. 7); domain 2	
Occupational Therapists Registration Board: Criteria and Standards of Proficiency for Education and Training Programmes	CORU: Occupational Therapists Registration Board (2014)	Recognise the shared expertise that exists between the professional and the service user (p. 21); domain 1	
		Empower service users to manage their well-being and recognise the need to provide information and advice to the service user on self-management, where appropriate (p. 28); domain 5	
		Be able to establish a client centered therapeutic relationship as the basis for change and enabling participation and engagement in occupation (p. 32); domain 6	
		Recognise the need for effective self-management of workload and resources and be able to practise accordingly (p. 21); domain 1	Focused on HCP

Policy	Organisation	References to Self-management Support	Comments
Health Service Executive (HSE) Irish Society of Chartered Physiotherapists (ISCP)	Therapy Project Office: Physiotherapy Competencies (2008)	Educating patient appropriately (p. 11); Graduate/Entry Competency B	Working in collaboration with clients and colleagues to manage complex patients (p. 13); Senior competencies A
eHealth Competencies for Undergraduate Medical Education	The Association of Faculties of Medicine of Canada in Partnership with Canada Health Infoway (2014)	Examine the components of eHealth literacy and appreciate how these components impact patients: Use context- and content-appropriate language and media resources to communicate health information to patients, their families and caregivers and to help patients support their care and manage their health where appropriate (p. 5); competency 1 Use technology appropriately to help patients understand and manage (to the degree possible) their health (p. 9); competency 4	
Core competencies for undergraduate students in clinical associate, dentistry and medical teaching and learning programmes in South Africa	Health Professions Council of South Africa (2014)	Develop a common understanding of issues, problems and plans with patients/clients, families, communities, colleagues and other professionals, to develop a shared plan of care/action (p. 6); role 2 Facilitate the learning of patients/clients, families (p. 12); role 6	
Global standards for the initial education of professional nurses and midwives	World Health Organisation (2009)		

Appendix 2: National Survey Findings

Findings from National Survey on the Teaching of Self-management Support For Chronic Disease (CD) to Undergraduate/Graduate Entry Healthcare Students in Ireland

Prepared by Dawn Sinclair (UCC) on behalf of a research team representing the National Working Group for Self-management Support for Chronic Conditions. Professor Eileen Savage (UCC), Dr Carmel Mullaney (HSE), Ms. Dawn Sinclair (UCC), and Mr Anthony O'Reilly (May 2018)

Aim of the Survey

What is the current practice and provision of Self-management Support for CD in curricula of undergraduate/graduate entry healthcare students attending HEIs in Ireland?

Methods

Questionnaire: The survey consisted of two sections: Section 1) demographic/background section and Section 2) Self-management Support for CD curriculum content (Appendix 1).

The survey takes approximately fifteen minutes to complete.

Survey Participants: The sampling strategy was to target all Higher Education Institutes (Universities (n=6 UCC, UCD, DCU, Trinity, NUI, UL), National University of Ireland, recognised Colleges (n=1 RCSI), and Institutes of Technology (n=6 AIT, WIT, Dundalk IT, GMIT, Letterkenny IT, ITT) that offer undergraduate/graduate entry level degrees for future healthcare professions (Medicine, Nursing, Midwifery, Dentistry, Dietetics, Pharmacy, Physiotherapy, Podiatry, Public Health, Psychology, Speech and Language Sciences, Occupational Health Sciences and Social Care).

The relevant HEIs were contacted through the heads of school, and programme co-ordinators/leads of the relevant healthcare departments/schools. Each were e-mailed and provided with a cover letter detailing the study. The relevant programme co-ordinators/leaders were requested to distribute the survey to the appropriate members of staff such as module leaders and lecturers directly involved in teaching students on chronic disease related content and skills.

This study received ethical approval from the Social Research and Ethics Committee, UCC. The reporting of results is anonymised whereby no individual or identifying information is reported.

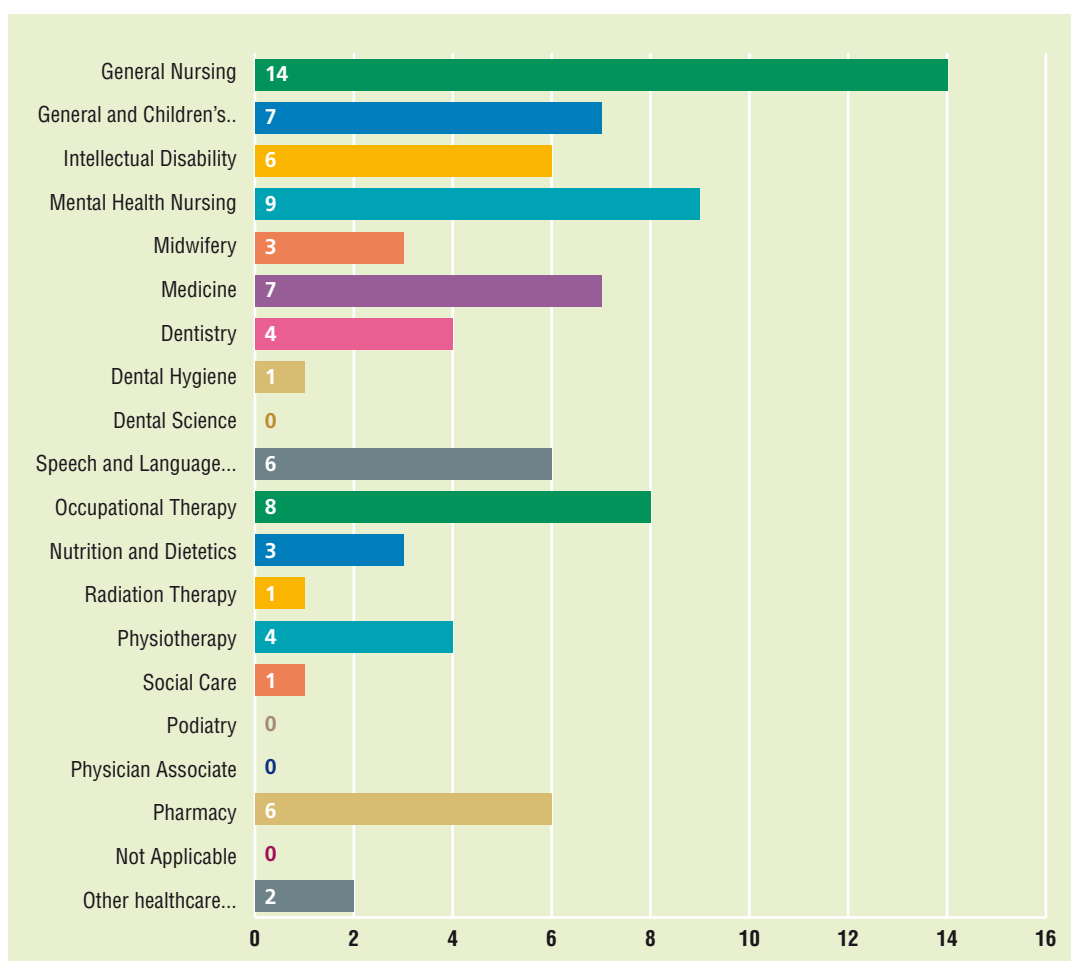
Results

A total of sixty-five academic staff from eleven Higher Educational Institutions responded to the survey reporting on fifteen degree programmes; General Nursing, General and Children's Nursing, Intellectual Disability Nursing, Mental Health Nursing, Midwifery, Medicine, Dentistry, Dental Hygiene, Pharmacy and Allied Health including; Speech and Language Therapy/Sciences, Occupational Therapy, Nutrition and Dietetics, Radiation therapy, Physiotherapy and Social Care.

(In some cases respondents reported on more than one degree programme therefore sixty-five responded capturing a total of eighty-four degree programmes; fifty-two reported on one degree programme, five on two degree programmes, five on three degree programmes, two on two postgraduate entry programmes and one on five degree programmes).

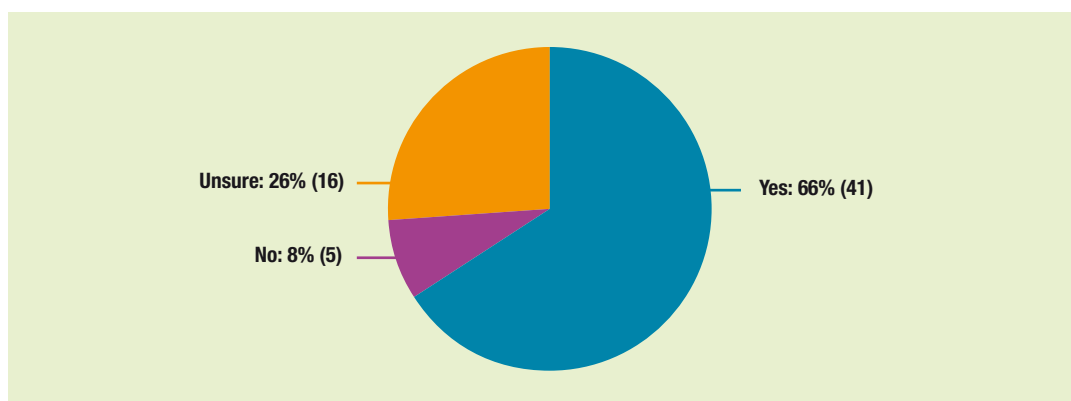
All nursing and midwifery programmes combined accounted for forty responses, medicine (n=7), dentistry and dental hygiene (n=5), allied health (n=24), pharmacy (n=6) and postgraduate entry programmes (n=2).

Figure 1: Breakdown of Programmes Reported



When asked whether Self-management Support for CD is taught to undergraduate students, of sixty-four responses, 66% reported yes, 8% no and 27% were unsure. Per programme breakdown; in all Nursing programmes combined 71% indicated that Self-management Support for CD is taught at undergraduate level, 43% indicated yes for Medicine, 25% yes for Dentistry and Dental Hygiene, 75% yes for Allied Health and 83% responded yes for Pharmacy.

Figure 2: Self-management Support for CD Taught



Of forty responses overall, 83% indicated that Self-management Support is taught across multiple modules. Responses from 41 respondents agreed that Self-management Support is taught for the following chronic conditions; cardiovascular disease (73%), respiratory disease (63%) diabetes (63%) musculoskeletal diseases (63%), multimorbidity (60%) and other including neurological diseases, cancer, mental health conditions, obesity, haematological disorders, childhood asthma and periodontal disease (53%). With greatest teaching occurring in years two, three and four.

Figure 3: Years in which Self-management Support for CD is taught

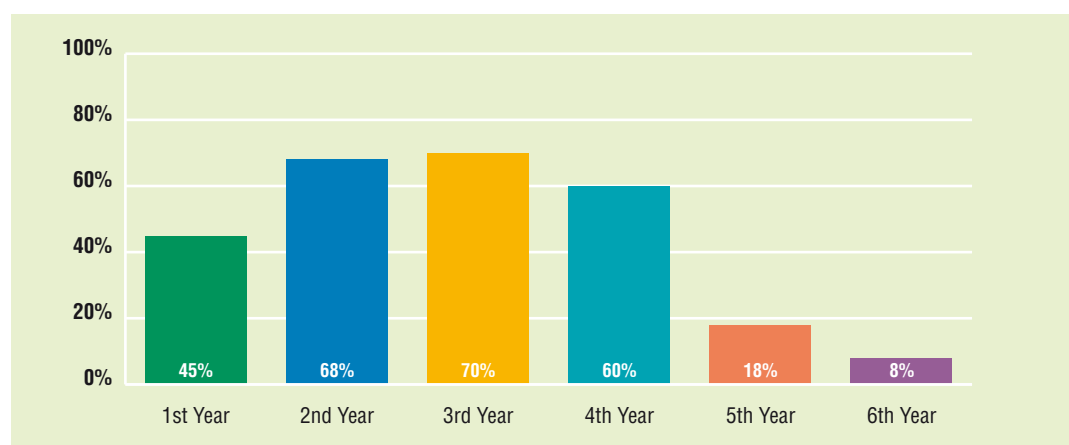
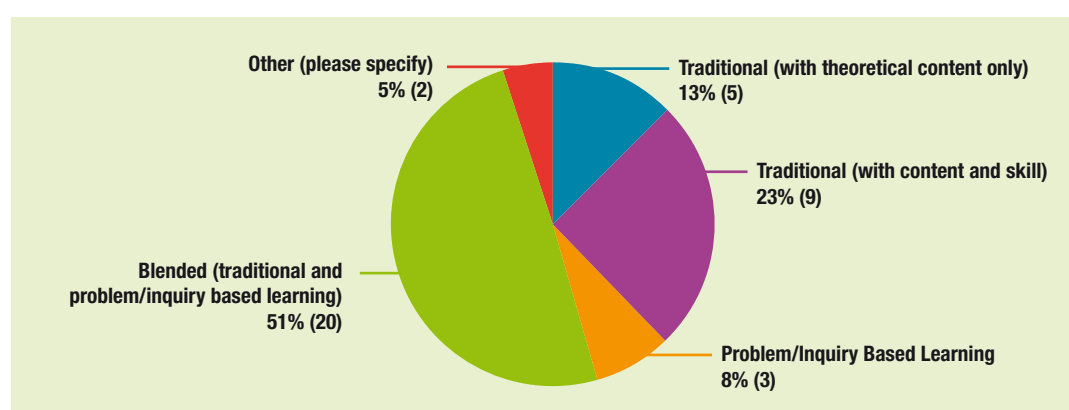


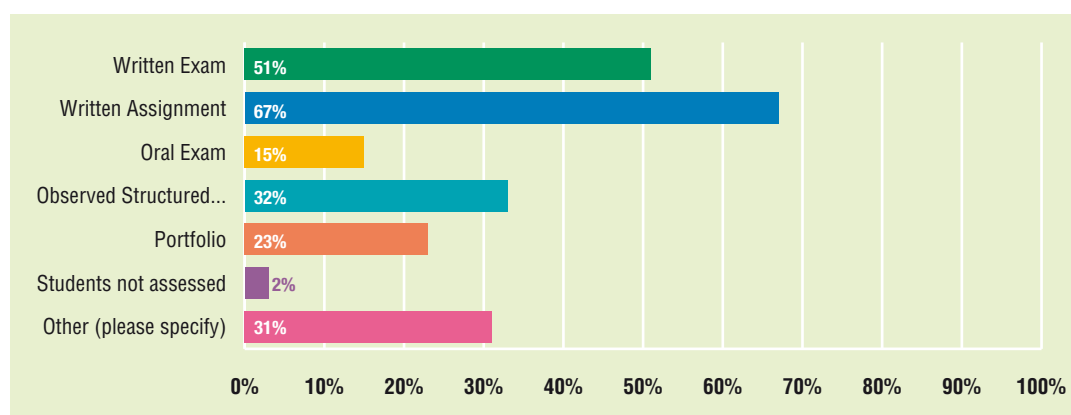
Figure 4: Teaching Approaches to Self-management Support for CD



Of thirty-nine respondents, the primary method of curriculum approach for Self-management Support was within a blended approach (51%), while 23% of respondents suggested it was within a traditional approach, including content and skill.

Of forty responses, written assignment (68%) and written exam (53%) were reported as the leading methods for assessment of Self-management Support for CD followed by observed structured clinical examination (33%). There were reports of other assessment methods (33%) including presentations, interactive case studies and demonstration and skills practice.

Figure 5: Methods of Assessment



Of forty responses, 20% indicated that they had received formal educational training in the teaching of Self-management Support for CD, 50% indicated that they had not and 30% were unsure.

All sixty-five responded to the question on whether there is a Self-management Support lead/champion within the department; and 20% responded yes, 62% no and 18% did not know.

Learning Areas for Self-management Support-CD Education Across all Programmes

Eight learning areas were identified for Self-management Support for CD education with a number of components/learning elements identified for each learning area. We asked to what extent each of these components were taught on a five point scale from strongly disagree to strongly agree.

Learning Area 1: Understanding and awareness of the concept of Self-management Support for Chronic Disease (CD) Management as an integral part of high quality care for people with chronic conditions.

- There was low to moderate agreement that the topics identified are taught with percentages of agreement to strong agreement ranging from 37-76%. Most agreement was for *Understanding health service structures (Acute services, Primary care, Social care, Mental Health, Chronic care model/integrated care)* (76%) and least agreement was achieved for *Examining Policy/Frameworks underpinning Self-management Support for CD* (37%).

Learning Area 2: Personalised care and support planning, regular clinical review linking to supports and services.

- For the most part the majority of respondents indicated that they either agreed or strongly agreed that these topics are taught for eleven of the twelve learning elements (64-81%). The least agreement overall was received for “Examining the topic of digitally assisted Self-management including use of mobile and smart devices” with just 28% agreeing or strongly agreeing that this topic is taught.

Learning Area 3: Provision of Information; consisted of four learning elements relating to information needs and health literacy. Respondents either agreed or strongly agreed that these elements are taught to undergraduate healthcare students in the majority (65-74%). However just 48% agreed or strongly agreed that “exploring dissemination of health information via multimedia and social media” is taught.

Learning Area 4: Evaluation Methods and Tools has seven learning elements with five items related to patients measures, one item on staff measures and one item on audit methods and tools. The highest level of agreement was in relation to teaching disease specific clinical outcome measures with 78% either agreeing or strongly agreeing that this topic is taught at undergraduate level. The least level of agreement was for staff satisfaction measures with just 28% agreeing or strongly agreeing that this topic is taught.

Learning Area 5: Health Behaviour Change Skills, Theory and Practice, which included elements relating to core communication skills, motivational interviewing, health coaching and behaviour change received very high levels of agreement overall. For seven of eleven learning elements the majority of respondents either agreed or strongly agreed that those topics are taught (80-96%). For the remaining four learning elements, agreement or strong agreement was still high (53-76%).

The learning area, which received the most consistent agreement overall was **Learning Area 6: Knowledge of impact of specific health behaviours on chronic disease, and services available to support health behaviour change**. Six learning elements were included in this Learning Area including, smoking and dietary effects on chronic conditions, stress management and adherence. In the majority, respondents either agreed or strongly agreed that these elements are taught in their programmes (69-85%)

Learning Area 7 People with Specific Needs consisted of four learning elements and received varying levels of agreement as to whether or not these elements are taught at undergraduate level. For example there was a high level of agreement that *Skills required when supporting people with specific needs, for example; people with mental illness; young people; people with drug addictions; those at risk of social isolation* is taught with 78% either agreeing or strongly agreeing with the statement. Alternatively just 17% agreed that *social prescribing* is taught and just 20% either agreeing or strongly agreeing that *Generic chronic disease Self-management education programmes (e.g. Stanford/Flinders/'Expert Patient programme' models)* is taught.

Learning Area 8: Effective Self-management Support interventions for COPD asthma, diabetes, and cardiovascular disease received moderate ratings with agreement or strong agreement that elements are taught (40-62%). The highest agreement was achieved for teaching self-management support provision for stroke (62%) and the least for heart failure (40%).

Teaching of Learning Areas per Programme

1) Nursing and Midwifery

A total of twenty-five respondents indicated that they were reporting on nursing and/or midwifery.

Learning Area 1: Understanding and awareness of the concept of Self-management Support for Chronic Disease (CD) Management as an integral part of high quality care for people with chronic conditions

Twenty HEI staff members responded to Learning Area 1, which consisted of seven learning elements. The average level of agreement was 61%, ranging from 35%-80%. Levels of agreement varied in the learning elements, ranging from 35% (*Examining Policy/Frameworks underpinning Self-management Support for CD*) to 80% (*Providing a rationale and context for Self-management Support for CD*). High levels of agreement were also indicated for *Understanding health service structures (Acute services, Primary care, Social care, Mental Health, Chronic care model/integrated care)* (75%) and *Defining Self-care/Self-efficacy/Self-management/Self-management Support* (75%).

Learning Area 2: Personalised care and support planning, regular clinical review linking to supports and services

Again, twenty HEI staff members responded to Learning Area 2, which involved twelve learning elements regarding patient empowerment, collaboration, shared responsibility, and mental health in the context of CD. The average level of agreement was 70%, ranging from 40%-85%. Nine out of the twelve learning elements achieved strong levels of agreement, with agreement ranging between 70% and 85%. The highest levels of agreement were indicated for *Patient empowerment to enhance Self-management Support for CD* (85%) and *Symptom management for chronic disease* (85%), while the lowest scores were achieved by *Collaborative agenda setting – 'what matters to you?'* (55%), and *Examining the topic of digitally assisted Self-management including use of mobile and smart devices* (40%).

Learning Area 3: Provision of Information

Learning Area 3 consisted of four learning elements, reported on by twenty HEI staff members. The average level of agreement was 69%, ranging from 55%-80%. The highest agreement in this learning area was achieved by *Determining patient's information preferences/needs* (80%), while 55% of staff members indicated agreement that *Exploring dissemination of health information via multimedia and social media* was taught.

Learning Area 4: Evaluation Methods and Tools

Learning Area 4 had seven learning elements, with five relating to patient measures, one on staff measures, and one on audit methods and tools. Again, twenty participants responded to this learning area. The average level of agreement was 60%, ranging from 40%-85%. *Disease specific clinical outcome measures* achieved the highest level of agreement, with 85% indicating that this element was taught, while the lowest agreement was regarding *Staff satisfaction measures* (40%). Low scores were also indicated for *Self efficacy and patient activation measures* (50%) and *Patient empowerment scores* (50%).

Learning Area 5: Health Behaviour Change Skills; Theory and Practice

Twenty HEI staff responded to Learning Area 5, which consisted of eleven learning elements involving core communication skills, MI, and HBC. The average level of agreement was 87%, ranging from 45%-100%. Learning Area 5 displayed a high level of agreement from respondents, with ten of the eleven learning elements between 70% and 100%. The one outlier was the *Role of health coaching*, which only has a 45% agreement from HEI staff members.

Learning Area 6: Knowledge of impact of specific health behaviours on chronic disease, and services available to support health behaviour change

Learning Area 6 consisted of six learning elements, regarding the impact of health behaviours on CD, and this was answered by twenty HEI staff. The average level of agreement was 89%, ranging from 80%-95%. The highest level of agreement was indicated with regard to *The effects of dietary behaviours on chronic disease* (95%) and *The effects of physical activity levels on chronic disease* (95%), while the lowest agreement related to *Exploring the role of stress management in chronic disease* (80%).

Learning Area 7: People with Specific Needs

Once more, twenty HEI staff responded to Learning Area 7, which consisted of four learning elements. The average level of agreement was 31%, the lowest of the eight learning areas, with agreement ranging from 10%-80%. *Skills required when supporting people with specific needs, for example; people with mental illness; young people; people with drug addictions; those at risk of social isolation* was met with the most agreement (80%); however, *Role of case management* (20%), *Social prescribing* (10%), and *Generic chronic disease Self-management education programmes (e.g. Stanford/Flinders/'Expert Patient programme' models)* (15%), all achieved significantly low levels of agreement.

Learning Area 8: Effective Self-management Support interventions for COPD, Asthma, Diabetes, and Cardiovascular disease

Learning Area 8 was the final learning area, and consisted of eleven learning elements, relating to Self-management Support interventions; again, twenty HEI staff responded to this area. The average level of agreement was 55%, with agreement ranging from 45%-60%. Ten out of the eleven learning elements had a moderate level of agreement between 50% and 60%, with no standout areas, while the lowest agreement was 45%, in relation to the *Provision of Self-management Support interventions for; Multimorbidity*.

2) Dental Health

Twenty-three respondents indicated that they were reporting on Dentistry and/or Dental Hygiene.

Learning Area 1: Understanding and awareness of the concept of Self-management Support for Chronic Disease (CD) Management as an integral part of high quality care for people with chronic conditions

Only one HEI staff member responded to Learning Area 1, which consisted of seven learning elements. All items were respondent with agreement, apart from *Understanding health service structures (Acute services, Primary care, Social care, Mental Health, Chronic care model/integrated care)* which received responses of neither agree/disagree.

Learning Area 2: Personalised care and support planning, regular clinical review linking to supports and services

Again, only one HEI staff member responded to Learning Area 2, which involved twelve learning elements regarding patient empowerment, collaboration, shared responsibility, and mental health in the context of CD. All items were met with agreement, apart from *Exploring and signposting social support resources with the patient, Examining the topic of digitally assisted Self-management including use of mobile and smart devices, and Exploring mental health issues in the context of chronic illness*, which received a neither agree/disagree response.

Learning Area 3: Provision of Information

Learning Area 3 consisted of four learning elements, reported on by one HEI staff member. Three items were met with agreement, apart from *Examining the topic of health literacy/plain English communication*, which received a neither agree/disagree response.

Learning Area 4: Evaluation Methods and Tools

Learning Area 4 had seven learning elements, with five relating to patient measures, one on staff measures, and one on audit methods and tools. Again, 1 participant responded to this learning area. All items received agreement, apart from *Staff satisfaction measures*, which received a neither agree/disagree response.

Learning Area 5: Health Behaviour Change Skills; Theory and Practice

One HEI staff member responded to Learning Area 5, which consisted of eleven learning elements involving core communication skills, MI, and HBC. In this instance, all items were met with agreement.

Learning Area 6: Knowledge of impact of specific health behaviours on chronic disease, and services available to support health behaviour change

Learning Area 6 consisted of six learning elements, regarding the impact of health behaviours on CD, and this was answered by one HEI member. Five out of the six learning elements were met with agreement, while one element was met with a neither agree/disagree response (*The effects of physical activity levels on chronic disease*).

Learning Area 7: People with Specific Needs

Once more, one HEI staff member responded to Learning Area 7, which consisted of four learning elements. However, in this instance, all learning elements received a neither agree/disagree response, and these were *Skills required when supporting people with specific needs, for example; people with mental illness; young people; people with drug addictions; those at risk of social isolation* was met with the most agreement, *Role of case management, Social prescribing, and Generic chronic disease Self-management education programmes (e.g. Stanford/Flinders/'Expert Patient programme' models)*.

Learning Area 8: Effective Self-management Support interventions for COPD Asthma, Diabetes, and Cardiovascular disease

Learning Area 8 was the final learning area, and consisted of eleven learning elements, relating to Self-management Support interventions; again, one HEI staff member responded to this area. Ten of the eleven items received disagreement, indicating that these were not taught in the curriculum. Of the remaining response, in relation to the *Provision of Self-management Support interventions for; Diabetes, including Diabetes structured patient education*, this item received a response of neither agree/disagree. As such, Learning Area 8 had no agreement with any learning element.

3) Allied Health

Twenty-three respondents indicated that they were reporting on Allied Health (Speech and Language Therapy/Sciences, Occupational Therapy, Nutrition and Dietetics, Radiation Therapy, Physiotherapy, and Social Care).

Learning Area 1: Understanding and awareness of the concept of Self-management Support for Chronic Disease (CD) Management as an integral part of high quality care for people with chronic conditions

Seventeen HEI staff members responded to Learning Area 1, which consisted of seven learning elements. The average level of agreement was 66%, ranging from 41%-88%. Levels of agreement varied in the learning elements, ranging from 41% (*Examining Policy/Frameworks underpinning Self-management Support for CD*) to 88% (*Understanding health service structures (Acute services, Primary care, Social care, Mental Health, Chronic care model/integrated care)*). High levels of agreement were also indicated for *Providing a rationale and context for Self-management Support for CD* (76%).

Learning Area 2: Personalised care and support planning, regular clinical review linking to supports and services

Again, seventeen HEI staff members responded to Learning Area 2, which involved twelve learning elements regarding patient empowerment, collaboration, shared responsibility, and mental health in the context of CD. The average level of agreement was 81%, ranging from 47%-94%. Ten of the twelve learning elements achieved strong levels of agreement, with agreement ranging between 82% and 94%. The highest levels of agreement were indicated for *Shared responsibility and shared decision making with the patient* (94%), *Collaborative goal setting with patients* (88%), *Exploring mental health issues in the context of chronic illness* (88%) and *Exploring and signposting social support resources with the patient* (88%), while the lowest scores were achieved by *Investigating the importance of Self-management Support in the management of all chronic conditions and multiple chronic conditions* (71%), and *Examining the topic of digitally assisted Self-management including use of mobile and smart devices* (47%).

Learning Area 3: Provision of Information

Learning Area 3 consisted of four learning elements, reported on by seventeen HEI staff members. The average level of agreement was 75%, ranging from 59%-88%. The highest agreement in this learning area was achieved by *Determining patient's information preferences/needs* (88%), while 59% of staff members indicated agreement that *Exploring dissemination of health information via multimedia and social media* was taught.

Learning Area 4: Evaluation Methods and Tools

Learning Area 4 had seven learning elements, with five relating to patient measures, one on staff measures, and one on audit methods and tools. Again, seventeen participants responded to this learning area. The average level of agreement was 61%, ranging from 29%-88%. *Disease specific clinical outcome measures* achieved the highest level of agreement, with 88% indicating that this element was taught, while the lowest agreement was regarding *Staff satisfaction measures* (29%). Low scores were also indicated for *Self efficacy and patient activation measures* (47%) and *Patient empowerment scores* (35%).

Learning Area 5: Health Behaviour Change Skills; Theory and Practice

Seventeen HEI staff responded to Learning Area 5, which consisted of eleven learning elements involving core communication skills, MI, and HBC. The average level of agreement was 80%, ranging from 41%-94%. Learning area 5 displayed a high level of agreement from respondents, with eight of the eleven learning elements between 82% and 94%. The one outlier was the *Role of health coaching*, which only had a 41% agreement from HEI staff members, while agreement relating to the teaching of *Motivational interviewing* was also lower than other learning elements (65%).

Learning Area 6: Knowledge of impact of specific health behaviours on chronic disease, and services available to support health behaviour change

Learning Area 6 consisted of six learning elements, regarding the impact of health behaviours on CD, and this was answered by seventeen HEI staff. The average level of agreement was 67%, ranging from 41%-82%. The highest level of agreement was indicated with regard to *Reasons for non-adherence/compliance* (82%), while low agreement was indicated for *The services available to support quitting smoking* (41%), *The effects of smoking on chronic disease* (65%), and *The effects of physical activity levels on chronic disease* (65%).

Learning Area 7: People with Specific Needs

Once more, seventeen HEI staff responded to Learning Area 7, which consisted of four learning elements. The average level of agreement was 56%, with agreement ranging from 24%-35%. *Skills required when supporting people with specific needs, for example; people with mental illness; young people; people with drug addictions; those at risk of social isolation* was met with the most agreement (88%) while the *Role of case management* (77%) also achieved strong agreement. However, *Social prescribing* (24%), and *Generic chronic disease self-management education programmes (e.g. Stanford/Flinders/'Expert Patient programme' models)* (35%), all achieved significantly low levels of agreement.

Learning Area 8: Effective Self-management Support interventions for COPD, Asthma, Diabetes, and Cardiovascular disease

Learning Area 8 was the final learning area, and consisted of eleven learning elements, relating to Self-management Support interventions; again, seventeen HEI staff responded to this area. The average level of agreement was 51%, the lowest of the 8 learning areas, with agreement ranging from 24%-82%. Six out of the eleven learning elements achieved agreement below 50%, with the lowest agreement for *Provision of Self-management Support interventions for; Asthma: including Asthma action plans, inhaler technique education and training* (24%) and *Provision of Self-management Support interventions for; Heart failure: including Heart failure education* (29%). The highest agreement was 82%, in relation to both the *Provision of Self-management Support interventions for; Stroke: including general rehabilitation* and the *Provision of Self-management Support interventions for; Chronic neurological conditions*.

4) Medicine

Seven respondents indicated that they were reporting on Medicine.

Learning Area 1: Understanding and awareness of the concept of Self-management Support for Chronic Disease (CD) Management as an integral part of high quality care for people with chronic conditions

Four HEI staff members responded to Learning Area 1, which consisted of seven learning elements. The average level of agreement was 57%, ranging from 25%-75%. Levels of agreement varied in the learning elements, with three learning areas showing 25% agreement (*Examining Policy/Frameworks underpinning Self-management Support for CD; Exploring the evidence on the impact of Self-management Support for CD on patient, carer, and health care professional; Addressing a whole system model for Self-management Support for CD: patient, professional, organisation and wider system*) and one 100% (*Understanding health service structures (Acute services, Primary care, Social care, Mental Health, Chronic care model/integrated care)*). High levels of agreement were also indicated for *Providing a rationale and context for Self-management Support for CD* (75%), *Exploring the principles of Self-management Support for CD* (75%) and *Defining Self-care/Self-efficacy/Self-management/Self-management Support* (75%).

Learning Area 2: Personalised care and support planning, regular clinical review linking to supports and services

Again, four HEI staff members responded to Learning Area 2, which involved twelve learning elements regarding patient empowerment, collaboration, shared responsibility, and mental health in the context of CD. The average level of agreement was 65%, ranging from 0%-100%. Eight out of the twelve learning elements achieved strong levels of agreement, with agreement ranging between 75% and 100%. The highest levels of agreement were indicated for *Exploring mental health issues in the context of chronic illness* (100%) and *Shared responsibility and shared decision making with the patient* (100%), while the lowest scores were achieved by *Patient and professional jointly agreeing a Self-management support plan* (25%) and *Examining the topic of digitally assisted Self-management including use of mobile and smart devices* (0%).

Learning Area 3: Provision of Information

Learning Area 3 consisted of four learning elements, reported on by four HEI staff members. The average level of agreement was 25%, the lowest of the eight learning areas, with agreement ranging from 0%-50%. The highest agreement in this learning area was achieved by *Determining patient's information preferences/needs* (50%) and *Examining the topic of health literacy/plain English communication* (50%), while 0% of staff members indicated agreement that *Exploring dissemination of health information via multimedia and social media* and *Exploring the design of health information materials* were taught.

Learning Area 4: Evaluation Methods and Tools

Learning Area 4 had seven learning elements, with five relating to patient measures, one on staff measures, and one on audit methods and tools. Again, four participants responded to this learning area. The average level of agreement was 43%, ranging from 0%-75%. *Disease specific clinical outcome measures*, *Patient quality of life measures*, and *Audit methods, and tools* achieved the highest level of agreement, with 75% indicating that these elements were taught. However, low levels of agreement were achieved for four of the seven learning elements, with the no level of agreement regarding *Staff satisfaction measures* (0%). Low scores were also indicated for *Self efficacy and patient activation measures* (25%), *Patient experience measures* (25%), and *Patient empowerment scores* (25%).

Learning Area 5: Health Behaviour Change Skills; Theory and Practice

Four HEI staff responded to Learning Area 5, which consisted of eleven learning elements involving core communication skills, MI, and HBC. The average level of agreement was 82%, the highest from all learning areas, with agreement ranging from 25%-100%. Learning area 5 displayed a high level of agreement from respondents, with ten of the eleven learning elements between 75% and 100%, and all four learning elements relating to communication skills achieving 100% agreement. The one outlier was the *Role of health coaching*, which only had a 25% agreement from HEI staff members.

Learning Area 6: Knowledge of impact of specific health behaviours on chronic disease, and services available to support health behaviour change

Learning Area 6 consisted of six learning elements, regarding the impact of health behaviours on CD, and this was answered by four HEI staff. The average level of agreement was 83%, ranging from 50%-100%. The highest level of agreement was indicated with regard to *The effects of smoking on chronic disease* (100%), *The effects of dietary behaviours on chronic disease* (100%), and *The effects of physical activity levels on chronic disease* (100%). Low agreement was indicated for *Exploring the role of stress management in chronic disease* (50%).

Learning Area 7: People with Specific Needs

Once more, four HEI staff responded to Learning Area 7, which consisted of four learning elements. The average level of agreement was 31%, with agreement ranging from 0%-50%. *Skills required when supporting people with specific needs, for example; people with mental illness; young people; people with drug addictions; those at risk of social isolation* was met with the most agreement (50%) while the *Role of case management* (50%) also achieved moderate agreement. However, *Social prescribing* (25%), and *Generic chronic disease Self-management education programmes (e.g. Stanford/Flinders/'Expert Patient programme' models)* (0%) achieved significantly low levels, or no level, of agreement.

Learning Area 8: Effective Self-management Support interventions for COPD, Asthma, Diabetes, and Cardiovascular disease

Learning Area 8 was the final learning area, and consisted of eleven learning elements, relating to Self-management Support interventions; again, four HEI staff responded to this area. The average level of agreement was 36%, with agreement ranging from 0%-75%. Five of the eleven learning elements achieved an agreement of 50%, including the *Provision of Self-management Support interventions for; Stroke: including general rehabilitation*, while the highest agreement was achieved by *Provision of Self-management Support interventions for; Enduring mental health problems* (75%). Two learning elements achieved no agreement (0%), and this was indicated in relation to the *Provision of Self-management Support interventions for; Chronic musculoskeletal conditions* and *Provision of Self-management Support interventions for; Multimorbidity*. Low levels of agreement were also indicated by respondents for the *Provision of Self-management Support interventions for; Chronic neurological conditions* (25%), *Provision of Self-management Support interventions for; COPD: including Pulmonary Rehabilitation* (25%), and *Provision of Self-management Support interventions for; Hypertension: including self-monitoring* (25%).

5) Pharmacy

Six respondents indicated that they were reporting on Pharmacy.

Learning Area 1: Understanding and awareness of the concept of Self-management Support for Chronic Disease (CD) Management as an integral part of high quality care for people with chronic conditions

Four HEI staff members responded to Learning Area 1, which consisted of seven learning elements. The average level of agreement was 18%, ranging from 0%-25%. Levels of agreement varied in the learning elements, with five learning areas showing 25% agreement (*Providing a rationale and context for Self-management Support for CD; Exploring the evidence on the impact of Self-management Support for CD on patient, carer, and health care professional; Exploring the principles of Self-management Support for CD; Defining Self-care/Self-efficacy/Self-management/ Self-management Support; and, Understanding health service structures (Acute services, Primary care, Social care, Mental Health, Chronic care model/integrated care)*). The remaining learnings areas achieved 0% agreement that they were taught in the healthcare curriculum (*Examining Policy/ Frameworks underpinning Self-management Support for CD; Addressing a whole system model for Self-management Support for CD: patient, professional, organisation and wider system*).

Learning Area 2: Personalised care and support planning, regular clinical review linking to supports and services

Again, four HEI staff members responded to Learning Area 2, which involved twelve learning elements regarding patient empowerment, collaboration, shared responsibility, and mental health in the context of CD. The average level of agreement was 27%, ranging from 0%-75%. Four out of the twelve learning elements achieved 0% agreement, including *Collaborative goal setting with patients* and *Patient and professional jointly agreeing a Self-management support plan*, while a further Four out of the twelve learning elements had a 25% agreement rating (including *Examining the topic of digitally assisted Self-management including use of mobile and smart devices*, and *Shared responsibility and shared decision making with the patient*). The highest agreement level was achieved in relation to *Symptom management for chronic disease* (75%).

Learning Area 3: Provision of Information

Learning Area 3 consisted of four learning elements, reported on by four HEI staff members. The average level of agreement was 12.5%, with agreement ranging from 0%-25%. The highest agreement in this learning area was achieved by *Examining the topic of health literacy/plain English communication* (25%) and *Exploring the design of health information materials* (25%). There was no agreement for teaching of *Exploring dissemination of health information via multimedia and social media* and *Determining patient's information preferences/needs*.

Learning Area 4: Evaluation Methods and Tools

Learning Area 4 had seven learning elements, with five relating to patient measures, one on staff measures, and one on audit methods and tools. Again, four participants responded to this learning area. The average level of agreement was 11%, ranging from 0%-25%. *Disease specific clinical outcome measures*, *Patient quality of life measures*, and *Audit methods, and tools* achieved the highest level of agreement, with 25% indicating that these elements were taught. However, no level of agreement was achieved for four of the seven learning elements; *Staff satisfaction measures* (0%), *Self efficacy and patient activation measures* (0%), *Patient experience measures* (0%), and *Patient empowerment scores* (0%).

Learning Area 5: Health Behaviour Change Skills; Theory and Practice

Three HEI staff responded to Learning Area 5, which consisted of eleven learning elements involving core communication skills, MI, and HBC. The average level of agreement was 39%, with agreement ranging from 0%-67%. All four learning elements in Learning Area 5 related to core communication skills received 67% agreement from respondents, while five out of the eleven elements received 33% agreement, including *Motivational interviewing*. Two items received no agreement, indicating that they were not taught in the healthcare curriculum; *Role of health coaching* and *Collaborative Goal setting*.

Learning Area 6: Knowledge of impact of specific health behaviours on chronic disease, and services available to support health behaviour change

Learning Area 6 consisted of six learning elements, regarding the impact of health behaviours on CD, and this was answered by three HEI staff. The average level of agreement was 50%, the highest of the eight learning areas, with agreement ranging from 33%-67%. The highest level of agreement was indicated with regard to *The effects of smoking on chronic disease* (67%), *The services available to support quitting smoking* (67%) and *Reasons for non-adherence/compliance* (67%). Low agreement was indicated for *Exploring the role of stress management in chronic disease* (33%), *The effects of dietary behaviours on chronic disease* (33%), and *The effects of physical activity levels on chronic disease* (33%).

Learning Area 7: People with Specific Needs

Once more, three HEI staff responded to Learning Area 7, which consisted of four learning elements. The average level of agreement was 8%, with agreement ranging from 0%-33%. The *Role of case management* was met with the most agreement (33%); however, *Skills required when supporting people with specific needs, for example; people with mental illness; young people; people with drug addictions; those at risk of social isolation* (0%), *Social prescribing* (0%), and *Generic chronic disease Self-management education programmes (e.g. Stanford/Flinders/'Expert Patient programme' models)* (0%) all achieved no level of agreement.

Learning Area 8: Effective Self-management Support interventions for COPD, Asthma, Diabetes, and Cardiovascular disease

Learning Area 8 was the final learning area, and consisted of eleven learning elements, relating to Self-management Support interventions; again, three HEI staff responded to this area. The average level of agreement was 6% the lowest of the eight learning areas, with agreement ranging from 0%-33%. Only two learning areas achieved any level of agreement that they were components of the curriculum; *Provision of Self-management Support interventions for; Asthma: including Asthma action plans, inhaler technique education and training* (33%) and *Provision of Self-management Support interventions for; Hypertension: including self-monitoring* (33%). The remaining nine of the eleven learning elements achieved no level of agreement (0%) including the *Provision of Self-management Support interventions for; Stroke: including general rehabilitation* and *Provision of Self-management Support interventions for; COPD: including Pulmonary Rehabilitation* (0%).

Appendix 3: Person-centred Care Definitions

Reference	Definition and Web link (where applicable)	Context
Institute of Medicine (2001)	<p>Person-centred means “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (p. 3).</p> <p>Available at: https://www.nap.edu/html/quality_chasm/reportbrief.pdf</p>	IOM's strategy for a new health system for the 21 st Century in the USA with an emphasis on quality improvement.
WHO (2007)	<p>A people centred approach “involves a balanced consideration of the rights and needs as well as the responsibilities and capacities of all constituents and stakeholders of the healthcare system” (p. 5)</p> <p>Available at: http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf</p>	A policy framework for people centred healthcare published by WHO's Western Pacific Region.
Health Innovation Network, South London (2016)	<p>“Person-centred is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome” (p. 1).</p> <p>Available at: https://healthinnovationnetwork.com/wp-content/uploads/2016/07/What_is_person-centred_care_HIN_Final_Version_21.5.14.pdf</p>	A document on what is meant by person-centred care and why it is important to high quality healthcare.
Morgan & Yodar (2012)	<p>Person-centred care is an approach to care characterised by the following defining attributes: “(a) holistic, (b) individualized, (c) respectful, and (d) empowering” (p. 8).</p> <p>Available at: Morgan, S., & Yodar, L. (2012). A Concept Analysis of Person-centered Care. <i>Journal of Holistic Nursing</i>, 30(1), 6-15.</p>	A concept analysis on person-centred care.
HIQA (2012)	<p>“Being person-centred means providers communicate in a manner that supports the development of a relationship based on trust. Good communication and the provision of adequate information sources ensures that service users make informed decisions about their care, including informed decision-making to give or refuse consent to treatment” (p. 19).</p> <p>Available at: https://www.hiqa.ie/system/files/Safer-Better-Healthcare-Standards.pdf</p>	Part of <i>National Standards for Safer Better Healthcare</i> in Ireland, which include a standard specific to Patient-centred Care and Support.
The Health Foundation UK (2014)	<p>Person-centred care involves health and social care professionals working “collaboratively with people who use services. Person-centred care supports people to develop knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and healthcare. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect” (p. 3).</p> <p>Available at: http://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf</p>	A document on person-centred care from the Health Foundation, an independent charity in the UK working to improve healthcare quality.

