

CHNC Educational Package

Developing Leadership Skills for a Community of Practice: Examples include Chronic Disease Prevention and Self-Management

Module 5: Toward Sustainability

This module is the fifth and final module in a series on developing leadership skills for forming and maintaining a CoP. The first module introduced the online educational package; modules 2-4 addressed the skills required to guide the development of the CoP to function effectively and begin to accumulate a body of practice knowledge. This final module examines issues of sustainability. The example used in this module is the Chronic Disease Prevention and Self-Management Workshop developed by an Ontario CoP to educate community staff on the tools and techniques to support self management. The workshop material is provided in Appendix D.

Learning Objectives

By the end of this module, you will be able to:

- 1) Identify the characteristics of a successful CoP
- 2) Determine what resources are required for the CoP to be sustainable and discuss how to provide the conditions and resources for success
- 3) Evaluate the effectiveness of a CoP using process and outcome measures

Possible Agenda for a Focused Discussion on Module 5 (1.5 hours)

- 1) Introductions and Check-in (15 minutes)
- 2) Module Work (60 minutes)
 - a) Learning objectives and preliminary material
 - b) Discussion of questions
- 3) Round table and wrap-up (15 minutes)

Identify the characteristics of a successful community of practice

There is widespread agreement on what constitutes a community of practice. According to Wenger (1998), who has written extensively on the topic, a community of practice defines itself along three dimensions: what it is about — its joint enterprise as understood and continually renegotiated by its members; how it functions — the mutual engagement that bind members together into a social entity, and what capability it has produced — the shared repertoire of communal resources (routines, sensibilities, artifacts, vocabulary, styles, etc.) that members have developed over time. This widely quoted definition was presented in module 1.

The growing number of accounts of communities of practice in health and other settings elaborate on this definition to specify what is required for a CoP to be successful. Although the purposes vary considerably, there is broad agreement that to be successful, a community of practice should have the characteristics listed below:

- A clearly defined purpose agreed by core members, that will engage members and gives momentum to community activities. Andrew, Tolson and Ferguson (2005) point out that the lifecycle of a community is dependent on its continuing value to members.
- Mutual engagement binding members together and supporting collaboration and shared learning. It is the social relationships that hold the community of practice together. Members are drawn together, face-to-face, or in virtual space, because they have a shared purpose; over time they develop a shared language, common values, and a shared identity, which bonds the group (Wenger, McDermott, & Snyder, 2002). To avoid cliques and exclusivity (Li, Grimshaw, Nielsen, Judd, Coyte, & Graham, 2009), communities of practice should be sufficiently diverse to encourage innovative thinking and members must remain open to new ideas, and willing to share experience (Tsui, Chapman, Shnirer & Stewart, 2006). While participants will self-select on the basis of common goals and interests, the community of practice can be structured to facilitate social relationships. For example, by employing a facilitator (Garcia & Dorohovich, 2005) or other support staff (Seniors Health Research Transfer Network, 2010), or assigning the role to the project leader (Gabbay, Le May, Jefferson, Webb, Lovelock, Powell, J., et al. (2003). Strategies to support engagement include providing a mix of activities, enabling story telling as a means of sharing practice and bringing in experts (Wenger, 1996; Probst & Barzillo, 2008).

- **Capability:** Exchanging ideas and building knowledge is the *raison d'être* of a community of practice. One study (Andrew, Tolson, and Ferguson, 2008) argues that communities of practice offer an innovative way to develop and manage new knowledge and emerging practice, especially if they include collaboration between academic and professionals. The CDPSM workshop is one example of knowledge development by a community of practice.

Discussion Questions

- 1. What are the pros and cons of story telling as a way to share practice experience?***
- 2. Reflect on a recent innovation in your workplace. How was the innovation transferred throughout the workplace? How might a CoP facilitate the process?***

Determine what resources are required for the CoP to be sustainable and discuss how to provide the conditions and resources for success

When a community of practice is forming, it seems premature to think about its long-term sustainability. Yet, this needs to be considered from the outset and planned for as the CoP becomes established. As identified in earlier modules, in order for communities of practice to develop and function, certain conditions and resources are required. Garcia and Dorovich (2005:19) warn that without a core, engaged membership and a systematic process for establishing, growing, and sustaining the community, there is less likelihood that a successful community of practice will emerge. They base this prediction on over twenty years of experience of communities of practice in business settings. Connectivity is equally important, ideally face-to-face or virtually through telecommunication. As well, communities of practice need capacity to store and retrieve their products. For the latter, Garcia and Dorohovich (2005) recommend using available in-house options to start with rather than seeking elaborate and costly technological solutions.

The membership could possibly sustain a community of practice through their individual efforts; however, most CoPs require some degree of organizational support, either from the workplace or a sponsoring agency. This is likely to be necessary, whether the CoP is introduced into a workplace by management or whether it evolves from the grass roots. Being able to show the value of a CoP can increase the possibility of it receiving continued support. Indeed, Garcia and Dorohovich (2003: 2) suggest that it is best not to conduct a formal launch until you are able to produce some evidence of its worth. Although this may not be

feasible, it is important to have on hand the evidence base that supports the effectiveness of communities of practice. Some key points are listed below.

- CoPs have been used successfully in business to support innovation and are being used increasingly in health sector
- The goals of a CoP fit with the demand for greater application of evidence-based practice
- There is some evidence of their potential to change practice (Barwick, 2009)

In addition to providing the conditions and resources for development, a community of practice needs to establish and promote its value, to members and to the organization, in order to maintain ongoing support. This responsibility can be shared but core members have to make sure it happens. Table 1 describes the potential value of communities of practice to community members and organizations in the short and long term.

**Table 1 Value of Communities of Practice to Organizations and Members
(adapted from Barwick, 2008).**

	Short-term value	Long-term value
	Improve practice & research outcomes	Develop individual & organizational capabilities
Benefits to the Organization	<ul style="list-style-type: none"> • Facilitates rapid identification of individuals with specific knowledge/ skills/expertise (a) • Fosters knowledge sharing across organizational and geographic boundaries (boundary spanning) (a) • Promotes and facilitates capture & reuse of existing knowledge and retention of organizational memory (a) • Improves rate of implementation of evidence-based practices (b) • Facilitates faster, better-informed decision-making (a) • Improves the quality of the research and practice (a) (b) 	<ul style="list-style-type: none"> • Greater ability to execute strategic plan (c) • Authority with clients (stakeholders) (c) • Increased retention of talent (practitioners/ researchers) (c) • Increased capacity for knowledge-development projects (c) • Forum for “benchmarking” against rest of industry (sector) (c) • Knowledge based alliances (partnerships, collaborations) (c) • Emergence of unplanned capabilities (c) • Capacity to develop new strategic options (c) • Ability to foresee technological developments (products) (c) • Ability to take advantage of emerging market opportunities (emerging strategic grants) (b) (c)
	<ul style="list-style-type: none"> • Improve Experience at Work 	<ul style="list-style-type: none"> • Foster Professional Development
Benefits to Community Members	<ul style="list-style-type: none"> • Provides safe environment for sharing problems, challenges, & for testing new ideas (a) • Reduces learning curve for new employees (a) • Improves topical knowledge among practitioners (b) • Fosters interaction between new/junior practitioners and experienced/senior practitioners (a) • Facilitates the building of mentor-protégé relationships (a) 	<ul style="list-style-type: none"> • Forum for expanding skills & expertise (b, c) • Network for keeping abreast of field (c) • Enhanced professional reputation (c) • Increased marketability & employability (c) • Strong sense of professional identity (c)

References in the table: (a) Garcia & Dorohovich 2007; (b) Barwick, Peters, Barwick & Boydell 2008; (c) Wenger, McDermott & Snyder, 2002(c)

Discussion Questions

3. *How would a CoP with a focus on improving practice for CDPSM (see attached workshop), fit with the mission, vision and values of your place of work? What aspects would / would not fit?*
4. *What structures already exist in your workplace that would support such a community of practice?*

Evaluating the effectiveness of the CoP using process and outcome measures

Being able to demonstrate success and show the worth of a community of practice is one way to ensure its sustainability. However, there are few reports of communities of practice that have been running for long enough to generate products like the gerontological nursing best practice guidelines, implemented and evaluated in practice settings in Scotland (Tolson, Schofield, Booth, Kelly & James, 2006). For the most part, the evaluation has examined the process of communities of practice rather than their outcomes. In a critical review of the literature, Li and colleagues (2009), draw attention to this lack of rigorous evaluation and given the lack of agreed standards recommend that practitioners focus on optimizing the conditions required for a community of practice to prosper. For example, they suggest focusing on characteristics such as support for members interacting with each other, knowledge sharing, and building a sense of belonging.

In essence, evaluating a community of practice is not dissimilar to program evaluation. A **logic model** is a useful tool for understanding how a program, here a community of practice, is expected to work. Applicable to almost any program, a program logic model provides a visual representation of activities, in a flow chart or table, and links them to the stated goals (Moyer, 2005, Chapter 13). As the name implies, a program logic model illuminates the underlying logic or causal reasoning that connects activities to the expected results. The simple Logic Model, shown in Table 2, sets out the projected activities for each phase of the CoP and the expected results.




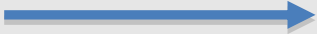
Table 2: Community of Practice Logic Model				
Phases				
Components	Form the CoP	Learn to Work Together	Develop Shared Body of Knowledge	Toward Sustainability
<i>Activities</i>	Set up steering committee Recruit CoP members Launch CoP	Define shared enquiry Form relationships Develop processes and conditions for success Promote & recruit members	 Create body of knowledge	
<i>-With whom</i>	Practitioners: management & staff; Champions	CoP steering group & members	CoP steering group & members 	CoP steering group & members Organizations/Sponsors
Outcomes				
<i>Short term</i>	CoP formed and launched	Processes & conditions for success in place Relationships formed	Body of knowledge	Renewal Strategy
<i>-Indicators</i>	Membership list Documentation of launch Statement of vision, values, goals	<i>Meeting records:</i> e.g. Schedule; Attendance; # consensus decisions <i>Operational</i>	<i>Resources developed:</i> e.g. Position paper; Reference list; Workshop	

Table 2: Community of Practice Logic Model

Phases				
	Initial meeting plan	<i>Documents:</i> e.g.: Work plan; Proposal; Logic model; Evaluation plan		
Intermediate			Knowledge Exchange	
<i>Long term</i>			Organisational Change Client Health Benefits	

Approaches to Evaluation

Keep in mind that natural settings are complex and difficult to control. Often, there are many changes happening at the same time, which makes it difficult to isolate cause and effect. Therefore, evaluation of the changes anticipated in a community of practice might seek to answer the following questions.

1. Did we do what we said we would do?
 2. What did we learn about what worked and what did not work?
 3. What difference did we make?
 4. What could we do differently?
 5. How do we plan to use evaluation findings for continuous learning?
- (Public Health Agency of Canada, Chapter 3. (1996, Revised: April 17, 2000).

Evaluation serves a different purpose at different times. In the early stages of introducing change, evaluation is concerned with the first two questions. For example, these questions might be asked in evaluating activities like the launch of a community of practice. Later on the focus of evaluation becomes the last three questions. The two sets of questions correspond to process evaluation and outcome evaluation, respectively. Process evaluation provides information of progress toward the achievement of the short/ long-term outcomes, and permits mid-course adjustments. It is particularly important when the long-term outcomes are difficult to measure, or, are not likely to be observed for many years. Process evaluation helps in understanding what is working and why. Garcia & Dorohovich (2005) offer practical advice on how to measure the success of the community in providing value to members and reaching goals through the use of surveys and simple counting methods. Others (e.g.: Gabbay et al., 2004; White et al., 2008) describe the use of ethnographic approaches with participant observation, including document review, interview and observation, as the main method of data collection.

Table 3, overleaf, provides a sample evaluation plan that might be used to guide an evaluation of a community of practice after one year. The plan addresses the following questions:

1. Did the Community of Practice provide the conditions and resources for success?
2. What difference did the community of practice make?

Based on the logic model, the first three columns of the plan links activities and indicators to community of practice goals. Columns four and five indicate what tools provide the information and who will gather the information, or, in the case of routinely collected data like meeting minutes, who holds the data.

Evaluation Plan March 8, 2010

Question	Project Activity	Indicator of Success	Evaluation Tool	Who has the information?
Have we provided the conditions and resources for success of the CoP?				
<ul style="list-style-type: none"> • <i>Developed sustainable processes</i> 	<ul style="list-style-type: none"> • Regular meetings & communication • Leadership • Champions/Organizational support • CoP supports 	<ul style="list-style-type: none"> • # meetings/members • Satisfaction with meetings, communication, leadership and support • #/type of supports provided • Organizational sponsorship 	<ul style="list-style-type: none"> • Survey of members 	Facilitator/Steering Group
<ul style="list-style-type: none"> • <i>Identified a common purpose</i> 	<ul style="list-style-type: none"> • Monthly meeting agenda & facilitation 	<ul style="list-style-type: none"> • Clarity of & satisfaction with direction and progress 	<ul style="list-style-type: none"> • Survey of members • CoP meeting notes 	Facilitator/Steering Group
<ul style="list-style-type: none"> • <i>Built relationships</i> 	<ul style="list-style-type: none"> • Meeting process: networking opportunity • Identification of facilitators & barriers 	<ul style="list-style-type: none"> • Attendance patterns • Facilitators & barriers identified 	<ul style="list-style-type: none"> • Meeting minutes • Facilitator notes • Survey of members 	Facilitator/Steering Group
<ul style="list-style-type: none"> • <i>Created a body of knowledge</i> 	<ul style="list-style-type: none"> • Meeting process 	<ul style="list-style-type: none"> • Resources produced 	<ul style="list-style-type: none"> • Resource inventory 	Facilitator/Steering Group

What difference has the Community of Practice made?

<p>Did the CoP facilitate:</p> <ul style="list-style-type: none"> • Knowledge exchange? • Provide other benefits? • Have impact on: a) members, b) member organisations? 	<p>Monthly meetings</p>	<ul style="list-style-type: none"> • Knowledge exchange • Benefits to community of practice members • Benefits to organisation 	<ul style="list-style-type: none"> • Meeting minutes • Survey of members • Interviews with practice leaders in member organisation 	<p>Facilitator/Steering Group</p>
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Did the community of practice provide the conditions and resources for success?

The following questionnaire was modified from Barwick's (2008) examination of the feasibility of using a community of practice for the design and implementation of a community of practice to support shared priorities for cancer and chronic disease prevention. The questionnaire was used to measure the provision of conditions and resources in the community health nursing communities of practice (Diem & Moyer, 2009).

Table 3: Success Factors Provided by the Community of Practice

Several factors have been identified as important for successful collaboration and knowledge exchange in a community of practice. <i>Please identify the extent to which this Community of Practice has provided those factors.</i>					
<i>Success Factors</i>	Not at all (1)	Some times (2)	Most of the time (3)	All of the time (4)	Don't know (9)
Focusing on topics that are important to community health and to our members	1	2	3	4	9
Finding a well-respected community member to coordinate the community	1	2	3	4	9
Making sure people have protected time and encouragement to participate from their leadership	1	2	3	4	9
Building on the core values and strategic goals of your organization	1	2	3	4	9
Getting key thought leaders involved (e.g. invited experts)	1	2	3	4	9
Building a personal relationship among community members	1	2	3	4	9
Developing an active and passionate core group of members	1	2	3	4	9
Creating a forum for thinking together as well as systems for sharing information	1	2	3	4	9
Making it easy to contribute and access the community's knowledge and practices	1	2	3	4	9
Creating real dialogue about cutting	1	2	3	4	9

Several factors have been identified as important for successful collaboration and knowledge exchange in a community of practice. ***Please identify the extent to which this Community of Practice has provided those factors.***

<i>Success Factors</i>	Not at all (1)	Some times (2)	Most of the time (3)	All of the time (4)	Don't know (9)
edge issues					
Creating expectations that benefits will increase in the future	1	2	3	4	9
Collaboratively developing a process or resources	1	2	3	4	9
Other factors (please specify)	1	2	3	4	9

Did the community of practice facilitate knowledge development?

Table 4 summarizes the knowledge developed in four communities of practice over an 18-month period (Diem & Moyer, 2009). The practice knowledge ranges from the identification and collection of existing resources to the custom development of resources for clients (Personal Health Passport, module 4) and practitioners (CDPSM Workshop). While the resources provide tangible evidence of knowledge development, it might be argued that the real knowledge development occurs in the minds, values and practice of participants in the community of practice.

Table 4: Summary of Knowledge Development in Four Communities of Practice

Ottawa	Cornwall	Nunavut	Vancouver
<i>Community of Practice Focus</i>			
Chronic disease self-management		Maternal-child/family health	Chronic disease self-management
<i>Knowledge Development</i>			
Package of Self-management assessment tools	An illustrated and reviewed 'Personal Health Passport' printed in English and French	Nunavut report on Nunavut nurses' work with pregnant women, families with young children Resource for linking with & supporting Canada Prenatal Nutrition Programs (CPNP) in the communities	Identification and sharing of resources
Resources for introducing organizational change to support self-management		Draft Nunavut specific material related to the CHNC Standards of Practice	
Outline for Self Management workshop package for front line community health workers*		Educational resources to support implementation of child developmental tools for Nunavut surveillance system	

*Developed later as Chronic Diseases Prevention and Self Management Workshop Guide and Participant Resource

Did the community of practice provide benefits to the organization?

As organizations struggle to maintain service excellence in times of fiscal constraint it is important for them to see the benefit of supporting a CoP. Providing tangible evidence of these benefits is a priority but difficult to do in the early days. As the model shows, it takes time for a CoP to get established and become productive. Documenting activities and products is one way of showing value.

Table 1 provides a framework for developing indicators of success within the realm of improved functioning of staff, increased recruitment and retention and improved organizational capacity. However, it must be acknowledged that it would take time and resources to define and capture measureable indicators like improved retention of staff. Besides, such potential benefits to an organization are likely to be influenced by many other factors. Translating these benefits into financial terms presents even more of a challenge. One possibility would be to show the cost of maintaining a CoP against the cost of professional development. While it is realistic to expect that a CoP could have benefit for clients, in the longer term, the pathways are complex and would require special studies. Demonstrating the value of a CoP in these various ways is important for sustainability and presents a challenge for the future.

Discussion Questions:

- 5. How might the CDPSM Workshop and Participant Resource be used to demonstrate the value of a Community of Practice in your organization?***
- 6. How does participation in a community of practice to develop such resources assist the nurse to meet the CCHN Standards of Practice?***

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Appendix A - List of Discussion Questions

1. *What are the pros and cons of story telling as a way to share practice experience?*
2. *Reflect on a recent innovation in your workplace. How was the innovation transferred throughout the workplace? How might a CoP facilitate the process?*
3. *How would a CoP with a focus on improving practice for CDPSM (see attached workshop), fit with the mission, vision and values of your place of work? What aspects would / would not fit?*
4. *What structures already exist in your workplace that would support such a community of practice?*
5. *How might the CDPSM Workshop and Participant Resource be used to demonstrate the value of a Community of Practice in your organization?*
6. *How does participation in a community of practice to develop such resources assist the nurse to meet the CCHN Standards of Practice?*

Appendix B

Facilitator Guide

Chronic Disease Prevention and Self-Management Workshop

Prepared by:

Alwyn Moyer, Liz Diem

Based on material created by Ottawa Community of Practice

Passport Prepared by Cornwall Community of Practice

March 2010

Organizing for workshop

This workshop has been provided to two groups so far: a group of 20 health professionals from different organizations in Ottawa in June, 2009 and 24 nursing students at the University of Ottawa in October 2009. For both those sessions, three or four groups of 6 to 8 participants were formed. Each group had a facilitator to lead the discussion and activities provided in the workshop resource package. Each group worked through exercises A to E together and then discussed E among all the groups.

The number of groups you form will depend on the number of people. Groups of 6 to 8 from different areas work well.

The Self-management workshop resource package can be modified for participants by removing the information for facilitators in italics. It can then be distributed to participants prior to the workshop by email. The participants are requested to read through the material, especially the introduction for health practitioners and the suggestions for using the personal health passport with clients, before the meeting.

Agenda

The following times are proposed and can be changed to fit with your schedule. Once the workshop starts, it will likely take three hours including a 15 minute break.

Before workshop

30 min: Organizing team- Set up room for 3 or 4 areas, flip charts and markers for each area and one for the front of the room. Envelop on each table to collect evaluation forms.

Start of Workshop

10 min: Welcome, overview of workshop, and introduction to self-management for health care staff

15 min: Exercise A- Learning about each other and identifying a topic for the group

20 min: Exercise B- Tools to Initiate Change

30 min: Exercise C: Tools to Assist with Problem Solving

15 min: Break

30 min: Exercise D: Assisting in the Development of an Action Plan

30 min : Exercise E: Drawing on Resources

30 min: Discussion:

- obtaining, distributing and documenting use of passport
- determining means (meetings, teleconference, email) of regularly exchanging information and support about using self-care management approaches and personal health passport

After the workshop

30 min: Team debriefing on what went well in workshop and what would be changed

Table of Contents

Pre-workshop material

Introduction to Chronic Disease Prevention and Self-Management
Health Passport and Suggestions on How to Use it with Clients

Workshop to Demonstrate Tools and Techniques for Supporting Self-Management

Exercise A: Learning about each other and identifying a topic for the group

Exercise B: Tools to Initiate Change

Exercise C: Tools to Assist with Problem Solving

Exercise D: Assisting in the Development of an Action Plan

Exercise E: Drawing on Resources

Pre-workshop Material

Introduction Chronic Disease Prevention and Self-Management

CD prevention and self-management depends on effective interaction between health care professionals, health care workers, and clients. This workshop and the personal health passport bring together information needed by everyone so a common language and a similar message become standard practice.

In preparation for the workshop, you are encouraged to read through the material. You will likely find it very useful to use the information to develop your own plan for something you would like to change, such as increasing exercise or reducing stress. You will then have your own examples to use at the workshop and with clients.

If you have been practicing for some time, you might wonder what all the fuss is about when people talk about chronic disease prevention and self management for clients or patients. We all believe that our practice supports people in the management of a chronic condition and, or, in trying to reduce risk factors. The difference introduced in self-management is an expansion of the types of support that we provide. We need to shift from being just a 'content' expert, teaching how to medically cope with a disease or reduce risk behaviours to a 'process' expert who assists people in making their own decisions and plans. The shift is realistic because people with a chronic condition manage on their own for all but 12 hours a year (Barlow, 2003).

Several authors and organizations have developed models and activities for working with people who have or who are at risk of chronic disease. For the most part, these resources are based on the theoretical work of Bandura (1997) and studies done by Lorig and colleagues (Lorig, 1993; Holman & Lorig, 2004). The person most recognized in Canada is Patrick McGowan from BC. Patrick McGowan's (2006) comparison of traditional patient education with self management is provided in the following table.

Comparison of Traditional and Self Management Education (McGowan, 2006)

Dimension	Traditional Patient Education	Self Management Education
What is taught?	Information and technical skills about the disease	Skills in how to act on problems
How are problems formulated?	Problems reflect inadequate control of the disease.	The person identifies problems that may or may not be related to the disease
What is the relation of the education to the disease?	Education is disease specific and teaches information and technical skills related to the disease	Education provides problem solving skills relevant to the consequences of chronic conditions in general.
What is the theory underlying the education?	Disease specific knowledge creates behaviour change, which in turn produces better clinical outcomes	Greater patient confidence in capacity to make life improving changes (self-efficacy) yields better clinical outcomes
What is the goal?	Compliance with behaviour changes taught to the patient to improve clinical outcomes	Increased self-efficacy to improve clinical outcomes
Who is the educator?	A health professional	A health professional, peer leader, or other patients, often in group settings

The generally accepted definitions in self management from the Institute of Medicine (2004) are:

Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

Self-management is defined as the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions.

The Flinders Program (2009) identifies six characteristics of a “good” self-manager.

They are individuals who:

1. Have knowledge of their condition
2. Follow a treatment plan (care plan) agreed with their health professionals
3. Actively share in decision making with health professionals
4. Monitor and manage signs and symptoms of their condition
5. Manage the impact of the condition on their physical, emotional and social life
6. Adopt lifestyles that promote health.

These six characteristics could be considered to be the “*Six Principles of Self-management*” (Flinders Program, 2009) and therefore all need to be included in the interactions with health professionals.

References and Resources

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Health Passport and Suggestions on How to Use it with Clients

The idea of a health passport was born at a workshop in Cornwall in January 2008. Nurses working in public health, home health, case management, community health centres, and community health nursing education determined this would enable them to better support adults in the Cornwall area to keep healthy or improve their health. The passport includes health information, problem solving tools, and places to record personal information.

Section A provides information on areas to address to improve health and prevent illness. The section begins with information on eating, activity, rest, and relationships including what to enjoy, what to avoid, options for change, and benefits. The section ends with health practices that prevent or reduce the occurrence of injury or disease, or increase early detection.

Section B provides self-management approaches and tools for people to use to improve health and manage a chronic illness. The purpose of the section is to encourage people to take action to improve their health either on their own, in a group, or with the assistance of their family or practitioners. Near the end of the section, the focus shifts to working with health care professionals to stay healthy with a chronic disease.

Section C provides forms for people to keep track of their health information. The form on the inside back cover is to document information for emergency situations.

Suggestions on Using the Passport with Clients

The passport can be used with individuals or groups in many different ways, depending on the nature of your practice. It is not meant to be a comprehensive guide, rather it is a tool to encourage dialogue on staying healthy with or without a chronic illness. While the passport is simple enough for most people to understand, many people would benefit from an introduction to the passport by health professionals.

Working with an individual. One way to introduce the passport would be to explain that Section A contains health topics, which they might like to look at, either with you, or on their own. A second step could be to have them look at page 25 (see example on p. 12 below) to consider topics they might like to work on. Or, turn to a topic that has already come up in discussion and point out they can get information on other topics in Section A. The pages following page 25 will help you in assisting them to develop and carry out a plan on a topic they have selected. In the home, home health nurses and case managers could both

work with the passport. There is space for clients to write their name on the front cover.

After looking through the passport, and considering the characteristics of your client, you might want to read and discuss the scenario on page 23 and 24. Another option could be to identify key people in their life using the form on page 37. For someone else, the choice might be to focus on the 'over the counter' medications, vitamins and prescription medications they are taking, or to review immunization status on page 44. The important thing is to use the passport together, complete some information in it, even if it is the date and time of the next appointment. For the next visit you might ask, or help, the client to complete the emergency information on the inside back cover. On subsequent visits, you can work together on the plan and progress in following the plan.

Working with a group. At the first meeting of the group, you could distribute the passports and explain that you will be using the passport to identify the health topics that are important to the group. You could use or adapt the following procedure to determine topics of interest to the group:

- a. Ask group members what they do to stay healthy and either:
 - i. Write responses on flip chart
 - ii. Ask them to quickly look through Section A and note a topic that might interest them.
 - iii. Ask them to turn to page 25 (see example on p. 12 below). If the topic is there, have them circle it; If it is not, they can write it in, or,
- b. Ask each person for one or two topics

Once the group has agreed on the topic, ask them to look it up in section A. You could lead them a discussion on the information either at that meeting or the next. During subsequent meetings, work with the group to develop a plan either on a topic of interest to the whole group, or to an individual in the group. Using the example of the group topic, explain the information on pages 26 to 30 and the blank forms on pages 38 and 39. Once members of the group have developed their own plan, include time at each session to discuss their progress in using the plan. Another important topic is how to discuss health care and plan with their health care practitioners (physician, nurse practitioner, nurse, dietician, physiotherapist) given on pages 31 to 33.

Explain that the passport belongs to them and that they can write their name on the front. Encourage them to use the passport to address their own topics and to bring the passport to each meeting and to appointments with health professions so they can discuss their progress in achieving their goals.

Workshop to Demonstrate Tools and Techniques for Supporting Self-Management

The workshop provides an opportunity to learn and apply tools that support self-management and the use of the personal health passport by clients.

Workshop Objectives:

- Explore the concepts of chronic disease prevention and self-management
- Explain a process of working with clients using the client's personal health passport
- Practice using different skills and tools to support client self-management
- Establish means to regularly exchange information and support in using self-care management approaches and personal health passport

The workshop includes five group exercises, which the groups work through in sequence, allowing 10 to 30 minutes per exercise

Exercise A: Learning about each other and identifying a topic for the group

Exercise B: Tools to Initiate Change

Exercise C: Tools to Assist with Problem Solving

Exercise D: Assisting in the Development of an Action Plan

Exercise E: Drawing on Resources

During the workshop, you will be asked to fill in sections of an evaluation form. Please submit your evaluation at the end of the workshop.

Exercise A: Learning about each other and identifying a topic for group (15 minutes)

This activity has several purposes:

- an icebreaker
- engages participants and provides opportunities to reflect on existing self-management practice
- allows members to learn about each other and for the facilitator to learn about the participants
- provides practice examples to draw on later

What is involved:

Ask people to:

- ✓ *introduce themselves and describe where they work*
- ✓ *Describe a situation where they felt they made a difference in helping a client/friend or group*
 - a) *manage a chronic illness, or*
 - b) *engage in healthy behaviour. E.g. individual- My friend signed up for yoga but kept forgetting about the class so now I call her ahead of time to remind her. She has not missed a class since. Group- we got a small group of women together to talk about how they could include some exercise in their day. Now others are joining them)*
 - *Ask someone who is fairly confident to start off and continue until everyone has described a situation*
 - *Ask someone to write examples on flip chart, board, or take notes at table to use in later exercises*
- ✓ *Discuss and decide on a topic that the group could use as an example throughout the following exercises. You can decide on a topic that applies to most people or look at the choices on page 26 in the passport.*

Exercise B: Tools to Initiate Change - Shifting the way we think and interact with clients (20 minutes)

The purpose of this exercise is to demonstrate how to initiate action on health and self management with clients, individually or in groups

- emphasis is on encouraging personal choice
- high priority on making change now
- does not require a lot of time in a busy practice

What is involved:

Ask group members to:

- ✓ *Describe how you initiate action on health or self management in your practice. The examples could be with individuals at home, in a clinic or with a group; or,*
- ✓ *Role-play, model or demonstrate techniques A, B, and, or, C below, in groups of two or three.*

A. The Three-Question Interview

1. What do you do to keep yourself healthy? /What worries you the most about your health?
2. What would you most like to change?
3. How do you think that you might do that?

B. Questions To Stimulate Discussion

How has your life changed since you developed ...?

Can you tell me what having ... is like for you?

What do you find challenging about living with ... ?

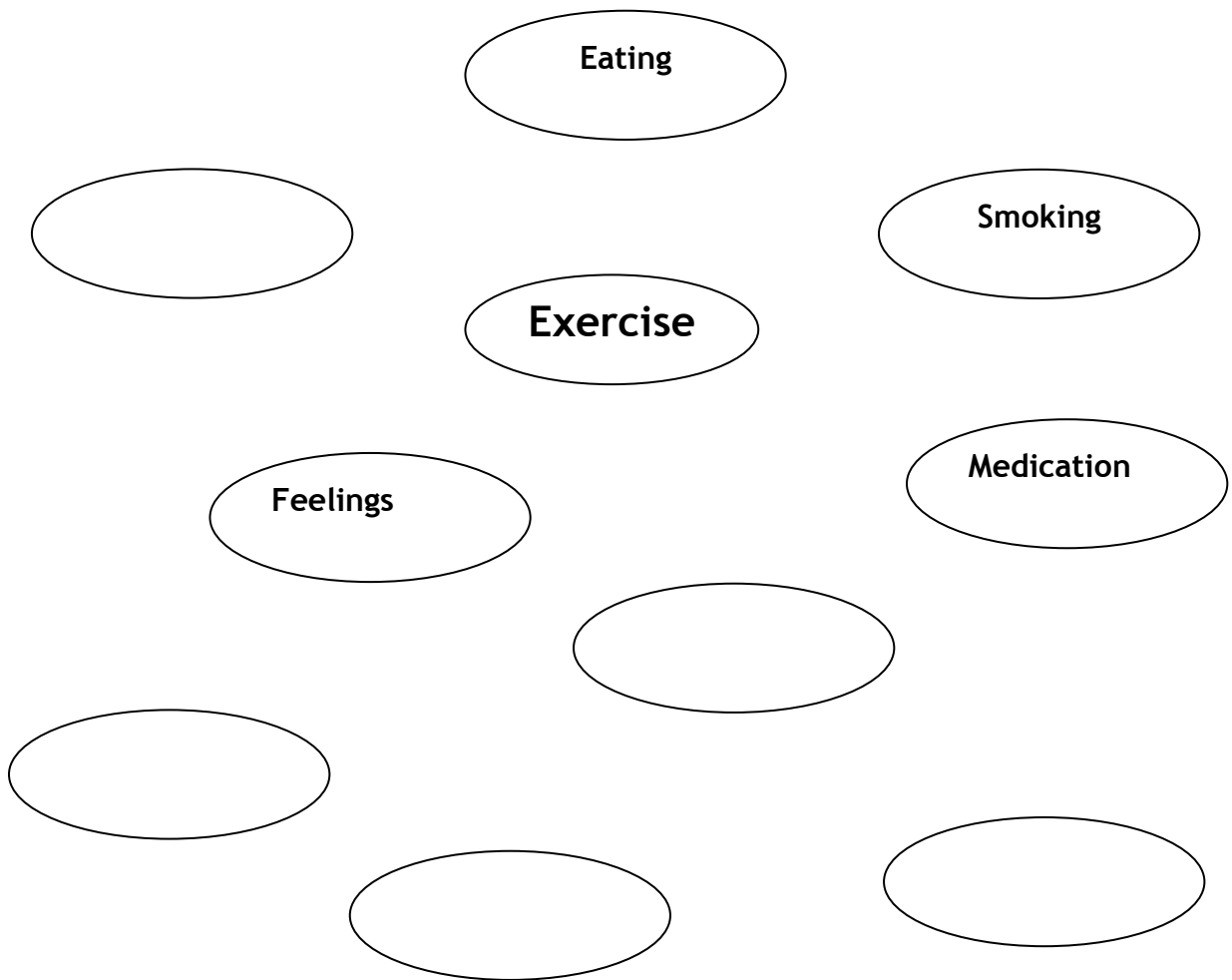
How do you feel you are managing your ...?

Is there anything about how you are managing your ... that you would like to change?

C. Review 'Actively trying to Stay Healthy' (see below and page 25 in passport) and role play how you would introduce the page and choices to clients. The purpose is to have the person state one topic from those they see or to identify another topic of interest.

Actively Trying to Stay Health (page 25 in Personal Health Passport)

Actively trying to stay healthy means thinking about what health means to you, being aware of what you do to stay healthy and what you could do and doing something about it. Some health topics are shown below to get you started. You can write in others that are important to you. To stay healthy, or improve your health, a topic for you might be the one that is the most important to you right now, or the easiest to do at this time.



Exercise C: Tools to Assist with Problem Solving (30 minutes)

The purpose of this exercise is to demonstrate how to help someone move through a problem solving process to accomplish behaviour change. You will:

- use problem solving skills to identify a focus (passport p. 26)
- use the Importance and Confidence scales to assess a person's readiness to make a change, in relation to the chosen focus (passport p. 28)
- discuss ways to increase perceptions of confidence and importance (diagram below)

What is involved:

- ✓ *Draw attention to key elements of a problem solving process (on flip chart)*
- ✓ *Ask participants, in groups of 2 or 3, to work through the first three steps of the problem solving process using a topic identified in exercise A (or, from page 26 in passport).*
- ✓ *Ask them to complete the Importance and Confidence Scales (Handout) for the chosen behaviour change or idea, applying it to themselves/or their scenario*
- ✓ *Explain how to interpret the Importance and Confidence Scales:
Success is more frequent when you have a higher score on both the Importance Scale and the Confidence Scale. Choose what issue to act on with that in mind.*

Problem Solving Process

1. Identify the problem. Be specific.
2. Brainstorm ideas that could solve the problem—from the ridiculous to the sublime. List all possible solutions.
3. Pick one idea to try. Sometimes a combination of a couple of ideas works.
4. Try it out for 2 weeks. Give it a good test!
5. Assess the results
6. If it doesn't work, try another.
7. If that still doesn't work, find a resource for ideas. Maybe a friend or professional can help.
8. If that still doesn't work, accept that the problem may not be solvable at this time. Set it aside for now and work on something else.

Scales to Help You with Change! [see Passport page 28]

Importance Scale

On a Scale of '1 to 10', where '1' means it isn't important, & '10' means it's just about as important as it can get ...

How important is it to you that you: _____?

1 2 3 4 5 6 7 8 9 10

Confidence Scale

On a scale of '1 to 10', where '1' means you aren't sure at all & '10' means you're 100% sure ...

How confident are you that you can: _____?

1 2 3 4 5 6 7 8 9 10

August 1, 2007/ Produced by Linda Manzon, Grand Forks, BC



- ✓ *Discuss Strategies to Increase Importance and Confidence (Handout, below).*
 - *Talk about how Box B is the ideal situation—the proposed behaviour change is rated as very important and the person is confident about making the change.*
 - *Ask for examples of people in situations A, C, & D (or use the examples provided on p. 16 –after 'Strategies to Increase Importance and Confidence').*
 - *Discuss strategies to increase readiness to change, that is to increase perceptions of 'importance' or 'Confidence' (to move clients from A, C, D, to Box B).*

Strategies to Increase Importance & Confidence

We can estimate whether a person is ready to make a behaviour change by assessing:

How important s/he feels the particular behaviour is; and
His/her confidence in being able to carry out the behaviour.

The table summarizes 4 possible situations and suggests Strategies to help people move into Box B (the ideal situation) from Boxes A, C and D.

CONFIDENCE 	
IMPORTANCE 	
A Behaviour is considered important but person has low confidence in being able to carry it out	B Behaviour is considered important and person has high confidence she/he can carry-out the behaviour.
Strategies Make small action plans. Talk about how she/he made hard choices in the past. Review how she/he resolved a difficult situation in the past.	Strategies Note and affirm progress. Plan for relapse. Identify and remove obstacles to maintaining course of action
C Behaviour has low importance and person has low confidence in being able to carry-out the behaviour	D Behaviour has low importance but person has high confidence she/he can carry out the behaviour.
Strategies Provide information. Offer assistance at every visit. Say: "You might want to think about it." Accept the situation without judgement.	Strategies Explore discrepancies in Information. Explore Pro's & Con's of making a change. Discuss client's hierarchy of values.
What can you do to get someone into Box B if she is in Box A? What can you do to get someone into Box B if she is in Box C? What can you do to get someone into Box B if she is in Box D?	

Source; Keller & White, 1997.

Examples for A, B, C, & D

<p>A Behaviour is considered important but person has low confidence in being able to carry it out</p>	<p>B Behaviour is considered important and person has high confidence she/he can carry-out the behaviour.</p>
<p>Example Oprah really wants to lose weight but feels she wont be able to keep to a diet or exercise</p>	<p>Example Oprah really wants to lose weight because she will get a leading role in a movie. She feels she can lose the weight because she has lost weight in the past.</p>
<p>C Behaviour has low importance and person has low confidence in being able to carry-out the behaviour</p>	<p>D Behaviour has low importance but person has high confidence she/he can carry out the behaviour.</p>
<p>Example Oprah is having trouble with her personal life and does not feel that losing weight is important right now She feels that she won't be able to keep to a diet or exercise.</p>	<p>Example Oprah is having trouble with her personal life and does not feel that losing weight is important right now. If she felt it was important she would be able to lose the weight because she has lost weight in the past.</p>

Exercise D: Assisting in the Development of an Action Plan (30 mins)

The purpose of this exercise is to demonstrate how to help someone prepare a simple action plan to change behaviour.

Action Plan (Passport p.39, example, p. 29-30)

1. The change I want to make is: (Something I want to do this week)
My goal is to: _____
2. The steps I will take: (So someone else can understand and see what I want to do)
What:
Where:
When:
How much:
How often:
3. What barriers might get in the way of my plan?
4. What could I do to overcome barriers?
5. How important is the plan is to me on a scale of 1-10? How confident am I that I can do the whole plan?
Ratings: Importance _____ Confidence _____
6. Follow-up: Who am I going to talk to about the plan and when?

What is involved:

- ✓ Complete an Action Plan, using ideas from the previous discussion (completed example p. 29-30, blank form p. 39). Suggest taking 5 minutes, working with one or two others on steps 1 & 2, or complete the action plan as a group, writing on flip chart.

Discussion points

- ✓ **1. Identify the change you want to make:** The first step in an action plan is to work with clients to help determine a goal - something that person wants to do (not what someone else thinks they should do); something the person would like to accomplish in the next three to six months (e.g., being able to walk a half mile, visit the grandchildren, or socialize with friends).

✓ **2. Identify the steps to making the change:**

- Goals are generally too big to work on all at once. Therefore a goal needs to be broken down into smaller, more “doable” steps or tasks. Something that can be accomplished in a week. For example, if the goal is to improve fitness, a person might break it into some of these steps:
 - Decide what type of exercise to do;
 - See if there are any swimming pools or adaptive physical education classes in the community;
 - Determine what level he or she can exercise comfortably;
 - Read about exercise in a book; or
 - Find a friend to exercise with.
- **Choose a step:** To get started, the person needs to decide what they will work on right now—this week—and what that will involve. The plan should answer the questions:

What? (for example, talk to my family, doctor, friends to get ideas about what exercise would be best for me)

How much? (Talk to 3 people (wife, doctor, Joe))

When? (Wife and Joe, on Monday; Doctor at check up on Friday)

How often? (number of times a day or week it will be done)

✓ **3 & 4. Identify possible facilitators and barriers to making a change** using Handout of the Pros and Cons of Making a Change (Decisional Matrix; Passport, p. 27). E.g.: “Good” and “Not So Good” Aspects of Behaviour Change

Identifying potential barriers and thinking about how to overcome them makes it more likely that the person will be able to carry out the action plan.

Ask how you might use the information to increase the likelihood of making a health change over staying the same.

✓ **5. Discuss how to use the information on ‘Importance’ and ‘Confidence’ level (Reinforces material used in Exercise C).**

✓ **6. Discuss the importance of follow-up. Identifying who you will work with on your plan, who you will ‘report back’ builds in support for making the change and increases commitment to change.**

Parts of an Action Plan – *Emphasize what is in italics*

Goal: Something YOU want to do (*not what someone else thinks you should do, or that you think you should do*)

Achievable step: (*something you can expect to be able to accomplish this week*)

Action-specific behaviour (*for example, losing weight is not a behavior, but avoiding snacks between meals is a behavior*)

Answer the questions:

What? (*for example, walking or avoiding snacks*)

How much? (*for example, walking 4 blocks*)

When? (*for example, after dinner or Monday, Wednesday, Friday*)

How often? (*for example, 4 times; try to avoid “every day”*)

Anticipate barriers

Confidence level of 7 or more (*0=no confidence to 10=total confidence; that you will complete the ENTIRE action plan*)

**Thinking About the Pro's & Con's of Making a Change (see passport p. 27)
(Decisional Matrix)**

What specific behaviour change are you considering? _____ _____		
Staying the Same	<i>I like:</i>	<i>I don't like:</i>
Making a Change	<i>I will like:</i>	<i>I won't like:</i>
Write some ideas in each of the 4 boxes. This will help you clarify your thoughts about what you want to change.		

Decisional Matrix, Janis & Mann, 1977

Example: Perceptions of “Good” and “Not So Good” Aspects of Behaviour Change

“Good” Aspects of Current Situation E.g.:“ Not Exercising”

No hassle and \$ of exercising
I feel fine - my life is pretty good
I am not that bad – at least I don't smoke
I really enjoy relaxing and watching TV

“No so Good” Aspects of Current Situation—Not Exercising

I am tired all the time	My levels are all out of control
I worry that I will have to go on insulin	I feel guilt
<i>I am not a good role model for my kid</i>	<i>I have trouble sleeping</i>
<i>I keep gaining weight</i>	<i>My clothes don't fit</i>

Additional Strategies—*can be integrated in any of the exercises.*

Ask-Tell-Ask Strategy- *A technique to elicit questions and discussion.*

Example 1:

Ask: HCP: *“What would you like to know about flu shots?”*

Client *“Do I need a flu shot every year?”*

Tell: HCP tells patient the information.

Ask HCP then asks *“Do you understand? What else do you want to know?”*

Example 2:

Ask: Is there anything else you would you like to discuss about the importance and confidence scale?

Client *“No”* [however, you feel the person is not certain]

Tell: I sense a bit of uncertainty. Maybe you are not sure about saying what is important to you. We have been talking about you losing some weight.

Ask: If I asked you what was more important to you: wearing a smaller size of clothes, having more energy, or reducing risk of heart problems, what would you answer?

Closing the Loop Strategy

A technique to make sure the client understands the information you provided

HCP: *“Three things will help prevent complications: improving your diet, exercising more, and taking medicines.*

“Can you repeat that back to me so I know it’s clear?”

Client: *“Sure OK. I eat less, walk more, and take pills”.*

HCP: *“Good”*

Exercise E: Drawing on Resources (30 minutes)

The purpose of this exercise is to raise awareness of resources for self-management in the home, neighbourhood and community. See following diagram.

What is involved:

- ✓ *Using the group's topic, decide what resources are available to support your plan in the following locations:
Home and family (Inner circle of diagram)
Neighbours, family and friends (Second circle)
Community (Outside circle)*
- ✓ *Prepare your responses to fit on the diagram that will be completed by all groups for sharing in the final large group discussion*

Example:

Inner circle: Ask: How could the people you live with, in your home, support your self-management plans for *increasing your exercise*?

Second circle: How could neighbours, family and friends support you?

Outside circle: What resources are available in the community to help you to make the healthy changes? Examples for exercise: a walking group, seated exercise class at the community centre, talk to doctor about possible limits to exercising.

What features of the environment in your community make it easy/not easy to follow through with your self-management plans? E.g. no sidewalks

Participants could also use the Social Support diagram (Passport, p. 37) to write in their resources.

- ✓ *Large group discussion to share examples of resources*

Wrap-up

Information about obtaining, distributing and documenting use of passport. Discuss and determine means (meetings, teleconference, email) to regularly exchange information and support in using self-care management approaches and personal health passport

