Physiotherapy in Primary Care

Module 7

Supporting Self-Management

Please note: This course was designed to be interacted and engaged with using the online modules. This **Module Companion Guide** is a resource created to complement the online slides. If there is a discrepancy between this guide and the online module, please refer to the module.

TABLE OF CONTENTS

MODULE INTRODUCTION

Please see the online learning module for the full experience of interactions within this document.

Physiotherapists in primary care work with people across their lifespan. While some may seek care for temporary or acute conditions, others may be learning to cope with or manage chronic conditions. Supporting the development of self-management skills is one way you can help people in your role as a physiotherapist in primary care.

This module will provide an overview of approaches to supporting self-management, the theoretical and empirical evidence on self-management supports, and strategies for implementing and evaluating self-management supports.

Module Learning Outcomes

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

1. Define and describe the principles and components of self-management.
2. Understand the theoretical foundation and empirical evidence for self-management supports.
3. Describe the different approaches to delivering self-management supports.
4. Describe the importance of interprofessional collaboration and the role of physiotherapists in supporting self-management in team-based primary care.
5. Identify strategies for assessing the outcomes of self-management supports.
6. Identify personal learning needs related to supporting self-management in team-based primary care and a plan to address those learning needs.

Note: A full reference list for topics discussed in this module can be found in the Conclusion section.

This module is intended to provide foundational knowledge related to supporting self-management, and to facilitate reflection on your learning needs and plans for professional development and networking related to competencies 1.7, 1.9, 3.1, and 3.2.

Continue to access the competencies that are relevant to this module.

Module Competencies

1.7 Provide education and support to persons seeking care, their families, and support networks, to promote successful self-management of their functioning and health.

1.9 Use virtual and/or digital health service delivery when appropriate to improve access to team-based primary care for individuals and communities

3.1 Engage the person seeking care, together with their family and support network, as core members of the interprofessional primary care team.

3.2 Collaborate with all primary care team members in a way that leverages the expertise and full scope of all team members to provide comprehensive health services that meet the needs of individuals and communities.

Continue to Section 01

SECTION 01: SELF-MANAGEMENT AND SELF-MANAGEMENT SUPPORTS

In this section, you will learn what self-management is and how self-management supports can help people with chronic conditions.

Self-Management

Self-management involves the day-to-day tasks an individual undertakes to control or reduce the impact of disease on their health.[1]

Persons with chronic conditions may do the following as part of their self-management:[2]

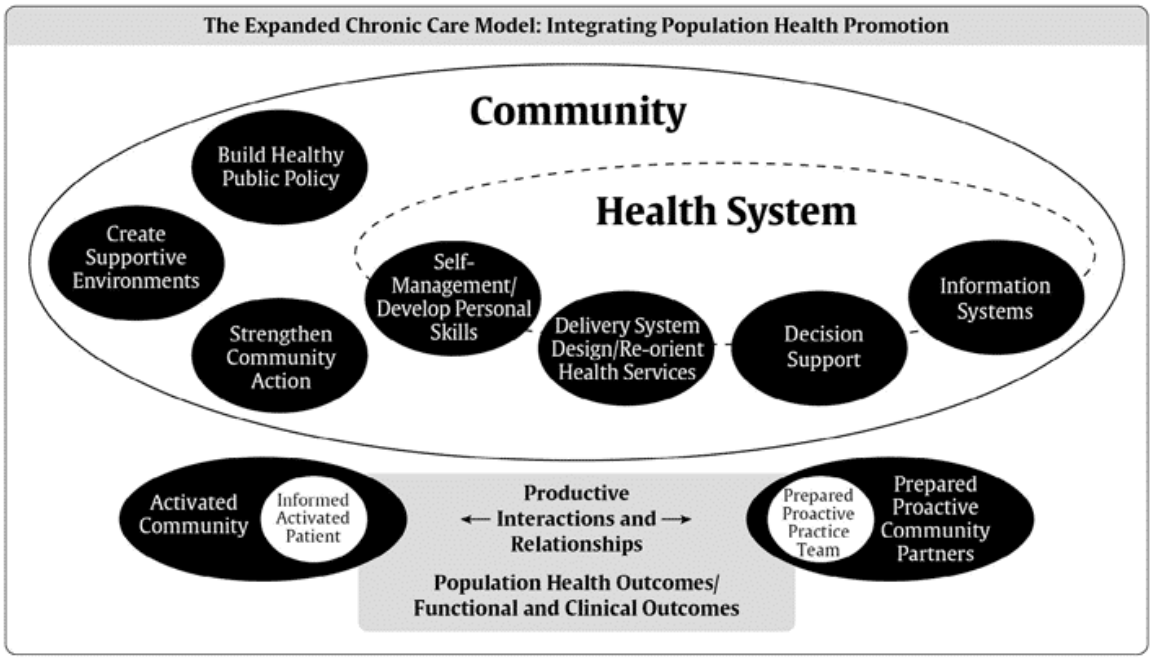
- Engage in activities that protect and promote health.
- Monitor and manage the symptoms and signs of illness.
- Manage the impact of illness on functioning, emotions, and interpersonal relationships.
- Adhere to treatment regimes.
- Make informed choices.
- Adopt new perspectives and generic skills that can be applied to new problems as they arise.
- Practice new health behaviours.

Self-management supports encompass a broad range of resources, services, and assistance to facilitate an individual's self-management efforts. These supports can be varied and may include social, emotional, or instrumental assistance to help individuals effectively manage their health. Self-management supports can come from healthcare professionals, community resources, support groups, family members, or technology tools that aid individuals in their self-management efforts.

The Role of Self-Management Supports in Managing Chronic Conditions

The Chronic Care Model suggests that improved health and functional outcomes for people with chronic diseases are the result of productive interactions between **informed**, **activated patients** and a **prepared, proactive practice team of health professionals**. The Chronic Care Model was expanded in 2003 to recognize the importance of population health promotion to support the prevention and management of chronic disease.

The expanded Chronic Care Model describes how community supports and health systems within those communities impact population health outcomes.3



Within the expanded Chronic Care Model, "**Self-Management/Develop Personal Skills**" refers to the importance of self-management in coping with a disease and the development of skills that promote health and wellness in the presence of a chronic health condition. Supporting self-management serves as a critical link between the health system and the community.

The Expanded Chronic Care Model

In this section, you learned how self-management supports can help individuals with chronic conditions to improve or maintain their health and functioning. In the next section, you will be introduced to theoretical and empirical evidence about self-management programs.

Continue to Section 02

Page link:

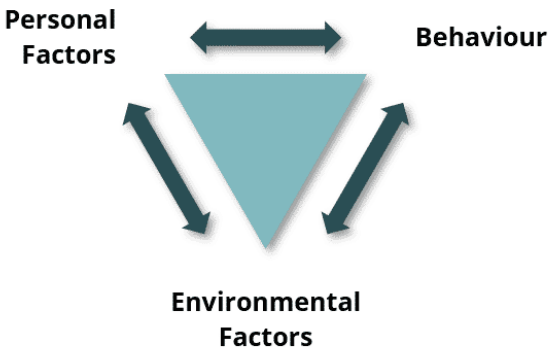
https://www.longwoods.com/content/16763/healthcare-quarterly/the-expanded-chronic-care-model-an-integration-of-concepts-and-strategies-from-population-health-pr

SECTION 02: HOW SELF-MANAGEMENT SUPPORTS CAN IMPROVE FUNCTION AND PARTICIPATION

Self-management supports have been informed by multiple theories and models. In this section, you will be introduced to Social Cognitive Theory and how it can be applied to self-management supports. You will learn about the empirical evidence on the effectiveness of self-management supports.

Social Cognitive Theory (SCT)

One of the most common theories used to inform self-management supports is Social Cognitive Theory (SCT). SCT proposes that human behaviour is the product of the interaction between personal factors, environmental influences, and behavioural patterns.[4, 5] SCT describes how people both actively influence their environments, and how they are influenced by them.[4, 5]



Changes in any one of the personal, environmental, or behavioural factors, because they interact, can contribute to the outcome of the self-management process.[6]

Self-efficacy is a key construct of SCT and refers to the person's confidence in their ability to perform a behaviour.[7]

Continue to compare definitions for self-efficacy related to task performance and self-regulation.

Self-Efficacy for the Task

Self-efficacy for the task is defined as a person's belief in their ability to perform a specific task or behaviour.[8]

Self-Efficacy for Self-Regulation

Self-efficacy for self-regulation is defined as a person's ability to change their routines by exerting control over inner processes of goal setting, self-monitoring, incorporating feedback, problem solving, and self-evaluating.[8]

Applying Concepts of SCT to Self-Management

Identifying the concepts within SCT that are mediators of the behaviours or outcome you want to change is an important step in applying SCT when planning self-management supports.

Continue to learn how the key concepts of SCT can be applied to physiotherapy when supporting self-management.

SELF-EFFICACY

One way to apply SCT is to implement strategies to improve **self-efficacy** (a personal factor).

Self-efficacy refers to the person's confidence in their ability to perform a behaviour.

One example of a strategy to improve self-efficacy is providing a mastery experience. Support the person in setting a short-term goal that is both important to them and realistic. You can then further support them in identifying an action plan that will help them master the activity and achieve the short-term goal. To make a short-term goal realistic, you may have to help them break down their chosen task into small steps.

OUTCOME EXPECTATIONS

Another way to apply SCT in providing self-management support is to address **outcome expectations** (another personal factor that influences behviour).

Outcome expectations refers to the outcomes that a person expects if they make the behviour change.

In practice, this may involve describing why you think introducing a new self-management strategy (e.g., action planning to achieve a physical activity goal) may help them before implementing the strategy. For example, before providing support for participating in physical activity and exercise for someone with chronic pain, share the evidence that physical activity and exercise are effective at improving pain, function, and/or quality of life. You can also have a peer share their experiences of how they benefited from physical activity and exercise.

OBSERVATIONAL LEARNING

An example of how to apply **observational learning** is incorporating peer supports (ideally peers with similar characteristics to the people participating in the program) as role models to share their experiences.

SELF-MONITORING

Another way to apply SCT is to help the person develop skills for **self-monitoring**.

Self-monitoring means monitoring one's behaviour, its determinants, and its consequences.

An example of how to support self-monitoring is by teaching the person to use an activity log to monitor their progress on their action plan and to problem-solve barriers to progressing with their action plan.

Empirical Evidence on Self-Management Supports

There is a growing body of evidence on the effects of self-management supports on health outcomes. Well-designed self-management supports can improve self-efficacy and support the self-management of people living with chronic conditions.[10, 11, 12, 13]

If you are interested in reading the evidence of the effectiveness of self-management supports for persons with specific chronic conditions, continue. If not, please proceed to the section on tailoring self-management supports.

Chronic Obstructive Pulmonary Disease (COPD)

For persons with COPD, self-management supports:

- Improved Health-Related Quality of Life score (mean difference –2.86 points on the St. George's Respiratory Questionnaire, 95% Confidence Interval (CI): -4.87 to –0.85).[14]
- Lowered the probability of respiratory-related hospital admissions (Number Needed to Treat (NNT): 15, 95% CI: 8 to 399).14

Type 2 Diabetes

For persons with Type 2 Diabetes, self-management supports:

- Reduced HbA1c levels (mean difference −0.21%, 95% CI: −0.38 to −0.04).[15]
- Reduced body weight (mean difference −2.36 kg, 95% CI: −5.77 to 1.05).[15]
- Reduced waist circumference (mean difference −1.8 cm, 95% CI: −5.63 to 2.04).[15]

There was no difference in:

- Blood pressure.[15]
- Levels of blood lipids.[15]
- Quality of Life.15

Chronic Kidney Disease

For persons with chronic kidney disease, self-management supports:

- Reduced anxiety, −0.95 (95% CI: −1.65 to −0.25).[16]
- Reduced depression, −0.63 (95% CI: −0.85 to −0.41).[16]
- Improved health-related quality of life:
    - Mental component of the SF-36, 0.71 (95% CI: 0.45 to 0.97).[16]
    - Physical component of the SF-36, 0.61 (95% CI: 0.35 to 0.86).[16]
    - The Kidney Disease Quality of Life scale, 0.41 (95% CI: 0.17 to 0.65).[16]

Stroke

For stroke survivors, self-management supports:

- Slight increase in basic activities of daily living (Standardized mean difference = 0.31, 95% CI: 0.16 to 0.46).[17]

There were no differences in:

- Levels of Health Related Quality of Life.[17]
- Instrumental IADLs.[17]
- Severity of depression.[17]

Chronic Low Back Pain

For persons with chronic low back pain, self-management supports:

- Reduced disability (standardized mean difference = −0.19, 95% CI: −0.34, −0.03).[18]
- Reduced pain (standardized mean difference = −0.25, 95% CI: −0.40 to −0.10).[18]

Fibromyalgia

For persons with fibromyalgia, self-management supports:

- Improved physical function (standardized mean difference 0.36, 95% CI: 0.20 to 0.53).[19]
- Reduced pain (standardized mean difference -0.38, 95% CI: -0.58 to -0.19).[19]

Osteoarthritis

For persons with osteoarthritis, self-management supports:

- Improved function (standardized mean difference = -0.24, 95% CI: -0.45 to -0.04).[20]
- Reduced pain (standardized mean difference = -1.51, 95% CI: -2.41 to -0.62).[20]

In this section, you were introduced to Social Cognitive Theory (SCT) and how to apply it when providing self-management supports. You were provided with empirical evidence on the effectiveness of self-management supports. In the next section, you will further examine the principles and components of self-management supports.

Continue to Section 03

SECTION 03: PRINCIPLES AND COMPONENTS OF SELF-MANAGEMENT SUPPORTS

In this section, you will be introduced to the principles and components of self-management supports, and the core self-management skills that benefit individuals with chronic conditions.

Self-management supports aim to empower and prepare individuals to manage their health and health care. Self-management supports encourage participants to set goals, create action plans to work towards those goals, identify barriers and challenges, problem-solve challenges, and monitor their own conditions. However, it is important to recognize that self-management requires work, and discussions with patients about their capacity and confidence are helpful, as well as identifying when external supports may be needed.

Self-management support strategies include:

- Tools and resources to provide visual reminders of their chosen action plans and self-monitoring activities.
- Supports for goal setting, action planning, problem-solving, and follow-up.

Continue for Amy Hondronicols, PT, PhD, reflecting on supporting self-management.

Start of the audio transcript:

In my clinical physiotherapy work in primary care, I had a lightbulb moment based on some learning from my mental health colleagues. They also support self-management but taught me to validate when people might need other supports instead. There is a significant mental load with illness or injury, and chronic diseases, and we need to make that explicit. Self-management can add to that load at times, especially when someone experiences worsening of their health status. That might be perceived as a failure to self-manage well enough. We need to recognize that self-management requires work. Discussions about a person's capacity are helpful and essential, as is identifying when external supports are needed. Although success with self-management is empowering, setbacks in health status are not always in a person's control and should not be equated with a lack of effort or willpower. Sometimes we have to take the extra step to make sure that's clear to the people we're working with.

End of the audio transcript

Areas of Focus for Engaging in Self-Management

Kate Lorig, a leader in supporting self-management, suggests there are three main areas of focus for a person engaging in self-management: medical/health, behavioural, and emotional management.30

Continue to learn about the three main areas of focus for self-management.

Medical/Health Management

Doing exercises, taking medication, or adhering to a special diet to manage a condition or illness.

Behavioural/Role Management

Creating meaningful roles for oneself in the context of the chronic illness (e.g., finding new ways to participate in favourite hobbies).

Emotional Management

Managing emotions such as sadness, anger, and frustration.

Self-Management Skills

According to Lorig and a report from a Robert Wood Johnson meeting on self-management, there are five core self-management skills: **problem-solving, decision-making, resource utilization, forming of a partnership with health care providers, and taking action.**30,31 Self-monitoring and self-tailoring are two additional self-management skills often necessary for applying the five core self-management skills.

Problem-Solving

Problem-solving includes:

1. Defining the problem;
2. Generating possible solutions (including suggestions from friends, members of self-management groups, and health care professionals);
3. Trying out different solutions; and
4. Evaluating the outcomes.

Decision-Making

People with chronic conditions need to make decisions in response to changes in their condition. In order to make good decisions, people require the appropriate information and knowledge.

For example, people with back pain can be taught to identify the serious symptoms or "red flags" that require medical attention, such as loss of bladder control. Additionally, they can be taught symptoms that don't require medical attention. If the symptoms are not serious, instead of seeking care, they can try new or different self-management strategies, such as a gradual increase in activity, which will likely help them to return to their usual activities.

Resource Utilization

People with chronic illnesses need to develop skills that will enable them to find the required resources, access the resources, and effectively use the resources.

Physiotherapists can share information about resources that meet the person's priorities and discuss questions that the person can ask of potential resources to find a match for their needs and preferences.[30]

Forming Partnerships with Health Care Providers

When dealing with a long-term illness, the role of the health care provider becomes that of teacher and partner. Here, the physiotherapist could share information about what their role in a partnership is and enact shared decision-making.

In this partnership, the person with the chronic condition shares information about the trajectory of their condition over time, contributes to informed choices about the management of their condition,

and communicates their preferences and choices to their provider. The physiotherapist can encourage the person to keep a diary, help them decide what to track, and review their self-monitoring with them.

Taking Action

Action planning is one strategy that can help people work towards their health behaviour goals. Action planning is behaviour-specific and involves making a short-term action plan (over one to two weeks) and carrying it out. For example, "This week I will walk around the block once before lunch on Monday, Tuesday, and Thursday." Notice that the action plan should be realistic or 'doable' within the timeframe proposed.

Taking action can seem more attainable when smaller goals are used. The SMART goals method can be a helpful place to start when developing an action plan. According to SMART goals, the goal should be specific, measurable, achievable, rewarding, and time-based.

Navigate to the online module to view a SMART goal worksheet that can be used to prepare for or support an action plan. The worksheet has been designed for a walking/mobility goal.

After creating a SMART goal, an action plan will help the person identify the small steps they can work on to achieve their goal. It is recommended that action plans be created weekly.

The action plan should be something that the person is confident they can accomplish. Using the walking/mobility goal example, determining confidence in the action plan would involve the individual asking themselves, "How confident am I in walking around the block before lunch on Monday, Tuesday, and Thursday?" This confidence can be measured on a scale from 0 (totally unconfident) to 10 (totally confident).

Note: When measuring confidence, self-efficacy theory would suggest that the answer needs to be a 7 or higher for the person to be successful in executing the action plan.[30] If the person rates their confidence with the behaviour at less than a 7, then the action plan needs to be reviewed and modified to make sure that the person feels more confident that they can complete it.

Navigate the online module for an action plan template and an example of a completed action plan to meet a walking/mobility goal.

Self-Monitoring

Self monitoring involves the individual having a consistent method for monitoring and recording the trajectory or changes in their symptoms, condition, or functioning.

For example, a person could record the number of falls they've had, what the outcomes of the falls were, and whether they needed to seek medical assistance. Using self-monitoring, the person can reflect on changes, more accurately describe their progress and setbacks to clinicians, and collaborate on any next steps or responses.

Self-Tailoring

Self-tailoring is the process of individualizing problem-solving, decision-making, and action planning. Tailoring is best done by the individual themselves after they have learned principles for changing behaviours and self-management skills.

For example, after learning about the principles for the use of exercise to help self-manage a chronic health condition, the person can self-tailor the action planning by identifying how best to implement this self-management strategy in their own life.

In this section, you learned about strategies to support self-management, areas of focus for self-management, seven self-management skills, and how physiotherapists can support persons with chronic conditions to apply these skills.

In the next section, you will be introduced to approaches to delivering self-management supports in team-based primary care.

Continue to Section 04

SECTION 04: DELIVERING SELF-MANAGEMENT SUPPORTS

In this section, you will learn about different approaches to delivering self-management supports, particularly in your role as a physiotherapist in team-based primary care. Specifically, you will consider differences between health professional-led and peer-led supports, generalized and condition-specific supports, and in-person and virtual (e-health) supports.

Health Professional-Led and Peer-Led Self-Management Supports

You can use different health professional- and peer-led models to implement self-management supports in a team-based primary care environment.

Continue to compare three different examples of health-professional led self-management supports.

The Health Change Methodology™

The Flinders Program

Choices and Changes

Continue to learn about two different examples of peer-led self-management supports.

Living Well Program

Take Control Take Charge

There is a lack of evidence to inform whether to recommend peer-led versus provider-led self-management supports.32 However, the theoretical underpinnings of the self-management supports you are developing or offering may lead you in one direction or another.

Continue to compare how the theoretical underpinnings of the self-management support can impact how the support is provided.

SOCIAL COGNITIVE THEORY (SCT)

Recall from Section 02 that Social Cognitive Theory (SCT) emphasizes the reciprocal determinism between individuals, their behaviours, and their social environment. This means that people implementing programs informed by SCT may argue that peer-led programs provide a greater opportunity for supporting self-efficacy, by having a peer-mentor act as a credible role model.

COGNITIVE BEHAVIOURAL THEORIES

People who use programs influenced by cognitive behavioural theories may argue that health professional-led programs can provide a greater opportunity to incorporate cognitive-behavioural approaches to help support people to address thought patterns that may be influencing their health-related behaviours.

Reflection Question: What health professional-led or peer-led self-management programs do you currently know about? Which programs do you want to learn more about?

Generalized and Condition-Specific Self-Management Supports

Recall from Section 03 that the five core self-management skills include:

- Problem-solving
- Decision making
- Resource utilization
- Forming a partnership with health care providers
- Taking actions

These skills are not condition-specific. Thus, self-management education and support resources can be inclusive of all people with chronic conditions. However, at times you may want to consider offering or referring a person to condition-specific self-management supports.

Note: One example of when you might decide to offer condition-specific self-management supports is when persons with certain chronic conditions may feel stigmatized by others without those chronic conditions. Persons who experience stigmatization and discrimination may include transgender or two-spirit persons, members of racialized groups, people with bigger bodies who are targeted by weight stigma, as well as people with conditions such as substance use problems or mental illnesses. Recall Stephanie Nixon's coin model discussed in **Module 03: Creating Safer and Braver Spaces for Clients, Support Networks, and Team Members**, and consider how the risk of microaggressions against some patients might influence the type of supports you offer or recommend.

There is a lack of evidence to recommend condition-specific versus generalized self-management programs.[33, 34] So, the decision to offer condition-specific self-management supports is often made based on theory or patient needs/preferences.

Continue to learn how theory, specifically SCT, influences the decision to offer generalized or condition-specific self-management supports.

SCT

SCT suggests that social learning is often greater when the role model or peer shares similar characteristics. Some may argue that a condition-specific self-management program may provide greater opportunities to create a group of peers with similar shared experiences. Additionally, condition-specific self-management supports may allow for the provision of more specific discussions about barriers to enacting change.

The Living Better with Pain Program

An example of a condition-specific, health professional-led self-management program is a chronic pain self-management program called "**Living Better with Pain**," also known as "**Chronic pain self-management support with pain science education and exercise (COMMENCE)**" in the peer reviewed literature.[35, 36]

Living Better with Pain is a self-management program developed with the aim of supporting people living with pain who identify functional and participation goals. It incorporates evidence-based strategies for improving function, including pain neuroscience education, cognitive-behavioural strategies, and individualized exercise.

Continue to learn about the core features of the COMMENCE program.

Physiotherapist-Led

Living Better with Pain was designed as a physiotherapist-led program so that participants could leverage the expertise of a physiotherapist to help individualize the self-management strategies provided. This format also allows for the incorporation of cognitive-behavioural approaches that would not be possible in a peer-led program.

Condition-Specific

Living Better with Pain was developed as a condition-specific self-management program to bring together people with the shared experience of living with pain.

Another reason was to facilitate the provision of more specific supports for problem-solving barriers to behaviour changes. For example, specific supports are provided to help people address negative pain-related cognitions that influence participation in physical activity, such as fear of symptom exacerbation or pain catastrophizing.

Living Better with Pain (COMMENCE) was evaluated in a randomized controlled trial that indicated that the program led to greater improvements in function and a number of secondary outcomes when compared to a usual care control.

If you are interested in learning more, continue to review the results from the 12-week COMMENCE follow-up.[35, 36]

12-Week Follow-Up

- Improvements in function (mean difference −8.0 on the Short musculoskeletal function assessment – dysfunction index; 95% CI: −14.7 to −1.3).
- Reduced bother with functional difficulties (mean difference −12.0 on the Short musculoskeletal function assessment – bother index; 95% CI: −20.8 to −3.2).
- Reduced pain intensity (mean difference on a 10-point numeric pain rating scale, −1.0; 95% CI: −2.1 to −0.1).
- Reduced catastrophizing (mean difference −8.2 on the Pain Catastrophizing Scale; 95% CI: −14.5 to −2.0).
- Increased self-efficacy (mean difference 7.0 on the Pain Self-Efficacy Scale; 95% CI: 0.8-13.2).
- Increased knowledge (mean difference 2.8 on the Neurophysiology of pain questionnaire; 95% CI: 1.6-3.9).
- Increased satisfaction (mean difference 1.2 on a 7-point rating scale; 95% CI: 0.7-1.8).
- Increased perceived change (mean difference 1.4 on a 7-point rating scale; 95% CI: 0.8-2.1).

Note: Details of COMMENCE, including the weekly objectives, self-management strategies included, and rationale for each strategy can be accessed by continuing. Training to offer this program can be organized by contacting Jordan Miller: jordan.miller@queensu.ca

Continue to access the appendices of the multiple case study publication that outlined the details of COMMENCE.[36]

Weekly Objectives

Self-Management Strategies and Rationale

In-Person and E-Health Self-Management Supports

Self-management education and support can also vary in delivery mode.

Continue to learn about the various delivery modes.

In-Person

In-person delivery involves a synchronous connection within the same physical space.

Virtual Face-to-Face

Virtual face-to-face delivery involves a synchronous connection using video and audio.

Telephone

Telephone delivery involves synchronous connection using audio.

Digital/E-Health

Digital or e-health interventions can involve asynchronous connections.

Answer the question using your existing knowledge as well as what you have learned so far in this module.

Question: In your practice setting, what are some of the advantages and disadvantages of supporting self-management using the following approaches: i) in-person; ii) virtual face-to-face; iii) telephone; and iii) asynchronous digital or e-health?

Feedback:

Asynchronous digital or e-health self-management supports provide an opportunity to extend the reach of the support by overcoming the resource intensiveness of in-person or synchronous self-management supports. However, emerging evidence indicates that while digital or e-health self-management programs increase access for some, it can be harder to access for persons with barriers related to the technology required for e-health or digital self-management.

The Importance of Person-Centredness When Supporting Self-Management

People seeking primary care need to be at the centre of self-management strategies. Access to technology, social support, financial resources, transportation, literacy, and numeracy are among the social determinants that shape what self-management will look like for each person.

Making changes to self-manage a condition can require additional material resources and access to technologies. Additionally, self-management influences and is influenced by a person's family and social supports.[25, 26] For some, these requirements can be a barrier to participating in self-management programs. It is important to help them feel safe to share the barriers they might experience, and describe the help they need to address them.

Self-management supports may not be a priority when people need basic resources for living, such as food, housing, or income. However, evidence shows self-management interventions can be successful

with persons experiencing socioeconomic deprivation when interventions are person-centred and thoughtfully tailored to meet the person's goals and needs.

Note: As introduced in earlier modules, **trauma-informed care** and **cultural safety** are also important to the delivery of equity-focused, person-centred primary care. Self-management support models have not consistently integrated these topics, though new models are emerging.

- **Trauma Informed Self-Management Supports**

Trauma can shape people's coping strategies and we never can be sure we know who has experienced trauma.[23] Self-management activities may spark trauma responses.

Trauma-informed self-management support models are beginning to be developed.[24] Our current best strategies to support self-management in a trauma-informed way are to a) foster psychological safety to engage, b) emphasize psychological self-care as important, and c) explore peer support.

- **Culturally Safer Self-Management Supports**

Cultural humility is needed when providing self-management support, given the harms of culturally unsafe care. For example, there is a growing understanding of the importance of culturally-responsive Indigenous health programs that recognize collective trauma while building upon existing community strengths.[27] Examples of self-management supports developed by Indigenous communities highlight how to begin doing this work with communities in ways that emphasize community engagement and cultural-centredness.[28, 29]

Continue to learn about Daasachchuchik, a trauma-informed chronic illness self-program created and deliveed by the Apsáalooke Nation.[28]

Daasachchuchik: A trauma-informed approach

Daasachchuchik: A trauma-informed approach to developing a chronic illness self-management program for the Apsáalooke people[28]

The Apsáalooke Nation in present day Montana co-designed a culturally-centered, trauma-informed chronic illness self-management program with the support of researchers at a local university. They created a team including members of an Apsáalooke Nation health non-profit and a mix of Indigenous and non-Indigenous university faculty. The team was accountable to a community advisory board from the Apsáalooke Nation. Their program developed through a participatory approach guided by Indigenous research methods and trauma-informed principles.

They started by inviting stories, speaking with 20 community members with different chronic conditions, asking about their health over their lifetime, their experiences with historical and current traumas, the impacts of those traumas on their chronic conditions, and ideas for what should happen to help community members like them. The team worked with these story-interviews, generating more ideas about a culturally safe and relevant intervention, one aiming to promote a sense of safety, support hopefulness, strengthen connectedness and support collective efficacy.

They decided on an intervention that emphasizes community members learning from the advice of other trusted community members, shared through stories in facilitated gatherings of 10 community

members. Gatherings opened with prayers or spiritual blessings, a traditional story chosen as an opening to the specific topic of the day, and sharing circles responding to the story. Between gatherings, the group members met in pairs or triads to support and encourage each other as they try new things. This approach is consistent with the cultural importance of story as sacred for the Apsáalooke, and cultural values of love, community care, and kinship. The home of the program is the community's health non-profit, keeping it rooted in the community with an emphasis on building supportive, trusting relationships that can support healing from trauma.

This is a very short summary; to learn more, read the **full article here.**(opens in a new tab)

Within your own context, we suggest working closely with colleagues to identify community programs that already exist, work together on strategies to improve cultural safety in your clinic's self-management programs, and work with communities to develop new opportunities.

Answer the question using your existing knowledge as well as what you've learned so far in this module.

Question: What other strategies could you use to facilitate participation in self-management supports to support equitable access?

Feedback:

Strategies for tailoring self-management supports as described in a review by Okpako et al. (2023)[22] included:

- Adaptations for low literacy (e.g., visual aids)
- The involvement of community health workers or peer leaders
- Providing helpful materials or financial resources to support participation (e.g., mobile phone, transportation costs)

Although progress is being made, more strategies for tailoring self-management strategies should be developed to ensure culturally-safe care that aligns with people's strengths and abilities.

Self-management supports are not one-size-fits-all models. Ultimately, your responsibility is to find out what approach will best fit with the individual person's life, and to help them access the support they need.

In this section, you were presented with the difference between health professional-led and peer-led supports, generalized and condition-specific supports, and in-person and virtual/e-health supports. You were given examples of programs that use these delivery methods and learned about the importance of person-centredness when supporting self-management.

In the next section, you will explore self-management supports in the context of interprofessional primary care, and the role that physiotherapy plays in these environments.

Continue to Section 05

Page links:

https://www.albertahealthservices.ca/info/Page16720.aspx

https://www.flindersprogram.com.au/about/

https://healthychange.ca/health-care-professionals/workshops-for-health-care-professionals/choices-and-changes/

https://selfmanagementresource.com/

https://takecontroltakecharge.ca/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759926/bin/40945_2017_32_MOESM1_ESM.pdf

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759926/bin/40945_2017_32_MOESM2_ESM.pdf

https://doi.org/10.1353/hpu.2020.0073

SECTION 05: INTERPROFESSIONAL COLLABORATION AND SUPPORTING SELF-MANAGEMENT

In this section, you will learn about strategies for interprofessional collaboration when supporting self-management. You will also learn about the unique perspectives that you, as a physiotherapist, bring to teams who are supporting self-management.

Importance of Interprofessional Collaboration

When a person is living with one or more chronic conditions, they will often be working with more than one professional within the primary care team. Each health professional may have specific suggestions of tasks that may improve health outcomes over time. Three things are especially important to think about in relation to team-based primary care and supporting self-management: improved self-efficacy through meaningful goals, clear team communication, and consistent messaging.

Continue to review the three strategies for supporting self-management.

Strategy 1

Improved Self-Efficacy through Meaningful Goals

The power of self-management comes from developing skills that improve self-efficacy for activities related to the participant's goals. This means the entire team needs to be supporting the person in activities that help them work towards their goals, even if these do not precisely align with what a given clinician would recommend. Ultimately, it is important to remember that the goals being worked on must be decided by the person. It is our role, as health professionals, to support the person as they work towards their goal rather than to set the goal for them. This is a great example of what it means to put the person at the centre of the team.

Strategy 2

Clear Team Communication

Members of a person's primary care team need to communicate clearly with one another, so that they understand and support what the person is working on. They must work together to support the person's action planning and problem-solving skills. To help support and build confidence in people trying to make changes in their lives, each member of the primary care team should emphasize the changes the person is making as positive in and of themselves.[37]

Strategy 3

Consistent Messaging

If there are particular strategies, such as physical activity, that improve the probability of better health outcomes and goal achievement, the team must provide consistent messaging about the potential value of that behaviour change when offering condition-specific education. This way, the team can avoid overwhelming the person seeking their support with mixed messages or too many suggestions.

The Physiotherapy Lens

Physiotherapists serve an important role within the primary care team when it comes to providing self-management support.

Continue for two examples of research that highlight the role of physiotherapists in supporting self-management development.

SELF-MANAGEMENT OF FUNCTION IN OLDER ADULTS

A review by Richardson et al. (2013) examines the contribution of physical therapy to self-management of function in older adults.[38] Self-management supports involving physiotherapists predominantly focused on physical activity but also included disease-specific education, and strategies for fatigue, posture, and pain management. This focus was slightly different than supports provided by occupational therapists which tended to concentrate on joint protection, fatigue, and stress management.[38] These differences highlight the unique contributions to supporting self-management that you, as a physiotherapist, can add based on your physiotherapy lens.

PHYSICAL REHABILITATION AND SELF-MANAGEMENT EDUCATION

Jansma (2010) compared rehabilitation interventions and self-management education.[39] Noting their similarities, she describes that they both:

- Strive to optimize functioning to allow people to participate fully in life role activities.
- Are goal-oriented (using self-selected goals).
- Are patient-centred.
- Take a problem-solving approach to delivering care.

As a physiotherapist in primary care, you are in a unique position to use your expertise to integrate rehabilitation strategies such as individualized, goal-oriented exercises into self-management supports when the patient identifies goals to enhance physical function. However, Jansma's comparative analysis highlights the lack of attention to social theory in physical rehabilitation. Bringing strategies informed by social theories, such as the application of social cognitive theory described previously, provides an important opportunity to enhance your rehabilitation services as well.

As a primary care physiotherapist, you are in an excellent position to further the integration of rehabilitation and self-management approaches to help patients reach their goals.

Some examples of specific self-management supports that physiotherapists can incorporate into their management are:

- Supporting action planning and self-tailoring.[38]
- Focusing on function and participation.[38]
- Assisting individuals to set up their own self-monitoring process to monitor and record changes in function (e.g., walking speed).[38]
- Helping individuals identify community exercise or walking programs to include in their action plans.[38]
- Helping individuals to identify chronic disease self-management programs that they can access.[38]
- Helping identify and engage self-management peer supports (e.g., a buddy system).[38]

- Increasing physical literacy.[40]
- Providing education about how the chronic conditions impact function and participation, and on preventive approaches.[38]
- Increasing expertise in seeking resources.[38]

In this section, you explored self-management support delivery in interprofessional care team environments. In the next section, you will be introduced to various assessment strategies for self-management support delivery.

Continue to Section 06

SECTION 06: ASSESSING THE OUTCOMES OF SELF-MANAGEMENT SUPPORTS

In this section, you will investigate various ways to assess the outcomes of self-management supports. For several outcome domains, you will be introduced to a tool that can be applied to assess it.

There have been relatively few measures developed to specifically assess the outcomes of self-management supports. However, four potential outcomes to consider measuring are: **Goal Achievement, Function, Activation**, and **Self-Efficacy**.

Goal Achievement

One way to measure goal achievement is the use of Goal Attainment Scaling (GAS). GAS is a measure of the extent to which people reach their individual goals throughout an intervention.

Continue to learn more about the process of using GAS.

Goal Attainment Scaling

GAS involves defining the criteria of a realistic 'successful outcome' with the person before the intervention starts. After the intervention, each goal is rated on a 5-point scale related to the extent to which the goal is attained. If the person achieves the expected level, a score of 0 is captured. If they achieve a better than expected outcome, they would score +1 (somewhat better) or +2 (much better). If they achieve a worse than expected outcome, this is scored as -1 (somewhat worse) or -2 (much worse).

A guide to using GAS.

Function

One way to measure function is to use the Patient Specific Functional Scale (PSFS). The PSFS is a patient-centred assessment of function.

Continue to learn more about the PSFS.

Patient Specific Functional Scale

To use this scale, individuals are asked to identify up to five important activities that they are unable to perform or are having difficulty with. They rate their current level of difficulty with each activity on an 11-point scale (from 0 "unable to perform" to 10 "able to perform at prior level"). Following the intervention, individuals are asked again to rate the activities previously identified.

A copy of the PSFS.

Activation

Activation refers to the degree to which individuals are engaged and motivated. One way to measure activation is to use the Patient Activation Measure® (PAM®). PAM® is a measure of a person's active behaviour in the self-management of chronic illness.

Continue to learn more about the PAM®.

Patient Activation Measure®

The PAM® is a 13-item scale with a 5-point Likert response scale (disagree strongly, disagree, agree, agree strongly, or N/A). Raw scores are transformed to a scale of 0-100, with 100 being the highest level of activation in self management.

The PAM® scale.

Self-Efficacy

One way to measure self-efficacy is to use the Chronic Disease Self-Efficacy Scale. It is a measure of how confident people with chronic disease are in doing certain activities.

Continue to learn more about the Chronic Disease Self-Efficacy Scale.

Chronic Disease Self-Efficacy Scale

The Chronic Disease Self-Efficacy Scale consists of six items that are rated on a 10-point scale ranging from "not at all confident" (1) to "totally confident" (10).[44] The scale covers several domains that are common across many chronic diseases, including symptom control, role function, emotional functioning, and communicating with physicians.

The Chronic Disease Self-Efficacy Scale.

Self-efficacy can also be measured using the Self-Efficacy for Exercise Scale.46 The Self-Efficacy for Exercise Scale uses SCT as its theoretical underpinnings.

The Self-Efficacy for Exercise Scale.

Additional Tools

Continue to access other resources that may be helpful in assessing self-management.

Evaluation Tools from the Self-Management Resource Center

Survey Tools from NHS

In this section, you were shown how to measure the outcomes of self-management strategies. In the next section, you will revise your ILP.

Continue to Section 07

Page links:

https://www.sralab.org/sites/default/files/2017-06/Tools-GAS-Practical-Guide.pdf

https://www.sralab.org/sites/default/files/2017-06/Patient-specific.pdf

https://mydoctor.kaiserpermanente.org/ncal/Images/Patient%20Activation%20Measure%20Questionnaire_tcm75-889764.pdf

https://selfmanagementresource.com/wp-content/uploads/English_-_self-efficacy_for_managing_chronic_disease_6-item.pdf

https://www.sralab.org/rehabilitation-measures/self-efficacy-exercise-scale

https://selfmanagementresource.com/resources/evaluation-tools/english-evaluation-tools/

https://www.england.nhs.uk/personalisedcare/supported-self-management/health-system-support-framework-for-supported-self-management/examples-of-survey-tools-for-use-in-supported-self-management/

SECTION 07: INDIVIDUALIZED LEARNING PLAN

This module, **Supporting Self-Management**, was designed to help you develop new foundational knowledge, identify potential learning needs, and identify opportunities to address your learning needs related to supporting self-management in team-based primary care.

Continue to review the new foundational knowledge presented in this module as well as the potential learning needs and opportunities you may have identified.

New Foundational Knowledge from Module 07

- Components of self-management and self-management supports.
- The importance of interprofessional collaboration and the role of physiotherapists in supporting self-management in team-based primary care.
- Strategies for assessing the outcomes of self-management supports.

Potential Learning Needs and Opportunities

- Identify existing self-management support programs available to people in your community.
- Discuss strategies to support self-management with the rest of the primary care team clinicians.
- Communication skill enhancement to emphasize person-led goal development and action planning.
- Discuss if and how your team would like to evaluate the impact of the self-management supports you offer.

Revising your Individualized Learning Plan (ILP)

Now that you have completed this module, you will revise each activity within your ILP.

First, revisit **Activity 1: Competency Self-Assessment.**

- Review the self-assessment ratings, learning needs, and priority levels you identified for the Module 07 competencies when you first completed **Activity 1**.

- Modify your self-assessment ratings, add any new learning needs that you've identified, and adjust your priority ratings, if needed.

Continue to reveal the competencies relevant to this module.

Module Competencies

1.7 Provide education and support to persons seeking care, their families, and support networks, to promote successful self-management of their functioning and health.

1.9 Use virtual and/or digital health service delivery when appropriate to improve access to team-based primary care for individuals and communities.

3.1 Engage the person seeking care, together with their family and support network, as core members of the interprofessional primary care team.

3.2 Collaborate with all primary care team members in a way that leverages the expertise and full scope of all team members to provide comprehensive health services that meet the needs of individuals and communities.

Next, revisit **Activity 2: Values Self-Assessment.**

- Refine your list of values if the module inspired you to consider any personal values that you did not initially identify.

Then, revisit **Activity 3: Professional Developing and Networking Self-Assessment.**

- Record any professional development or networking goals or opportunities you may have identified by completing this module.

Finally, revisit **Activity 4: Creating your Individualized Learning Plan.**

- Examine the competencies, learning goals, and professional development and networking opportunities you identified for the short-, intermediate-, and long-term. Update your ILP based on the refinements you made to your learning needs and priority ratings (**Activity 1**), values (**Activity 2**), and professional development and networking opportunities (**Activity 3**).

Continue to Conclusion

MODULE CONCLUSION

In this module, you were introduced to self-management, strategies to support self-management, and important considerations in implementation. Given the longitudinal and comprehensive nature of team-based primary care, and the goal of providing equitable access to care, supporting self-management is an important part of the role of primary care physiotherapists.

Additional Resources for Consideration

Continue to access additional resources relating to Module 07 content.

What do you mean by engagement?

Living a Healthy Life with Chronic Conditions: Self-Management Skills for Heart Disease, Arthritis, Diabetes, Depression, Asthma, Bronchitis, Emphysema and Other Physical and Mental Health Conditions

Note: There is also a Canadian version of Living a Healthy Life with Chronic Conditions titled **Living a Healthy Life with Chronic Conditions: For Ongoing Physical and Mental Health Conditions**, but it hasn't been updated in terms of the resources people can access.

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Page links:

https://doi.org/10.1186/s12939-020-01346-6

https://www.bullpub.com/living-a-healthy-life-with-chronic-conditions-5th-edition.html

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