MSSU KNOWLEDGE SNAPSHOT 2

MODELS OF TRAINING FOR HEALTH CARE PROVIDERS TO DELIVER SELF-MANAGEMENT SUPPORT

INTRODUCTION

This snapshot briefly outlines the evidence pertaining to effective training models for health care providers (HCPs) to deliver self-management support (SMS). SMS can be defined as "*The process of providing multi-level resources in health care systems (and the community) to facilitate a person's self-management. It includes the social, physical and emotional support given by health professionals, significant others and/or carers and other supports to assist a person in managing their chronic condition* (p. 12)".[1] Further, it includes a health system with a variety of self-management supports that are evidence-based and resourced with adequately trained, culturally sensitive HCPs who support and believe in a person's ability to learn and apply self-management skills.[1] There is increasing evidence for the crucial role that HCP's play in SMS, especially due to the strong influence patients report HCP's have over their own behaviors.[2]

This snapshot includes key functions of the training, knowledge and skills obtained/required to deliver SMS, and some highlighted barriers/facilitators to training. Spotlights on formalized training models are also outlined. This snapshot does not focus specifically on the implementation of these models by HCPs.

KEY FUNCTIONS OF TRAINING

Mode

Various models of training require different levels of training expertise and intensity.[2] Sessions can be as brief as 1 to 2 hours, such as general Motivational Interviewing training.[3,4] A series of brief sessions may be more effective than a one-time only training of several hours [5] and can improve the delivery of SMS.[6]

Training Delivery

Adult learning principles that use interactive, sequential learning opportunities in a variety of formats such as workshops, small groups, and individual training sessions are acknowledged as effective methods for provision of training.[6,7] It is suggested that all staff should be competent in SMS strategies, including directors and managers. The level of training should be appropriate for the context (e.g. patient population, time factors) and provider's scope of practice.[2,9]

Personnel

SMS trainers with a background in behavior change are recommended as an effective strategy to establish sustainable SMS skills in health care providers.[5] If a designated staff is to support ongoing training and serve as a self-management support "coach" they should have formal training in behavior change methods.[5] Nurses are suggested as competent HCPs to deliver this support due to their expertise in preventative education.[3,7,8]

Ongoing support for HCPs

A variety of approaches are required to support HCPs to increase competence and confidence in the implementation of SMS skills. Follow-up support and training in the form of mentoring from experienced senior staff could be a useful strategy to adopt knowledge/skills over time.[7] Other strategies include innovative learning methods (e.g. online tool kits, webinars),[2,8] incorporating support into daily administrative activities (e.g. regular meeting agendas),[2] repeated opportunities for learners to practice skills (with standardized patients) and receive feedback from instructors.[9]

KEY KNOWLEDGE AND SKILLS

Evidence suggests that HCPs need to acquire knowledge and skills in three main areas to effectively deliver SMS to patients:

Behavioral Change

Competencies in psychosocial techniques and concepts implicating behavior change, including goal setting,[7,10] readiness (e.g. contemplation), stages of change (e.g. preparation to change),[7,10,11] motivation[7,11] and identification of peoples' strengths and current capabilities (e.g. self-efficacy).[7]

Person-centered Approach

Skills in communication and interactions (e.g. counselling, consultation)[7] to promote a person-centered approach including establishing an empathic relationship,[7,10,12] joint participation in decision-making[10,12] and empowering the voice of the person.[7,12]

Contextual

Capability to support specific populations (e.g. youth, mental health and addictions) and flexibility to tailor interventions to peoples unique needs (e.g. health literacy)[12] through knowledge, collaboration and awareness of community resources.[7]

Barriers and facilitators

Table 1. Key barriers and facilitators to training

FACILITATORS
• Policy-level endorsement[2] • Supportive organizational culture[2,7] • Champions within the organization (e.g. director, senior management)[2,6] • Availability (e.g. multiple sessions) and accessibility of training (e.g. web-based component)[2] • Resources to support training (e.g. self-management guidelines, prompts for providers)[6] • Training factors embedded into operational structure (e.g. SMS strategies become a part of performance evaluation, time allocated in staff meetings)[2]
BARRIERS
• Limited knowledge and exposure to effective SMS skills and strategies at all levels of the health system[2] • Lack of buy-in from HCPs and administration for self-management training[7] • Lack of time to complete training[7] • Lack of time to adopt/execute approach with patients[3,7] • Low[13] or high perception of knowledge/skills in person-centered care can impact adoption of approach[3] • Perception that training is not relevant for all providers (low readiness to change practice)[7]

SPOTLIGHTS

There are an increasing number of SMS training programs in use for HCPs across the world, which emphasizes the important role HCPs play in SMS. Programs of training should be evidence-based and grounded in behavior change theory (e.g. Transtheoretical Model of Change (TTM), Capability, Opportunity, Motivation-Behavior (COM-B) model). The choice of training model depends on a range of factors, including HCP role and readiness to participate, context, and resources available.[9]

More detailed information on formalized training models (with the most evidence based on the review) and/or new emerging models are outlined to further understand the purpose, training methods and barriers/facilitators related to each approach.

5 A's Construct

5 A's (Assess, Advise, Agree, Assist and Arrange) is a framework for brief counselling[14] used by HCPs in consultation with their patients to develop a personalized plan that includes specific behavioral strategies to encourage patients to set goals, outline barriers to reaching goals and develop a plan of action.[13]

Content of training to deliver the 5A's construct includes motivational interviewing, facilitating problem solving, goal setting, action planning and ability to aid in empowerment.[12]

Training for providers should adopt adult learning principles by being interactive, offer opportunities to practice new skills, and provide reinforcement and mentorship strategies.[12] Identification of champions to support implementation of the 5A's construct model as well as print resources (e.g. posters and pocket cards) may be useful to promote use of skills within practice.

The model is judged to have support[6] and is considered a best practice approach for providing SMS.[13] It has been widely endorsed as the framework for behavioral counselling in primary care. Briefer interventions such as the 5A's (i.e. those that can be delivered in 3-5 minute sessions) may be more attractive to busy clinicians, and require less expertise to administer. A limitation to this approach is that person-centered communication skills to promote collaboration and empowerment may not be adequately captured in the 5A's alone.[14] As well, further evidence and follow-up is suggested to examine if this approach is effective for improving patient outcomes.[12]

Motivational Interviewing (MI)

Motivational Interviewing (MI) is a person–centered method of communication used throughout SMS with the goal of enhancing motivation to change behavior by exploring and resolving indecision.[15]

Models of training to develop skills in MI vary, but the majority of HCPs learn through self-study or in a brief workshop (1 to 2 hours).[13] Although relatively easy to administer, brief trainings such as these merely scratch the surface of MI, and require repeated practice with feedback and encouragement from knowledgeable trainers to increase comfort and use of the technique.

Those wanting to expand their skill set would need to undergo further training which focuses less on educational material and more on practice exercises including video recordings, digital audio, telephone, online and in person approaches.[2] Additionally, more advanced training and competence with the model may not be appropriate for all members of the HCP team (e.g. due to scope of practice, role in team), therefore it may not be a viable training framework for an entire team.[2]

Training is typically designed to address the guiding principles of MI including: expressing empathy, developing discrepancy, rolling with resistance, avoiding argument, and supporting self-efficacy.[16]

Evidence suggests that training should be delivered by a skilled HCP who is trained in MI or a behavioral health professional.[4]

Strategies to embed training in HCPs include repeated practice to aid in skill development and comfort of use, as well as feedback from those with proficiency in the model (e.g. MI trainer).[13]

MI as a counselling tool can be effective in short encounters (<15 minutes), yet the "dose" of effectiveness alters based on individual patient factors.[13] Some studies show great efficacy when combined with other models (e.g. part of the 5A's Construct).[12] The targeted behavior or outcome can also impact the effectiveness of this method. In one study it was found that positive effects were present in some areas (e.g. body mass index, quality of life)[13, 17] and not in others (e.g. cigarettes per day),[13] yet there is variability across the evidence.

Health Coaching

Health Coaching is an emerging approach in which trained individuals of varied backgrounds apply behavior change principles (e.g. readiness to change, empowerment, and self-regulation)[13] to assist patients with adhering to treatment and lifestyle recommendations.[1]

A wide range of definitions of health coaching exist, and within the literature there is lack of agreement on what health coaching actually entails, what the role of the coach is, and what background and training are required for competence.[12]

A systematic review showed that training often includes educating coaches in behavioral change techniques, communication skills, and patient-centered approaches.[16] Trainees must also be trained in the self-discovery process to ensure they are facilitating patients to explore their own goals rather than dictating direction.[16] Often the training incorporates other models including 5A's[2] and MI.[16] Training intensity varies for Health Coaching (i.e. <2 hours to > 2 years) with a median of 6-40 hours.[16]

Unfortunately, the wide range of variability in evidence on training and lack of an agreed upon definition of what health coaching is, makes it difficult to determine whether it is an effective approach for health behavior change and in reducing the burden of chronic disease.[12]

EVIDENCE OF OUTCOMES

The majority of evidence related to SMS focuses on patient outcomes, rather than evaluating the fidelity (i.e. how well HCPs delivered the intervention) or comparative efficacy of different training approaches.[7] The lack of evaluation and description of training models makes it difficult to determine the most effective training to help support self-management.[7] That said, the most widely implemented and evidence-based training models available are the 5A's Construct and MI.[2] Other tools that have been developed and implemented such as Health Coaching[12] and 3 Minute Empowerment[13] lack evidence of effectiveness.[2]

METHODS

In consultation with the Primary Health Care team, MSSU refined the purpose of this review to focus on effective training models for HCPs to provide SMS.

A total of 17 articles were reviewed based on a selection of key, highly-relevant articles provided by the Primary Health Care team, in addition to a selective search conducted by the MSSU.

Information pertaining to specific models, methods or descriptions of approaches to training health care providers in supporting patients with self-management strategies were extracted and synthesized.

LIMITATIONS

This snapshot is not intended to be an exhaustive synthesis of the literature, but a high-level overview of the evidence related to the primary objective.

REFERENCES

1. Battersby M, Martin A, Hood C, Lawrence-Wood E, Lawn S, Misan G, et al. Educating future health care professionals to support people with chronic conditions to live better and live longer: A chronic condition self-management support tertiary education curriculum framework. Australia: Flinders Human Behaviour and Health Research Unit; 2007.

2. McGowan P. The challenge of integrating self-management support into clinical settings. *Can J Diabetes*. 2013; **37**(1):45-50.

3. Kennedy A, Gask L, Rogers A. Training professionals to engage with and promote self-management. *Health Educ Res*. 2005; **20**(5):567-78.

4. Jacobson D, Gance-Cleveland B. A systematic review of primary healthcare provider education and training using the Chronic Care Model for childhood obesity. *Obes Rev*. 2011; **12**(5):e244-56.

5. Schaefer J, Miller D, Goldstein M, Simmons L. Partnering in self-management support: A toolkit for clinicians. Cambridge, MA: Institute for Healthcare Improvement; 2009.

6. Whitlock EP, Orleans CT, Pender N, Allan J. Evaluating primary care behavioral counseling interventions: an evidence-based approach. *Am J Prev Med*. 2002; **22**(4):267-84.

7. NHS Education for Scotland. Supporting people to self-manage - Education and training for healthcare practitioners: A review of the evidence to promote dicusssion. Scotland: NHS Education for Scotland; 2012.

8. Massimi A, De Vito C, Brufola I, Corsaro A, Marzuillo C, Migliara G, et al. Are community-based nurse-led self-management support interventions effective in chronic patients? Results of a systematic review and meta-analysis. *PLOS ONE*. 2017; **12**(3):e0173617.

9. Hauer KE, Carney PA, Chang A, Satterfield J. Behavior change counseling curricula for medical trainees: a systematic review. *Acad Med*. 2012; **87**(7):956-68.

10. National Healthcare Charter You and Your Health Service Executive. Framework for self-management support, long-term health conditions. Ireland: Health Service Executive; 2012.

11. Vallis M, Lee-Baggley D, Sampalli T, Ryer A, Ryan-Carson S, Kumanan K, et al. Equipping providers with principles, knowledge and skills to successfully integrate behaviour change counselling into practice: A primary healthcare framework. *Public Health*. 2018; **154**:70-8.

12. Registered Nurses' Association of Ontario. Strategies to support self-management in chronic conditions: Collaboration with clients. Toronto, Canada: Registered Nurses' Association of Ontario; 2010.

13. BC Ministry of Health. Self-management support: A health care intervention. British Columbia: BC Ministry of Health; 2011.

14. Carroll JK, Fiscella K, Epstein RM, Sanders MR, Williams GC. A 5A's communication intervention to promote physical activity in underserved populations. *BMC Health Serv Res*. 2012; **12**(1):374.

15. Miller WR, Rollnick S. Motivational interviewing–second addition. New York, USA: Guildford; 2002.

16. Wolever RQ, Simmons LA, Sforzo GA, Dill D, Kaye M, Bechard EM, et al. A systematic review of the literature on health and wellness coaching: Defining a key behavioral intervention in healthcare. *Glob Adv Health Med*. 2013; **2**(4):38-57.

17. Rochfort A, Beirne S, Doran G, Patton P, Gensichen J, Kunnamo I, et al. Does patient self-management education of primary care professionals improve patient outcomes: A systematic review. *BMC Fam Pract*. 2018; **19**(1):163.

CONTRIBUTORS

This Knowledge Snapshot was developed by the Maritime SPOR SUPPORT Unit (MSSU) in consultation with Nova Scotia Health Authority (NSHA) Primary Health Care (PHC).

MARITIME SPOR SUPPORT UNIT (MSSU)

Julia Kontak, Knowledge Translation Coordinator

Liam Rowe, Research Assistant

Amy Grant, Senior Health Policy Researcher

Elizabeth Jeffers, Research Project Manager

NSHA PRIMARY HEALTH CARE (PHC)

Sarah Manley, PHC Operations Consultant, Behavior Change and Self-Management

Laura Wentzell, PHC Health Services Manager, Chronic Disease Management and Wellness

Shannon Ryan-Carson, Provincial PHC Director, Chronic Disease Management and Wellness

Tara Sampalli, Director of Research, PHC & Chronic Disease Management

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