

Happenings

Nursing the System in Chronic Disease Self-Management

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“Nursing took the lead” was the first comment that Maylene Fong¹ made when asked to describe the evolution of the Vancouver Coastal Health Authority’s Chronic Disease Management/Self-Management Support Learning project.

When the case management model in use appeared not to be meeting the needs of chronically ill patients, members of the multidisciplinary team began to consider ways to enhance client self-management (in the context of a chronic care model). A first step in effecting this change was to acknowledge that health authority staff from all disciplines would require an educational component, to enable them to move away from traditional approaches to care that were grounded in the medical model and in concepts of acute and episodic care.

The Particulars

Beginning in July 2006, the goal of this project was to develop a curriculum that would provide health professionals with the knowledge, attitudes, and tools to support clients in chronic illness management. A multidisciplinary team of experts from the Vancouver Coastal and Fraser health authorities and the Universities of British Columbia and Victoria worked collaboratively to develop e-learning modules, face-to-face workshops, a toolkit of resources, and an online discussion platform to support staff from medicine, nursing, social work, dietetics, and rehabilitation sciences in the adoption of a new approach to care and in the development of the requisite skills for its implementation. With guidance from the project advisory committee, this team developed and used a logic model for the project, which guided the development of competency statements, the curriculum itself, the learning activities, and the evaluation of outcomes. The entire educational process evolved between May

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2007 (pilot workshops) and March 2008; content and strategies for face-to-face educational sessions were continually refined based on the outcomes of the pilot workshops and the input of the learners.

Challenges

Concepts of collaboration, partnership, and client-directedness were at the core of this paradigm shift. One early challenge was to acknowledge and address the tension that arose between “deliverables” and the philosophy of client-centred care; for example, the label “noncompliant” (traditionally affixed in situations where clients do not produce the outcomes mandated or expected by health professionals) was inappropriate within the self-management rubric. Other implementation issues ranged from the practicalities entailed in the development of technical platforms for e-learning and online discussion to the time and energy requirements of learners engaged with the curriculum and the various learning tools.

Insights

An early pilot project within this innovation involved a group of diabetic clients who, with members of the multidisciplinary team, structured their diabetes education classes in a collaborative fashion. Members of the group *learned from each other* through goal-setting and through co-analysis of barriers and facilitators in diabetes management. Allowing clients to act as the experts in this context was a huge learning step for the health professionals engaged in the education process, and the insights gained formed the basis for the design of a workshop for self-care facilitators. This workshop, whose curriculum was based on research evidence from the implementation of chronic disease management models in other jurisdictions, was useful to health professionals in developing the attitudes, skills, and strategies needed to support client self-management.

Commitment

Ms. Fong made the point that management support within the health authority was critical to the success of the project. From inception through to evaluation, it was essential that care managers and senior administrators be aware of the philosophy underlying self-management and the concomitant learning needs of staff. In her role as a clinical nurse specialist, Ms. Fong was able to act as the point person for project implementation, ensuring that resources were available for staff to develop and test new strategies for goal-setting and co-management with clients. She also made it clear that traditional models of care — “medical,” “acute” —

were not being abandoned but, rather, were being augmented by self-management support.

This project is one of many across the country, all derived from the observation that chronic illness cannot be effectively managed within an interventionist framework. As is clear from the research reported in this issue of *CJNR*, chronic illness is multifaceted and complex and is not amenable to “magic bullet” approaches that lack grounding in a philosophy of client self-management. Furthermore, our disease-specific traditions of management (and indeed research) may have outlived their efficacy, as we increasingly realize that common themes and issues permeate the illness experiences of clients. As we incorporate the knowledge gained through research into program development and implementation, the implications for both health and research policy will need to be considered, debated, and discussed in the academic and public domains. Nursing leaders are in an ideal position to support and champion new approaches to the care of chronic illness because of their unique vantage point within the multidisciplinary context: they are able to appreciate the complexity of illness management from client and systems perspectives and to discern the implications for staff development and program delivery.

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