Health Literacy

Collaboration in interprofessional rehabilitation team

Learning outcomes

You are able to:

-Develop your understanding of interprofessional teamwork related to health literacy.
-Gather knowledge to understand the person-centred approach using the ICF framework with interprofessional rehabilitation team.
-Shared decision making
-Person-centred goal setting using SMART principles (GAS).
-Identify and support clients in limited health literacy and self-care

Content

- Interprofessional collaboration
- ICF and Interprofessional person-centered gathering information
- Person Centered approach clients with LHL
- SMART
- Case example

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Interprofessional collaboration

- The process of rehabilitation is a standard problem-solving process where the client is at the center (Rauch et al. 2008).

- According to the Wade (2020) the important features that characterize effective rehabilitation are as follows:
  - Basing the process on the biopsychosocial model of illness;
  - Having an **expert interdisciplinary team**, which uses structured protocols to ensure a consistent, comprehensive (holistic) approach.
  - Undertaking a comprehensive (holistic) initial (diagnostic) assessment to achieve a full understanding of the person's situation, both the factors that influence it and the factors that may determine interventions;
  - Using many different interventions tailored to the particular person;
  - Monitoring changes in the measures, assessing them against the objectives

- Effective communication is important for team building. Communication can facilitate or undermine collaboration at all levels of healthcare. Taking the patient's perspective into account is key issue (Paxine et al. 2020)

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Interprofessional collaboration built on

To Know others name and field of expertice

Appreciation of the work of others

Multidisciplinary identity

Shared goal and understanding

Know each other well

Common practices, meetings, reciprocity e.g. consultation

Communication

How information is shared

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(Packard et. al.2012; Paxine et al. 2020; van Dongen et.al. 2016 & 2018)

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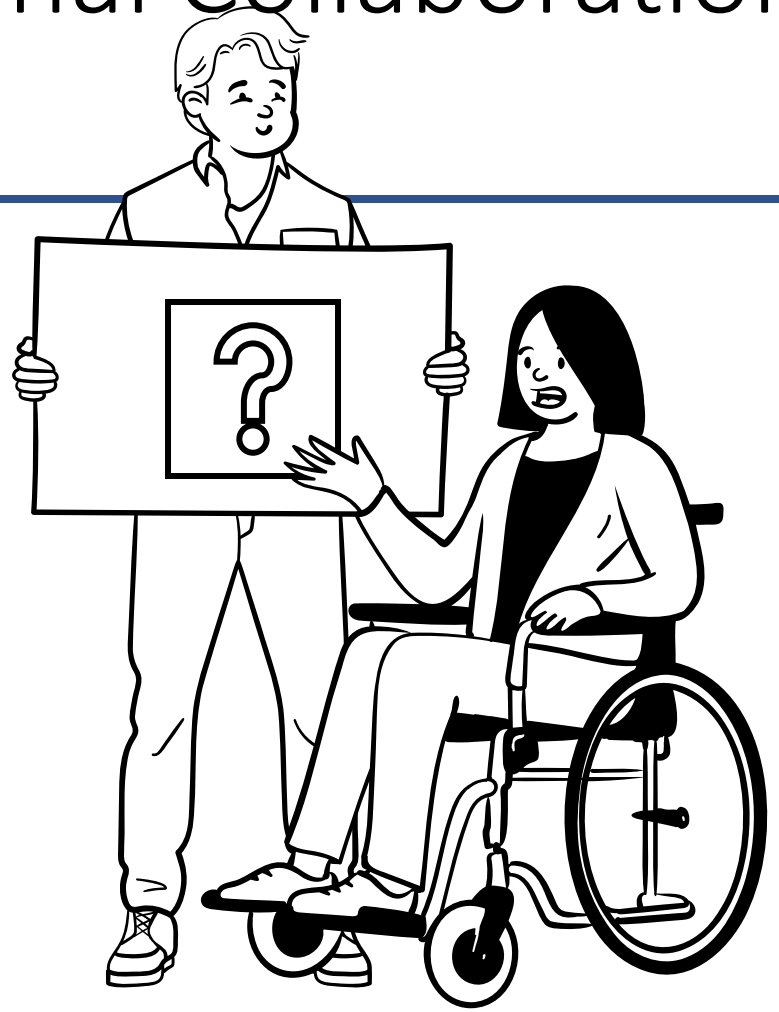
Interprofessional Collaboration built on

Jointly agree on the criteria for discussing clients, formulating goals and developing care plans

Specify what each team member hopes to contribute or gain



Organisational purpose and support (number of staff, working hours, practices)

Jointly create a goal on care and rehabilitation

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(Packard et. al.2012; Paxine et al. 2020; van Dongen et.al. 2016 & 2018)

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Creating secure and constructive team climate

My personal place in the team?

- ✓ Have trust in each other and give each other the necessary space and voice
- ✓ Recognice each other´s contribution
- ✓ Question each other without prejudge
- ✓ Confront each other

How do we interact?

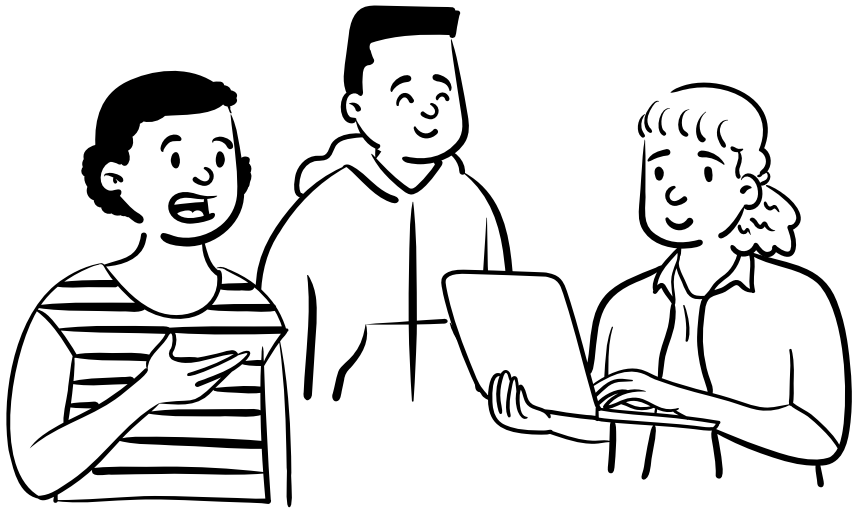
- ✓ Jointly agree on rules concerning interaction and communication
- ✓ Create a sense of belonging
- ✓ Evaluate regularly the teams´s collaboration
- ✓ Apply the rules for giving and receiving feedback
- ✓ Recognize other´s contribution to the group process

(Packard et. al.2012; Paxine et al. 2020; van Dongen et.al. 2016 & 2018)

How do we negotiate

The underlying framework to discuss patients´ functioning

Which steps to follow during the meeting

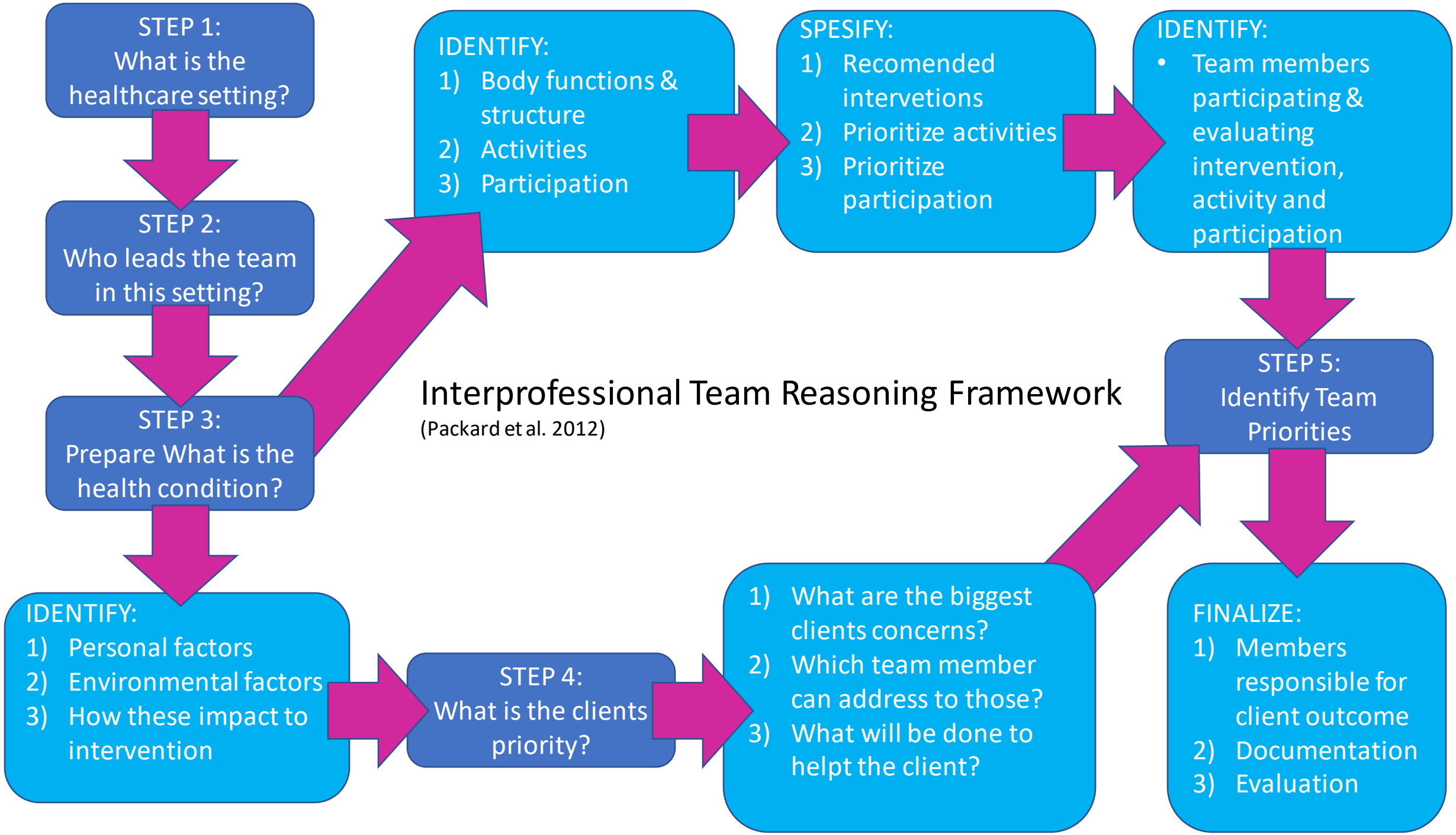


Everyone is preparing for the meeting

Everyone role during the meeting: chairperson, minutes taker, coordinator, participant

Recognize and acknowledge one´s own, and each other´s role

(Packard et. al.2012; Paxine et al. 2020; van Dongen et.al. 2016 & 2018)


STEP 1:
What is the healthcare setting?
STEP 2:
Who leads the team in this setting?
STEP 3:
Prepare What is the health condition?
IDENTIFY:
1) Personal factors
2) Environmental factors
3) How these impact to intervention
STEP 4:
What is the clients priority?
1) What are the biggest clients concerns?
2) Which team member can address to those?
3) What will be done to helpt the client?
IDENTIFY:
1) Body functions & structure
2) Activities
3) Participation
SPESIFY:
1) Recomended intervetions
2) Prioritize activities
3) Prioritize participation
IDENTIFY:
• Team members participating & evaluating intervention, activity and participation
STEP 5:
Identify Team Priorities
FINALIZE:
1) Members responsible for client outcome
2) Documentation
3) Evaluation
Interprofessional Team Reasoning Framework
(Packard et al. 2012)

SMART goal setting

- Goal attainment scaling (GAS) is a structured approach to recording goal achievement and for evaluating the attainment of goa ls. It was first introduced by Kiresuk and Sherman in the 1960s. (Boven`Eerdt et al. 2009)
- An important feature of GAS is a ´prior goal´ which is agreed with the client/patient and family/relatives before the intervention. Each sub-goal is rated on a 5-point scale, with the degree of attainment captured for each goal area. There is evidence that goals are more likely to be achieved if clients/patients are involved in setting goals. Moreover, there is also evidence that GAS h as positive therapeutic value in encouraging the clients/patients to reach their goals. (Turner-Stokes 2009)
- One particular question is 'how should one write and specify a goal?'. It is generally agreed that a good goal is:

S = specific

M = measurable

A = achievable

R = realistic/relevant

T = timed.

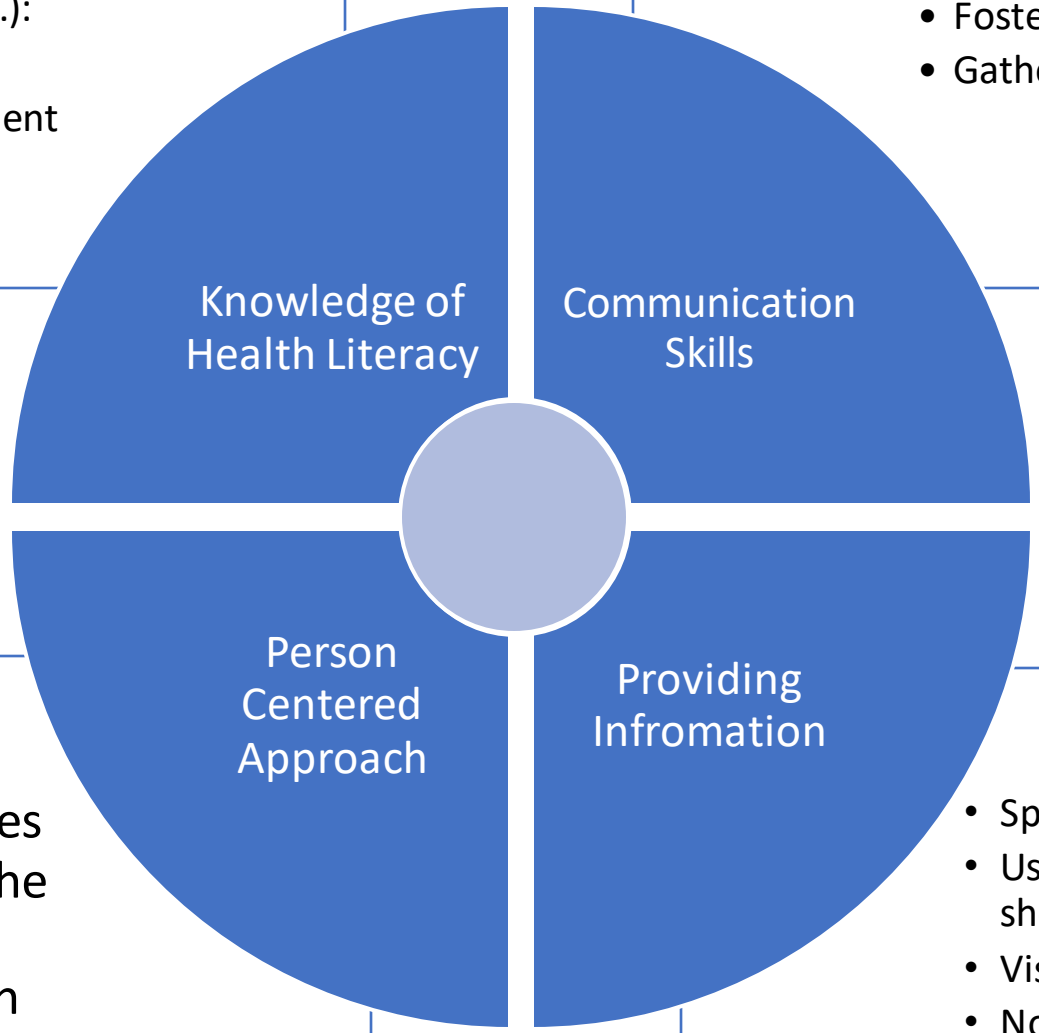
(Boven`Eerdt et al. 2009)

- In the context of setting specific and measurable goals it is easiest to focus upon behaviours concerned with activity and participation. The behaviour should be specified as clearly as possible: 'walking indoors' rather than 'mobilizing', and 'cooking a three-course meal 'rather than 'preparing food.' (Turner-Stokes 2009) .

Person centered approach, clients with LHL

- Understanding typical signs of limited health literacy (f.ex.):
  - Missed appointments
  - Nonadherence in treatment programs
  - Incompleted forms

- Shared desicion making
- Fostering the relationship
- Gathering information



- Person centered approach emphasizes the importance of the reciprocity of communication with the person or client

- Speaking slowly
- Using plain language and short sentences
- Visualization
- Non-verbal communication

(McCormack and McCance 2017; Paxino, Denniston, Woodward-Kron & Molloy 2022; Verlinge et al 2012.)

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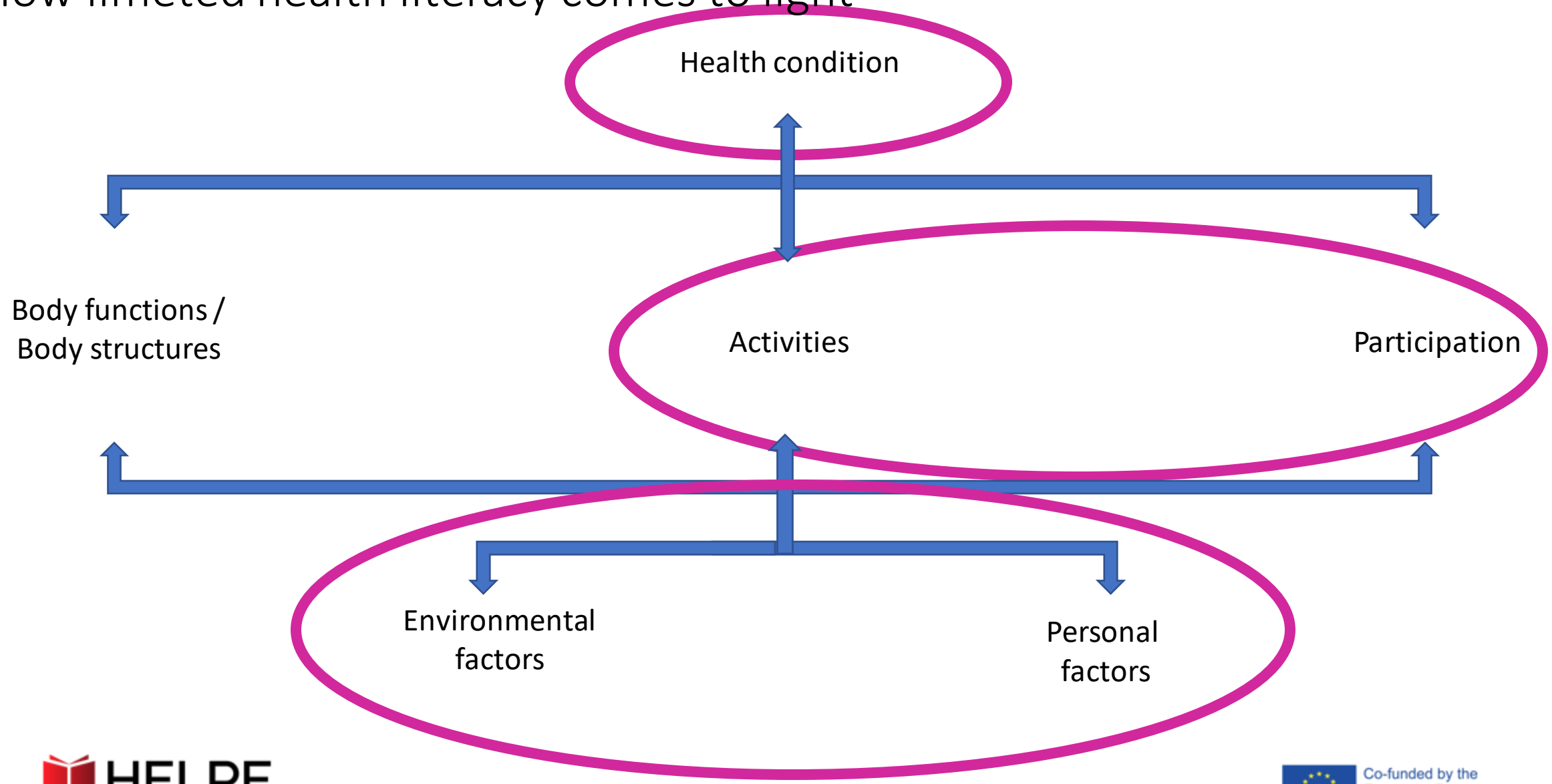
The ICF biopsychosocial model of functioning and disability
How limeted health literacy comes to light



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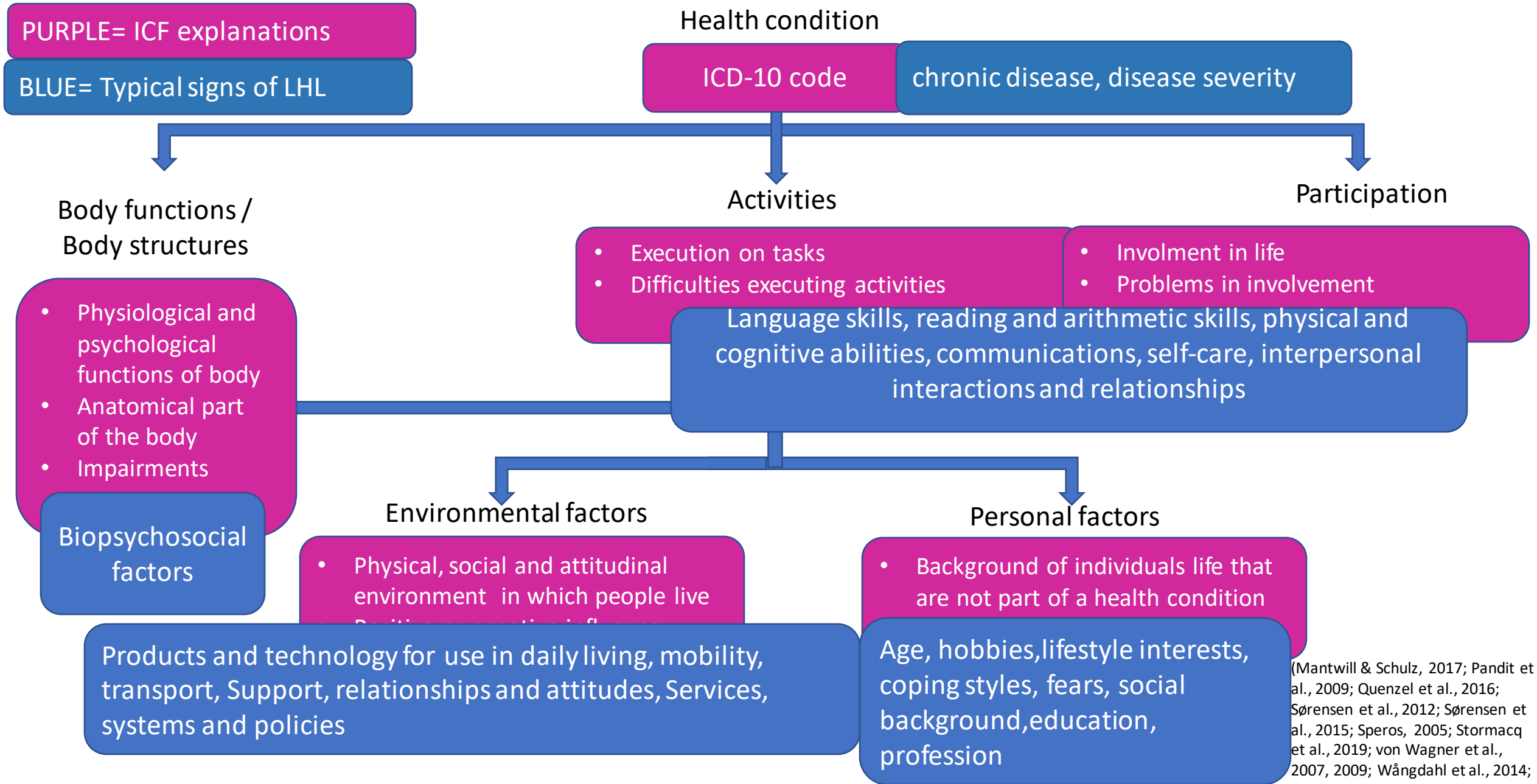
The ICF biopsychosocial model of functioning and disability with LHL



(Mantwill & Schulz, 2017; Pandit et al., 2009; Quenzel et al., 2016; Sørensen et al., 2012; Sørensen et al., 2015; Speros, 2005; Stormacq et al., 2019; von Wagner et al., 2007, 2009; Wångdahl et al., 2014;

Case Example Mary 53 years

- The client Mary is a 53-year-old cleaner. She lives with her husband on the 3rd floor of an apartment building with a lift. She has been on temporary disability pension for six months because she is waiting for knee replacement surgery.

- Social history: The client has adult children. Her son has been experiencing financial difficulties and Mary has provided him with financial assistance. She also has elderly parents who need help with daily living. Nowadays she spends all her free time with her husband at home. In their spare time, they watch television. Mary has a mobile phone which she uses to contact health professionals and other people. She does not have a computer.

- Medical history: Mary has hypermobility syndrome, which is diagnosed when she was under 40. She has osteoarthritis of the joints, particularly pain in her shoulders, wrist and fingers. In her right knee joint, the osteoarthritis has progressed to the point where she is facing knee replacement surgery when her weight drops. Maria weighs 92 kg height 162cm BMI 35 (severe obesity), waist circumference 98 cm. She will have knee replacement surgery when she has lost 20 kg. Joint pains interfere with sleep at night. Sleep is intermittent, wakes up at night. Her husband says she snores, so sleep apnea is suspected. Daytime fatigue and difficulty concentrating. Movement has been limited due to pain, she uses crutches and knee brace. He has to take painkillers every day. Blood pressure 175/95. She is on medication for high blood pressure, but she takes medicines when she remember.

- She has accumulated excess weight in adulthood. Tried different diets, where the weight went down, but after the diet the weight went back up again. She has received advice from health professionals on diet and exercise but has preferred to try diets such as weight watchers, Cambridge diet, crepe-fruit diet, Atkins diet, carp diet. She finds it very difficult to walk or exercise because of the pain. She has failed to go to agreed health checks

The ICF biopsychosocial model and signs of LHL – Case Example Mary

Fullfill boxes based on your case description

ICD Joint hypermobility syndrome

Possible signs of LHL
Level of education, no computer, tried diets, forgotten appointments, forgotten appointments

Body functions / Body structures

Pain, oedema, poor muscle strength overweight, sleep problems, fatique, blood pressure

Activities

Participation

difficulty concentrating in daily activity general task Mobile phone, no computer, drive car, needs help with shopping bags, use crutches when walking in shopping centre or outside, housework like cooking succeeds without help, needs help with vacuum cleaner, husband..

Environmental factors

temporary knee brace, crutches,, pain despite medication, no computer, apartment-house 3. floor with elevator, lives with husband, who helps with housework vacuum cleaner, carrying, health care professionals

Personal factors

Mary 53 years old female, cleaner for 30 years, invalidity pension temporary. She likes her job and colleagues. She spends all her free time with her husband at home watching tv. She is motivated to lose weight. Poor physical condition

Case Child Laura

Laura is 12 years old white Finn and has been gaining weight since she was very young. She has always been a bit bigger than her friends of the same age. Laura thinks part of the reason she continued to gain weight is because she started eating recklessly after her mum and dad split up and when her grandmother died. The parents have joint custody and Laura and her younger sister live alternately one week with their mother and one week with their father. Mother has a dog that Laura likes to take care of.

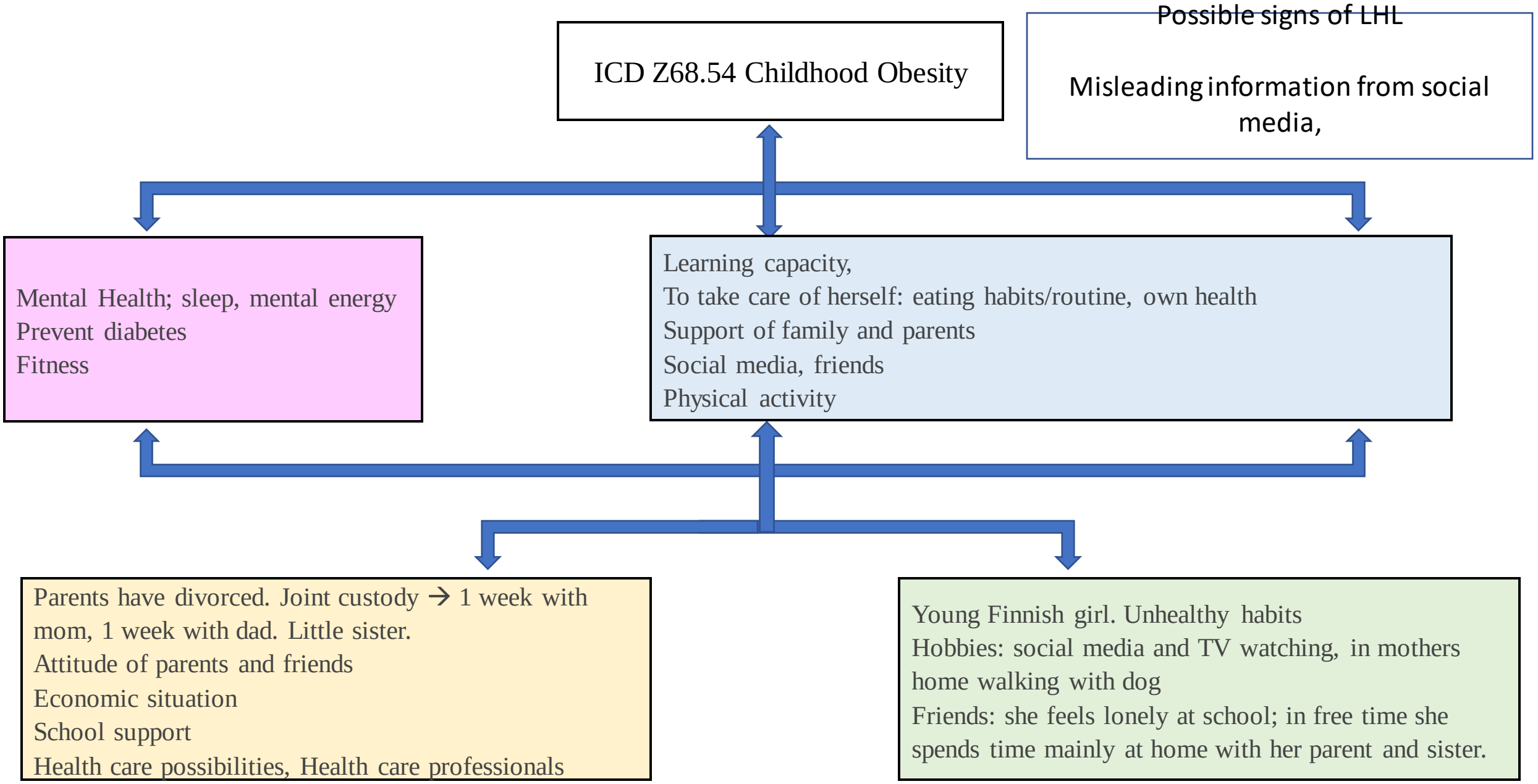
Laura says she has been bullied – called names – by other kids at school. Her mum made a complaint at the school, but Laura was embarrassed because the teachers told the bullies that she'd told on them, so now she prefers to try to sort it out herself (and if she can't, she tells her teacher).

She spend her free time with computer and mobile phone mainly chatting in social media. Very often she is up late with mobile or computer. She is very interested in following different social media influencers, weight programs that are not based in correct health information. She likes to eat snacks while spending time with computer or mobile phone.

Father is unemployed. Mother is a cleaner. Her parents like to watch tv during the evenings and eat snacks and fast food. These moments together with mother or father and sister are very important to Laura and she feels happy. They have no regular eating times during the day because single parents do a quite long hours in their work. Family members eat any time and what they like.

Both parents are overweight as Laura and her sister. Laura´s BMI is 28. Parents think that this is quite normal and explains that kids tends to be a bit chubby. The nurse of school has asked to come Health check appointment. Teacher has been worried because Laura has been tired during the school day. Does she sleep enough?

The ICF biopsychosocial model and signs of LHL – Case Laura



Interprofessional Collaboration Form (ICF)

Interprofessional Collaboration Form ("ICF") Modified in INPRO project

INTERPROFESSIONAL PERSON-CENTRED ASSESSMENT AND REFERRAL/DISCHARGE REPORT

1.	Facility:		
2.	Name / Mary	Gender:	female
	Folder no:	Date of birth (age):	53 years
	Address:	Occupation:	cleaner
	Tel:		

3. Current health problems / health conditions / health status *(including method of injury, onset, progression, previous treatment, medication)*

Headache

High Blood Pressure

Oedema and pain in knee joint because of hypermobility syndrome

Sleep problems

Overweight BMI 35

Medication: Painkillers, cortisone for inflammation

4. Medical history *(e.g. chronic diseases, previous episodes, previous injuries)*

Joint hypermobility syndrome that affects all her joints hips, ankles and knees.

Hip replacement surgery 5 years ago. She is waiting to have her knee repaired because of arthritis.

5. Social history *(e.g. social determinants of health, grants)*

Husband, adult children, old parents, colleagues

6. Outcome level:	5: Productive activity	4: Community reintegration	3: Residential integration	2: Physiological maintenance	1: Physiological stability	0: Physiological instability
Initial assessment Date:						
Discharge / Referral Date:						

7. Special investigations *(HIV, TB, X-rays, etc.)*

x-ray knee joint (arthritis)

8. Reason for referral *(if applicable)*

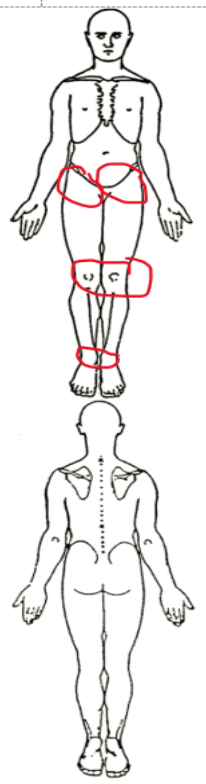
to lose weight because of health and to because of her knee operation. (She need to lose weight 20 kilos)

9. IMPAIRMENT: CHANGES IN BODY FUNCTIONS AND STRUCTURES

Guidance: Use the diagrams below to indicate relevant body impairment and use the space to describe impairment and the actions taken or needed.

CHANGES IN THE FOLLOWING BODY FUNCTIONS?
Mental functions
Sensory functions and pain
Voice and speech functions
Functions of the cardiovascular, haematological, immunological and respiratory systems
Functions of the digestive, metabolic and endocrine systems
Genitourinary and reproductive functions
Neuromusculoskeletal and movement-related functions
Functions of the skin and related structures

CHANGES IN THE FOLLOWING BODY STRUCTURES?
Structures of the nervous system
The eye, ear and related structures
Structures involved in voice and speech
Structures of the cardiovascular, immunological and respiratory systems
Structures related to the digestive, metabolic and endocrine systems
Structures related to the genitourinary and reproductive systems
Structures related to movement
Skin and related structures



Describe changes in body functions and structures	Actions Needed/Taken
pain and oedema in knee	
hypermobility in knee and ankle joints	
weak leg muscle strength, grip strength	
weight management functions:	
overweight (92 kg, BMI 35), Waist circumference 98 cm,	
sleep problems, sleep apnea	
headache	
fatigue during the day, concentration	
unhappiness	

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Interprofessional Collaboration Form (ICF)

10. FUNCTIONING

Describe the relevant life areas according to how the person performs during an assessment and/or how the person performs in his/her usual environments (e.g. home, school, community, work).

Domain	Performance (strengths & restrictions based on clients experience)	Actions Needed/Taken:
Learning and applying knowledge (listening, learning, focusing attention, thinking, making decisions)	difficulty concentrating in daily activity general task	
General tasks & demands (undertaking single/multiple tasks, carrying out daily routine, handling stress)		
Communication (receiving and producing messages: spoken, nonverbal, formal sign language, written, devices)	(-) mobile phone (+) no computer	
Mobility (changing and maintaining body position, carrying, objects, walking, moving using transport)	(+) drives a car, getting into the car by her self (-) needs help with shopping bags (-) use crutches when walking in shopping centre or outside 300 meters	
Self-care (washing oneself, caring for body parts, toileting, dressing, eating, drinking, looking after health)	(+) have made a lifestyle change (-) fluctuated weight in past years gaining and losing weight (looking after health) (+) a new eating pattern (managing diet and fitness)	
Domestic life (acquisition of necessities, place to live, goods, preparing meals, household tasks, assisting others)	(+) housework like cooking succeeds without help (-) needs help in vacuum cleaner and going to the store	
Interpersonal interactions and relationships (formal, family, intimate relationships)	(+/-) two adult children, worry about son, who cannot refuse paying son`s unexpected big bills resulting problems with own economy (-) Mary needs to help her old parents in housework	
Major life areas (education, work and employment, economic life)	comprehensive school	
Community, social & civic life (community life, recreation, leisure, religion, spirituality, human rights, political)	Would like to be active again (yoga, dance, spend time with friends)	

11. ENVIRONMENTAL FACTORS

Physical, social and attitudinal factors, external to the individual, that make it easier to function well (facilitators), or if present, are barriers to the way the person lives and conducts his/her life.

Domain	Facilitator (+) Barrier (-)	Actions Needed/Taken
Products & technology (for consumption (food, medication), for use in daily living, mobility, transport, education communication, employment, culture, etc.)	(+) temporary knee brace (+/-) crutches (-) pain despite medication (-) no computer	
Physical environment (neighbourhood, housing, sanitation, roads, light, noise, air quality, etc.)	(+) apartment-house 3. floor with elevator	
Support, relationships and attitudes (from immediate/extended family, friends, employer, health professionals, etc.)	(+) lives with husband, who helps with housework vacuum cleaner, carrying (+) health care professionals	
Services, systems and policies (health, housing, transportation, social security, labour, etc.)		

12. Personal factors (positive and negative) influencing health

Background of individual's life and living, which comprise features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, ideas, fears, expectations, social background, education, profession, past and current experience (past life events and concurrent events), overall behaviour pattern and character style, individual psychological assets and other characteristics, all or any of which may play a role in disability at any level.

Mary 53 years old female, cleaner for 30 years, invalidity pension temporary. She likes her job and colleagues

She spends all her free time with her husband at home watching tv.

She is motivated to lose weight

poor physical condition

13. PERSON-CENTRED GOAL SETTING AND SHARED DECISION-MAKING

Priority list / unresolved issues	Actions taken/needed

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Interprofessional Collaboration Form (ICF

13.	PERSON-CENTRED GOAL SETTING AND SHARED DECISION-MAKING	
	Priority list / unresolved issues	Actions taken/needed
	pain, sleep	medicine, respiratory support, self-management support
	lose weight (20kg) with eating habits and training for 6 months	regular eating and training, LHL methods: ASKme3, Chunk and check, Teach back etc
	sick leave arrangements, guidance to son, assistance for parents	information who to contact, use plain language, help with filling in the forms etc

14	Name of Health Professional(s)	Signature	Professional number	Date and time:

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