**Health Education Proposal for Healthcare Professionals**

**Introduction**

 Diabetes has become one of the leading causes of mortality and morbidity around the world.  According to the World Health Organization (WHO, 2017), in 2014, there was an estimate of 422 million individuals with diabetes around the world.  The global prevalence of the disease among adults 18 years and above has increased from 4.7% in 1980 to 8.5% in 2014, and the number of cases of diabetes has steadily risen in middle and low-income nations (WHO, 2017).  It is the leading cause of blindness, kidney failure, heart attacks, as well as lower limb amputations (WHO, 2017).  About 1.6 million deaths in 2015 were directly associated with diabetes and 2.2 million deaths were associated with elevated blood glucose.  This disease is projected to be the seventh leading cause of death by 2030 (WHO, 2017).

**Main Body**

 Based on the details above, there is a need to address the management and treatment of this disease.  The improved management and treatment of this disease can start with the improvement of the health education of health professionals about diabetes (Plumb, Plumb, Roy & Salzman, 2016).  There are identified gaps in diabetes knowledge among health professionals.  Some of these gaps include inadequate information transmitted to health professionals about current developments in the disease and its management (Golden, Hager, Gould, Mathioudakis, & Pronovost, 2018).  Other gaps also include failures in the coordination and collaboration of diabetes knowledge for nurses and medical practitioners (Golden, et al., 2018).  This has resulted to doctors and nurses having different perspectives on how the management of diabetic patients can be carried out.  There also seems to be a disconnection between public health and hospital and/or clinical based management (Golden, et al., 2018). Moreover, nurses and medical professionals are also not fully informed about the evidence-based knowledge and practice which can be applied for patients (Golden, et al., 2018).  In order to improve diabetes education outcomes for nurses and medical professionals, there is a need to implement a collaborative diabetes educational program for nurses and medical professionals (doctors/physicians).

**Proposal: Collaborative diabetes educational program for nurses and medical professionals**

**Opportunities**

 This educational proposal is an opportunity to develop a standard nursing and medicine curriculum where the treatment and management of the disease would be developed and taught to both nursing and medicine students.  In this case, it is an opportunity for the boards of education in both nursing and medicine to come together to develop such a study guide.  This study guide would therefore include details about the disease which would then be taught to both medicine and nursing students.  An integrative practice among health professionals has been highlighted by Lown, McIntosh, Gaines, McGuinn, and Hatem (2016) as a means of promoting better collaboration between nurses and physicians in the actual practice when they finally are managing diabetic patients.  This shared curriculum would inform them about the duties of their fellow health professionals and what each health professional is expected to know and to do in managing diabetic patients (Plumb, Plumb, Roy & Salzman, 2016).  This curriculum would provide an opportunity to include details on patient-centered care, with a focus not just on the symptoms of the disease, but on how the patients must be feeling following their diabetes diagnosis (Plumb, Plumb, Roy & Salzman, 2016).  Stone and Knowles (2015) highlight how the curriculum would also provide a chance to include lessons on how rapport can be established with patients and how communication skills can be improved.  The curriculum must also include instructions for health professionals on which support groups are available in the vicinity of patients (Plumb, Plumb, Roy & Salzman, 2016).

 The curriculum would also provide an opportunity to inform the students on how they can work with each other in developing an efficient plan of care for diabetic patients (Plumb, Plumb, Roy & Salzman, 2016). Potentially, the curriculum has to include a liaison committee which would work with the boards of education in nursing and medicine, helping to establish open lines of communication between the nursing boards and medicine boards (Sanders, Singh, and Braun, 2018).  The curriculum change would also present an opportunity for the educational boards in both nursing and medicine to include community immersions, with shifts for nursing and medicine students who would be required to monitor and manage community-based diabetic patients (Sanders, Singh, and Braun, 2018).

**Challenges**

 There are major challenges in implementing such a curriculum.  For one, it would be a difficult challenge to develop a curriculum which can work for both the nursing and medicine profession and education (Byrne, Davies, Willaing, Holt, Carey, Daly & Peyrot, 2017).  While both professions are in the medical fields, their approach to healthcare is different (Paradis & Whitehead, 2015).  The two educational curriculums for either profession cannot simply be meshed or blended with each other.  Byrne and colleagues (2017) acknowledge that the challenge would be on how to blend the curriculums in such a way as to make the change appear seamless while also ensuring that each profession has its specific role to play in the management of diabetic patient.

 Another challenge is on how to implement this curriculum on a nationwide scale.  The curriculum may not be accepted by the boards of education for either profession and it would have to undergo screening and assessment by the different universities and colleges (Mwangome, Geubbels, Klatser & Dieleman, 2016).  Another challenge is on who will teach this improved curriculum on diabetes education.  Dalcól, Garanhani, Fonseca and Carvalho (2017) mention that the teachers who would be recruited would have to have a background in both the medical and nursing field in order to make the curriculum change work.

 Still another challenge in implementing the new blended curriculum is on how to designate boundaries in responsibilities and accountability between the nurse and the physician in actual practice (Williams & Webb, 2015).  As the responsibility in caring for the diabetic patient would now fall on both nurses and doctors giving joint and collaborative care for the patient, there is a question now on what and who would be considered accountable for possible errors or issues in medical care (Williams & Webb, 2015).  It is important to define such boundaries in order to establish better lines of authority and collaboration between two medical professions administering care (Williams & Webb, 2015).

**Barriers**

 The barriers to the implementation of change of format of education for nurses and physicians would be first noted in the difficulty in overcoming resistance from nurses and physicians, the difficulty in finding visionary leaders who can reframe the healthcare practice to accommodate the curriculum change, and the difficulty in securing sufficient resources and personnel to implement the format change (Baid & Hargreaves, 2015).   The first barrier would be an expected one especially with nurses and physicians having a poor attitude towards working collaboratively with each other (Paradis & Whitehead, 2015).  The second barrier would be related to the first barrier, but would be observed mostly in the difficulty of finding visionary leaders who can actually implement and lead the change in the curriculum (Baid & Hargreaves, 2015).  The last barrier would be noted in the implementation of the change in curriculum where changes health education would have to be made and those involved in the academic change would have to adopt a collaborative attitude to the new learning and the new style of managing diabetic patients (Baid & Hargreaves, 2015).

**Options to reframe education**

 In reframing health education, the boards of education for the different allied medical courses must work together from the very start.  While this paper recommends the integration of nursing and medical education, there is a need to actually expand the integration to encompass other medically-related courses (Plumb, Plumb, Roy & Salzman, 2016).  The integration can include pharmacy, radiotherapy, physical therapy, and other related medical courses (Plumb, Plumb, Roy & Salzman, 2016; Plumb, Plumb, Roy & Salzman, 2016).  The reframing would not represent a complete change in the health education system, but the inclusion of collaborative areas where the different students of the health profession can meet and understand each other’s work and role in the healthcare system.  The option for reframing health education must also be based on a community-based approach (Thistlethwaite & Jackson, 2016; Plumb, Plumb, Roy & Salzman, 2016).  Where more doctors, nurses, and other medical professionals are immersed, from the very start of their health education in the communities, the general population is also more likely to be engaged in health-related activities (Thistlethwaite & Jackson, 2016; Plumb, Plumb, Roy & Salzman, 2016).  All too often, health education is confined to the schools and hospital/clinical setting (Plumb, Plumb, Roy & Salzman, 2016). When medical and healthcare students graduate, their practice is also confined to the clinical setting (Thistlethwaite & Jackson, 2016).  There is a need to reframe that practice by starting with a reframing of the health education into a more community-based practice or at least a more holistic and patient-centered practice.

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