**Assessment criteria for in-class group work by educators**



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| Date |  |
| Subject |  |
| Students’ names and surnames |  |
| Educator's name and surname |  |
|  |  |
| Total points |  |
| Final grade |  |

### Assessment criteria for in-class group work by educators

| **Learning outcome** | **Insufficient level of achievement**  **1** | **Moderate level of achievement**  **2** | **Good level of achievement**  **3** | **Points** |
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| **BC5.1** Assess the person's behaviour in self-management using appropriate measures | The group does not *know how* to assess self-management behaviours using appropriate measures. | The group *knows how* to assess self-management behaviours, by listing measurement approaches appropriate for specific target behaviours (e.g., medication adherence questionnaires, physical activity questionnaires, dietary questionnaires, wearables data). | The group *knows how* to assess self-management behaviours, by explaining how to apply and interpret measurement approaches that are appropriate for specific target behaviours (e.g., explaining how open questions are used in an interview; explaining how to use a pedometer to gain insights on physical activity; explaining how to use the medication adherence report scale - MARS). |  |
| **BC5.2** Compare actual versus desirable health behaviours to identify self-management needs, based on assessment data | The group does not *know how* to compare actual versus desired health behaviours to identify self-management needs, based on assessment data. | The group *knows how* to compare actual versus desired health behaviours to identify self-management needs, by interpreting assessment data and identifying a gap in relation to the desired behaviour (e.g., interpreting pedometer readings and identifying a gap in relation to step count recommendations; interpreting the results of dietary questionnaires in relation to eating recommendations for a chronic disease). | The group *knows how* to compare actual versus desired health behaviours to identify self-management needs, by interpreting assessment data and having the knowledge about the desirable health behaviour (e.g., interpreting pedometer readings and stating what are the recommendations for step count; interpreting the results of dietary questionnaires and stating what are the diet recommendations for a chronic disease). |  |
| **BC6.1** Generate with the person opportunities for behavioural change | The group does not *know how* to create with the person opportunities to change behaviour (e.g.,1 no knowledge on appropriate questioning, listening and reflective responding); (e.g., 2 wrong conceptions, such as suggesting closed-questions to start a talk, suggesting leading or directive questions, being unable to list active listening strategies). | The group *knows how* to use communication to generate with the person opportunities to change behaviour but lacks knowledge on techniques to initiate health behaviour change talk (e.g., knowledge on appropriate questioning, listening and reflective responding but unable to list preferred techniques to initiate health behaviour change talk). | The group *knows how* to use communication to generate with the person opportunities to change behaviour and has knowledge on techniques to initiate health behaviour change talk (e.g., knowledge on appropriate questioning, listening and reflective responding, able to list a minimum of one of the preferred techniques to initiate health behaviour change talk: person-initiated discussion; direct questioning, non-personalised initiation). |  |
| **BC6.2** Assess the extent to which the person wishes and is able to become co-manager of their chronic disease | The group does not *know how* to assess the extent to which the person wishes and is able to become a co-manager of his/her chronic disease (e.g.1 unable to list indicators related to capacities, feelings, beliefs or resources, including self-efficacy, health literacy); (e.g. 2 unable to list indicators related to things the person does, such as participating in shared decision-making, active information seeking about the condition, active self-management of the condition, participating in patient support or advocacy groups). | The group *knows* one or two of indicators related to the person’s wishes and ability to become co-manager of a chronic disease (e.g. 1 indicators related to ability, perceived control and feelings, beliefs or resources, including self-efficacy, health literacy); (e.g. 2 indicators related to things the person does, such as participating in shared decision-making, actively seeking information about the disease, actively self-managing the disease, participating in support or advocacy groups). | The group *knows how* to recognize a range of indicators (>2) related to the person’s wishes and ability to become co-manager of a chronic disease (e.g. 1 recognises capabilities, beliefs or resources, e.g. self-efficacy, health literacy); (e.g. 2 indicators related to things the person does, such as participating in shared decision-making, actively seeking of information about the condition, actively self-managing the condition, participating in support or advocacy groups). |  |
| **BC6.3** Demonstrate how to promote coping skills to manage the physical, emotional, and social impacts of chronic disease in everyday life | The group does not *know how* to promote coping skills to manage the physical, emotional, and social impacts of chronic disease in everyday life. | The group *knows how* to promote coping skills, by merely giving example(s) of coping strategies (e.g. creating a to-do-list, mindfulness). | The group *knows how* to promote coping skills, by giving examples of problem-focused and emotion-focused strategies relevant for the case (e.g. creating a to-do-list, changing behaviour). |  |
| **BC6.4** Assist the person to become co-manager of his/her chronic disease in partnership with professionals | The group does not *know how* to help the person to become a co-manager of his/her chronic disease in collaboration with health professionals (e.g., 1 share decision-making); (e.g. 2 empowering the person with resources for self-management, such as information and directions for support groups). | The group *knows how* to help the person to become a co-manager of his/her chronic disease in collaboration with professionals, by giving examples of at least one approach in practice (e.g., 1 shared decision making); (e.g. 2 empowering the person with resources for self-management), without being able to give examples of related communication skills (e.g. paraphrasing, parroting, open-ended questions). | The group *knows how* to help the person to become a co-manager of his/her chronic disease in collaboration with professionals, by giving examples of at least approach in practice (e.g., 1 shared decision making); (e.g. 2 empowering the person with resources for self-management), and related communication skills (e.g. paraphrasing, parroting, open-ended questions). |  |
| **BC7.1** Apply strategies to support the co-operative working relationship between the person and the professional | The group does not *know how* to use strategies to support a collaborative working relationship between the person and the professional (e.g. adapting the structure of the session to the person's needs avoiding negative interpersonal behaviours, such as impatience; overcoming relational barriers such as talking too much or too little; using the person's summaries to gauge understanding rather than 'teach and tell', solution orientation in the face of challenges, avoiding potential pitfalls such as judging, controlling). | The group *knows how* to use two strategies to support the co-operative working relationship between the person and the professional (e.g. adapting the structure of the session to the person's needs, avoiding negative interpersonal behaviours such as impatience; overcoming relational barriers such as talking too much or too little; using the person’s summaries to gauge understanding rather than “teach and tell”, solution orientation in the face of challenges, avoiding potential pitfalls such as judging, controlling). | The group *knows how* to use >2 strategies to support a collaborative working relationship between the person and the professional (e.g. adapting the structure of the session to the person's needs, avoiding negative interpersonal behaviours such as impatience; overcoming relational barriers such as talking too much or too little; using the person’s summaries to gauge understanding rather than “teach and tell”, solution orientation in the face of challenges, avoiding potential pitfalls such as judging, controlling). |  |
| **BC8.1** Demonstrate the importance of collecting holistic information about the person to tailor the behaviour intervention | The group does not *know how* to tailor a behaviour change intervention based on information about the person (e.g.1 information about behaviour determinants, such as knowledge about the disease and consequences of adopting/not adopting a health promoting behaviour, memory issues, beliefs about medication necessity, concerns about medication, impulses, stress/anxiety, social support); (e.g.2 information about the target behaviour, such as current step count or fruit intake) (e.g. 3 preferences and resources, such as affinity to new technology, possession of a mobile device, broadband connectivity). | The group *knows how* to tailor a behaviour change intervention based on limited information about the person, i.e. only one of the three examples below (e.g. 1 information about behaviour determinants, such as knowledge about the disease and consequences of adopting/not adopting a health promoting behaviour, memory issues, beliefs about medication necessity, concerns about medication, impulses, stress/anxiety, social support); (e.g. 2 information about the target behaviour, such as current step count or fruit intake); (e.g. 3 preferences and resources, such as affinity to new technology, possession of a mobile device, broadband connectivity). | The group *knows how* to tailor a behaviour change intervention based on comprehensive information about the person, i.e. at least two of examples below (e.g. 1 information about behaviour determinants, such as knowledge about the disease and consequences of adopting/not adopting a health promoting behaviour, memory issues, beliefs about medication necessity, concerns about medication impulses, stress/anxiety, social support); (e.g. 2 information about the target behaviour, such as current step count or fruit intake); (e.g. 3 preferences and resources, such as affinity to new technology, possession of a mobile device, broadband connectivity). |  |
| **BC8.2** Demonstrate how to assess behaviour determinants  through structured questionnaires, interview and other approaches | The group does not *know how* to assess behaviour determinants through structured questionnaires (e.g., Beliefs about medicines questionnaire, Basic Psychology Needs questionnaire, Fagerstrom test for nicotine dependence, regulation of eating behaviour scale), interview and other approaches. | The group *knows how* to assess behaviour determinants, by listing measurement approaches appropriate for specific determinants (e.g., Beliefs about medicines questionnaire, Basic Psychology Needs questionnaire, Fagerstrom test for nicotine dependence, regulation of eating behaviour scale), interview and other approaches. | The group *knows how* to assess behaviour determinants, by explaining how to apply and interpret measurement approaches that are appropriate for specific determinants (e.g., explaining how open questions are used in an interview; explaining how to use the Beliefs about Medicines questionnaire). |  |
| **BC8.3** Discuss opportunities and barriers that influence target behaviours in a person-centred fashion | The group is unable to *identify* and *discuss* behaviour determinants for a specific case (e.g., 1 individual determinants, such as knowledge about the disease and consequences of adopting/not adopting a health promoting behaviour, memory, beliefs about medication necessity, concerns about medication impulses, stress/anxiety); (e.g., 2 social support, health policy). | The group is able to *identify* behaviour determinants but does not *know how* to explain their influence in target behaviours in a specific case (e.g., absence of a safe place to walk near home or activity friendly communities may or may not be a barrier for physical activity, depending on the case). | The group is able to *identify* behaviour determinants and *knows how* to discuss their influence in target behaviours for a specific case (e.g., explaining how absence of a safe place to walk near home is not a barrier to physical activity as the person enjoys driving to the seaside). |  |
| **BC9.1** Recognise the person's views, knowledge and skills, developed through his/her experience with chronic disease, to aid prioritisation of target behaviours | The group does not *know how* to *recognise* the opinions and experiential knowledge and skills of the person to prioritise high or low level target behaviours (e.g. in a person with obesity prepared to walk more but not contemplating other modalities of physical activity, recommending resistance training instead of aerobic exercise, such as brisk walking). | The group *knows how* to integrate the person's views, knowledge and skills in a limited fashion to prioritise high or low level target behaviours (e.g. recognising that brisk walking is ideal in a person living with obesity who is prepared to walk more but recommending consultations with a nutritionist when the persons believes she has the knowledge and skills to manage her/his diet). | The group *knows how* to integrate the person's views, knowledge and skills to prioritise high or low level target behaviours (e.g. recognising that brisk walking is ideal in a person living with obesity who is prepared to walk more and accepting that a recommending a nutritionist is suboptimal when the person believes she has the knowledge and skills to manage her/his diet). |  |
| **BC10.1** Discuss behaviour change techniques (BCTs) addressing behaviour determinants (opportunities and barriers) with the person | The group is unable to *select* any BCT for a specific case. | The group is able to *select* one or more BCTs but does not *know* to *discuss* their alignment with behaviour determinants in a specific case (e.g., selecting “Information about health consequences” but being unable to explain that is adequate for a person in whom lack of knowledge is a barrier to changing behaviour). | The group is able to *select* one or more BCTs and *knows* how to *discuss* their alignment with behaviour determinants in a specific case (e.g., selecting “Information about health consequences”  and explain that is adequate for a person in whom lack of knowledge is a barrier to changing behaviour). |  |
| **BC10.2** Among BCTs addressing behavioural determinants, decide on which can included in the intervention plan, according to the person's views and resources | The group is unable to *provide* an example of *tailoring* BCTs that address behaviour determinants based on person's views and resources. | The group is able to *provide* one example of *tailoring* BCTs that address behavioural determinants based on a person's views and resources (e.g., action planning to address fatigue as a barrier to physical activity). | The group is able to *provide* two or more examples of *tailoring* BCTs that address behavioural determinants based on the person's views and resources (e.g., 1 action planning to address fatigue as a barrier to physical activity); (e.g., 2 information about health consequence to address lack of knowledge about the importance of physical activity). |  |
| **BC11.1** Demonstrate critical understanding of BCTs appropriate for brief or long-term behaviour interventions | The group is *unable* to appropriately *select* BCTs according to intervention length in a specific case. | The group is able to *provide* one example of a BCT *adequate* to intervention length in a specific case  (e.g., feedback on outcomes of behaviour for a brief intervention where multiple contacts are envisaged). | The group is able to *provide* two or more examples of BCTs *adequate* to intervention length in a specific case. (e.g., 1 feedback on outcomes of the behaviour for a brief intervention when multiple contacts are included); (e.g., 2 review behavioural goals for a long intervention). |  |
| **BC12.1** Apply behaviour change techniques according to the intervention plan | The group is *unable* to explain how to *apply* BCTs according to the intervention plan. | The group is able to *provide* an example of *applying* a BCT according to the intervention plan (e.g., when using feedback on behaviour, explaining how it can be operationalised across sessions). | The group is able to *provide* two examples of *applying* BCTs according to the intervention plan (e.g., 1 when using feedback on behaviour, explaining how it can be operationalised across sessions); (e.g., 2 when using review behaviour goals, explaining how it can be operationalised across sessions). |  |
| **BC12.2** Assess the person's target behaviour regularly using appropriate data collection approaches | The group does not *know how* to assess person's target behaviour using appropriate data collection approaches (e.g., medication compliance questionnaires, physical activity questionnaires, nutrition questionnaires, wearable device data, interview). | The group *knows how* to assess person’s target behaviour regularly, by listing appropriate measurement approaches (e.g., using medication adherence questionnaires, physical activity questionnaires, dietary questionnaires, wearables data across sessions). | The group *knows how* to assess person's target behaviour regularly by explaining how to apply and interpret measurement approaches that are appropriate for specific target behaviours (e.g., explaining how open questions are used in an interview, explaining how to use a pedometer to gain insights on physical activity; explaining how to use the medication adherence report scale - MARS across sessions). |  |
| **BC12.3** Demonstrate how to monitor the implementation of BCTs as part of the intervention plan | The group does not *know how* to monitor the implementation of BCT as part of the intervention plan (i.e., assessing whether the person is using the BCT or BCT bundle and whether it is working). | The group *knows how* to ascertain if the person is using the BCT or BCT bundle but is unable to *explain* ways to assess if BCTs are working (e.g., explains how they would inquiry if self-monitoring using a digital activity tracker was implemented but does not collect data to ascertain its potential effect). | The group *knows how* to ascertain if the person is using the BCT or BCT bundle and is able to *explain* ways to assess if BCTs are working (e.g., interpreting step count in a person that implements self-monitoring of behaviour via a pedometer). |  |
| **BC12.4** Demonstrate how to redefine the intervention plan as appropriate | The group does not *know how* to redefine the intervention plan in light of changes in behaviour determinants and/or results. | The group *knows how* to redefine the intervention plan but does not *take into account* all relevant information about the person (e.g., integrating only information about unsuccessful results without considering changes in behaviour determinants). | The group *knows how* to redefine the intervention plan considering all relevant information about the person (e.g., integrating information about unsuccessful results whilst considering changes in behaviour determinants). |  |
| **BC13.1** Plan the end of the intervention and the use of BCTs and resources beyond its end to promote maintenance of the target behaviour | The group does not *know how* to plan the end of the intervention (e.g., plan for the use of BCT and resources after the end of the intervention in order to maintain the target behaviour). | The group *knows how* to plan the end of the intervention but is not able to suggest self-enactable BCTs to promote maintenance of the target behaviour, i.e. BCTs that the person can use on her own, such as action planning, self-monitoring of behaviour, problem solving, partially aware of the resources that promote the maintenance and maintenance of target behaviour after interventions, but the group does not *know how* to recommend them. | The group *knows how* to plan the end of the intervention and is able to suggest self-enactable BCTs to promote maintenance of the target behaviour, i.e., BCTs that the person can use on her own, such as action planning, self-monitoring of behaviour, problem solving. |  |
| **BC14.1** Share information and adequate educational materials according to individual factors (e.g., knowledge gaps, health literacy level and preferences) | The group does not *know how* to select information and appropriate educational materials; according to individual factors (e.g., 1 suggesting a MOOC for a person with good internet usage and affinity to new tech); (e.g., 2 using paper-based infographics in a person without access to a computer or a mobile device); (e.g., 3 suggesting a website directed at a knowledge gap to a person with good digital health literacy). | The group is able to *list* available educational resources and materials but does not *know how* to tailor them to individual factors (e.g., 1 suggesting a MOOC for a person with good internet usage and affinity to new tech); (e.g. 2 using paper-based infographics in a person without access to a computer or a mobile device); (e.g. 3 suggesting a website directed at a knowledge gap to a person with good digital health literacy). | The group is able to *tailor* available educational resources and materials to individual factors (e.g., 1 suggesting a MOOC for a person with good internet usage and affinity to new tech); (e.g., 2 using paper-based infographics in a person without access to a computer or a mobile device); (e.g., 3 suggesting a website directed at a knowledge gap to a person with good digital health literacy). |  |