

Best Practice to Reduce ACH: Patient Self-Management through Planned Care



What is self-management?

“Learning and practicing the skills necessary to carry on an active and emotionally satisfying life in the face of a chronic illness.” (Lorig 1993)

Based on patient perceived concerns and problems



Chronic Conditions

- Chronic Conditions are now the leading cause of illness, disability, and death in the U.S. and affect the majority of elderly home health patients.
 - ◆ Affects the quality of life of 100 million Americans
 - ◆ Cause of 1.7 million deaths per year (7 out of 10 deaths)
 - ◆ 90% of the elderly have at least one chronic illness
 - › Approximately 77% have at least two illnesses
 - › 25% have 4 or more chronic illnesses



Self-Management Tasks

- Managing their health condition: diet, exercise, medications, treatments, self-testing, and record keeping
- Maintaining their functions and roles in life
- Dealing with the emotional demands of their conditions and their lives



“One cannot *not* manage”

- Patients are responsible for the day-to-day management of living with chronic illness
- If one decides not to engage in a healthful behavior or to not be active in managing their illness, this decision reflects a management style
- It is impossible to *not* manage one’s health, for better or worse



The Case for Self-Management Support

- Improved patient outcomes depend on correct diagnosis, correct treatment, and an ongoing series of healthy choices, behaviors and decisions by the patient.
- To be an informed, activated patient and make healthy decisions, patients need self-management support including:
 - ◆ Timely, accurate, understandable information
 - ◆ Involvement in collaborative decision making
 - ◆ Goal setting and problem solving
 - ◆ Help managing psychosocial issues



Benefits of Self-Management Support (SMS)

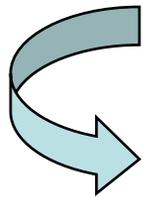
- Reduced hospitalizations up to 50%
- Reduced service demand
- Improved consumer and clinician satisfaction
- Improved health outcomes
- Improved medication adherence



Patient Education v. Self Management Support

Patient Education:

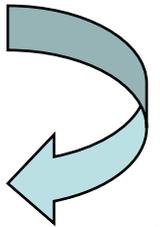
- Information & skills are taught
- Usually disease specific
- Assumes that knowledge creates behavior change
- Goal is compliance
- Healthcare professionals are the teachers



Gives information
Provide Tools

Self-Management Support:

- Skills to solve patient identified problems are taught
- Assumes that confidence (self-efficacy) yields better outcomes
- Goal is increased self-efficacy
- Teachers can be professionals or peers



Gets patient involved in
making day to day decisions

Key Principles



1. To know and understand one's condition;
2. To monitor and manage signs and symptoms of one's condition;
3. To actively share in decision-making with health professionals;
4. To adopt lifestyles that promote health;
5. To manage the impact of the condition on one's physical, emotional, and social life;
6. To follow a treatment plan agreed with one's health care providers.



The Clinician's Role: Support

- Emphasize the patient's central role in managing their illness.
- Assess patient self-management knowledge, behaviors, confidence, and barriers.
- Provide effective behavior change interventions and ongoing support with peers or professionals.
- Help patients understand their health behaviors and develop strategies to live as fully and productively as they can.



Elements of a Successful SMS Program

1. Collaborative problem identification

Patients & providers contribute their perspective and priorities in defining issues to be addressed by the clinical and educational interventions.

2. Targeting, Goal Setting, and Planning

Target the issues of greatest importance, set realistic goals, and develop a personalized improvement plan.



Elements of a Successful SMS Program

3. Continuum of self-management training & support services

Includes instructions in disease management, behavioral change support, exercise options, and interventions that target the psychosocial impact of chronic illness.

4. Active and sustained follow up



Behavior Change Principles

- Attitudes, Beliefs & Moods Matter: They matter in deciding to change a behavior, being successful in changing, & can directly impact health outcomes.
- Perversity Principle: If you are told what to do, it is likely that you will do the opposite.
- Self-Talk Principle: Your beliefs are more influenced by what you hear yourself say than by what others say to you.



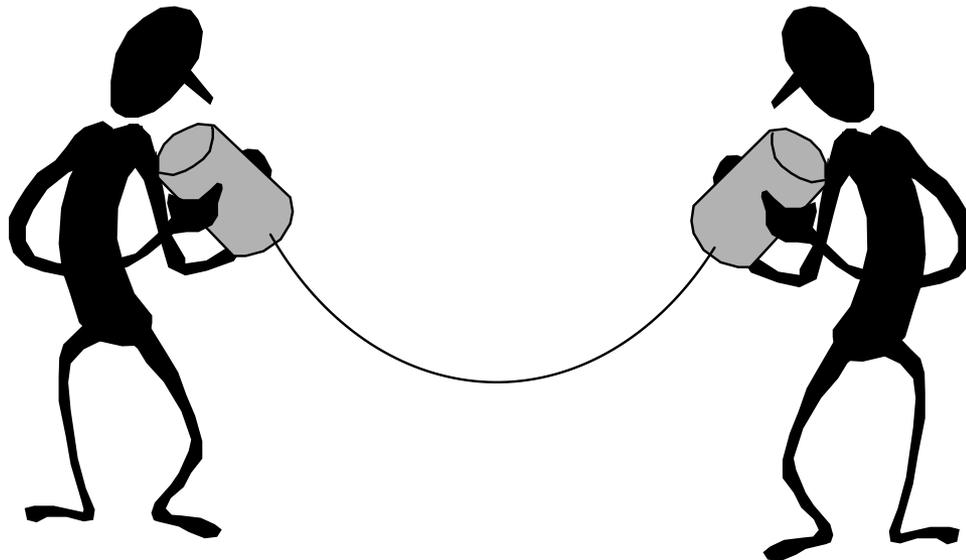
Behavior Change Principles (cont'd)

- Change Talk: Self-motivating statements made by patients
 - ◆ Recognition of an issue
 - ◆ Personal reasons for making a change
 - ◆ Potential consequences of current behavior
 - ◆ Hope of confidence about making a change



Communication

- Good communication skills and interview techniques, together with a clear understanding of the change being undertaken, are required by the clinician in order to begin the process of encouraging a patient to change their behavior.



Questions Can Be More Powerful than Answers

- What worries you most about your problem?
- What do you think might be causing your symptoms?
- What have you already tried to treat your problem?
- There are several alternatives, which do you prefer?
- Do you anticipate any problems with this treatment plan?
- So that I am sure I explained things clearly, can you tell me what you are going to do next?



Motivational Interviewing (MI)

- Introduced by William Miller and Stephan Rollnick in 1990s
- Patient-centered counseling style for eliciting behavior change which helps patients explore and resolve ambivalence
 - ◆ Acknowledges that patients both want and do not want to change
 - ◆ Patients can perceive the advantages and disadvantages of changing or continuing with current behavior



Communication Styles

Standard Approach

- Focused on fixing the problem
- Paternalistic relationship
- Assumes the patient is motivated
- Advise, warn, persuade
- Ambivalence means the patient is in denial
- Goals are prescribed
- Resistance is met with argumentation & correction

Motivational Interviewing

- Focused on patient's concerns and perspectives
- Collaborative partnership
- Interventions are matched to patient goals and readiness to change
- Emphasizes personal choice
- Ambivalence viewed as a normal part of the change process
- Goals are collaboratively set
- Resistance seen as an interpersonal pattern influenced by the clinician's behavior

Express Empathy

- Show interest and caring in understanding the patient's experiences
- Seek to understand the patient's frame of reference
- Use reflective listening:
 - ◆ Use open-ended questions to draw out the patient's feelings
 - ◆ Avoid "why" questions, as they imply judgment



Develop Discrepancy

- Help the patient see that some behaviors do not jive with their ultimate goals that are important to them
- Engage in discussion about present behavior and valued goals
 - ◆ Define what their most important goals are
 - ◆ What is he/she doing now that is contrary to those goals?

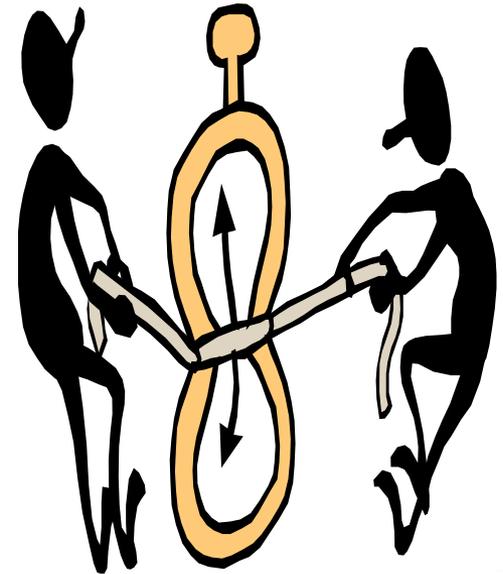


Roll with Resistance

- Explore both the positive and negative consequences of change or continuing the current behavior
- Acknowledge and respect the patient's concerns
- Invite new perspectives

Reduce resistance by:

- Using reflective statements
- Focus on building the relationship rather than the change
- Exploring concerns



Build Confidence

- Promote self-esteem.
- Promote belief in the patient's ability to do the skill needed, take the action needed...and stick with it!
- Focus on the patient's skills that show they can do the behavior.



What is a planned visit?

- A planned visit is an encounter with the patient initiated by the clinician to focus on aspects of care that are important to the patient.
- The clinician's objective is to deliver evidence-based clinical management and patient self-management support at regularly scheduled intervals.

To be effective, self-management education and support needs to be viewed as part of care and incorporated into each visit.



What does a planned visit look like?

- The clinician conducts a visit (30-40 minutes) to systematically review care priorities
- Visits occur at regular intervals as determined by the case manager and patient
- Each team member has clear roles and tasks
- Patient self-management support is the key aspect of care
- Encounters may be in person or via the telephone



Format of the Visit: The 5 As

Sequential series of steps to facilitate patient self-management and behavior changes (WHO, 2004).

1. **A**ssess knowledge, behavior, readiness
2. **A**dvice and inform
3. **A**gree on goals and methods
4. **A**ssist to overcome barriers
5. **A**rrange for follow up



ASSESS

Evaluate the patient's beliefs, behaviors, and knowledge:

- Ask the patient what they know about their illness(es)
- Use open ended questions
- Evaluate behavior changes and how the patient feels about this
- Ask what the patient most wants to discuss today
- Review the goals the patient has or that have been set previously



ADVISE

Provide personally relevant information about health risks and the benefits of change:

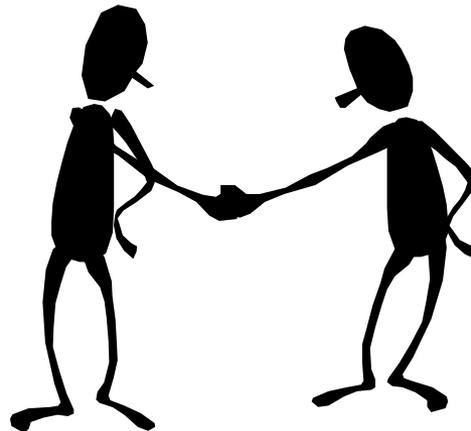
- Communicate that what the patient does is as important as medication
- Short statements with specific recommendations
- Ask what patient thinks about the recommendations

Ask Permission
Ask Understanding
Tell (personalize)
Ask Understanding

AGREE

Collaboratively set goals with the patient based on their confidence in their ability to change their behaviors:

- Ask the patient what he/she most wants to work on
- Ask what he/she thinks would be a reasonable goal
- Assess confidence level using a scale of 1-10
- Start when the patient has a confidence level of 7 or higher



Goal Setting & Action Planning

Self-Management: Healthy Changes Plan

Are you ready to make changes?

Your short-term goals or self-management goals are the small changes you can make over a short period of time that will help you reach your long-term goals for managing _____.

You and your home health team can work together better and plan the best ways to reach your health goals when you both know your plan for behavior change.

The healthy change I want to make is: _____.

I will do this (how):	
When:	
How often:	

The goal I will work on between now and my next visit is:

The steps I will take to achieve my goal(s) are:

The things that could make it difficult to reach my goal(s) are:

This is how I plan to overcome this barrier:

Support and resources I will need to reach my goal(s) are:

How confident are you that you can reach this goal?

Not Confident 1 2 3 4 5 6 7 8 9 10 Very Confident

MY ACTION PLAN

DATE: _____

I _____ (name) and _____ (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:

 _____ Work on something that's bothering me: _____

 _____ Stay more physically active! _____

 _____ Take my medications. _____

 _____ Improve my food choices. _____

 _____ Reduce my stress. _____

 _____ Cut down on smoking. _____

2. Choose your confidence level:
This is how sure I am that I will be able to do my action plan:



3. Complete this box for the chosen activity:

What: _____

How much: _____

When: _____

How often: _____

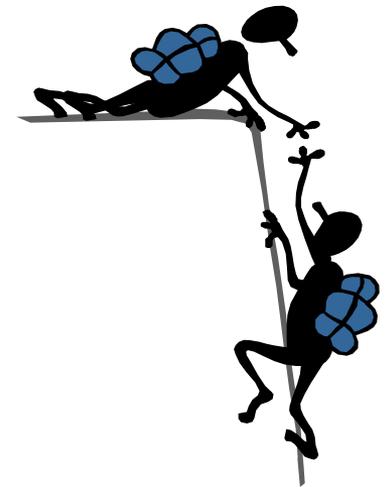
(Signature) _____

(Signature of clinician) _____

ASSIST

Problem solving with the patient by identifying personal barriers, strategies, and social/environmental supports:

- Ask patient what he/she sees as the greatest challenges to achieving the goal
- Ask what he/she has done in the past to overcome obstacles
- Teach problem-solving skills
- Include supports and resources to help with the goal and enhance confidence



ARRANGE

Collaboratively develop specific follow up plans to check on progress:

- Set specific date and time for the next encounter
- Negotiate an agenda for the next encounter
- Begin next contact/visit with review of progress on goal(s)
- Follow up on patient experiences with any referrals to community resources



Self-Management Transition

Self-management helps move people from being passive recipients of health services to becoming engaged and informed partners.



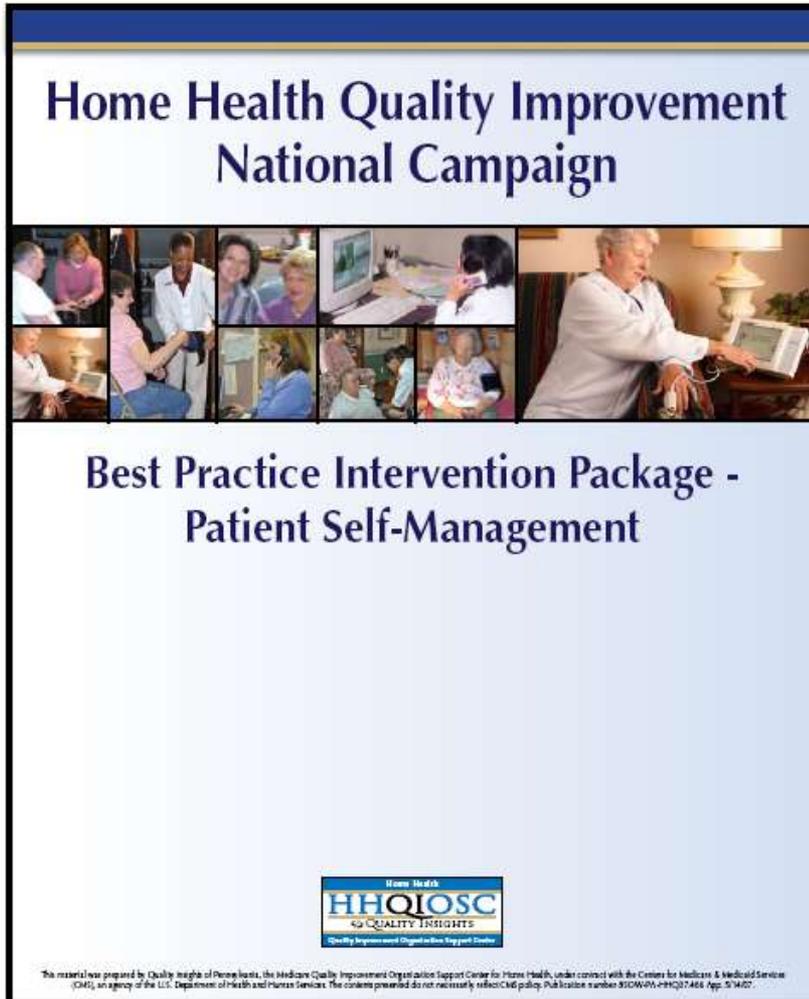
Resources

➤ New Health Partnerships
<http://www.newhealthpartnerships.org/>

➤ Planned Care Workbook
<http://www.masspro.org/HH/index.php>



Best Practice Intervention Package



The image shows the cover of a report titled "Home Health Quality Improvement National Campaign Best Practice Intervention Package - Patient Self-Management". The cover features a collage of photos showing healthcare professionals interacting with patients in home settings. At the bottom, there is a logo for "Home Health HHOIOSC 40 QUALITY INSIGHTS Quality Improvement Organization Support Center".

Home Health Quality Improvement
National Campaign

Best Practice Intervention Package -
Patient Self-Management

Home Health
HHOIOSC
40 QUALITY INSIGHTS
Quality Improvement Organization Support Center

The material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: HHCN-011-0007-0001, App. 5, 1/07.

- For more information related to Self-Care Management reference the Best Practice Intervention Package: Patient Self-Management
- Located at www.homehealthquality.org