Patient Self-Management Support
Help your patients help themselves!

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SELF-MANAGEMENT SUPPORT

What and Why?
What is Self-Management Support

**Self-management support** is:

the care and encouragement provided to people with chronic conditions and their families to help them understand their central role in **managing** their illness, make informed decisions about care, and engage in healthy behaviors.
How does it relate to GLPTN?

>> Milestone 4 of the Practice Assessment Tool

*Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.*

>> Phase Score Description:

0 = Not Yet
1 = Getting Started
2 = Implementing, partially operating
3 = Functioning, performing
Milestone 4 Goals

>> Phase 2 Goal

*Practice is training its staff in shared decision making approaches and developing ways to consistently document patient involvement in goal setting, decision making, and self-management.*

>> Phase 4 Goal

*Practice can demonstrate that patients and families are collaborating in goal setting, decision making and self-management (e.g. shared care plans, documentation of self-management goals, compacts, etc.)*
Why is self-management support important?

- Better outcomes
- Higher quality of life
- Lower costs
Shifting Mindsets – Start with your own

- Patient success = Practice success
- Your patients are teammates, not opponents
- Changing behavior is a marathon, not a sprint
- Logical solutions don’t solve emotional problems
- Assume positive intent
Why don’t patients do more for themselves?

- Passive wellness mindset
- Feel overwhelmed with options
- Don’t believe they can change
- Over-committed/No time or energy
- Consequences are theoretical, not real
- Rebellion
- Just don’t know better
Passive wellness mindset
Feel overwhelmed with options
Don’t believe they can change
Over-committed/No time or energy
Consequences are theoretical, not real
Rebellion
Just don’t know better
Engage
Simplify
Encourage
Prioritize
Visualize
Ask
Educate
SELF-MANAGEMENT SUPPORT

How?
Educate

Use evidence-based decision aids to inform patients of risks and benefits of options in preference-sensitive conditions

- Web search for “Decision Aids {condition}”

Routinely share test results, along with appropriate education about implications of those results

Provide condition-specific chronic disease self-management support programs or coaching or link to those programs in the community

- YMCA Diabetes Prevention Program
- Kidney Smart classes
Educate

>> Educate patients and families on health care transformation using appropriate language so they can be active, informed change agents

• Avoid jargon!

• “The Patient-Centered Medical Home is responsible for providing for all of your health care needs or arranging care with other health care providers.”
Engage

>> Provide a pre-visit development of a shared visit agenda with the patient
  • Ask Me 3

>> Use tools to assist patients in assessing their need for support of self-management
  • Patient Activation Measure
  • How’s My Health
Engage

Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as

- **Teach Back**
  https://www.youtube.com/watch?v=bzpJJYF_tKY
- **Goal setting with structured follow-up**
  https://www.youtube.com/watch?v=nP1blg7qc9o
- **Action Planning**
  https://www.youtube.com/watch?v=bvWkIe1pNTk
- **Motivational Interviewing**
  https://www.youtube.com/watch?v=IIIWlhrjLpc
Engage

>> Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR


>> Ensure patient leaves the office with care plan in hand
Support

>> Provide peer-led support for self-management
   Web search “chcf.org Building Peer Support Programs”

>> Provide group visits for common chronic conditions

>> Provide coaching between visits with follow-up on care plan and goals
   https://www.youtube.com/watch?v=nP1blg7qc9o
Team Approach

>> Train staff in self-management goal setting
>> Train staff in motivational interviewing approaches
>> Standardize action planning and plan follow-up process so entire team can participate

QUESTIONS? COMMENTS?
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NEXT SESSION

Identifying and Treating Your High Risk Patient Population
August 15, 2017 11:30 am – 1:00 pm
Soin Hospital – Kumar Conference Center