Self-Management Support in Everyday Care

Brought to you by the **IHS IPC SMS Workgroup***
Presented by Jennifer Casey, RD, CD
Gerald L Ignace Indian Health Center
Jcasey@gliihc.net

Diabetes Day May 26th Sacramento, CA

**Special thanks to Connie Davis, MN, ARNP, Candice Donald, IPC Program Manager, Chinle IPC team and the entire IPC SMS Workgroup*

Session Objectives

Successful self-management support may require changing the way we practice: training staff in effective SMS techniques, re-working the flow of office visits, finding workable documentation and follow up strategies, integration of community education and services into care, can all help healthcare teams create sustainable self management support systems.

Objectives:

- Review SMS basic definitions & evidence base
- Contrast SMS with SM Ed
- Explore ideas about how to make self management support part of everyday.
- Understand the roles that care team members can provide with SMS.
- Demonstrate using SMS techniques and identify opportunities throughout an office visit.

Last Time:

- April 12 2011 CAN-DO Web-ex
  - **Self-Management Support 101: Developing Basic SMS Skills using Brief Action Planning**
    - Define self management support & describe basic evidence base
    - Understand the importance of establishing rapport
    - Use Brief Action Plan skills to help patients create action plans for health including problem solving and follow up.

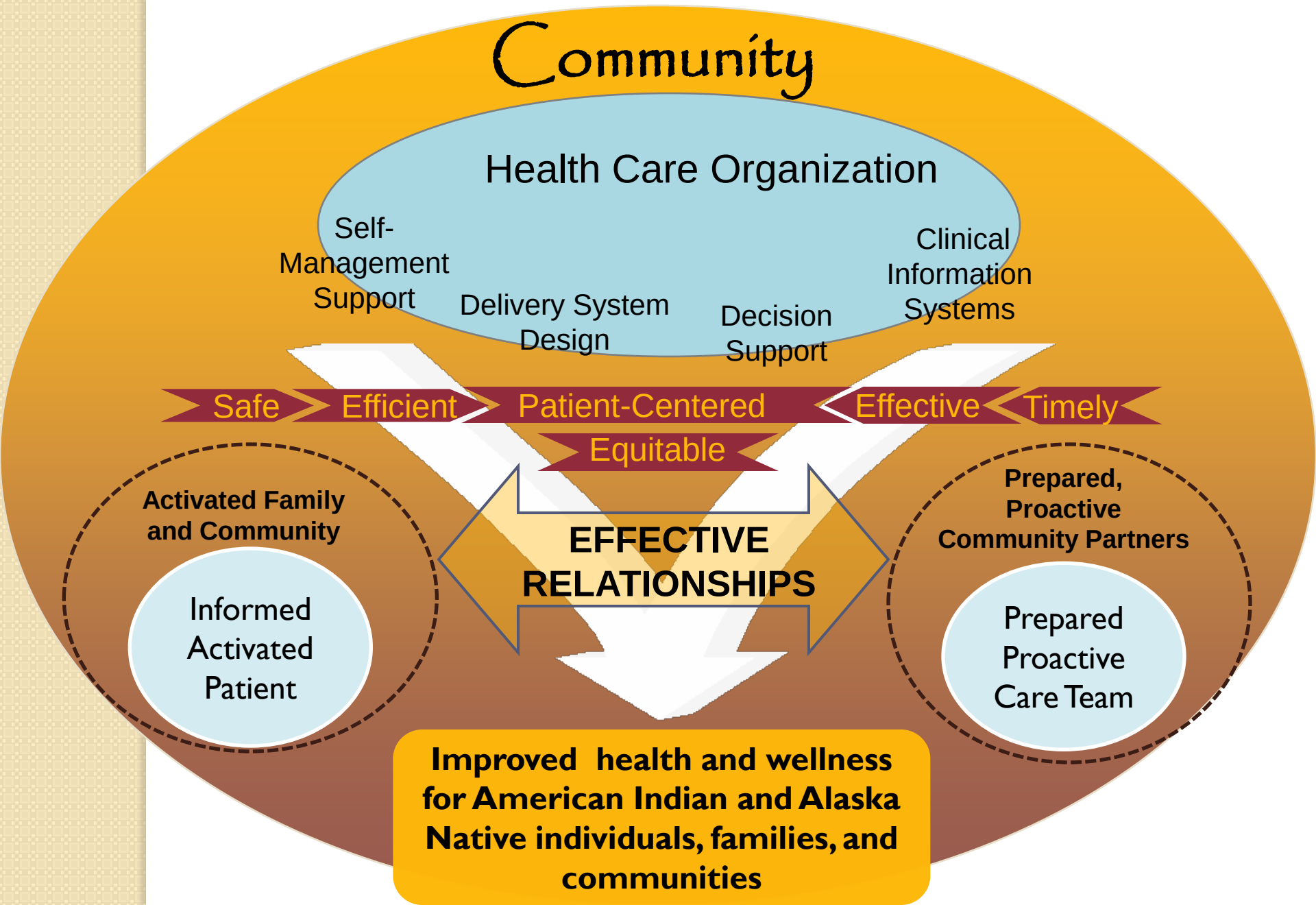
What is IPC?
IPC = Improving Patient Care

The Aim of the IPC collaborative is to improve health and promote wellness for American Indians and Alaska Natives and to support the four (*IHS*) agency priorities.

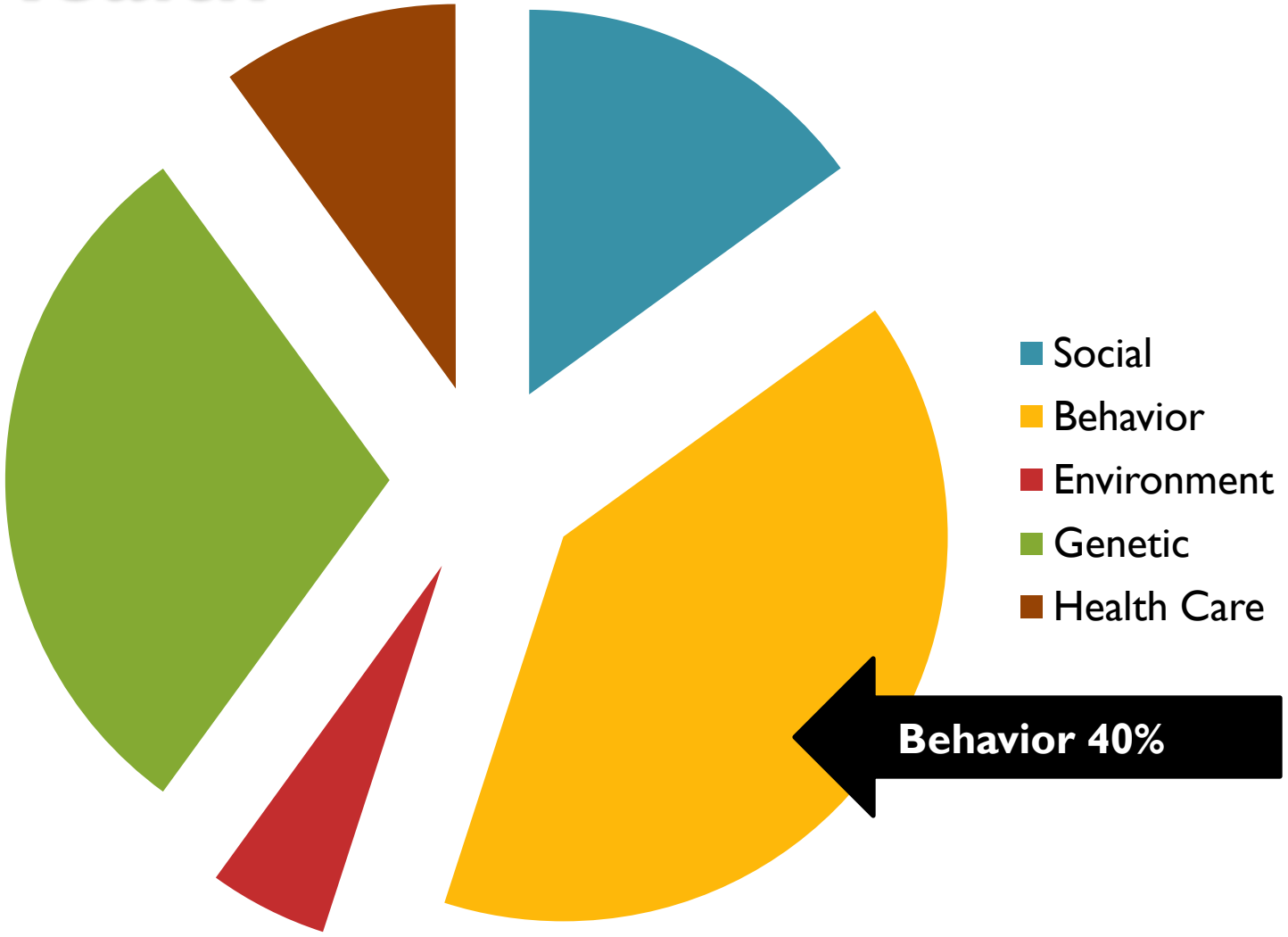
SMS Workgroup grew out of IPC

IPC IMPROVING PATIENT CARE

IPC Care Model



Leading Determinants of Health



What is self-management?

"The individual's ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition."

Barlow et al, client Educ Couns 2002;48:177

All patients self manage *everyday*.

What is self-management *Support?*

"**Self-Management Support** is the assistance caregivers give *patients and their self-defined circle of support* so patients can manage their conditions on a day-to-day basis and develop the confidence to sustain healthy behaviors for a lifetime."

- T Bodenheimer, et al. Helping Patients Manage their Chronic Conditions. Available at http://www.chcf.org

What is self-management *Support?*

SMScan be approached in 2 ways:

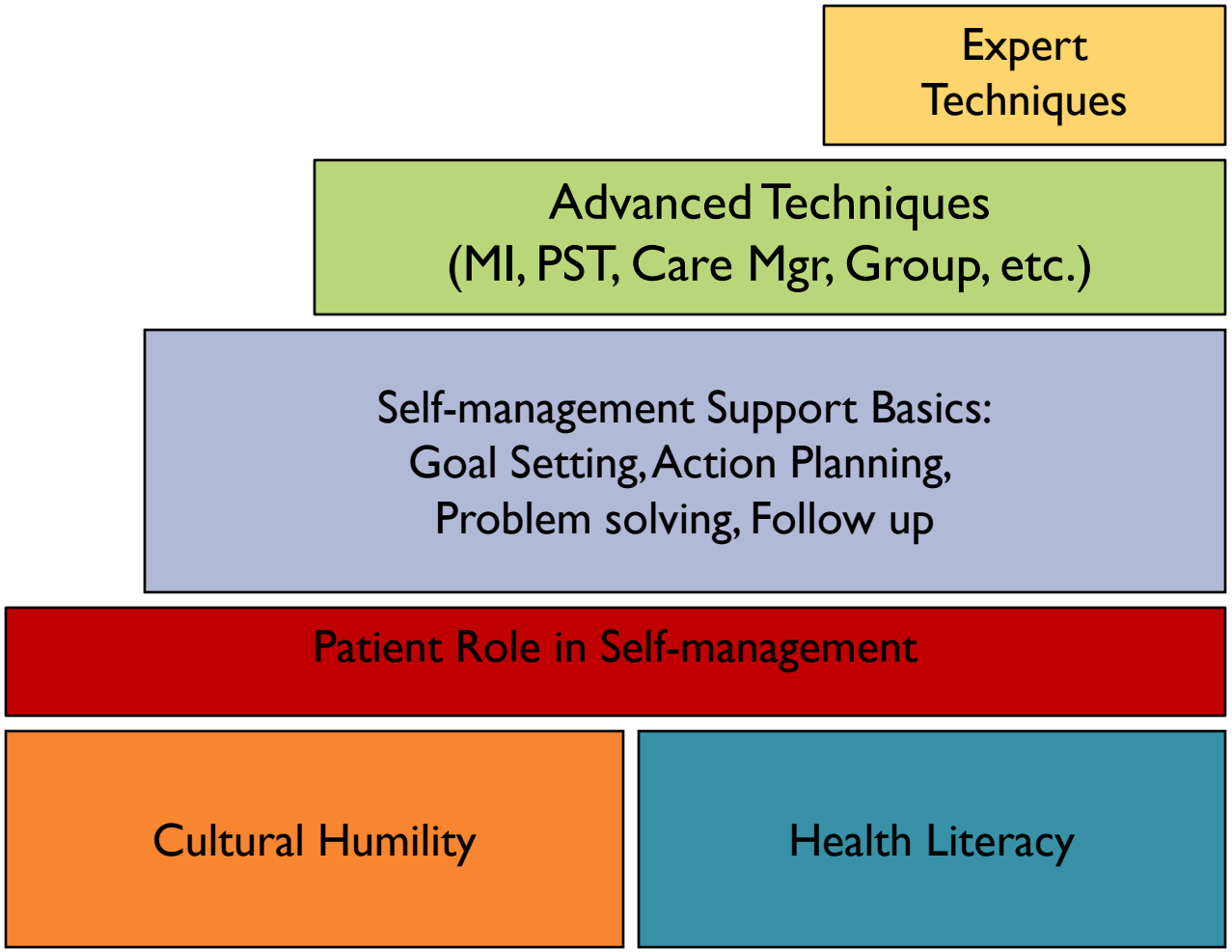
- A series of techniques or tools that encourage patients to choose healthy behaviors

and/or….

- A fundamental shift in the patient-caregiver relationship

  - T Bodenheimer, et al. Helping Patients Manage their Chronic Conditions. Available at http://www.chcf.org

Stepped Care for Self-management Support



Health Literacy

- Health literacy is the match between the expectations , preferences and skills of individuals seeking health information and services and the expectations, preferences and skills of those providing information and services.

- If we don't address health literacy, people have more health problems and health care costs more.

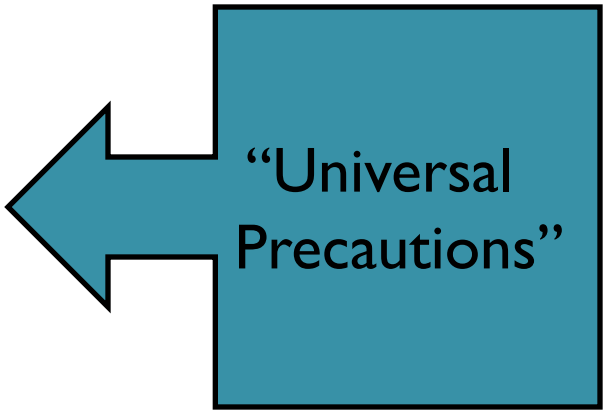
Courtesy of Dr Irv Rootman

Health Literacy

Health Literacy

Key Communication Strategies:

- Warm Greeting
- Eye Contact
- Slow Down
- Limit Content
- Teach-Back
- Repeat Key Points
- Patient Participation
- Plain, Non-medical Language
- Use Graphics When Explaining



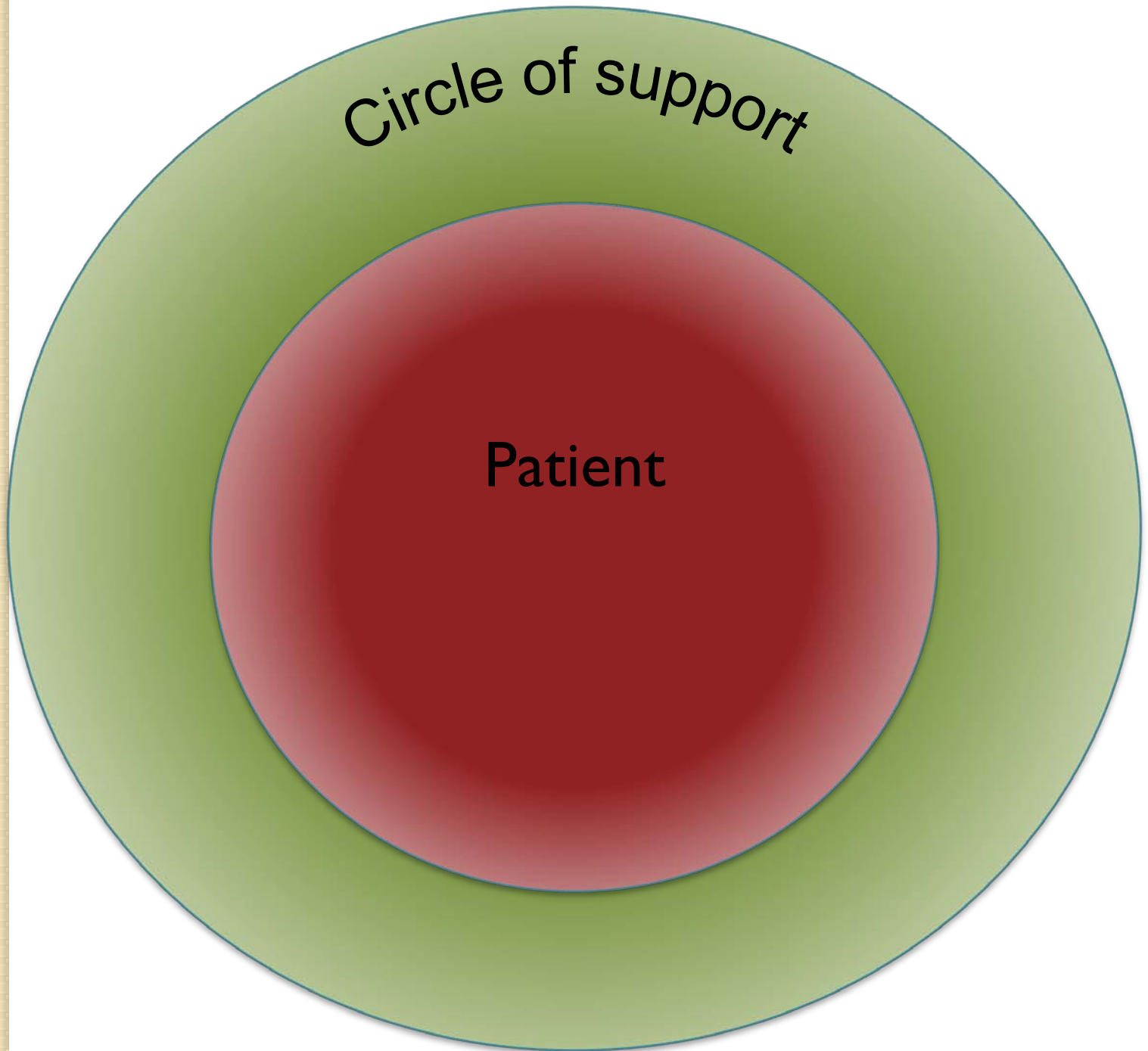
Health Literacy

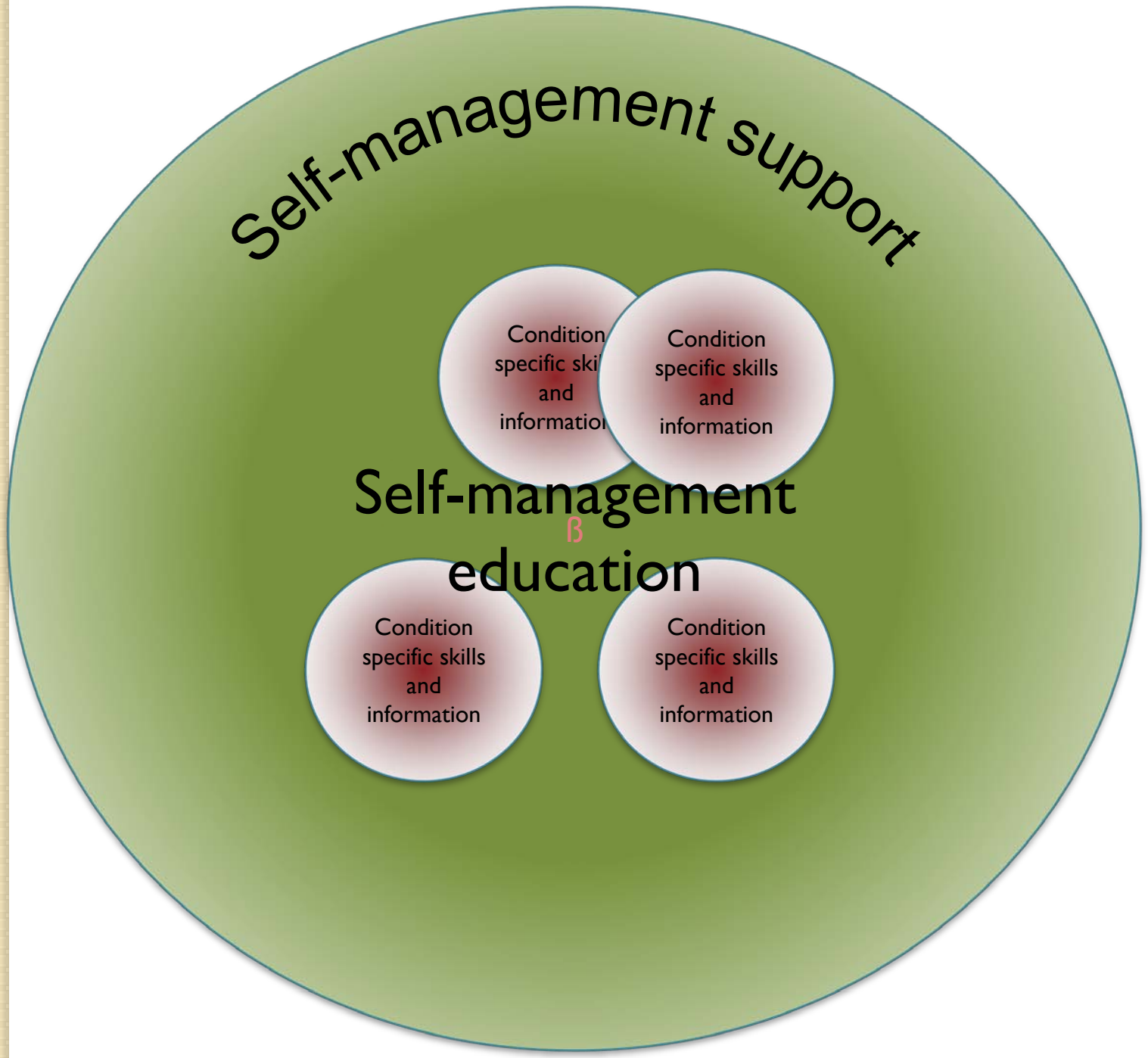
Cultural Humility

- "Effectively exploring cultural issues in the client/provider encounter should begin with recognition that "cultural difference" refers to a relationship between two perspectives."
- "It is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origin."
- Provider encouraged to develop a respectful partnership with *each* patient.

Cultural Humility

CHA , *Are You Practicing Cultural Humility?* http://www.cahealthadvocates.org/news/disparities/2007/are-you.html


Circle of support
Patient


Self-management support
Condition specific skills and information
Condition specific skills and information
Self-management education
Condition specific skills and information
Condition specific skills and information

What self-management support ***isn't***...

- Didactic patient education
- Sage on the stage
- You should…
- Finger wagging
- Lecturing
- Waiting for clients to ask for help

What self-management support *is*... 2 interrelated activities

Providing information about pt's chronic conditions

Working in partnership with patients to make medical decisions, including whether pts agree to take medications rec'd by clinicians, whether pts wish to undergo diagnostic or surgical procedures, & which health-behavior-related goals the pts choose to pursue

T Bodenheimer, et al. Helping Patients Manage their Chronic Conditions. Available at http://www.chcf.org

Patient education vs. SMS

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

- Skills to solve pt. Identified problems are taught
- Skills are generalizable
- Assumes that confidence yields better outcomes
- Goal is increased self-efficacy
- Teachers can be professionals or peers

Bodenheimer et al JAMA 2002;288:2469

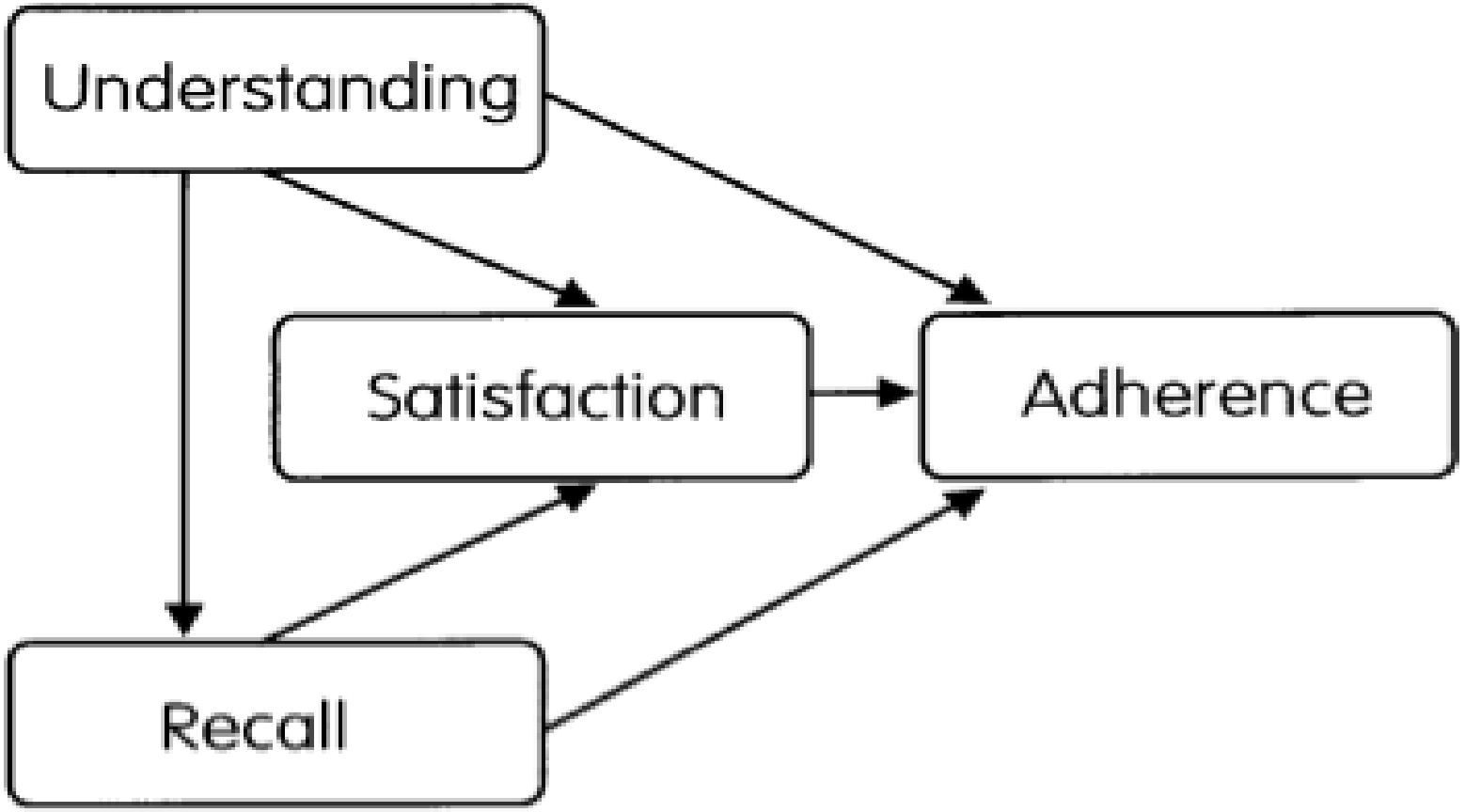


Figure 1 **Overview of Ley's model on the interactions between patient-related factors and therapy adherence (see Ref. 3)**

Ley, Communicating with patients: Improving Communication, Satisfaction and Compliance. NYL Croom Helm, 1988,

Why is self-management so important? What is different?

- Self-management is inevitable.
- The professional's role is to be in partnership with the client.
- Professionals are experts about diseases, clients are experts about their own lives.
- Clinical outcomes are dependent on client actions.

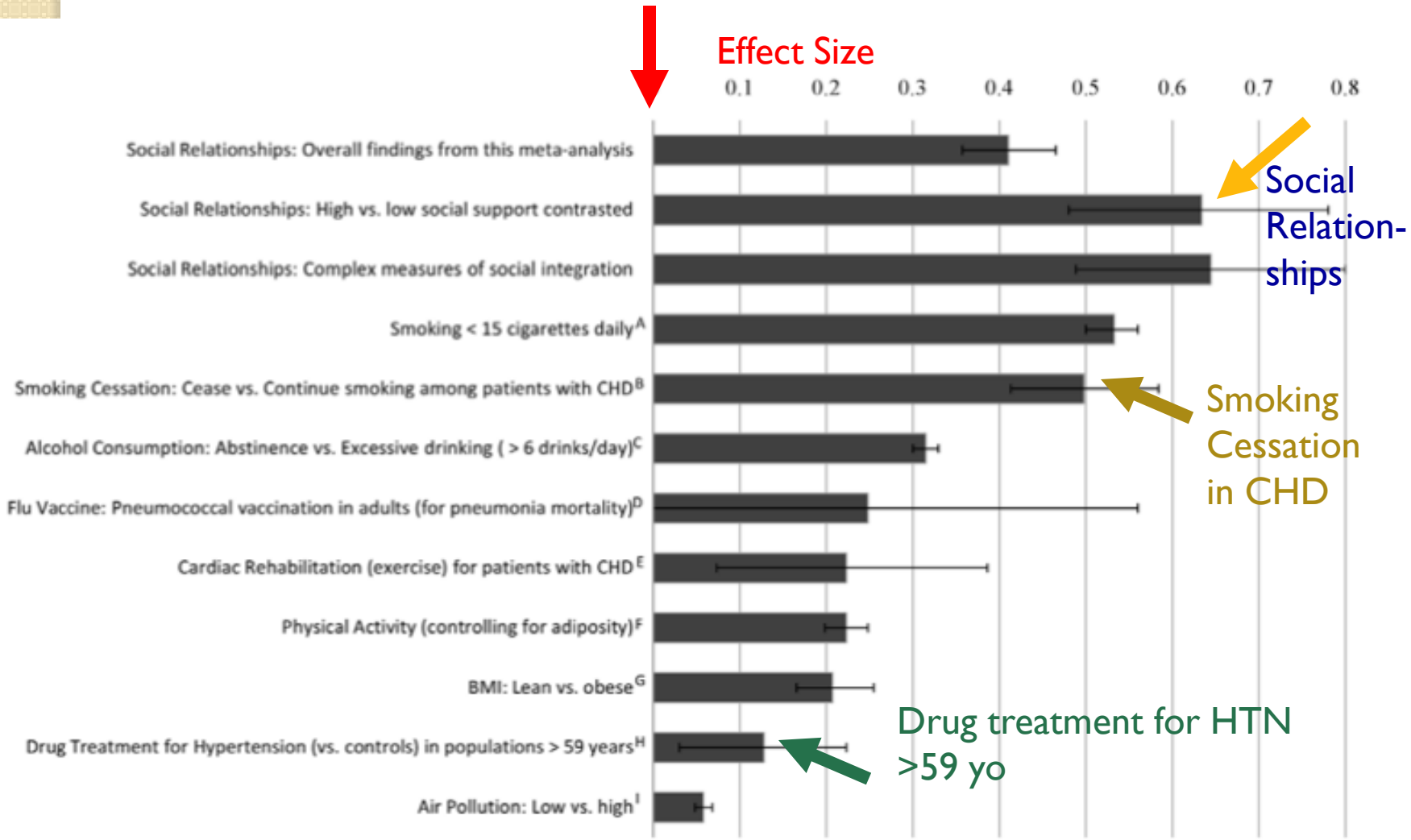


Figure 6. Comparison of odds (lnOR) of decreased mortality across several conditions associated with mortality. Note: Effect size of zero indicates no effect. The effect sizes were estimated from meta analyses: ; A = Shavelle, Paculdo, Strauss, and Kush, 2008 [205]; B = Critchley and Capewell, 2003 [206]; C = Holman, English, Milne, and Winter, 1996 [207]; D = Fine, Smith, Carson, Meffe, Sankey, Weissfeld, Detsky, and Kapoor, 1994 [208]; E = Taylor, Brown, Ebrahim, Jollife, Noorani, Rees et al., 2004 [209]; F, G = Katzmarzyk, Janssen, and Ardern, 2003 [210]; H = Insua, Sacks, Lau, Lau, Reitman, Pagano, and Chalmers, 1994 [211]; I = Schwartz, 1994 [212].
doi:10.1371/journal.pmed.1000316.g006

It's all about Relationship

Successful SMS begins with a trusting relationship and the foundational skills to help patients

The Spirit of Motivating People for Change*

- Collaboration

Provider and patient equal

- Evocation

Ideas for change come from the patient

- Respect for Autonomy

Patient has the right to change or not

- Compassion

**Clinician's global MI Spirit adherence ratings strongly predict patient outcomes*

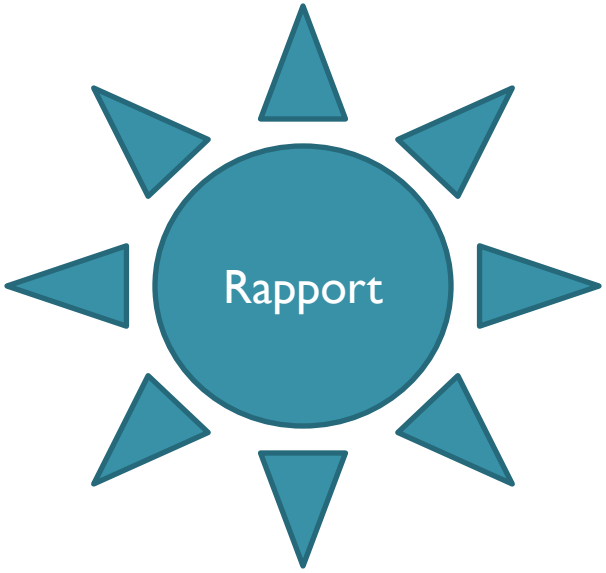
Miller W, Rollnick S. Motivational Interviewing: Preparing People for Change, Guilford Press, 2002; Miller, Advanced MI training, 2010

Question

How many of you have used the Brief Action Plan (BAP) with patients at your site?

Self-management Support

- *Is there anything you would like to do for your health in the next week or two?*



Brief Action Planning (B.A.P.)
A Self-Management Support Tool for Chronic Illness Care, Health and Wellness Coaching

The B.A.P. Checklist©

B.A.P. ™ is structured around 3 core questions:

1. ___ Elicit person's preferences/desires for behavior change

"Is there anything you would like to do for your health in the next week or two?"*
___ What?
___ Where?
___ When?
___ How often?
___ Elicit commitment statement
"Just to make sure we understand each other, would you please tell me back what you've decided to do?"

___*Some persons need or request ideas for change. Clinicians can offer a behavioral menu:
"If you would like, I can share some ideas that might help you feel better…"

2. ___ Evaluate confidence

"I wonder how confident you feel about carrying out your plan. Considering a scale of 0 to 10, where "0" means you are not at all confident and '10' means you are very confident, about how confident do you feel?"

___ If the confidence level is <7, problem solve overcoming barriers or adjusting plan:
"5 is great. A lot higher than 0. I wonder if there is any way we might modify the plan to get you to a level of 7 or more? Maybe we could make the goal a little easier, or you could ask for help from a friend or family member, or even think of something else that might help you feel more confident?"

3. ___ Arrange follow-up (or accountability)

"Sounds like a plan that's going to work for you. When would you like to check in with me to review how you're doing with your plan?"

The Nine Core Principles of B.A.P.

1. Action planning is individual-centered, i.e. what the person wants, not what he/she is told to do.[1]
2. Action planning is collaborative.[2]
3. Action planning respects the right of the individual to change or not to change.[3]
4. The most effective Action Plans are 'SMART' (specific, measurable, achievable, relevant, and timed).
5. After the plan has been formulated, the clinician/coach elicits a final "commitment statement."
6. Offer a behavioral menu when needed or requested.
7. Confidence levels are elicited and problem-solving utilized for confidence levels less than 7.
8. Action planning includes arranging follow-up or other accountability.
9. Question one is routinely integrated into chronic care, preventive, coaching and therapeutic visits.

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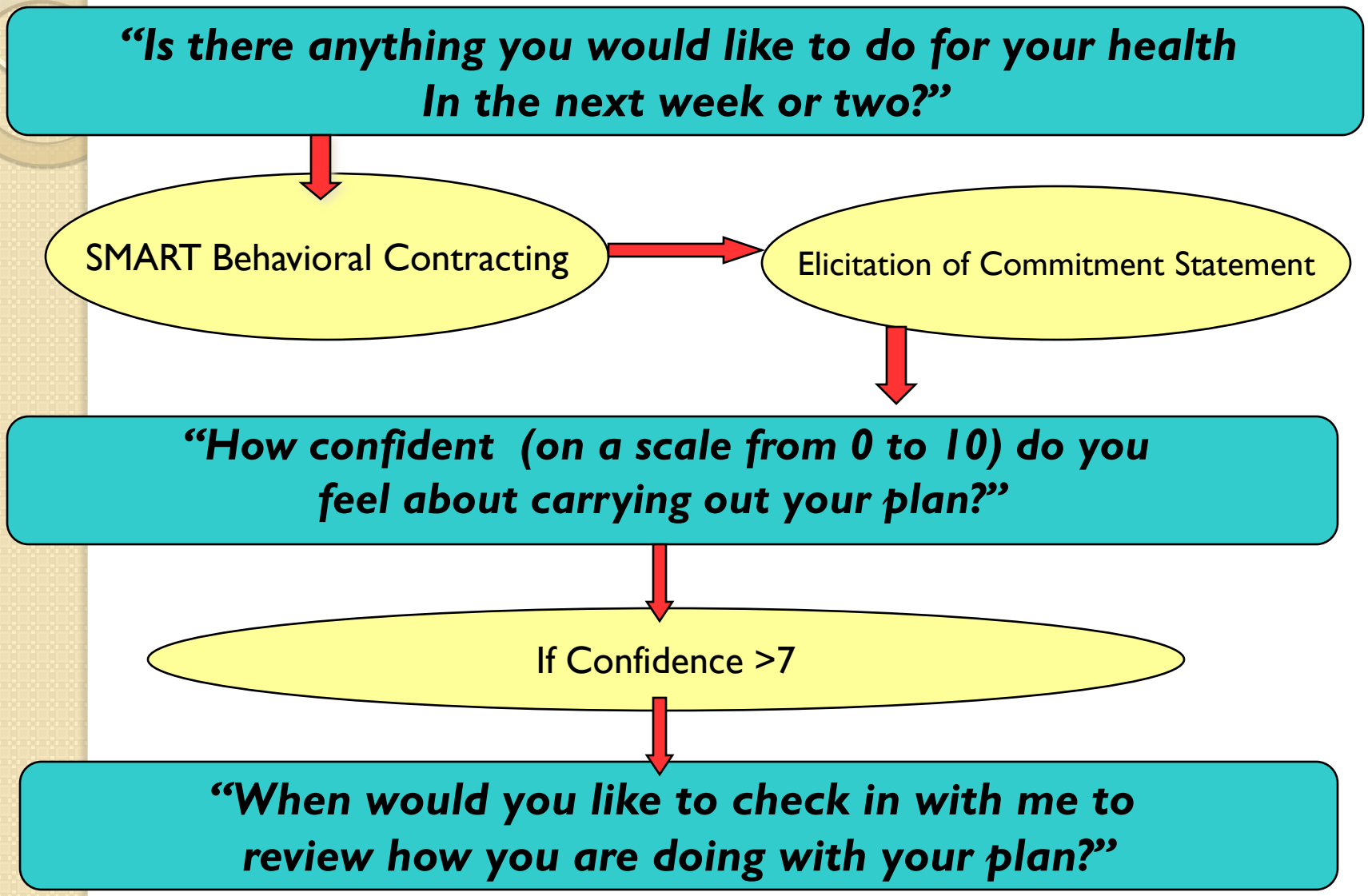
[1] This principle demonstrates alignment of B.A.P. with the "Spirit" of Motivational Interviewing: Evocation
Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*, NY, Guilford Press, 2002.
[2] Spirit of Motivational Interviewing: Collaboration
[3] Spirit of Motivational Interviewing: Support Autonomy
An earlier version of the BAP Checklist was published in Schwartzberg J et al, Physician resource guide to patient self-management support. American Medical Association, http://www.ama-assn.org/ama1/pub/upload/mm/433/phys-resource-guide.pdf

The B.A.P. Checklist is the core self-management support tool of Comprehensive Motivational Interventions (CMI) ™

9 Principles & the Evidence Base

1. Individual-centered
2. Collaborative
3. Respects right of not changing
4. SMART
5. Commitment statement
6. Behavioral menu
7. Measure confidence
8. Follow-up
9. Occurs in every interaction

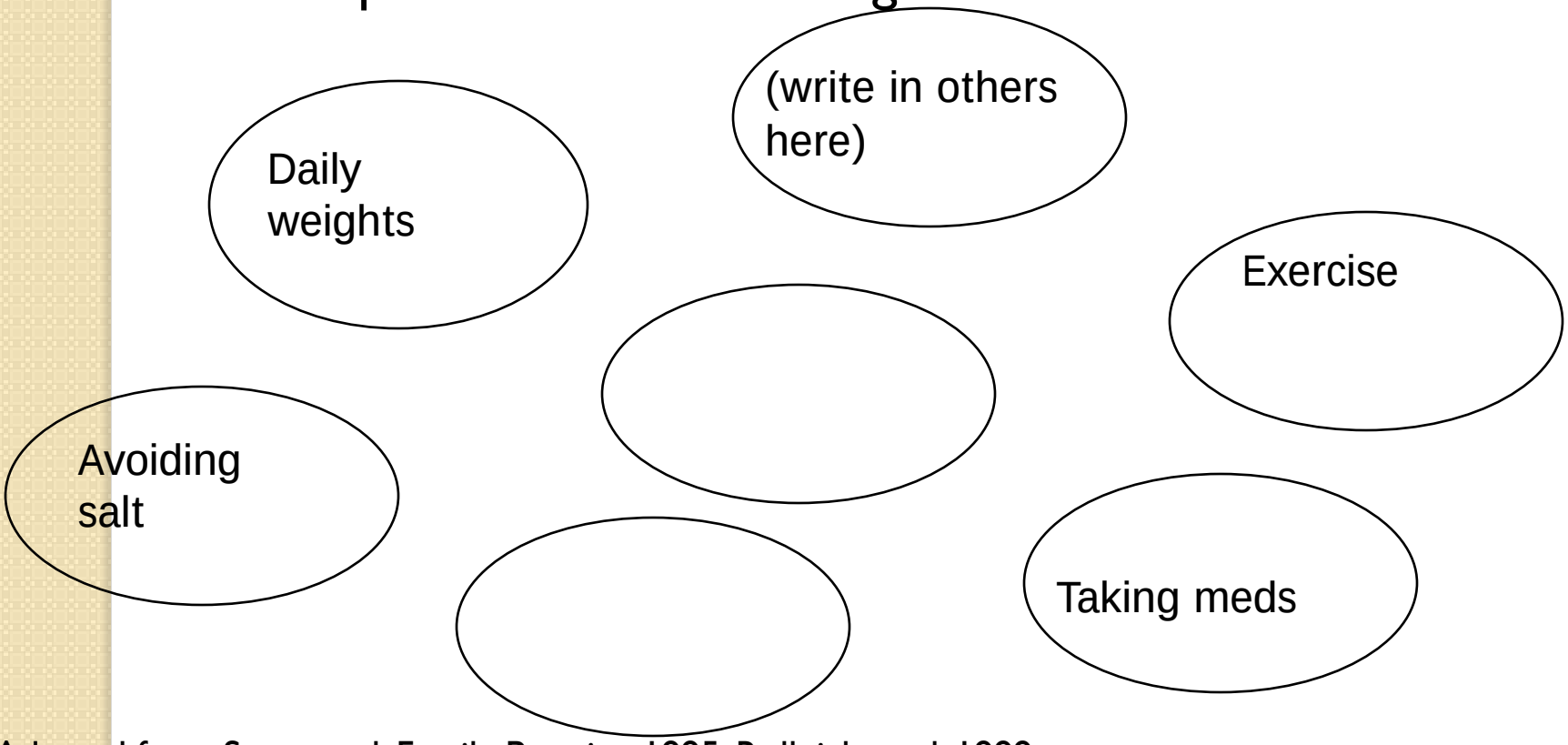
Brief Action Planning (B.A.P.)



Steven Cole, *et. al.*

Behavioral menu

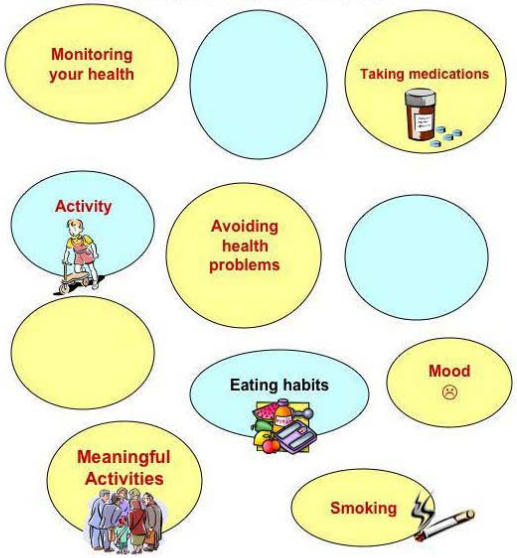
"Here are the things we have talked about. Which one is most important to work on right now?"



Adapted from Stott et al, Family Practice 1995; Rollnick et al, 1999

There are many things people do to improve their health. Here are some things you might want to talk to your health care team about.

→*Consider the items in circles and add other concerns in the blank circles.*



Health is Life in Balance

Being healthy allows us to enjoy life to the fullest! There are many things you can do to improve your health- here are some ideas of things you may wish to focus on and you may want to talk to your health care team about. You may have different concerns and can add them to the blank circles.

My Goal:

GERALD L IGNACE INDIAN HEALTH CENTER
1711 South 11th Ave. | 414-383-9526
Milwaukee, WI 53204 | www.gliihc.net

HEALTH VISIT

Name: _____ Date: _____

Blood Pressure: _____mm Hg
[Target BP is usually less than 120 (systolic)/80 (diastolic) mm/Hg]

Blood Sugar: _____ mg/dL **[Target when fasting is70-100]**

Weight: _____ Height: _____

Body Mass Index **(HT to Wt ratio):** _____ **[Normal BMI is 18-25]**

Problems or Questions: (why are you here today?)

Information from Doctor/Provider:

Is there anything you would like to do for your health?

Here are some things you have some control over:

Medications

Eating and drinking,

Exercise and activity

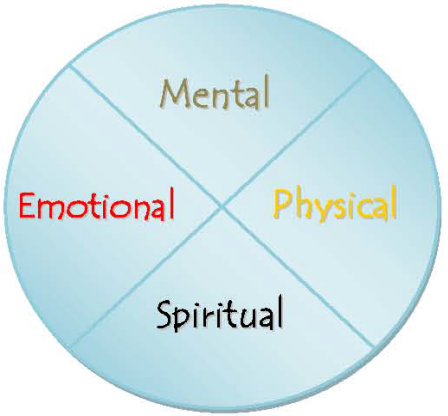
Stress management

Smoking or Drinking

What would you like to work on right now? Your health care provider can help you set an action plan.

My Plan:

Health is Life in Balance



5 Key Elements in Brief Action Planning (BAP)

1. Being patient-centered, including assessing patient's needs
2. Helping a patient make a behaviorally specific action plan
3. Eliciting a commitment statement (have patient restate the plan)
4. Assessing confidence and problem-solving to improve confidence regarding plan
5. Providing regular follow-up

Steve Cole, MD Stoneybrook University, Adapted from AMA tip sheet for SMS

Problem Solving

1. Identify the problem.
2. List all possible solutions.
3. Pick one.
4. Try it for 2 weeks.
5. If it doesn't work, try another.
6. If that doesn't work, find a resource for ideas.
7. If that doesn't work, accept that the problem may not be solvable now.

Source: Lorig et al, 2001

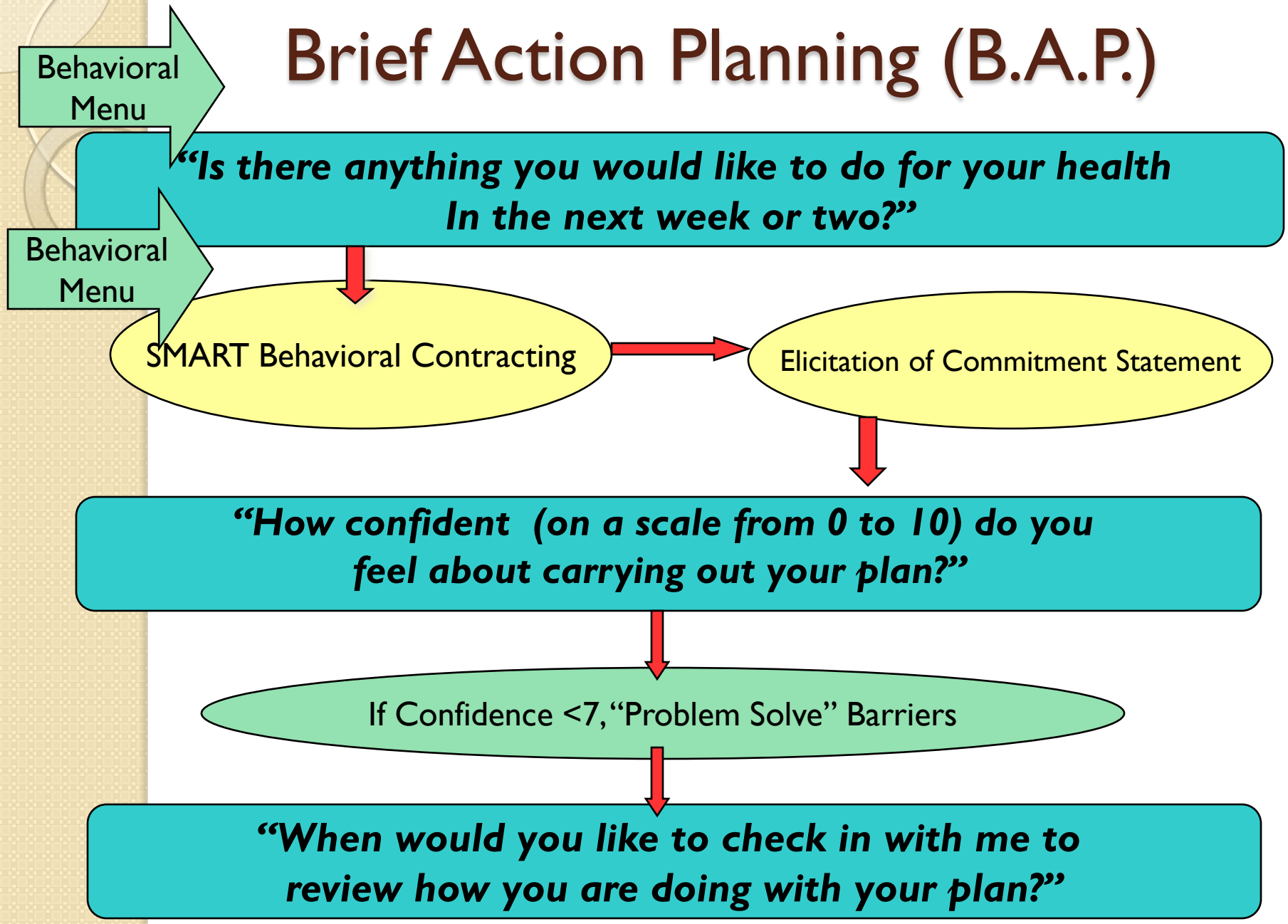
Follow-up

- Inquire about patient's experience
- Identify, affirm and reinforce progress towards goals
- Identify slips or lapses
- Identify existing or potential barriers and obstacles
- Revise the action plan
- Establish next follow-up

Tips for follow-up

- Try a wide variety of methods, whichever client prefers (in person, phone, group, email)
- Make sure follow-up happens, client trust can be destroyed by missed follow-up
- Use outreach and community opportunities

Brief Action Planning (B.A.P.)



Steven Cole, *et. al.*

Basic SMS Skills

Video Excerpt:

Chapter 3 (5:48)

Fitting into daily practice

- Client readiness
- Visit mapping
  - Walk through
- Roles & sequencing
  - From pre-visit planning to follow-up
- Documentation

Roles in Self Management Support

preparation							
Question 1: "Is there anything …?"							
Behavioral menu							
SMART action plan							
Commitment statement							
Question 2: "How confident are you…?"							
Problem solving							
Question 3: "When can we follow-up…?"							
Documentation							

SMS in Everyday Practice

- Lessons learned from two IPC teams:
  - Chinle Service Unit

  - GLIIHC

Roles and Sequencing

Morning Huddle
1. HT prints out icare template
2. Review all pts, decide what preventive care to focus on

NA rooms pt
1. Greets patient
2. Vital signs
3. Determines chief complaint
4. Determines and does appropriate GPRA screenings
5. Performs POC testing (a1c etc)
6. Writes exams/tests that pt needs from prescreening onto PCC
7. Provides and briefly discusses menu of options; tells them we're trying something new
8. Empanels patients
9. Has pt sign release of information, send it to appropriate facility for records

General
Translation by either NA or HT, whoever is available

Provider sees pt
1. Greets patient
2. Evaluates chief complaint
3. Follows up chronic medical problems
4. Orders labs/exams needed on pt
5. Discusses pt's choice on menu of options
6. Provides pt education
7. Provides teach back
8. Fills out f/u appt sheet with provider, MR#, and when f/u should be set; leaves in chart or in room for HT to set appt

Nurse
1. Greets patient
2. Provides follow-up on action plan
3. Take phone calls re med refills, questions
4. Leader of PI projects, reviews data and determines where to improve
5. Team leader for SMS; helps with coaching, monitoring education codes etc
6. Sees pts in f/u

HT sees pt
1. Greets patient
2. Gives immunizations
3. Provides education based on menu of options
4. Makes action plan
5. Determines appropriate f/u
6. At follow-up session provides feedback on previous action plan
7. Reviews plan agreed on by pt and provider to ensure pt understanding
8. Make f/u appt if MSA can't do it
9. Send pt to lab if needed

Slide courtesy of Chinle Team

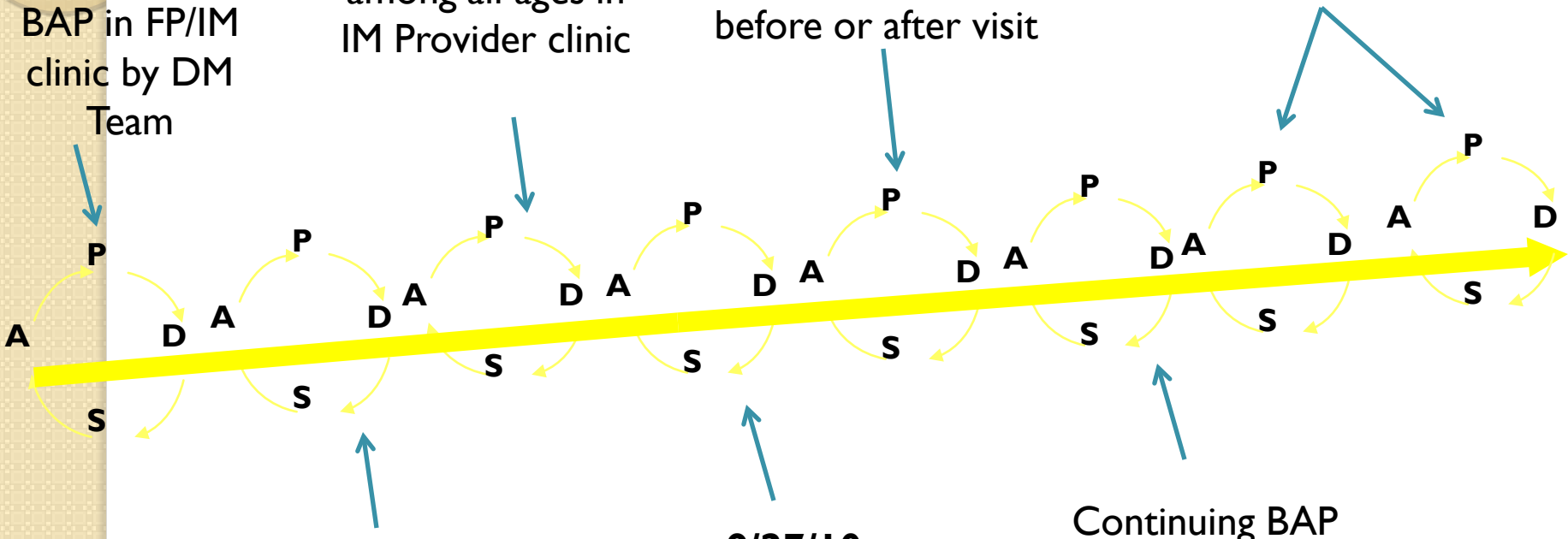
PDSA Ramp BAP Timeline

9/13/10 Tested BAP in FP/IM clinic by DM Team

9/15/10 Tested BAP among all ages in IM Provider clinic

9/28/10 Tested BAP by provider preference before or after visit

Future BAP PDSAs planned for refinement to fit Chinle patient population needs



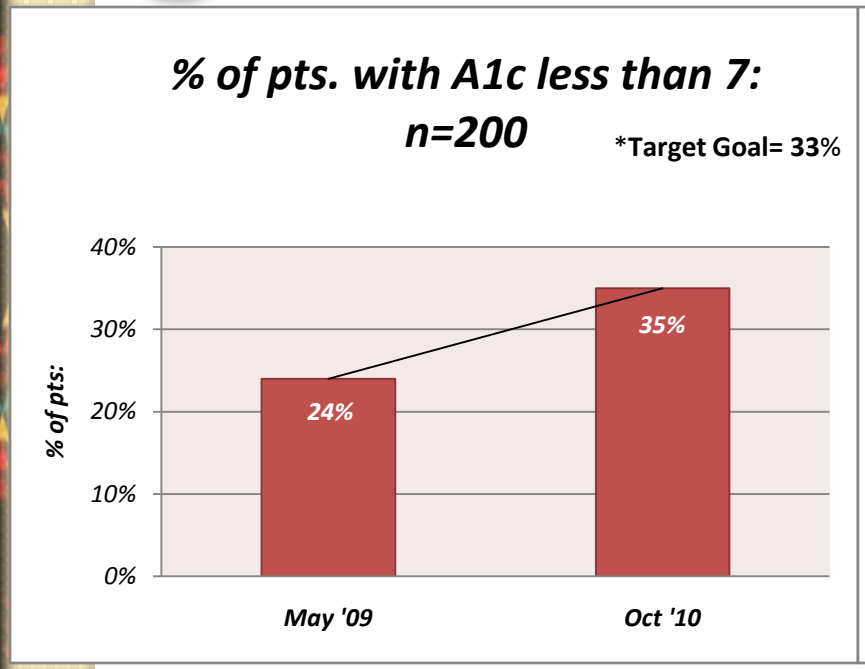
9/14/10 Tested BAP among IM Clinic

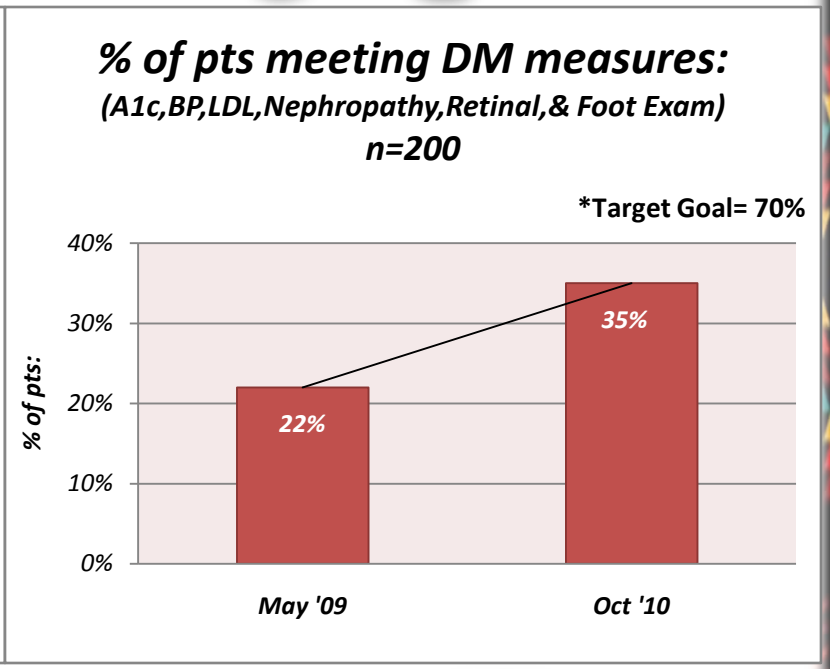
9/27/10 Tested BAP among selected age group w/ a selected provider

Continuing BAP testing w/ HT completing visit

Slide courtesy of Chinle Team

Improvement Results From Juniper Team





Change Ideas Leading to Improvement:

- Setting up clinical care teams.
- Tracking monthly data that monitors progress.
- Promoting medical homes to patients.
- Empanelling patients to a Team.
- Prescreening patients.
- Self Management support skills introduced to Team.
- Navajo Wellness Model used as the basis for teaching Self Management Support.

Slide courtesy of Chinle Team

GREAT TEAM WORK!

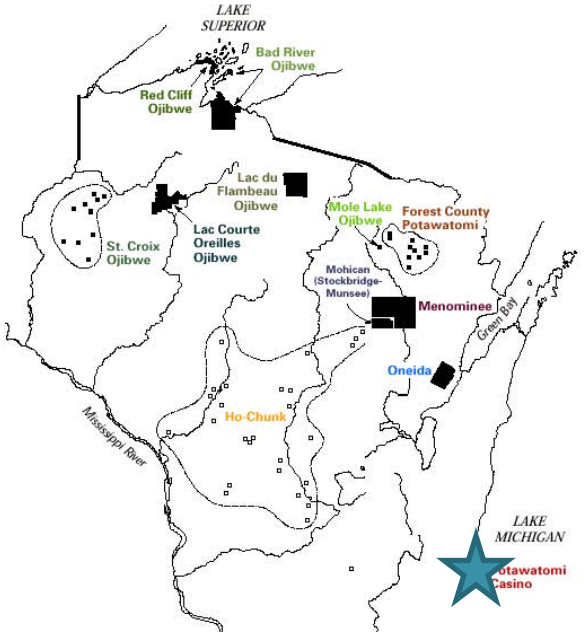
Summary Thoughts

- Administration support is essential.
- Include support for patient self reliance in your strategic plan and in employee performance plans.
- Physician advocate is important in engaging all members of the team.
- Staff needs to be developed as trainers and advocates.
- Great partners are important.
- Set the foundation for SMS by creating awareness among patients and setting up a supportive environment.
- Be flexible and know that you will have to keep adapting and thinking on your feet!
- Measure results.
- Have fun!

Slide courtesy of Chinle Team

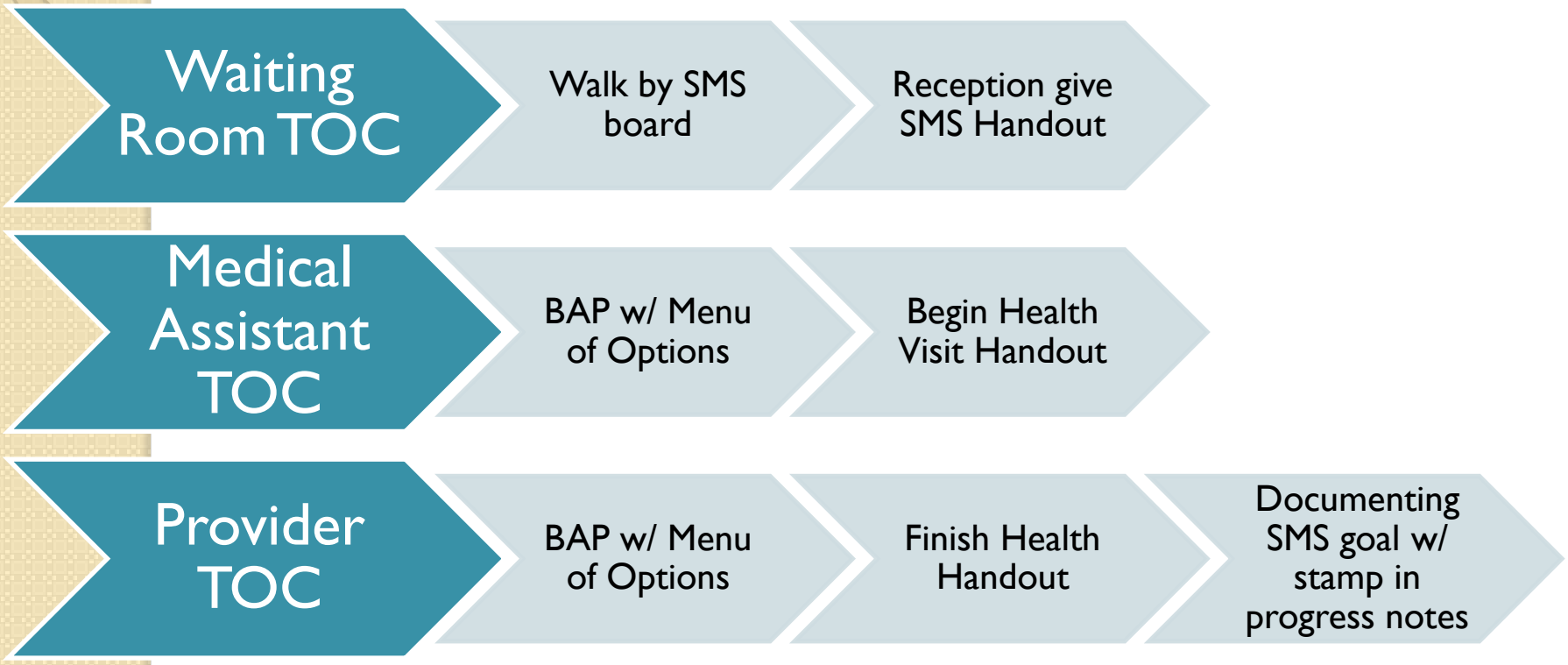
Gerald L Ignace Indian Health Center

- Multicultural population—11 tribes in WI
- Urban site in Milwaukee, WI
- Microsystem is entire clinic ~2,500



GLIIHC:

Testing opportunities for Integrating SMS into clinic flow



SMS in Everyday Practice

- What opportunities exist at your site to address:
  - Client readiness?
  - Visit mapping?
    - Walk through
  - Roles & sequencing?
    - From pre-visit planning to follow-up
  - Documentation?

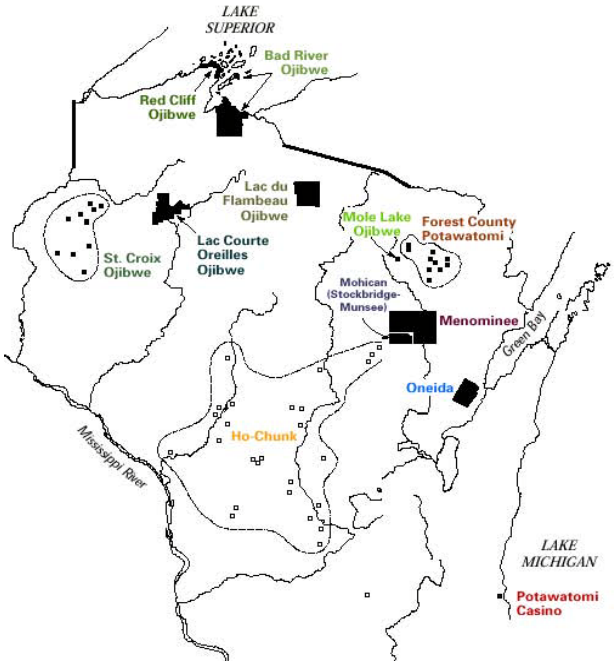
SMS in Everyday Practice

- What ideas can you test when you return to your clinic?

- Ideas: test teach back, brown bag medication review, BAP, plain language ed review, health visit handouts, SMS marketing, patient confidence survey

Thank you!

- Questions?
- Comments?
- Stories?



Jennifer Casey, RD, CD Jcasey@gliihc.net
GLIIHC: urban Site in Milwaukee, WI

More resources:

- IHS Health Communications http://www.ihs.gov/healthcommunications/index.cfm?module=dsp_hc_health_literacy
- Health Literacy Universal precautions toolkit can be downloaded here: http://www.ahrq.gov/qual/literacy/
- Problem-solving treatment http://impact-uw.org/training/problem_solving.html
- Motivational Interviewing www.motivationalinterview.org
- Comprehensive Motivational Interventions www.comprehensiveMI.com