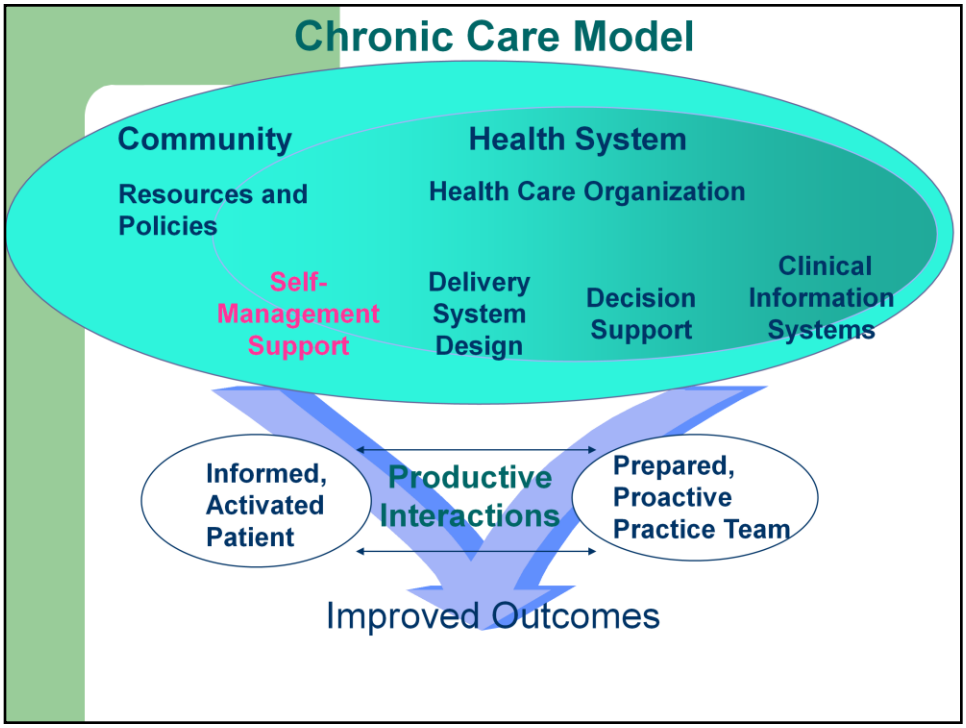
Using Self-Management Support In Your Coaching Approach

Mike Hindmarsh
Hindsight Healthcare Strategies

QIIP Practice Facilitator Training
May 12-13, 2008
Toronto, ON



You are here.

Wagner EH, Davis C, Schaefer J, Von Korff M, Austin B. A survey of leading chronic disease management programs: Are they consistent with the literature? *Managed Care Quarterly.* 1999;7(3):56-66.

Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA* 2002 Oct 16; 288(15):1909-14.

Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A., Improving chronic illness care: translating evidence into action. *Health Aff* (Millwood). 2001 Nov-Dec;20(6):64-78.

Self-Management Support

- Emphasize the patient's central role in managing their illness
- Use effective self-management strategies that include assessment, goal-setting, action planning problem-solving and follow-up.
- Organize internal and community resources to provide ongoing self-management support to patients.

Bodenheimer, Lorig, Holman, and Grumbach Patient self-management of chronic disease in primary care. JAMA 2002;288:2469-2475

Glasgow, Davis, Funnel and Beck, in submission

Whitlock et al Evaluating primary care behavioral counseling interventions: an evidence-based approach

http://www.ahrq.gov/clinic/3rduspstf/behavior/behsum1.htm

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, Patient Educ Couns 2002;48:177

Barlow goes on to say:

Efficacious self-management encompasses ability to monitor the condition and to effect cogitive, behavioral and emotional responses necessary to maintain a satisfactory quality of life.

It is a dynamic, continuous process of self-regulation.

Patient educ. 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

Both patient education and SMS are necessary.

Some aspects of patient education work well, some do not. Information is necessary and skills must be taught.

Knowledge does not create behavior change, and compliance is not a useful goal.

Adapted from Bodenheimer, JAMA 2002;288:2469

Norris et al. Effectiveness of self-management training in type 2 diabetes, Diabetes Care 2001;24:561-587.

Self-Management Tasks in Chronic Illness

- To take care of the illness
- To carry out normal activities
- To manage emotional changes

Based on work by Corbin and Straus

Take care of illness means handling medical management such as taking medication, changing diet, or self-monitoring.

Carrying out normal activities means creating and maintaining life roles, such as job, family, friends (how do I manage working night shift with diabetes? How do I play soccer and keep my asthma in control?)

Emotional changes are most frequently anger, fear and frustration, often depression. Changes view of future and relationships with others.

When you are interacting with a patient, or designing a system to support self-management, consider if you have touched on every task.

Corbin J, Strauss A. Unending work and care: managing chronic illness at home. San Francisco, Jossey Bass, 1988

Collaborative care

"If physicians view themselves as experts whose job is to get patients to behave in ways that reflect that expertise, both will continue to be frustrated…Once physicians recognize patients as experts on their own lives, they can add their medical expertise to what patients know about themselves to create a plan that will help patients achieve their goals."

Funnell & Anderson JAMA 2000;284:1709

This describes the patient empowerment philosophy.

Need interaction of clinician's ideas and patient's ideas.

Professionals may blame pts for poor outcomes, attribute it to noncompliance, denial.

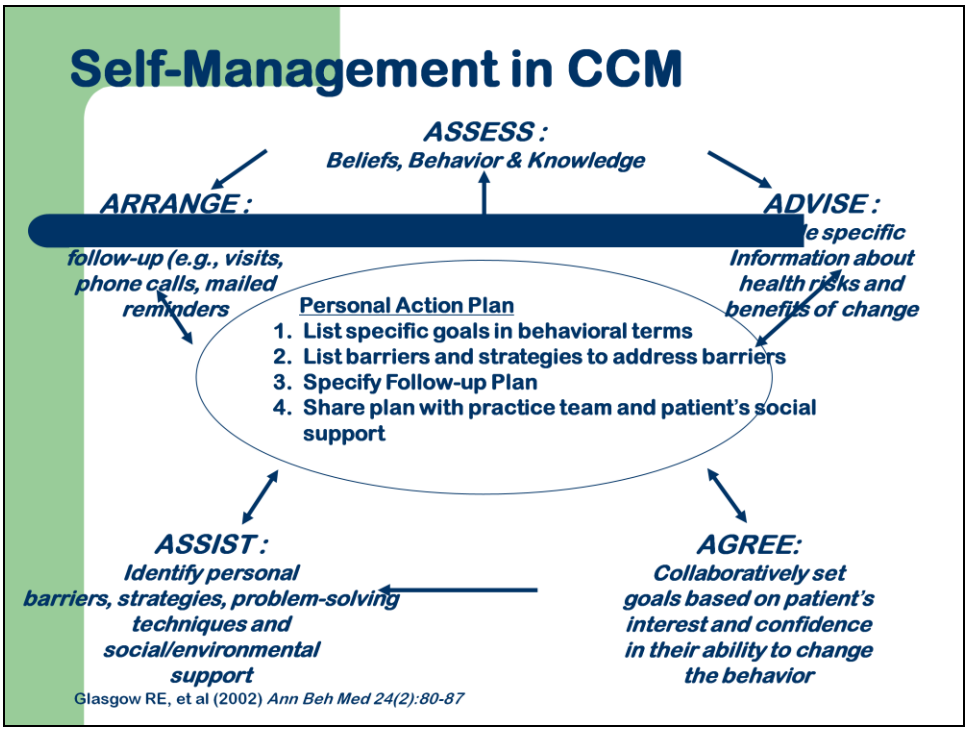
If we accept that pts define their problems, compliance and adherence aren't relevant concepts.

What self-management support isn't...

- Didactic interaction
- Sage on the stage
- You should…
- Finger wagging
- Lecturing
- Waiting for patients to ask for help

Not sage on the stage, but the guide on the side (Karen Artz)

Source: ICIC



One way to make sure that you are using effective strategies is to incorporate the 5 A's into care.
Assess, Advise, Agree, Assist, Arrange.
This diagram draws on the 5 A's that some of you may be familiar with from smoking cessation brief counseling.
(Start at the top and go around the figure, reviewing each A.)
The central activity is the creation of a Personal Action Plan.

Glasgow RE, et al (2002) *Ann Beh Med 24(2):80-87*

Using the Five A's as a Facilitator

Now we will look at each of the A's in succession. They will help us organize our efforts in self-management support.

Tips on assessing your practice team

- Ask questions about them….get to “know” them
- Provide feedback to team when appropriate
- Assess their view of QI progress and how easy/difficult it is to get things done.

Here are some tips to consider during assessment.

Many of the patient choices are behaviors, but some are also attitudes about their illness.

The second A is Advise.

Tips on providing advice

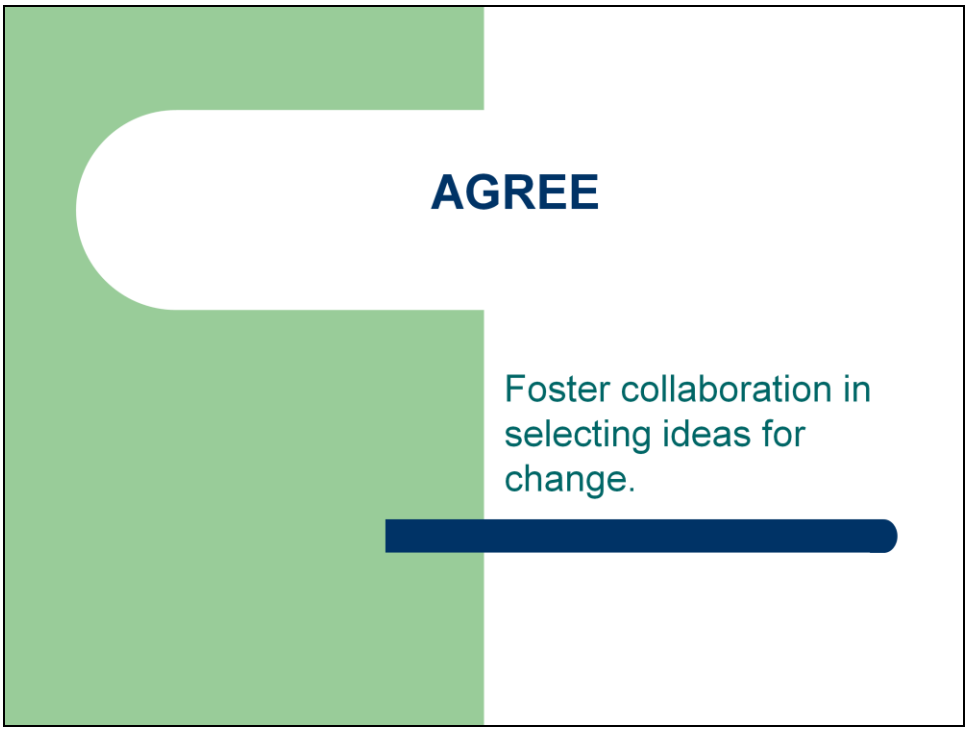
- Make the source of advice clear (medical knowledge or best practice)
- Personalize advice to the FHT/CHC environment
- Listen more than you talk
- Have a key message for each idea you present
- Don't overwhelm them with information

It is important to clarify what kind of information you are providing. Regarding clinical care, remember techniques from shared decision making. If it is in relation to some lifestyle decision, patients like to hear information from patients like them.

There is much evidence that supports the power of physician advice. (see Whitlock for refs)

One example of personalizing lab values is to graph them. For people with diabetes, draw a body with areas to put in their HbA1c, BP, microalbumin, eye exam, etc. Help patients understand how their choices influence their health status, for example how regular exercise contributes to better function for people with arthritis, or how trying new things contributes to a sense of confidence.

Source, Glasgow et al in submission



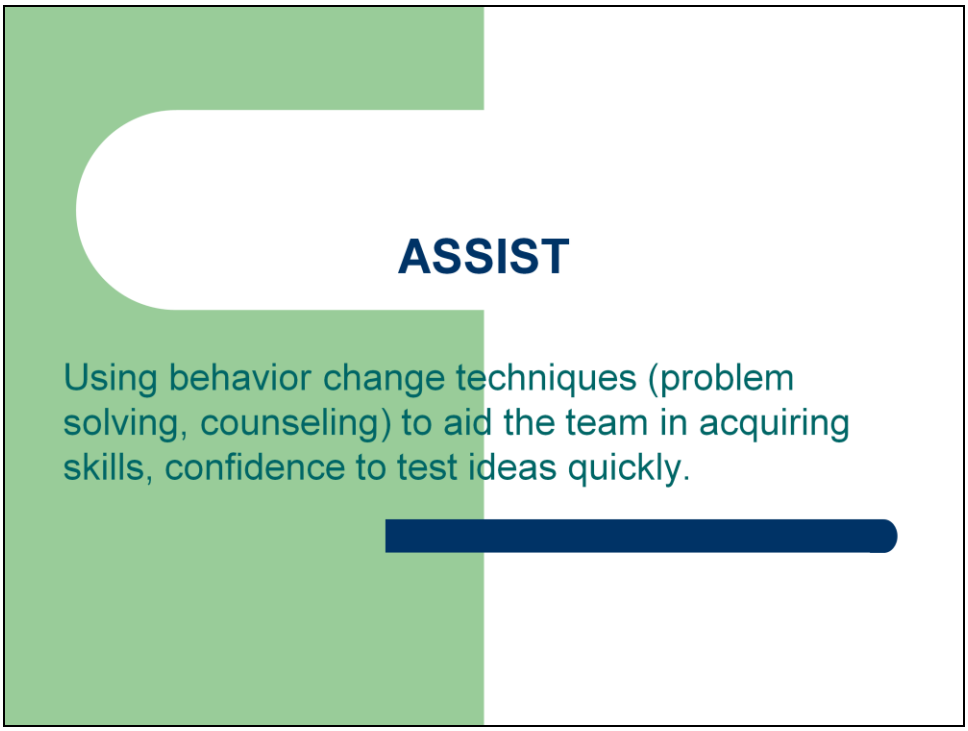
The third A is Agree.

Tips to create agreement

- Base goals and measures and team's priorities
- Let then start where they want
- Do not judge ideas for change
- Do not make them agree with you
- Team consensus on testing ideas is not critical unless there is obvious opposition or discomfort

Remember the goal is the patient's and we want them to be successful. Often the goal or plan does not seem related to the chronic illness from our point of view, but to the patient they make sense. Sometimes patients choose something small or apparently peripheral to do, but with success, they will take on more challenging and specific things to try.

Source, Glasgow et al in submission



Agree and assist are the steps that lead to the creation of a personal action plan.

Tips on assisting patients

- Use other teams as examples
- Address helplessness
- Learn and use a problem-solving approach
- Link to the assessment of barriers and environment
- Avoid telling them what to do
- Avoid speeches
- Avoid cheerleading

Problem Solving

1. Identify the problem.
2. List all possible solutions.
3. Pick one.
4. Try it in the next testing cycle.
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.

This is a very straightforward problem solving approach, which is used in many successful self-management programs. It can be done individually or as a group.

The first step may be tricky. If the patient can't think of ideas for the second step, ask them if they would like ideas from other patients like them. Check up on their progress.

From Kate Lorig, Chronic Disease Self-management program

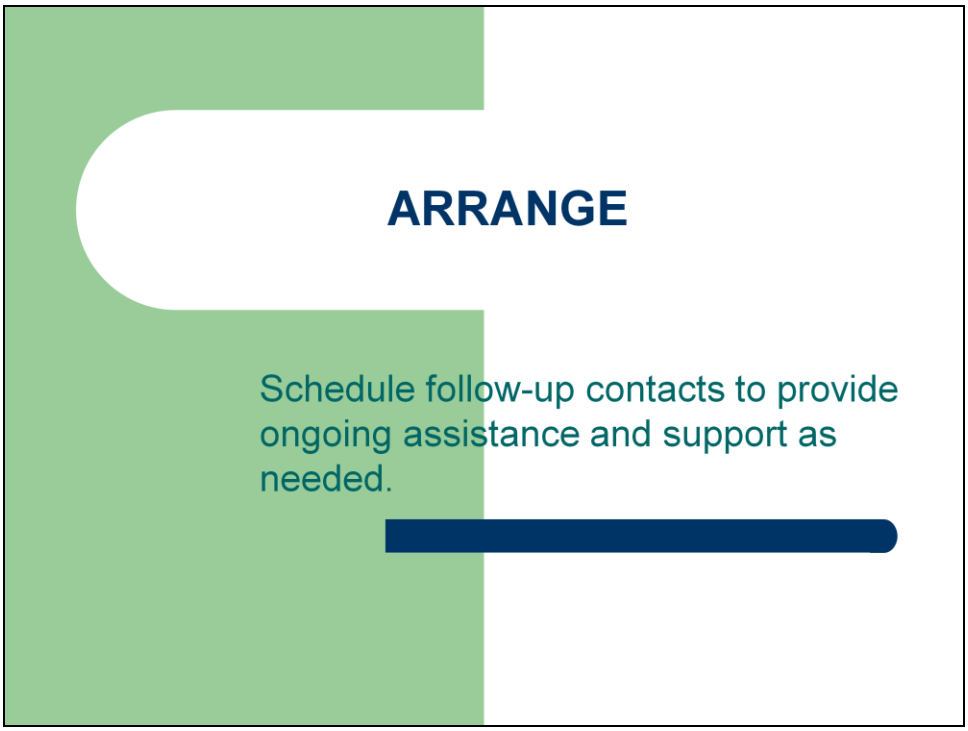
Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001

Thoughts on Team QI Literacy

- People can read and function above their cognitive level on topics that interest them
- People are very sensitive about being talked down to.
- Be cognizant of power inequities among team members

Key point is to give patients a choice on whether or not they want written material and to have options

From an email response of Kate Lorig to leaders of the CDSMP program, Sep 2002



The final A

Whitlock et al

Tips for follow-up

- Try a wide variety of methods, whichever team prefers (in person, phone, email)
- Make sure follow-up happens, team trust can be destroyed by missed follow-up
- Determine follow-up based on team preference

Glasgow et al in press.

Efficacy of other methods Whitlock et al Evaluating primary care behavioral counseling interventions: an evidence-based approach

http://www.ahrq.gov/clinic/3rduspstf/behavior/behsum1.htm

Personal Action Plan

1. Something you WANT to do
2. Describe
   - How
   - What
   - When
   - Where
   - Frequency
3. Barriers
4. Plans to overcome barriers
5. Confidence rating (1-10)
6. Follow-Up plan

Source: Lorig et al, 2001

This is the center of the diagram.

Goals are too big to work on all at once, and need to be broken down into steps. Action plans should be made for 1-2 week periods of time.

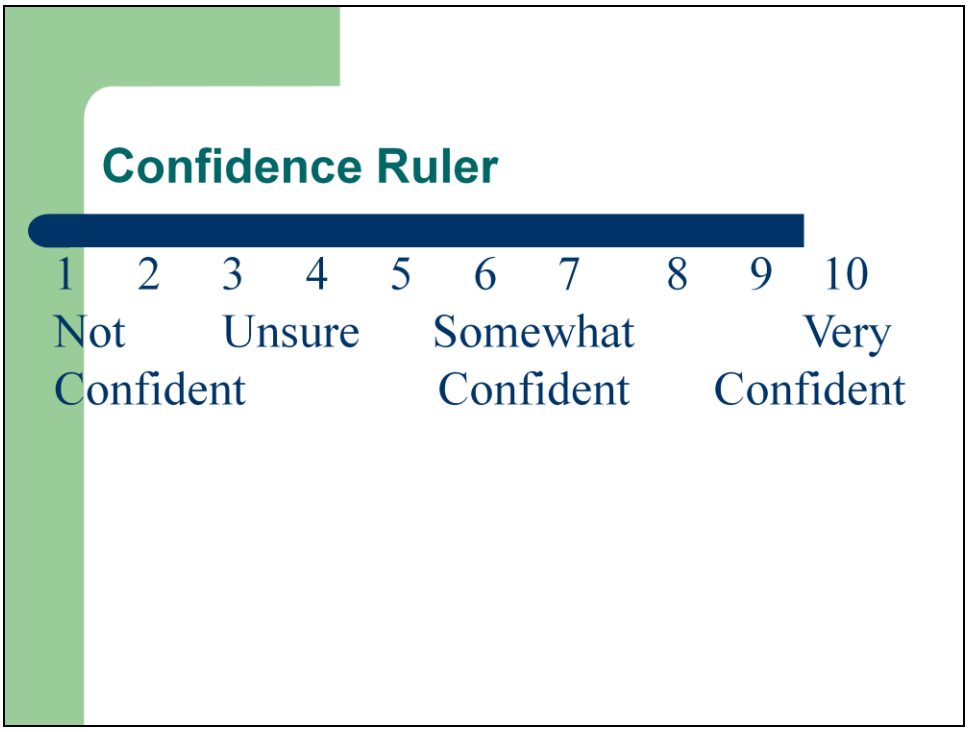
Need to be behavior-specific (someone could observe them doing it).

Confidence see next slide. Confidence is behavior specific. Can be very confident can take meds, but not confident can avoid salt at the church pot-luck if have CHF.

Follow up may be in person, on phone, email. Important to follow-up!!!

(From Kate Lorig, Chronic Disease Self-management program

Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001



People can quickly learn to gauge their confidence.

You can ask, how confident are you that you can complete the entire plan we just set?

If their confidence is less than 7, look at the plan more closely. It is more important for patients to succeed than to have an ambitious plan. Review all the steps. Sometimes the confidence is low because the plan is not something that the patient wants to do. Sometimes they have been overly ambitious with the plan and chosen too much or too often. Remind the patient that they can always do more.

For More Information on Self-management Support

www.improvingchroniccare.org

thanks