Adaptation of the Chronic Care Model*-
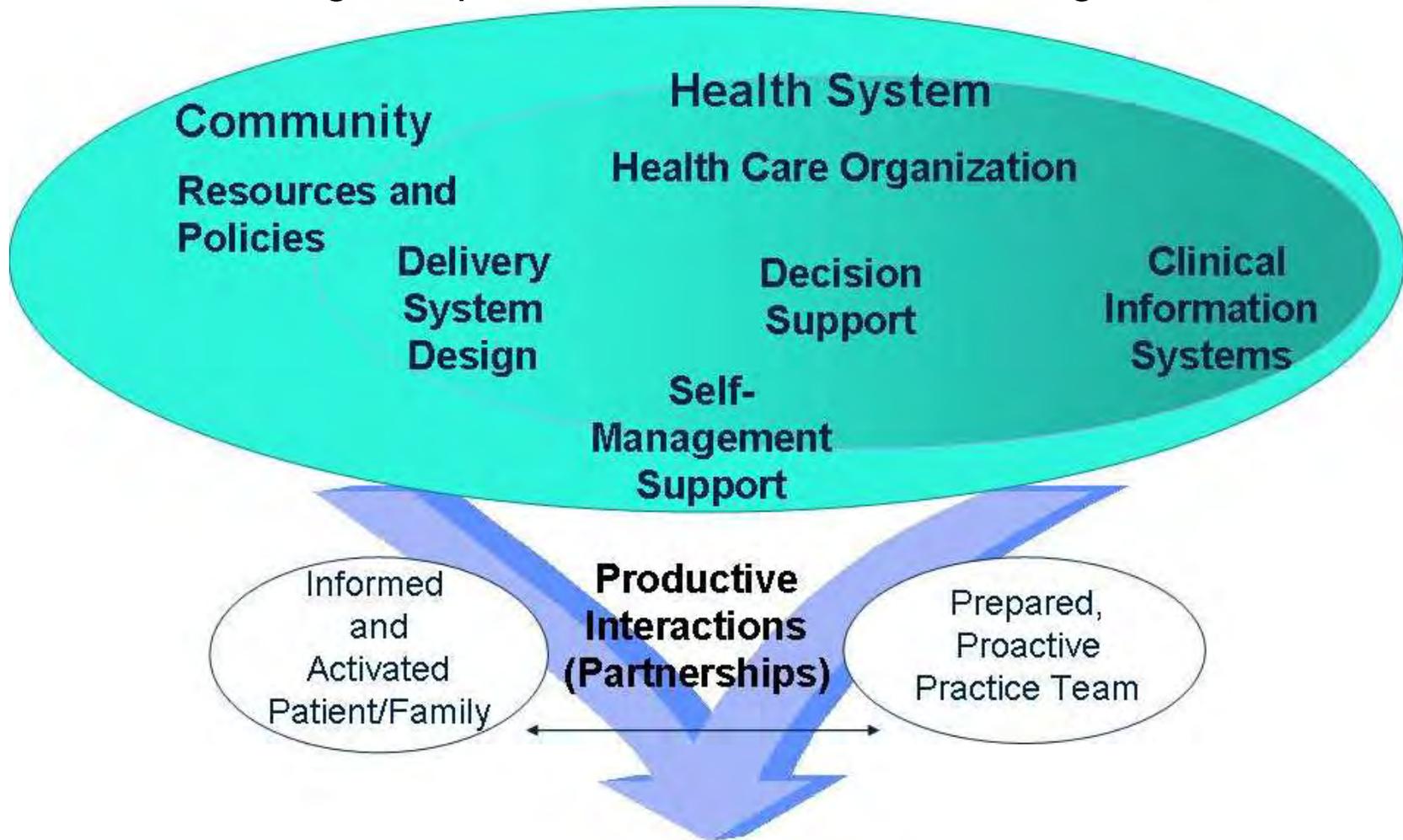# Using Components to Enhance Self-Management

Patients engage in effective self-management

* Adapted from the Chronic Care Model developed by
The McColl Institute for Healthcare Innovation

22 Key Change Concepts to Implement Self-Management Support

SELF-MANAGEMENT SUPPORT- Core Competencies
*What can we do at every interaction with patient/family to
promote the patient as the expert in managing his or her chronic condition?*

- **Describe and promote** self-management by emphasizing the patient's central role in managing his/her health.
- **Include family** members at patient's discretion.
- **Build** a **relationship** with each patient/family.
- Explore patient's **values, preferences**, cultural, and personal beliefs.
- Patient and providers **share Information** and communicate in a way that meets patients' and families' needs and preferences.
- **Collaboratively set goal(s)** and develop action plans and document patient's confidence, use **skill building** and **problem-solving** strategies that help patients and families identify and overcome barriers to reaching goals.
- Provide **follow-up** on action plans and connect patients with community programs to sustain healthy behaviors.

System Supports for Self-Management Support (SMS)

Delivery System Design	**Decision Support**	**Clinical Information System**	**Health Care Organization**	**Community**
How can we provide patient- and family-centered SMS and who can do it?	*How can SMS consistently occur with evidence based care?*	*How can we organize and use patient and population data to facilitate SMS?*	*How can we accomplish comprehensive system change - in culture and mechanisms - to promote safe, high quality SMS?*	*How can we mobilize the community to strengthen SMS?*
• **Determine process and define roles** and responsibilities of individual team members to support self-management.	• Share **evidence-based guidelines** with patients and families so they recognize optimal care.	• Create **easy access to** all clinical and patient-oriented **information.**	• **Partner with patients and families** in a variety of improvement, advisory, and leadership roles.	• **Identify** effective community programs as SMS resources.
• **Use Planned Visits** for delivering self-management support.	• **Train the practice team** (including peer trainers, community health workers, and specialists) to use effective self-management support strategies.	• Create capacity to **identify and contact** relevant subpopulations for **proactive care**.	• Visibly and vocally **support improvement of self-management support** at all levels of the organization.	• **Partner** with community workers.
• **Plan peer interactions**.		• Provide a **written care plan** or visit summary to assure patients know what to do to manage at home.	• **Assure resources** to sustain and spread self-management support.	• **Raise community awareness** of self-management support through networking, outreach, and education.
• Provide **support** and **coordination according to level of need**.				

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The Next 4 Pages: 22 Key Change Concepts Presented with Examples of Specific Ideas

SELF-MANAGEMENT SUPPORT – Core Competencies
What can we do at every interaction with patient/family to recognize and promote the patient as the expert in managing his or her health and care?

KEY CHANGE CONCEPTS	*EXAMPLES* OF SPECIFIC CHANGE IDEAS
1. **Describe and promote** self-management, especially by emphasizing the patient's role in managing their health.	Educators, providers verbalize patients' role and SM concepts at each encounter. Education pamphlets include self management support. Patient advisors create bulletin board or poster in waiting or exam rooms highlighting patient self-management stories. Physician, staff, and patient advisors create newsletter with SM info/stories.
2. **Include family** as patient wishes.	Ask patient if they would like to include their family and invite agreed upon family to appts. Give examples of how family could be included/involved at both the visit and at home.
3. **Build** a **relationship** with each patient/family.	Ask patients how they feel about their illness? Living with their condition. Ask patients how their condition affects their home and work lives, family dynamics. Use reflective listening to get a better understanding of the meaning of patient's symptoms or concerns. Express empathy, affirmation, and support.
4 .Explore **values, preferences**, cultural, and personal beliefs.	Ask what patient knows or believes about their condition(s), treatment, or self-management Ask patients how they like to receive information and explore barriers to communication and learning such as literacy or internet availability. Ask about patients' agenda for the visit and what is most important to accomplish. Ask about patients' conviction and confidence to engage in treatment and SM.
5. Patient and providers **share Information** and communicate in a way that matches patients' and families' needs and preferences.	**Providers**: Direct patients to web sites or peer groups or buddy. Use data/graphs to enhance patient understanding of their condition. Identify and use websites for more info, topic specific educ.-perhaps show in office visit. Review understanding with patients, such as teachback to enhance understanding. Share tool for patients to prepare priorities for visit **Patients:** Create tools for patients to bring info to visit such as self-monitoring log. Encourage patients to share info through video or diary. Peers share information with each other through buddy system, group.
6. **Collaboratively set goal(s)** and develop action plans including: • documentation of patient's confidence and potential barriers, • **skill-building** and **problem-solving** strategies so patients/ families can identify and overcome barriers to reach goals.	Use Goal Sheet or Action Planning Forms. Provide menu of choices if requested. Encourage patients to choose goals that are meaningful to them. Use importance ruler to assess goal/action plan and discuss feelings about change. Use confidence ruler to assess patient's confidence for action plan success and uncover potential barriers.
7. Offer and provide **follow-up** on goal(s)/action plans as patients prefer with a system for ensuring that it will occur.	After visit, arrange for resources within healthcare system Refer patient to appropriate community resources. List follow up preferences/contact info on action plan (e.g. who can help, email or phone…)

NEW HEALTH PARTNERSHIPS
IMPROVING CARE BY ENGAGING PATIENTS

DELIVERY SYSTEM DESIGN

How can we provide patient- and family-centered self-management support and who can do it?

KEY CHANGE CONCEPTS	*EXAMPLES* OF SPECIFIC CHANGE IDEAS
8. **Determine process and define roles** and responsibilities of individual team members to support self-management.	Make all staff a part of SMS and flow process. Introduce practice <u>team</u> to patient. Pre-session Huddles-nurse ID chronic patient and needs, and update team Medical assistant has SM visits prior to patients seeing provider. Dieticians or pharmacists engage in goal setting during nutritional or medication counseling. Create tool to track follow-up such as follow-up calendar or tickler system. Determine back-up staff for each task.
9. **Plan visits** for delivering self-management support.	Use 1:1 visits; proactive planned visits. Use Group Medical visits. Supplement physician visit with education classes, workshops.
10. **Plan peer interactions**.	Set up a peer mentor/buddy system for follow-up, education, and support. Patient expert shares how to use health center. Trained peers lead group visits. Trained peers contact newly diagnosed patients, with permission from patient.
11. Provide **support** and **coordination according to level of need.**	Develop patient selection criteria for more complex patients such as HbA1c at certain levels. Utilize case managers to provide self-management support for complex patients for example: meets every 3 months with patients whose HbA1c > 9. Establish pharmacist visits for medication support Develop protocols for managing specific needs.

DECISION SUPPORT

How can self-management support consistently occur with evidence based care?

KEY CHANGE CONCEPTS	*EXAMPLES* OF SPECIFIC CHANGE IDEAS
12. Use and share locally adapted **evidence-based guidelines** with healthcare providers and with patients and families.	At visits, use depression screening tool. Use guidelines to collaboratively develop a written action plan form that is completed with and given to patient and other providers. Place educational kiosk; computer learning, other resources w/ guidelines in waiting room. Develop algorithms for helping patients to adjust medication, diet, and exercise to control symptoms and understand/use measures of disease activity.
13. **Train providers** (including peer trainers, promotores, and specialists) to understand and deliver self-management support with evidence based care.	Assess clinician and team knowledge, skills and confidence regarding providing self-management support. Invite patient advisors to educational settings to share their perspectives about the value of self-management and self-management support. Provide skills training for core competencies. Include self-management skill training as a component of new employee orientation. Educate residents and train faculty on use of self-management section of EMR or registry. Have weekly provider meeting with case presentations to address SMS challenges. Use practice inquiry model - like peer support group for providers. Train and support patient advisors from different cultures to train staff in beliefs, preferences and communication techniques. Train staff for literacy issues with AMA "Literacy and Health Literacy" video.

CLINICAL INFORMATION SYSTEM

How can we organize and use patient and population data to facilitate self-management support?

KEY CHANGE CONCEPTS	*EXAMPLES* OF SPECIFIC CHANGE IDEAS
14. Create **easy access to** all clinical and patient-oriented **information.**	Create registry/data base that contain patient data and prompts for care at each interaction. Document goals, follow-up, and progress in registry or data base. Provide medical record to patients on "jump drive". Provide "care notebook" to patients for sharing data with doctors. Use web-based Shared Care Plans. Employ web based interactive networks such as My Health Link.
15. Create capacity to **identify and contact relevant subpopulations for proactive care**.	Identify patients who need follow-up or are overdue labs or tests or timely care. Use email prompts to patients that are behind in planned or preventive services.
16. **Monitor and share performance data** of practice team and care system.	Have registry or database that can yield data for measures. Share data/run charts with practice – with both clinicians and patients.

HEALTH CARE ORGANIZATION

How can we accomplish comprehensive system change -
an organizational culture and mechanisms that promote safe, high quality self-management support?

KEY CHANGE CONCEPTS	*EXAMPLES* OF SPECIFIC CHANGE IDEAS
17. Partner with **patients and families in a variety of improvement, advisory, and leadership roles**.	Patients and families are included on improvement teams. Create Patient/Family Advisory Councils. Have Patient Advisor job descriptions. Have a "point" person for patient/family advisors.
18. **Visibly and vocally support** improvement of self-management support at all levels of the organization.	Give presentations to Organization Senior Leaders, Boards. Integrating SMS core competencies into staff evaluations. Put SMS in mission statement. Executive sponsor requests and views reports. Executive sponsor takes responsibility for spread of self-management support.
19. **Assure resources** to sustain and spread self-management support.	Assess the business case for self-management support. Assure resources such as appropriate staffing for self-management support. Have an executive sponsor that monitors and is responsible for spread SMS improvements.

COMMUNITY

How can we mobilize the community to strengthen self-management support?

KEY CHANGE CONCEPTS	*EXAMPLES* OF SPECIFIC CHANGE IDEAS
20. **Identify** community programs as SMS resources.	Make/Update community resources list to assist with patient referrals. Designate staff member or patient/family advisor to be "community resource expert." Patients and families create list of community organizations offering services and programs that support health promotion, disease prevention, and self-management. Call patients after referral to a program to see if it was acceptable.
21. **Partner** with community workers.	Negotiate improved health plan and worker benefit structure to support self-management. Local pharmacist answers questions at group visit or education session. Promotores visit community sites such as migrant camps or schools. Promotores provide follow-up with patients. Partner with community outreach workers to provide follow-up in homes/community.
22. **Raise community awareness** of self-management support through networking, outreach, and education.	Create broadcast on local cable TV, such as "Health Views Segment" on Depression Make SMS part of health fairs. Patients give presentations about SMS to community groups.