Self Management Support

Ontario FHT Pharmacists Networking Day
Nov 10, 2009

Tracy Howson
Mission

The Quality Improvement and Innovation Partnership will be the provincial leader in quality improvement methods for primary healthcare.

Vision

Ontario’s primary healthcare system will be recognized as providing exemplary primary healthcare driven by a commitment to continuous quality improvement.

Goal

To advance the development of a high performing primary healthcare system.
Ontario’s CDPM Framework

INDIVIDUALS AND FAMILIES

- Healthy Public Policy
- Community Action
- Supportive Environments
- Personal Skills & Self-Management Support
- Delivery System Design
- Provider Decision Support
- Information Systems

HEALTH CARE ORGANIZATIONS

COMMUNITY

COMMUNITY

Productive interactions and relationships

- Activated communities & prepared, proactive community partners
- Informed, activated individuals & families
- Prepared, proactive practice teams

Improved clinical, functional and population health outcomes
24-Hour Diet & Exercise Challenge

What did you eat and drink yesterday?

Breakfast
Snack
Lunch
Snack
Dinner
Snack
Bedtime

How were you physically active yesterday?
Changing from me to we

Self Management Support
‘Chronic Disease’ Patient Contact with Health Professionals (Diabetes, Arthritis, Lung/Heart Disease)

Time spent over 1 year:

- GP visits per annum = 1 hour
- Visits to specialists = 1 hour
- Nurse, PT, OT, Dietitian = 10 hours

Total = 12 hours

- 364.5 days managing on their own or 8748 hours

Barlow, J. Interdisciplinary Research Centre in Health, School of Health & Social Sciences, Coventry University, May 2003.
Definitions

• Self Management
  ◦ Actions taken by *patients* in caring for chronic conditions (e.g. taking medications, exercise, managing functional limitations)

• Self Management Support
  ◦ Actions by *health care providers* that strengthen and support self management
People with chronic illness who are able to self manage their disease are likely to more appropriately use health care services, have fewer disease related complications, and experience greater quality of life and better overall health than those who do not self manage their condition.

- Bycroft & Tracy, 2006
- Chodosh, Morton, Jojica et al 2005
- Decoster & Cummings 2005
- National Health Priority Action Council 2006
The problem (with Physicists) is not that we can not learn ---

it is that we can not forget.

Werner Heinsberg

Changing a paradigm
# Patient Education v.s. Self-Management Support

<table>
<thead>
<tr>
<th>Patient Education</th>
<th>Self-Management Support</th>
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</thead>
<tbody>
<tr>
<td>Disease focused</td>
<td>Patient focused</td>
</tr>
<tr>
<td>Education on how to manage symptoms of chronic condition</td>
<td>Support on managing stress and emotional impact of condition</td>
</tr>
<tr>
<td>Education on how to manage disease to reduce impact on life</td>
<td>Support on how to improve lifestyle to minimize impact of disease</td>
</tr>
<tr>
<td>Treatment goals and changes determined by HCP</td>
<td>Lifestyle goals and changes chosen by patient</td>
</tr>
<tr>
<td>Patient educated to comply with treatment</td>
<td>Patient supported to make action plans to meet goals</td>
</tr>
<tr>
<td>HCP monitors patient outcomes and recommends changes to therapy</td>
<td>Patient supported to self-monitor and to modify changes to action plans</td>
</tr>
</tbody>
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Video

Coaching Patients for Effective Self Management

August 2008
California Healthcare Foundation

Tom Bodenheimer, MD
5 Core Self Management Skill components

1. Problem Solving
2. Decision Making
3. Resource Utilization
4. Forming a *productive* Patient Health Care Provider Partnership
5. Taking Action – making action plans

*If a program does not include 3 of 5 then it can not be called “self management support” (Wagner)*
Self Management Approaches

Individual
  – 5 As
  – Health Promoting Process
  – Flinders Model
  – 3 Minute Empowerment

Group Approaches
  – Stanford (peer led)
  – NHS
Self-Management Support Interventions are Varied & Complementary

**Group Programs**
- Stanford University Chronic Disease Self-management Program
- NHS’ Expert Patient Program

**1:1 Empowerment Counselling**
- NP/ Physician Visit
- Home Care Nursing Visit

**Follow-up**
- By Health Professional or Lay Staff/ Volunteer
  - Face to Face
  - Tele-monitoring & Telephone Call
  - Internet e.g. Patient Portal
Making it your own

Quality improvement
Measurement is critical to improvement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act
Plan
Study
Do
The SM one minute Challenge

Self Management Support

Parts of an Action Plan

1. **Something YOU want to do** (not what someone else thinks you should do, or that you think you should do)
2. **Achievable** (something you can expect to be able to accomplish this week)
3. **Action-specific** (for example, losing weight is not a behavior, but avoiding snacks between meals is a behavior)
4. **Answer the questions:**
   - What?
   - How much? (for example, walking 4 blocks)
   - When? (for example, after dinner or Monday, Wednesday, Friday)
   - (for example, 4 times: try to avoid “every day”)
5. **Confidence level of 7 or more** (0=no confidence to 10=total confidence; that you will complete the ENTIRE action plan)

Quality Improvement

![Diagram showing the cycle of Act, Plan, Study, and Do]
Improving your practice

The Envelop, please!

• At least one thing you are going to do,
• Address the envelop where you want it to be sent
• Seal it, no one else will read this
• I will mail it to you in the next few weeks
PLAN

One thing you are going to test, that you believe is achievable

How long are you going to undertake the test? 1 pt/1 min/1 hr?

When are you going to do this? day of the week, time of the day?

Is there anyone else you need to recruit?

Measure: How will you know if the change is an improvement? how confident are you? 1...2....3....4....5....6...7....8....10?

ACT
Plan the next cycle
Decide whether the change can be implemented

PLAN
Define the objective, questions and predictions. Plan to answer the questions. What, where, when?
Plan data collection to answer the questions

STUDY
Complete the analysis of the data
Compare data to predictions
Summarize what was learned

DO
Carry out the plan
Collect the data
Begin analysis of the data

DY

Resources tool box:

- **Books and Documents**
  - Partnering in Self Management Support: A toolkit for Clinicians (IHI)
  - Self Management in Theory and Practice; a guide for Healthcare Providers (www-selfmanagementtoolkit.ca)

- **Websites**
  - SWLHIN
    - [www.Selfmanagementtoolkit.com](http://www.Selfmanagementtoolkit.com)
  - CELHIN
  - ImpactBC
  - Optimizing Health
    - [http://www.optimizinghealth.org](http://www.optimizinghealth.org)

- **Courses**
  - Self management tool kit website modules
  - Optimizing Health Conference November 24, 25, 2009
  - Become a Stanford peer leader
  - Impact BC modules

- **People**
  - Kate Loring
  - Patrick McKowen
  - Tom Bodenheimer
  - Mike Hindmarsh
Improving Chronic Illness Care - Chronic Care Model
www.improvingchroniccare.org

California Health Care Foundation (videos)
www.chcf.org

Brief Negotiation Roadmap - Kaiser Permanente
(online tutorial)
http://kphealtheducation.org/bnroadmap/index.htm!

Quality Improvement and Innovation Partnership
www.qiip.ca

Stanford University
http://patienceducation.stanford.edu/programs/cds(mp.html

NHS Expert Patients Programme
http://www.selfmanagementtoolkit.ca

With Companion literature –

**Self Management in Theory and Practice: A guide for Healthcare Providers**
Welcome

"Help me get through the maze of self-management models and instruction! Where can I start?" Anonymous Healthcare Worker
Go from here?

Take the Time it Takes, so it takes less Time

• 1. Recommend reviewing the resources, highly recommend mining, http://www.selfmanagementtoolkit.ca

• 2. Allow yourself to do test of change/ pdsas, building your skill and your patients ability to self manage, it is a life long journey ---

• 3. And if you can, participate as a patient in a Stanford CDSM program workshop. Not to necessary become a peer leader but to really understand and walk in the shoes of your patients, so you can become a better partner
Questions