# Best Practice:
# Patient Self-Management

# Nurse Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.608 App. 12/2007

# Nurse Track

This best practice intervention package track is designed to educate nurses in patient self-management and self-management support principles that will support reducing avoidable acute care hospitalizations.

## Objectives

After completing the activities included in the Nurse Track of this **Best Practice Intervention Package – Patient Self-Management**, the learner will be able to:

1. Describe patient self-management and self-management support as they relate to home health care delivery
2. Describe how patient self-management will support reducing avoidable acute care hospitalizations
3. Describe two nursing actions that encompass self-management support

Complete the following activities:

| | Activity | Location | Estimated Time |
|---|---|---|---|
| ❑ | Read the Nurses Guide to Patient Self-Management and Self-Management Support and Self-Management Support: The Clinician Connection | Page 73 | 10 minutes |
| ❑ | Complete the Self-Management Support Nurse Self-Assessment | Page 75 | 5 minutes |
| ❑ | Review the My Action Plan tool and Action Plan Script | Page 76 | 10 minutes |
| ❑ | Listen to *Strategies to Improve Patient Self-Care Management Skills* podcast | Page 78 | 15 minutes |
| ❑ | Watch or listen to: *Supporting Patient Self-Management through Planned Care: Evidence and Techniques* WebEx or podcast | Page 78 | 45 minutes |
| ❑ | Read Examples of Excellence | Page 79 | 10 minutes |
| ❑ | RNs: Complete the nursing evaluation and post-test online for free CNEs | See link below | 10 minutes |
| ❑ | LPNs: Complete the nursing post-test online for free certificate of participation | See link below | 10 minutes |
| | **Total time for completion** | | **105 minutes** |

**RNs:** Apply for **free** 1.75 Continuing Nursing Education units for completing the nursing track activities. **Complete evaluation/post-test online at:** http://www.zoomerang.com/survey.zgi?p=WEB2277VKJZG2C

**LPNs/LVNs:** Apply for a certificate of attendance for completing the nursing track activities. **Complete evaluation/post-test online at:** http://www.zoomerang.com/survey.zgi?p=WEB2277VKJZG2C

# Nurse's Guide to Patient Self-Management and Self-Management Support

## Definitions:

- **Patient self-management** includes the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions.

- **Self-management support** is the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support. (IOM, 2003)

- **Action Planning** is a tool or technique that helps people change their behavior over a short period of time. (Lorig, 2006)

## Parts of an Action Plan

1. **Something YOU want to do**

2. **Achievable** (something you can expect to be able to do this week)

3. **Action-specific** (for example, losing weight is not an action or behavior, but avoiding snacks between meals is)

4. **Answers the questions:**
   **What?** (For example, walking or avoiding snacks)
   **How much?** (For example, walking 4 blocks)
   **When?** (For example, after dinner on Monday, Wednesday and Friday)
   **How often?** (For example, 4 times a week; try to avoid "every day")

5. **Confidence level of 7 or more**
   ("On a scale of 0 = ***no confidence*** to 10 = ***total confidence,*** how confident are you that you will complete the ENTIRE action plan?" If the patient rates confidence below a 7, you might want to look at the barriers and consider reworking the action plan so that it's something the patient is confident that he/she can accomplish.)

(From the Chronic Disease Self-Management Program Copyright Stanford University 2006)

BUILDING UPON THE BASICS

# Self-Management Support: The Clinician Connection

## Seven Clinician Tips for Self-Management Support

1. Understand that self-management support is more than patient education
2. Work **with** patients to develop realistic health changes
3. Help patients evaluate with they are already doing to manage their health
4. Help patients to see the relationship between behaviors and outcomes
5. Translate clinical measures to terms that are **relevant and understandable** to the patient and caregiver
6. Focus on small measurable changes
7. Reinforce and praise **consistent, unattended** performance

"Our experience has been that, done well, implementing self-management support can be very fulfilling and positive for providers. It expands the clinicians' role to include more of what many consider their core competencies and it can stretch their role in welcome ways."

***Laurel Simmons,*** Deputy Director, New Health Partnerships: Improving Care by Engaging Patients

Nurse

BUILDING UPON THE BASICS

# Self-Management Support: Nurse Self Assessment

**Purpose of Tool:** To provide parameters to assess your capability to support patient self- management in your clinical practice

| ***Establish a Focus*** | **Yes** | **No** |
|---|---|---|
| At start of care and on an ongoing basis, I assess patient beliefs, behavior and knowledge with a standardized assessment. | ❑ | ❑ |
| I ask open-ended questions whenever possible to learn about patients' perceptions and concerns, adapting the level of my conversation based on cognitive and language deficits. | ❑ | ❑ |
| I actively listen to my patients as they tell their illness story. | ❑ | ❑ |
| ***Share Information*** | **Yes** | **No** |
| I share information about the illness with the patient to help my patients make informed decisions on where to focus their efforts. | ❑ | ❑ |
| I provide personalized feedback on lab values and functional status related to risks/benefits and ways behaviors can affect outcomes. | ❑ | ❑ |
| I provide feedback to patients, the home health team and physicians regarding the patient's progress/status with an emphasis on the patient's self-defined goals. | ❑ | ❑ |
| ***Develop Shared Goals*** | **Yes** | **No** |
| I collaboratively develop a patient-centered emergency care plan that correlates with my patient's goals and is reinforced with each encounter. | ❑ | ❑ |
| I collaboratively set goals with the patient/caregiver based on the patient's interest and confidence in his or her ability to change the behavior. | ❑ | ❑ |
| I refer to speech therapy to identify the best possible way to present information to patients with hearing loss, cognitive deficits, memory deficits, vision issues and/or processing deficits and various learning styles. | ❑ | ❑ |
| ***Develop an Action Plan*** | **Yes** | **No** |
| I establish a patient/caregiver driven action plan with my patients to support self-management goals. | ❑ | ❑ |
| I provide an opportunity for my patients to identify their confidence levels in achieving specified goals. | ❑ | ❑ |
| Identify personal barriers, strategies, problem- solving techniques and social/environmental support available for all patients. | ❑ | ❑ |
| ***Use Problem Solving Techniques*** | ***Yes*** | **No** |
| I offer tools and coaching to ensure medication simplification and reconciliation occurs effectively according to patient's ability. | ❑ | ❑ |
| I support and encourage my patients to develop skills needed to communicate effectively with physicians. | ❑ | ❑ |
| I define plans for follow-up including setting a specific date to revisit or check in by phone to follow-up with the patient's progress towards goals. | ❑ | ❑ |

# MY ACTION PLAN

DATE: _____

I _____ and _____
(name) (name of clinician)

have agreed that to improve my health I will:

**1. Choose one of the activities below:**

_____Work on something that's bothering me:

_____

_____Stay more physically active!

_____Take my medications.

_____Improve my food choices.

_____Reduce my stress.

_____Cut down on smoking.

**2. Choose your confidence level:**
This is how sure I am that I will be able to do my action plan:

**10 VERY SURE**

**5 SOMEWHAT SURE**

**0 NOT SURE AT ALL**

**3. Complete this box for the chosen activity:**

What:_____

_____

How much:_____

When:_____

_____

How often:_____

_____
(Signature)

_____
(Signature of clinician)



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# ACTION PLAN SCRIPT

## I. Deciding what one wants to accomplish

"What will you do this week?"

It is important that the activity come from the participant and not you. This activity must be something that the participant wants to do to change behavior. Do not let anyone say, "I will try." The person should say, "I will . . ."

## II. Making a plan

"Let's talk about exactly how you will do that."

This is the difficult and most important part of making an action plan. Part I is worthless without Part II. The plan should contain all of the following elements:

1. Exactly what is the participant going to do (i.e., how far will you walk, how will you eat less, what relaxation techniques will you practice)? Make sure this is an ACTION, not the result of an action!

2. How much (i.e., walk around the block, 15 minutes, etc.)?

3. When will the participant do this? Again, this must be specific (i.e., before lunch, in the shower).

4. How often will the activity be done?

This is a bit tricky. Many participants tend to say every day. **In making an action plan, the most important thing is to succeed.** Therefore, it is better to commit to do something 4 times a week and exceed the commitment by actually doing it 5 times than to commit to do something every day and fail by only doing it 6 days. To insure success, encourage people to commit to do something 3 to 5 days a week. Remember that success and self-efficacy are as important, or maybe even more important, than actually doing the behavior.

## III. Checking the action plan

"On a scale of 0 to 10, with 0 being not at all confident and 10 being totally confident, how confident are you that you will (repeat the participant's action plan verbatim)?"

If the answer is 7 or above, this is probably a realistic action plan. If the answer is below 7, then the action plan should be reassessed.

"What makes you uncertain? What barriers do you have?"

Then discuss the problems. YOU should offer solutions LAST. Once the problem solving is completed, have the participant restate the action plan and return to repeat Part III, checking the action plan.

*NOTE:* This planning process may seem cumbersome and time consuming. However, it does work and is well worth the effort. The first time you make an action plan, plan to spend 6 minutes. Making an action plan is a learned skill. Your participant will soon be saying "I will _____4 times this week before lunch and have a confidence level of 8 that I can do this." Thus, after two or three sessions, making an action plan should take less than a minute.

From the Chronic Disease Self-Management Program
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# Patient Self-Management Multi-Media Activities

## Podcast*

**Patient Self-Management Clinician Podcast Instructions:**
Listen to the podcast to learn more about patient self-management from Lisa Gorski, MS, APRN, BC, CRNI, Senior Associate Consultant with OASIS Answers, Inc.

| Title | Description | Link |
|---|---|---|
| **Strategies to Improve Patient Self-Care Management Skills** | A 15-minute podcast highlighting how to work collaboratively with patients to develop plans to assist in reducing acute care hospitalizations and improving patient goals | The podcast link is located at http://www.homehealthquality.org/hh/hha/interventionpackages/patient_sm.aspx |

There are several ways to listen to the podcast:

- Visit the link above and listen directly through the Web site
- Download the podcast by right clicking on the audio file and selecting "Save Target As ..." This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or can save the audio file to a CD or MP3 player.

*A podcast is a digital media file, often an audio recording, placed on the Internet and made available to the listener on their home computer or personal digital recording device for convenience.

## Patient Self-Management WebEx

Watch the WebEx or listen to the podcast to learn more about patient self-management from Kathleen Foss, BSN, RN, Performance Improvement Advisor II at Masspro.

| Title | Description | Link |
|---|---|---|
| **Supporting Patient Self-Management through Planned Care: Evidence and Techniques** | A 45-minute WebEx or podcast that addresses the difference between patient self-management and self-management support, and the need for collaboration with the patient in order to be successful with self-management | The WebEx and podcast link is located at http://www.homehealthquality.org/hh/hha/interventionpackages/patient_sm.aspx |

**Note -** The Planned Care: Patient Self-Management Support Staff Education Workbooks (referenced in the WebEx/podcast) are located on www.homehealthquality.org under Associated Resources with the Patient Self-Management package.

# Examples of Excellence

## Reducing Acute Care Hospitalization: The Impact of Chronic Illness Assessment Staff Education

Reaching Goals at South Davis Home Health

**Aiming "LOW"**

South Davis Home Health (SDHH) is a small, hospital-based agency in Bountiful, Utah. The staff is committed to reducing the number of patients who experience an avoidable acute care hospitalization and providing effective self-management support. As a voluntary participant in the national ReACH (Reducing Acute Care Hospitalizations) Collaborative, SDHH set its outcome goal at nine percent based upon OBQI data. As of the July 2007 OBQI data, the acute care hospitalization (ACH) rate for South Davis is 9.90 percent, which is 11 percent better than the Utah state average. "We aimed low, and have been amazed at our progress," says Denise Cook, QI Director.

**Methods**

How are they doing it? Leadership has incorporated quality improvement into the agency's organizational culture. They have created a blame-free learning environment that has promoted teamwork. "We value staff involvement and input," says Ms. Cook. "We want our clinicians to be involved in developing processes that will improve our patients' care and support patient self management."

SDHH conducted strategic process investigations to determine how to decrease avoidable hospitalizations. The investigation findings revealed that OASIS assessments were not always capturing patient acute care hospitalization risk factors. Consequently, South Davis decided to focus staff education efforts on comprehensive chronic illness assessment, which is the first step to ensure that patients remain safe in their homes, improve their level of functioning and develop effective self management skills.

The ability to identify risk factors that are associated with chronic illnesses requires clinicians to look beyond immediate acute conditions. SDHH realized that this level of knowledge and assessment skill required chronic illness expertise, so they sought the help of external chronic illness experts. Staff education emphasized that accurate assessments translate into patient-centered care plans that guide appropriate treatment, including determining the self-management support patients will need to manage their chronic conditions. They learned the characteristics of a comprehensive chronic illness assessment, how to gather patient information effectively and efficiently and how to evaluate patients' conditions based on these data. This comprehensive assessment and evaluation then serves as the basis for the development of a patient-centered self-management plan.

In order to strengthen patient assessments and determine a patient's ability to self-manage, clinicians are now administering the CLOX test to patients upon admission, at resumption of care and anytime a patient seems to have a cognitive decline. They also test caregivers when appropriate. The CLOX test is a clock-drawing activity used to detect early signs of cognitive impairment. The tool helps clinicians assess the patients' ability to initiate and sequence tasks or events. This information can lead to more effective care plans by helping clinicians determine what level of assistance each patient needs to safely self-manage his/her chronic conditions as independently as possible. This is important because even the most appropriate care plan will fail if clinicians and patients don't execute it correctly.

After patients are assessed appropriately, clinicians use personalized emergency care plans, which list early warning signs and symptoms, and standardized teaching tools to educate patients and their caregivers on chronic disease management. The teaching tools have been organized in a file cabinet drawer for easy access for clinicians and can be taken to the home as a handout if appropriate. Clinicians also use the tools as a guide for documentation of teaching and evidence of the patient's self-management skill development.

**Outcomes**

Following the chronic illness assessment training, agency clinicians reported a positive shift in the way they assess patients with chronic diseases. Many sources of information are considered, starting with the H & P. Clinicians are now using their observational skills, and they're asking open-ended questions to gather objective and subjective evidence. They are looking at patient health status from physiological, functional, psychosocial and cognitive perspectives to create a whole picture. Their clinical skills have been enhanced and they are seeing the benefits in their patient care and their ability to provide individualized patient self-management support. Because fewer patients are requiring hospitalization, this means more are being cared for safely at home, while developing effective self-management skills. Data are collected regularly to determine if clinicians are performing these new best practices consistently and accurately. As noted, they are definitely seeing a reduction in the number of avoidable hospitalizations.

**Staff Engagement**

To promote staff involvement, the agency is ensuring the outcomes data is visible to everyone in very creative ways. A picture of a bed, representing hospitalization, is hanging on a wall in the agency office. If a patient experiences an acute care hospitalization, a cutout figure is added to the bed.

To learn more about what South Davis Home Health is doing to reduce avoidable hospitalizations, contact Denise Cook at denisecook@sdch.com or 801.299.4866.

*Denise Cook, RN, QI Coordinator, South Davis Home Health*
*Cher Edmonds, MS, CHES, SSW, Project Coordinator, HealthInsight*

** Content and data provided by Denise Cook, South Davis Home Health*

# Identification of Self-Management Support Strategies: The Role of Technology

**The ACH Reduction Directive**
For HMO Group Health in Seattle, Wash., reducing acute care hospitalization rates was a directive from leadership, expedited by a confluence of outside influences and the manipulation of existing company technology.

The home health and hospice segment of Group Health covers all of western Washington, an area encompassing an urban, suburban and rural customer base of about 500,000. The home health segment has an average daily census of 500 patients.

Paul Ehrlich, RN, Performance Improvement and Quality Specialist, has been with Group Health for 25 years. Ehrlich says the home health group began addressing ACH rates through the ReACH project, introduced by Washington state's QIO, Qualis Health, several years ago. The program contained similar elements to the current national Home Health Quality Improvement Campaign.

**High-Risk Identification Strategies: The Role of Technology**
Through the work of the ReACH project, a pilot program through the New York Visiting Nurses Association addressing acute care hospitalizations, the HMO developed methods to identify patients that were at high-risk, and then incorporated these risk factors into the electronic OASIS start of care (SOC) assessment. Company technology was then employed to calculate a numerical score to flag high-risk patients. Clinicians need not complete additional paperwork to assess those at high-risk for ACH.

"Other agencies have an additional form," said Ehrlich. "Our clinicians only had to do what they normally do, and the score is calculated and available right there in front of them. As soon as they pull up the patient's name they see 'high-risk' flagged in the non-clinical note."

According to Ehrlich, technology was an important piece of the puzzle. Since the HMO's system was partially in place, IT staff had time to devote to this project. However, he emphasizes that even though "we are a little ahead of the curve, it's not by leaps and bounds."

**Patient Emergency Planning: A Self-Management Support Strategy**
After the assessment, Group Health created a single, simplified emergency planning form for high-risk patients called "Steps to Health," which includes

a lot of space to fill in the blanks. The form is completed on the first visit and then placed on the patient's refrigerator so it is visible to everyone. "Everyone knows how to call 911," said Ehrlich. "Almost every form we've seen has 911 printed prominently on the form, so we specifically left it off ours. We think it's redundant, and without it, patients are prompted to call our home health nurses first." **

GroupHealth

**STEPS TO HEALTH CENTRAL**

FROM 8:00 AM TO 5:00 PM CALL YOUR VISITING NURSE OR THERAPIST AT 1-800-393-0890

AFTER 5:00 PM to 8:00 AM
CALL GROUP HEALTH CONSULTING NURSE AT 1-800-297-6877

Diagnosis: Special Instructions:

PLEASE CALL IF YOU HAVE:

**Heart/Lung Problems**
- ☐ A productive or frothy cough
- ☐ A dry hacking cough
- ☐ New congestion/cold symptoms
- ☐ Increased shortness of breath
- ☐ More swelling in your legs or feet
- ☐ Weight gain of_____in 24 hours

**Signs of Infection**
- ☐ Increased redness
- ☐ More or different drainage
- ☐ Wound gets bigger
- ☐ Temperature of 100 degrees F. or more
- ☐ Change or new odor from wound

**Diabetic Problems**
- ☐ Sudden weakness
- ☐ Increased urination
- ☐ Sweating spells
- ☐ Frequent headaches
- ☐ Drowsiness
- ☐ Blood sugar level greater than_____ or less than_____

**Urinary Problems**
- ☐ Foul odor to urine
- ☐ Catheter not draining
- ☐ Back or flank pain
- ☐ Unable to urinate
- ☐ Increased weakness
- ☐ Bloody, cloudy, or change in urine color
- ☐ Body aches

**Other Problems**
- ☐ No bowel movement in 3 days
- ☐ New skin problems
- ☐ Change in balance, coordination, strength
- ☐ Fall with small or no injury
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:

**PLEASE POST ON REFRIGERATOR**

## Leadership's Role: ACH Risk Identification and Self-Management Support

Group Health's leadership was attuned to national efforts that were underway, including a discussion of the HHQI Campaign. They also were moving along a parallel path because patients want to stay at home, and because reducing ACH is good for the bottom line. Everything began to come together simultaneously for Ehrlich and Group Health—ReACH, HHQI in the national pipeline and a leadership directive.

"We've had support and encouragement from leadership, but it is a lot of work," said Ehrlich. "Teaching the staff and getting buy-in at the staff level means that a lot of ongoing effort is involved, but the results show what can be done."

Group Health's ACH rates have dramatically improved. Prior to the program, Group Health's ACH percentage was consistently in the low 20s—for years it was tracking between 20-22 percent (OBQI reports). Since implementing the program two years ago, their ACH rate has gradually declined each month. "The last two months, rates have been down to 17.6 percent using this program," said Ehrlich. "This is the lowest it has ever been and we're still on a downward trend."

According to Ehrlich, technology, management support, national programs and the efforts of the QI staff and clinicians have led to measurable improvements.

** Content and data provided with permission by Group Health Home Health & Hospice*
*** The "Steps to Health" form is available for download at www.homehealthquality.org.*

# Nursing Post-test
## Patient Self-Management

Clinician_____ Date_____

**RNs – May apply for 1.75 FREE CNEs and LPN/LVNs may apply for certificate of participation by following directions on page 72.**

**Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.**

1. Individuals must undertake tasks to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions. This is the definition for:
   A. Patient self-management
   B. Self-management support

2. Provision of education and supportive interventions systematically by health care staff increases patients' skills and confidence in managing their health problems. This can include regular assessment of progress and problems, goal setting and problem-solving support. This is the definition for:
   A. Patient self-management
   B. Self-management support

3. All of the following activities are examples of self-management support **except:**
   A. Patient weighs self and takes medications independently
   B. Sharing information about the disease with patient
   C. Completing shared goal setting with the patient
   D. Developing an action plan with the patient

4. Developing an Action Plan with the patient can provide for all the following **except**:
   A. Initiating a conversation with patient to determine what the patient would like to accomplish
   B. Making a decision to accomplish the plan
   C. Determining how confident the patient is in reaching the goal
   D. Providing opportunities for clinicians to follow-up with patients and encourage them to continue their self-management efforts
   E. Ensuring action plan success

5. The clinician can determine what specific action plan the patient needs to develop and act upon it without patient involvement.
   A. True
   B. False

**Answers to Post-test are located in the Leadership Section page 70.**