A Systems Approach to Quality Improvement in Home Health:

Planned Care: Self-Management Support in Home Healthcare

MASSPRO

Making an Impact.

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Tab 1: Introduction, Vision & Outcomes

Introduction

Mastering and integrating self-management skills are important parts of living with chronic illness. According to the Centers for Disease Control and Prevention, chronic illness is now the leading cause of death and disability in the U.S., affecting quality of life for 100 million Americans per year. The emerging prevalence of chronic illness has created the need for a fundamental shift in the values, attitudes, skills, and work processes within the healthcare system.

In a system designed to deliver acute symptom-related care, healthcare providers have practiced prescriptively - "Do as I say." The level of patient adherence to a prescribed treatment regimen has been the measure of successful self-management rather than the patient's ability to manage all health-related issues on a daily basis and sustain a healthy lifestyle for the long term. Chronically ill patients require planned, regular interaction with their caregivers, with a focus on prevention and intervention, and a shift from a provider-centered model to one that is patient- and family-centered.

Self-management entails all aspects of the patient's life, focusing not only on disease management, but incorporating measures to promote an overall healthy and productive lifestyle. Important components of a self-management support program include: patient education, problem solving, monitoring and taking actions based on those results, symptom management, communicating with the physician and other providers, and utilizing community resources to promote success and sustainability with self-management after home health services end. Multiple studies have shown that patients who are involved with their healthcare decisions and management have better outcomes than those who are not.

In a study conducted by the Institute for Healthcare Improvement (IHI), four key components were identified for a planned care concept design:

- A care team approach to service delivery
- Patient activation as one of the primary sources of reliability
- A clinical information system that supports the care team and the patient
- Organizational leadership to drive and support these elements of care

The concept that *every patient would have his or her own care plan* is the center of this new design for planned care.

Effective self-management support will help activate and inform patients to better cope with the challenges of living and treating chronic illness. Interactions between the patient and care team result in creating a shared care plan and building the patient's confidence in doing his or her part to manage their own care. The care team, patient and their interactions are supported by the clinical information system, with leaders providing the foundation, vision, and resources for the system to operate.

The Planned Care Model for home health is conceptually based on the IHI design, the Chronic Care Model designed by Edward Wagner, MD, MPH, Senior Investigator at the MacColl Institute for Healthcare Innovation's Center for Health Studies, and the self-management framework developed by Kate Lorig, DrPh, MS, Professor and Director of the Patient Education Research Center at the Stanford School of Medicine. Recognizing that the patient has primary responsibility over his/her own health, this model is based on the premise that the patient and caregiver are integral parts of the care team who participate in a collaborative partnership with healthcare providers to achieve successful health management.

The framework for the Planned Care Model for Patient Self-Management has been designed to promote consistent, evidence-based care that is comprehensive. The process begins by actively engaging patients in their health. A collaborative partnership is established in which the patient and clinician transition through stages of responsibility. Clinical interventions focus on fostering self-efficacy and moving the patient from a role of dependency to independence, with identified patient outcomes to be met at each transitional stage. These patient outcomes form the basis for evaluation and decision making to move to the next stage.

The model consists of standardized protocols that include the basic components of self-management, while retaining the ability to customize interventions to the needs of the patient. A variety of approaches are utilized to teach and promote self-efficacy in ways that are relevant and meaningful to the patient. Individualized action plans with long- and short-term goals that are achievable, patient driven, and culturally appropriate are developed.
Interactions between the patient and clinician result in goal setting, problem solving, and building the patient's confidence for doing his or her part in managing their health.

Vision

Through collaborative decision-making and goal setting, patients and families embrace the behavior changes necessary to manage their condition outside of the healthcare setting, improve outcomes, and exhibit the self-efficacy to direct their own care.

Outcomes

- Improved patient self-efficacy in self-reporting health status and symptom management
- Reduction in the utilization of emergent care services and fewer hospitalizations
- Improved communication across healthcare settings
- More efficient, proactive delivery of care

Key Points

- **Health belongs to the individual and the individual has primary responsibility over his/her own health**
- **Self management by patients is not optional but inevitable because clinicians are only present for a fraction of a patient's life, and nearly all outcomes are mediated through patient behavior (Bodenheimer et al. 2002)**
- **Patient self-management has been associated with improved health status and decreased utilization of healthcare services**
- **If every patient, including those without chronic conditions, had an evidence-based plan that is shared among providers, then the evidence-based care would be delivered more often, more reliably, and outcomes for patients would improve as a result (IHI 2006)**

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Tab 2: Planned Care Framework

Model Framework

The Planned Care Model combines traditional home visits with technology and supportive services, transitioning the patient from dependency to independence. There are three stages the patient progresses through, with specific outcomes to be achieved at each stage before moving on to the next.

Stage I: Individualized Plan & Goal Setting

Goal: Patient Safety and Stabilization

The clinician's role is one of educator and facilitator. A plan of care is created that is culturally sensitive and individualized to meet the patient's needs, lifestyle, and priorities.

At the end of this stage, and before moving on to the next stage, the patient will:

- Establish at least three mutually defined goals
- Verbalize a confidence level of at least seven on a 1-10 scale, for attainment of two of the three goals set
- Identify potential/actual barriers that may impede goal attainment
- Have a scheduled visit with their primary care physician, using their personal health record (PHR) to engage the physician in the shared care plan
- Verbalize understanding of reportable signs and symptoms, when to contact the agency or physician, or seek emergent care
- Maintain a log of tele- monitored data, as well as any other relevant clinical data (e.g., blood sugars, weights, diet intake, etc.)
- Verbalize readiness to progress to the next stage

Stage II: Collaboration

Goal: Problem Solving & Accountability

In this stage, the clinician's role becomes one of a mentor or coach, as the patient begins to accept more responsibility for his or her own health and well-being. The clinician supports the patient's efforts to progress toward goals identified in Stage I, accessing relevant community and educational resources.

At the end of this stage, and before moving to the next stage, the patient will:

- Use problem-solving techniques to overcome identified barriers that may limit his or her ability to self-manage health issues
- Assume a more active role in self-management as demonstrated by managing physician appointments and implementing the Zones of Management, as indicated, with minimal assistance from the clinician
- Understand the relationship between their log of health data, their health status, and what actions to take based on that information

Stage III: Patient Autonomy

Goal: Autonomy and Self-Efficacy

In this stage, the focus is on the patient's autonomy and ability to self-manage their disease with limited assistance from the home health clinician. Telemonitoring is phased out as the patient achieves self-efficacy.

At the conclusion of this phase, the patient will be able to:

- Demonstrate his or her ability to carry out the self-management plan every day and deal with challenges as they arise
- Utilize support group, Internet, and community resources to sustain self-management
- Verbalize readiness for discharge of home health services

Consistent, evidence-based care is provided through a combination of in-person and remote encounters. Patient self-management is emphasized in every encounter. The method and frequency of contact is based on the patient's needs, health literacy, and preference for learning.

Home Visits

Face-to-face visits are made based on the patient's need and progress. The "5 As" (Assess, Advise, Agree, Assist, Arrange) approach and motivational interviewing are utilized to facilitate health behavior changes. Goal setting is collaborative and based on the patient's confidence level of success.

Telephone Contacts

Telephone assessments are used to augment home visits and promote a positive patient-clinician relationship. These calls may be supportive, educational, and/or reinforcing in nature.

Telemonitoring

Electronic monitoring equipment is used in the patient's place of residence to collect clinical data. This data is transmitted electronically to the home health agency and reviewed by the telehealth nurse. Abnormal findings will then trigger action to be taken (call and/or visit) to intervene early and prevent emergent care.

All patients are evaluated for appropriateness of planned care. Patients who are accepted for the Planned Care Model must be committed to and agreeable to achieving self-management of their disease.

Exclusion Criteria

- Moderate-to-severe cognitive impairment with no able and willing caregiver
- Evidence of patient non-adherence
- Palliative and end-of-life care

Key Points

- **A patient who understands his or her illness, knows how to monitor and manage symptoms, and knows how to obtain assistance when needed, will follow through and be able to manage his or her care**
- **Clinical practices need to be redesigned to include planned visits for patients with chronic conditions**
- **The role of the clinician is to provide self-management support to patients to assist and encourage patients to be informed and activated**

Tools

- Patient Self-Management Brochure

Choose a Healthy Lifestyle:

- ❑ Take all medications as prescribed
- ❑ Contact your physician when your condition changes
- ❑ Follow dietary recommendations
- ❑ Keep all scheduled doctor appointments
- ❑ Exercise daily
- ❑ Maintain your personal health record
- ❑ Use available community and Internet (computer) resources
- ❑ Stay up-to-date with health screenings and immunizations

Insert agency name, address, telephone number, etc. here

Insert Agency Logo Here

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Live Your Best

Become an Active Participant in Your Care!

Look inside to see how we can help you create a realistic plan to manage your healthcare at home.

We want to help you successfully manage your health and live the best life possible. Every day, you make decisions that affect your health: you decide what to eat, when to take medications, and whether to exercise or keep doctor appointments. Making these decisions can be confusing and stressful.

“Planned care” can help you feel more in control of your health by involving you in more decisions about it. For example, you would help set treatment goals based on what is important to you, instead of someone else setting them for you.

Planned Care Components:

- Home visits by nursing, physical therapy, occupational therapy, social service and/or other support staff as needed
- Scheduled telephone calls between visits to monitor your progress
- Collect data by phone, including your blood pressure, weight, blood sugars, or other measurements (also called telemonitoring)
- Development of your own personal health record to help you manage your healthcare

Your Role:

- ❑ Be available for all scheduled home visits and telephone contacts
- ❑ Use the telemonitoring system each day and record findings
- ❑ To keep all scheduled doctor appointments
- ❑ Take ownership of your health management
- ❑ Become an informed and active participant in your healthcare
- ❑ Adopt healthy behaviors/lifestyle

Our Role:

- ❑ Work with you and your family on goals that you and the agency have set
- ❑ Assist you with solving issues related to living with a chronic illness, including symptoms, treatment plans, lifestyle changes, etc.
- ❑ Provide educational materials and resources related for your healthcare needs and lifestyle
- ❑ Support you and help you build confidence in your ability to handle the day-to-day challenges of living with a chronic illness

Tab 3: The Clinical Visit

Clinical Visit

Each clinical encounter is designed to educate and motivate patients to achieve sustained behavior changes that will help them adhere to treatment plans and achieve self-efficacy in directing their healthcare. These encounters are patient-centered, focusing on concerns and perspectives of the patient rather than the clinician. The emphasis is on patient choice, self-efficacy and overall responsibility of the patient to determine his own goals.

Combinations of techniques are used to integrate self-management into every patient contact. Self-management evolves from the patient's frame of reference. It is necessary to assess the patient's readiness to change health-related behaviors and assume responsibility. Intervention techniques are used to help patients increase their willingness and confidence in making the desired changes. Once the patient is motivated to change, strategies such as problem solving and goal setting are implemented.

Motivational Interviewing

Motivational interviewing is a person-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Moyers and Rollnick 2002). This technique provides guidance to clinicians when assessing the patient's motivation and confidence necessary to implement changes in their lifestyle. Once the patient has the level of confidence to implement and sustain healthy behavior changes, the clinician and the patient engage in a collaborative partnership to undertake the agreed upon changes. The clinician avoids giving advice, and instead elicits from the patient his/her experiences, beliefs, and ideas that will motivate the patient.

The cornerstone of any collaborative relationship is meaningful dialogue and good communication skills. Direct, open-ended questions and reflective listening are critical when engaging patients.

Essential Principles

Empathy: Acceptance and understanding of the patient's feelings helps to facilitate behavior change. The clinician reflects without judging, conveying to the patient that the patient's feelings and perspectives are important.

Discrepancy: Motivation to change is enhanced when patients are able to perceive discrepancies between their current situation and their goals. The clinician facilitates the patient's awareness of the consequences of his or her behavior.

Adjustment: The clinician needs to be able to adjust to resistance rather than opposing it, recognizing that patients choose how to behave. Communication styles that avoid provoking the patient, encourage careful attention to the patient's readiness to change, and that encourage patients to make their own assessments of problems and solutions, enhance a patient's motivation and are more effective than simply giving advice. *(Butler, Rollnick et al. 1996)*

Self-Efficacy and Optimism: Patient commitment towards goal attainment is enhanced and supported. The clinician encourages the patient to move forward, problem solve, and utilize community resources.

The Five As

The Five As is a counseling approach that entails a series of sequential steps to facilitate patient self-management and behavior change (World Health Organization 2004). This approach forms the framework for the patient encounter, keeping the interaction patient-centered. The techniques employed are consistent with the core elements of self-management. Each component is utilized at a patient encounter (face-to-face or telephonic):

- Assess
- Advise
- Agree
- Assist
- Arrange

Assess knowledge, behavior, readiness:

The contact begins with an assessment of relevant clinical data and review of patient goals. These goals may be new or previously set. The agenda is planned with the patient. Consider the following:

- Beliefs
- Intentions/readiness
- Conviction
- Confidence
- Barriers
- Resources

Advise and inform:

Specific information about the health risks and benefits of change are discussed with the patient. The clinician uses patient-specific data to present information that is personally relevant to the patient. It is important to ask the patient what he or she thinks about the recommendations:

- Ask permission
- Ask understanding
- Tell (personalize)

Agree on goals and methods:

Ask the patient what he or she most wants to work on and what would be a reasonable goal. Goals should be reasonable and collaboratively set. A personal action plan is then developed with the patient to meet these goals. The plan addresses the following questions:

a. What will you do?
b. How much will you do?
c. When will you do this?
d. How often will you do it?

To be successful, patients not only need to be motivated to change but also to have the confidence that they can succeed in reaching those goals. Assess the patient's confidence using a 1- 10 scale (1 = no confidence, 10 = total confidence). Begin the action plan when the patient has a confidence level of 7 or greater for the desired behavior change.

Assist to overcome barriers:

Identify personal barriers, and the strategies and social/environmental support that are needed. Ask the patient what he or she sees as the greatest obstacle to achieving the goals. Review past experiences with the patient; discuss what has worked or not worked in the past.

Teach problem-solving skills:

a. Identify the problem
b. List ideas that may solve the problem
c. Choose one method to try for one-to-two weeks
d. Evaluate the results
e. Identify and refer the patient to community resources for support

Arrange follow up:

Set a specific date for the next visit or telephone call. Negotiate an agenda for that contact. Begin each contact with a review of progress on goal(s).

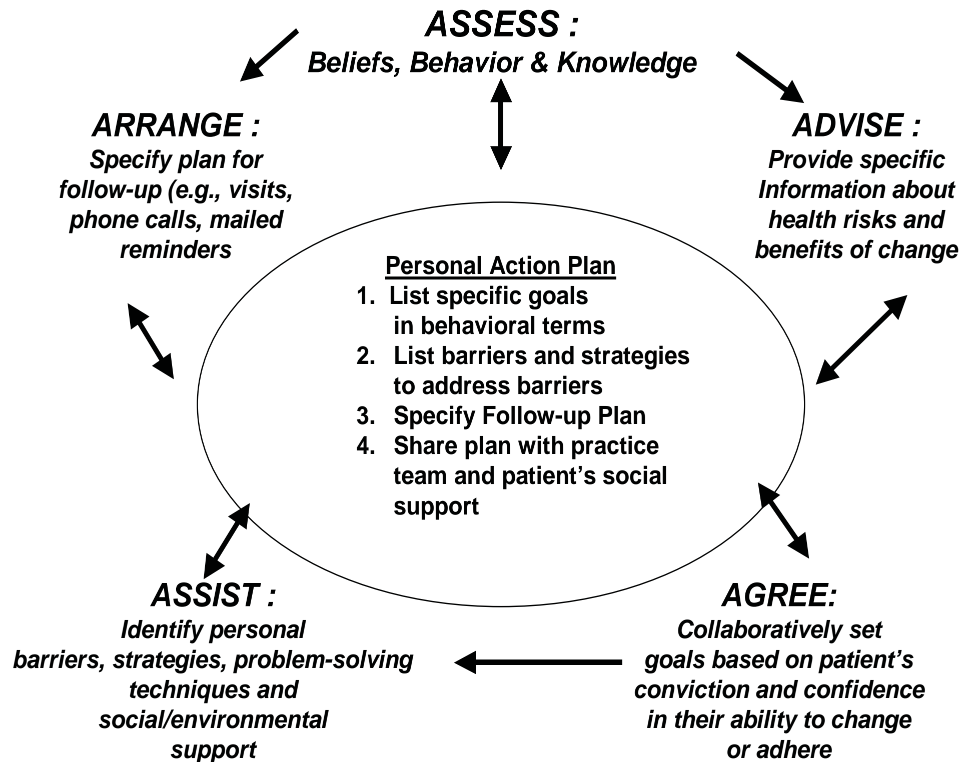
Key Points

- **The likelihood of improved patient outcomes is far greater when home visits/encounters are organized and goal directed**
- **People are motivated differently- patients have to believe change is possible and that they can make the necessary changes**
- **It is the action the patient takes, not the pamphlets, lectures, or behaviors you recommend, that has the greatest impact on how well a patient self-manages**

Tools

- 5 As Model for Self-Management
- Principles of Motivational Interviewing
- Turning Patient Education into Self-Management
- Self-Management Healthy Changes Plan
- Confidence Scales

5 As and Self-Management



Glasgow, R, and Funnell, M, et al. 2002.

Principles of Motivational Interviewing

- Explore the person's thoughts and feelings about the good and not-so-good things about the issue(e.g., about being very overweight, about smoking, about drinking harmfully, etc.)
- Use reflective listening: listen to what the person says, and then summarize it back (e.g., "So, what you're saying is…" or "So, it seems that on the one hand it's… and on the other it's…")
- Show respect and willingness to understand the person's perspective. You do not have to agree, but it is important not to show any disapproval or blame.
- Give accurate health information that is relevant to him/her.
- Help the person clarify his/her personal goals or role in the community- what he/she wants to be or what he/she wants to do in life. You could ask, "What's important to you?" Then, help the person to think about whether what he/she is doing now is helping get there. The person needs to see the conflict or discrepancy within himself/herself.
- Avoid arguing- this will encourage the person to defend his/her opinion and behavior patterns.
- Help the person to look at his/her behavior and how it impacts others.
- At times, the person may be unwilling to consider the effects of his/her behavior. Go with this and acknowledge the person's ambivalence or reluctance. Try another way to move forward with the intervention. It is important not to impose new views or goals, but rather to invite the person to consider new information or perspectives.
- Encourage the person to generate the proposed solution. This means he or she will be more likely to follow it through. Help the person to set realistic personal goals for making changes.
- Try to build the person's confidence. The person needs to believe he or she has the ability to achieve his/her goals and change behavior.
- Ask the person what things he/she may find difficult about changing.
- Offer help and support. Encourage him/her to identify others in the community who may be able to offer support. (e.g., "Are there other people who have changed, too?")

References:
Miller, W.R. and Rollnick, S. 1991.
Rollnick, S. and Miller, W.R. 1995.

Turning Patient Education into Self-Management Support

Self-management support is a counseling technique based on the idea of creating a partnership between the clinician and the patient. One of the primary principles of self-management is that the patient needs to be actively involved in managing his/her health. Self-management strategies strive to help patients understand their disease, make informed decisions, participate in the management of care, and adapt to life with chronic illness. The ultimate goal is to enable patients to live as normal and full a life as possible.

The following is a description of techniques that can be used with patients:

1. *Establish a Focus*

Establishing a focus for the encounter is an important first step in ensuring effective self-management. This is an opportunity for the clinician to learn from the patient about his/her concerns about living with chronic illness. By asking open-ended questions, the clinician can learn about the patient's perceptions and concerns.

2. *Share Information*

Clinicians need to share information about the disease with the patient, emphasizing the concerns that involved healthcare providers may have. This will help the patient make informed decisions on where to focus efforts. Information should be shared in a non-judgmental manner, reinforcing important issues that may have been raised during the initial discussion.

3. *Develop Shared Goals*

Shared goal setting is a collaborative process that incorporates both the clinician's and the patient's perspective. Using a few open-ended questions, the clinician can identify not only the patient's perceptions but also the barriers the patient perceives in reaching those goals. For goals to be useful, they must be meaningful to the patient.

4. *Develop an Action Plan*

After collaborative goal setting, it is important to create an action plan with the patient. The action plan includes a discussion of how, what, when, where, and the frequency of the new behavior. It also includes a discussion of the likely barriers to success and some strategizing about how to overcome these barriers. An important step in self-management is rating the patient's confidence for success.

5. *Use Problem-Solving Techniques*

It is important to agree on a follow-up plan. It is usually as simple as setting a specific date to revisit or check-in. The key point is that the patient knows you will follow-up and that he/she will be expected to report on their progress toward the goals.

Adapted from Turning Patient Education into Self-Management, Center for Health Care Quality, Cincinnati Children's Hospital Medical Center, http://www.cincinnatichildrens.org/cgi-bin/msmfind.exe?RESMASK=MssRes.msk&CFGNAME=MssFind.cfg&query=self-management+education

Self Management: Healthy Changes Plan

Are you ready to make changes? Your short –term goals, or self-management goals, are the small changes you can make over a short period of time that will help you reach your long-term goals for managing ____.

You and your Home Health team can work together better and plan the best ways to reach your health goals when you both know your plan for behavior change.

The Healthy Change I want to make is:______________________________________

I will do this: (how)	
When	
How Often	

The goal I will work on between now and my next visit is:

The steps I will take to achieve my goals are:

The things that could make it difficult to reach my goal are:

This is how I plan to overcome this barrier:

Support and resources I will need to reach my goal are:

How confident are you that you can reach this goal?

Not Confident 1 2 3 4 5 6 7 8 9 10 Very Confident

Adapted from the Healthy Changes Plan, Improving Chronic Illness Care, 2007. www.improvingchroniccare.org

Confidence Scale

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly.

Exercise Regularly

1. How confident are you that you can exercise without making symptoms worse?

   Not Confident 1 2 3 4 5 6 7 8 9 10 Very Confident

Getting Information About Your Illness(es)

1. How confident are you that you can get information about your disease from community resources?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Obtain Help from Community, Family, Friends

1. How confident are you that you can get family and friends to help you with the things you need (such as household chores like shopping, cooking, or transportation)?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

2. How confident are you that you can get help with your daily tasks (such as housecleaning, yard work, meals, or personal hygiene) from resources other than friends or family, if needed?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Communicating with Your Physician

1. How confident are you that you can ask your doctor things about your illness that concern you?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

2. How confident are you that you can discuss openly with your doctor any personal problems that may be related to your illness?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Managing Your Illness

1. How confident are you that you can do all the things necessary to manage your condition on a regular basis?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

2. How confident are you that you can judge when the changes in your illness mean you should visit a doctor?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

3. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

4. How confident are you that you can reduce the emotional distress caused by your health condition so that it does not affect your everyday life?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Social/Recreational Activities Scale

1. How confident are you that you can continue to do your hobbies and recreation?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

2. How confident are you that you can continue to do the things you like to do with friends and family (such as social visits and recreation)?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Managing Symptoms

1. How confident are you that you can reduce your physical discomfort or pain?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

2. How confident are you that you can keep your shortness of breath from interfering with what you want to do?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

3. How confident are you that you can control any symptoms or health problems you have so that they don't interfere with the things you want to do?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Control/Manage Depression

1. How confident are you that you can do something to make yourself feel better when you are feeling discouraged?

   Not at all Confident 1 2 3 4 5 6 7 8 9 10 Totally Confident

Source: Stanford Patient Education Research Center, http://patienteducation.stanford.edu

Tab 4: Communicating with Healthcare Providers

Communicating with Healthcare Providers

An important part of patient self-management is for patients to be able to effectively communicate with the healthcare providers involved in their care.

Effective patient–physician relationships should be a partnership, with patients taking an active role in their healthcare. Immediately after leaving the physician's office, patients are able to recall 50 percent or less of the important information they just received. *(Ong, Haes, Hoos, Lammes, 1995)*

Obstacles to Communication

Studies have indicated that the treatment outcome of a condition or disease is partly dependent upon how well the patient is able to understand and discuss their healthcare with their physician.

Commonly identified obstacles to effective patient-healthcare provider communication include low patient health literacy, patients' lack of office visit preparation, and the decreased time the physician spends with the patient during the visit.

Nearly 90 million people have difficulty understanding and using health information, and there is a higher rate of hospitalization and use of emergent services among patients with limited health literacy. *(IOM 2004)*

Health literacy is defined as the degree to which individuals have the ability to obtain, process, and understand basic information and services needed to make appropriate healthcare decisions. Health literacy affects people of all ages, races, income levels, and educational levels. Low literacy results in poor adherence to physician appointments, medical regimens, poor understanding of instructions or patient education materials, infrequent use of preventive health services, increased hospital and ER visits, and poor control of chronic diseases.

Patients do not prepare for office visits by developing a list of symptoms and questions to ask. Many patients find it difficult to ask their physician questions. Physicians, juggling a number of scheduled and emergent patient visits each day, have less time available to spend with their patients during office visits. Helping patients organize their health information and planning for physician visits will focus the visit and can result in a more effective encounter.

Patient Empowerment

There are specific actions and behaviors patients can adopt to improve communication with physicians and ultimately improve their health. These include:

- Sharing current medical history with all healthcare providers
- Writing down questions before the visit
- Bringing a family member or friend to the visit to help understand the information given
- Asking questions on any piece of information not understood
- Writing down instructions and taking notes

Key Points

- **Communication failures account for nearly 65 percent of the sentinel events reviewed by the Joint Commission(formerly JCAHO) since 1995**
- **Patients need to be able to understand healthcare information to effectively self-manage**
- **Health literacy affects patients' ability to engage in self-care and chronic disease management**

Tools

- Quick Tips – When Talking with Your Doctor
- Talking with Your Health Care Provider (Patient SBAR)
- A Guide for Older People: Talking with Your Doctor

Quick Tips— When Talking with Your Doctor

The single most important way you can stay healthy is to be an active member of your own health care team. One way to get high-quality health care is to find and use information and take an active role in all of the decisions made about your care. This card will help you when talking with your doctor.

Research has shown that patients who have good relationships with their doctors tend to be more satisfied with their care—and to have better results. Here are some tips to help you and your doctor become partners in improving your health care.

Give information. Don't wait to be asked!

- You know important things about your symptoms and your health history. Tell your doctor what you think he or she needs to know.
- It is important to tell your doctor personal information—even if it makes you feel embarrassed or uncomfortable.
- Bring a "health history" list with you, and keep it up to date. You might want to make a copy of the form for each member of your family.
- Always bring any medicines you are taking, or a list of those medicines (include when and how often you take them) and what strength. Talk about any allergies or reactions you have had to your medicines.
- Tell your doctor about any herbal products you use or alternative medicines or treatments you receive.
- Bring other medical information, such as x-ray films, test results, and medical records.

Get information.

- Ask questions. If you don't, your doctor may think you understand everything that was said.
- Write down your questions before your visit. List the most important ones first to make sure they get asked and answered.
- You might want to bring someone along to help you ask questions. This person can also help you understand and/or remember the answers.

(over)

- Ask your doctor to draw pictures if that might help to explain something.
- Take notes.
- Some doctors do not mind if you bring a tape recorder to help you remember things. But always ask first.
- Let your doctor know if you need more time. If there is not time that day, perhaps you can speak to a nurse or physician assistant on staff. Or, ask if you can call later to speak with someone.
- Ask if your doctor has washed his or her hands before starting to examine you. Research shows that handwashing can prevent the spread of infections. If you're uncomfortable asking this question directly, you might ask, "I've noticed that some doctors and nurses wash their hands or wear gloves before touching people. Why is that?"

Take information home.

- Ask for written instructions.
- Your doctor also may have brochures and audio tapes and videotapes that can help you. If not, ask how you can get such materials.

Once you leave the doctor's office, follow up.

- If you have questions, call.
- If your symptoms get worse, or if you have problems with your medicine, call.
- If you had tests and do not hear from your doctor, call for your test results.
- If your doctor said you need to have certain tests, make appointments at the lab or other offices to get them done.
- If your doctor said you should see a specialist, make an appointment.

Remember, quality matters, especially when it comes to your health. For more on health care quality and materials to help you make health care decisions, visit http://www.ahrq.gov/consumer/pathqpack.htm

www.ahrq.gov
AHRQ Pub. No. 01-0040a

Talking with Your Healthcare Provider

When you talk with your healthcare provider, it's important to tell him/her just what's happening. Use the tips below to talk with your provider.

Before making the call, have the following information with you:

- ❑ Your personal health record
- ❑ List of your medications
- ❑ Pharmacy name and telephone number
- ❑ Your current problems/illnesses/diagnoses

S SITUATION

I am having:

- ❑ Pain (explain where pain is felt): ______________________________
- ❑ Unexplained weight gain
- ❑ Difficulty sleeping
- ❑ Vomiting
- ❑ Harder time breathing
- ❑ Weight loss
- ❑ Nausea
- ❑ Bleeding
- ❑ Foul drainage from my wound
- ❑ Other (explain): ______________________________

B BACKGROUND

I began to feel this way: ______________________________
(When did it start?)

What makes it better is: ______________________________

What makes it worse is: ______________________________

How long it lasts: ______________________________

It prevents me from doing my usual activities: ❑ Yes ❑ No

My last: Weight ______________ Blood sugar ______________

Temperature ______________ Blood pressure/pulse ______________

A ASSESSMENT

I think I feel this way because (Include any other possible reasons: emotional, stress, finances, new medication): ______________________________

____

____

R RECOMMENDATION (by your doctor) *Write down your doctor's instructions:* ______

____

____

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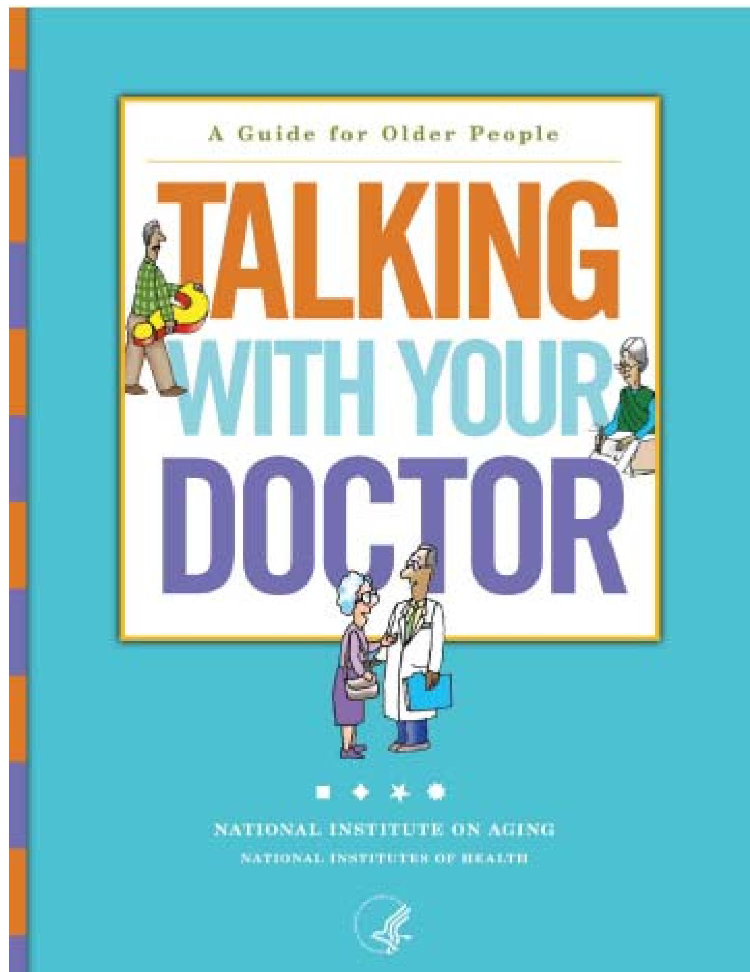

- **Talking with Your Doctor**
  A 48-page National Institutes of Health publication that guides an older person in choosing a doctor and improving communication with their doctor.

  Assist patients in planning for their doctor appointments, what information to report at the visit, how to ask questions and other resources.

  The document is located under Patient Self-Management, Associated Resources—
  http://www.homehealthquality.org/

Tab 5: Personal Health Record

Personal Health Record

Today, health information is scattered among the many healthcare providers that patients see during their lives. Typically, patients have more than one doctor, making information sharing across providers especially critical to planned care. A patient's knowledge of their medical history test results, medications, diet and exercise habits is essential to managing health.

The personal health record (PHR) is a collection of important information about a person's health that is designed to track health and support healthcare activities. It is a comprehensive collection of health information, generated and maintained by patients, that enhances their interaction with healthcare professionals and allows the patient to take a more active role in their healthcare. The PHR becomes a shared care plan that puts information about patients in the hands of everyone who needs to know it. It ensures that patients know what to do to care for themselves and when and how to get the care they need.

Benefits of the PHR

- Empowers patients to take an active role in healthcare-related decisions
- Improves the relationship between patients and healthcare providers
- Improves the quality of care a patient receives
- More efficient delivery of care

Elements of the PHR

- Personal identification, including name, birth date
- Emergency contacts
- Name, addresses, and telephone numbers of physician(s) and specialists
- Family medical history
- Health insurance information
- Allergies
- Current medications and dosages
- Dates of illnesses and hospitalizations
- Surgeries and procedures
- Immunizations and dates
- Results of recent physical examination
- Eye and dental records
- Laboratory test results
- Advance directives and living wills

Key Points

- **Patients need effective and efficient tools to manage their health**
- **A PHR enables patients to share health information with the various healthcare providers they interact with throughout their life**

Tools

- Your Personal Health Record Handout

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8sow-ma-hh-07-165 PHRbrochure-apr

Your Personal Health Record

Remember to take this record with you to all your medical appointments and hospitalizations

The Personal Health Record of:

______________________________DOB__/__/__

Personal Information

Address:__________________________________

____

Home Phone: _______________________________

Alternate Phone: ____________________________

Physician: ____________________Tel____________

Specialist:___________________Tel____________

Specialist:___________________Tel____________

Advance Directives? Yes ☐ No ☐

DNR ☐ Comfort Care ☐ Health Care Proxy ☐

Name of Proxy ______________________________

Caregiver Information

Name:_____________________________________

Home Phone:________________________________

Alternate Phone:_____________________________

Relationship:_______________________________

Homecare Provider:__________________________

☐ I understand what symptoms I need to watch out for and whom to call should I notice them.

☐ I understand how to keep my health problems from becoming worse.

☐ My doctor or nurse has answered my most important questions prior to leaving the facility.

☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.

☐ If I am going directly home, I have scheduled a follow-up appointment with doctor, and I have transportation to this appointment.

This tool was created with information gathered from Quality Insights of Pennsylvania and from Dr. Eric Coleman, UCHSC, HCPR, who was funded by the John A. Hartford Foundation and the Robert Wood Johnson Foundation

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8sow-ma-hh-07-165 PHRbrochure-apr

Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
  - * Discharge to other facility
  - * Discharge to a Home Health Agency
  - * Discharge home to care of self/family
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.

Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the Arteries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Hip Fracture/Replacement
- ☐ Lung Disease
- ☐ Medical/Surgical Back Conditions
- ☐ Pacemaker Serial #___________
- ☐ Pneumonia
- ☐ Stroke

Other Diagnoses: __________________

____

____

____

To better manage my health and medications, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Hospitalization Information

Admitted:___/___/___ Discharged ___/___/____

Hospital:____________Reason _____________

Admitted:___/___/___ Discharged ___/___/____

Hospital:____________Reason _____________

Admitted:___/___/___ Discharged___/___/____

Hospital:___________Reason ______________

Admitted:___/___/ Discharged___/___/____

Hospital:___________Reason ______________

Admitted:___/___/___ Discharged ___/___/____

Hospital:___________Reason ______________

MD VISITS

Date	MD	Reason

Recent Test Results and Immunizations

Date	Wt	BP	HR	BS	Lab Result

Wt = weight BP = Blood Pressure HR = Heart Rate BS – Blood Sugar

Recent Test Results and Immunizations

Date	Wt	BP	HR	BS	Result

Wt = weight   BP = Blood Pressure   HR = Heart Rate   BS – Blood Sugar

Notes:

Medicines I Take

Name	Dose	When	D/C'd On

Medications

Pharmacy:_______________________**Tel:** ___________

Allergies:____

____

Medicines I Take

Name	Dose	When	D/C'd On

Medicines I Take

Name	Dose	When	D/C'd On

Medicines I Take

Name	Dose	When	D/C'd On

Tab 6: Telehealth

Telehealth

The majority of elderly Americans live with at least one chronic disease or condition, such as diabetes or heart disease, and many times, both. Upon discharge from the hospital, particularly for those home care patients who are newly diagnosed and needing more support, telehealth provides a means for meeting patients' needs for instruction in self-management routines. The greatest opportunity for impacting a patient's health and utilization costs occurs in the home setting.

Telehealth is defined by the American Telemedicine Association as the "remote delivery of care or monitoring between a healthcare provider and a patient outside of a clinical facility, in their place of residence." Telehealth may be as simple as a nurse speaking with a patient on the telephone, or more sophisticated using electronic monitoring equipment to transmit clinical data from the patient's home to a home health agency.

Using telehealth as an adjunct to conventional care provides increased opportunities for communication between patients and health professionals. Patients learn to understand their condition and recognize potential problems quicker for improved overall management. The health professional can assess the patient's status, detect early signs of deterioration, and reinforce teaching as frequently as needed. Data has shown that appropriate and timely telehealth services can dramatically improve the quality of patient care without adding significant costs. The contact provides a chance to reiterate information provided to patients in person, or to offer new information.

Both health professionals and patients benefit from the focused and frequent contact that telehealth provides:

- Improved patient outcomes
- Early treatment intervention
- Technology-assisted health promotion
- Mechanism to educate patients for long-term self-management

The Planned Care Model uses telehealth to supplement on-site visits. Patients are monitored via the telephone and/or a electronic system in the home for the first 30-45 days of the patient's admission. The clinician is in frequent contact with the patient, using this time to reiterate instructions and teaching, and to coach the patient toward goal achievement. Services are provided during the last 30 days of the episode in the form of in-person visits and telephone contacts to ensure self-care routines are followed regularly and correctly.

Telephone Monitoring

Telephone monitoring is the most basic form of telehealth. Scheduled encounters via the telephone occur between a healthcare provider and patient and/or caregiver. Every telephone contact is viewed as a learning or teaching opportunity.

Telemonitoring

Telemonitoring provides a link between the patient and the healthcare professional, using clinical data that is transmitted electronically to a central station. The telehealth nurse reviews the data and provides a response relating to the data. The patient takes on a more active role in self-monitoring, collecting clinical data when cued and transmitting that data for ongoing measurement of his/her health status.

Planning for Telehealth

Planning for telehealth may necessitate system design changes within the organization to assure there is a systematic and comprehensive approach to patient assessment that is performed electronically or telephonically. Written protocols, polices and/or procedures will support consistent and evidence-based care.

Clinical and operational considerations may include:

Job Descriptions

- Minimum years and type of clinical experience required
- Communication skills
- Critical thinking skills
- Documentation skills

Patient Selection Criteria

- Specific diagnosis or at-risk population
- Emergent and/or acute hospitalization utilization
- Complex medication regimen and/or >8 medications
- Exclusion criteria such as physical, sensory, or cognitive impairment

Confidentiality and Informed Consent

- Include if using photography or imaging (i.e., video monitoring)

Equipment Maintenance and Safety

- Transporting, installation and discontinuation of equipment

Infection Control

- Cleaning equipment between patient use

Staff Education and Competency

- "Zones," algorithms, competency checklists

Documentation

- Integration into a point-of-care system and/or development of paper tools
- Physician orders and parameters for reporting to the physician

Patient Education

- Instruction sheets for using the monitor
- Safety instructions
- Data logs to maintain, if applicable

Operation Issues

- Productivity and time management allowances for telephone assessments
- Cost/benefits of telehealth

Key Points

- **Telehealth empowers the patient as an active participant in his own care**
- **Telephone monitoring encourages positive behavioral changes by coaching the patient on appropriate steps to take regarding their medical conditions**
- **Patients who receive telehealth interventions can receive more comprehensive management, leading to more rapid stabilization and, ideally learn how to become more competent in self-management skill**
- **Telehealth reduces the utilization of emergent care services**

Tools

- Phone Monitoring Assessment Guide
- Sample Telemonitoring Employee Orientation Checklist

Phone Monitoring Assessment Guide

Date of last home visit: ________________

Patient Name ______________________________ MR# ________________

❑ ✓ Understanding of emergency plan & on call

❑ ✓ Review patient's action plan

REVIEW PURPOSE OF CALL WITH PATIENT / CAREGIVER

- To check for current signs/symptoms of worsening condition
- To help overcome problems with self-care management
- To promote early action for worsening condition
- To answer any questions about your treatment/condition

Goal and Status Updates

Have you been able to stay on track with your goal(s)? .... ❑ Yes ❑ No

What barriers are getting in the way?

____

____

How have you felt since the last telephone call or home visit? .... ❑ Better ❑ Same ❑ Worse

Since the last call/visit, have had to call your doctor? .... ❑ Yes ❑ No

Go to the ER? .... ❑ Yes ❑ No

Medications

Review all medications the patient is taking:

Have you taken your meds today? .... ❑ Yes ❑ No

Do you understand why you are taking these medications? .... ❑ Yes ❑ No

All Rx's filled? .... ❑ Yes ❑ No

Any missed doses? .... ❑ Yes ❑ No

Problems or side effects? .... ❑ Yes ❑ No

Compliant w/meds? .... ❑ Yes ❑ No

Any questions about your medications? .... ❑ Yes ❑ No

Activity/Sleep Patterns

What type of activities have you been doing on a daily basis? ________________

Activities WNL for patient? ________________

Any change in energy level? .... ❑ Yes ❑ No

Increased fatigue? .... ❑ Yes ❑ No

Sleep problems? .... ❑ Yes ❑ No

Pain

Have you had any pain? .... ❑ Yes ❑ No

Location ____________ 1-10 scale: ________

Pain relief measures taken: ________________

Effectiveness: ________________

Bowel problems? .... ❑ Yes ❑ No

Dietary Intake

Any questions about your diet? .... ❑ Yes ❑ No

What have you eaten in the past 24 hours? ________________

____

Any change in appetite? .... ❑ Yes ❑ No

Any nausea/vomiting? .... ❑ Yes ❑ No

Any problems with diet adherence? .... ❑ Yes ❑ No

What has your fluid intake been in the past 24 hours? ❑ Adequate ❑ Inadequate

Condition Specific

COPD

Any changes in: ❑ Cough? ❑ Sputum? ❑ SOB? ❑ Anxiety? ❑ Confusion? ❑ O_2 use? _____l/min

Diabetes

Blood sugar ________ Patient action taken ________

Checked feet/skin? .... ❑ Yes ❑ No

Cardiac/CHF

Today's weight __________ ❑ Change ______ lbs

Patient action taken ________________

Any changes in: ❑ SOB ❑ Edema ❑ # pillows

Wounds

Did you do your wound care today? .... ❑ Yes ❑ No

Any change in: ❑ Pain? ❑ Drainage? ❑ Odor?

Today's temp ________________

Cancer

Sores/bleeding? .... ❑ Yes ❑ No

Pt action taken: ________________

Last chemo/radiation Tx? ________________

Other Information

Changes since last call/visit: ________________

____

Next MD appointment: ________________

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8sow-ma-hh-07-155 phonemonitoring-apr

Sample: Telemonitoring Employee Orientation Checklist

	Preceptor Initials	Employee Initials	Comments
Review of Telehealth Policy & Procedures			
• Protocol for Telemonitoring			
• Protocol for Phone Monitoring			
• Protocol for Teletriage			
• Patient Selection Criteria			
• Patient Satisfaction Survey			
Central Station Monitor			
Set up of In-Home Monitor			
Removal of In-Home Monitor			
Equipment Maintenance/Infection Control			
Documentation:			
• Informed Consent form			
• Encounter Forms			
• Initial Visit Checklist			
• Patient/Caregiver Instruction Sheets			
Telemonitoring Skills Checklist			
Troublshooting			
Telehealth Nurse/Therapist Job Description			

Employee Signature:_________________________ Employee Initials:__________

Preceptor Signature:_________________________ Preceptor Initials:__________

Source: Home Telehealth Reference, 2005

(Insert Agency-Specific Policies & Procedures,
Forms, Job Descriptions Here)

Tab 7: Measurement & Evaluation

Clinical Measurement

Monitoring healthcare quality is impossible without measurement. It is essential to build strong measurement into quality improvement projects to produce reliable results and information. By systematically measuring patient satisfaction and perceptions, healthcare providers can increase the effectiveness of care, improve patient outcomes, and control costs.

The development and application of quality measurement is first attributed to Florence Nightingale. Using evidence-based practice, she showed through data that basic nursing interventions could not only aid in the healing process, but actually prevent disease as well. Her efforts to improve sanitary conditions in the 19th century positively impacted the alarming infant and pediatric mortality rates.

Clinical performance measurements are designed to answer critical questions regarding the impact of a planned intervention or test of change. These measures allow for comparison, help determine priorities, support accountability, support quality improvement, and provide transparency within the healthcare system.

Quality measures may be used in multiple ways. Using measures for improvement involves three basic steps: identifying problems or opportunities for improvement, selecting appropriate measures and using them to obtain baseline assessment of current practices, and using them to reassess or monitor the effect of improvement efforts on measure performance. Healthcare providers use measures to implement internal quality improvement programs.

Many accreditation organizations, such as the Joint Commission *(formerly JCAHO)* and the National Committee on Quality Assurance *(NCQA)*, have developed clinical performance measures for internal quality improvement programs.

Key Points

- **Performance measures are tools that can provide valuable information to help providers make better decisions and lead to improvements in quality healthcare and quality of service**
- **The ultimate goal is to manage quality. But you cannot manage it until you have a way to measure it, and you cannot measure it until you are able to monitor it. (Florence Nightingale)**

Tools

- Patient Assessment of Self-Management

Patient Assessment of Self-Management

Tell us what you think about your health care and your ability to manage your health.

1. My health care team asked about my ideas and beliefs when we talked about my health problems and treatment.

Yes No Don't know

2. My health care team told me in a way I could understand how I could help take care of my health problems.

Yes No Don't know

3. My health care team talked with me about setting goals to take care of my health problems.

Yes No Don't know

4. My health care team helped me to solve problems so that I could meet my goals and improve my health.

Yes No Don't know

5. My health care team talked with me about how to get help from my friends, family and community.

Yes No Don't know

6. I was able to achieve at least one goal I set to improve my health.

Yes No Don't know

Are you confident that you:

7. Can self-manage your health?	Yes	No
8. Know when to get medical care and when you can handle a health problem yourself?	Yes	No
9. Can talk to your doctor about what concerns you?	Yes	No
10. Can find solutions to new situations or problems that come up with your health?	Yes	No

Thank you.

Tab 8: Self-Management Tools

(Insert Agency-Specific Self-Management Tools Here)

Tab 9: Resources

General Resources:

Medline Plus
1 888-346-3656
www.medlineplus.gov

AARP
1 888-687-2277
www.aarp.org

Advance Directives:

The American Geriatric Society
212-308-1414
http://healthinaging.org/public_education/pef/advance_directives.php

Alcohol:

National Institute on Alcohol Abuse and Alcoholism
301-443-3860
www.niaaa.nih.gov

Assisted Living:

National Center for Assisted Living
202-842-4444
www.ncal.org

Terminal Care:

National Hospice & Palliative Care Organization
1-800-658-8898
www.nhpco.org

Alzheimer's Disease:

Alzheimer's Disease Education & Referral Center
1-800-438-4380
www.alzheimers.nia.gov

Caregiving:

Children of Aging Parents
1-800-227-7294
www.caps4caregivers.org

National Center on Elder Abuse
202-898-2586
www.elderabusecenter.org

Support:

Massachusetts General Hospital
www.socialwork.org/SupportGroups/Chronic.htm

Illness Related:

American Heart Association
1-800-242-8721
www.americnheart.org

American Diabetes Association
www.diabetes.org

American Chronic Pain Association
www.thecpa.org

Arthritis Foundation
www.arthritis.org/resources

National Heart, Lung, & Blood Institute
301-592-8573
www.nhlbi.nih.gov

Education Materials:

Ethnomed
www.ethnomed.org

Medscape
www.medscape.com/nurses/patiented

E-Medicine
www.emedicinehealth.com

Personal Health Record
www.myphr.com

Resource Table

Resource Description	Web Link	Source
Patient self-management tools in English and Spanish for a variety of diagnoses: asthma, CVD, diabetes, goals setting	http://www.champsonline.org/tools/ClinicalResources/PatientEducationTools/patientMgtTools.asp	Community Health Association of Mountain/Plains States
Variety of goal setting and action plan forms for diabetes, and "Zones" tool for diabetes	http://collaborativeselfmanagement.org/HomeToolTool-561.php	Pilot Collaborative on Self-Management Support; A Project of the Health Research and Education Trust funded by the Robert Wood Johnson Foundation
Oregon Heart Failure GAP (guideline applied in practice) Toolkit	http://www.cardiologyinoregon.org/information/information.html#toolkit	American College of Cardiology, Oregon Chapter
Consumer and patient information	http://ahrq.gov/consumer/	Agency for Healthcare Research and Quality
Quick Tips When Talking with Your Doctor	http://ahrq.gov/consumer/quicktips/doctalk.pdf	Agency for Healthcare Research and Quality
Talking With Your Doctor: A Guide for Older People	http://www.nia.nih.gov/HealthInformation/Publications/TalkingWithYourDoctor/	National Institute on Aging

Resource Table

Resource Description	Web Link	Source
Literature on self-management	http://her.oxfordjournals.org/cgi/reprint/20/5567?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&author1=kennedy%2C+anne&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&volume=20&resourcetype=HWCIT	Anne Kennedy, Linda Gask, and Anne Rogers, Training Professionals to Engage with and Promote Self-Management, Health Educ. Res., Oct 2005; 20 567-578
Self-management Tools	http://www.doh.wa.gov/cfh/wsc/model_info/self_management_support/default.htm	Washington State Collaborative
Chronic disease care	http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768	California Healthcare Foundation: Helping Patients Manage Their Chronic Conditions
Patient Self-Management Tools: An Overview	http://www.chcf.org/documents/chronicdisease/PatientSelfManagementToolsOverview.pdf	California Healthcare Foundation: Helping Patients Manage Their Chronic Conditions
Using Telephone Support to Manage Chronic Disease	http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768	California Healthcare Foundation: Helping Patients Manage Their Chronic Conditions
Literature on planned care	http://www.ihi.org/IHI/Results/WhitePapers/InnovationsinPlanned+CareWhitePaper.htm	Kabcenell AI, Langley J, Hupke C. Innovations in Planned Care. IHI Innovation Series White Paper. Cambridge, MA: Institute for Healthcare Improvement, 2006.
Literature on chronic illness management	http://www.jcrinc.com/ppdf/pubs/pdfs/JQS/JQS-11-03-Glasgow.pdf	Joint Commission Journal on Quality and Safety, "Implementing Practical Interventions to Support Chronic Illness Self-Management"

(Insert Agency/Community Resources Here)

Tab 10: References

References

Baker, D, Parker, R, Williams, M, and W. Clark. 1998. Health literacy and the risk of hospital admissions. *J Gen Intern Med* 13:791-8.

Bandura, A. 1997. Self-efficacy: The exercise of control. New York: WH Freeman Co.

Bodenheimer, T, et al. 2002. Patient self-management of chronic disease primary care. *JAMA* 288:2469-2475.

Bodenheimer, T, MacGregor, K, and C. Sharifi. 2005. Helping patients manage their chronic conditions. Prepared for the California HealthCare Foundation.

Butler, C. and S Rollnick. et al. 1996. The practitioner, the patient and resistance to change: Recent ideas on compliance. *Can Med Assoc J* 154(9):1357-1362.

California HealthCare Foundation. *http://www.chcf.org/programs/chronicdisease* (accessed May 2, 2007).

Coleman, M. and K. Newton. 2005. Supporting self-management in patients with chronic illness. *Am Fam Physician* 72:1503-10.

Funnell, M. and R. Anderson. 2003. Patient empowerment: A look back, a look ahead. *Diabetes Educ* 29:454-462.

Glasgow, R. and M. Funnell et al. 2002. Self-management aspects of the improving chronic illness care breakthrough series: Implementation with diabetes and heart failure teams. *Ann Beh Med*, 24(2):80-87.

Glasgow, R, Davis, C, Funnell, M, and A. Beck. 2003. Implementing practical interventions to support chronic illness self-management. *Joint Commission Journal on Quality and Safety*, 29(1):563-574.

Health Research & Educational Trust: Pilot Collaborative on Self-Management Support. *http://www.collaborativeselfmanagement.org* (accessed May 2, 2007).

Holman, H. and K. Lorig. 2000. Patients as partners in managing chronic disease. *Br Med J*, 320:526-527.

Institute for Healthcare Improvement. Innovation Community: Building an Effective "Planned Care" System for All Patients in Ambulatory Settings. *http://www.ihi.org/IHI/Programs/InnovationCommunities/BuildingaReliableSystemforAllPatientswithChronicConditions.htm* (accessed May 9, 2007).

Institute for Healthcare Improvement. Self-Management Support. *http://www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/* (accessed May 9, 2007).

Institute of Medicine. 2001. Crossing the quality chasm: A new health system for the 21st century. Washington: National Academies Press.

Joint Commission on Accreditation of Healthcare Organizations. 2006. Patients as partners: How to involve patients and families in their own care. Washington DC: Joint Commission on Accreditation of Healthcare Organizations.

Kabcenell, A, Langley, J, and C. Hupke. 2006. Innovations in Planned Care Innovation Series White Paper. Cambridge, MA: Institute for Healthcare Improvement.

Long Term Care Link. *http: //www.longtermcarelink.net/eldercare/home_telehealth.htm* (accessed June 12, 2007).

Lorig, K, et al. 1999. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization. *Med Care* 37:5-14.

Lorig, K. and H. Holman. 2003. Self-management education: history, definition, outcomes, and mechanisms. *Ann Beh Med* 26:1-7.

Miller, W. and S. Rollnick. 2002. Motivational interviewing. New York: Guilford Press.

National Chronic Care Consortium. 1999. Self-efficacy/self-health care among older adults: A literature review. *http://www.nccconline.org/products/M28099.pdf* (accessed April 25, 2007).

National Quality Measures Clearinghouse. *http://www.qualitymeasures.ahrq.gov* (accessed April 27, 2007).

Ong, L, Haes, J, Hoos, A, and F. Lammes. 1995. Doctor-patient communication: A review of the literature. *Soc Sci Med* 40:903-918.

Robert Wood Johnson Foundation. Improving chronic illness care. *http://www.improvingchroniccare.org* (accessed May 1, 2007).

Rollnick, S. and W. Miller. 1995. What is motivational interviewing? *Behav Cog Psy* 23:325-334.

Shinitzky, H. and J. Kub. 2001. The art of motivating behavior change: The use of motivational interviewing to promote health. *Public Health Nurs* 18(3):178-85.

Solberg, L, Mosser, G, and S. McDonald. 1997. The three faces of performance measurement: Improvement, accountability, and research. *Jt Comm J Qual Improv* 23(3):135-147.

Stanford Patient Education Research Center, Stanford University School of Medicine, Department of Medicine. Chronic disease self-management program: *http://patienteducation.stanford.edu/programs/cdsmp.html* (accessed May 1, 2007).

Telehealth Resource Manual 2006-2007. *www.medqic.org* (accessed May 1, 2007).

U.S. Department of Health and Human Services. 2000. Healthy People 2010. Washington, DC: U.S. Government Printing Office.

Wagner, E., Austin, B, and M. Von Korff. 1996. Improving outcomes in chronic illness. *Man Care Qtr* 4(2):12-25.

Washington State Collaborative.
http://www.doh.wa.gov/cfh/wsc/model_info/default.htm (accessed May 2, 2007).