Best Practice:
Patient Self-Management

Therapist 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

Therapist Track

This best practice intervention package track is designed to educate therapists 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 Therapist 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 therapy actions that encompass self-management support

Complete the following activities:

	Activity	Location	Estimated Time
❑	Read the Therapist Guide to Patient Self-Management and Self-Management Support and Self-Management Support: The Clinician Connection	Page 87	10 minutes
❑	Complete the Self-Management Support Therapist Self Assessment	Page 89	5 minutes
❑	Review the My Action Plan tool and Action Plan Script	Page 90	5 minutes
❑	Listen to *Strategies to Improve Patient Self-Care Management Skills* podcast	Page 92	15 minutes
❑	Watch or listen to: *Supporting Patient Self-Management through Planned Care: Evidence and Techniques WebEx* or podcast	Page 92	45 minutes
❑	Read Examples of Excellence	Page 93	10 minutes
❑	Complete the therapy post-test online for free certificate of participation	See link below	10 minutes
	Total time for completion		**105 minutes**

Therapists (PT, PTA, OT, COTA, & SLP): Apply for a certificate of attendance for completing the therapist track activities.

Complete evaluation/post-test online at:

http://www.zoomerang.com/survey.zgi?p=WEB2277VLFZGL3

Therapist'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 what 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

BUILDING UPON THE BASICS

Self-Management Support: Therapist Self Assessment

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

Establish a Focus	**Yes**	**No**
At start of care (when applicable) 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 and actively listen to my patients as they tell their illness story.	❑	❑
My professional philosophy is patient-centered and acknowledges patients' expertise in managing their own lives.	❑	❑
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 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 set functional short-term (what can be achieved during the course of skilled therapy) and long-term goals (what can be achieved after therapy discharge) with the patient/caregiver.	❑	❑
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.	❑	❑
Physical Therapist: I work with other disciplines in creating the patient's home exercise program to improve movement and function.	❑	❑
Occupational Therapist: I work with other disciplines to incorporate self-management tasks into ADL and IADL routines.	❑	❑
***Speech Therapist*:** I serve as a resource within the agency to assist other disciplines with the best possible way to present information to patients with hearing loss, cognitive deficits, memory deficits, processing deficits and/or vision issues.	❑	❑
Develop/Support an Action Plan	**Yes**	**No**
I provide an opportunity for my patients to identify their confidence levels in achieving specified goals.	❑	❑
I identify personal barriers, strategies, problem- solving techniques and social/environmental support available for all patients.	❑	❑
Use Problem Solving Techniques	**Yes**	**No**
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:

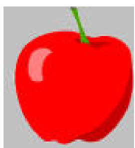
1. Choose one of the activities below:

_____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)

This material is distributed 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. Publicaion number: 8SOW-PA-HHQ07.686. App. 11/07.

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
Copyright Stanford University 2006

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*

Collaborative Interdisciplinary Self-Management Support: Patient Case Study

Situation

Rosa is a 68-year-old woman who has type 2 diabetes mellitus. Rosa was referred to home health care after she sustained a mild stroke. She had received inpatient rehabilitation and was discharged to her home with orders for nursing and physical therapy.

Assessment Findings – Objective:

During the initial assessment, Rosa demonstrated the following skills:

- Unassisted toilet transfer
- Unassisted shower transfer

Rosa was able to:

- Remove shoes, socks and sweater
- Check and record blood sugar using her own glucometer
- Be supervised while ambulating with walker, but had difficulty at doorways and on carpet
- Know the name of a new medication—a circulating anticoagulant—but was not sure why it was prescribed and seemed confused by an alternating dose schedule

Assessment Findings – Subjective:

Rosa reported that she was able to:

- Shower and dress using equipment by the time she left the rehabilitation unit
- Identify the names and doses of medications she had been taking prior to her stroke, and stated that she was used to taking these medications

Care Plan

The care plan included skilled nursing visits to focus on medication education and physical therapy to address gait training and functional mobility.

New Findings

One week after admission, Rosa complained that she felt weak and shaky after performing her self-care. As a result, PT added strengthening exercises to Rosa's home program as well as activities to increase her endurance. The nurse verified that Rosa was taking her medications as directed, but obtained an OT referral to evaluate Rosa's self-care performance.

The OT assessment revealed that Rosa's usual routine was to take her Glucotrol upon waking, then shower and dress. She would then return to the kitchen to prepare her breakfast. She typically started eating about 30 minutes after taking the Glucotrol. The care team recognized that Rosa was able to perform the activities without assistance, but the additional 20 minutes and effort required for morning self-care tasks meant that her Glucotrol was administered too early, resulting in low blood sugar levels while Rosa was heading to the kitchen. Her blood sugar levels were continuing to drop as she prepared her meal, and the meal preparation also took longer than it had before the stroke. It was noted that as her blood sugar levels dropped, Rosa could sustain a fall while walking to the kitchen or sustain other injuries while preparing her breakfast.

Collaborative Care Planning

Morning
The team collaboratively formulated a plan with Rosa to adjust her medication administration tasks to integrate with her existing daily routines. Initially, this included carrying her glucometer and her Glucotrol to her bedside table at night, so that she could check her blood sugar and take her Glucotrol without having to walk to and from the kitchen. She also kept some crackers available on her nightstand so she could ingest a few crackers as soon as she got out of the shower. When she entered the kitchen to prepare her breakfast, she immediately poured some juice to drink while she prepared the rest of her breakfast. With these modifications, Rosa was able to maintain her overall morning routine but avoid the risk of her blood sugar bottoming out.

Monitoring
The care team also collaboratively worked with Rosa to develop a plan to monitor the duration of her activities so that as her mobility improved and activities required less effort, and her medication administration schedule was adjusted.

This plan also included more frequent blood sugar monitoring—three times a day instead of twice a day—so that Rosa could consider her activity and her blood sugar reading when she timed her medications and meals.

Interdisciplinary Collaboration (Nursing, PT and OT)
All three disciplines tapered visits as Rosa became more proficient at managing these tasks. As her balance improved, PT worked with her to transition from a walker to a cane, which also reduced the time and effort of routine mobility. OT worked with Rosa to adjust her meal preparation routines to reduce activity demands. OT also worked with her to incorporate new tools and techniques during self-care and meal preparation to modify her use of sharp objects. Nursing monitored Rosa's blood sugar diary and coached her with implementing the anticoagulant dosing schedule. Nursing also collaborated with Rosa, Rosa's physician and Rosa's daughter to develop a plan for venipuncture completion to occur post discharge from home care.

Pre-Discharge Outcomes
At the time of discharge, Rosa was:
(1) Continuing to check her blood sugar three times daily
(2) Managing her medications independently
(3) Working to improve her mobility skills
(4) Resuming additional home management activities

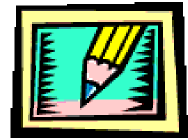
It had been arranged for venipunctures to be done on a pre-determined schedule at Rosa's physician's office with Rosa's daughter accompanying her. Rosa had agreed to take her blood sugar diary with her to the physician's office for the nurse to review.

**Content submitted by:*
Carol Siebert, MS, OTR/L, FAOTA, Representative, American Occupational Therapy Association
Karen Vance, OTR/L, Representative, American Occupational Therapy Association

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-HHQ07.695 App. 11/07.

Therapy Post-test

Patient Self-Management



Clinician Name________________________________ Date_________________

All therapists, including OTAs and PTAs, can apply for a certificate of attendance to use towards continuing education for 1.75 continuing education hours by following the directions on page 86.

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.