



Best Practice: Patient Self-Management

Medical Social Worker Track



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Medical Social Worker Track

This best practice intervention package track is designed to educate medical social workers 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 Social Worker 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 social worker actions that encompass self-management support

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read the Medical Social Worker's Guide to Patient Self-Management and Self-Management Support	Page 101	10 minutes
<input type="checkbox"/>	Complete the Self-Management support: Social Worker Self Assessment	Page 102	5 minutes
<input type="checkbox"/>	Review the My Action Plan tool and Action Plan Script	Page 103	10 minutes
<input type="checkbox"/>	Listen to <i>Strategies to Improve Patient Self-Care Management Skills</i> podcast	Page 105	15 minutes
<input type="checkbox"/>	Watch or listen to: <i>Supporting Patient Self-Management through Planned Care: Evidence and Techniques</i> WebEx or podcast	Page 105	45 minutes
<input type="checkbox"/>	Complete the social worker post-test	Page 106	10 minutes
	Total Time		95 minutes



Medical Social Worker'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: Social Worker Self Assessment

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

<i>Establish a Focus</i>	Yes	No
I actively listen to my patients as they tell their illness story.	<input type="checkbox"/>	<input type="checkbox"/>
I ask open-ended questions whenever possible to learn about patients' perceptions and concerns.	<input type="checkbox"/>	<input type="checkbox"/>
My professional philosophy is patient-centered and acknowledges patients' expertise in managing their own lives.	<input type="checkbox"/>	<input type="checkbox"/>
<i>Share Information</i>	Yes	No
I make community resource linkages that support my patients self-defined goals.	<input type="checkbox"/>	<input type="checkbox"/>
I provide community resource information for ongoing self-management beyond the home health episode of care.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
<i>Develop Shared Goals</i>	Yes	No
I collaboratively set goals with the patient/caregiver based on the patient's interest and confidence in his or her ability to change behaviors.	<input type="checkbox"/>	<input type="checkbox"/>
<i>Develop/Support an Action Plan</i>	Yes	No
I establish/reinforce a patient/caregiver driven action plan with my patients to support self-management goals.	<input type="checkbox"/>	<input type="checkbox"/>
I provide an opportunity for my patients to identify their confidence levels in achieving specified goals.	<input type="checkbox"/>	<input type="checkbox"/>
I identify personal barriers, strategies, problem-solving techniques and social/environmental support available for all patients.	<input type="checkbox"/>	<input type="checkbox"/>
<i>Use Problem Solving Techniques</i>	Yes	No
I provide counseling as needed to overcome patient identified barriers to goal achievement.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
I establish an expectation that my patients will report on their progress toward their goals.	<input type="checkbox"/>	<input type="checkbox"/>

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)

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.



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) is located on www.homehealthquality.org under Associated Resources with the Patient Self-Management package.



Medical Social Worker Post-test Patient Self-Management



Clinician Name _____

Date _____

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 on page 70.