fraserhealth Better health. Best in health care.

Self Management Support:

A Study and Implementation Guide

For Health Care Professionals

October 2009

Prepared by Michelle Medland, BScN, for

Fraser Health

Acknowledgements

In preparation of this Study and Implementation Guide a number of key resources were utilized and should be acknowledged:

- Dr. Patrick McGowan and his work on Self Management and Management Support through the Center on Aging, Victoria BC
- Dr. Chris Rauscher and his work on Self Management Support
- Impact BC and their work on providing Self Management Support using the Institute of Healthcare Improvement in the USA's Quality Improvement Methodology through the Practice Support Program in British Columbia
- Fraser Health's Chronic Disease Management Toolkit prepared by Anna Sherlock

In addition, all of the resources utilized in the preparation of this manual are listed in alphabetical order in the Reference Section.

Table of Contents

Introduction

Self Management support is an approach that healthcare practitioners can use during patient encounters to increase the likelihood patients with chronic diseases will become vigilant and active managers of their own health.

Helping patients learn how to self manage their chronic conditions is not as straight forward as it might seem. The traditional strategy of advising patients in a short 10-15 minute encounter in a primary care setting is usually met with superficial agreement. Rarely does *real* behaviour change result from those brief encounters with health care professionals.

Self Management and self management support requires an attitudinal shift. It is about supporting people to decide what support they need, when they need it and how. This guide will help practitioners move beyond traditional beliefs about how patients make changes. Patients bring much more to the table besides their chronic illness. People with chronic conditions are their own principal caregivers, living with their illnesses 24 hours a day. This study and implementation guide will give you the knowledge and tools needed to empower patients to better manage their chronic conditions.

The guide has been prepared in two sections: a study guide and an implementation guide:

1. The **study guide** is there to support self directed learning on the theory of self management support.

2. The **implementation guide** will support you in integrating the learned techniques into your practice.

If you are familiar with the theory of Self Management Support, you may choose to begin with the implementation guide as it will refer you to the study guide for reference should you need it.

Objectives:

After completing both guides, clinical practitioners will be able to:

- Understand the meaning of self management and self management support
- Assess the current communication techniques used in patient encounters
- Evaluate their existing attitudes and beliefs about self management and self management support
- Establish a Team Action Plan to implement self management techniques into their practice

- Establish roles and responsibilities of team members to support patient self management
- Have an ability to measure and evaluate progress made within their practice
- Identify a patients readiness to change and use specific techniques to enhance the readiness for change
- Use communication techniques such as the 3 Questions, 5A's and communication techniques in patient encounters
- Help patients develop a Personal Action Plan that will enable them to make behavioural changes
- Use the problem solving technique to help patients set reasonable and achievable self-management goals
- Adopt practice procedures and roles that embed self management principles into most patient encounters

What is Self Management

In order to better understand what Self Management and Self Management support really are, we need to define the terms and understand how they relate to some of the clinical aspects of a patient encounter, in any setting. So let us begin by defining the relevant terms and how they relate to or connect with a Treatment Plan or Care Plan for a particular Chronic Condition.

Definition of commonly used terms

Self Management:

Self management relates to the task that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, lifestyle management, and emotional management.

Self Management Support:

Self management support is defined as 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.

Self Management Goal:

In Self Management, patients choose and commit to a goal or behaviour change that is realistic and achievable. Goal setting is an effective strategy, when patient driven; those patients who actively participate in the selection of their own goals are more likely to be successful in achieving those goals.

Self Management Action Plan

The Self Management Action Plan or Personal Action Plan is typically a short- term, very specific, realistic plan that proposes a behaviour that patients are confident they can accomplish. The Action plan should be recorded by both the patient and the health care provider and follow up by the health care provider is necessary in order to assist the patient with problem solving through barriers they encounter while trying to implement the behaviour change.

Treatment Plan / Care Plan

A patient's treatment or care plan is often designed around a specific illness or disease. It typically outlines the various components that a health care professional and patient need to be aware of: medication management, symptom management, nutrition and exercise management, mental and social health management. A self management goal and action plan can be directly or indirectly linked to the treatment plan, depending on what the patient chooses the goal and action plan to be. So while the treatment/care plan is guided by the medical condition, the self management goals and action plans are the patient's choice and may not be directly linked to their medical condition. Evidence from the CDSMP Self Management courses suggest however, that more often than not a patient's self management goals are directed towards nutrition (weight loss) and or exercise which ultimately have positive health outcomes on most chronic conditions.

NOTE: The above definitions highlight the fact that self management is more about empowerment than it is about teaching a particular skill or technique. Chronic diseases require a collaborative daily self management plan and this plan needs to fit a patient's priorities, goals, resources, culture and lifestyle.

How do you go about teaching Self Management

This study and implementation guide will focus on the self management elements of problem solving, goal setting and action planning. It will give you the two most common approaches used in British Columbia and enhance your knowledge of self management with some common communication techniques that can be applied in interactive patient encounters that support patient self management. It will also guide you through a brief discussion on understanding the stages of change and how they relate to behavioural change.

The Benefits

Are you still sceptical?

The following table depicts some of the benefits of Self Management Support as experienced by both the patients and the health care providers.

Benefits for Patients	Benefits for Providers
• Experience better health and well being • Reduction in perceived severity of symptoms (pain, fatigue) • Improved medication management • Increase chance of remaining in their home • Greater confidence and a sense of control • Better mental health and less depression • Problem solving skills are transferrable to all aspects of their life and so improve quality of life	• Care is better planned and coordinated (more effective use of time in an encounter) • Patients become more adherent to treatment/ care plans because their needs are being met • Possible reduction in health care services (emergency, hospital visits) • Improved ability to help the more 'challenging' patients • Improved professional satisfaction • Improved practice team work

Resources

Self Management Support is not a new concept in Health Care. There is however a movement towards adopting Self Management Support techniques in a variety of settings within the health care community and there are various programs and courses available to assist you into incorporating some of the well researched and proven techniques into your practice. Understanding what information and support is available to you as a practitioner will help you make an informed decision should you choose to participate in any of these programs offered throughout the Fraser Health Region:

For Health Care Professionals

1. Fraser Health Self Management Support with Dr. Patrick McGowan

This is an interactive half day workshop where the focus is to teach practical self management support tools and skills to all health care professionals that can be used in any patient encounter.

Several models and techniques are covered in the workshops:

- Mastery Learning: Goal setting, Action plans, problem solving
- Strategies that enhance Mastery Learning: 5As, 3 Questions
- Communication techniques: close the loop, ask-tell-ask

If you are interested in attending one of these workshops please contact the Center on Aging to see if Dr. McGowan is currently offering any of these workshops:

Patrick McGowan: Associate Director at 604-940-3574 or mcgowan@dccnet.com

2. Practice Support Program

Your Regional Practice Support Program offers a variety of workshops to assist Family Physicians with the reality of the challenges family medicine encounters on a daily basis. The workshops offer physicians and one staff member per physician re-imbursement for attending the workshops and for the time it takes to implement the changes into their practice.

To date the workshop topics include:

- Advanced Access
- Chronic Disease Management

- Mental Health
- Self Management Support

For more information on this program please contact your Fraser Health Regional Practice Support Program at psp@fraserhealth.ca or view the website at www.psp.bc.ca.

3. Pfizer's 3 minute empowerment workshop

The main focus of the 3-Minute Empowerment program is to help healthcare professionals motivate patients to make lifestyle changes. Healthcare professionals who actively participate in this program will learn practice strategies that will facilitate their efforts to:

- Engage in effective partnerships with their patients to support positive behaviour changes
- Perform rapid assessments of their patients' readiness for change
- Help patients to increase motivation and overcome barriers to change
- Use practical and efficient strategies, given the significant time constraints of clinical practice

This activity will be both informative and highly interactive. The format will allow all participants to gain insight into the communication of new approaches to encourage patient lifestyle modifications through the 3-Minute Empowerment program. This is a 2 hour course that is accredited for both physicians and pharmacists.

For more information on an upcoming course running in your area please contact:

Stephanie Sauer, Account Manager - Health Networks, Pfizer Canada at 1-800-267-2553 x 1113
Cell: 604-787-4782

4. Web-based learning

This toolkit was created by the Institute of Healthcare Improvement (IHI) through the New Health Partnership initiative which is a national program of the Robert Wood Johnson Foundation at the IHI funded to develop and test efficient approaches to empower patients and families to manage their chronic conditions. The program also engages patients and families as advisors to improve the design and delivery of health care services.

Institute for Healthcare Improvement (IHI): Robert Wood Johnson Foundation:

Implementing Self-Management Support: A toolkit for Clinicians
http://www.newhealthpartnerships.org/ or
www.IHI.org

5. Additional Tools (attached in appendix)

Flinders University of Australia and the American Medical Association have also documents and tools to support the implementation of self management support into your practice. Please refer to the appendix section for the following two documents:

a. Flinders University: Capabilities for Supporting Prevention of Chronic Conditions: A resource for Educators of Primary Health Care Professionals
b. American Medical Association (AMA): Physician Resource Guide to patient self management support.

For Patients

1. Chronic Disease Self Management Program: CDSMP

A. CDSMP: Living a Healthy Life with Chronic Conditions

This is a lay-led patient education program offered in communities throughout British Columbia. Participants are adults experiencing chronic health conditions, their family members, friends and caregivers. The program provides information and teaches practical skills on managing chronic health problems. Most importantly, the CDSMP gives people the confidence and motivation they need to manage the challenges of living with a chronic health condition.

The workshop is offered over six-weeks and is FREE.

To register or for additional information please contact:

Challayne Kenney, Program Coordinator , University of Victoria, Centre on Aging (Ladner Office)
Toll Free: 1-866-902-3767 Fax: 604-940-2099
ckenney@eastlink.ca Website: http://www.coag.uvic.ca/cdsmp/

B. Volunteer Leaders of the CDSMP

The leader trainer workshops teach the skills needed to effectively lead the course: Living a Healthy Life with Chronic Conditions. It takes place over four full days and ideally is offered as two days one week, and two days the following week. Cost is free.

To register or for additional information please contact:

Challayne Kenney Program Coordinator at 1-866-902-3767 or email at: ckenney@eastlink.ca

Website: http://www.coag.uvic.ca/cdsmp/

What needs to be done next: The next 4 chapters

In order to continue at this time you must make some decisions. There are several options, all of which will require some effort on your part as well as some dedication to making a change, an open mind and some investment of your time. The study guide has been designed to help you learn some of the Self Management support techniques commonly taught in various programs, courses and self directed learning tools. The additional implementation guide will give you a step by step approach with practical tools and tips on how to implement the information learned into your practice. More importantly, it will also give you the tools on how to sustain the change within your practice.

If you chose not to participate in any of programs listed in the Resource section, you can use the implementation guide in a self directed learning approach to implementing self management support techniques into your practice. Any or all the techniques discussed in this guide should enhance your patient interactions leading to healthier patients and happier providers.

The practitioner's mindset is more important than proficiency in a specific technique.

The physician's belief that a patient can become an active self-manager is itself a powerful force.

The three main chapters of the *STUDY GUIDE* reflect the <u>theory</u> for enabling self management support in your practice:

I. Plan: Learning how to communicate differently
II. Do: Steps in Implementing Change in your Practice
III. Study: Outcomes Development and Measurement

The *IMPLEMENTATION GUIDE* is a step by step approach to support independent integration of self management support into your practice setting. It covers the 4th chapter:

IV. Act: Implementing and Sustaining Change

The most efficient way of using this manual is to begin with Chapter IV which will lead you through the study guide and support the integration of your learning into your practice.

Self Management Support:

A Study Guide

For Health Care Professionals

October 2009

Prepared by Michelle Medland, BScN, for

Fraser Health

I. Plan: Learning how to communicate differently

This chapter will focus on providing you with the theory and concepts of self management.

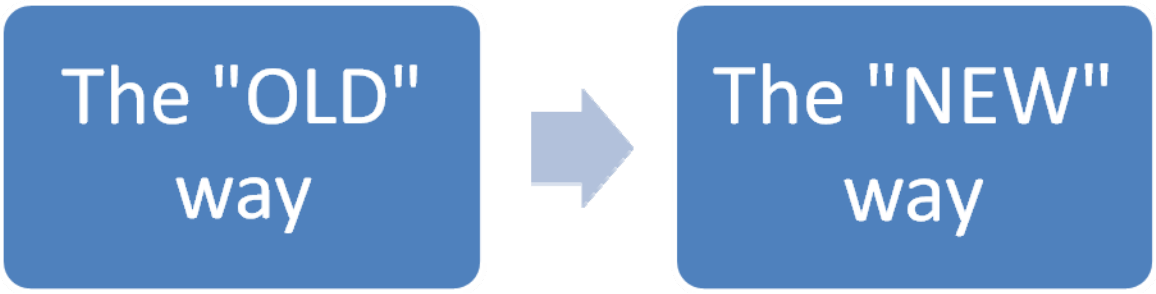
Objectives:

After completing this chapter you should have an understanding of:

- the difference between a traditional patient encounter and a patient centered encounter
- the 3 main concepts of self management: problem solving, goal setting and action plans
- the 2 main approaches for providing self management support in British Columbia: the 5As and the 3 Questions
- the communication techniques that enhance the use of the 5As and the 3 Questions
- the confidence-conviction model and how this applies to your patients

A. Understanding Interactive Relationships

Traditional views regard physician and other health care professionals as experts, with patients bringing little to the table besides their illness. In chronic disease, however, a new paradigm is emerging: people with chronic conditions are their own principal care givers, and health care professionals – both in primary and specialty care – should be consultants supporting them in this role. The patient can be viewed as the center of the health care system, making choices, decisions and taking actions themselves. Self management is about a cultural and attitudinal shift, helping people decide what support they need, how they need it and when they need it. An example of the traditional relationship between physician and patient is compared with the new interactive relationship proposed below:



The “OLD” way:

- The physician teaches the patient about his disease, very dependent on time and priorities of the clinician
- The patient is told what he needs to do
- When the patient leaves the office the physician really does not know what the patient plans to do to manage his illness
- Documentation of teaching and patient response is not routinely done, making it difficult to follow-up on the next visit
- The patient, at the end of the visit, does not formally assume responsibility for completing his end of the bargain

The “NEW” way:

- The entire primary care team works collaboratively with the patient to develop and follow-up with a self-management plan
- The team works with the patient to identify and define problems and time allows for coaching and problem solving
- The patient sets goals and formulates an action plan (activities he is responsible for such as medication management, daily exercise, healthy diet)
- Action plan is documented as well as the patient’s goal is that follow-up is possible by phone or at the next visit.

Adapted from: Rauscher, C. Chronic Disease Management through Quality Improvement – the Basics: A Discussion Paper: http://www.vch.ca/professionals/docs/phcn/cdm thru qi basics pdf

Most of you are likely somewhere between the two extremes with your patient encounters. You recognize the need for the patient to articulate his views and express his needs and wants, however, you are limited by the time of your traditional 10-15 minute encounter and often run way over time when you engage your patient fully. So how do you have this meaningful, goal –oriented, action- driven, patient-centered encounter and still manage to get your clinical priorities addressed in a timely fashion? Learn some of the techniques described in this guide and adopt and implement them into your practice. Then enhance this new way of practicing by empowering your team (RNS and MOAS) to assist you.

B. The Techniques: Problem Solving, Goal Setting, Action Planning

The triad of goal setting, action planning, and problem solving are viewed as the most important elements for improving health-related behaviours and clinical outcomes, when combined with follow-up. Setting a goal, problem solving and writing the goal down in the form of an Action Plan are three things that can be done by any practitioner attempting to elicit a behaviour change in a person. They do not have to be done in a particular order but the three work best when used together.

The following section simply describes the concept s so that you can gain an understanding of what they are and how they could be used. The section entitled “ACT: Implementing the change into your practice” will give you practical tips and tools on how to use the concepts in your Practice.

1. Goal setting

Goal setting can be accomplished in an interaction between a caregiver and a patient resulting in the patient agreeing to a concrete, usually short term goal. Often the patient, when asked, already has a specific goal in mind (ie. I would like to lose some weight). If this is the case, the Action Plan can be used to record the specifics. On the other hand, if the patient does not have a goal in mind, then the Problem solving technique below can be used to elicit a goal from the patient.

2. Problem solving:

Problem solving is an evidence based 4- step process that can be utilized by anyone facing difficult choices or encountering real or perceived barriers. It is a valuable life- skill that can be applied to any situation.

The role of the health care professional is to guide the patient through the following 4 steps in an effort to elicit a healthy behaviour change:

1. Identify the Problem:
    - This is the most difficult step
    - ASK the patient questions to get down to the root of the problem so that the problem is very specific:
      For example: I cannot exercise BECAUSE I do not have time.
2. List ideas to solve the problem:
    - ASSIST the patient in identifying as many ideas that THEY can come up with to solve the problem
      For example: I could walk to the bus stop instead of getting dropped off every day
      I could walk around the track when attending my child's soccer game
      I could walk during my lunch hour at work.
3. Select one of the listed ideas to try:
    - The patient then chooses one of the methods from the list and tries this out for a specific period of time (called the follow up period)
    - The specifics of this can be determined on the ACTION PLAN

4. Assess the results:
    - During the follow up period the health care provider contacts the patient to ask how he is doing with his action plan and if he is meeting his goal. IF yes, the patient can continue with the same goal or build on that goal . IF no, the health care provider can re-schedule an appointment or provide telephone support by following the next 3 steps:

    a. Substitute another idea
        - Re-visit the original list of solutions or come up with a new list (step 2)
        - The patient chooses a new method from the list and tries it out for a specific period of time (step 3)

    b. Utilize other resources

- If the patient repeatedly encounters difficulties in meeting his goal, the health care professional can assist the patient in seeking other possible ideas or solutions in overcoming the barrier (at this time advice is heard more readily)

c. Recognize and accept that the problem may not be solvable now
   - Accepting that the problem may not be solved at this time is an important realization to come to
   - This does not confirm failure but helps identify to the patient and health care provider that possibly the patient's original goal might have to be revised in order to better manage the barrier
   - A revised goal should be identified at this time

3. Action Plan:

An action plan is highly specific, achievable and is based theoretically on self-efficacy. Self efficacy is depicted through the level of confidence that someone has in carrying out a behaviour change necessary to reach a desired goal. Once the patient and practitioner have identified a specific goal the Action Plan tool can be used to record the specifics, allowing both the patient and practitioner to have a clear understanding and expectations on what needs to be accomplished over the follow up period (typically 2 weeks).

The purpose of the question " How confident am I in meeting my goals" is provided to determine the likelihood of the patient engaging in the Action Plan. If the patient responds with a 6 or less, he is less likely to engage in the behaviour change and the health care professional spend some additional time with the patient re-working the goal. The patient should have a confidence level of greater than 7 to stimulate success.

Goal setting is the process, and the Action plan is the result of this process.

The most important outcome of using this triad is to assist the patients in being successful in the choices they make. Success will empower the patient to continue on the right path and there will be greater option of choices and fewer barriers as the patient gains some control over his life and his illness.

This is an example of an Action Plan.

NOTE: *the writing in blue depicts an example only*

ACTION PLAN: Michelle Medland
My Goal is: To floss my teeth daily
What am I going to do? Floss twice a week for the next 2 weeks
How much and how often? I will floss my teeth once a day every Tuesday and Thursday
Where? In the bathroom beside my bedroom
When? When I wake up before taking a shower
How confident am I in meeting my goal? (0 is no confidence and 10 is highly confident) I am 8/10 confident that I can accomplish this
How will I know if I have been successful? I will keep a calendar and checklist beside my mirror so I can check off when I have flossed
Follow up plan: Set a new goal for the following 2 weeks.

So how do you go about setting goals and creating Action plans with your patients? For some, simply using the above techniques will suffice. However, using this triad can be challenging, especially in the beginning. There are several approaches that can be used to support using the triad in your patient encounters. Each approach will take some time to learn but once mastered can be used efficiently and quickly to support patients through creating a meaningful and achievable action plan.

The following section describes the two most common approaches of self management support used in British Columbia: the 5As and the 3 Questions. The approaches are described briefly and supplemented

with tools for you to use in a clinical setting. These approaches are then followed by some additional evidence based communication techniques that can be used to further enhance the interaction.

C. The Approach: The 5As and the 3 Questions

The 5As: ASSESS/ASK, ADVISE, AGREE, ASSIST, ARRANGE

The 5As approach is a model of behaviour change counselling that is evidence-based and appropriate for a broad range of different behaviours and health conditions. It is feasible to utilize in primary care settings because it can be quick once you learn the steps. The overall goal of the 5As, in the context of self management support, is to develop a personalized, collaborative action plan that includes specific behavioural goals and a specific plan for overcoming barriers and reaching those goals.

It is recommended that the 5As approach be the basic approach adopted in BC for provider self management support. Please note that the 5As approach is a circular approach, they do not have to be carried out in order and where you begin depends on where your patient is at.

In order to effectively use this approach there are communication techniques available to guide you through the process. The following section describes these as they relate to the 5A approach.

The first two As: Assess or Ask and Advise are there to ascertain what your patient knows about their condition, what questions they may have and what information they are looking for. The primary focus is on information gathering and giving.

1. ASSESS/ ASK:

This helps assess the patients' level of behaviour, beliefs and motivation:

Establishing the Agenda and Collaborative Decision making

With chronic disease patients, often with a typical patient encounter, there is no specific agenda. The patient arrives with a slew of problems and the practitioner has his own agenda of clinical and medical information that needs to be addressed. This often leaves the patient feeling overwhelmed and not heard. Using the 3 Questions (described in the next section) is a quick and effective way to establish the Agenda for this particular encounter and usually results in a focused and outcomes driven appointment.

Patients and professionals each bring expertise to the table, but the priority of the agenda is the problem indentified by the patient. In the collaborative model, an agenda for the visit is negotiated between the patient and caregiver, but the patient ultimately decides what they would like to accomplish in the visit.

Example: when a patient arrives with a list of problems he would like addressed this technique is a way to narrow it down to a specific issue that he would like addressed. This should allow for both the patient and the provider to focus on this one issue and all that pertains to it. A follow up appointment should be scheduled prior to the patient leaving in order to address the next important issue on the list.

2. ADVISE:

These techniques support patient retention when advising patients on personal health risks or their conditions.

Ask-Tell-Ask and Closing the Loop

Ask-Tell-Ask is a technique used for exchanging information with patients. It involves asking patients: "What do you know about your condition" and after giving the patient information that they are interested in, asking if the patient needs any further information. This technique supports a more staggered approach to information giving, resulting in patients having more control over how much information they are receiving and therefore may reduce information overload. It is also a method that supports information the patient wants to know instead of the traditional method of delivering all the facts and treatment regimes intended for the particular condition.

Patients are far more likely to retain the information if it is information they want to know

Closing the Loop is used to assess the patient's level of understanding. Giving the patient the ability to restate what they were told helps ensure that the patient is leaving with the correct information. The practitioners using this technique may initially feel awkward asking the patient to repeat what they just heard, however, you might be surprised on how different the information the patients tell you they heard is from what you actually said.

The following As: Agree, Assist and Arrange are more 'action' oriented and help you move your patient towards setting realistic goals and arranging follow up.

3. AGREE:

These techniques support the patient with setting realistic goals.

Goal Setting and Action Plans

By collaboratively setting a goal and working through an Action Plan, the health care provider and the patient agree on what steps need to be taken towards better health. When there is mutual understanding and an agreement on how to move forward, the patient might feel like he has more control over his condition and start moving towards better managing his health.

Evidence suggests that goal setting using action plans can result in better diet, exercise and weight loss. Most if not all patients with chronic conditions will have better health if they can incorporate any of these behaviour changes into their daily living.

4. ASSIST:

These techniques help support patients to anticipate barriers and develop a specific action plan

Reviewing Goals and Action Plans and Teaching Problem Solving Skills

By teaching the patient the 3 pivotal self management techniques (goal setting, action planning and problem solving), you are helping someone learn life skills that can be used daily. We can all benefit from applying the skill of problem solving to our lives as we encounter many barriers in life that prevent us from moving forward or making a change.

If the patients find self management challenging and you do not have the time to support their learning, send them to one of the "living with chronic conditions" courses described in the resource section of the introduction. You can also give them some of the tools from this manual to support their learning at home.

Patients setting specific goals with performance feedback improved levels of goal achievements and adherence more than informal goal-setting or planning without specified goals.

5. ARRANGE:

Arranging follow up support is an important part of providing self management support.

The importance of follow up.

It has been demonstrated that a one-time educational program or intervention is rarely effective to sustain the types of behavioural changes needed for a lifetime of care for chronic conditions. Patients need on-going self-management support from their providers to maintain gains achieved through education and counselling.

Follow up is perceived to be time consuming and has been stated to be the most difficult aspect of providing self management support, from a time perspective. It is also one of the most important aspects of providing self management support. With some proper planning and some discussion with your office team, follow up can be organized and effectively included into your weekly routine through the means of telephone calls, emails or follow up visits depending on the need of the patient.

Please refer to APPENDIX A for the tool: Providing Self Management Support

Each of these communication techniques can be used independently or together. One technique might resonate more with you than another, it is simply a matter of trying them out to see how they fit into your communication style.

Patient participation in decision making increases the concordance of physician and patient goals, the understanding of physician recommendations and self-efficacy.

THE 3 QUESTIONS:

A more brief approach has also been used in the primary care physician office which when combined with the personal action plan and follow up evaluation seems to capture the pivotal elements of the 5As.

The 3 Questions are as follows:

- What worries you most about your condition?
- What would you most like to change?
- How do you think you might do that?

Please refer to APPENDIX b for the tool: The 3 Questions

The tools for these two approaches, the 5As or the 3 Questions are simple reminders to the health care professional when they are having trouble initiating a patient centered conversation. Posting the tools in the office as a prompt or reminder, is often enough to help bring the interaction with the patient back on track.

D. The Challenging Patient: Strategies to Enhance Readiness to Change

We are often surprised and confused by the health behaviours of our patients and how difficult it is to deal with these issues. There is a vast amount of literature that both describes the challenges of dealing with health behaviour and presents techniques for the clinician to employ in the intervention. However, there is still a large number of patients that we as health care professionals view as “non-compliant”. Knowing this, there is an additional technique that you might find useful while providing self management support; in particularly with your more “challenging” patients.

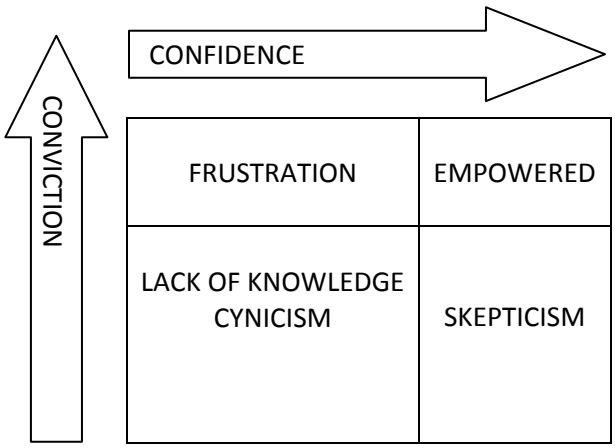
Change usually involves two distinct processes. First, the patient tries to **convince** himself that the change is necessary in the first place: “ Do I believe that making this change will enhance my well-being”. And second, the patient tries to establish if he has the **confidence** to work through the change: “Do I believe that I can make this change”.

The easiest way to determine or assess a patient’s conviction and confidence levels is to ask the patient. Using a scale can make things easier for both the patient and the provider.

For example: “On a scale of 1 to 10, how convinced are you that losing 30 lbs is in your best interest?” followed by “ On a scale of 1 to 10, how confident are you that you will be able to achieve this goal?”

The way the patient answers those two questions will help you determine where they are at in terms of the Conviction- Confidence Model depicted below:

Conviction-Confidence Model:



The model demonstrates that if a person is convinced that the behaviour change is important, however is not confident that he is able to make that change then he most likely is frustrated. However, if the patient is both convinced and confident in making the behaviour change, then he is usually empowered to do so. As a health care professional, you can use this simple model to help you assess how ready your patients are to make a change and then support them through whichever quadrant they find themselves in. Most of the strategies and communication techniques that have are described throughout this study guide can assist you in your interaction with your patient, regardless of how little they are convinced or how low their confidence is.

Please refer to APPENDIX C for the tool: Strategies to Enhance Readiness for Change

E. Putting it all together

Providing self management support within a practice setting can be achieved through any of the means described above. Initially, changing the way you interact with a patient might take some additional time and effort, however, it has been demonstrated that with practice and continued use of the tools, providing self management support can result in a smooth and positive patient interaction.

Dr. Neil Baker, together with the Provincial Practice Support Team recently explored the time dilemma associated with providing self management support in a practice setting. The following is an excerpt of the conclusion the discussion generated:

- Time for self management can be a dilemma for BOTH practitioners and patients varying according to contextual issues (e.g. co-morbidities, psychosocial issues, financial status, resources available etc.)
- There is time to listen and achieve mutual understanding in the context of current visits
- "Brief" and "low intensity" interventions can make a difference
- The time available for physicians should be targeted
- The basic skills to "do good" (e.g. listening and brief advice) are within reach of most practitioners
- The system must be redesigned to take into account time issues

In addition, the panel discussion resulted in some suggestions for system changes to support self management support:

- Optimize Care Team roles with delegation of tasks away from the physician where protocol based delegation may have the highest impact
- Stepped self management support, tailored according to need
    - Range of service from in-visit action planning to telephone coaching to intensive case management
    - Multiple modalities: in person, e-mail, group, clinics
- Active, sustained follow – up intensified according to need

This highlights the need for some planning on how to implement self management support into your unique practice setting. You have to decide on who will be providing the self management support in your office and how you will support this change in order for it to be both successful and sustainable.

The following chapter : " Do: Steps in Implementing Change in your Practice" will help you put in place the key steps for implementing change in your practice, so that you can begin to apply what you have learned.

II. Do: Steps in Implementing Change in your Practice

This chapter will focus on providing you with some of the necessary steps required in order to implement self management support into your practice.

Objectives:

After completing this chapter you should be able to:

- Understand that providing self management support takes capacity, either in the form of your time or by enabling your office team
- Understand the main tasks associated with providing self management support can be delegated to other health care professionals within your office team
- Understand how to create an Action Plan for your office
- Understand that recording and measuring the change will impact the change's sustainability
- Understand the various ways of recording the self management support activities in your practice

A. Adopting Practice Roles and Procedures

When implementing this particular change in your practice setting you have to make some decisions about who will help you provide self management support; what particular aspects of self management support can the various people within your office provide and where and when is this going to take place.

1. Defining Roles

Self Management support requires planned proactive care, usually with set appointments, active review and ongoing action. Typically, self management support is best implemented once a practice has already established roles and procedures around chronic disease management. Self management support is an integral component of optimal chronic disease care. However, this is not to say that you cannot implement self management support into your practice without the help of your team. In its purest form, self management support is about productive patient centered interactions.

If you decide to elicit the help of your team, either through an RN or an MOA, or both, there are various ways to approach their involvement. Unless you are interested in providing the education to your team on your own, registering for one of the provider self management support programs is probably the best place to start .Otherwise, you can organize an in-service at your practice or engage your RN or MOA with this study guide so that they may be actively involved in t he planning and implementation.

Once you have your team together the following is a list of the specific tasks associated with providing self management support. Decide as a team which task is best performed by which member.

- Assist patients in choosing a goal, document goals
- Assist patient with completing Action Plans, keep track of plans
- Problem solve
- Arrange follow up calls
- Arrange follow up appointments
- Provide follow up care

2. Creating a Team Action Plan

One of the simplest ways to plan a new behaviour or a change is done through the use of an ACTION PLAN. Not unlike the action plan used by your patients, this action plan can help you organize the change your are planning to implement in your office by helping you come up with specific and realistic changes.

THE TEAM ACTION PLAN:

Now that you have familiarized yourself with some of the key techniques for providing self management support in your setting, you have to decide how you are going to actually do this. There are a number of decisions that you will have to make and planning the following steps will help you set up that initial

change. Once you have thought about what you are trying to accomplish, writing this down in a simple one page ACTION PLAN will help you move towards actually implementing the change.

The following is a list of decisions you will have to make:

- Decide what it is that you are trying to accomplish. Set a short term goal that is SMART (Specific, Measurable, Attainable, Resourced and Timed)
- Decide how you will accomplish this goal. Select a method that you would like to try. Select your tools. Decide how you will select the patients that you will try this method on.
- Decide what people in your office will be involved. Will you try this out by yourself first? Is there a primary care RN or MOA in your office that could help you with this? IF so, what will their roles be?

NOTE: Engaging your entire team in providing self management support could be a long term goal that will require some planning, regular team meetings, education sessions as well as organization.

- Decide on a time that you would like to begin this process. Decide on the length of time to try this initial change
- What challenges do you anticipate? Can you problem solve through them now and contingency plan? Set up some measures that will help you minimize or avoid some of the obvious challenges?
- Look over the plan that you have created. Are you confident that you can achieve this plan? If not, revise it so that you become confident.
- How will you know that you have been successful? What measures have you put into place to help you track your progress?

NOTE: Measurements are put into place in order to assist you with making a change, tracking your progress and helping you sustain this change. How would you ever know that you are losing weight unless the weight comes off either in cm or in kg? The scale helps you stay on track in a weight loss program, recorded measures will help you stay on track when implementing change.

This is an example of a Team Action Plan:

NOTE: *the writing in blue depicts an example only*

Practice Name: *Healthy Changes Clinic*
Physician/RN/NP/MOA Names: *Dr. Change and RN Miss Achieve*
What are we trying to accomplish over the next month (GOAL): *We will use the triad of problem solving, goal setting and action plans on 1 patient each, every Tuesday Wednesday and Thursday*

How are we going to do this? *Check the day sheet the night before or the morning of, select my patient and have the MOA ensure that all the tools I need are provided in their chart*
Who will be involved? *Dr and RN to pick patient, MOA to prepare chart with tools*
When will we start? *The week of April 14th, 2008*
What barriers/challenges do we anticipate? *Forget to check the day sheet* *Miss the opportunity during the encounter* *Not enough time during the encounter*
What plan can we make today to overcome these barriers/challenges? *MOA to remind Dr and RN to pick their patient for the day* *Begin the visit with the 3 Questions to promote using self management support in the encounter* *Schedule 5 minutes of extra time with these patients (just in case)*
How confident are we in meeting our goals? *7 or 8*
How will we know that we have been successful? *We have recorded action plans for each of the patients* *We have documented our efforts if the Action plans were not achieved during the encounter* *We are feeling more comfortable using the communication techniques with each encounter*
Next team meeting set for: *Thursday May 15th, 2008.*

The importance of capturing a goal and monitoring goal achievement related to the desired outcomes is pivotal. In addition to learning new techniques and changing your own behaviour, what is helpful in reaching the desired health outcomes are two things: capacity, in terms of a team to assist you with providing proactive care and a means to capture and monitor the care that you are providing. The following section describes some of the ways you can capture self management support in your patient records.

3. Methods of Recording

Clinical information systems in the form of electronic medical records (EMR) are demonstrating to be important enablers for providing planned pro-active care. Physicians can use the technology to identify their Panel Size (number of patients that they are currently responsible for), identify various target populations within their patient population and plan care around the needs of that population. They can keep track of the care that has been provided, identify the care that is due and set up recall systems to

provide preventative and pro active care. Self Management support is enabled by the use of an EMR, however, not limited by it.

The **Personal Action Plan** itself is a useful tool for capturing and monitoring the goals of the patient. An updated copy can be maintained in the patient chart accompanied by dates and notes regarding follow up.

The **Personal Health Record** is a booklet carried around by the patient that includes relevant information such as personal information, list of current medications, current test results, medical appointments with provider information, a health planning section for the future and an area for self management action plans. These booklets are being distributed to patients who have taken the CDSMP courses as well as to providers who take the Patrick McGowan Self Management workshops

Under development is currently an electronic "**Shared Care Plan**" that will eventually link all health information pertinent for the care that is provided by each health care professional and will ensure that all health related information is looped back to the family physician, the person most responsible for the care of the individual and the one who the patient trusts the most.

Now that you have planned the change you will make in your practice there is a need for recording and measuring progress so that you are aware of that whether or not you are successful in your endeavour. Just like the scale tells you that you are losing weight and thus motivating you to continue moving towards your goal, recording and measuring your progress encourages you to move forward with this particular change in your office.

The following chapter : " Study: Outcomes Development and Measurement" will help you put in place some of the Quality Improvement steps to ensure a focused and outcomes driven effort, so that you can begin to measure what you have applied.

III. Study: Outcomes Development and Measurement

Objectives

After completing this chapter you should have an understanding of:

- the Model of Improvement used in BC
- how to write an AIM statement
- how to set measures for the improvement you are trying to make
- what a PDSA cycle is

A. Quality Improvement: What is it?

The Model of Improvement that has been adopted in BC was developed by the Institute for Healthcare Improvement in the States. This particular model has been successfully used by many health care organizations in many countries in an effort to improve a variety of health care processes and outcomes.

The model has two parts; it asks three fundamental questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

And then incorporates the Plan-Do-Study-Act cycle (PDSA) to test and implement changes in real work settings.

The following section describes how to address the three fundamental questions:

B. Aims and Measures

First, you must decide as a team what you are trying to accomplish. This would be your aim or long term Goal. The aim or goal should be time-specific and measurable and should define the specific population of patients that will be affected.

Here is an example of an AIM statement for implementing self management support into your practice:

AIM: To encourage self efficacy in all my patients, beginning with my Diabetic patients, through a coordinated multidisciplinary approach in our patient care that includes:

- Planned proactive care
- The use of self management techniques, approaches and communication techniques to enhance patient centered care

Second, you must decide on how you are going to measure this improvement. The purpose of the measure is to determine if a specific change actually leads to improvement.

Here is an example of some measures that will help you determine if self management support is having an impact on your team and your patients:

MEASURES:

1. General Measures:

   These are measures you should be aware of when targeting a specific patient population for pro-active and preventative care within your practice:

Measure	Description	Target	Data Source	Rationale/Comment
Panel Size	All patients seen at least once within the past 18 months	100%	Patient Registry/ EMR	To track measures/improvements
Patients with Diabetes	All patients who have specific diabetes diagnostic codes	!00%	Patient Registry/ EMR	This is my initial target population for providing self management support

2. Specific Measures:

   These are measures specific to your Aim or Goal of providing self management support to a specific patient population within your practice.

Measure	Description	Target	Data Source	Rationale/Comment
Goals/Action Plans	% of those with a recorded patient goals and action plans within chart	75%	Chart or Patient Registry/ EMR	Self Management is recommended in the BCMA Clinical Practice Guidelines for patients with Chronic Conditions
Care Plan – Follow up Care	% of those with a recorded Action Plan receiving follow up care q1month	50%	Chart or Patient Registry/EMR	This is the most important element of providing self management support to build self efficacy
Clinical Practice Guidelines	% of those patients who are within target range for: A1C Blood pressure Lipids	 %75 %85 %65	Chart or Patient Registry/EMR	Through patient centered encounters and active follow up, patients are encouraged to take an active role in their health and diabetes care.

The third question "What changes can we make that will result in improvement?" can be addressed using an incremental improvement approach using Plan Do Study Act cycles. Following is a brief description of a PDSA cycle:

C. PDSA Cycles

Fail to plan, plan to fail.

The PDSA cycle is what you do in the real work setting when implementing a change. You plan it, you try it out, you take a look at your results and then you act on what you have learned. It is a scientific method used for learning that is ACTION oriented.

NOTE: The specifics of this change are what you will record on your Team Action Plan.

The goal is to pick a small and manageable target population, as well as something that is easy to measure and after a predetermined amount of time you then measure whether or not it worked. You

refine the change as necessary and then implement the change on a larger scale. This process results in effective changes that are implemented more rapidly than ones that are broad but take longer to adopt.

This entire manual has been organized in a PDSA framework. The study guide covers the Plan/Do/Study sections of a PDSA cycle:

I. Plan: Learning how to communicate differently
II. Do: Steps in Implementing Change in your Practice
III. Study: Outcomes Development and Measurement

And the final chapter will give you practical tips and tools to implement what you have learned in this practice guide so that you may be successful in making a positive and lasting change in your practice:

IV. Act: Implementing and Sustaining Change

Self Management Support:

An Implementation Guide

For Health Care Professionals

October 2009

Prepared by Michelle Medland, BScN, for

Fraser Health

IV. Act: Implementing and Sustaining Change

The focus of this chapter is to guide you through a step by step process to implementing self management support into your practice. All of the tools are provided in the Appendix section.

Objectives

After completing this chapter you should have:

- A full understanding of self management support: the concepts, approaches and communication techniques that are relevant to your communication style
- Successfully begun the implementation process for self management support:
    - Know how to involve your team
    - Know how to set a Team Action Plan
    - Follow up with regular team meetings
- Have an understanding of how the quality improvement cycle can improve your work environment as well as the well being of your patients:
    - Know how to set targets
    - Know how to measure changes
    - Know how to interpret the results and
    - Know how to make improvements based on those results
- Have an understanding of what it takes to create sustainable change

Step 1: Read/ Learn the Materials

This step is about learning and understanding the material.

1. Educate yourself

Please read Chapter I: Learning how to communicate differently

Useful tools: **Personal Action Plan**
Steps to Problem Solving
Providing Self Management Support
The 3 Questions
Confidence-Conviction Model

- Use the checklist (APPENDIX I)provided to guide you through the objectives to ensure that you have an understanding of:
    - The 3 main concepts
    - The 2 main approaches
    - The various communication techniques
    - The confidence-conviction model

Decision point:

1. Access one of the many self management support courses or supplemental learning offered throughout the Fraser Health Region as described in the Resources section or
2. Continue with this self directed learning guide below:

A. Exercise: A personal Action Plan

Please use one of the Personal Action Plan sheets (APPENDIX F) to guide you through a personal change that you would like to make. Follow the Action Plan for a period of time (2 weeks) and take note of some of the challenges you may experience while attempting to make this change. This reflection might help you relate to some of the difficulties your patients will have when making their own lifestyle behavioural changes. Use the Problem Solving Skill (APPENDIX G) to find possible solutions to your dilemma. Repeat this cycle until you feel comfortable using the tools or you have made your change and are able to sustain it.

NOTE: You can attempt to change a lifestyle behaviour (ie lose weight, exercise more) or you can attempt to make a change to the way you work (ie. Arrive at your first appointment on time or leave the office on time). The point is to try something and use the tools and techniques in chapter I to guide you through the change.

Checklist for Step 1: Learning the Materials

Check off on completion

1. Read chapter I: Learning how to communicate differently O

2. Tools to use: Personal Action Plan O
   Steps to Problem Solving
   Providing Self Management Support
   The 3 Questions
   Confidence Conviction Model

3. Exercise: complete a Personal Action Plan over a period of 2 weeks O

4. I have met the following Objectives:

   a. I am confident in my ability to use the 3 main concepts of self management support: Goal setting, problem solving, action plans O

   b. I understand and know how to use the tools of the 2 main approaches used in British Columbia: 5As and 3 Questions O

   c. I understand how the various communication techniques can be used in the approaches and I have been able to pick a at least one technique that resonates with my communication style O

   d. I am confident in my ability to use the conviction-confidence Model to assess my patients O

My confidence level that I can move on to the planning phase of this study and Implementation guide is?

If you are less than 7/10 confident that you understand the materials please take the time to review the section again until you feel confident in your ability to proceed.

Step 2: Identifying key players

This step is about assembling your team, planning your approach and pulling together the tools you will need to implement self management support in your setting.

1. Educate yourself

Please read Chapter II: Steps in Implementing Change in your Practice and Chapter III: Outcomes Development and Measurement

Useful tools: **Office Team Action Plan**
Aims and Measures Tool

- Use the checklist (APPENDIX J)provided to guide you through the objectives to ensure that you:
    - Have an understanding of the tasks associated with providing self management support
    - Complete the aims and measures tool
    - Complete the office team action plan
    - Understand what your first PDSA cycle will look like

2. Educate your Team

Once you have decided on engaging your team, the individual members must be educated on self management support.

Decision point:

1. Send your team to the many self management support courses offered throughout the Fraser Health Region as described in the Resources section or
2. Have them read and learn this self management practice guide
3. Teach them the techniques you would like them know

A. Exercise: A personal Action Plan

At this time have each team member go through the same exercise you went through in Step 1. Have them chose a behaviour goal and help them create a personal action plan. In addition, you can buddy people up and have them take responsibility of providing follow up support to their buddy. Decide on a timeframe for this activity (2 weeks to 1 month) and then set up a staff meeting for the following step.

NOTE: Once everyone on your team is has gone through one or two cycles of creating an Action Plan and implementing the change you can organize a staff meeting. The objective of the staff meeting is to create an office team action plan on how you will implement self management support into your unique practice setting.

B. Long Term Goals (Aims and Measures)

At this time you need to create your vision or long term goal for implementing self management support into your practice. This can be done by completing the Aims and Measures Tool.

Decision point:

1. Complete the aims and measures tool prior to your meeting with your colleagues or staff or
2. Take the time during the staff meeting to complete the aims and measures tool along with the entire team

C. Short Term Goals

Once you have decided on a short term goal with specific measurable attached to it, you can put together your Office Team Action Plan. This should be a highly specific and time sensitive plan created under the same principles as the personal action plan. Use the example in the guide. Remember that you need to be confident that your team can carry this out over the designated time so start small and build on your success. Set a date and time for a follow up meeting no longer than 6-8 weeks out in these initial stages.

D. Implement!

Now you are finally ready for action. Go out and implement your Team Action Plan.

Checklist for Step 2: Identifying Key Players

Check off on completion

1. Read chapter II: Steps in Implementing Change in your Practice O
2. Read chapter III: Outcomes Development and Measurement O
3. Tools to use: Team Action Plan and Aims and Measures Tool O
4. Select your team and teach them about providing Self Management support O
5. Exercise: have each team member complete a Personal Action Plan O
6. Long Term Goals: complete the Aims and Measures Tool O
7. Short Term Goal: complete the Team Action Plan O
8. Next team meeting set for no later than 6-8 weeks from now O
9. I have met the following Objectives:
    a. I understand the main tasks associated with providing self management support and understand that this takes time and capacity O
    b. I have engaged my team to support me in this endeavour O
    c. I understand that recording and measuring the change will impact the sustainability of the change and so I have set my aims and measures O
    d. I know how to use the Model of Improvement used in BC O

My confidence level that I can move on to the next phase of this study and Implementation guide is?

If you are less than 7/10 confident that you understand the materials please take the time to review the sections again until you feel confident in your ability to proceed.

Step 3: Reviewing Successes and Moving Forward

This final step is the most important if you are trying to achieve sustainability. This is where you repeat several of the PDSA cycles until you have established a process that works well for your environment. Only then is it safe to spread to a larger target population.

1. Review Aims and Measures

After each 'action period' review your aims and measures to ensure that you are actually capturing the information that you set out to measure.

2. Staff meeting to review Office Team Action Plan

After each 'action period' review the Office Team Action Plan and discuss the challenges that you had with the plan. Problem solve through the barriers and pick a solution.

3. Revise Goals to reflect changes needed

Based on your discussions and problem solving, create a new Office Team Action Plan and implement it. If you are not experiencing any difficulties during the 'action period' then start increasing your target population until you have reached your goal as defined by your aims and measures statements.

4. Celebrate Success

Congratulations! You are well on your way to implementing self management support into your office setting. This is directly related to your hard work and effort that you put into studying a concept, planning, implementing the change and measuring your progress. Take the time to reflect on the changes you have made towards creating healthier patients and happier providers, and thank yourself and your team for the effort it took to get here.

Checklist for Step 3: Reviewing Successes and Moving Forward

Check off on completion

1. Spend no more than 6-8 weeks during this "action period" O
2. Review your Aims and Measures to ensure you are on target O
3. If necessary, have a staff meeting to discuss your Aims and Measures O
4. Have a staff meeting to review your Team Action Plan
    - Did you implement as planned? Then create a Team Action Plan For the next 6-8 weeks O
    - If not, problem solve on the barriers and create a new Team Action Plan O
5. Repeat steps 1-4 as many times as you need to refine your actions to meet your Goal O
6. Once you are comfortable with your new skill and have implemented the new routine into the office, start broadening your Target Population O
7. Begin to offer self management support to all of your patients with chronic disease by: O
    - Increasing your target population slowly, adding new patients slowly O
    - Remaining focused on your goal O
    - Making adjustments to your team and approach as recognized through regular and focused staff meetings O
8. Reflect on the change you have made with your patient interactions and celebrate your success with your team. O

9. I have met the following Objectives:
    a. I know how to make a sustainable change in my practice O

Summary

This self management support manual (study and implementation guides) has been designed to provide you with the knowledge and practical tools to enable you to provide self management support in your practice.

Not unlike the population health improvement work being done throughout British Columbia (ie. Collaboratives), this guide has followed the principle steps in the Overall Planning for change which are as follows:

1. Define a population of interest (the patients in your practice)
2. Identify the population needs, gaps in care, including the patient journey or experience (unable to follow treatment regime, unable to take control of their lives)
3. Develop a consensus Aim statement and set measures for improvement based on evidence and expert opinion (self efficacy, planned proactive care, self management support techniques)
4. Build the service delivery approach, including the team to address the needs and gaps in care and improve the patient and provider experience (Role identification, Office team action plan)
5. Assume collective responsibility for the population (provide follow up care)
6. Measure the results in a feedback loop for ongoing improvement (ongoing staff meetings to stay on track)
7. Ensure sustainability and spread (encourage others to learn about self management support)

These steps mirror the clinical process and therefore may resonate with all health care providers across the spectrum of healthcare.

You can use this approach when implementing any change in your practice or in your life.

NOTE: If you have completed this guide and would like to offer some feedback to the Primary Care Team at Fraser Health we have provided you with a feedback survey to complete. Thank you for taking the time to learn the module and for implementing Self Management Support into your Practice.

Self Management Support:

For Health Care Professionals

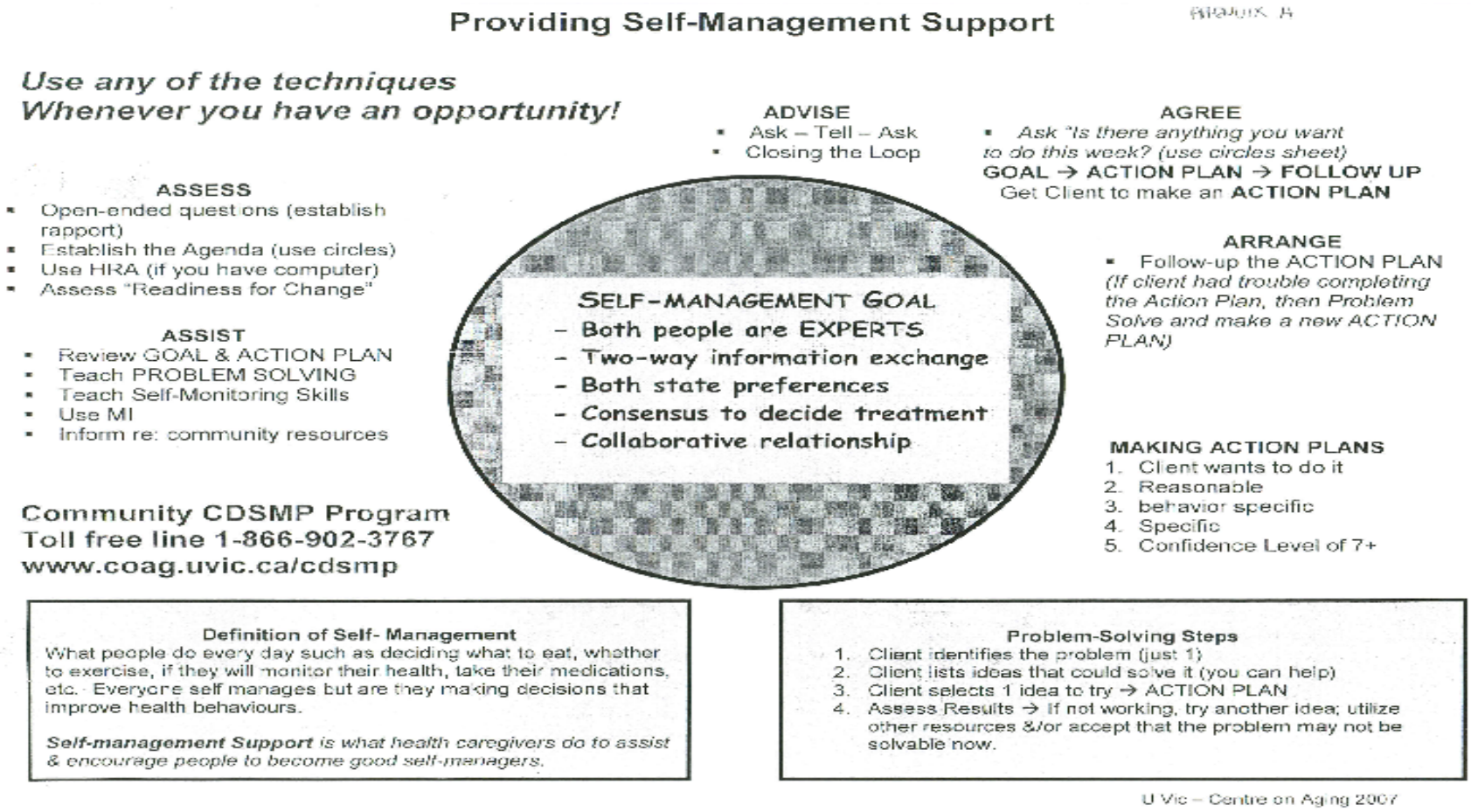
Appendices

October 2009

Prepared by Michelle Medland, BScN, for

Fraser Health

Appendix A: Providing Self Management Support using the 5As



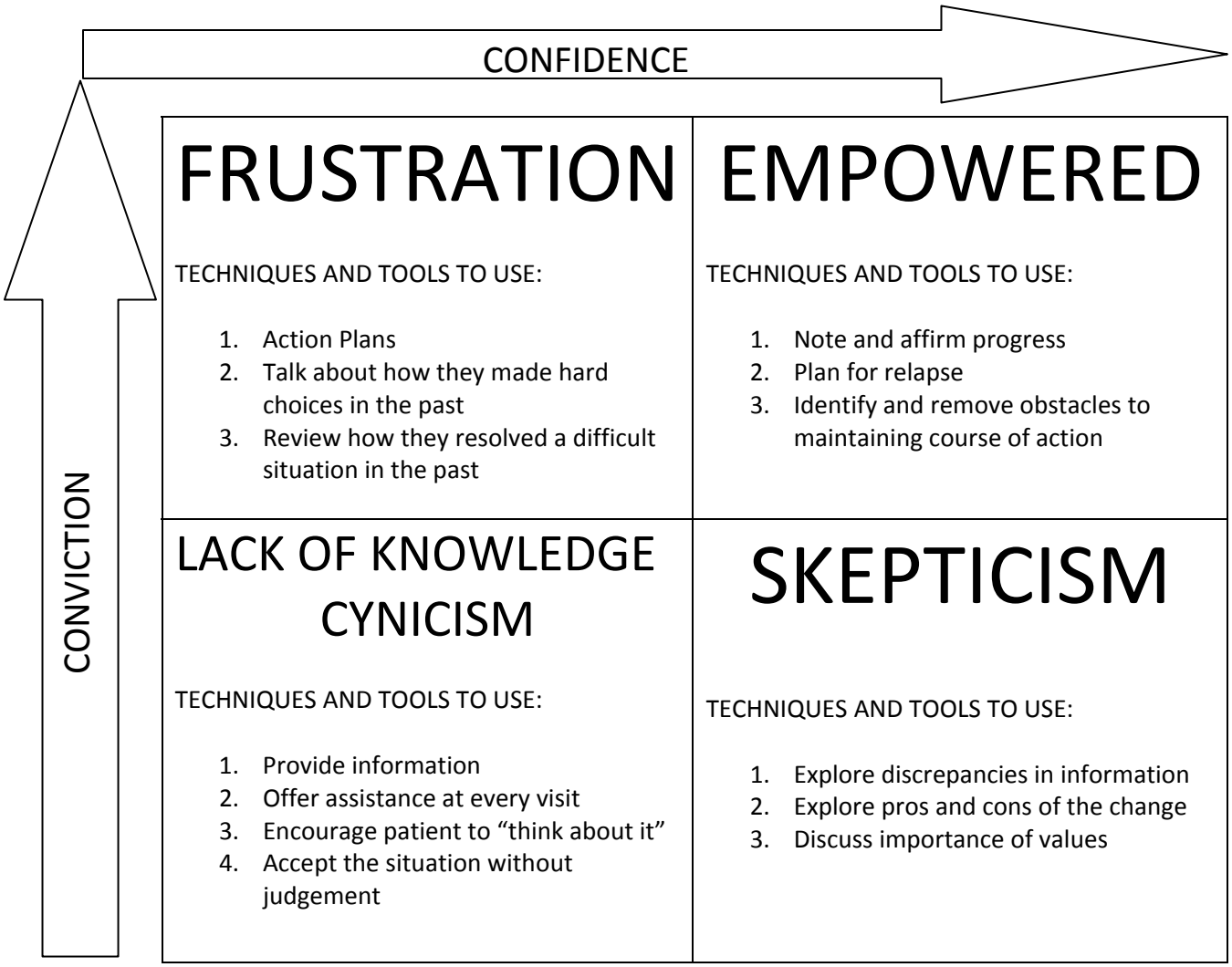
Appendix B: The 3 Questions

1. What worries you most about your condition?

2. What would you most like to change?

3. How do you think you might do that?

Appendix C: Strategies to Enhance Readiness for Change



Confidence relates to Barriers: low confidence is associated with powerlessness while high confidence indicates unwavering.

Conviction relates to Beliefs: if you are not convinced then you are ambivalent and often cynical, if you are convinced then you are often prepared to make a change.

Appendix D: Team Action Plan

TEAM ACTION PLAN

NAME OF PARTICIPANTS:

GOAL: WHAT ARE WE TRYING TO ACCOMPLISH?

HOW ARE WE GOING TO DO THIS?

HOW WILL BE INVOLVED AND WHAT IS EACH PERSON'S FUNCTION?

WHEN WILL WE START?

WHAT BARRIERS/CHALLENGES DO WE ANTICIPATE?

WHAT PLAN CAN WE MAKE TODAY TO OVERCOME THESE BARRIERS/CHALLENGES?

HOW CONFIDENT ARE WE IN OUR ABILITY TO MEET OUR GOAL?

HOW WILL WE KNOW THAT WE HAVE BEEN SUCCESSFUL?

NEXT TEAM MEETING DATE:

Appendix E: Aims and Measures Tool

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

AIM STATEMENT:

MEASURES:

Measure	Description	Target	Data Source	Rationale/Comment

Appendix F: Personal Action Plan

PERSONAL ACTION PLAN

1. This is a Goal that YOU want to achieve
2. It should be achievable and action specific
3. You should be at least 7/10 confident that you can achieve this plan

MY GOAL IS:

WHAT AM I GOING TO DO?

HOW MUCH AND HOW OFTEN?

WHERE?

WHEN?

MY CONFIDENCE LEVEL THAT I WILL ACHIEVE MY ACTION PLAN IS: _____

HOW WILL I KNOW IF I HAVE BEEN SUCCESSFUL?

FOLLOW UP PLAN OR APPOINTMENT:

TODAY'S DATE: _____ SIGNATURE: _____

Appendix G: Steps to Problem Solving

1. Identify the Problem
    - This is the most difficult step
    - ASK the patient questions to get down to the root of the problem so that the problem is very specific

2. List ideas to solve the problem
    - ASSIST the patient in identifying as many ideas that THEY can come up with to solve the problem

3. Select one of the listed ideas to try
    - Let the patient chose one of the methods from the list to try for a specific period of time
    - Record this on the Personal Action Plan

4. Assess the results
    - If for whatever reason the patient was unsuccessful at carrying out his Personal Action Plan then do the following:

    a. Substitute another idea from the previously identified list or come up with a new list (step 2) and the patient repeats step 3

    b. Utilize other resources
        - If the patient repeatedly encounters difficulties in meeting his goal assist the patient in seeking other possible ideas or solutions for overcoming the barrier
        - A useful tool at this time is found in APPENDIX H: Costs and Benefits of Change: A decision Matrix

    c. Recognize and accept that the problem may not be solvable now
        - With the patient's permission a revised goal can be identified at this time

Appendix H: The Costs and Benefits of Change: A decision Matrix

What specific behaviour change are you considering at this time?

ACTION	BENEFITS (GOOD ASPECTS)	COSTS (NOT SO GOOD ASPECTS)
NO ACTION TAKEN (STAY THE SAME)	I LIKE:	I DONT LIKE:
TAKING ACTION (MAKING A CHANGE)	I WILL LIKE:	I WILL NOT LIKE:

Write some ideas in each of the 4 boxes. This will help you clarify your thoughts about what you do not want to change.

References:

American Medical Association, Physician resource guide to patient self-management support.

Baker, Neil. (2008). The Time Dilemma in Self Management: an exploration. PSP Teleconference, March 11, 2009.

Best, Allen.(2006). A population-based Framework for Chronic Disease Self Management Support. Vancouver Coastal Health Research Institute.

Blumen, B. A Practice Support Program Interactive Workshop. Patient Self Management: Approaches To Support Behavioural Change. The Division of Continuing Professional Development and Knowledge Translation. Faculty of Medicine. www.cpdkt.ubc.ca

Bodenheimer et al. (2002). Patient Self Management of Chronic Disease in Primary Care. JAMA, 288 (19). 2469-2475.

Grumbach, K. and Bodenheimer, T. (2004). Can Health Care Teams Improve Primary Care Practice? JAMA. 291(10). 1246-1250.

Impact BC. Practice Support Program. www.impactbc.ca/practicesupport

Keller, F. V. and White, M.K. (1997). Choices and Changes: A New Model for Influencing Patient Health Behaviour. JCom. 4(6). 33-36.

Martha. M Funnell and Robert M. Anderson (2004). Empowerment and Self-Management in Diabetes. Clinical Diabetes, 22(3). 123-127.

McGowan, P. (2006). Self-Management support. University of Victoria.

McGowan, P. (200?). Strategies and Tools to Provide Self-Management Support in Clinical Practice.

Rauscher, C. (2006). Self Management and Self Management Support. BC Renal Agency.

Rauscher, C. (2007). Self Management and Self Management Support. Design Template and Discussion

Document. Kidney Summit Core Group. BC Renal Agency.

Rauscher, C. Chronic Disease Management through Quality Improvement. The Basics - A discussion Paper.

Rothman, A. and Wagener, E.H.(2003). Chronic Illness management: what is the role of primary care? Annals of Internal Medicine. 138(3). 256-262.

Sherlock, A and Medland, M (2006) Chronic Disease Management Implementation Guide. Primary and Chronic Care Development, Fraser Health.