Integrating self-management support into clinical practice

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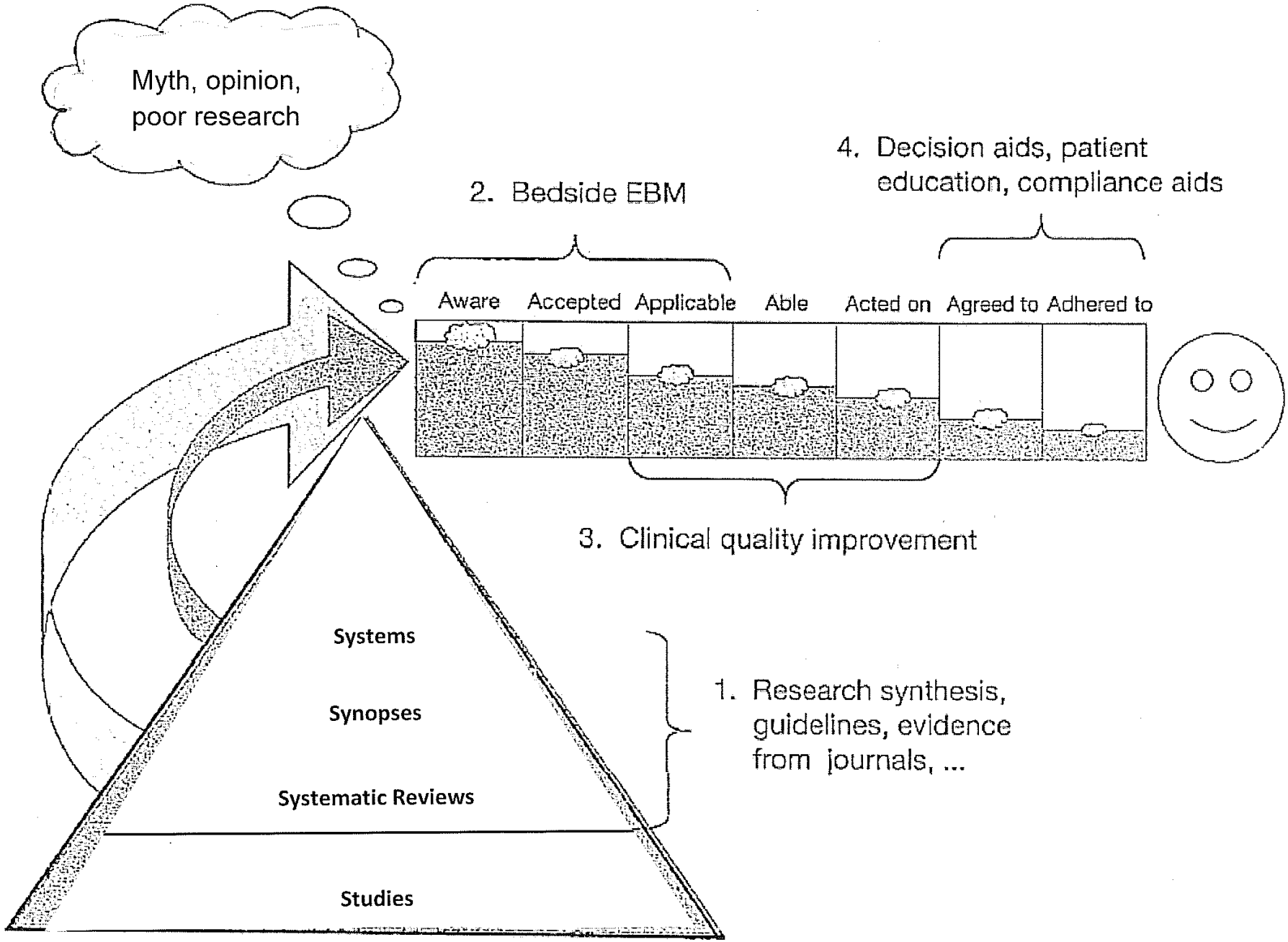
Myth, opinion, poor research
2. Bedside EBM
4. Decision aids, patient education, compliance aids
Aware
Accepted
Applicable
Able
Acted on
Agreed to
Adhered to
3. Clinical quality improvement
Systems
Synopses
Systematic Reviews
Studies
1. Research synthesis, guidelines, evidence from journals, ...

BACKGROUND and AIMS

Barriers to embedding self-management support

Health care professional characteristics

- mindsets and preconceptions
- concerns about risk
- knowledge of wider support services

AWARE

Goal - The goal of this project is to integrate self-management support (SMS) into the clinical practice of our Diabetes Health Centres.

Objectives - At the end of the period:

- The concept of self-management support is clearly understood by all staff members;
- The Centre's Vision statement will reflect commitment to SMS;
- SMS support will be discussed at all staff meetings;
- The site will have a clear set of criteria which defines "implementation" of SMS;
- Educators will have undertaken SMS training and be skilled using SMS strategies;
- Educators will have high self-efficacy in being able to use SMS strategies with clients;
- Educators will teach all clients how to problem-solve and how to make action plans;
- Educators will initiate client feedback on their action plans;
- Staff (in collaboration with the client) will develop a follow-up plan for each client;
- Staff will use an IT system to record client SMS activity;
- Staff will link patients to community programs and supports;
- A measurement tool to gauge client progress towards activation is being used
- Staff will submit abstracts to the national diabetes conference(s).

AWARE

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DIABETES HEALTH CENTRES

Our Vision

Our vision is to provide best practice and holistic client-centered care, integrating diabetes education with self-management support.

Our Purpose

Our purpose is to empower our clients to manage their health by using evidence-based strategies that provide the knowledge, skills and confidence to enhance wellness for individuals and families.

Our Values

Respect. Caring. Trust.

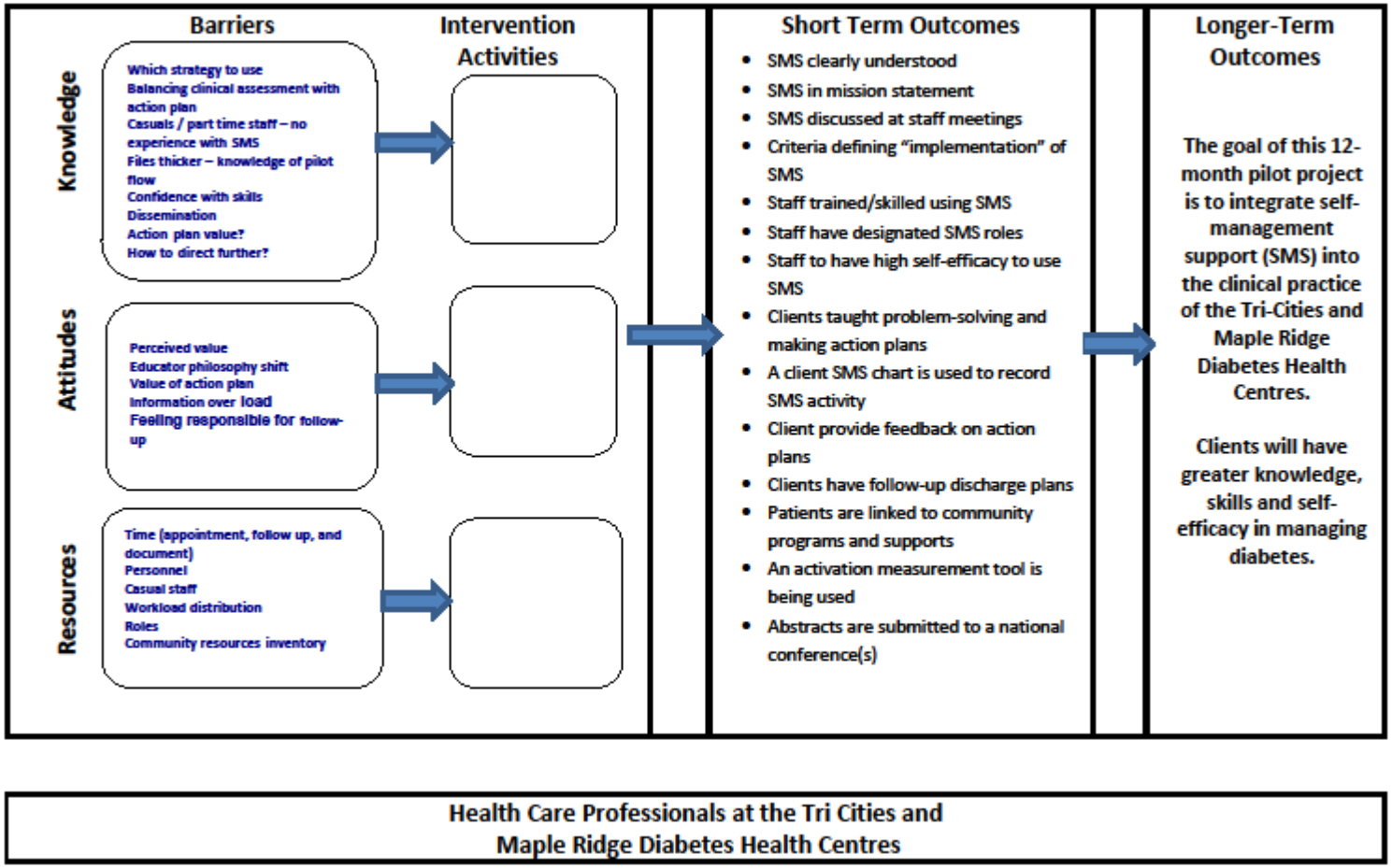
Our Commitment

Our commitment is to

- be passionate in our pursuit of quality and safe health care
- inspire individual and collective contribution
- focus on outcomes
- be open to evidence, new ideas and innovation
- embrace new partners as team members and collaborators
- respect diversity
- be accountable

ACCEPTED

Basic Logic Model




ABLE
Self-Management Support
Group Training

Diabetes Education Modules

- Eat to Reduce Risk
- Carbohydrate Know-How
- Fit for Health
- Stress and Sleep
- Making Sense of Rapid Acting Insulin
- More from your Insulin Pump

IT Fields

- Action plan made
- Problem solving
- Follow-up plan
- Other SMS strategies used
- SMS community resources discussed
- Community self-management programs
- Diabetes Coach Program

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SELF-MANAGEMENT SUPPORT

Self-Management British Columbia

ASSESS

Establish Rapport

Open ended questions...

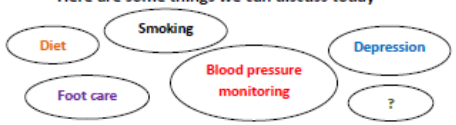
- What are the biggest problems you're having?
- Tell me about a typical day.
- What else is happening?

Setting the Visit Agenda (example)

Hello Ralph, long time no see.
We have 30 minutes together today.
I need to talk to you about your medications.
What is it that you need to talk to me about?

Setting the Visit Agenda (example)

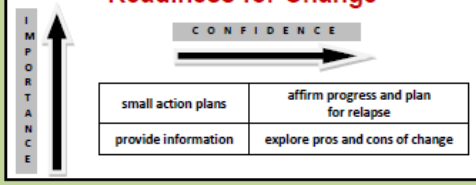
Here are some things we can discuss today



Readiness to Change

Readiness = importance of the behaviour and person's confidence to carry out the behaviour

Readiness for Change



Pros & Cons

Example
"Not exercising"

"Good" Aspects of Current Situation

- *No hassle and cost of exercising*
- *I can deal with the extra pain*
- *I can take the pain killers*
- *I really enjoy relaxing and watching TV*

"Not so Good" Aspects of Current Situation

- *I'm feeling weaker and weaker*
- *There seems to be more pain*
- *I am afraid I will lose my ability to walk*
- *I keep gaining weight*

ADVISE

"Ask-Tell-Ask"

Problems:

- Patient doesn't get the information he/she wants
- Patient doesn't understand the information
- Patient gets overwhelmed with information

Closing the Loop

HCP	Three things help prevent complications: improving your diet, exercising more, and taking medication. Can you repeat that back to me so I know it's clear?
Patient	Eat less, walk more, and take pills.
HCP	Good.

AGREE

Action Plan (example)

"Is there anything you would like to do this week to improve your health?"

- Patient chooses a behaviour he/she is motivated to change.
- Patient chooses a personally meaningful outcome.

Action Plan (example)

"Is there anything you would like to do this week to improve your health?"

Action Plan

A. Goal
Something person wants to achieve in 3 to 6 months
B. Action Plan
A small doable step person wants to take in working toward reaching the goal
C. Confidence Level
Person specifies his/her confidence level in achieving the action plan (scale 0 to 10)
D. Reporting Back and Problem Solving
At the next appointment or via telephone or email

Parts of an Action Plan

1. Something YOU want to do
2. Achievable
3. Action–specific
4. Answer the questions:
   - What?
   - How much?
   - When?
   - How often?
5. Confidence level that you will complete the ENTIRE action plan

Follow-up on the Action Plan

Ensuring that follow-up takes place facilitates the success of making action plans.

ASSIST

Problem Solving Steps

1. Identify the problem
2. List ideas that could solve the problem
3. Select one idea to try
4. Assess the results
5. Substitute another idea
6. Utilize other resources
7. Accept that the problem may not be solvable now

ARRANGE

Follow-Up

- Regular and sustained follow-up is crucial for the success of goal-setting and action-planning
- Follow-up includes problem-solving of barriers to goal achievement
- Follow-up can be done in person, by phone, by medical office assistants, or other patients

Systematic reviews of evidence on the performance of the Patient Activation Measure conducted by the National Health Service in 2012 and 2014 found that:

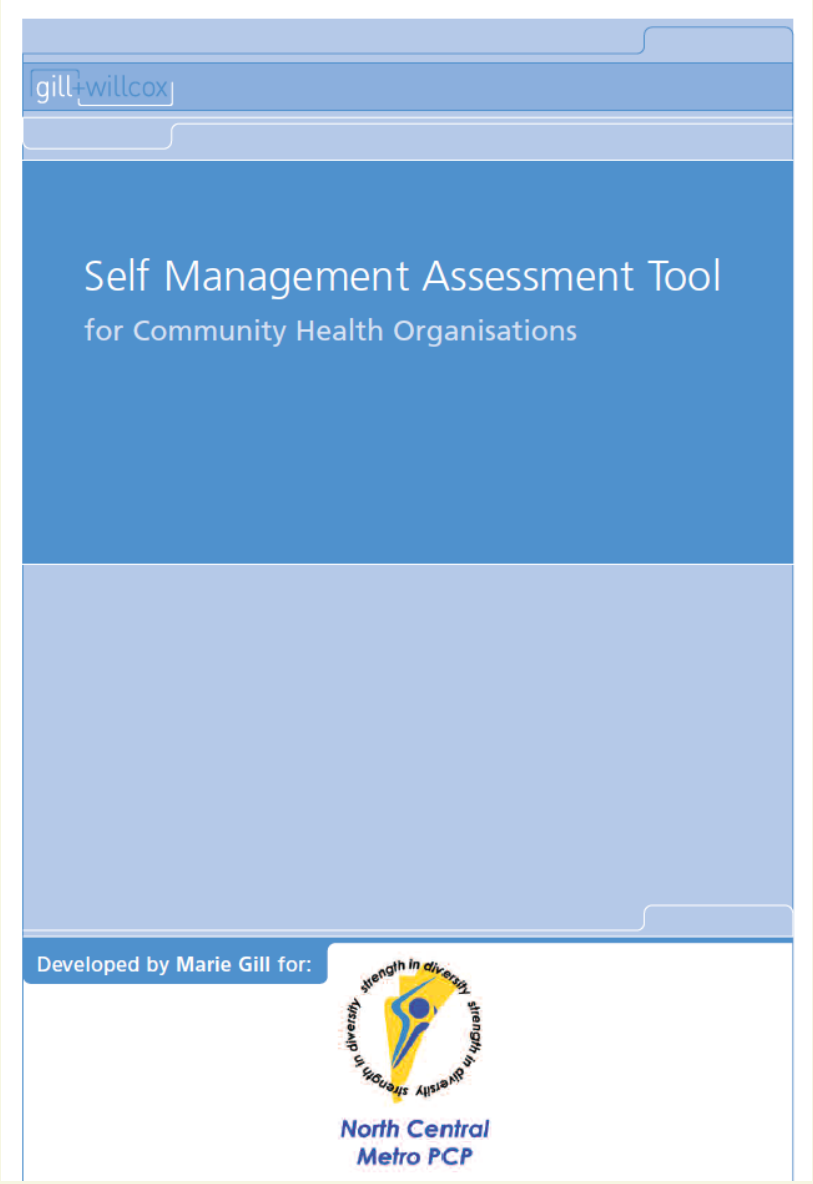
- activation scores have been robustly demonstrated to predict a number of health behaviours and individuals with higher PAM scores were significantly more likely to exhibit healthy behaviours;

- the relationship between patient activation and health outcomes has been demonstrated across a range of different populations and health conditions;

- PAM scores are closely linked to clinical outcomes, the costs of health care and patients' ratings of their experience and to report higher levels of satisfaction with services; and

- PAM scores were strongly associated with improved adherence to treatment, with doctor-patient communication; and with increased patient participation.

ADHERED TO


gill+willcox
Self Management Assessment Tool
for Community Health Organisations
Developed by Marie Gill for:
strength in diversity
North Central
Metro PCP

RESULTS

Integrating SMS into Diabetes Care

1. A Vision that includes Self-Management Support
2. Objectives for Integrating SMS
3. Using a Logic Model to identify perceived challenges and barriers
4. Training staff how to use SMS strategies
5. One-two month trial (i.e., PDSA)
6. Feedback and problem resolution session
7. Developing “twigglers”
8. Defining which and when to use SMS
9. Recording use of SMS strategies in client’s electronic file
10. Reviewing use of SMS strategies by period
11. Using the PAM to gauge patient activation
12. Making a SMS sustainability plan

BOTTOM LINE


Working context
Clinician expertise
Best practice evidence
Patient values and circumstances