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Best Practice: Patient Self-Management

Leadership Track
Leadership Section Objectives

Objectives
After completing the activities included in the Leadership Section of this Best Practice Intervention Package – Patient Self-Management, the leader will be able to:
1. Recognize strengths and weaknesses in the agency’s current approach to patient self-management and self-management support
2. Identify areas for patient self-management and self-management support
3. Develop a plan to incorporate and promote an interdisciplinary approach to patient self-management and self-management support

Best Practice Intervention Package – Patient Self-Management

This is the tenth Best Practice Intervention Package for the national Home Health Quality Improvement (HHQI) Campaign. Many of the previous packages have focused on foundational interventions, such as hospitalization risk assessment, emergency care planning, medication management and phone monitoring/frontloading visits. Home health agencies nationally have been implementing or optimizing these foundational interventions as they strive to reduce avoidable acute care hospitalizations.

Other Best Practice Intervention Packages have focused on a unique intervention that related to or built upon the foundational packages. Examples of these topics include teletriage, telemonitoring, immunizations, physician relationships and fall prevention. Agencies were able to continue to build and refine their strategies or interventions toward reducing avoidable hospitalizations.

The last three packages in this year long campaign highlight interventions that continue to build upon the foundational interventions. Patient Self-Management, Disease Management and Transitional Care Coordination will continue to assist agencies to progress to a higher level of care, improved patient outcomes, improved patient satisfaction and to reduce avoidable hospitalizations. This series is called Building Upon the Basics.
How to Use This Package

Note: Tools/Resources are denoted throughout in dark red.

- Review the **Patient Self-Management Introduction** (page 8)
- Evaluate the **Building Upon the Basics Crosswalk** to review the basic interventions as they relate to patient self-management (page 11)
- Read **Planned Care: Self-Management Support in Home Health Care** (page 12)
- Complete the **Self-Management Support Agency Assessment** (page 58)

**Decision: Do you want to implement a patient self-management Action Plan?**

- Select one of the three sample **Patient Action Plans** and adapt for your agency (pages 25, 64 and under associated resources – www.homehealthquality.org)
- Select **Agency Self-Management Support Action Items** (page 60)
- Establish the **Agency Self-Management Support Action Plan** (page 62)

**Decision: Which patient self-management clinician education resources to use:**

- Review the **Patient Self-Management Tools and Self-Management Support Tools and Resources** (page 63)
  
  1) **HHQI WebEx: Supporting Patient Self-Management through Planned Care: Evidence and Techniques** (under Patient Self-Management, Associated Resources - www.homehealthquality.org)

  2) **Planned Care: Patient Self-Management Support, Staff Education Workbook** (under Patient Self-Management, Associated Resources - www.homehealthquality.org)

  3) **Video: Video with Techniques for Effective Patient Self-Management** (link on page 64)

- Place **Patient Self-Management Poster** in strategic places in the office (page 69)

Distribute and encourage completion of the discipline-specific **Care Tracks:**

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<th>Read Action Plan</th>
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SM- Self-Management  SMS- Self-Management Support
Patient Self-Management Introduction

The focus of this Best Practice Intervention Package – Patient Self-Management is to promote patient self-management as an intervention to improve the patient and caregiver’s involvement in care and reduce avoidable hospitalizations. Self-management support is addressed as the health care provider’s role. The previous Best Practice Intervention Packages have included patient self-management principles. A Building Upon the Basics Crosswalk (see page 11) is provided to correlate these key points from the previous packages. This package will help your agency move toward more formalized patient self-management.

Patient self-management is not new to the health care industry, but there is now a focus and a need to promote patient self-management in home care. Patients and their caregivers need to collaboratively make health care decisions with their health care providers and to take on a more active role in their health maintenance. To begin, look at definitions from the Institute of Medicine (IOM) to understand and learn how to apply self-management principles.

Definitions

- **Patient self-management (SM)** 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 (SMS)** 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).

This package will increase understanding of the differences between self-management, which addresses the patient/caregiver, and self-management support, which is what the healthcare provider (in this case, home care) does to assist the patient and caregiver to be able to self-manage.

**Note:** Patient self-management does not begin and end with a home health episode. Home care represents one segment in the continuum of chronic illness management. The challenge for home care is to identify its role and then apply the self-management support principles that will assist the patient/caregiver to improve quality of life.

Focus on Self-Management

Prominent organizations are actively educating and promoting self-management with health care providers and consumers. Below are a few of the organizations with some significant resources or Web links.
Institute of Medicine (IOM)

The nation turns to the Institute of Medicine (IOM) of the National Academies for science-based advice on matters of biomedical science, medicine and health. The Institute provides a vital service by working to ensure scientifically informed analysis and independent guidance. The IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, identified six aims for improvement in health care. One is that health care must be: **Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

For more information, please visit [http://www.iom.edu/](http://www.iom.edu/)

Masspro, Quality Improvement Organization for Massachusetts

Masspro, the Quality Improvement Organization for Massachusetts, developed materials for a home health care collaborative that will be shared in this package. The Leadership Track contains *Planned Care: Self-management Support in Home Healthcare*. This is a comprehensive systems approach to self-management support. The tools referenced throughout the package are available for agencies to use as desired and are posted under Associated Resources on [www.homehealthquality.org](http://www.homehealthquality.org).

Staff education materials are also included under Associated Resources:

- **Planned Care: Patient Self-Management Support – Staff Education Workbook**
- **HHQI WebEx: Supporting Patient Self-Management through Planned Care: Evidence and Techniques** – pre-recorded WebEx presentation

For more information please visit [http://www.masspro.org](http://www.masspro.org)

New Health Partnerships

New Health Partnerships is a project of the [Institute for Healthcare Improvement](http://www.ihi.org) under a grant from the Robert Wood Johnson Foundation. The mission of New Health Partnerships is to support and manage an online community by providing information, resources, and opportunities for discussion and real-world examples. In this community you will find information and support to improve the lives, care and
health of people with long-term conditions. This site is for patients, family members and health care providers who want to work together as partners to promote collaborative self-management in health care. A modified version of the New Health Partnership’s My Action Plan to assist patients with creating a health care action plan is available on the Associated Resource page for this Best Practice Intervention Package (www.homehealthquality.org).

For more information please visit http://www.newhealthpartnerships.org/

**Joint Commission on Accreditation of Healthcare Organizations**

The Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the United States. Since 1951, The Joint Commission has maintained state-of-the-art standards that focus on improving the quality and safety of care provided by health care organizations. A Joint Commission home care patient safety goal for 2008 is to encourage patients’ active involvement in their own care as a patient safety strategy.

*The Patient Centeredness – Implementing Practical Interventions to Support Chronic Illness Self-Management* article is included on the Associated Resource page for this Best Practice Intervention Package (www.homehealthquality.org).

For more information please visit http://www.jointcommission.org

**Self-Management Support: Reducing Acute Care Hospitalization**

- Patient self-management has been associated with improved health status and decreased use of healthcare services.
- The patient who understands his/her illness and knows how to manage symptoms and how to obtain assistance when needed will be less likely to require acute care hospitalization.
- Many patients express a goal of remaining in their home and prefer not to be hospitalized.
**Patient Self-Management & Self-Management Support**

Linkage to Previous Best Practices

This document references previous **Best Practice Intervention Packages** to demonstrate **patient self-management activities** and **provider self-management support activities** as they relate to interventions to reduce avoidable hospitalizations.

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**Hospitalization Risk Assessment**

- Patient/caregiver tells illness story including recent hospital encounter if applicable
- *Provider determines patient risk for ACH by listening to patient illness story & using ACH risk assessment tool

**Emergency Care Planning**

- Patient/caregiver develops problem-solving capability for responding to symptom change(s) & accessing assistance and/or emergency care
- *Provider collaboratively develops patient-centered emergency care plan

**Medication Management**

- Patient/caregiver collaboratively participates in medication adherence & reconciliation activities
  - *Provider offers tools and coaching to ensure medication simplification & reconciliation occurs effectively according to patient ability

**Telemetry**

- Patient/caregiver demonstrates the understanding & ability to recognize a “problem/symptom” in conjunction with how & when to seek assistance
  - *Provider considers patient goals when determining appropriate response and follow-up to incoming calls

**Telemonitoring**

- Patient/caregiver recognizes the rationale & accepts the use of telemonitoring for self-management purposes
  - *Provider instructs & coaches in accordance with patient-centered parameters as defined by patient’s physician

**Physician Relationships**

- Patient/caregiver sees self as partner with physician in self-management
  - *Provider supports & encourages patient to develop the skills needed to communicate with physician effectively

**Immunization**

- Patient/caregiver recognizes the importance of influenza & pneumococcal immunization
  - *Provider informs patient/caregiver of importance of vaccine(s) and supports method for patient to track immunization status

**Fall Prevention**

- Patient/caregiver reveals accurate fall history
  - *Provider completes an accurate fall risk assessment post gaining patient/caregiver trust

**Phone Monitoring/Frontloading**

- Patient/caregiver reveals learning is occurring as demonstrated by changes in health management behaviors
  - *Provider phone encounters are supportive, educational and reinforcing of patient goals

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**Patient Self-Management**

**Self-Management Support**
A Systems Approach to Quality Improvement in Home Health:

**Planned Care:**
**Self-Management Support in Home Healthcare**

**MASSPRO**

*Making an Impact.*
Introduction

A Systems Approach to Quality Improvement in Home Health:

Planned Care:
Self-Management Support in Home Healthcare

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This material was prepared by Maspro, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily represent CMS policy. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.
Introduction

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

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

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

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

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

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

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

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

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

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

Vision

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

Outcomes

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

Key Points

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

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- Southcoast Home Care
- VNA Care Network
- VNA of Cape Cod
Model Framework

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

Stage I: Individualized Plan & Goal Setting
Goal: Patient Safety and Stabilization

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

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

Stage II: Collaboration
Goal: Problem Solving & Accountability

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

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

Stage III: Patient Autonomy
Goal: Autonomy and Self-Efficacy

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

At the conclusion of this phase, the patient will be able to:
- Demonstrate his or her ability to carry out the self-management plan every day and deal with challenges as they arise
- Utilize support group, Internet, and community resources to sustain self-management
- Verbalize readiness for discharge of home health services
Consistent, evidence-based care is provided through a combination of in-person and remote encounters. Patient self-management is emphasized in every encounter. The method and frequency of contact is based on the patient’s needs, health literacy, and preference for learning.

**Home Visits**

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

**Telephone Contacts**

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

**Telemonitoring**

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

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

**Exclusion Criteria**

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

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

Live Your Best

Become an Active Participant in Your Care!

Look inside to see how we can help you create a realistic plan to manage your healthcare at home.
We want to help you successfully manage your health and live the best life possible. Every day, you make decisions that affect your health: you decide what to eat, when to take medications, and whether to exercise or keep doctor appointments. Making these decisions can be confusing and stressful.

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

**Planned Care Components:**

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

**Your Role:**

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

**Our Role:**

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

Tab 3: The Clinical Visit

Clinical Visit

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

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

Motivational Interviewing

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

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

Essential Principles

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

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

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

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

The Five As

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

- Assess
- Advise
- Agree
- Assist
- Arrange
The Clinical Visit

Assess knowledge, behavior, readiness:
The contact begins with an assessment of relevant clinical data and review of patient goals. These goals may be new or previously set. The agenda is planned with the patient. Consider the following:
- Beliefs
- Intentions/readiness
- Conviction
- Confidence
- Barriers
- Resources

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

Agree on goals and methods:
Ask the patient what he or she most wants to work on and what would be a reasonable goal. Goals should be reasonable and collaboratively set. A personal action plan is then developed with the patient to meet these goals. The plan addresses the following questions:
- What will you do?
- How much will you do?
- When will you do this?
- How often will you do it?

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

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

Teach problem-solving skills:
- Identify the problem
- List ideas that may solve the problem
- Choose one method to try for one-to-two weeks
- Evaluate the results
- Identify and refer the patient to community resources for support

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

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

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

**ASSESS:**
Beliefs, Behavior & Knowledge

**ADVISE:**
Provide specific Information about health risks and benefits of change

**ARRANGE:**
Specify plan for follow-up (e.g., visits, phone calls, mailed reminders)

**ASSIST:**
Identify personal barriers, strategies, problem-solving techniques and social/environmental support

**AGREE:**
Collaboratively set goals based on patient's conviction and confidence in their ability to change or adhere

**Personal Action Plan**
1. List specific goals in behavioral terms
2. List barriers and strategies to address barriers
3. Specify Follow-up Plan
4. Share plan with practice team and patient's social support

Principles of Motivational Interviewing

- Explore the person's thoughts and feelings about the good and not-so-good things about the issue (e.g., about being very overweight, about smoking, about drinking harmfully, etc.)

- Use reflective listening: listen to what the person says, and then summarize it back (e.g., “So, what you're saying is…” or “So, it seems that on the one hand it's… and on the other it's…”)

- Show respect and willingness to understand the person's perspective. You do not have to agree, but it is important not to show any disapproval or blame.

- Give accurate health information that is relevant to him/her.

- Help the person clarify his/her personal goals or role in the community- what he/she wants to be or what he/she wants to do in life. You could ask, “What's important to you?” Then, help the person to think about whether what he/she is doing now is helping get there. The person needs to see the conflict or discrepancy within himself/herself.

- Avoid arguing- this will encourage the person to defend his/her opinion and behavior patterns.

- Help the person to look at his/her behavior and how it impacts others.

- At times, the person may be unwilling to consider the effects of his/her behavior. Go with this and acknowledge the person's ambivalence or reluctance. Try another way to move forward with the intervention. It is important not to impose new views or goals, but rather to invite the person to consider new information or perspectives.

- Encourage the person to generate the proposed solution. This means he or she will be more likely to follow it through. Help the person to set realistic personal goals for making changes.

- Try to build the person's confidence. The person needs to believe he or she has the ability to achieve his/her goals and change behavior.

- Ask the person what things he/she may find difficult about changing.

- Offer help and support. Encourage him/her to identify others in the community who may be able to offer support. (e.g., “Are there other people who have changed, too?”)

References:
The Clinical Visit

Turning Patient Education into Self-Management Support

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

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

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

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

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

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

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

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

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

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

The Healthy Change I want to make is:______________________________

I will do this: (how)

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

The steps I will take to achieve my goals are:

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

This is how I plan to overcome this barrier:

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

How confident are you that you can reach this goal?

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

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

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

Exercise Regularly

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

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

Getting Information About Your Illness(es)

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

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

Obtain Help from Community, Family, Friends

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

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

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

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

Communicating with Your Physician

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

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

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

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

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

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

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

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

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

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

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

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

Social/Recreational Activities Scale

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

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

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

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

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

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

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

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

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

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

Control/Manage Depression

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

   Not at all Confident  1  2  3  4  5  6  7  8  9  10  Totally Confident
Communicating with Health Care Providers

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

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

**Obstacles to Communication**

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

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

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

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

**Patient Empowerment**

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

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

**Key Points**

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

**Tools**

- Quick Tips – When Talking with Your Doctor
- Talking with Your Health Care Provider (Patient SBAR)
- A Guide for Older People: Talking with Your Doctor
The single most important way you can stay healthy is to be an active member of your own health care team. One way to get high-quality health care is to find and use information and take an active role in all of the decisions made about your care. This card will help you when talking with your doctor.

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

**Give information. Don’t wait to be asked!**

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

**Get information.**

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

(over)
• Ask your doctor to draw pictures if that might help to explain something.

• Take notes.

• Some doctors do not mind if you bring a tape recorder to help you remember things. But always ask first.

• Let your doctor know if you need more time. If there is not time that day, perhaps you can speak to a nurse or physician assistant on staff. Or, ask if you can call later to speak with someone.

• Ask if your doctor has washed his or her hands before starting to examine you. Research shows that handwashing can prevent the spread of infections. If you’re uncomfortable asking this question directly, you might ask, “I’ve noticed that some doctors and nurses wash their hands or wear gloves before touching people. Why is that?”

**Take information home.**

• Ask for written instructions.

• Your doctor also may have brochures and audio tapes and videotapes that can help you. If not, ask how you can get such materials.

**Once you leave the doctor’s office, follow up.**

• If you have questions, call.

• If your symptoms get worse, or if you have problems with your medicine, call.

• If you had tests and do not hear from your doctor, call for your test results.

• If your doctor said you need to have certain tests, make appointments at the lab or other offices to get them done.

• If your doctor said you should see a specialist, make an appointment.

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

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

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

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

**S SITUATION**

I am having:

- Pain (explain where pain is felt):
- Unexplained weight gain
- Difficulty sleeping
- Vomiting
- Harder time breathing
- Other (explain):

**B BACKGROUND**

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

What makes it better is:

What makes it worse is:

How long it lasts:

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

My last:  
- Weight  
- Blood sugar  
- Temperature  
- Blood pressure/pulse  

**A ASSESSMENT**

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

**R RECOMMENDATION (by your doctor)** Write down your doctor’s instructions:
Talking with Your Doctor
A 48-page National Institutes of Health publication that guides an older person in choosing a doctor and improving communication with their doctor.

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

The document is located under Patient Self-Management, Associated Resources—
http://www.homehealthquality.org/
Today, health information is scattered among the many healthcare providers that patients see during their lives. Typically, patients have more than one doctor, making information sharing across providers especially critical to planned care. A patient's knowledge of their medical history test results, medications, diet and exercise habits is essential to managing health.

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

**Benefits of the PHR**

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

**Elements of the PHR**

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

**Key Points**

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

**Tools**

- Your Personal Health Record Handout
Remember to take this record with you to all your medical appointments and hospitalizations.
The Personal Health Record of:  
__________________________________DOB __/__/__

**Personal Information**

Address: ____________________________________  
___________________________________________

Home Phone: _________________________________  
Alternate Phone: _______________________________

Physician: _____________________Tel ____________  
Specialist: _______________________Tel ____________  
Specialist: _______________________Tel ____________

Advance Directives? Yes ☐ No ☐

DNR ☐ Comfort Care ☐ Health Care Proxy ☐

Name of Proxy ________________________________

**Caregiver Information**

Name: _____________________________________

Home Phone: _________________________________

Alternate Phone: ______________________________

Relationship: _________________________________

**Homecare Provider:** _______________________

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

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

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

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

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

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

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Hospital/Facility Discharge Checklist

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

☐ I have been involved in decisions about what will take place after I leave the facility.

☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
  * Discharge to other facility
  * Discharge to a Home Health Agency
  * Discharge home to care of self/family

☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.

☐ I understand what my medications are, how to obtain them, and how to take them.

☐ I understand the potential side effects of my medications and whom I should call if I experience them.

Medical History

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

Other Diagnoses: __________________
_______________________________
_______________________________
_______________________________
To better manage my health and medications, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.

- Call my doctor if I have questions about my medications or if I want to change how I take my medications.

- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.

- Update my Medication Record with any changes to my medications.

- Know why I am taking each of my medications.

- Know how much, when and for how long I am to take each medication.

- Know possible medication side effects to watch out for and what to do if I notice any.

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

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Wt = weight   BP = Blood Pressure   HR = Heart Rate   BS = Blood Sugar
### Medicines I Take

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<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>When</th>
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</table>

### Medications

**Pharmacy:** _____________  **Tel:** ___________

**Allergies:** __________________________________________

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### Medicines I Take

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

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

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

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

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

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

**Telephone Monitoring**

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

**Telemonitoring**

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

**Planning for Telehealth**

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

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

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

**Confidentiality and Informed Consent**
- Include if using photography or imaging (i.e., video monitoring)

**Equipment Maintenance and Safety**
- Transporting, installation and discontinuation of equipment

**Infection Control**
- Cleaning equipment between patient use

**Staff Education and Competency**
- “Zones,” algorithms, competency checklists

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

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

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

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

**Tools**
- Phone Monitoring Assessment Guide
- Sample Telemonitoring Employee Orientation Checklist
Phone Monitoring Assessment Guide

<table>
<thead>
<tr>
<th>Date of last home visit: ____________________________</th>
</tr>
</thead>
</table>

| Patient Name _____________________________________________ | MR# __________________________ |
|-------------------------------------------------------------|

REVIEW PURPOSE OF CALL WITH PATIENT / CAREGIVER

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

Goal and Status Updates

Have you been able to stay on track with your goal(s)?

☐ Yes ☐ No

What barriers are getting in the way?

________________________________________

How have you felt since the last telephone call or home visit?

☐ Better ☐ Same ☐ Worse

Since the last call/visit, have had to call your doctor?

☐ Yes ☐ No

Go to the ER?

☐ Yes ☐ No

Dietary Intake

Any questions about your diet?

☐ Yes ☐ No

What have you eaten in the past 24 hours?

________________________________________

Any change in appetite?

☐ Yes ☐ No

Any nausea/vomiting?

☐ Yes ☐ No

Any problems with diet adherence?

☐ Yes ☐ No

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

☐ Adequate ☐ Inadequate

Condition Specific

COPD

Any changes in:

☐ Cough? ☐ Sputum? ☐ SOB?

☐ Anxiety? ☐ Confusion? ☐ O₂ use? _____l/min

Diabetes

Blood sugar _____ Patient action taken ________________

Checked feet/skin?

☐ Yes ☐ No

Cardiac/CHF

Today's weight ___________ ☐ Change _____ lbs

Patient action taken ________________

Any changes in:

☐ SOB ☐ Edema ☐ # pillows

Wounds

Did you do your wound care today?

☐ Yes ☐ No

Any change in:

☐ Pain? ☐ Drainage? ☐ Odor?

Today’s temp ___________

Cancer

Sores/bleeding?

☐ Yes ☐ No

Pt action taken: ________________

Last chemo/radiation Tx?

Other Information

Changes since last call/visit:

________________________________________

Next MD appointment: ____________________________

This material was prepared by Masspro, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily represent CMS policy.

8sow-ma-hh-07-155 phonemonitoring-apr
## Sample: Telemonitoring Employee Orientation Checklist

<table>
<thead>
<tr>
<th>Review of Telehealth Policy &amp; Procedures</th>
<th>Preceptor Initials</th>
<th>Employee Initials</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>• Protocol for Telemonitoring</td>
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<td>• Protocol for Phone Monitoring</td>
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<td>• Protocol for Teletriage</td>
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<tr>
<td>• Patient Selection Criteria</td>
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<tr>
<td>• Patient Satisfaction Survey</td>
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</table>

| Central Station Monitor                 |                      |                   |          |
| Set up of In-Home Monitor              |                      |                   |          |
| Removal of In-Home Monitor             |                      |                   |          |
| Equipment Maintenance/Infection Control |                     |                   |          |

| Documentation:                         |                      |                   |          |
| • Informed Consent form                |                      |                   |          |
| • Encounter Forms                      |                      |                   |          |
| • Initial Visit Checklist              |                      |                   |          |
| • Patient/Caregiver Instruction Sheets |                      |                   |          |

| Telemonitoring Skills Checklist         |                      |                   |          |
| Troubleshooting                        |                      |                   |          |
| Telehealth Nurse/Therapist Job Description |                  |                   |          |

Employee Signature: ___________________________  Employee Initials: _______

Preceptor Signature: ___________________________  Preceptor Initials: _______
(Insert Agency-Specific Policies & Procedures, Forms, Job Descriptions Here)
Measurement & Evaluation

Tab 7: Measurement & Evaluation

Clinical Measurement

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

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

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

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

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

Key Points

- Performance measures are tools that can provide valuable information to help providers make better decisions and lead to improvements in quality healthcare and quality of service

- The ultimate goal is to manage quality. But you cannot manage it until you have a way to measure it, and you cannot measure it until you are able to monitor it. (Florence Nightingale)

Tools

- Patient Assessment of Self-Management
Patient Assessment of Self-Management

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

1. My health care team asked about my ideas and beliefs when we talked about my health problems and treatment.
   
   Yes  No  Don’t know

2. My health care team told me in a way I could understand how I could help take care of my health problems.
   
   Yes  No  Don’t know

3. My health care team talked with me about setting goals to take care of my health problems.
   
   Yes  No  Don’t know

4. My health care team helped me to solve problems so that I could meet my goals and improve my health.
   
   Yes  No  Don’t know

5. My health care team talked with me about how to get help from my friends, family and community.
   
   Yes  No  Don’t know

6. I was able to achieve at least one goal I set to improve my health.
   
   Yes  No  Don’t know

Are you confident that you:

7. Can self-manage your health?  
   
   Yes  No

8. Know when to get medical care and when you can handle a health problem yourself?
   
   Yes  No

9. Can talk to your doctor about what concerns you?
   
   Yes  No

10. Can find solutions to new situations or problems that come up with your health?
    
   Yes  No

Thank you.
Tab 8: Self-Management Tools
(Insert Agency-Specific Self-Management Tools Here)
# Tab 9: Resources

## General Resources:
**Medline Plus**  
1 888-346-3656  
[www.medlineplus.gov](http://www.medlineplus.gov)

**AARP**  
1 888-687-2277  
[www.aarp.org](http://www.aarp.org)

## Advance Directives:
**The American Geriatric Society**  
212-308-1414  

## Alcohol:
**National Institute on Alcohol Abuse and Alcoholism**  
301-443-3860  
[www.niaaa.nih.gov](http://www.niaaa.nih.gov)

## Assisted Living:
**National Center for Assisted Living**  
202-842-4444  
[www.ncal.org](http://www.ncal.org)

## Terminal Care:
**National Hospice & Palliative Care Organization**  
1-800-658-8898  
[www.nhpco.org](http://www.nhpco.org)

## Alzheimer's Disease:
**Alzheimer’s Disease Education & Referral Center**  
1-800-438-4380  
[www.alzheimers.nia.gov](http://www.alzheimers.nia.gov)

## Caregiving:
**Children of Aging Parents**  
1-800-227-7294  
[www.caps4caregivers.org](http://www.caps4caregivers.org)

**National Center on Elder Abuse**  
202-898-2586  
[www.elderabusecenter.org](http://www.elderabusecenter.org)

## Support:
**Massachusetts General Hospital**  
[www.mghsocialwork.org/SupportGroups/Chronic.htm](http://www.mghsocialwork.org/SupportGroups/Chronic.htm)

## Illness Related:
**American Heart Association**  
1-800-242-8721  
[www.americnheart.org](http://www.americnheart.org)

**American Diabetes Association**  
[www.diabetes.org](http://www.diabetes.org)

**American Chronic Pain Association**  
[www.thecpa.org](http://www.thecpa.org)

**Arthritis Foundation**  
[www.arthritis.org/resources](http://www.arthritis.org/resources)

**National Heart, Lung, & Blood Institute**  
301-592-8573  
[www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)

## Education Materials:
**Ethnomed**  
[www.ethnomed.org](http://www.ethnomed.org)

**Medscape**  

**E-Medicine**  
[www.emedicinehealth.com](http://www.emedicinehealth.com)

**Personal Health Record**  
[www.myphr.com](http://www.myphr.com)
<table>
<thead>
<tr>
<th>Resource Description</th>
<th>Source</th>
<th>Web Link</th>
</tr>
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<tbody>
<tr>
<td>Patient self-management tools in English and Spanish for a variety of diagnoses: asthma, CVD, diabetes, goals setting</td>
<td>Community Health Association of Mountain/Plains States</td>
<td><a href="http://www.champsonline.org/tools/">http://www.champsonline.org/tools/</a></td>
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<tr>
<td>Oregon Heart Failure GAP (guideline applied in practice) Toolkit</td>
<td>American College of Cardiology, Oregon Chapter</td>
<td><a href="http://www.cardiologyinoregon.org/information/toolkit">http://www.cardiologyinoregon.org/information/toolkit</a></td>
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<tr>
<td>Resource Table</td>
<td>Source</td>
<td>Web Link</td>
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<tr>
<td>Chronic disease care</td>
<td>California Healthcare Foundation: Helping Patients Manage Their Chronic Conditions</td>
<td><a href="http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768">http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768</a></td>
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<tr>
<td>Using Telephone Support to Manage Chronic Disease</td>
<td>California Healthcare Foundation: Helping Patients Manage Their Chronic Conditions</td>
<td><a href="http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768">http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768</a></td>
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## Resource Table

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<tr>
<th>Resource Description</th>
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<tr>
<td>Health literacy kit for healthcare professionals.</td>
<td>American Medical Association</td>
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<tr>
<td>Initiative using behavior change and care models to promote self-management support.</td>
<td>Institute for Healthcare Improvement Strategic Initiatives</td>
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<table>
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<th>Web Link</th>
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</table>
# References

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<tr>
<td>Institute for Healthcare Improvement. Innovation Community: Building an Effective “Planned Care” System for All Patients in Ambulatory Settings. <a href="http://www.ishi.org/IHI/Programs/InnovationCommunities/BuildingaReliableSystemforAllPatientswithChronicConditions.htm">http://www.ishi.org/IHI/Programs/InnovationCommunities/BuildingaReliableSystemforAllPatientswithChronicConditions.htm</a> (accessed May 9, 2007).</td>
</tr>
<tr>
<td>Joint Commission on Accreditation of Healthcare Organizations. 2006. Patients as partners: How to involve patients and families in their own care. Washington DC: Joint Commission on Accreditation of Healthcare Organizations.</td>
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</table>


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


**Self-Management Support: Agency Assessment**

**Purpose of Tool:**
To provide parameters to assess your agency’s current status with patient self-management (SM) and self-management support (SMS)

<table>
<thead>
<tr>
<th>Culture/Processes</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Has your agency implemented at least three of the previous best practices introduced in the Home Health Quality Improvement Campaign? Examples: Hospitalization Risk Assessment, Emergency Care Planning, Medication Management, Physician Relationships</td>
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<tr>
<td>Do you have a formal self-management support program with defined policies or guidelines, procedures and staff education?</td>
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<tr>
<td>Is leadership committed to the support of the systems/processes necessary for development and/or sustaining a chronic illness self-management support program including allocation of time and resources for education and evaluation?</td>
<td>☐</td>
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</tr>
<tr>
<td>Are all provider staff given sufficient time to include self-management activities in their visits, including home health aides?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Education</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a designated person or champion to ensure that patient self-management resources and interventions are followed?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you send your clinical experts to training outside your organization, when needed, to keep them current with practice guidelines?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you provide patient self-management education to clinicians in living with chronic illness and how to engage patients/caregivers? At orientation and ongoing?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Is discipline specific self-management support education provided to therapists, social workers and home health aides?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Is self-management patient instruction/coaching/motivational interviewing included as a competency indicator during new hire orientation and with annual onsite competency assessments?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
# Self-Management Support: Agency Assessment (cont.)

## Interactions/Communication

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there processes to support development of a patient specific action plan to assist the patient in meeting goals?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Does your agency provide standardized patient education materials that can be modified to the specific goals of the patient/caregiver?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are individual patient-centered goals discussed at case conferences?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Can clinical staff differentiate between patient education and patient self-management?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do phone-monitoring encounters include an update on the status of patient-defined goals?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are home health aide care plans routinely updated to reflect progressive, increased patient self-management when applicable?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are patient-defined goals communicated with the physician early in the episode and at discharge from services?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

## Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you clearly defined your desired outcomes for patient self-management and agency self-management support?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Does your agency routinely review patient records to assure that collaborative patient self-management education is occurring effectively?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you have a designated person or champion to monitor staff application of self-management principles?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Is self-management achievement an indicator on your patient satisfaction survey?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do changes occur to your processes based upon the results of internal record review and patient satisfaction surveys?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
**Purpose of Tool:**
To provide suggestions to develop or enhance your agency’s patient self-management (SM) and self-management support (SMS) program based upon your agency assessment.

### Culture/Processes

Prepare to Build Upon the Basics. Review selected HHQI Best Practice Intervention Packages:

<table>
<thead>
<tr>
<th>Hospitalization Risk Assessment</th>
<th>Telemonitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Emergency Care Planning</td>
<td>Immunization</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Physician Relationships</td>
</tr>
<tr>
<td>Phone Monitoring/Frontloading</td>
<td>Fall Prevention</td>
</tr>
<tr>
<td>Teletriage</td>
<td></td>
</tr>
</tbody>
</table>

- Review or develop policies/guidelines for a structured self-management program
- Commit time and resources to the development of the processes necessary for a chronic illness self-management support program
- Establish a timeline for development/enhancement of your agency’s self-management support program

### Staff Education

- Identify a patient self-management champion or expert to be responsible for ensuring self-management interventions are supported by evidence and applied
- Plan and budget to send your clinical expert to training outside your organization to keep him/her current with practice guidelines
- Refine or develop a patient self-management educational program for all clinicians that includes living with chronic illness and how to engage patients/caregivers in education
- Review Associated Resources for staff education (under Patient Self-Management, Associated Resources—[www.homehealthquality.org](http://www.homehealthquality.org)):
  - HHQI WebEx: **Supporting Patient Self-Management through Planned Care: Evidence and Techniques** by Masspro
  - Workbook: **Planned Care: Patient Self-Management Support, Staff Education Workbook** by Masspro
    - Turning Patient Education into Self-Management Support
    - Principles of Motivational Interviewing
  - **Action Planning** (page 66)
  - Podcasts: **Self-Care Management Skills for Clinicians** by Lisa Gorski AND **Self-Care Management for Home Health Aides** by Carol Siebert, OTR/L and Karen Vance, OTR/L
- Include self-management patient instruction/coaching/motivational interviewing demonstration as part of new hire orientation and competency evaluation
- Include therapists, social workers and home health aides in self-management support education
Build Upon the Basics

Self-Management Support: Action Items (cont.)

Interactions/Communication

- Provide standardized patient education materials that can be modified to the goals of the patient (www.homehealthquality.org):
  - Patient Self-Management Brochure (page 19)
  - Sample Patient Action Plans (pages 25, 64 and under Associated Resources on www.homehealthquality.org Spanish and Chinese versions are also available)
  - Patient SBAR (page 33)
  - Talking with Your Doctor (page 34)
  - Your Personal Health Record (page 36)

- Include Action Plan in admission packets
- Modify phone-monitoring scripts to include status of patient self-management goals
  - Phone Monitoring Assessment Guide (page 46)

- Include patient-centered goals as a standard agenda item at case conferences
- Modify home health aide care plans to include a patient-centered approach that includes patient goals
- Identify process to communicate patient goals to physician

Evaluation

- Document desired outcomes for patient self-management and agency self-management support
- Share those desired outcomes with staff and professional advisory committee
- Develop a plan to regularly evaluate self-management support program
- Review patient records to assure that collaborative patient self-management education is occurring
- Identify a self-management champion to monitor staff application of self-management principles
- Modify patient satisfaction survey to include self-management achievement
  - Patient Assessment of Self-Management (page 50)
# Self-Management Support: Action Plan

Using the Leadership Action Items (pages 59 - 60), leadership team members should select and prioritize items to be implemented or modified. The development of a Patient Self-Management program may be a yearlong effort.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>By Whom</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Establish a timeline for development/enhancement of your patient self-management program</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Review care discipline tracks to determine what portions of this <strong>Best Practice Intervention Package - Patient Self-Management</strong> you choose to use and how you want to utilize them</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review the tools and associated resources and select the most appropriate to initiate or optimize your <strong>patient self-management</strong> program: (see pages 63 for description of tools)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Patient Self-Management Brochure</strong> (page 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Patient SBAR</strong> (page 33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Talking With Your Doctor</strong> (page 34)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Personal Health Record</strong> (page 36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Patient Assessment of Self-Management</strong> (page 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review the tools and resources and select the most appropriate to initiate or optimize your <strong>self-management support</strong> program: (see page 63 for description and location of tools and resources)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Phone Monitoring Assessment Guide</strong> (page 46)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Planned Care: Patient Self-Management Workbook, Staff Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>HHQI WebEx: Supporting Patient Self-Management through Planned Care: Evidence and Techniques</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Video: Video with Techniques for Effective Patient Self-Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Action Planning</strong> (page 66)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Podcasts: Clinician and HHA</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Self-Management Tools (For Patients)

- **Patient Self-Management Brochure** (page 19)
  Brochure to help patients understand how to become an active participant in their care

- **Sample Patient Action Plans**
  Plan for patients to record their health actions, goals and confidence levels for health changes. Three sample Action Plans to choose from:
  1. **Self-Management: Healthy Changes Plan and Confidence Scales** (in Masspro package page 26 & 27)
  2. **My Action Plan** from Thomas Bodenheimer, MD of UCSF Department of Family and Community Medicine (page 65)

- **Patient SBAR** (page 33)
  SBAR script for patient to follow when talking with healthcare providers

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

- **Your Personal Health Record** (page 36)
  A record for patients to record personal information, health history and medications with purpose of taking this health record to all medical appointments

- **Patient Assessment of Self-Management** (page 50)
  A patient evaluation of the healthcare team’s ability to promote self-management support and the patient’s success with self-management
Self-Management Support Tools and Resources: How to Use (For Home Health Staff)

- **Form:** Phone Monitoring Assessment Guide (page 46)
  Clinician script to encourage and coach patients and promote their self-management skills

- **HHQI WebEx:** Supporting Patient Self-Management through Planned Care: Evidence and Techniques by Masspro
  Educational WebEx for clinicians that addresses the difference between patient self-management and self-management support, and the need for collaboration with the patient to be successful with self-management

- **Video:** Video with Techniques for Effective Patient Self-Management by California Healthcare Foundation
  Video that shows techniques to promote patient self-management through 3 patient demonstrations

- **Workbook:** Planned Care: Patient Self-Management Support, Staff Education Workbook by Masspro
  This 20-page staff education workbook guides clinicians to better understand their role in patient self-management and self-management support. This workbook may be completed individually or with group sessions.

- **Action Planning (goal setting)** (page 66)
  A description of action planning is included in the Leadership Track written by Kate Loring from Stanford University School of Medicine to understand what action plans are and how they work.

- **Podcast:** Strategies to Improve Patient Self-care Management Skills by Lisa Gorski
  A 15-minute audio recording that describes self-care management skills for clinicians

- **Podcast:** Self-Care Management for Home Health Aides by Carol Siebert, OTR/L and Karen Vance, OTR/L
  A 15-minute audio recording for home health aides that describes their role in promoting patient self-care management

* The HHQI WebEx: Supporting Patient Self-Management through Planned Care: Evidence and Techniques and Podcasts are part of the Discipline Care Tracks. The other tools and resources are either included as documents or links in this package or on the Website, [www.homehealthquality.org](http://www.homehealthquality.org)
MY ACTION PLAN

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 Planning (goal setting)

By Kate Lorig, RN, DrPH/ Stanford University School of Medicine

**What is Action Planning?**
This is a tool or technique that helps people change their behavior over a short period of time. In Spanish it is called a self-promise or something one promises themselves they will do.

**What is Goal Setting?**
Goals are usually larger than action plans and are things that we aim to accomplish over months or years. However, sometimes goal setting and action planning are used interchangeably. In this document we will talk about action planning.

**Why Should I do Action Planning With my Patients?**
From research going back as far as the 1960’s it appears that action planning is one of the best means of accomplishing short-term behavior change. Once this change becomes a habit—this usually takes two to three months—then it usually becomes part of one’s ongoing life.

Action plans also allow people to get started and to try out a new behavior. Often something like exercise or losing weight is too big and so people do nothing. Instead they can make an action plan for what they are going to do this week. For example “this week I will not eat after 7 p.m. on four nights.”

**Why do Action Plans Work?**
From psychology, specifically the work of Albert Bandura, we know that people who have self-efficacy or confidence that they can do something, will probably do it. Action plans, by breaking very big goals into doable tasks, allow people to be successful and gain confidence or self-efficacy in their ability to do something. Success tends to build on success.

**Are There Different Types of Action Plans?**
Yes, there are at least two types. A tailored action plan is when a health professional asks a patient to set an action plan in a specific area. For example “How would you like to increase your exercise this week?” Another means of tailoring is that used by Dr. Tom Bodenheimer in his study of the use of action plans in primary care. He gave people a choice of any of five domains in which they could make action plans; something that is bothering me, exercise, eating, medications or stress.

A self-tailored action plan is one where the individual can choose any behavior he or she wants to work on during the next week. For example, “This week I will learn two new French words every day.”

There are advantages and disadvantages to each of these. The advantage to the tailored plan is that the clinician can guide the action plan to an area of health behavior that he or she sees as most important. The disadvantage is that this may not be an area of importance to the patient and thus there is no real buy in. The patient does not do the action plan and everyone loses.
The advantage of self-tailoring is that the patient chooses a behavior that is important to him or her, and probably has a better chance of succeeding. The disadvantage is that sometimes the behavior seems inappropriate to the clinician. In our example, learning French does not seem to have much to do with health. However, this patient was having cognitive problems due to chemotherapy and had decided to learn the French words as a memory exercise. It should be noted that the Bodenheimer approach is probably a good middle ground between tailoring and self-tailoring. *(Note: The Bodenheimer Action Plan is the primary tool in the Patient Self-Management Best Practice Intervention Package).*

**But Doesn’t This Take too Much Time?**
The very first time you make an action plan with a patient it will probably take about six minutes. Once both you and the patient get comfortable with this approach, additional action plans should take about a minute.

**OK. So how do I do Action Plans With my Patients?**
Make an action plan with yourself and try it for a week. This will help you see the power of action plans. Then pick one or two patients a day with whom to try this new skill. Do not worry if it seems awkward at first. It will get easier.

**References**
Lorig K, Sobel d, Laurent D, Gonzalez V, Minor M. *Living a Healthy Life with Chronic Conditions.* Bull Publishing Company 2006
Basics of Self-Management Support

- Our agency has implemented several action items from three or four of the previous best practice interventions.
- Our leadership team sees the value in developing a structured patient self-management program to enhance the self-management support provided to our patients.
- Our leadership has reviewed and discussed the Patient Self-Management Best Practice Intervention Package. We have selected some action items to begin implementing.
- Our agency is prepared to educate and utilize the Care Provider Tracks for all of our clinicians, including the home health aides.

Beyond the Basics:
Patient Self-Management Support Patient Education

The following resources are for agencies wanting to offer additional educational information for staff in patient self-management and self-management support. The following workbook and video may be used as individual learning modules or in a group instructional setting.

- **Planned Care: Patient Self-Management Support, Staff Education Workbook** by Masspro
  This 20-page staff education workbook guides clinicians to better understand their role in patient self-management and self-management support. Exercises include changing behavior, problem solving, dealing with ambivalence and goal setting.

- Review the California HealthCare Foundation (CHCF) short training video called **Video with Techniques for Effective Patient Self-Management**
  - 33-minute presentation provides strategies and tools that busy clinicians can use to help patients adopt healthy behaviors
  - Featured techniques are based on the principles of motivational interviewing and provide a sampling of how to effectively support patients
  - The material is presented by William H. Polonsky, PhD, CDE, of the University of California, San Diego The video is located at: [http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673](http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673)
Living with chronic illness...

How do you support your patients?

Self-Management Support: more than Patient Education

<table>
<thead>
<tr>
<th>Patient Education</th>
<th>Self-Management Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching</td>
<td>Information &amp; skills</td>
</tr>
<tr>
<td>Assumes</td>
<td>Knowledge yields</td>
</tr>
<tr>
<td></td>
<td>behavior change</td>
</tr>
<tr>
<td>Goal</td>
<td>Compliance</td>
</tr>
<tr>
<td>Outcome</td>
<td>Information</td>
</tr>
</tbody>
</table>
Patient Self-Management
Post-Test Answer Keys

Each track of the Best Practice Intervention Package has a post-test that providers may choose to complete after reviewing the track and completing the activities.

For the Patient Self-Management package, the post-tests are found on the following pages:
Nurse Track – page 83
Therapist Track – page 97
Medical Social Work Track – page 106
Home Health Aide Track – page 111

Use the answer keys below to score the post-tests included with the Best Practice Intervention Package – Patient Self-Management.

Nursing post-test answers:
1. A
2. B
3. A
4. E
5. B

Therapist post-test answers:
1. A
2. B
3. A
4. E
5. B

Medical Social Worker post-test answers:
1. A
2. B
3. A
4. E
5. B

Home Health Aide post-test answers:
1. A
2. B
3. A
4. E
5. A
Best Practice:
Patient Self-Management

Nurse Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.608 App. 12/2007
Nurse Track

This best practice intervention package track is designed to educate nurses 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 Nurse 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 nursing actions that encompass self-management support

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete the Self-Management Support Nurse Self-Assessment</td>
<td>Page 75</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Review the My Action Plan tool and Action Plan Script</td>
<td>Page 76</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Listen to Strategies to Improve Patient Self-Care Management Skills podcast</td>
<td>Page 78</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Watch or listen to: Supporting Patient Self-Management through Planned Care: Evidence and Techniques WebEx or podcast</td>
<td>Page 78</td>
<td>45 minutes</td>
</tr>
<tr>
<td>Read Examples of Excellence</td>
<td>Page 79</td>
<td>10 minutes</td>
</tr>
<tr>
<td>RNs: Complete the nursing evaluation and post-test online for free CNEs</td>
<td>See link below</td>
<td>10 minutes</td>
</tr>
<tr>
<td>LPNs: Complete the nursing post-test online for free certificate of participation</td>
<td>See link below</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total time for completion</strong></td>
<td><strong>105 minutes</strong></td>
<td></td>
</tr>
</tbody>
</table>

**RNs:** Apply for free 1.75 Continuing Nursing Education units for completing the nursing track activities. **Complete evaluation/post-test online at:**
http://www.zoomerang.com/survey.zgi?p=WEB2277VKJZG2C

**LPNs/LVNs:** Apply for a certificate of attendance for completing the nursing track activities. **Complete evaluation/post-test online at:**
http://www.zoomerang.com/survey.zgi?p=WEB2277VKJZG2C

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)
**Self-Management Support: The Clinician Connection**

**Seven Clinician Tips for Self-Management Support**

1. Understand that self-management support is more than patient education
2. Work **with** patients to develop realistic health changes
3. Help patients evaluate what they are already doing to manage their health
4. Help patients to see the relationship between behaviors and outcomes
5. Translate clinical measures to terms that are **relevant and understandable** to the patient and caregiver
6. Focus on small measurable changes
7. Reinforce and praise **consistent, unattended** performance

“Our experience has been that, done well, implementing self-management support can be very fulfilling and positive for providers. It expands the clinicians’ role to include more of what many consider their core competencies and it can stretch their role in welcome ways.”

*Laurel Simmons*, Deputy Director, New Health Partnerships: Improving Care by Engaging Patients
Self-Management Support: Nurse Self Assessment

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

<table>
<thead>
<tr>
<th>Establish a Focus</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>At start of care and on an ongoing basis, I assess patient beliefs, behavior and knowledge with a standardized assessment.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I ask open-ended questions whenever possible to learn about patients’ perceptions and concerns, adapting the level of my conversation based on cognitive and language deficits.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I actively listen to my patients as they tell their illness story.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share Information</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I share information about the illness with the patient to help my patients make informed decisions on where to focus their efforts.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I provide personalized feedback on lab values and functional status related to risks/benefits and ways behaviors can affect outcomes.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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.</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Develop Shared Goals</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I collaboratively develop a patient-centered emergency care plan that correlates with my patient’s goals and is reinforced with each encounter.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I collaboratively set goals with the patient/caregiver based on the patient’s interest and confidence in his or her ability to change the behavior.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I refer to speech therapy to identify the best possible way to present information to patients with hearing loss, cognitive deficits, memory deficits, vision issues and/or processing deficits and various learning styles.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Develop an Action Plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I establish a patient/caregiver driven action plan with my patients to support self-management goals.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I provide an opportunity for my patients to identify their confidence levels in achieving specified goals.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Identify personal barriers, strategies, problem-solving techniques and social/environmental support available for all patients.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use Problem Solving Techniques</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I offer tools and coaching to ensure medication simplification and reconciliation occurs effectively according to patient’s ability.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I support and encourage my patients to develop skills needed to communicate effectively with physicians.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
**MY ACTION PLAN**

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.

From the Chronic Disease Self-Management Program
Copyright Stanford University 2006
Patient Self-Management Multi-Media Activities

Podcast*

Patient Self-Management Clinician Podcast Instructions:
Listen to the podcast to learn more about patient self-management from Lisa Gorski, MS, APRN, BC, CRNI, Senior Associate Consultant with OASIS Answers, Inc.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategies to Improve Patient Self-Care</td>
<td>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</td>
<td>The podcast link is located at <a href="http://www.homehealthquality.org.hh/hha/interventionpackages/patient_sm.aspx">http://www.homehealthquality.org.hh/hha/interventionpackages/patient_sm.aspx</a></td>
</tr>
<tr>
<td>Management Skills</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Patient Self-Management through Planned Care: Evidence and Techniques</td>
<td>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</td>
<td>The WebEx and podcast link is located at <a href="http://www.homehealthquality.org.hh/hha/interventionpackages/patient_sm.aspx">http://www.homehealthquality.org.hh/hha/interventionpackages/patient_sm.aspx</a></td>
</tr>
</tbody>
</table>

Note - The Planned Care: Patient Self-Management Support Staff Education Workbooks (referenced in the WebEx/podcast) are located on www.homehealthquality.org under Associated Resources with the Patient Self-Management package.
Reducing Acute Care Hospitalization: The Impact of Chronic Illness Assessment Staff Education

Aiming “LOW”
South Davis Home Health (SDHH) is a small, hospital-based agency in Bountiful, Utah. The staff is committed to reducing the number of patients who experience an avoidable acute care hospitalization and providing effective self-management support. As a voluntary participant in the national ReACH (Reducing Acute Care Hospitalizations) Collaborative, SDHH set its outcome goal at nine percent based upon OBQI data. As of the July 2007 OBQI data, the acute care hospitalization (ACH) rate for South Davis is 9.90 percent, which is 11 percent better than the Utah state average. “We aimed low, and have been amazed at our progress,” says Denise Cook, QI Director.

Methods
How are they doing it? Leadership has incorporated quality improvement into the agency’s organizational culture. They have created a blame-free learning environment that has promoted teamwork. “We value staff involvement and input,” says Ms. Cook. “We want our clinicians to be involved in developing processes that will improve our patients’ care and support patient self management.”

SDHH conducted strategic process investigations to determine how to decrease avoidable hospitalizations. The investigation findings revealed that OASIS assessments were not always capturing patient acute care hospitalization risk factors. Consequently, South Davis decided to focus staff education efforts on comprehensive chronic illness assessment, which is the first step to ensure that patients remain safe in their homes, improve their level of functioning and develop effective self management skills.

The ability to identify risk factors that are associated with chronic illnesses requires clinicians to look beyond immediate acute conditions. SDHH realized that this level of knowledge and assessment skill required chronic illness expertise, so they sought the help of external chronic illness experts. Staff education emphasized that accurate assessments translate into patient-centered care plans that guide appropriate treatment, including determining the self-management support patients will need to manage their chronic conditions. They learned the characteristics of a comprehensive chronic illness assessment, how to gather patient information effectively and efficiently and how to evaluate patients’ conditions based on these data. This comprehensive assessment and evaluation then serves as the basis for the development of a patient-centered self-management plan.
In order to strengthen patient assessments and determine a patient’s ability to self-manage, clinicians are now administering the CLOX test to patients upon admission, at resumption of care and anytime a patient seems to have a cognitive decline. They also test caregivers when appropriate. The CLOX test is a clock-drawing activity used to detect early signs of cognitive impairment. The tool helps clinicians assess the patients’ ability to initiate and sequence tasks or events. This information can lead to more effective care plans by helping clinicians determine what level of assistance each patient needs to safely self-manage his/her chronic conditions as independently as possible. This is important because even the most appropriate care plan will fail if clinicians and patients don’t execute it correctly.

After patients are assessed appropriately, clinicians use personalized emergency care plans, which list early warning signs and symptoms, and standardized teaching tools to educate patients and their caregivers on chronic disease management. The teaching tools have been organized in a file cabinet drawer for easy access for clinicians and can be taken to the home as a handout if appropriate. Clinicians also use the tools as a guide for documentation of teaching and evidence of the patient’s self-management skill development.

**Outcomes**
Following the chronic illness assessment training, agency clinicians reported a positive shift in the way they assess patients with chronic diseases. Many sources of information are considered, starting with the H & P. Clinicians are now using their observational skills, and they’re asking open-ended questions to gather objective and subjective evidence. They are looking at patient health status from physiological, functional, psychosocial and cognitive perspectives to create a whole picture. Their clinical skills have been enhanced and they are seeing the benefits in their patient care and their ability to provide individualized patient self-management support. Because fewer patients are requiring hospitalization, this means more are being cared for safely at home, while developing effective self-management skills. Data are collected regularly to determine if clinicians are performing these new best practices consistently and accurately. As noted, they are definitely seeing a reduction in the number of avoidable hospitalizations.

**Staff Engagement**
To promote staff involvement, the agency is ensuring the outcomes data is visible to everyone in very creative ways. A picture of a bed, representing hospitalization, is hanging on a wall in the agency office. If a patient experiences an acute care hospitalization, a cutout figure is added to the bed.

To learn more about what South Davis Home Health is doing to reduce avoidable hospitalizations, contact Denise Cook at denisecook@sdch.com or 801.299.4866.

*Denise Cook, RN, QI Coordinator, South Davis Home Health  
Cher Edmonds, MS, CHES, SSW, Project Coordinator, HealthInsight*
The ACH Reduction Directive
For HMO Group Health in Seattle, Wash., reducing acute care hospitalization rates was a directive from leadership, expedited by a confluence of outside influences and the manipulation of existing company technology.

The home health and hospice segment of Group Health covers all of western Washington, an area encompassing an urban, suburban and rural customer base of about 500,000. The home health segment has an average daily census of 500 patients.

Paul Ehrlich, RN, Performance Improvement and Quality Specialist, has been with Group Health for 25 years. Ehrlich says the home health group began addressing ACH rates through the ReACH project, introduced by Washington state’s QIO, Qualis Health, several years ago. The program contained similar elements to the current national Home Health Quality Improvement Campaign.

High-Risk Identification Strategies: The Role of Technology
Through the work of the ReACH project, a pilot program through the New York Visiting Nurses Association addressing acute care hospitalizations, the HMO developed methods to identify patients that were at high-risk, and then incorporated these risk factors into the electronic OASIS start of care (SOC) assessment. Company technology was then employed to calculate a numerical score to flag high-risk patients. Clinicians need not complete additional paperwork to assess those at high-risk for ACH.

“Other agencies have an additional form,” said Ehrlich. “Our clinicians only had to do what they normally do, and the score is calculated and available right there in front of them. As soon as they pull up the patient’s name they see ‘high-risk’ flagged in the non-clinical note.”

According to Ehrlich, technology was an important piece of the puzzle. Since the HMO’s system was partially in place, IT staff had time to devote to this project. However, he emphasizes that even though “we are a little ahead of the curve, it’s not by leaps and bounds.”

After the assessment, Group Health created a single, simplified emergency planning form for high-risk patients called “Steps to Health,” which includes
a lot of space to fill in the blanks. The form is completed on the first visit and then placed on the patient’s refrigerator so it is visible to everyone. “Everyone knows how to call 911,” said Ehrlich. “Almost every form we’ve seen has 911 printed prominently on the form, so we specifically left it off ours. We think it’s redundant, and without it, patients are prompted to call our home health nurses first.”**

Leadership’s Role: ACH Risk Identification and Self-Management Support

Group Health’s leadership was attuned to national efforts that were underway, including a discussion of the HHQI Campaign. They also were moving along a parallel path because patients want to stay at home, and because reducing ACH is good for the bottom line. Everything began to come together simultaneously for Ehrlich and Group Health—ReACH, HHQI in the national pipeline and a leadership directive.

“We’ve had support and encouragement from leadership, but it is a lot of work,” said Ehrlich. “Teaching the staff and getting buy-in at the staff level means that a lot of ongoing effort is involved, but the results show what can be done.”

Group Health’s ACH rates have dramatically improved. Prior to the program, Group Health’s ACH percentage was consistently in the low 20s—for years it was tracking between 20-22 percent (OBQI reports). Since implementing the program two years ago, their ACH rate has gradually declined each month. “The last two months, rates have been down to 17.6 percent using this program,” said Ehrlich. “This is the lowest it has ever been and we’re still on a downward trend.”

According to Ehrlich, technology, management support, national programs and the efforts of the QI staff and clinicians have led to measurable improvements.

*Content and data provided with permission by Group Health Home Health & Hospice

**The “Steps to Health” form is available for download at www.homehealthquality.org.
Nursing Post-test
Patient Self-Management

Clinician ___________________________ Date ______________________

RNs – May apply for 1.75 FREE CNEs and LPN/LVN may apply for certificate of participation by following directions on page 72.

Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

1. Individuals must undertake tasks to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions. This is the definition for:
   A. Patient self-management
   B. Self-management support

2. Provision of education and supportive interventions systematically by health care staff increases patients’ skills and confidence in managing their health problems. This can include regular assessment of progress and problems, goal setting and problem-solving support. This is the definition for:
   A. Patient self-management
   B. Self-management support

3. All of the following activities are examples of self-management support except:
   A. Patient weighs self and takes medications independently
   B. Sharing information about the disease with patient
   C. Completing shared goal setting with the patient
   D. Developing an action plan with the patient

4. Developing an Action Plan with the patient can provide for all the following except:
   A. Initiating a conversation with patient to determine what the patient would like to accomplish
   B. Making a decision to accomplish the plan
   C. Determining how confident the patient is in reaching the goal
   D. Providing opportunities for clinicians to follow-up with patients and encourage them to continue their self-management efforts
   E. Ensuring action plan success

5. The clinician can determine what specific action plan the patient needs to develop and act upon it without patient involvement.
   A. True
   B. False

Answers to Post-test are located in the Leadership Section page 70.
Best Practice: Patient Self-Management

Therapist Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.608 App. 12/2007
Therapist Track

This best practice intervention package track is designed to educate therapists in patient self-management and self-management support principles that will support reducing avoidable acute care hospitalizations.

Objectives

After completing the activities included in the Therapist Track of this Best Practice Intervention Package – Patient Self-Management, the learner will be able to:

1. Describe patient self-management and self-management support as they relate to home health care delivery
2. Describe how patient self-management will support reducing avoidable acute care hospitalizations
3. Describe two therapy actions that encompass self-management support

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Complete the Self-Management Support Therapist Self Assessment</td>
<td>Page 89</td>
<td>5 minutes</td>
</tr>
<tr>
<td>☐ Review the My Action Plan tool and Action Plan Script</td>
<td>Page 90</td>
<td>5 minutes</td>
</tr>
<tr>
<td>☐ Listen to Strategies to Improve Patient Self-Care Management Skills podcast</td>
<td>Page 92</td>
<td>15 minutes</td>
</tr>
<tr>
<td>☐ Watch or listen to: Supporting Patient Self-Management through Planned Care: Evidence and Techniques WebEx or podcast</td>
<td>Page 92</td>
<td>45 minutes</td>
</tr>
<tr>
<td>☐ Read Examples of Excellence</td>
<td>Page 93</td>
<td>10 minutes</td>
</tr>
<tr>
<td>☐ Complete the therapy post-test online for free certificate of participation</td>
<td>See link below</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total time for completion</strong></td>
<td></td>
<td><strong>105 minutes</strong></td>
</tr>
</tbody>
</table>

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

**Complete evaluation/post-test online at:**


**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)
Self-Management Support: The Clinician Connection

Seven Clinician Tips for Self-Management Support

1. Understand that self-management support is more than patient education
2. Work with patients to develop realistic health changes
3. Help patients evaluate what they are already doing to manage their health
4. Help patients to see the relationship between behaviors and outcomes
5. Translate clinical measures to terms that are relevant and understandable to the patient and caregiver
6. Focus on small measurable changes
7. Reinforce and praise consistent, unattended performance

“Our experience has been that, done well, implementing self-management support can be very fulfilling and positive for providers. It expands the clinicians’ role to include more of what many consider their core competencies and it can stretch their role in welcome ways.”

Laurel Simmons, Deputy Director, New Health Partnerships: Improving Care by Engaging Patients
**Self-Management Support: Therapist Self Assessment**

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

<table>
<thead>
<tr>
<th>Establish a Focus</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>At start of care (when applicable) and on an ongoing basis, I assess patient beliefs, behavior and knowledge with a standardized assessment.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>I ask open-ended questions whenever possible to learn about patients’ perceptions and concerns and actively listen to my patients as they tell their illness story.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>My professional philosophy is patient-centered and acknowledges patients’ expertise in managing their own lives.</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share Information</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I share information about the illness with the patient to help my patients make informed decisions on where to focus their efforts.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>I provide personalized feedback on functional status related to risks/benefits and ways behaviors can affect outcomes.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>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.</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Develop Shared Goals</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I collaboratively set functional short-term (what can be achieved during the course of skilled therapy) and long-term goals (what can be achieved after therapy discharge) with the patient/caregiver.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>I collaboratively set goals with the patient/caregiver based on the patient’s interest and confidence in his or her ability to change the behavior.</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

**Physical Therapist:** I work with other disciplines in creating the patient’s home exercise program to improve movement and function.

**Occupational Therapist:** I work with other disciplines to incorporate self-management tasks into ADL and IADL routines.

**Speech Therapist:** I serve as a resource within the agency to assist other disciplines with the best possible way to present information to patients with hearing loss, cognitive deficits, memory deficits, processing deficits and/or vision issues.

<table>
<thead>
<tr>
<th>Develop/Support an Action Plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I provide an opportunity for my patients to identify their confidence levels in achieving specified goals.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>I identify personal barriers, strategies, problem-solving techniques and social/environmental support available for all patients.</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use Problem Solving Techniques</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I support and encourage my patients to develop skills needed to communicate effectively with physicians.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>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.</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>
MY ACTION PLAN

I _________________________________ and _________________________________
(name) (name of clinician)

have agreed that to improve my health I will:

<table>
<thead>
<tr>
<th>1. Choose one of the activities below:</th>
<th>2. Choose your confidence level: This is how sure I am that I will be able to do my action plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____Work on something that’s bothering me:</td>
<td>10 VERY SURE</td>
</tr>
<tr>
<td>____Stay more physically active!</td>
<td>5 SOMEWHAT SURE</td>
</tr>
<tr>
<td>____Take my medications.</td>
<td>0 NOT SURE AT ALL</td>
</tr>
<tr>
<td>____Improve my food choices.</td>
<td></td>
</tr>
<tr>
<td>____Reduce my stress.</td>
<td></td>
</tr>
<tr>
<td>____Cut down on smoking.</td>
<td></td>
</tr>
</tbody>
</table>

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 ____________ times this week before lunch and have a confidence level of 8 that I can do this." Thus, after two or three sessions, making an action plan should take less than a minute.

From the Chronic Disease Self-Management Program
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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.

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**Note** - The Planned Care: Patient Self-Management Support Staff Education Workbooks (referenced in the WebEx/podcast) are located on [www.homehealthquality.org](http://www.homehealthquality.org) under Associated Resources with the Patient Self-Management package.
Examples of Excellence

Reducing Acute Care Hospitalization: The Impact of Chronic Illness Assessment Staff Education

Aiming “LOW”
South Davis Home Health (SDHH) is a small, hospital-based agency in Bountiful, Utah. The staff is committed to reducing the number of patients who experience an avoidable acute care hospitalization and providing effective self-management support. As a voluntary participant in the national ReACH (Reducing Acute Care Hospitalizations) Collaborative, SDHH set its outcome goal at nine percent based upon OBQI data. As of the July 2007 OBQI data, the acute care hospitalization (ACH) rate for South Davis is 9.90 percent, which is 11 percent better than the Utah state average. “We aimed low, and have been amazed at our progress,” says Denise Cook, QI Director.

Methods
How are they doing it? Leadership has incorporated quality improvement into the agency’s organizational culture. They have created a blame-free learning environment that has promoted teamwork. “We value staff involvement and input,” says Ms. Cook. “We want our clinicians to be involved in developing processes that will improve our patients’ care and support patient self management.”

SDHH conducted strategic process investigations to determine how to decrease avoidable hospitalizations. The investigation findings revealed that OASIS assessments were not always capturing patient acute care hospitalization risk factors. Consequently, South Davis decided to focus staff education efforts on comprehensive chronic illness assessment, which is the first step to ensure that patients remain safe in their homes, improve their level of functioning and develop effective self management skills.

The ability to identify risk factors that are associated with chronic illnesses requires clinicians to look beyond immediate acute conditions. SDHH realized that this level of knowledge and assessment skill required chronic illness expertise, so they sought the help of external chronic illness experts. Staff education emphasized that accurate assessments translate into patient-centered care plans that guide appropriate treatment, including determining the self-management support patients will need to manage their chronic conditions. They learned the characteristics of a comprehensive chronic illness assessment, how to gather patient information effectively and efficiently and how to evaluate patients’ conditions based on these data. This comprehensive assessment and evaluation then serves as the basis for the development of a patient-centered self-management plan.
In order to strengthen patient assessments and determine a patient’s ability to self-manage, clinicians are now administering the CLOX test to patients upon admission, at resumption of care and anytime a patient seems to have a cognitive decline. They also test caregivers when appropriate. The CLOX test is a clock-drawing activity used to detect early signs of cognitive impairment. The tool helps clinicians assess the patients’ ability to initiate and sequence tasks or events. This information can lead to more effective care plans by helping clinicians determine what level of assistance each patient needs to safely self-manage his/her chronic conditions as independently as possible. This is important because even the most appropriate care plan will fail if clinicians and patients don’t execute it correctly.

After patients are assessed appropriately, clinicians use personalized emergency care plans, which list early warning signs and symptoms, and standardized teaching tools to educate patients and their caregivers on chronic disease management. The teaching tools have been organized in a file cabinet drawer for easy access for clinicians and can be taken to the home as a handout if appropriate. Clinicians also use the tools as a guide for documentation of teaching and evidence of the patient’s self-management skill development.

**Outcomes**

Following the chronic illness assessment training, agency clinicians reported a positive shift in the way they assess patients with chronic diseases. Many sources of information are considered, starting with the H & P. Clinicians are now using their observational skills, and they’re asking open-ended questions to gather objective and subjective evidence. They are looking at patient health status from physiological, functional, psychosocial and cognitive perspectives to create a whole picture. Their clinical skills have been enhanced and they are seeing the benefits in their patient care and their ability to provide individualized patient self-management support. Because fewer patients are requiring hospitalization, this means more are being cared for safely at home, while developing effective self-management skills. Data are collected regularly to determine if clinicians are performing these new best practices consistently and accurately. As noted, they are definitely seeing a reduction in the number of avoidable hospitalizations.

**Staff Engagement**

To promote staff involvement, the agency is ensuring the outcomes data is visible to everyone in very creative ways. A picture of a bed, representing hospitalization, is hanging on a wall in the agency office. If a patient experiences an acute care hospitalization, a cutout figure is added to the bed.

To learn more about what South Davis Home Health is doing to reduce avoidable hospitalizations, contact Denise Cook at denisecook@sdch.com or 801.299.4866.

*Denise Cook, RN, QI Coordinator, South Davis Home Health  
Cher Edmonds, MS, CHES, SSW, Project Coordinator, HealthInsight*
Situation
Rosa is a 68-year-old woman who has type 2 diabetes mellitus. Rosa was referred to home health care after she sustained a mild stroke. She had received inpatient rehabilitation and was discharged to her home with orders for nursing and physical therapy.

Assessment Findings – Objective:
During the initial assessment, Rosa demonstrated the following skills:
• Unassisted toilet transfer
• Unassisted shower transfer
Rosa was able to:
• Remove shoes, socks and sweater
• Check and record blood sugar using her own glucometer
• Be supervised while ambulating with walker, but had difficulty at doorways and on carpet
• Know the name of a new medication—a circulating anticoagulant—but was not sure why it was prescribed and seemed confused by an alternating dose schedule

Assessment Findings – Subjective:
Rosa reported that she was able to:
• Shower and dress using equipment by the time she left the rehabilitation unit
• Identify the names and doses of medications she had been taking prior to her stroke, and stated that she was used to taking these medications

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

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

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

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

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

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

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

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

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

*Content submitted by:*
Carol Siebert, MS, OTR/L, FAOTA, Representative, American Occupational Therapy Association
Karen Vance, OTR/L, Representative, American Occupational Therapy Association
All therapists, including OTAs and PTAs, can apply for a certificate of attendance to use towards continuing education for 1.75 continuing education hours by following the directions on page 86.

Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

1. Individuals must undertake tasks to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions. This is the definition for:
   A. Patient self-management
   B. Self-management support

2. Provision of education and supportive interventions systematically by health care staff increases patients’ skills and confidence in managing their health problems. This can include regular assessment of progress and problems, goal setting and problem-solving support. This is the definition for:
   A. Patient self-management
   B. Self-management support

3. All of the following activities are examples of self-management support except:
   A. Patient weighs self and takes medications independently
   B. Sharing information about the disease with patient
   C. Completing shared goal setting with the patient
   D. Developing an action plan with the patient

4. Developing an Action Plan with the patient can provide for all the following except:
   A. Initiating a conversation with patient to determine what the patient would like to accomplish
   B. Making a decision to accomplish the plan
   C. Determining how confident the patient is in reaching the goal
   D. Providing opportunities for clinicians to follow-up with patients and encourage them to continue their self-management efforts
   E. Ensuring action plan success

5. The clinician can determine what specific action plan the patient needs to develop and act upon it without patient involvement.
   A. True
   B. False

Answers to Post-test are located in the Leadership Section page 70.
Best Practice: Patient Self-Management

Medical Social Worker Track
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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the Medical Social Worker’s Guide to Patient Self-Management and Self-Management Support</td>
<td>Page 101</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Complete the Self-Management support: Social Worker Self Assessment</td>
<td>Page 102</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Review the My Action Plan tool and Action Plan Script</td>
<td>Page 103</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Listen to Strategies to Improve Patient Self-Care Management Skills podcast</td>
<td>Page 105</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Watch or listen to: Supporting Patient Self-Management through Planned Care: Evidence and Techniques WebEx or podcast</td>
<td>Page 105</td>
<td>45 minutes</td>
</tr>
<tr>
<td>Complete the social worker post-test</td>
<td>Page 106</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

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)
### 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

<table>
<thead>
<tr>
<th>Establish a Focus</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I actively listen to my patients as they tell their illness story.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I ask open-ended questions whenever possible to learn about patients’ perceptions and concerns.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My professional philosophy is patient-centered and acknowledges patients’ expertise in managing their own lives.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share Information</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I make community resource linkages that support my patients self-defined goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I provide community resource information for ongoing self-management beyond the home health episode of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Develop Shared Goals</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I collaboratively set goals with the patient/caregiver based on the patient’s interest and confidence in his or her ability to change behaviors.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Develop/Support an Action Plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I establish/reinforce a patient/caregiver driven action plan with my patients to support self-management goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I provide an opportunity for my patients to identify their confidence levels in achieving specified goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I identify personal barriers, strategies, problem-solving techniques and social/environmental support available for all patients.</td>
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</table>

<table>
<thead>
<tr>
<th>Use Problem Solving Techniques</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>I provide counseling as needed to overcome patient identified barriers to goal achievement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I establish an expectation that my patients will report on their progress toward their goals.</td>
<td></td>
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</table>
MY ACTION PLAN

I ________________________________ and ________________________________
(name)       (name of clinician)

have agreed that to improve my health I will:

<table>
<thead>
<tr>
<th>1. Choose one of the activities below:</th>
<th>2. Choose your confidence level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____Work on something that’s bothering me:</td>
<td>This is how sure I am that I will be able to do my action plan:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Stay more physically active!</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Take my medications.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Improve my food choices.</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Reduce my stress.</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Cut down on smoking.</td>
<td></td>
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</tbody>
</table>

2. Choose your confidence level:
This is how sure I am that I will be able to do my action plan:

<table>
<thead>
<tr>
<th>10 VERY SURE</th>
<th>5 SOMEWHAT SURE</th>
<th>0 NOT SURE AT ALL</th>
</tr>
</thead>
</table>

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.

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   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:
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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:
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   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.
Best Practice:
Patient Self-Management

Home Health Aide Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.608 App. 12/2007
Home Health Aide Track

This best practice intervention package track is designed to educate home health aides 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 Home Health Aide 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 home health aide actions that support patient self-management

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Review the My Action Plan tool</td>
<td>Page 110</td>
<td>5 minutes</td>
</tr>
<tr>
<td>☐ Listen to Self-Care Management for Home Health Aides podcast and use the discussion questions for group interaction</td>
<td>Page 111</td>
<td>35 minutes</td>
</tr>
<tr>
<td>☐ Complete the home health aide post test and give to your clinical manager</td>
<td>Page 112</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total Time</strong></td>
<td></td>
<td>60 minutes</td>
</tr>
</tbody>
</table>
**Home Health Aide Guide to Patient Self-Management and Self-Management Support**

**Definitions:**
- **Patient self-management** involves the tasks that individuals must undertake to live well with one or more chronic conditions.

  **Example:** Mrs. A has COPD, which makes her get short of breath with very little activity. She dislikes sponge baths. A goal for her is to be able to get in the shower.

- **Self-management support** involves providing education and interventions by health care staff to increase patients’ skills and confidence in managing their health problems (IOM, 2003).

  **Example:** You can help Mrs. A achieve her goal by gradually increasing her participation in her personal care with each of your visits. Offer encouragement and talk to the nurse or occupational therapist about possibly getting a tub chair.

**Consider your self-management support role as the home health aide:**

<table>
<thead>
<tr>
<th><strong>Self-Management Support</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I make sure my care plan includes the patient’s personal goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I talk to my patients about their personal goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I listen to my patients tell their illness story and how they feel about achieving their goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I ask to see my patient’s Action Plan (when applicable).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I talk with my patients about what they see as problems in achieving their goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I talk with the patient’s nurse and therapists when the patient is having problems achieving their goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I give my patients the extra time it may take during my visits to permit them to participate in their personal care if that supports their goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I offer encouragement toward achieving goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I offer praise when a patient goal is achieved.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I _________________________________ and _________________________________
(name)       (name of clinician)

have agreed that to improve my health I will:

<table>
<thead>
<tr>
<th>1. Choose one of the activities below:</th>
<th>2. Choose your confidence level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____Work on something that’s bothering me:</td>
<td>This is how sure I am that I will be able</td>
</tr>
<tr>
<td></td>
<td>to do my action plan:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Stay more physically active!</td>
<td>10  VERY SURE</td>
</tr>
<tr>
<td></td>
<td>5    SOMEWHAT SURE</td>
</tr>
<tr>
<td></td>
<td>0    NOT SURE AT ALL</td>
</tr>
<tr>
<td>____Take my medications.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Improve my food choices.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Reduce my stress.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>____Cut down on smoking.</td>
<td></td>
</tr>
</tbody>
</table>

3. Complete this box for the chosen activity:

What:____________________________________

How much:________________________________
When:____________________________________

How often:________________________________

(Signature)

(Signature of clinician)
Patient Self-Management Podcast Instructions:
Listen to the podcast to learn more about patient self-management and self-management support.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Care Management for Home Health Aides</td>
<td>A 15-minute podcast (audio recording) by Carol Siebert, OTR/L and Karen Vance, OTR/L</td>
<td>The podcast link is located at <a href="http://www.homehealthquality.org/hh/hha/interventionpackages/patient_sm.aspx">http://www.homehealthquality.org/hh/hha/interventionpackages/patient_sm.aspx</a></td>
</tr>
</tbody>
</table>

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.

Discussion Topics

- Why don’t patients always think of themselves as self-managers?
- What are some ways that home health aides can encourage patients to self-manage?
- How can home health aides work with the other clinicians to improve patient self-management?
- Name some specific examples of information you could share with the home health team on barriers to patient self-management.
- Discuss these points from the podcast Self-Care Management for Home Health Aides
  - You are an aide...not a maid
  - Use your brains...not your bodies
  - Talk to your team: Tell them what you know and ask them what you need to know
Home Health Aide Post-test
Patient Self-Management

Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

1. Tasks that individuals must undertake to live well with one or more chronic conditions is a definition for:
   A. Patient self-management
   B. Self-management support

2. Providing education and interventions by health care staff to increase patients’ skills and confidence in managing their health problems is a definition for:
   A. Patient self-management
   B. Self-management support

3. The patient’s goals are the center of setting up an action plan.
   A. True
   B. False

4. Home Health Aides can help with self-management support by:
   A. Talking with patients about their goals
   B. Talking with patients about what the patient/caregiver believes are problems in reaching their goal
   C. Offering encouragement towards goals
   D. Offering praise when goal is achieved
   E. All of the above

5. Health care staff should work together with the patient, family, caregivers, doctor and other disciplines to help the patient set up an action plan and work towards their goal.
   A. True
   B. False

Answers to Post-test are located in the Leadership Section page 70.