I have no financial interests to disclose.
“The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.”

– Tom Bodenheimer, MD
Two Views of SMS

- Portfolio of Tools and Techniques to help patients change behavior

- A fundamental transformation of the patient caregiver relationship into a **collaborative** partnership.
### Session Overview and Objectives

1) Brief overview of a framework for implementing SMS and creating collaborative care plans

2) Review of roles and tasks for team implementation of SMS

3) Skills and tools to improve collaboration
Effective SMS Interventions

- Setting goals and following up on achievement
- Involving people in decision making; proactive education
- Helping people manage the social, emotional and physical impacts of chronic conditions
Collaborative Care: Cycle of Self-Management Support

Before the Visit
- Gather Clinical Data
  - labs, screenings, specialist reports
- Gather Patient Experiences
  - symptom monitoring, medication taking, stressors

During the Visit
- CARE PLAN
- Front Office
  - build relationships, explore needs and preferences
- Provider Exam
  - set agenda, review clinical and patient experience information, collaborate to set SM goals in care plan
- Nurse/MA Coaching & Support
  - create action plan, assess barriers, support change, patient education & skill building

After the Visit
- Follow Up
  - revise action plan, problem solve
- Specialist Referrals
  - coordinate care referrals
- Community Linkages
  - patient education programs, fitness and nutrition, Web-based resources and social networking
- Peer Programs
  - voluntary health organizations, web-based chat rooms, lay-led groups

Improved Outcomes
- Increased Healthy Behaviors
- Improved Clinical Outcomes
- Increased Collaboration between Patient and Provider
- Improved Physician Satisfaction and Retention

“The purpose of self management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment” — Bodenheimer 2005
# Roles & Tasks

<table>
<thead>
<tr>
<th>Role</th>
<th>Provider</th>
<th>Nurse</th>
<th>Medical Assistant</th>
<th>Clinical Care Manager</th>
<th>Nutritionist, PT, OT</th>
<th>Lay Staff</th>
<th>Patient</th>
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</thead>
<tbody>
<tr>
<td>Introduce SMS and patient role</td>
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<td>Set visit agenda</td>
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<td>Collaboratively Set Goals</td>
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<td>Provide information and training to patients</td>
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<td>Create an Action Plan</td>
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<tr>
<td>Link patients with system and community resources</td>
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<td>Proactive follow up</td>
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</table>
Self-Management Support: An Ongoing Process

EXPLORE: Beliefs, Behavior & Knowledge

SHARE: Provide specific Information about health risks and benefits of change

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

BUILD SKILLS: Identify personal barriers, strategies, problem-solving techniques and social/environmental support

COLLABORATE: Collaboratively set goals based on patient’s interest and confidence in their ability to change the behavior

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

What is Self-Management Support

A process to help people to:
- Understand
- Decide among treatments & strategies
- Identify and set goals
- Adopt and change behaviors
- Cope and problem-solve to address barriers
- Learn skills
- Follow-through
Self-Management Support Core Tasks

- Relationship Building
- Assessing patients’ experience and needs, expectations and values
- Information Sharing
- Collaborative Goal Setting
- Action Planning
- Problem Solving
- Follow up
If you have DIABETES, here are some things you can talk about with your health care provider.

→ Add other concerns in the blank circles.

Blood glucose monitoring

Taking medications to help control blood sugar

Taking insulin

Physical Activity

Diet

Losing weight

Daily foot care

Smoking

Depression 😞
Assess: Agenda

- “What are you hoping to accomplish today?”
- “What aspect of your diabetes care is most important to address?”
- Which of these self-care behaviors would you like to work on?
Ask Permission
Ask Understanding
Tell (Personalize)
Ask Understanding
Assess Conviction

“How convinced are you that it is important to monitor your blood sugars?”

Not at all convinced 0 1 2 3 4 5 6 7 8 9 10 Totally convinced

“What makes you say 4?”

“What leads you to say 4 and not zero?”

“What would it take to move it to a 6?”

From Keller and White, 1997; Rollnick, Mason and Butler, 1999
Nearly half of all American adults—90 million people—have difficulty understanding and acting upon health information.

This affects ability to read and understand dosage instructions on medication bottles, poison warnings, appointment slips and consent forms.
Assist: When Conviction is Low
Explore Ambivalence

- “What are the good things about changing?”
- “What’s the down side of staying the same?”
- “What’s the down side of taking action?”
- “What are the good things about staying the same?”
- “What would you have to give up in order to make this a priority?”
Enhance Conviction: Respond to Ambivalence

- **Reflection**
  - simple reflection and summaries
  - double sided reflection: “So on the one hand……., while on the other hand……..”

- **Empathy**

- **Acknowledge and affirm any change talk**
Enhance Conviction: Rolling with Resistance

Use your OARS

• Open-ended Inquiry
• Affirmation
• Reflections
• Summaries
Agree: Collaboratively Set Goals

• Consider patient readiness, conviction and confidence
• Consider clinician priorities
• Offer options
• Support patient autonomy and choice
Assist: Action Plan

1. Goals: Something you WANT to do
2. Describe
   ✓ How
   ✓ What
   ✓ When
   ✓ Where
   ✓ Frequency
3. Barriers
4. Plans to overcome barriers
5. Confidence rating (1-10)
6. Follow-Up:
Assist: Enhance Confidence

“How confident are you that you can follow the dietary guidelines I outlined?”

Not at all confident 0 1 2 3 4 5 6 7 8 9 10 Totally confident

“What makes you say 6?”

“What might help you to get to a 7 or 8?”

“What could I do to help you to feel more confident?”

From Keller and White, 1997; Rollnick, Mason and Butler, 1999
Assist: Enhance Confidence

- Review past experience - especially successes
- Define small steps that are likely to lead to success
Assist: Enhance Confidence

- Provide tools, strategies, resources, skills
- Address barriers
- Attend to progress and to perceive slips as occasions for problem solving rather than as failure
Identify Barriers & Problem-Solve

- *What will get in the way?*
- *Anything else?*
- *What might help you to overcome that barrier?*
- *Anything help in the past?*
- *Here is what others have done...*
- *Ok, now what is your plan?*
The Patient

Leaves with scripts, referrals, and instructions

The Medical Assistant

The Provider

July 19, 2017
The Patient

The Medical Assistant

Other Activated Patients

Integrated plan Medical & SMG

The Provider
First Key Service: MA Planned Visits

Planning and preparation:

Assure all information is up to date in chart
- Do goal setting on patient determined goal
- Provide follow up after the visit
The Provider – Integrated Medical Plan and Self-Management Goals

BACKGROUND

BARRIERS

SUCCESSES

WILLINGNESS...

ACTION PLAN

REMEMBER

NON-DIRECTIVE COUNSELLING
Helping Patients Manage Their Chronic Conditions

June 2005

Patient Self-Management Tools: An Overview

June 2005
Thank You!

- Resources:
  - [www.improvingchroniccare.org](http://www.improvingchroniccare.org)
  - [www.chcf.org](http://www.chcf.org)
  - [http://www.orau.gov/ahrq/sms_how.html](http://www.orau.gov/ahrq/sms_how.html)