

IN-HOME QUALITY IMPROVEMENT

BEST PRACTICE: PATIENT SELF-MANAGEMENT

NURSE TRACK



Best Practice Intervention Packages were designed for use by any In-Home Provider Agency to support reducing avoidable hospitalizations and emergency room visits. Any In-Home care nurse/clinician can use these educational materials.

Best Practice Intervention Packages were designed to educate and create awareness of strategies and interventions to reduce avoidable hospitalizations and unnecessary emergency room visits.

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 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 optional activities:

- Read the Nurses Guide to Patient Self-Management and Self-Management Support.
- Read the Self-Management Support: The Nurse Connection.
- Complete the Self-Management Support Nurse Self Assessment.
- Review the Action Plan tool and Action Plan Script
- Complete the Nursing Post Test.

Disclaimer: Some of the information contained within this Best Practice Intervention Package may be more directed and intended for an acute care setting, or a higher level of care or skilled level of care setting such as those involved in Medicare. The practices, interventions and information contained are valuable resources to assist you in your knowledge and learning.

Disclaimer: All forms included are optional forms; each can be used as Tools, Templates or Guides for your agency and as you choose. Your individual agency can design or draft these forms to be specific to your own agency's needs and setting.



Nurse'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 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 Nurse Connection

Seven Nurse Tips for Self-Management Support

1. Understand the 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 see the relationship between behaviors and outcomes
5. Translate clinical measure 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

Self-Management Support: Nurse Self Assessment

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

<i>Establish a Focus</i>	Yes	No
At start of care and on an ongoing basis, I assess patient beliefs, behavior and knowledge with a standardized assessment.		
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.		
I actively listen to my patients as they tell their illness story.		
<i>Share Information</i>	Yes	No
I share information about the illness with the patient to help my patients make informed decisions on where to focus their efforts.		
I provide personalized feedback on lab values and functional status related to risks/benefits and ways behaviors can affect outcomes.		
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.		
<i>Develop Shared Goals</i>	Yes	No
I collaboratively develop a patient-centered emergency care plan that correlates with my patient's goals and is reinforced with each encounter.		
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.		
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.		
<i>Develop an Action Plan</i>	Yes	No
I establish a patient/caregiver driven action plan with my patients to support self-management goals.		
I provide an opportunity for my patients to identify their confidence levels in achieving specified goals.		
Identify personal barriers, strategies, problem-solving techniques and social/environmental support available for all patients.		
<i>Use Problem Solving Techniques</i>	Yes	No
I offer tools and coaching to ensure medication simplification and reconciliation occurs effectively according to patient's ability.		
I support and encourage my patients to develop skills needed to communicate effectively with physicians.		
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.		

MY ACTION PLAN

I _____ and _____
(name) (name of nurse)

have agreed that to improve my health I will:

1. Choose one of the activities below:



_____ Work on something that is bothering me: _____



_____ Stay more physically active!



_____ Take my medications.



_____ Improve my food choices.



_____ Reduce my stress.

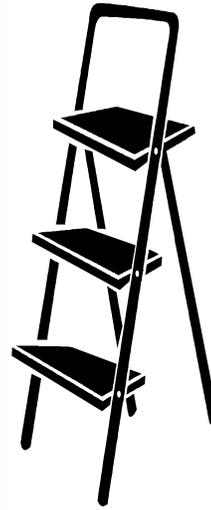


_____ Cut down on smoking.

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 Nurse)

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 a 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 make 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 patient 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

Nurse Name: _____

Date: _____

NURSING POST TEST

Patient Self-Management

Directions: Choose the ONE BEST response to the following questions. Circle the 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 share 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 nurse can determine what specific action plan the patient needs to develop and act upon it without patient involvement.
 - A. True
 - B. False