Integrating SMS into the clinical setting

Practical Tips

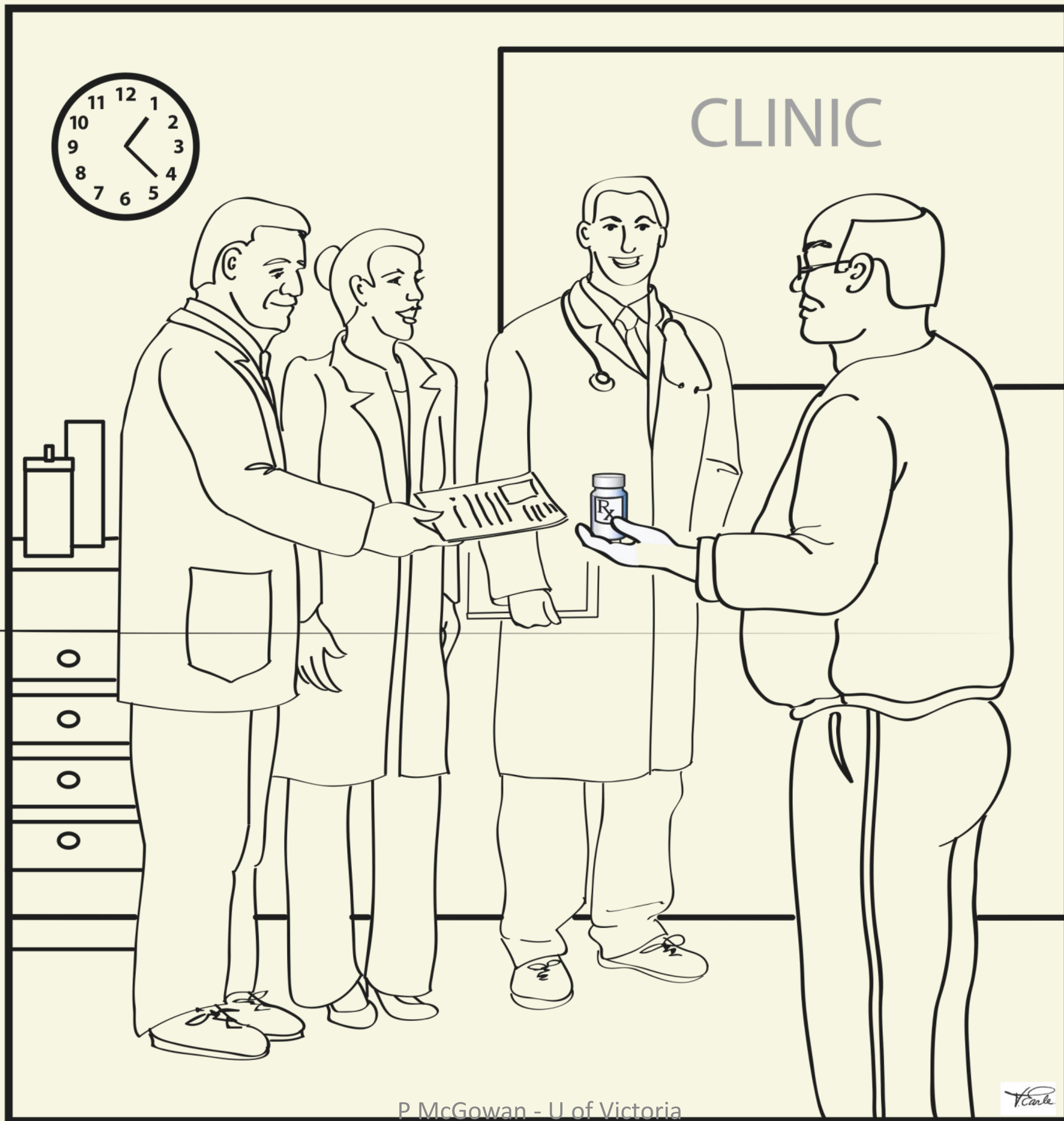
MEDICATION EFFECTS
No noticeable effect
-Medication is working but the symptoms don't change
- Medication is working but you feel the same
- Medication hasn't started to work yet
- Medication just isn't
Negative effects
-Allergy: dangerous and need
reporting
Side effects: annoying and unwanted but often not dangerous
21
Sleep
Physical Limitations
Pain
Stress/ Anxiety
PROBLEM

HEALTHY EATING MEANS...
·Eating a variety of foods
·Eating our meals and snacks regularly
·Watching portion size
·Eating breakfast
16
SELF MANAGEMENT TOOL BOX
Physical activity
Problem solving
Using your mind
Sleep
Communication
Healthy eating
Emotions
Poor Sleep
Fatigue
Physical Limitations
Shortness of Breath
Depression
PROBLEM-
STEPS
Identify the
List ideas
Marcia
Frank

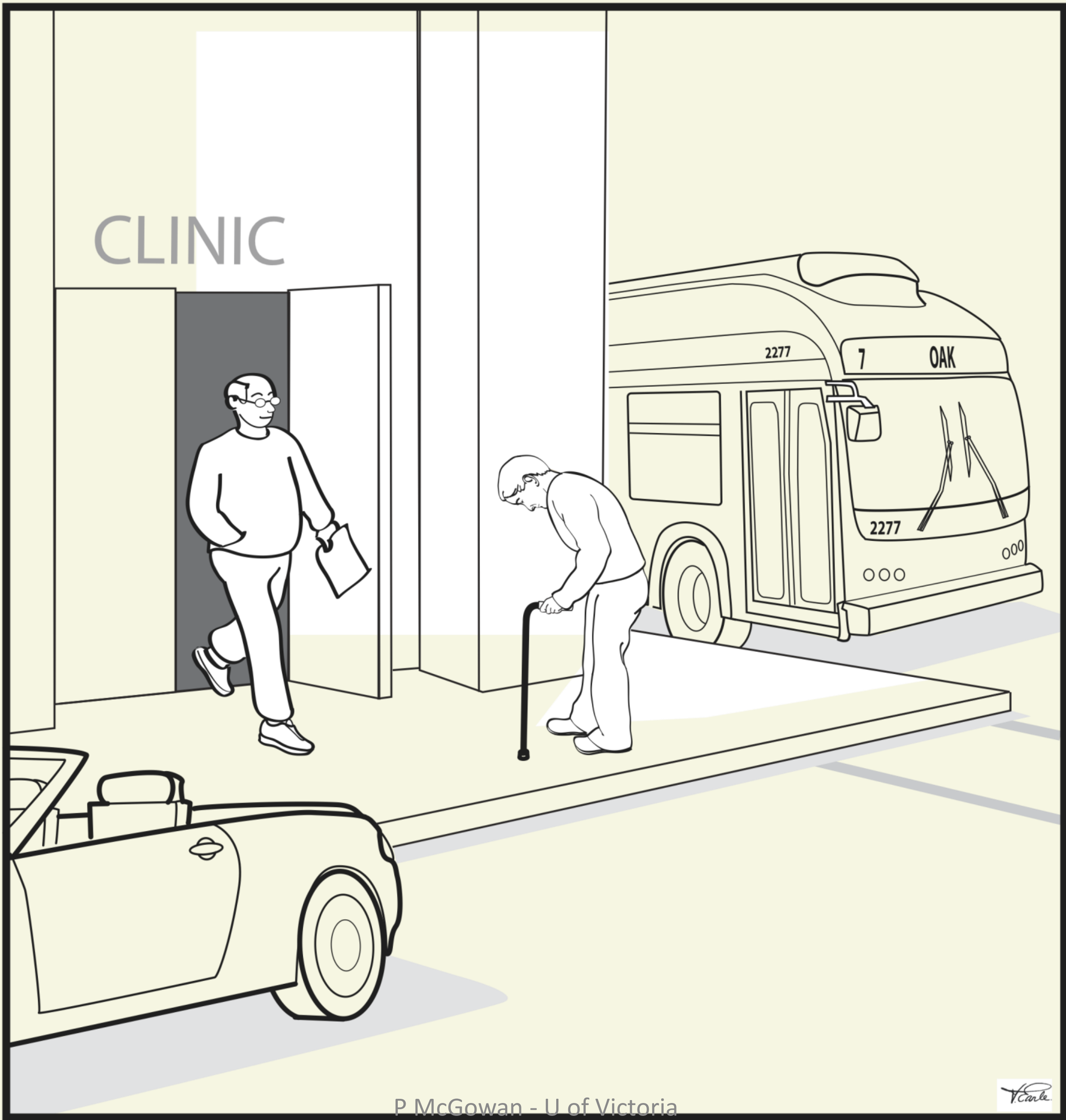
Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management.

Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

Adams, K., Greiner, A.C., & Corrigan, J.M. (Eds). (2004). *Report of a summit. The 1st annual crossing the quality chasm summit-A focus on communities.* Washington, DC: National Academies Press. Alderson, M., Starr, L., Gow, S., & Moreland, J. (1999)


CLINIC

1.	**Assess**	**Establish rapport** **Establish visit agenda** **Assess client readiness** **Health risk appraisals**
2.	**Advise**	**Ask-tell-ask** **Closing the loop**
3.	**Agree**	**Action plans and follow-up**
4.	**Assist**	**Teach problem solving** **Awareness of community resources**
5.	**Arrange**	**Follow-up**


CLINIC
2277
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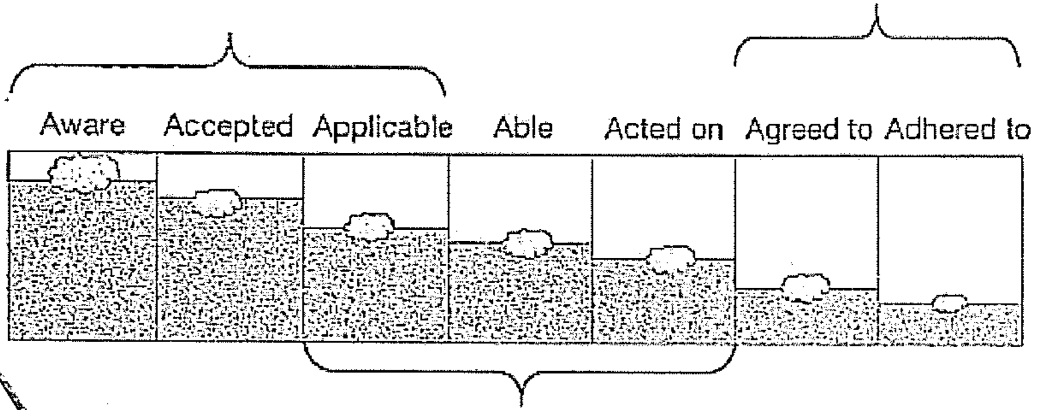
Myth, opinion,
poor research

4. Decision aids, patient
education, compliance aids

2. Bedside EBM



3. Clinical quality improvement

Systems

Synopses

Systematic Reviews

Studies

1. Research synthesis,
guidelines, evidence
from journals, ...

Barriers to embedding self-management support

Health care professional characteristics

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

Challenges

- Senior level support and ongoing commitment

- Core team to drive change

- Alignment with wider priorities and agendas

- IT systems and system capacity

- Supportive commissioning and payment systems

Aware

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

Objectives - At the end of the period:

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

Our Arthritis Education Center

Our Vision

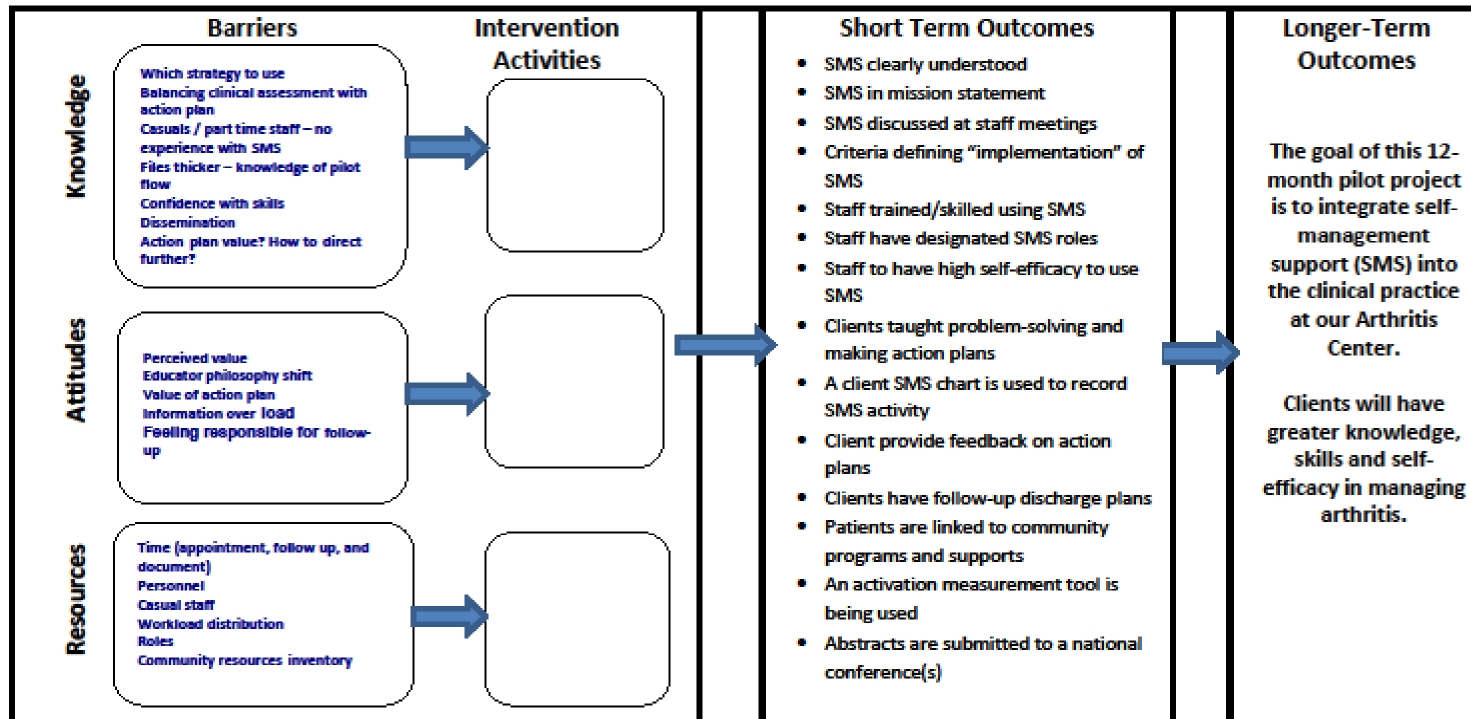
Our Vision is to provide best practice and holistic client-centered care, integrating arthritis education with self-management support.

Our Purpose

Our Values

Our Commitment

Accepted



Arthritis Health Care Professionals

Barriers: Barriers to producing outcomes.
Intervention Activities: Activities that make up the intervention.
Short-Term Outcomes: Changes in knowledge, skills, attitudes and behaviours you expect to be able to see immediately

Longer-term Outcomes: Changes in knowledge, skills, attitudes and behaviours you expect to achieve as a result of the intervention, but that will not be seen until later.
Participants: This is the group of people receiving the intervention.

Self-Management Support Group Training & PDSA Cycles

Agreed to

SELF-MANAGEMENT SUPPORT PILOT

CLIENT SMS ACTIVITY RECORD

Client Name ______________________________PHN______________________________

VISIT 1	VISIT 2	VISIT 3
Date:	Date:	Date:
SMS Strategies Used	SMS Strategies Used	SMS Strategies Used
☐ Establish rapport ☐ Set the agenda ☐ Health Risk Appraisal ☐ Readiness for change ☐ Ask-tell-ask ☐ Closing the loop ☐ **Action plan** ☐ Established feedback method for action plan ☐ **Problem solving** ☐ Made a follow-up plan __Phone __Email __Visit ☐ PAM completed ☐ Community resources used:	☐ Establish rapport ☐ Set the agenda ☐ Health Risk Appraisal ☐ Readiness for change ☐ Ask-tell-ask ☐ Closing the loop ☐ **Action plan** ☐ **Feedback on action plan** ☐ **Problem solving** ☐ Made a follow-up plan __Phone __Email __Visit ☐ Community resources used:	☐ Establish rapport ☐ Setting the agenda ☐ Health Risk Appraisal ☐ Readiness for change ☐ Ask-tell-ask ☐ Closing the loop ☐ **Action plan** ☐ **Feedback on action plan** ☐ **Problem solving** ☐ Made a follow-up plan __Phone __Email __Visit ☐ Community resources used:
Educator Narrative	Educator Narrative	Educator Narrative
Educator	Educator	Educator

Include SMS activity in the patient's clinical record

IT Fields

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

Problem Solving Steps

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

Self-Management British Columbia

fraserhealth
Better health. Best in health care.

SELF-MANAGEMENT SUPPORT

Self-Management British Columbia

ASSESS

Establish Rapport

Open ended questions…

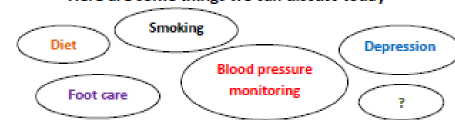
- What are the biggest problems you're having?
- Tell me about a typical day.
- What else is happening?

Setting the Visit Agenda (example)

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

Setting the Visit Agenda (example)

Here are some things we can discuss today



Readiness to Change

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

Readiness for Change

CONFIDENCE →
IMPORTANCE ↑

small action plans	affirm progress and plan for relapse
provide information	explore pros and cons of change

Pros & Cons

Example
"Not exercising"

"Good" Aspects of Current Situation

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

"Not so Good" Aspects of Current Situation

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

ADVISE

"Ask-Tell-Ask"

Problems:

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

Closing the Loop

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

AGREE

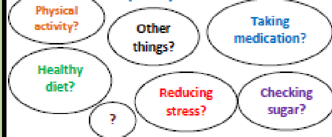
Action Plan (example)

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

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

Action Plan (example)

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



Action Plan

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

Parts of an Action Plan

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

Follow-up on the Action Plan

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

ASSIST

Problem Solving Steps

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ARRANGE

Follow-Up

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

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

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

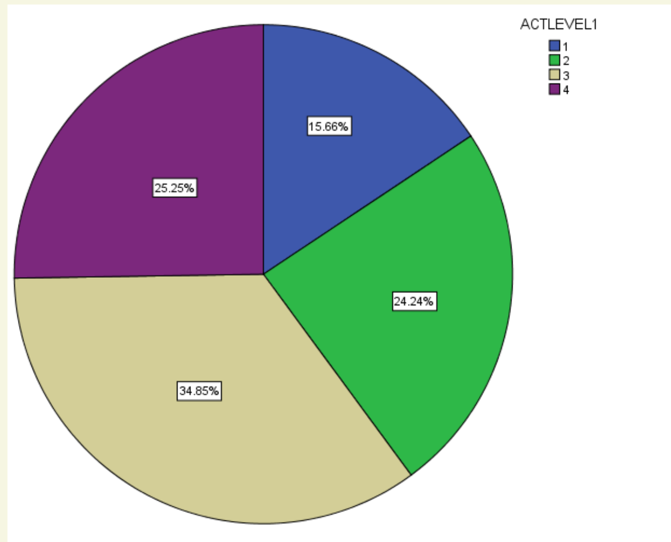
- the relationship between patient activation and health outcomes has been demonstrated across a range of different populations and health conditions;

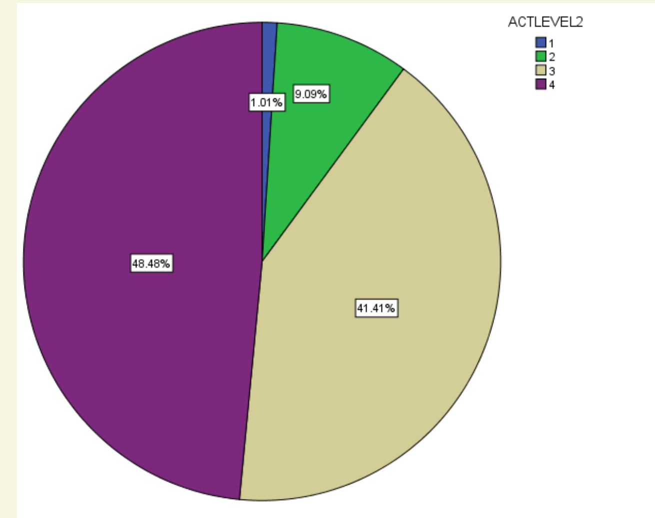
- PAM scores are closely linked to clinical outcomes, the costs of health care and patients’ ratings of their experience and to report higher levels of satisfaction with services; and

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

www.insignia.com

Activation levels pre and six-month post





At six months the proportion of clients:

- who were in level 1 at baseline had decreased 15%
- who were In level 2 at baseline had decreased 14%
- who were In level 3 at baseline had increased 7%
- who were In level 4 at baseline had increased by 23%.

This analysis illustrates that participants moved to higher activation levels and this is associated with positive outcomes.

gill+willcox

Self Management Assessment Tool

for Community Health Organisations

Developed by Marie Gill for:

TO REFLECT ON THE COLLECTIVE PRACTICE AND SERVICES OF THE AGENCY – TO REVIEW CAPACITY TO EFFECTIVELY PROMOTE SELF-MANAGEMENT

Agency support
Staff skills
Initial contact/Initial needs identification
Assessment
Care planning
Group programs / health promotion
Information resources
Consumer/peer involvement

Integrating SMS into Arthritis Care

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

Working context
Clinician expertise
Best practice evidence
Patient values and circumstances