

# SELF-MANAGEMENT

Ginny Hosbach RN, MSN  
Director of Training and Education



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# OBJECTIVES

- ▶ Define Self-Management
- ▶ Identify the skills that patients need to master, in order to manage their chronic conditions
- ▶ Identify the four basic strategies to self-management
- ▶ Define Self-Management Support (SMS)
- ▶ Introduce the topic of mutual expectations

# SELF-MANAGEMENT

- ▶ Means the interventions, training and skills by which patients with a chronic condition, disability, or disease can effectively take care of themselves and learn how to do so.

*Wikipedia*

# IN ORDER TO MANAGE THEIR CONDITIONS, PATIENTS NEED TO MASTER MANY SKILLS:

- ▶ Monitor their condition
- ▶ Communicate with family, friends and health care providers
- ▶ Make adjustments in physical activity and diet
- ▶ Manage the impact of the condition on their emotional, physical and social life
- ▶ Manage their medications
- ▶ Make informed decisions

# STRATEGIES TO SELF-MANAGEMENT

- ▶ Goal Setting
- ▶ Action Planning
- ▶ Tracking Changes
- ▶ Problem Solving

# SELF-MANAGEMENT SUPPORT (SMS)

The care and encouragement provided to people with chronic conditions to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviors

# SMS IS ACCOMPLISHED BY SYSTEMATICALLY:

- ▶ Using education and supportive interventions to increase patient's skills and confidence in managing their health problems.

# KEY ELEMENTS OF SMS INTERVENTION

- ▶ Patient-centered approaches that build trust, shared understanding and strong provider-patient relationships
- ▶ Individualized assessment of patient needs, values and preferences
- ▶ Collaborative goal setting and action planning
- ▶ Skill building and problem-solving
- ▶ Linkage to community resources and programs
- ▶ Repeated follow-up contacts

# BENEFITS OF SMS

- ▶ Reduced hospitalizations
- ▶ Reduced service demand
- ▶ Improved patient and clinician satisfaction
- ▶ Improved health outcomes and quality of life
- ▶ Improved medication adherence and reduced drug expenditure
- ▶ Cost-effectiveness

# Mutual Expectations

## Patient Roles

<b>Old</b>	<b>New</b>
<b>Defer to provider's authority</b>	<b>Share responsibility for own health</b>
<b>Be passive</b>	<b>Be active (Provider supplies tools)</b>
<b>Share history when asked</b>	<b>Share goals, history, beliefs and preferences. Be assertive.</b>
<b>Follow providers orders</b>	<b>Decide what to do with support from provider</b>

# MUTUAL EXPECTATIONS (*CONTINUED*)

## Patient Roles

<b>Old</b>	<b>New</b>
<b>Rely on provider to solve problems</b>	<b>Seek provider support for solving problems</b>
<b>Learn about condition from provider</b>	<b>Learn from provider; inform self</b>
<b>Respond to provider questions about progress during encounter visits</b>	<b>Keep track of own progress between visits</b>
<b>Don't worry about medications</b>	<b>Share responsibility for keeping medication list up to date</b>

# Teamlet Model of Primary Care

Bodenheimer and Laing

- ▶ The 15-minute visit does not allow the physician sufficient time to provide the variety of services expected of primary care.
- ▶ A *teamlet* (little team) model of care is proposed to extend the 15-minute physician visit.
- ▶ The teamlet consists of 1 clinician and 2 health coaches.

- ▶ A clinical encounter includes 4 parts:
  - a previsit by the coach
  - a visit by the clinician together with the coach
  - a postvisit by the coach
  - and between-visit care by the coach.
- ▶ Medical assistants or other practice personnel would require retraining to assume the health coach role.
- ▶ Some organizations have instituted aspects of the teamlet model.
  - Primary care practices interested in trying out the teamlet concept need to train 2 health coaches for each full-time equivalent clinician to ensure smooth patient flow.

- ▶ The teamlet model proposes a transformation of the universal dyad of physician and MA.
- ▶ This transformed dyad is called the teamlet because it is only a small part of the primary care team.
- ▶ In this model, medical assistants or other appropriate personnel are retrained in such skills as chronic disease self-management support to assume the role of a health coach.
- ▶ Each patient cared for by the teamlet would participate in an expanded visit with both a clinician and a health coach.

# The goals of the teamlet model are fivefold:

- ▶ (1) to improve the patient experience and enhance patients' self-management skills by expanding the encounter to include one-on-one time with a trained health coach
- ▶ (2) to improve process and outcome measures for preventive and chronic care by delegating routine processes (eg, ordering periodic cholesterol measurements or mammograms based on standing orders) to health coaches and by working more intensively with patients on their chronic disease self-management skills

- ▶ (3) to enhance the work life of primary care clinicians by offloading tasks that can be completed by nonclinician staff
- ▶ (4) to ensure that all practice personnel are working to their fullest potential by providing additional training, cross-training, and mentoring so that they are able to function as health coaches
- ▶ (5) to cut health care costs by reducing unnecessary hospitalization and emergency department visits through intensive management of high-risk and high-utilizing patients by using health coaches to provide frequent personal contact with these patients.

# **The Teamlet Model of Primary Care by Thomas Bodenheimer, MD and Brian Yoshio Laing, BS**

2007 Annals of Family Medicine, Inc.

<http://www.annfammed.org/cgi/content/full/5/5/457>

Additional details on the components of the teamlet encounter function can be found in this article.

# CONCLUSION

- ▶ In self-management the patient and their health care provider are partners.
- ▶ The health care provider can provide valuable advice and information, but it will not do any good unless the patient follows the treatment plans.
- ▶ Only the patient can change their behavior.

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Self-Management Support: A win win solution for the 21<sup>st</sup> century  
Janine j Bycroft MBChB Dip.Obs Dip.PaedS FRNZCGP MPH (Hons and Jocelyn Tracey  
MBChB FRNZCGP PhD

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