

Primary Care Practice Facilitation Curriculum

Module 32: Improving Self-Management Support
and Engaging Patients in Care and
Practice Improvement Topics



Agency for Healthcare Research and Quality

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Primary Care Practice Facilitation Curriculum

Module 32. Improving Self-Management Support and Engaging Patients in Care and Practice Improvement Topics

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Module 32. Improving Self-Management Support and Engaging Patients in Care and Practice Improvement Topics

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of primary care environments
- Professionalism in patient culture

Time

- Pre-session preparation for learners: 110 minutes
- Session: 90 minutes

Objectives

After completing this module, learners will be able to:

1. Explain why self-management support is important to improving patient care outcomes and discuss how it fits in the Care Model and the patient-centered medical home.
2. List the actions facilitators can take to assist practices to improve self-management support for their patients.
3. Identify online resources that facilitators can use to increase practice member knowledge of self-management support.

Exercises and Activities To Complete Before and After the Session

Pre-session preparation. Ask the learners to review items 1-4 and explore item 5. (105 minutes)

1. The content of this module.
2. What, why, and how of self-management support videos. Available at http://www.ora.gov/ahrq/sms_what.html; http://www.ora.gov/ahrq/sms_why.html; http://www.ora.gov/ahrq/sms_how.html.
3. Helping patients help themselves: how to implement self-management support. California HealthCare Foundation; 2010. Available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPtsHelpThemselvesImplementSelfMgtSupport.pdf>.
4. Helping patients manage their chronic conditions. California HealthCare Foundation; 2005. Available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPatientsManageTheirChronicConditions.pdf>.
5. Partnering in Self-Management Support: A Toolkit for Clinicians. Institute for Healthcare Improvement. Available at <http://www.ih.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx>.
6. AHRQ self-management support site. Available at http://www.ora.gov/ahrq/sms_home.html

During the session. Presentation (30 minutes)

1. Present key concepts from this module.
2. Transforming Practices into Medical Homes slide show by Safety Net Medical Home Initiative. PCI Pt. 2: Self-Management Support in the PCMH, showing capture of self- management goals in an electronic health record and case examples of health coach implementation. Available at <http://www.safetynetmedicalhome.org/sites/default/files/Webinar-Patient-Centered-Interactions-2.pdf>.

Activity for learners (30 minutes)

1. Have learners divide into pairs or small groups. Assign roles: practice facilitator and participant(s).
2. Review the Self-Management Support section in the Assessment of Chronic Illness Care (ACIC) tool. Complete the section on PracticeOnlyOneforMiles or practice with whatever tool the learner is already using. Have practice facilitator “facilitate.”
3. Use Self-Management Support Roles and Assignments to model an enhanced self-management support program for the practice.

Discussion. Ask questions and explore answers with learners. (30 minutes)

1. What role can a facilitator play in assisting practices to improve self-management support and why does this matter?
2. What were some lessons learned from the Bodenheimer article on implementing self-management support?
3. What role does it play in the Care Model and the patient centered medical home?
4. What were the results of your ACIC assessment? What did you learn from using the tool?

Module 32.

An individual with chronic disease is in the medical office an average of 6 hours a year. The patient spends the remaining 8,754 hours a year outside the medical office. Self-management support is about helping patients improve or maintain their health during those 8,754 hours.

An increasing number of people have at least one chronic illness that requires day to day management. Outcomes for these patients with chronic needs can be improved by helping them become more active in self care.

—Agency for Healthcare Research and Quality

Self-management consists of all the activities and tasks that patients engage in to live with chronic illness including managing symptoms, treatment, emotional impact, physical and social consequences, and lifestyle changes. It includes patients' beliefs in their ability to manage their conditions, their ability to navigate and interact effectively with clinicians and the health care system to ensure they receive needed care, and the behaviors they engage in to manage their conditions and their care. Activities required for self-management can be divided into three categories: 1) actions needed to deal with physical aspects of the illness, 2) actions needed to manage the emotional aspects of the illness, and 3) actions needed to deal with the social impact of the illness (Strauss & Corbin, 1988).

Impact of Social Determinants and Poverty on Self-Management

A significant percentage of individuals who receive care through the safety net have chronic conditions. These individuals face special challenges to self-management. Low levels of health literacy can make it difficult for patients to understand instructions provided by clinicians about caring for their conditions. The perceived power differential between clinicians and patients can make it difficult for patients to ask questions or effectively advocate for their care. Norms of different cultural groups that view questions or engagement of clinicians as disrespectful also can inhibit effective communication.

Poverty and lack of insurance reduce access to needed specialty care services and medications. Patients' adherence to treatment recommendations can be affected by inaccurate information and myths in the patient community about treatments such as insulin, which sometimes results in amputations and death. Similarly, patients' views of illness in general and their ability to influence its course can be shaped by cultural norms that suggest an inevitability of outcome, inhibiting the patients' willingness to engage in what may be perceived as futile attempts at self-care.

Behaviors essential to healthy living may also be affected by cultural traditions, as well as the overabundance of fast foods and limited access to healthy low-cost foods and safe spaces for exercise in low-income neighborhoods. Social cohesion and support, vital to effective management of chronic conditions, may be compromised by fear. High crime rates and immigration enforcement actions can wreak havoc on social networks and support available to individuals living with chronic illness and their families.

How Can Practices Provide Self-Management Support?

In 2003, the Institute of Medicine defined self-management support 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.” Although in the early days self-management support primarily consisted of providing information, research has demonstrated that these educational interventions affected patients’ knowledge but not their self-care behavior (Pearson, et al., 2007).

Coaching is needed by professionals who, in addition to teaching skills, have the psychosocial skills to facilitate a patient’s change in behavior. Evidence is emerging that self-management support programs, which now often include an interactive, empowerment approach, improve a variety of outcomes for different chronic conditions (Pearson, et al., 2007).

Practices provide self-management support to patients in a variety of ways. According to the Agency for Healthcare Research and Quality (AHRQ), these include:

- providing empathic, patient-centered care
- involving the whole care team in planning, carrying out, and following up on a patient visit
- planning patient visits that focus on prevention and care management, rather than on acute care
- involving the patient in goal setting
- providing tailored education and skills training using materials appropriate for different cultures and health literacy levels
- making referrals to community-based resources, such as programs that help patients quit smoking or follow an exercise plan
- regularly following up with patients via email, phone, text messages, and mailings to support their efforts to maintain healthy behaviors. (Available from http://www.ora.gov/ahrq/sms_what.html)

Self-management support is a core feature of the Care Model and fundamental to the provision of patient-centered care. Effective self-management support, however, can be time intensive. Fortunately, self-management support programs are often offered in the community and can be used to augment practice staff activities.

Practices usually combine some in-house self-management support activities with referrals to community-based resources. Practices using this approach will need to identify and vet these community-based programs. A self-management program should be evidence-based, linguistically competent (meaning it is delivered in the preferred language of the patient), appropriate to the health literacy level of the patient, and culturally sensitive and appropriate.

How Can Facilitators Help?

As a facilitator, you can help practices with a variety of self-management support tasks, such as:

- assessing existing self-management support services
- mapping current roles and workflows related to self-management and helping the practice redesign them
- setting goals to improve these services
- using the Model for Improvement to design and test improvements to services (see [Module 8](#), Approaches to Quality Improvement)
- identifying appropriate patient self-management support materials
- identifying self-management support training and resources for clinicians and other staff (e.g., AHRQ's Self-Management Support Resource Library)
- introducing and training staff on evidence-based and exemplar self-management support programs
- conducting an inventory of community-based programs
- developing referral relationships and protocols with community-based programs (DeWalt, et al., 2010, Health Literacy Universal Precautions Toolkit, Tool 20, Use Health and Literacy Resources in the Community <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/>)
- establishing followup routines to check in with patients between visits.
- setting up performance reporting for monitoring the delivery and impact of these services

Self-management support involves the entire care team. As shown in [Module 29](#), you can help your practice think through the various tasks involved in self-management support (SMS) and which staff members could perform those tasks. Case studies of care teams that incorporate self-management support in the work that they do day-to-day are available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareCaseStudies.pdf>. Table 32.1, adapted from the Institute for Healthcare Improvement, provides a template. You and your practices will need to customize the list of tasks and staff.

Table 32.1. Self-management support tasks and assignments

Task	Primary Care Clinician	Nurse/ Pharmacist	Medical Assistant	Clinical Care Manager	Nutritionist, PT, OT	Health Educator/ Dietitian	Clerical Staff & Other
Call patient in for visit							
Plan patient visit							
Introduce SMS and patient role							
Develop action plan with patient							
Educate and train patient							
Confirm patient understanding							
Refer patient to community resources							
Schedule followup visits							
Conduct followup with patient between visits							
Establish referral and information sharing protocols with community SMS programs							
Maintain inventory of patient education materials							
Maintain inventory of community resources							
Identify SMS-related training opportunities for staff							
Collect and report on SMS performance measures							

Adapted from Institute for Healthcare Improvement.

Note: this module is based on Module 21 of the Practice Facilitation Handbook. Available at <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/>

References

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Agency for Healthcare Research and Quality. Self Management Support. Available at http://www.ora.gov/ahrq/sms_home.html. Accessed October 7, 2014.

Corbin JM, Strauss A. Unending work and care: Managing chronic illness at home. Jossey-Bass; San Francisco, CA: 1988.

DeWalt DA, Callahan LF, Victoria H. Hawk, et al. Health literacy universal precautions toolkit. Rockville, MD: Agency for Healthcare Research and Quality; 2010. AHRQ Publication No 10-0046-EF. Available at <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html>. Accessed October 7, 2014.

Pearson ML, Mattke S, Shaw R, et al. Patient self-management support programs: an evaluation. Final Contract Report (Prepared by RAND Health under Contract No. 282-00-0005). Rockville, MD: Agency for Healthcare Research and Quality; November 2007. AHRQ Publication No. 08-0011.

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Appendix 32. Self-Management Support Tasks and Assignments: Role Visualization Exercise for Self-Management Support

Complete the chart by describing what each team member will do for each of the listed tasks for self-management support. Not all team members will be involved in each activity, nor is the list of tasks exhaustive.

Role	PCP	Nurse	MA	Clinical Care Manager	Dietitian/PT/OT	Administrative Staff/Patient Navigator	Other
Introduce SMS, describe roles.							
Set visit agenda.							
Collaborate on patient goal setting.							
Provide information and skills training to patients.							
Create an action plan.							
Connect patients with resources in community and elsewhere in health system.							
Oversee disease registry/proactive followup.							
Conduct previsit chart reviews.							

Adapted with permission from Institute for Healthcare Improvement, Cambridge, MA.

Module 23: Documenting Your Work With Practices

Appendix 23. Sample Practice Record

Encounter Notes

Clinic ALLOVERTHEPLACE			
Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:
PF Standing Visit (day/time):	Mondays 1-4		
Practice status	Active		
Nominate as Exemplar on:			
Pneumococcal Vaccine delivery	80% of indicated vs. 20% in similar practices in area		
Improvement & Study Projects participating in:			
Start date	End date	Description	
1) Chronic Kidney Disease guideline implementation	9/1/12	10/2/13	Improve quality and outcomes for patients with CKD
2) Implement Care Teams	11/21/12	11/21/12	Implement care teams to support transformation to patient-centered medical home and to improve access and quality
Encounter Notes - Overview (date)			
	Practice Status	Notes	
	0=no progress, 1=some progress, 2=solid progress		
9/1/12	2	CKD: Met with CKD champion for practice and his team; held project kick-off meeting; academic detailing on CKD guidelines and their use in primary care	
9/8/12	1	CKD: Met with registry manager at request of Dr. Like Data. There are problems pulling eGFR data into the registry. Also, clinicians are coding CKD as	
10/12/12	0	CKD: Dr. CKD not able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to	
10/22/12	0	CKD: No progress with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with	
11/8/12	2	CKD: Met with Dr. CKD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date	
11/18/12	2	CKD: Provided 15 minute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.	
PRACTICE PROGRESS DASHBOARD PROJECT			
Overall Assessment Scales:		0 = No activity; 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete	
A. Create Quality Improvement team/cmt and performance monitoring system			
OVERALL SCORE:	CKD	4	NOTES/COMMENTS
A1. Designate Project team leader		6	Dr. CKD is the champion.
A2. Identify performance metrics		6	
A3. Develop performance report generator using EHR and registry data		3	
A4. Map workflow for performance reporting & use		3	
A5. Train Project team on Model for Improvement and PDSA cycles		6	
A6. Review performance report monthly and carry-out PDSAs		0	
B. Use registry to manage target population			
OVERALL SCORE:	CKD	3	NOTES/COMMENTS
B1. Create registry		3	Underway, waiting for registry manager to return from vacation
B2. Populate registry			
B3. Assess & leverage existing population management resources			
B4. Train staff in population management			
B5. Map workflow for population management			
B6. Create reports/templates/alerts to allow population management & planned care			
B7. Monitor use of registry to manage patient care and support population management			
C. Use templates			
OVERALL SCORE:	CKD	1	NOTES/COMMENTS
C1. Select template tool from registry/EHR (or create)		1	Dr. CKD plans to meet with EHR manager to create template.
C2. Map workflows to use template			
C3. Use template at every patient visit			
C4. Ensure registry/EHR updated after every patient visit			
C5. Monitor use of templates			
D. Standardize care			
OVERALL SCORE:	CKD	3	NOTES/COMMENTS
D1. Select protocol/guideline for clinical care issue		3	Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of the labs are expensive and hard to obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr. CKD and his team to discuss this issue with him.
D2. Modify for use in safety net environment			
D3. Map workflow to implement/use protocol			
D4. Use protocol at every patient visit			
D5. Monitor use of protocol			
E. Self Management support			
OVERALL SCORE:	CKD		NOTES/COMMENTS
E1. Assess existing SMS resources at practice			

Baseline Performance Data

Baseline		
N for performance data abstraction	30	CKD pts seen at least 2x from 8-30-10 to 9-1-11 collected 10/24/11
%	#	
Demographics		
Male	26.67%	8
Female	73.33%	22
Average age	61.07	
Age range	36-75	-
Latino	76.67%	23
African American	10.00%	3
White (Hispanic & non-Hispanic)	0.00%	0
Not Stated/Other	13.33%	4
Insurance status		
None	3.33%	1
Medicare	20.00%	6
Medicaid	0.00%	0
Other gov't (H/WLA, etc.)	76.67%	23
Private	0.00%	0
CKD patients comorbidities/risk indicators		
DM Dx	3.33%	1
HTN Dx	13.33%	4
DM & HTN	80.00%	24
BP>130/80	53.33%	16
LDL<100		10
Calcium >8.5**		15
PO4 <4.6**		3
Smoker	3.33%	1
Smoking status missing	6.67%	2
CKD on problem list?		
Yes	93.33%	28
No	6.67%	2
Medication		
Aspirin/blood thinner (yes)	80.00%	24
ACE/ARB (yes)	60.00%	18
Vit D 3 (yes)	20.00%	6
NSAIDS (yes)	83.33%	25
Metformin (yes)	30.00%	9
Labs		
45< eGFR <60	43.33%	13
30< eGFR <45	33.33%	10
eGFR <30	20.00%	6
eGFR missing	0.00%	0
In the past 12 months:		
eGFR	96.67%	29
Referral if eGFR<30	33.33%	2
HbA1c	53.33%	16
Lipid panel	60.00%	18
Serum Ca++	86.67%	26
HGB	50.00%	15
25 hydroxy Vit D	50.00%	7
PTH	23.33%	7
Serum phosphate	20.00%	6
M/C	43.33%	13
Preventive care		
Flu vaccine last 12 months	40.00%	12
Pneumococcal		

Race/Ethnicity

Race/Ethnicity	%
Latino	76.67%
African American	10.00%
White (Hispanic & non-Hispanic)	0.00%
Not Stated/Other	13.33%

Insurance status

Insurance status	%
None	3.33%
Medicare	20.00%
Medicaid	0.00%
Other gov't (H/WLA, etc.)	76.67%
Private	0.00%

Sex

Sex	%
Male	26.67%
Female	73.33%

CKD on Problem List?

CKD on Problem List?	%
No	7%
Yes	93%

CKD patient eGFRs

eGFR Category	%
45< eGFR <60	43.33%
30< eGFR <45	33.33%
eGFR <30	20.00%

Medications

Medication	%
Aspirin/blood thinner (yes)	80.00%
ACE/ARB (yes)	60.00%
Vit D 3 (yes)	20.00%
NSAIDS (yes)	83.33%
Metformin (yes)	30.00%

Labs within the past 12 months

Lab	%
eGFR	96.67%
Referral if eGFR<30	33.33%
HbA1c	53.33%
Lipid panel	60.00%
Serum Ca++	86.67%
HGB	50.00%
25 hydroxy Vit D	50.00%
PTH	23.33%
Serum phosphate	20.00%
M/C	43.33%

Comorbidities/Risk factors

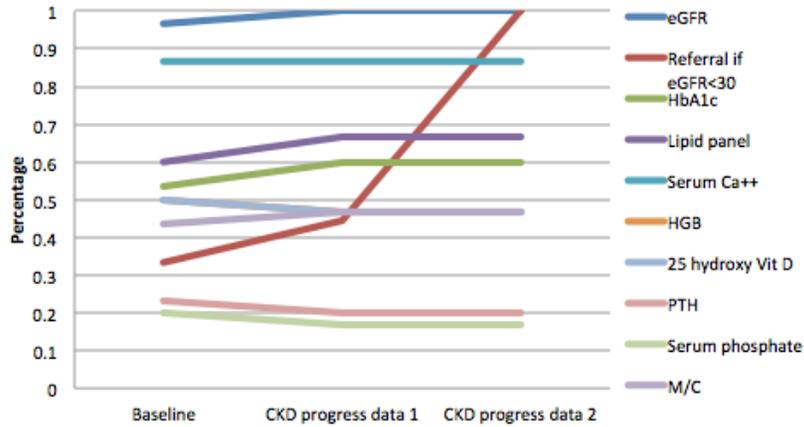
Comorbidity/Risk Factor	%
DM Dx	3.33%
HTN Dx	13.33%
DM & HTN	80.00%
BP>130/80	53.33%
LDL<100	0.00%
Calcium >8.5**	0.00%
PO4 <4.6**	0.00%
Smoker	3.33%

Prevention

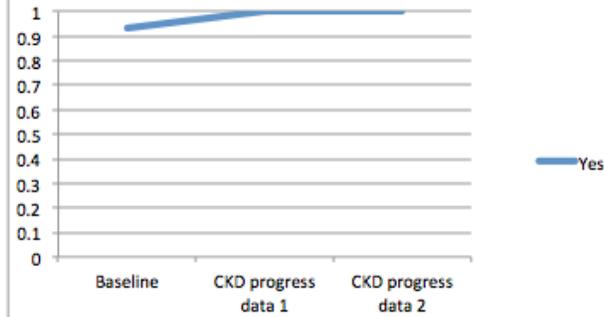
Prevention	%
Flu vaccine last 12 months	40.00%
Pneumococcal	0.00%

Performance Data Run Chart

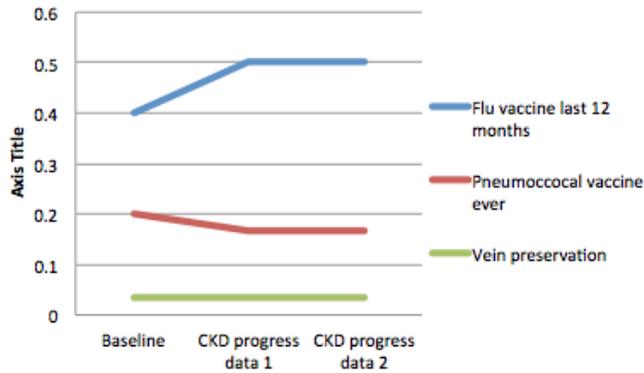
Adherence to recommended labs



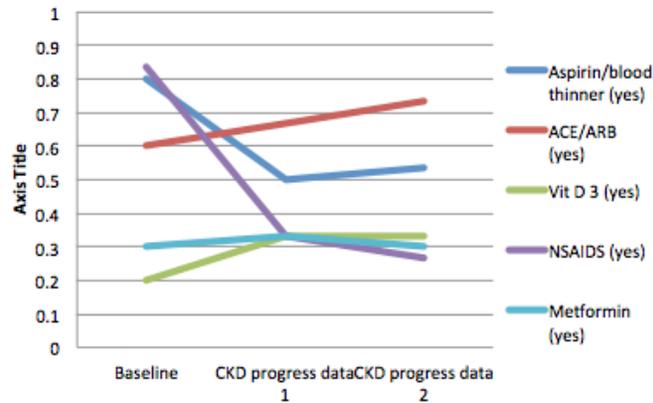
CKD on Problem List?



Prevention



Medications



Plan Do Study Act Reporting Template

PLAN DO STUDY ACT (PDSA) REPORT

Aim: (overall goal you wish to achieve):

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan
List the tasks needed to set up this test of **Person responsible** **When to be done** **Where to be done**

Predict what will happen when the test is **Measures to determine if prediction succeeds**

Do: Describe what actually happened when you ran the test

Study: Describe the measured results and how they compared to the predictions

Act: Describe what modifications will be made to the plan for the next cycle based on what you learned