

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 <https://www.ahrq.gov/health-literacy/improve/precautions/tool6.html>; <https://www.ahrq.gov/ncepcr/tools/self-mgmt/why.html>; <https://www.ahrq.gov/ncepcr/tools/self-mgmt/how.html>.
3. Helping patients help themselves: how to implement self-management support. California HealthCare Foundation; 2010. Available at <https://www.chcf.org/publication/helping-patients-help-themselves-how-to-implement-self-management-support/>.
4. Helping patients manage their chronic conditions. California HealthCare Foundation; 2005. Available at <https://www.chcf.org/wp-content/uploads/2017/12/PDF-HelpingPatientsManageTheirChronicConditions.pdf>.
5. Partnering in Self-Management Support: A Toolkit for Clinicians. Institute for Healthcare Improvement. Available at <http://www.ihl.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx>.
6. AHRQ self-management support site. Available at <https://www.ahrq.gov/ncepcr/tools/self-mgmt/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 <https://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. Complete the section for the PracticeOnlyOneforMiles ([Appendix 12C](#) at the end of the module) or for a practice the learner is already working with.
3. Use Self-Management Support Tasks and Assignments in [Appendix 32](#) 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?

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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.

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).

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

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 <https://www.ahrq.gov/health-literacy/improve/precautions/tool6.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 (Health Literacy Universal Precautions Toolkit, Tool 20, Use Health and Literacy Resources in the Community <https://www.ahrq.gov/health-literacy/improve/precautions/tool20.html>)
- 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 <https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingTeamsInPrimaryCareCaseStudies.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 <https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html>

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AHRQ Health Literacy Universal Precautions Toolkit. Agency for Healthcare Research and Quality, Rockville, MD. Available at <https://www.ahrq.gov/health-literacy/improve/precautions/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.

Appendix 12C. Case Example: OnlyOneforMiles

The practice OnlyOneforMiles is interested in working with you to implement panel management and to improve their diabetes care. The Chief Medical Officer is excited about the project and responds to your emails to them about the project within a day. You schedule a meeting with him. You ask him to identify key individuals who might participate on the Care Model project team for the intervention period. He says okay. When the day of the meeting comes, Dr. Enthusiasm shows up for the meeting. But no one else is with him. You ask where the others are and he says that everyone was too busy that day to join.

As the two of you visit about project expectations, he mentions that the CEO is not interested in participating and is concerned the project and changes will make the practice lose money. The practice is also implementing its EHR in the next two months and so staff and clinicians are stretched thin. Despite the challenges, the practice is financially fairly stable, and has a low rate of clinician and staff turnover. The practice recently began to transition to care teams from traditional physician-centric models, which has been causing some conflict, but so far things are going okay with that change.

Dr. Enthusiasm is excited about working with you as he thinks it complements the change to care teams and might help improve them. He also thinks that the practice should try to implement panel managers and wants a practice facilitator to help. He wants to know next steps to starting work with you. Dr. Enthusiasm's practice is located in a semi-rural community and is one of the only sources of primary care for low-income patients in the region.