Implementing the Chronic Care Model for the Management of Noncommunicable diseases (NCDs) in the Primary Care Setting

Lecture: Self-Management Support

We will now discuss another element of the chronic care model, self-management support.

What is self-management support? Self-management support is the help given to people with chronic conditions that enables them to manage their conditions day-to-day. Using self-management support skills and tools, primary care teams can help patients to manage their chronic conditions and develop the confidence to make healthy choices.

Self-management support is important as an increasing number of people have at least one chronic illness that requires daily management and outcomes of patients with complex needs can be improved by helping them become more active in self-care. Family education is an integral part of self-management support.

There should be emphasis on the role of each family member with collaborative care planning and problem solving. There should also be ongoing educational activities and connections that facilitate social support. The effectiveness of efforts should be determined with standardized assessments of self-management. Patients need support from their healthcare providers to engage in self-management activities. All patients with chronic illnesses make decisions and engage in behaviors that affect their health. Disease Control and outcomes are largely dependent on the effectiveness of that self-management. Self-management tasks include taking care of the illness or medical management, carrying out normal activities, or role management, and managing emotional changes emotional management. Care providers responsibilities in self managing support for patients include acknowledging that patients have a central role in their care, fostering among patients a sense of responsibility for their own health. I'm using evidence-based strategies to provide basic information. It also includes providing emotional support and acquiring the skills needed to be positive self-managers. In so doing, patients and providers can have productive communication that will promote shared decision making and better outcomes for patients with chronic conditions. The desired outcomes of self-management support include people with chronic conditions and their families be more aware, informed, engaged, activated, empowered, and confident they can self-manage and form partnerships with healthcare providers. For effective self-management support patients and providers must have productive communication that will promote shared decision making and better outcomes for patients with chronic conditions. Interactions to promote the patient as the expert in managing chronic conditions include emphasizing patient's central role involving family members, building a relationship, exploring patients values, preferences, cultural and personal beliefs, sharing information, collaboratively setting goals, using skill building and problem solving strategies to help patients identify and overcome barriers, following up on action plans, and connecting patients with community resources.

Self-management support is not didactic patient education, lecturing, inducing fear, finger wagging, shaming or waiting for a patient to ask questions.

The five A's of behavioral change can be used to help patients to modify their behavior. As shown the five A's are assessments advice, agree, assist and arrange. assessments include not only knowledge but beliefs and behavior. Knowledge isn't enough to change behavior, we need to understand more about what patient's value and what they do. Advice needs to be given carefully and linked to things that are important to patients. For example, graphing lowered blood sugars after a patient has successfully exercised regularly. Agree on goals that are important to patients. Goals are usually broken down into smaller steps, typically called action plans that lead to better outcomes. Assist with problem solving by identifying barriers, strategies and social or environmental support. And arrange a specific follow up plan. Follow-up is not left to chance and can be done in person over the phone or via email, or by using peers and outreach workers.

In essence, the 5 A's are a sequential series of steps that serve as how to guidelines for facilitating self-management. They have been extensively used in smoking cessation but have also been found useful for helping. They have been extensively used in smoking cessation but have also been found useful for helping patients self-manage chronic diseases. The approach is consistent with the core elements of the chronic care model, in that it is collaborative, patient centered and build self-management support, particularly through actions of the last two A's, assisting to anticipate barriers problem solve solutions, and complete action plans and by arranging follow-up contacts and resources. The five A's can be used by any healthcare team member and in all types of health care settings. During each stage of the process, the following steps are recommended. When Assessment Review goals that the patient has or that have been set previously, evaluate both levels of behavior and how the patient feels about the behavior he or she is trying to implement. Ask what the patient wants to discuss. For advice, communicate that when the patient for advice communicate that what the patient does is as important as taking medication. Provide short statements with specific recommendations. Link recommendations to the patient's views, risks and symptoms to make them relevant. Ask what the patient thinks about the recommendation. For agree to ask the patient what he or she most wants to work on. Ask the patient what he or she thinks would be a reasonable goal. Use questions and comments to help patients focus and be specific. The patients should set a goal they want to work on not a goal the provider thinks they should work on. In the assist stage. Ask the patient what he or she sees as the greatest challenge to achieving the goal. Ask what he or she has done in the past to overcome obstacles. Create a written action plan for the patient to refer to be aware of low literacy, as many patients will need simple wording and some will need an action plan with pictures instead of words. Include supports and resources to help with a goal. For arrange or the follow-up stage, set a specific time for the next contact. Tell the patients you want and need to hear how they're doing. Begin the next contact with a review of progress on the goal or goals. Follow-up on the patient's experience with any referrals to community resources. Research conducted on the implementation of the five A's to facilitate self-management suggests four keys to success. Employ all five A's during each interaction with the patient. Use open ended questions to enhance patient centeredness. Use the five A's in

conjunction with proactive care and follow up. Document the delivery of the five A's and provide the patient with written or in the case of low literacy diagrammatic copies of the action plan.

This diagram outlines a continuum of strategies to support self-management. Motivational Interviewing is an important strategy in the continuum that emphasizes behavior change and is a directive client centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Motivational Interviewing can be implemented in most healthcare settings. However, training in the technique is needed. The principles of motivational interviewing include expressing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy. The goals of motivational interviewing are identifying the patient's attitude toward change, having patients articulate pros and cons of change, and empathizing and empowering the client to take steps toward change. Other areas along the continuum focus on information provision and influence behavior change. Examples of self-management education interventions include face to face consultation, telephone forging, online courses, written information, group rehabilitation programs, multimedia and social marketing.

The core clinical competencies of self-management support include relationship building, exploring patient's needs expectations. core clinical competencies of self-management support include relationship building, exploring patient's needs, expectations and values, information sharing, collaborative goal setting, action planning, skill building and problem solving, as well as following up on progress.

An example of the application of self-management for patients with diabetes in fluids promoting tasks such as blood glucose monitoring, managing blood sugar levels, modifying diet and increasing physical activity. It also includes empowering the patient to manage medication taking medical monitoring or clinic visits, educating them on heels were coping with emotions or to ensure visits are conducted for foot care, eye care, and dental care. self-management tasks for asthma can also be applied and include tools for treatment adherence, and structured education on various topics. It is important to define each team members role in empowering patients.

This activity is a row visualization exercise for self-management support. Utilize the table shown here to describe 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. Health Service system barriers to self-management support include lack of awareness at all levels of the organization regarding the challenges associated with chronic disease management and self-management support. misconceptions that self-management support is an alternative to clinical care or equates to chronic disease management or client education. Lack of decision supports to assist providers assess, plan and intervene in self-management problems. Lack of tools to help clients develop adaptive health behaviors or change maladaptive ones. service gaps inadequate opportunities for clients to receive

coordinated evidence based clinical care and self-management support some optimal sub optimal communication between clients and providers in appropriate design of delivery systems that do not allow adequate time for the effective provision of plant self-management support interventions, or that inhibit continuity of care. Inadequate demand management which can contribute to reduce access or provider workloads, science safety in appropriate design of delivery systems that do not allow adequate time for the effective provision of planned self-management support interventions, or that inhibit continuity of care. Inadequate demand management which can contribute to reduced access or provider workloads that compromise client safety are the provision of effective proactive care. inadequately trained providers who lack the knowledge and skills required inadequate linkages or pathways between local services and clinical care services, and lack of adequate processes for service access assessment, care planning, monitoring and review as well as follow up. barriers to implementing the chronic care model. There are barriers related to executing intervention processes. implemented the multiple components of the chronic care model into practice creates additional responsibilities for staff who are limited by time constraints. Sustainability of the interventions can be difficult in some instances. Staff buying is a very important aspect of implementation to ensure program non-stop buying is a very important aspect of implementation to ensure program longevity.

The health service system barriers to self-management support include:

- **Lack of awareness** at all levels of the organization regarding the challenges associated with chronic disease management and self-management support.
- **Misconceptions** that self-management support is an alternative to clinical care or equates to chronic disease management, or client education.
- **Lack of decision support** assists providers assess, plan and intervene in self-management problems.
- **Lack of tools** to help class develop adaptive health behaviors or change maladaptive one's.
- **Service gaps**, which can include inadequate opportunities for clients to receive coordinated evidence based clinical care and self-management support.
- It also includes **suboptimal communication** between clients and providers.
- **Inappropriate design of delivery systems** that do not allow adequate time for the effective provision of planned self-management support interventions, or that inhibit continuity of care.
- **Inadequate demand management**, which can contribute to reduce access or provide a workloads that compromise client safety for the provision of effective proactive care.
- **Inadequately trained providers** who lacked the knowledge and skills required.
- **Inadequate linkages or pathways** between local services and clinical care services,
- And the **lack of adequate processes or service** access assessment, care planning, monitoring and review as well as follow-up.