CPCPracticeSpotlight43

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Beyond Patient Education: Self-Management Support

Hunterdon Family Practice & Obstetrics, Flemington, New Jersey; independent, 5 physicians, 2 NPs; 6,000 patients

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This strategy stems from **CPC Change Driver 1: Comprehensive Primary Care Functions**

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk Stratified Care Management
- 1.4: Patient and Caregiver Engagement
- 1.5: Coordination of Care Across the Medical Neighborhood

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: Health care providers as well as patients often mistake self-management support (SMS) as a variation of patient education. While providing information is a part of SMS, the larger framework of an effective SMS program is "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."*

Strategy: Hunterdon Family Practice & Obstetrics engages patients in SMS by way of a structured SMS visit where patients are guided to take the lead on improving their health through appropriate goal setting, planning strategies to overcome barriers and using the practice's guidance and support.

The practice offers SMS to patients based on their general risk status, a poorly controlled disease state, provider referral and patient expression of interest. About 60 patients are currently enrolled, two-thirds of whom have been recently identified as high risk for developing diabetes. To date, three SMS patients have "graduated" by meeting their goals, such as controlling their A1c and lowering their lipids.

Providers introduce patients to their "health coach" (an RN care coordinator) either during an office visit or at a later scheduled appointment. During this 30-minute meeting, the nurse describes SMS and health coaching to the patient, framed as the patient learning to take charge confidently of his or her health with the health coach providing support, guidance, information and resources as needed. Together they review a few pages of SMS materials, starting with the definition of SMS and health coaching and then assessing the patient's confidence in self-management with an 11-question survey. The nurse then offers a PHQ-2, a two-question depression screening tool, and if needed, a PHQ-9 is provided as follow-up.

The SMS appointment continues with the nurse guiding the patient in tailoring a one-page personal action plan. With the nurse's assistance, the patient describes his or her goal and then maps out steps toward success. This includes describing barriers and strategies to overcome them. Next, the patient rates how well he or she understands why the goal is important and how confident he or she is about making this change. Finally, the patient sets up a follow-up plan.

SMS at Hunterdon:

"Patient A is overweight and has hyperlipidemia. At our first meeting, she set a goal to lose 15 pounds in three months and make healthier food choices. As we talked, she realized one of her barriers was that she did not know how to put herself first so that she could focus on eating better and exercising. The more we talked, the more she realized its importance, and that it was okay to put herself first.

I also recommended that she schedule an appointment with the nutritionist at a local grocery store to learn about healthier food choices and meal planning.

At the follow-up phone call, she reported that she is exercising three times a week for 30 minutes on her treadmill and that she chooses raw vegetables as snacks instead of chips and candy. She had lost 5 pounds. Most importantly, she stated that she feels better both physically and emotionally because she is putting herself first to manage her health. I gave her positive feedback and encouraged her to keep going.

Our next call will be in a month."

The health coach call patients every two weeks until the patients demonstrate progress and a plan to sustain that progress. The calls are then made monthly. The practice offers to contact patients through the portal, but coaches have found that patients prefer a phone call. The coaches often call patients when new lab results come in — it's an opportunity to check in, celebrate progress or re-assess patient confidence in meeting goals. Coaches report that patients tell them they enjoy the real-time opportunity to ask their health coach questions between check-ins. Providers also assess their patients' SMS progress during regularly scheduled appointments.

Hunterdon has found documenting SMS a work in progress. While process measures such as patient goals and follow-up phone calls are easily tracked in the EHR, the practice follows their SMS patients' progress by tracking outcomes in a spreadsheet. Health coaches record lab results, assessment scores, PHQ scores, and any community resources patient's access to support their goals as well as notes from their check-in calls. To keep the team updated on SMS patients, weekly team meetings with providers and care coordinators, and the practice culture also encourages "drive by" questions from care coordinators as needed throughout the day.

While SMS is intensive work, Hunterdon providers find the successes highly rewarding and worth the effort. Helping patients live healthier lives is why they sought health care careers. Success with patients confirms it was the right choice.

**Source: Institute of Medicine. Priority areas for national action: transforming health care quality. Washington, DC: National Academies Press; 2003.*

TMF Health Quality Institute

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