National: Case Studies in Self-Management Support

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—everyone, I'm Krystal Gomez from TMF Health Quality Institute. Welcome to our national CPC webinar entitled Milestone 2, Case Studies and Self-Management Support. The slides for today's presentation will be available for download on the Collaboration site. You can also download the sites directly from the WebEx environment today by using the top tool bar and selecting File which will open a dropdown menu. Then select Save As and then Documents. Today's program is being recorded and will be posted on the Collaboration site once transcript has been completed. We appreciate the presenter's time and effort in preparing for ensuring the valuable knowledge. Any statements regarding their technology product or vendors are expressions of and opinions of the person speaking and not an opinion of nor endorsement by the centers for Medicare and Medicaid innovations nor TMF health quality institute nor the host of the program. As a reminder, all lines will remain muted throughout today's session to submit questions click on the Q&A tab on the right hand side of your screen. I'm delighted to introduce today's speakers. I would fist like to introduce our subject matter expert for today's presentation Judith Schaefer. Judith Schaefer is a senior research associate at the MacColl Center for Health Care Innovations located at the group health research institute in Seattle, Washington. You've heard Judith Schaefer on several of our national webinars so extensive experience in the ambulatory care team process improvement which specific expertise in patient self-management support which she'll be speaking to today. Now, I'd like to hand the presentation over to Dr. Laura Sessums who is a Division Director of Advance Primary Care at the Center for Medicare and Medicaid innovations. Dr.Sessums.

Thanks Krystal. Today's webinar is the second one we've had this year on self-management support. In the first webinar our expert Judith Schaefer who we're going to hear from were today provided us with a lot of educational information to introduce the concept and to give you all the rational for the use of self-management support in CPC . Today, she's going to spend more time on the nuts and bolts of self-management support and what promises to be a very interactive and practical session. She has representatives from three separate practices here to share with you some of their work on this advanced primary care strategy and of course we will have plenty of time to take your questions. One thing I want to point out is we begin this sessions is the difference between self-management and support, Shared Decision Making and then simple patient education. Judith is going to talk some about this herself and it's a really important distinction especially given the confusion so many practices have had on the issue of Shared Decision Making. It can be confusing after all each of these concepts can involve the use of a tool or a resource that we give to patients to help them understand the medical

condition. Each can also involve follow-up conversations with patient, and self-management support and Shared Decision Making are both described by three words and begin with the letter S. So, that makes it even more difficult. Yes, there are also really critical differences between each of these. Patient education of course is just a provision of information to patients whether on paper, the internet, a video, a conversation or the like. So, that one is pretty easy. Shared Decision Making on the other hand must involve a choice about a preference-sensitive condition and these are conditions where there—where the scientific evidence is not clearly pointing in one direction so there's more than one possible choice from which patient can choose based on their own individual values. The tool or the resource for patients addresses the specific choice as well as the risk and benefits of the various medical options. As contrast to these concepts with self-management support, that is about behaviors that affect patient's health and can be about any medical condition or risk factor for a condition not just a preference-sensitive one. Education may be a necessary precursor to behavior change but it's often not sufficient. There may be different ways that the patient can change their behavior but these different ways are not the result of inclusive—the inconclusive state of scientific evidence instead the various options often to patients result from practical differences in their life and their very personality than need. I encourage you to think about this today during the webinar and be sure the differences are clear in your own mind. Judith is going to review this again so that it should help clear up any lingering confusion and allow you to focus on the specific of self-management support. With that, I'll turn it over to Judith.

Thank you very much Dr. Sessums, that was a great introduction to some of what we're going to be talking about today. So, we're calling this Case Studies in Self-Management Support because we really want to share from people who are—who are right out there using self-management support intervention and I want to thank the three presenters who are working with me today to help clarify some of these concepts and also to give you some ideas about how it’s actually comes to pass in a clinical setting and what they're doing that makes the difference right in their actual visits. So, we're going to hear from—today, from a physician, a case manager and a nurse practitioner. So, we're going to get three different views of how the tools and skills of self-management support are used. But before we do that, I'd like to talk just a little bit more and kind of reinforce some of the ideas that I've talked about earlier and that Dr. Sessums has just alluded to dispel any kind of confusion but also to touch some ideas about some of these concepts. And first, I'd like to go back to this notion that Tom Bodenheimer from UCSF has put forwards for all of us. I think it's a really important concept and that is that self-management support can be thought of as a tools and techniques so skills that you build to help patients change behavior. In other words, we're supporting behavior change and we can use a lot of skills and tools and there are things we can do. We can use vivid platforms or checklists or patient ed materials and these are all the kind of operational things. But really the real goal is to change the way we practice so that we are collaborative. We are really required that we recognize that patients have the central role in this ongoing day to day management of their condition. And we need to support and empower them so that they really know what to do just when they get home and that they feel like you're their partner. You're their partner and coach in helping them do the best job they can in managing day to day. And that's central factor changes a lot of what we do. So, here we are. We want to make sure that self-management support isn't confused with Shared Decision Making. I mean it's possible that they would—that some of the patients would require both of these tools but certainly not

all of them. The patients that for which these processes and techniques are used might not be the same at all. Self-management support is really a much more general technique and it can be used with any patients who have the chronic condition. We use these tools really generally even if they have only a risk factor whereas Shared Decision Making is for those preference-sensitive conditions or risk factors that are specific to a preference-sensitive condition. So, self-management support is more general. Shared Decision Making tools are specific. They're decision tools for preference-sensitive conditions. They're specific to the specific risk factors specific tools. And so, [inaudible] what's the purpose? So, our real goal with self-management support is changing health behaviors and specifically building confidence, not only knowledge but confidence about those behaviors. Well, as of Shared Decision Making, these are around really specific treatment decisions that maybe about whether to have a cancer procedure or whether—which method of heart intervention you want to take to undertake. So, Shared Decision Making tools usually are primarily interested in helping the patient understand their options and they do also then precipitate a conversation with your provider that can be efficiently managed or some clinician in your—in the practice so that that you can make decisions about what you as a patient want.

10:03

And so, these tools help make the choices and options clear. And then the core activities with these are somewhat different tune. So, with self-management support we want to do—we want to understand patient-driven goals, what is important to the patient, what do they want to change first and then we want to use goal setting and action planning and problem solving and follow-up practices to help them achieve those behavioral goals. In Shared Decision Making, the activity usually utilizes prepared, conditioned-specific tools which are often increasingly this day's videos about a specific procedure or condition so that you can help patient make their decisions about that and work with them collaboratively to make decisions that will best serve their needs. I hope that really helps clarify that distinction. In here again, there's a lot of confusion between separating self-management support from patient education. And these are just a list of factors that help—might help understand that. Some people even used the term self-management education. I think that's confusing the issue even more but the factor here that is the patient education is usually about giving information, providing information for a patient. But that is not—I mean it is an important factor but it is certainly not the only factor. And again, it's not the chief factor. So, patient education looks at information and skills that are taught whereas self-management support, the skills are usually used to solve patient identified problems. So, we're looking at how do I implement this treatment plan and list the action plan of mine in my daily life. Patient education is usually very specific and skills for self-management are generalizable across all conditions. They often have to do with medication management, with fatigue management, with pain management, with changing the health behaviors around diet and exercise or healthy eating and exercise, stress management, all of these things are generalizable and are pertinent across chronic conditions. One important thing and this is a very basic big assumption that we make is that we—if we give people information, it's going to create or create this environment for behavior change and of course we know that in order to for patients to believe that changing their behavior is important they need to know why but they also need to know that they can do it and that there are things they can do and they have to have confidence that they can do it. So, confidence around being able to change the factors that are creating obtained or distress or whatever in your life is an important basic underpinning

of self-management support. And creating confidence yield the outcomes that we hope because building incrementally through small behave—small changes in behavior. The increased confidence that I can manage my own condition is really what we're aiming for. So, vocation education most of the time, people who are—have professional for the teachers and it's usually done didactically. They—It's usually done in telling. So, in self-management support we want to look at more asking and less telling. And so, anybody can do self-management, I mean self-management support does not entirely need all those clinical skills. So, because it is around behavior change and action planning and patient's own views of their own life. So, again, I also want to stress that self-management support is a team sport and it requires real preparation, it requires changes in the actual visited self-using a lot of team members preferably but especially focusing on the fact that everybody on your team no matter how many or who they are can take some role in self-management support while looking to increased detaches, we want to be prepared both with clinical data and rich information from the patients themselves. That's why using those visit prep forms are important. Then during the visit we want to make sure that every person who has a role in seeing the patient during that visit can have some sort of self-management support activity that they can use and intervene with the patient so that the visit time itself is optimized, everybody is doing something that supports the patient in their self-management. And then of course after the visit we want to continue to support the patient and family into their lives, into their other specialist visits, into the community programs or peer programs that might help them. And simply checking back with them about their actions plans and following up because we know that changes don't happen without repeated efforts and problem solving around those efforts. So, that's an important—those are the important things that I want to talk about in terms of self-management support and what changes it means. But now we're going to hear from Dr. Nancy Beran from Westchester Health Associates and I'd like to just turn the—as the physician of our three speakers today I'd like to turn the microphone over to here to talk to you about what's been important to her and then her practice in implementing self-management support, Dr. Beran?

When we try to take over and think about self-management we'd like rights of lefts at the end looking at where we're doing more patient education or were we really implanting self-management. And we set some goals out for ourselves for self-management, and the goals that we set out where we really need to increase our patient engagement in the process. And we needed—it really to address the educational level of our patient. And we recognize that we needed more of a team of professionals and not to be driven just by the physician. We needed it to be less time consuming for the physicians much less handout driven and more engaging across our entire organization. And we realized that we needed to assess each patient's readiness. Advise them of the different programs that we're going on and advise them of the different areas that there are for self-management support. Agree on different goals and methods, a system in overcoming barriers and arrange follow-up. And that really simulated a process change for us in our organization. We incorporated it into our morning huddle. So, when we sat down and we talked about the patients that were coming in for the day we talked about anyone who might be a good candidate for self-management support so that would start then with perfectionist, you know, they might recognize a patient that could use some self-management support or a self-management program that could be introduced from perception, from medical assistance, from the case manager, or from the physician. A support tool or program could be discussed with the patient by anybody. The goals

are just—were discussed with the patient, the willingness of the patient to participate was discussing agreed upon those goals were set or the referral to the self-management program was made. And then all of this was recorded in the health record and we customize the health records so that we could document and then the readiness of the patient, the goals and the entire process into what we put it under our care management template that we created in our EMR. So, that that could carry forward from visit to visit. That was how we modified our process and we tried to then kick it up a notch and develop programs that would, would go across multiple conditions that would be good for the patient, good for overall health and good for our practice that would help our patients develop self-management skills that were needed in their life style, to live healthier life style. So, in collaboration with our local hospital center we did a prescription to wellness where they get an integrated program that helps them lead a healthier lifestyle and diet and nutrition and exercise. So, even for patient's that have a lot of barriers to beginning an exercise program it is done at the same center where they do the assessments for cardiac and pulmonary rehab. So, they are very comfortable with patients that have medical condition. Invitations feel a lot less threatened by doing an exercise program there and there's nutrition classes there. And that has been a successful way. They also work with the adolescence in our practice that may have issues with eating or exercise, make them feel comfortable. And that has broadened the amount of access that patients have had and teaching them to work with themselves and have self-management skills around their own illnesses. And that has been that helpful for our diabetics, our patients of hypertension, our patients with high cholesterol, our patients with diabetes. In addition, we've done a much broader campaign around hypertension that has been part of the AMGA campaign for measure up pressure damp which has both an educational component for the staff in the offices.

20:07

But also a large tough management component for our patients on teaching them to take control has an entire plank on self-management on educating patients on lifestyle, diet, exercise, importance of taking their own medication, teaches them all the self-management skills, and help some we've if purchased home monitoring blood pressure cost the patient can take and we'd have a process where they can take their blood pressure, take it home, bring home logs and engage with the physicians and the staff on trying to help manage their blood pressure as well. We're really trying to engage both our staff, our patients, and everyone on the office on setting goals and setting priorities and doing that in conjunction with our patients. So, that it's not just your blood pressure should be this but rather the conversation around what strategies can we together achieve and be getting that dialog with patients. For those of us at our primary care physician is sometimes very intuitive. It's what we do every day having those conversations with patients. But it's more of a philosophy of making sure that everybody in the office is supporting. And paper modification for patient is the most difficult thing that we do. And just making sure that they know that they're very supported and that if one time they don't achieve a goal that we can go reset and we can go and we can continue to support them and move forward to the next and keep trying.

Dr. Beran can I ask a specific question at this point?

Sure.

You mentioned assessing readiness and that's not something I've talked a lot about. So, I'm wondering can you just tell us briefly how you assess readiness.

For the most part, you know, it really is kind of an intuitive conversation that you'll have with a patient. So, when we start for example for an obesity patient, every patient has their height and weight done in our practice even if you're coming in for a sore throat. It's done every time, every visit. And it's in a flagged in the electronic medical record but you may say to a patient, "I see that, you know, you're height and weight is a little high" is that something that we can discuss today. Or a patient will say, "I don't want to get on the scale." And you have to begin a conversation about that and my staff slowly and carefully begins a conversation. We are all—we all ask, is this something that we can address together today? And if a patient says, "I don't want to talk about it today." So, I'm going to say, "OK, then we'll talk about it the next time you come in." And we'll even write that in our notes, you know, patient, you know, they don't want to discuss today, we'll discuss next time. But we really do ask them, you know, are you prepared to address this today? Is this something that we can talk about? We have—

That's a very important tool. It offers suggesting asking the question. Before you give information asking, can we address this together today is an excellent way to begin. How can the patient understand that they have a lot to say in this conversation? That what they think is important that—and that you're respecting their priority. So, people begin then to relax and that barrier that might exist between a clinician and the patient or maybe it even helps them relieve a little bit the guilt that so often patients feel when they haven't been able to meet their behavioral goals of haven't even bothered to make any behavioral goals because they're still overwhelmed. So, that's a terrific tool, thank you for that.

Krystal, I'd like to ask you if there are any clarifying questions for Dr. Beran before I ask another one or two of my own.

I am seeing one, I'm not sure if it's more of a statement or question. But CHF, DM and asthma are issues with clear self-management activities. The side pound weight rule Basal and Bolus all titration rules and inhaler titration based on symptom clearly define what is self-flash home management and what that responsibility is.

[Inaudible] my only comment on for some parts are education, patient education there which is patient education around how the proper use of their—of their inhalers are. But if you're talking about what's the self-management role for CHF it's educating them completely on. These are the roles of daily weights, this is how high you go, this is where your goal way is. It's more specific to the disease and the condition. I think when we're talking more broadly here on self-management support sometimes we're talking almost about self-management support for behavior modification. Which is how do you behave or modify? How do you help people do behave your modification for things like obesity or life dial changes? But there are more specific self-management support processes for CHF which is making sure that they have the entire process and understand the entire process. But if they're not going to be ready to own the whole process or they're not going to do daily weights then they're not going to be able to do self-management support for CHF no matter what you do. But if you can assess if they're ready and they're informed then you can agree on how you're going to do it.

So, the action planning about weights, taking daily weights for instance might begin with, well, how do you feel about taking daily weights? And then also looking at what—what time of the day can you remember? What—how can you help—what can help you record your weight every day so that you can see the variances, things like that, and figure out what's available to them in terms of scale, do they have a scale? Can they afford it? If so, if you are—is your practice able to have a resource that can help people get skills if they don't have them. So, that's the kind of a panoply but—and really takes that treatment decision right into the [inaudible] experience of the patient. Well—

We call it the [inaudible]. The assess, advice and inform, agree, assist and reach. So, you have to get through each step in order to get to the next one.

That's terrific. OK, very briefly I have one more question for you Dr. Beran, because you are the physician on this panel I'd like to ask you this. That solution is part of a physician's job is to develop treatment plans for patients, you know, suggestions about optimal blood glucose levels for example or something like that, that patients often don't really relate to those numbers or those outcomes, the medical outcomes. And they often have a much more functional view of better outcomes. Like, I want to be able to play with my grandchildren or I want to be able to lift my suitcase into the overhead bin. Or how can you—what do you do that helps bridge your treatment goals for the patient? With their priorities for how they function in their life to make an action plan so that they can really change behaviors.

I mean I normally pick the time suggest educate them on the, you know, quickly on what my goals from outcomes and why it's important? You know, why do I care about your hemoglobin A1cB, what the numbers are? Why does your blood pressure matter? And then ask them what's really important to them. You know, and we have—I have tremendous amount of conversations with my patients about weight. Probably is the number one conversation we will be talking about more than anything, you know. Because fortunately, most of the other stuff is controllable but we will have a conversation about weight and what is the goal weight loss, you know, for them, and how much to exercise. And we will really have conversations about how important is it to you to be functional. What is your lifestyle goal, how active do you want to be? And overall the goal is to be healthy. So, we kind of talk about from that perspective and going back and forth along those lines and then—and then sitting there and not treating to a certain BMI as much as treating and setting goal setting together. Because especially around things that require patient's compliance such as everything but specifically, you know, I find it tremendously so in weight, weight loss. You can't motivate for somebody else so if you don't find out what their motivation is, what their commitment to change is you'll never got any buy in with genes.

Exactly.

Management support is all about under CNA what motivates somebody to change?

29:59

Exactly, that's right. So, trying these activities that more exercise is great for their hemoglobin A1c. But it's also great if they learn to play with their grandchildren. So, using what you know about your patient

in asking questions about what's important to them helps you tie the behavior change activities to something that really use that motivational energy to change their behaviors.

Thank you very much for that Dr. Beran, yes?

Judith, this is Krystal I just have one more comment that came through, if we could please restate the rule of five one more time for the attendee.

The rule of five, you mean the five As?

Yes.

Dr. Beran, would you do that for us again?

Sure. So, it's A for assess which is a patients readiness or confidence to change, advice, and inform with the patient's permission, agree of goals and message, assist in overcoming barriers and our A for arranging follow up.

Thank you so much. That has been really helpful a wonderful session. So, right now I'd like to again introduce our next speaker who has another role with patient. From another clinic this one [inaudible] integrate practice association. So, Jane Bilello is the case manager in this system. And she works with more than one practice. So, she has a different kind of position within the practices and within the visits and I'd like to hear from her how she implements self-management support.

Hi, good afternoon. So, I'm just wondering if maybe the two of you have read my speech for today because so much from what I talked about, we've already touched on but I will talk a little bit about the two practices I work with and I work with four primary care providers as their care manager. I kind of break my job down into three different areas. First, looking I first work with the patients to identify as we said the desired health outcome. And what we're going to work on we will get readiness. What support they have to achieve their goal and what their past experiences have been in this like we were talking about the weight loss. Have you tried this before, what worked? What didn't? I look at the tools that they need to achieve and to be engaged in self-management. What they'll need to help change their behavior and then we look at an evaluation of outcomes. We look at what the outcome is. When I first begin working with a case management patient, the first thing I want to do is get to know them. I may get them as a referral from the physician or from someone else in the office. So, I want to get to know them. We do that initially by doing our intake. It can take up to 90 minutes to do this and maybe done in one session or broken up in the office or on the phone. And during this time I'll get to learn about your past, their current health history. What's important for them to change, what is their health conditions, what motivates them? I have one patient who her motivation is to go to Hawaii in the fall. So, we look at, well, what health things do we need to work on to make that trip attainable for her. We'll look at what obstacles may be in their way. And what is health look like. And I actually do sometimes actually draw pictures with them. Create image boards of what is health look like and what do we need to get to that. Health might look like? You said playing, you know, [inaudible] with their grandchildren. This is kind of where the motivational interviewing starts with the patient. During the process we may

actually make a list of some of the goals, the topics, the things that they want to work on overtime. I've had some diabetics who will, you know, identify a bunch of things that they know need work. Behaviors they need to change to lose weight to learn about their diet and their meds. Seeking other health professionals, the dietary or ophthalmology to go to. So, some of them they actually start to form a list and we identify how we're going to tackle that and what's the most important for the patient to work on first so that they aren't overwhelmed. Others may present which is one thing that they need to change. Maybe the behavior is smoking and what are we going to do to stop that? And then there are some patients who don't really identify anything. We know that they have a lot of comorbid health problems, we know that there are things that they can change for better outcomes. But they themselves can't identify anything so that patient I may do more interviewing, talk more about their life, or do that education piece so they start to connect this specific condition with their health and why they don't have the energy or why they're not able to do things. But either way it's about gathering information, starting a care plan, and then we develop an action plan. In the action plan we specify what it is the patient agrees to do, what time frame, how long they think that might take. When are we going to talk again? Will it be on the phone or will it be in person. You know, ask some question like, well, is it OK if I call you in a week and see how that is working for you? Or they may say, "Well, you know, I don't like to be called. What if—what if we talk about when I come in the next visit" and that's fine too. We work on that coaching the encouragement of what they might need to get to that next goal. Our action plans are done through our computer system CCMR part of our electronic record ECW. So, we actually—we actually create a plan and write and, you know, prints that I can give to them or mail to them that they can see what it is they're going to work on. For these action plans to work I try and provide them with all of the tools they'll need. And maybe something simple like a log for keeping their blood pressure with their blood sugar. Or it might be educational material so they understand why follow up is important, why losing weight will have a good outcome on their energy level. So, we'll work on that education piece as it's needed depending on what the patient knows. Sometimes we'll send the patients to education classes that's very individualized. Some patients are great with classes, some want one on one, some are more stand-offish and will only take one thing. Well, give me something to read and I'll do that at home. And then I'll do, you know, or follow up and we'll do we teach back to see if they understood that and know can identify better what behavior change they're going to make as a result of that. It might be resources about community involvement, community resources for maybe an alcoholic where our AAA meetings. Why is this important to you, what's has stopped you in the past from going. It might be use of computer systems or apps or home delivery systems, helping them to see what is available to them to reach these goals. And then third, the section of evaluation or what I like to look at is self-reflection. Encouraging the patient to look back at our action plan that we developed, what was their desired outcome, their desired change? The behavior they were looking to modify and do they reach that? Some of them are going to be short-term goals that they need help at home with meals on wheels or maybe it's on stress reduction and that's an ongoing process. Or it might be a long term goal of the weight loss of 50 pounds that we're not going to accomplish in a short period. But are we working towards that? Whatever the goal is I'm trying to help the patient to achieve that healthy outcome through implementing their action plan by reviewing it, rejoicing with them when there has been change made. Readjusting their care plan when it's been unsuccessful. Maybe we need to set different goals and different actions. The idea of the whole process always going back to self-management what's

important to the patient? What is the patient willing to do to make this happen? Small steps, big steps whatever works best for them. All done with patience and encouragement and trying to keep our eye in the price of healthy outcomes and what they view as health. What does it look like to them? That's it.

Thank you, Jane. Thank you so much. I do have a couple of questions for you. I know that and if I have the wrong view of care management or case management here you can straight me out. But very often these managers have a big long checklist of behaviors and information to provide. And those can be helpful when we're learning or when—or for an insurance company and we have to make sure that that the basis are covered in terms of what information has given to a patient. So, if you have certain checklist tool that you're asked to use in guiding patient self-management. How do you use them and still get beyond the checklist to support that individual patient self-management goal and really get down to that motivational aspect of the tailored action plan for that patient?

40:12

I don't have a checklist of things that we have to do or encourage to use with patients. It's not like case management where we look at insurance company. It's not driven by the insurance company it's within our practice. So, I don't—I have a list of tools available to me. And that's—and I kind of look at them as I'm meeting with the patient and kind of offer them different options. So, I don't have to use any one thing but if it's about, you know, if they say, I just need to get this diabetes under control. I just don't know why my blood sugar is just so crazy. We'll talk about where—what they know about their diabetes and then I can offer them different avenues to learn more if that's what they need to get—if they need to get their diabetes under control. Maybe it's because they don't have the basic knowledge. This one person, they may say, "Oh, you know, I can't get to a group setting or I can't get to hospital for classes." "Well, can you come here to the office like maybe in a week?" "Oh yeah, this is an easy location for me. Well, then I'll bring an educator here if that's what you want." If the education is what you want and you can't get to the hospital I'll provide an educator for you here in the office.

Thanks Jane. We just have one question that came to the panelist from Thomas Castillo. He says, since Jane is using NCW, clinical works and I'm changing to clinical works and can we get those files so that we can use them in RETW system? Is that a possibility, Jane, for you to share some of the tools that you used with the clinical work in self-management approach?

Yeah, I think this—we created our—some of our own templates for care plans. But most if it’s through if their purchasing ECW, CCMR, it's a separate software for—just for case management within ECW. So, they would have to purchase that software in ECW for it's a template that what we do for the initial intake it has a care plan template. And then as we do the action plan, it actually prints it out with what they're going to do recommendations, red flag. So, for talking about congestive heart failure and the weighing of themselves. What are the red flags that the patient is going to look for to learn their provider that maybe they're getting into trouble.

Thanks Jane. So, Krystal, can we—do we have a website that we can post that information on so maybe people can—who have the clinical words can all have the same kind of information?

Yes, yes. Also, I'll put Jane afterwards and we can post it to the collaboration site.

Terrific, terrific. Thank you so much, Jane.

You're welcome.

Very much, we're going to now move to our third speaker who is Leslie Ferguson who is a nurse practitioner from Summit Medical Clinic. And Leslie, take it away, I'd like to hear what you have to say about engaging patients and self-management.

Great, thank you Judith. Good afternoon everyone. So, at our clinic what we do with self-management is we're really striving to help the patient gather a better understanding of their disease process. Through education in the collaborative support I think as we all know education is really the key to success to any situation particularly with one that deal with chronic medical conditions. One of the main comment, I hear from a lot of my patients is I feel helpless. I feel like my life is not in control anymore. I don't know what to do with it. So, we really try to focus our self-management on giving the patient the education and the tools to kind of take back their health to try to put them back in that driver seat. We have actually three specific chronic disease processes that we like to focus on our clinic. And those are diabetes particularly those patients with the A1c greater than nine. Chronic kidney disease generally stage 3 or above or Chf. We do mainly focuses on our high risk patients which right now we currently have about a 100 of those. But we open this up to anyone in the practice as well as their family members. Anybody can attend this, they kind of help them gain better understanding of it. And what we have done is we have implemented a new watch and learn program that provides about a 45-minute educational session. And also give each patient a unique plan of care. What we do is we have different speakers come in to kind of teach this class as we offer them once a week. And we kind of rotate the different disease processes through. So, right now we currently have our orient care manager that teaches this as well as a local diabetes educator. We have a cardiologist that comes in as well as our own physician Dr. Aurora who is a nephrologist. We've actually gotten great results with this. We are averaging about 10 to 12 patients each session that we have. And its new patient seeks time. So, what we try to do each session is different, we don't just repeat the same stuff over and over again. We kind of see what patients we have that show up what family members and kind of find out from them what do they want to learn about today? You know, do they want to focus on the different medications and learn about them. Or did they want to focus on their diet? So, we just kind of go over those things with them. We also have a care plan for each patient and that is reviewed with the patient with the care manager. And what this plan does is it kind of helps them set goals for themselves. Usually, they name three goals. This is what I want to accomplish. And as I mentioned earlier some of these goals may not necessarily be—necessarily medical driven such as I want my A1c to be 7. It might be, I want to attend, you know, my grandchild's graduation in California. So, we try to figure out what are the patients' motivation, what are their encouragement? What are their goals and then we try to help them take control of that and get those under control. We also—we'd like to advertise these classes a lot. We put them in our newsletter. We also hang up posters and then as providers we also encourage our patients to attend. And I talk with a lot of my patients during their visits about coming to these classes. And I think that also kind of helps kind of engage how motivated they are as well. We find that patients that will come and attend these classes tend to be more motivated with their health. We tend to get better results and reduction of their A1c getting their cholesterol down, getting their kidney disease under

control. So, we really try to focus, you know, how well our patients engage. There's also a few tools as well that you can use to kind of figure out patient engagement that includes the Palm tool and the How's My Health tool. So, there's definitely different options that you can use for that as well. We also try to partner with some of the local community resources as well to kind of help our patients get those further referrals that they need. So, we—there's a CHF clinic at one of the local hospitals. And so, we can refer patients to that that are having some problems. There's also a particular place called the community center for diabetes which is a community base center here in Colorado Spring. It's open to the public and it provides additional teaching and support to patients with diabetes as well as their family members. They can really give the patient some intensive training and they can also support patients who may have difficulty getting their medications or have some other financial issues around that that can help them as well. There's also a program called Kidney Smart which is offered through DaVita or anybody in the community that has kidney disease or just wants to learn more about it. Like I said, they're completely open to the public, they don't necessarily have to be DaVita patients. All these require is a referral and you can do it online and find a patient up. And then they go to these classes and learn more. We've actually had a great result with that as well. DaVita is in the Kidney Smart program will send us back paperwork for them that we scan into the chart where they have set goals with them as well. So, vainly we'd really try to focus our self-management on education. You know, we start this process back in April and so far we've seen great results in it. We're just kind of coming up to them about that third month mark where we'll start checking A1cs and see if there's been a difference in it. So, we're really interested to see that. As far as follow up our nurse care manager of course follow that quite frequently with our high risk patients either on a weekly or biweekly basis. And the percent of our lower risk patients, our medical assistants, there will be a note made in the chart, they didn't follow up with them in about four to six weeks just to kind of check on them and see how they're doing. Any questions, any changes that need to be made in their care plan and then as a provider as well we do have a certain code that we place in the chart when we scan in their self-management plan. And so, as a provider I can see that when I pull up their chart to see them for their visit about CHF or diabetes and I also go over it with them. I see how far off for our goals, do we need to, you know, try to rearrange those a little bit. Maybe make some new goals and see what I can do to help them achieve that as well. I think with a lot of patients, you know, as providers we tend to be more focused on the numbers. You know, we want to get their LDL under 100. We want our A1c, you know, to be around 7. But for patients they tend to more focus on, you know, their health like the things that they want to do. So, we just try to marry both of those to really help the patients. Now, some of the challenges that we've had with this implementing this new program is of course patient involvement. At first we were concerned we might not have a lot of patients sign up. And a lot of our patients, you know, of course work there on the day or may not have transportation to get here. But we've actually found that that's really not been a huge barrier at this point.

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I'm interested to see over the next six months do we continue to get the same patients, do we need patients enough to participating to kind of see how that goes. It was also a challenge of course kind of implementing a new change in policy in the office. You know, it took us a little bit to kind of get used to that and get used to the setup of that. But it seems to be going well. And, you know, as any time change

happens, you know, there—you're going to have a feud. Little bumps in the road but every thing's gone very well with that. Our goals for the future, we'd like to expand our self-management to some other disease processes like COPD and depression, tend to be another too big chronic diseases that are pretty prevalent in our practice. And we'd also like to take and create some support groups for our patients where they have that peer support? Just like you see and, you know, in other peer support groups I think that gives the patient somebody to talk to who knows what they're going through who may have had some of the same experiences and can really relate to. Sometimes, I think that tends to help patients instead of relating more to a provider or to their nurse sometimes if they talk to appear they have a buddy that they can really talk to. They tend to do better with that so we'd really like to create some support groups that made it our practice.

Leslie.

Yes. Leslie.

Yes. I'm really interested in this—I have a question for you. We're almost running out of time and I want to leave some time for questions. So, you [inaudible] these education sessions in which they're groups of patients who come together, and I imagine many clinics to have some education sessions. I'm wondering—there are two aspects to these, one we want to learn how to turn an education session which is primarily focused on information to one that had—that includes self-management support activities. I'm wondering if you'll include any self-management support activities in your patient education session like do you do goal setting together. Do the patients have conversations with each other about what's work for them that helps to build empowerment and things like that? Could you talk just briefly about that please? And then I have one more question.

Absolutely. Our patients they do talk to each other. It's a very interactive learning session. They're able to ask question, discuss what's worked for them in the past, what hasn't. And as far as the goal setting, the nurse care manager does meet individually with each one of them to set those goals. So, they do have that individualized attention instead of, you know, just a group goal which may not work for everybody so we do try to individualize it a little bit with that.

So—so, I'd like to just suggest that there—I don't know how many of you know about the chronic disease self-management program which is they can stand for them has been around for 15 or 20 years now and it's actually been worldwide, a program that's helped many people. It is a peer lead program, but many, many clinics particularly taking that provider clinics to have, have started the peer lead programs they start by beginning—they begin them with the clinician or an [inaudible] or some other person in the process learning how to do the groups. And so, that means that then they have a way to engage more patients in self-management activities. And clinical content can then be addressed during the visit but the self-management, the ongoing self-management support happens during this session. So, before we leave Leslie, I want you—there is a question about tool. She mentioned a couple of tools. How is your health—is the tool that's available online and you can just Google it, how is your health and you will find a tool that was created by Dr. John Watson some time ago and it's a good—it's a very helpful tool. You also see that there's a website on the—in the chat line that is the is the

insigniahealth.com, that is the organization that is in charge of or administers the [inaudible], the patient activation measure tool. And, you know, this patient activation measure is a very helpful tool in terms of assessing where people are and their degree of activation around any specific behavior or in general so you can use that tool to begin conversation to let your patients around things that are important to them. Many—if there is a charge for it but many people use the services that organization and patients come happily in order to help utilize the tool as a self-management support tool in their practice. But also to get coaching from their organization around the use of the tool and how it can be used in practice by various practice members. And also [inaudible] has been giving you the website for the Stanford program on chronic disease self-management program. Well, I'd like to thank all of our speakers today. But I would like to just tea up a couple of questions that I'd like them to open up and respond to as a panel. So, if the speakers could just open their lines now. We heard of some of these questions that I've heard lots of people talk about implementing action plan. That I wonder if you could just make a couple of petty comments about how you are assuring that you are really focusing on what patients want. How do you make it happen that you focus on what patients want?

We really when we meet with our patients do the self-management goals. We tell them these are your goals, not my goals. What do you want to do? What is the goal that you would like to see in three months? What is the goal that you would like to see in six months?

But Leslie, if you tell them that these are your goals, how can they become the patients own—how, how do you translate? What I think you're saying is, "Here, these are our treatment goals?"

No.

How do you translate that into your action plan and goals? OK. So, make it more clearer to me.

Now, we actually we ask the patient what their goals are.

Good.

Yeah. We don't, you know, tell them their treatment. I mean, obviously we go over their treatment goals after visits and such but when we do their self-management plans, we try to leave all that out and we just say to the patient, "What is your goal? What is your three months goal? What is your six month goal? And how confident are you that you can achieve this goal?" Because like I said if we set goals for the patients, you know, it's not going to have as much mean as if they set their own goals. That gives them the motivation so don't suggest skilled form. We let them come up with their own.

If they say that they're not very confident, what's the next thing you do to help them?

We look at that goal and then we say, "Well, what is the goal that we can accomplish in three months?" You know, maybe you can't lose, you know, 10 pounds in three month. What about five? Do you think you could do that? How confident are you in that? So, sometimes, you just have to take the broader goal and just make it a little bit more specific for the patient to where they feel comfortable that they could achieve it.

So, the important part of action planning is translating a goal like losing weight into actionable discrete behavior specific steps. So, that's the real helpful goal really changes that treatment goal of losing weight into an actionable action plan for patients at home. So, instead of saying that that my goal is to lose weight, they change that into actions like, "I am going to have ice cream only two nights a week instead of five. And I'm going to do it on Tuesdays and Wednesdays I'm going to have that ice cream, but the rest of the week, I am not or maybe its Friday and Saturday." That you see how that translates that kind of overarching goal of losing weight into something that people apply this week. On this Friday night, note I say it, I made this decision and with my care manager that I'm not going to eat ice cream on Friday night. So, these are the small incremental steps. The test for an action plan is can I tell? Is there a way I can tell I did it? Do I know whether I meant made my action plan or not. So, that is, that—I would say in my position that that is the big step that change needs to make between just providing education for patients and really helping in self-management is to make sure that you've done some steps and we call that action plan but made some steps towards personalizing and specifying what those patients can do or want to do and want to do when they get home in order that they can change their behaviors. I'm going to open up to our other two speakers Dr. Beran and Jane Bilello to—for any last comments before we leave. You got about a minute. That's all. I'm sorry.

Hi, this is Jane. I would just—in addition to what you said about, "I love that thing about the eating the ice cream two days a week." We sometimes then take it a step further in replacing that activity. Well, what are you going to do in place of that?

Great.

That comes really clear when we're talking about stopping to smoke. So, you have to identify, well, when do you smoke? I smoke when I drive. OK, so what are you going to do in place of that? You have to sometimes replace that, give something else to do when you're changing a behavior.

Thank you so much. I apologize Dr. Beran, and I've been told we're out of time. We really want to thank you all for contributing today and I wish everybody really good luck in doing the hard work of really making your practices patient centered and supporting your patients in improving their health over time and then in their own lives. Thank you very much.

Thank you.

Thank you.

And I want to thank Judith Schaefer and then all three of our wonderful panelist today for sharing what's happening in their practices. We hope that you found this presentation to be informative. You can exit the session by clicking on the File Menu option at the top left of your screen and select the option to leave the session. You'll be taken to a post webinar survey that needs to be completed in order to receive credits for attending this presentation. Thank you all again.

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