Education & Training Curriculum on Multiple Chronic Conditions (MCC)

Strategies & tools to support healthcare professionals caring for people living with MCC.

Module 2

Self-Management Support

Full citations for this presentation appear in the notes section of the slides.

Slide 1 Speaker Notes

This is the second module of the HHS Education & Training Curriculum on Multiple Chronic Conditions (MCC) —a six-module curriculum designed for academic faculty, educators and trainers to inform healthcare professionals caring for persons living with multiple chronic conditions. Based on the MCC Education and Training Framework *(http://www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html)*, these modules provide knowledge and tools healthcare professionals can use as they improve quality of care of persons living with MCC.

Terminology used throughout this presentation:

- Multiple chronic conditions (MCC) is defined many ways in the literature and in practice. For the purposes of this presentation, MCC is defined as a person with two or more concurrent chronic conditions. Other similar terms used are complex patient, multimorbidity and comorbidity for this population.
- "Persons living with multiple chronic conditions" (PLWMCC) is used instead of "patient" to place greater emphasis on the individual being at the center of care.

Each module contains a PowerPoint® slide presentation that can used as part of the MCC curriculum series or independently as an introduction to the concepts of Self-Management Support for healthcare professionals new to this material. The presentation can be saved, modified, and used in your presentations with healthcare professionals at any stage of education (undergraduate, graduate or continuing education). The notes in the presentation will help guide your talking points during the presentations.

Visit http://www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html to download this and other modules—and to access helpful tools and resources.

Suggested citation:

U.S. Department of Health and Human Services. Multiple Chronic Conditions Initiative. Education and Training Curriculum on Multiple Chronic Conditions. Washington, DC. June 2015.

Learning Objectives for this module

After completing this module, you will know how to:

- Articulate why self-management support (SMS) is important in providing high quality care to persons living with multiple chronic conditions (PLWMCC)
- Take a step-by-step approach to incorporating SMS strategies and tools into practice

Slide 2 Speaker Notes

This module of the MCC curriculum, “Self-Management Support” provides:

1. An overview of self-management support and its importance for healthcare professionals to help people manage their multiple chronic conditions and
2. A step by step approach to incorporating self-management strategies and tools into your practice.

Overview of Contents in this module

- Identifying the benefits of self-management support (SMS) for PLWMCC
- Incorporating SMS for PLWMCC into practice

Slide 3 Speaker Notes

The module introduces self-management support (SMS) as an effective mechanism for healthcare professionals to help people manage their multiple chronic conditions. The first section describes the benefits of self-management support. In the second section, strategies to help you incorporate SMS into your practice are identified. Links to useful resources that further support the identified strategies are also included.

Section 1

The Benefits of SMS for PLWMCC

Slide 4 Speaker Notes

This section defines self-management support (SMS), identifies key SMS competencies to care for persons living with multiple chronic conditions (PLWMCC) and presents the benefits of SMS with PLWMCC.

Self-Management Support (SMS)

Definition:

The systematic provision of education and supportive interventions to increase skills and confidence of PLWMCC in managing their health problems, including regular assessment of progress and problems, and problem-solving support.

Slide 5 Speaker Notes

Self-Management Support (SMS) is defined as: The systematic provision of education and supportive interventions to increase skills and confidence of persons living with MCC (PLWMCC) in managing their health problems, including regular assessment of progress and problems, and problem-solving support[1][2].

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[1] Corrigan, J. M., & Adams, K. (Eds.). (2003). *Priority Areas for National Action:: Transforming Health Care Quality.*: National Academies Press.

[2] Chassin, M. R., & Loeb, J. M. (2011). The ongoing quality improvement journey: next stop, high reliability. *Health Aff (Millwood), 30*(4), 559-568.

Self-Management

Definition:

The tasks that the individuals must undertake to live well with multiple chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their condition.

Slide 6 Speaker Notes

Self-Management is defined as: The tasks that the individuals must undertake to live well with multiple chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their condition[12].

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[1] Corrigan, J. M., & Adams, K. (Eds.). (2003). *Priority Areas for National Action: Transforming Health Care Quality.*: National Academies Press.

[2] Chassin, M. R., & Loeb, J. M. (2011). The ongoing quality improvement journey: next stop, high reliability. *Health Aff (Millwood), 30*(4), 559-568.

SMS Competencies

1. Support PLWMCC, their families and caregivers in setting goals, developing action plans, and continuously re-evaluating and revising them as needed.

2. Assist PLWMCC in identifying and evaluating information for appropriateness to inform their plans of care.

3. Assist PLWMCC to link to appropriate community-based resources to support healthy behaviors and learn self-management techniques.

Slide 7 Speaker Notes

The following six competencies of Self-Management Support are necessary to appropriately provide care to PLWMCC. The underlying concepts that support these competencies are discussed in greater detail in this presentation.

The competencies are:

SMS 1. Support PLWMCC, their families and caregivers in setting goals, developing action plans, and continuously re-evaluating and revising them as needed.

SMS 2. Assist PLWMCC in identifying and evaluating information for appropriateness to inform their plans of care.

SMS 3. Assist PLWMCC to link to appropriate community-based resources to support healthy behaviors and learn self-management techniques.

SMS Competencies (Continued)

4	Use skill building and problem-solving strategies to support PLWMCC, their families and caregivers in managing MCC by adopting and maintaining health self-management behaviors, and in overcoming barriers to quality of life preferences.
5	Discuss with PLWMCC, their families and caregivers how emotional responses to illness and mental health disorders may affect their ability to manage MCC.
6	Incorporate evidence-based behavior management strategies, such as peer leadership and coaching, to support PLWMCC engagement in managing MCC.

Slide 8 Speaker Notes

SMS 4. Use skill building and problem-solving strategies to support PLWMCC, their families and caregivers in managing MCC by adopting and maintaining health self-management behaviors, and in overcoming barriers to quality of life preferences.

SMS 5. Discuss with PLWMCC and their families and caregivers how emotional responses to illness and mental health disorders may affect their ability to manage MCC.

SMS 6. Incorporate evidence-based behavior management strategies, such as peer leadership and coaching, to support PLWMCC engagement in managing MCC.

The Importance of SMS for PLWMCC

99%

Is the amount of time PLWMCC spend outside of the healthcare system.

Assisting PLWMCC manage a variety of chronic diseases in the home or community setting

Supporting PLWMCC to develop the skills and confidence to manage their conditions, role, and emotional consequences of their conditions

Promoting self-care with PLWMCC in their day-to-day lives

Slide 9 Speaker Notes

PLWMCC spend 99% of their time outside the healthcare system. Self-Management Support (SMS) from healthcare professionals is central to optimal self-care in day-to-day life for PLWMCC[1]. Evidence-based self-management strategies are central to managing a variety of chronic diseases.

Here we are talking about self management and what PLWMCC does. PLWMCC are better able to address their unique needs when self-management tasks for coexisting and often interacting diseases are integrated into their daily lives[2]. One self-management education program was shown to improving medical, emotional and social pressures for PLWMCC[3].

For healthcare professionals, self-management support means:

1. Assisting PLWMCC to manage a variety of chronic diseases in their day-to-day lives in their home and community setting
2. Supporting PLWMCC to develop the skills and confidence to manage their conditions, role, and emotional consequences of their conditions
3. Promoting self-care with PLWMCC in their day-to-day lives by fostering decision-making, problem-solving, and action panning skills

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[1] Walters, J. A., Courtney-Pratt, H., Cameron-Tucker, H., Nelson, M., Robinson, A., Scott, J.,… & Wood-Baker, R. (2012). Engaging general practice nurses in chronic disease self-management support in Australia: insights from a controlled trial in chronic obstructive pulmonary disease. *Aust J Prim Health, 18*(1), 74-79.

[2] Bayliss, E. A., Ellis, J. L., & Steiner, J. F. (2007). Barriers to self-management and quality-of-life outcomes in seniors with multimorbidities. *Ann Fam Med, 5*(5), 395-402.

[3] Ory, M. G., Ahn, S., Jiang, L., Smith, M. L., Ritter,… & Lorig, K. (2013). Successes of a national study of the Chronic Disease Self-Management Program: meeting the triple aim of health care reform. *Med Care, 51*(11), 992-998.

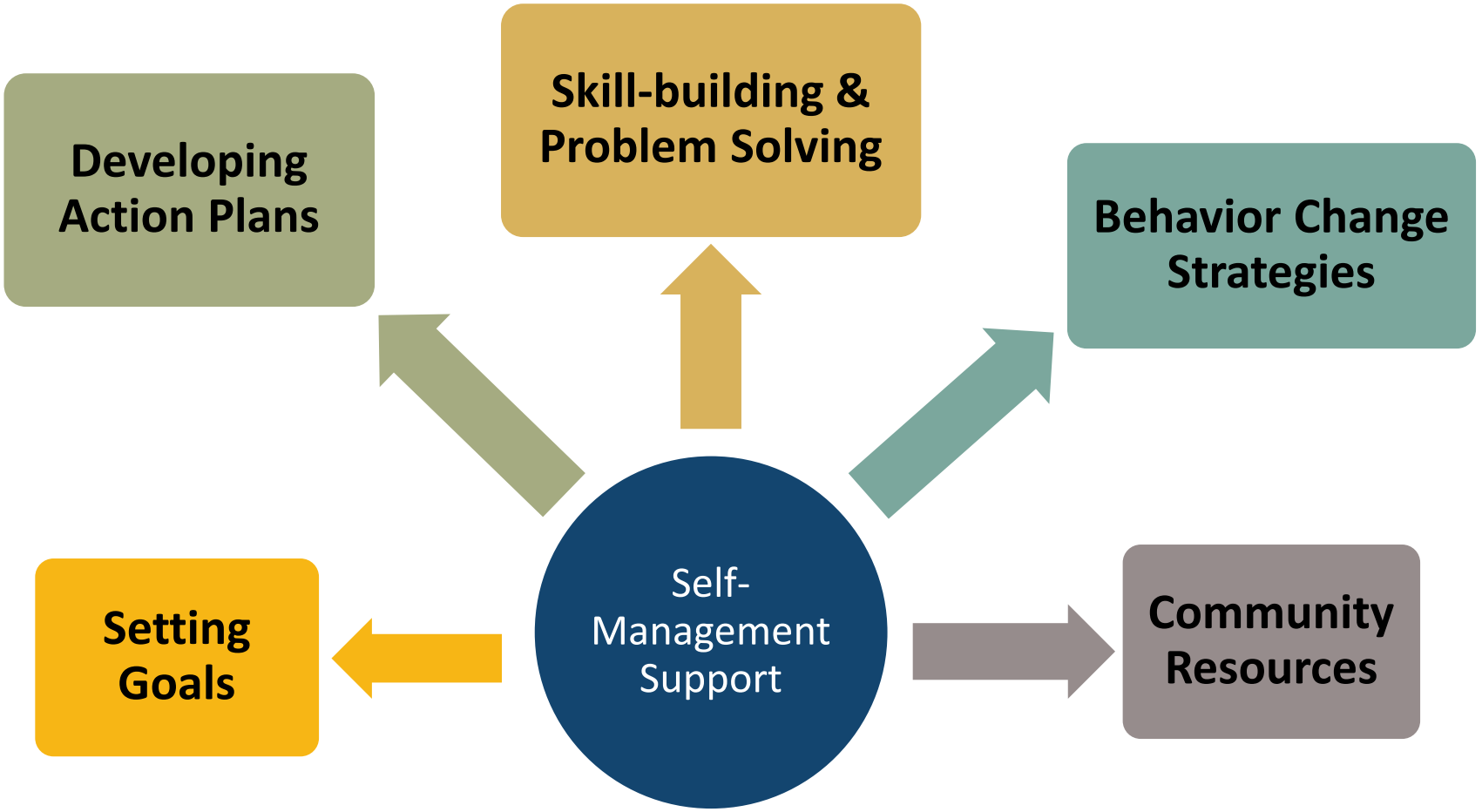
Section 2

Incorporating SMS for PLWMCC into Practice

Slide 10 Speaker Notes

In this section, key components of self-management support along with current evidence-based strategies are described that will enhance your practice.

Applying SMS in practice



Slide 11 Speaker Notes

Self-management support is addressed in the follow key areas of practice:

1. Setting goals
2. Developing action plans
3. Skill-building and problem solving
4. Behavior change strategies
5. Community resources

Let’s take a closer examination of each area and how SMS may have an impact.

Setting Goals

- Is a collaborative process between the health provider and PLWMCC with their caregivers in which health-related goals are determined.

- Requires ongoing follow-up by the interprofessional healthcare team with the PLWMCC to reevaluate and revise goals over time.

Slide 12 Speaker Notes

Collaboratively setting health improvement goals with PLWMCC and their caregivers is an important step in motivating healthy behaviors[1]. Clinicians elicit the PLWMCCs goals (what they would like to work on to improve their health) and together they assess feasibility. The clinician contributes their professional judgment and knowledge of treatment recommendations while the PLWMCC contributes their knowledge of their values and personal situation. The agreed upon goal is documented in the clinical chart to assist with follow up. An interprofessional healthcare team should follow-up with PLWMCC usually by phone, to continuously reevaluate and revise the goals of PWLMCC over time, as needed.

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[1] Schaefer, J., Miller, D., Goldstein, M., & Simmons, L. (2009). Partnering in self-management support: A toolkit for clinicians. Cambridge, MA: Institute for Healthcare Improvement.

Action Plans

Core Components

- Specificity
- Important to the individual (PLWMCC)
- Public disclosure
- Degree to which PLWMCC believe the plan was derived from free choice

Slide 13 Speaker Notes

Any member of the interprofessional team may work with PLWMCC to complete an action plan[1]. Within healthcare, an action plan is an agreement between the PLWMCC and clinicians on specific behavior changes the PLWMCC intends to make[2]. The purpose of an action plan is to increase self-efficacy through incremental successes and help the PLWMCC make small but meaningful behavior changes[3].

Action plans should include the following core components[2]:

- Specificity – It should be simple, very specific and short-term.
- Important to the individual (PLWMCC) – It should be small but meaningful behavior change that the person values.
- Public disclosure meaning the PLWMCC would articulate the plan in the healthcare interaction and to family/caregivers or friends.
- Degree to which the individual believes the plan was derived from free choice – It should be developed by the individual.

Action plans can increase patient activation or empowerment. By accomplishing small but meaningful behavioral changes long-term changes can be achieved.

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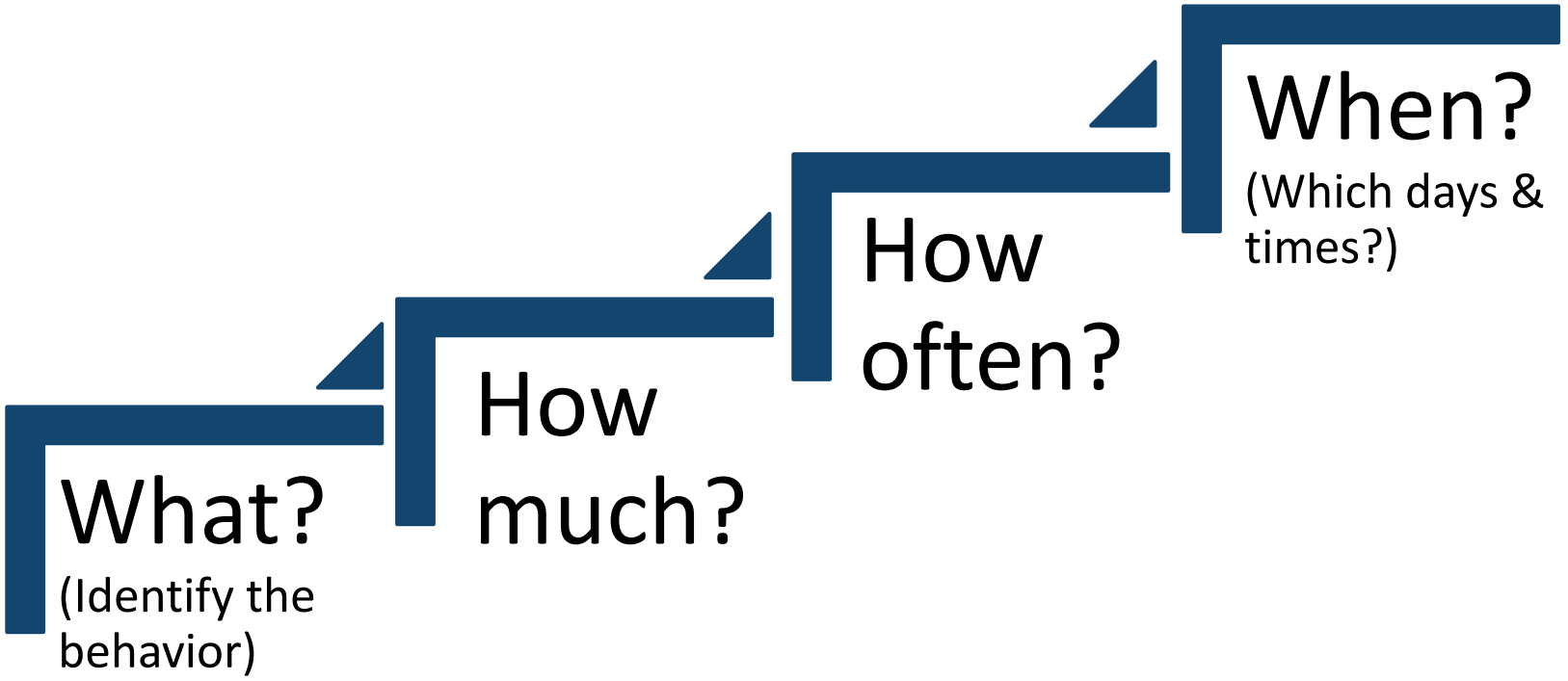
[1] Schaefer, J., Miller, D., Goldstein, M., & Simmons, L. (2009). Partnering in self-management support: A toolkit for clinicians. Cambridge, MA: Institute for Healthcare Improvement.

[2] Lorig, K., Laurent, D. D., Plant, K., Krishnan, E., & Ritter, P. L. (2014). The components of action planning and their associations with behavior and health outcomes. Chronic Illn, 10(1), 50-59.

[3] Bodenheimer, T. (2008). Training Curriculum for Health Coaches.

Action Plans: Key Questions to Answer



Slide 14 Speaker Notes

Action plans should answer the following questions:

- What (identify the behavior)?
- How much?
- How often?
- And usually when (which days and times)?

Skill-Building and Problem Solving: Strategies for PLWMCC

Education	• Provide information on their chronic conditions and treatment options in order to effectively self-manage their conditions.
Self-Care Routines	• Utilize organizational tools such as alarm reminders and online patient portals to assist in the management of self-care.
Support System	• Link with others for tangible assistance or emotional support.

Slide 15 Speaker Notes

The following skill-building and problem-solving strategies are for healthcare professionals to consider:

Education:

- PLWMCC should be provided information on their chronic conditions, treatment options and choices in order to effectively self-manage their conditions, in a manner they can understand and use.

Establishing Self-Care Routines[1]:

- PLWMCC can utilize organizational tools, such as alarm reminders and online patient portals to assist with the management of their multiple conditions as part of their daily routines.

Developing a Support System[1]:

- PLWMCC benefit from actively gaining support from others for tangible assistance or emotional support.

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[1] Ridgeway, J. L., Egginton, J. S., Tiedje, K., Linzer, M., Boehm, D.,… & Eton, D. T. (2014). Factors that lessen the burden of treatment in complex patients with chronic conditions: a qualitative study. *Patient Prefer Adherence, 8*, 339-351.

Behavior Change Strategies for PLWMCC

Peer Leadership

- Utilizes peer support workers as sources of support in the community who share personal experiences and/or similarities as PLWMCC.
- Offers PLWMCC additional support and efficient delivery of care.

Health Coaching

- Utilizes health coaches to help PLWMCC articulate their health goals, concerns, and challenges.
- Improves clinical outcomes and quality of life of PLWMCC by supporting them to improve/maintain their health goals.

Slide 16 Speaker Notes

Peer leadership and health coaching are two additional modes of supporting behavior change among PLWMCC.

Peer leadership utilizes "peer support workers" as sources of support, internal to a community, who share salient target population similarities (e.g. age, ethnicity, health concern, or stressor) and possess specific knowledge that is concrete, pragmatic and derived from personal experience rather than formal training[1]. Peer support workers can offer PLWMCC additional support and efficient delivery of care[2].

Health coaching is an emerging role in primary care teams. Coaching functions can be performed by any member of the healthcare team including physicians, nurse practitioners, physician assistants, pharmacists, health educators, nutritionists, or community health workers. Clinical health coaching has increased PLWMCC engagement and satisfaction as well as improved clinical outcomes for many innovative healthcare organizations across the country. Health coaching helps PLWMCC

- articulate their health goals, concerns, challenges,
- enhances their primary care experiences by supporting effective self-management behaviors and
- supports them in their efforts to take steps needed to improve or maintain their health and achieve their health goals.

To learn more about coaching techniques, review the following resources:

1. Clinical Health Coach. (2014). Clinical Health Coach Training Program, from http://clinicalhealthcoach.com/online-overview/.
2. California Healthcare Foundation. (2014). Video on Coaching Patients for Successful Self-Management, from http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=133717

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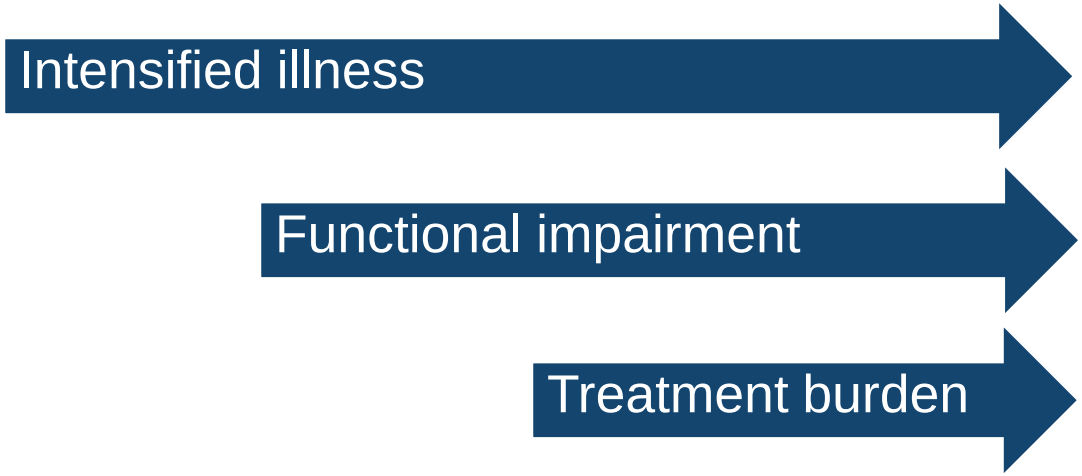
[1] Small, N., Blickem, C., Blakeman, T., Panagioti, M., Chew-Graham, C. A., & Bower, P. (2013). Telephone based self-management support by 'lay health workers' and 'peer support workers' to prevent and manage vascular diseases: a systematic review and meta-analysis. BMC Health Serv Res, 13, 533.

[2] Dale, J., Caramlau, I., Sturt, J., Friede, T., & Walker, R. (2009). Telephone peer-delivered intervention for diabetes motivation and support: the telecare exploratory RCT. Patient Educ Couns, 75(1), 91-98.

Barriers to Self-Management Support

These Top 3 Health Changes



Can lead to emotional distress:

- ✓ Anxiety
- ✓ Depression
- ✓ Loss of life roles
- ✓ Redefining new roles

Slide 17 Speaker Notes

PLWMCC may face intensified illness, functional impairment and treatment burden that can lead to emotional distress including depression, anxiety, and loss of life roles and redefining new ones[1]. These changes may negatively impact their self-management and decision making abilities.

Effective clinicians recognize that PLWMCC may focus on functional capacity, and acknowledge the everyday burden of illness and negative emotions (anger, fear, frustration) that accompany managing chronic diseases[2].

Motivation may be especially reduced when both mental and physical conditions are present. PLWMCC express frustration in dealing with multiple information sources, providers and medications, and have difficulty interacting with providers and systems[3]. It is important that self-management support addresses social and emotional issues along with educational and skill-building functions of PLWMCC[4].

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[1] Sevick, M. A., Trauth, J. M., Ling, B. S., Anderson, R. T., Piatt, G. A.,… & Goodman, R. M. (2007). Patients with Complex Chronic Diseases: perspectives on supporting self-management. J Gen Intern Med, 22 Suppl 3, 438-444.

[2] Schaefer, J., Miller, D., Goldstein, M., & Simmons, L. (2009). Partnering in self-management support: A toolkit for clinicians. Cambridge, MA: Institute for Healthcare Improvement.

[3] Corser, W., & Dontje, K. (2011). Self-management perspectives of heavily comorbid primary care adults. Prof Case Manag, 16(1), 6-15.

[4] Bodenheimer T, A., S. (2010). Helping Patients Help Themselves: How to Implement Self-Management Support. Oakland: California HealthCare Foundation.

Community Resources

PLWMCC may benefit from the following resources:

- Family and friends
- Peer support groups
- Self-Management support groups
- Self-Management education classes

Slide 18 Speaker Notes

In addition to support from their interprofessional care teams, PLWMCC may benefit from the following resources:

- Family and Friends;
- Peer support groups (via; in person, phone or email);
- Self-Management Support groups;
- PLWMCC Education Classes.

Delivering effective self-management support to PLWMCC with poor access to healthcare can be problematic because of geographical location, mobility issues, or competing demands on their time[1]. It is important to identify and address any of these barriers with PLWMCC when identifying self-management support groups and/or education classes.

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[1] Dale, J., Caramlau, I., Sturt, J., Friede, T., & Walker, R. (2009). Telephone peer-delivered intervention for diabetes motivation and support: the telecare exploratory RCT. Patient Educ Couns, 75(1), 91-98.

Community Resources

Connecting PLWMCC to community resources may increase their use of self-management support.

Helpful resources:

- National Association of Area Agencies on Aging Resources
  http://www.n4a.org/
- Eldercare Locator
  http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx
- Self-Management Education Programs Map
  http://www.ncoa.org/improve-health/center-for-healthy-aging/chronic-disease-1.html

Slide 19 Speaker Notes

Resources available to PLWMCC in community settings increase participation and satisfaction among PLWMCC[1]. However, connecting PLWMCC to community resources to enhance self-management support can be challenging for interprofessional teams.

Here are some helpful resources that can be used to identify community resources in your state.

- The National Association of Area Agencies on Aging offers many community resources throughout the United States. For example, Aging and Disability Resource Centers (ADRCs) serve as single points of entry into the long-term services and supports system for older adults, people with disabilities, caregivers, veterans and families.
- The U.S. Administration of Aging manages the Eldercare Locator that connects people to services for older adults and their families.
- The National Council on Aging's Chronic Disease Self-Management Education Programs Map lists self-management workshops offered in communities throughout the United States. http://www.ncoa.org/improve-health/center-for-healthy-aging/chronic-disease-1.html

[1] Schaefer, J., Miller, D., Goldstein, M., & Simmons, L. (2009). Partnering in self-management support: A toolkit for clinicians. Cambridge, MA: Institute for Healthcare Improvement.

Community Resources

Additional helpful resources:

- Stanford Patient Education Chronic Disease Self-Management Program (CDSMP)
  http://patienteducation.stanford.edu/programs/cdsmp.html
- Organizations Licensed to Offer Stanford's Self-Management Program
  http://patienteducation.stanford.edu/organ/cdsites.html

Slide 20 Speaker Notes

The Chronic Disease Self Management Program (CDSMP) is the most widely available self management program for persons living with MCC, and is available in communities throughout the United States and around the world. CDSMP was developed and tested at Stanford University. CDSMP is a standardized workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. http://patienteducation.stanford.edu/organ/cdsites.html.

If you are interested in learning more about the Chronic Disease Self-Management Program, its curriculum, or becoming a trainer, visit http://patienteducation.stanford.edu/programs/cdsmp.html.

SMS Resources

- Teaching Principles of Managing Chronic Illness Using a Longitudinal Standardized Patient Case
  www.mededportal.org/publication/7833

- HHS MCC Education and Training Repository
  http://www.hhs.gov/ash/initiatives/mcc/educationalresources

Slide 21 Speaker Notes

SMS Resources:

Teaching Principles of Managing Chronic Illness Using a Longitudinal Standardized Patient Case is a standardized patient vignette to expose first- and second-year medical students to caring for a patient with several chronic illnesses and a complex psychosocial situation. Other health professions might find it a useful tool for group discussions as well.

To find more MCC related education and training resources for health professionals, visit the MCC Education and Training Repository at http://www.hhs.gov/ash/initiatives/mcc/educationalresources.