HEALTH MANAGEMENT ASSOCIATES

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Self-Management Support and Patient Action Plan

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Self-management support is the assistance that clinicians give to patients with chronic diseases to encourage daily decision making that improves their health-related behaviors. It is an evidence-based approach that has been shown to increase patients' feelings of self-efficacy and to increase collaboration with healthcare providers in making decisions and developing shared care plans. The purpose of self-management support is to aid and inspire patients to become informed about their health conditions and develop the confidence they need in taking an active role in their management.

Self-management support is an important component of the chronic care model, an evidence-based framework for organizing and providing care for people with chronic disease. The model was initially created by the MacColl Center for Health Care Innovation at Group Health Research Institute, led by Dr Ed Wagner, and refined over time. It describes how the health care system can be optimized to promote safe, high quality care. Self-Management Support is depicted as a key strategy to empower and prepare patients to manage their health while the health system works to collaborate with the patient in goal setting, action planning, problem-solving, and follow-up. Effective implementation of this model results in "informed, activated patients" where patients manage their care on a daily basis, have supportive caregivers, and seek professional care to guide them through questions and challenges.

To begin self-management, patients are coached to understand their role as central to all health care decisions, the importance of their active participation. and how the practice plans to support them. Patient motivation is developed by showing them the connection between clinical care priorities and their desired level of functioning.

Self-management support requires that the patient identify target behaviors that they have the energy and resources to accomplish. With so many behaviors that may help improve their chronic condition, it can be overwhelming to choose just one to focus on. A bubble diagram may be helpful to elicit their most significant concerns. Once the target behavior has been identified, a patient action plan can be developed.

Patient Action Plans are patient-friendly self-management support tools that identify specific activities the patient agrees to do to help reach a goal. For example, if the healthy change desired is to lose weight, the goal could be to lose 4 pounds in the next month, and the behavior change might be to eat carrots for a snack instead of potato chips. The behaviors needed to achieve the healthy change goal are incorporated into an Action Plan. The best action plans are clear, simple, and concrete and very easy to understand and follow. Action plans address achievable goals that help the patient and providers know if the interventions are working and how to measure progress. SMART goals are often used to support effective goal setting. The acronym, SMART, stands for Specific, Measurable, Attainable, Realistic, and Time Limited. An example of a patient SMART GOALS is "I will take a walk for 30 minutes 3 days a week after work for 1 month." It is important to define the following elements as specifically as possible to create a supportive Action Plan:

- **Exactly what are you going to do?** How will you eat less, how far will you walk, what meditative technique will you practice?
- **How much will you do?** Will you walk 2 blocks walk for 20 minutes, not eat between meals for 2 days, practice yoga for 10 minutes?
- **When will you do this?** Will you do this before lunch, in the shower, when you arrive home from work?

- **How often will you do the activity?** Every other morning? Twice a week? It is important to begin with a frequency that is reasonable to start slow and build on successes to increase frequency.
- **Anticipate barriers**. Help the patient imagine what might get in the way of their plan.
- **Potential solutions for barriers**. Ask the patient for ideas that might help them overcome the barriers. What has been successful for them in the past?
- **Follow-up plan**. When, where and how you will check in with the patient about their experience.

Assess the patient's confidence in their ability to be successful using a confidence ruler rating scale. Patients indicate on a scale of 1-10, how confident they are, from no confidence that the plan can be completed to being absolutely certain that they can complete the plan. Action plans should start when the patient has a confidence level of 7 or greater. If less than 7, the plan should be revised to something more achievable.

Effective coaching is used in self-management support to:

- Encourage the patient to take an active role in achieving their goals at every step in the process.
- Anticipate when the patient may feel overwhelmed by the condition or barriers and help them overcome it.
- Guide being very realistic in terms of developing options and potential barriers they may encounter.
- Offer support tools, information, and encouragement for self-care activities.
- Promote patient problem-solving skills by asking questions rather than giving answers.
- Build motivation by highlighting successes and promoting belief in their own abilities, skills, and knowledge in order to be actively involved in their health.

When self-management support is effectively implemented, patients are well-informed and actively engaged in managing their care on a daily basis, supported by caregivers who understand their role guiding them through questions and challenges as they grow in their capability and confidence to manage their chronic illness.