Patient Engagement and Self-Management Support

Kelly Kruse Nelles MS RN APRN-BC
Lead Faculty

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KEYWORDS

- Patient Engagement
- Activation
- Compliance
- Adherence
- Partnership/Alliance
- Social Determinants of Health
- Social Needs
- Self-Management
- Self-Efficacy
- Self-Care

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Patient Engagement & Activation

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PATIENT ENGAGEMENT

"***Actions*** individuals must take to obtain the greatest benefit from the health care services available to them."

(Center for Advancing Health, 2010, p. 2).

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PATIENT ACTIVATION

"Individual's ***knowledge, skill, and confidence*** for managing their own health and health care."

(Hibbard, J.H. and Mahoney, E., 2010)

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What About Provider Activation?

- Requires Clinicians/Team to have the knowledge, skills and confidence to effectively manage engaged patients
- Higher levels of activation correlate with lower costs of care

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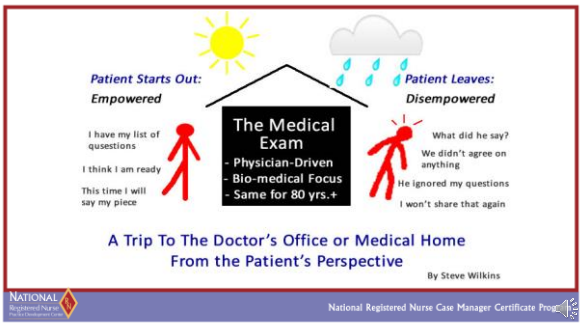

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RNCMs:

- Form relationships with patients and their identified caregiver that support continued patient engagement and activation in health and care
  - Emphasize the patient role in health and care
  - Assist with Goal Setting
  - Support Self-Management & Health Behavior Change

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Patients with chronic conditions are asked to manage complex treatment regimes often on their own with little or no support

High risk for failure

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Requires a Shift in Thinking & Language

- Compliance linked to coercion
- Adherence reflects conformity
- **Partnership** describes the alliance between the provider/team and the patient to support interactions of self-management

RNCMs practice in partnership with patients to support their success

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Patients Who Have Failed

- **AVOID Health Behavior LABELS**
  - Uncooperative
  - Noncompliant
  - Poorly controlled
  - Resistant
  - Irresponsible
  - Careless
- **ASSESS/CONSIDER**
  - Health Literacy
  - Psychological Factors
  - Social Support
  - Prior Health Behavior
  - Somatic Factors
  - Regimen Characteristics
  - Economic Factors
  - Cultural Factors
  - Patient Provider Interactions
  - ***Social Determinants of Health***

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Social Determinants of Health *(SDofH)*

"Conditions in which people are born, live, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks." (Healthy People 2020)

- Socioeconomic status
- Education
- Neighborhood and physical environment
- Employment
- Social support networks
- Healthcare

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Social Needs (NASEM, 2019)

"Individual level nonmedical acute resource needs related to SDoH such as housing, reliable transportation, strong support system at home, that must be met for individuals to achieve good health outcomes and for communities to achieve better health."

"Person centered concept that incorporates each person's perceptions of his or her own health-related needs, which therefore vary among individuals."

Unmet social needs describe factors that prevent people from experiencing positive health outcomes

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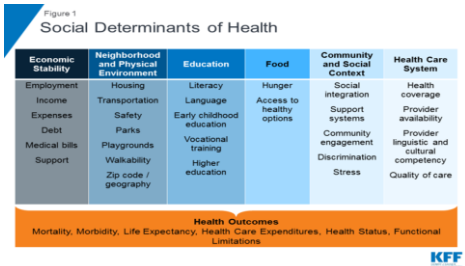

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Social Determinants Impact Everyone

- Not something an individual can have or not have
- Not positive or negative (although often portrayed negatively)
- In advancing health equity, it is important to remember that there are social factors that confer health benefits to certain populations and cause harm to others
  - Economic stability can confer health benefits while economic instability can create health risks and challenges

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Addressing SDoH and Social Need

Population Level = SDoH

Individual Level = Social Need

- Advances Health Equity
- Supports a high degree of patient engagement
- Higher activation in self-management of chronic conditions

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Strategies for Engaging Patients to Improve Health Outcomes

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Patient Engagement Strategies that Improve Health Outcomes

- **Involving Pts in Prioritizing Health Problems & Plan of Care**
  - Shared Decision Making
  - Advanced Care Planning
- **Empowerment**
  - Questions Are the Answer
  - Ask Me 3
  - Patient Education
  - Teach Back
- **Addressing Health Literacy**
  - First Language
  - Reading, Numeracy & Understanding
- **Effective Use of Technology**
  - mHealth
    - Reminders, prevention options
  - Secure messaging
    - Ask questions, make appointments, refill Rx
  - Patient Portal & Open Notes
    - Review medical records
    - Message healthcare team
    - Blue Button to share medical records
  - Telehealth
    - Virtual, RPM, telephone

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Patient and Family Advisory Council

- CMS ACO engagement requirement
- ACO beneficiaries – patients and families
- Provide insights to the ACO specific to the patient health care experience
  - Describe challenges
  - Collaborate to design initiatives to address
  - Provide feedback
- Goal: Improved patient experience

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Medicare Annual Wellness Visit

- Yearly preventive service
- Medicare Part B covered service
- Includes
  - Health Risk Assessments
  - Preventive Screenings
  - Review of current providers and medications
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

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Self-Management & Self-Management Support

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Self-Management - requires the patient to monitor and manage symptoms as well as "functional, emotional, psychosocial and physical" aspects of a chronic illness

Depends on the development of:

Self-efficacy – "one's own belief in their ability to perform specific self-care activities and produce a desired result

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Self-Management Support

"the help given to people with chronic conditions that enables them to manage their health on a day-to-day basis. Self-management support can help and inspire people to learn more about their conditions and to take an active role in their health care."

- Agency for Healthcare Research and Quality (AHRQ)

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Successful Chronic Disease Self-Management Support

- ***Focuses on illness needs***
  - Learning about the illness
  - Taking responsibility for meeting related health care needs
- ***Makes use of resources***
  - Health care, psychological, spiritual, social and environmental support
- ***Living with chronic illness***
  - Processing emotions
  - Adjusting to the illness and the "new normal"
  - Making practical lifestyle modifications
  - Striving for personal growth and satisfaction

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Patient Self-Efficacy Tasks of Chronic Illness

- To understand the physical illness and management of symptoms and pain
  - Patient education, tailored interventions and support
- To maintain roles and relationships
  - Caregiver involvement and support
- To carry out routine and self care activities
  - Quality of life
- To manage emotional changes
  - Adjust to the new normal

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Self-Management interventions are most successful when

- Patients participate in a collaborative process of care
- Both patient and the clinician share responsibility for outcomes and decision making

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Characteristics of Successful Collaborative Self-Management Support

- Care provided is patient-centered
- The whole care team supports
- Patient visits focus on prevention and care management
- Patients are involved in goal setting
- Education and skills training is tailored to the patient.
- Referrals include community-based resources that support self-management
- Regular follow up is in place with patients that supports self-care

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Groups that Support Self-Care

- Group Visits
- Shared Appointments
- Self-Management Support Groups

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Group Medical Visits or Shared Medical Appointments

- Combines medical care, patient education, and patient empowerment in a group setting
- Patients with a common chronic condition meet as a group under the guidance of one or more clinicians
- Groups of 10-16 patients
- Typically, visits are 90 minutes to 2 hours
- The goal: Identify patients who seem in need of more care, more advice on self-management, and more support

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Group Visits by Specific Chronic Condition

1. Patients are invited to meet as a group with the team
2. Prior to the visit, the team conducts chart review
3. As patients arrive, vital signs are obtained & pre-visit survey is completed
4. At the start of the group visit, the team leader explains the format of the group and obtains HIPAA consent
5. Medical review is integrated into the session either in the room or private space
6. Team members provide disease-related education and facilitate group discussion
7. If time, group relaxation or meditation exercise
8. Team leader facilitates post-visit documentation, triage, referrals and follow up

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- Barriers:
  - Privacy concerns
  - Resistance from patients who do not want to participate in a group
  - Practical issues like adequate meeting space and available personnel
- **Outcomes:**
  - Increased satisfaction with care
  - Lower healthcare costs
  - Fewer ER visits, subspecialists visits and calls to the physician
  - Nurse contact both by phone and face to face results in better outcomes

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Self-Management Support Groups

- Many different models
  - Education
  - Empowerment
  - Skill Acquisition
  - Modeling of Behaviors
  - Reinterpreting Symptoms
  - Peer Support
- Can be led/facilitated by professionals, trained lay persons, peers

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Nurse Led Groups (Education, Empowerment, Skill Acquisition)

- **The Community based RN Care Management Program for Older Adults** (Health Quality Partners)
- Part of Medicare Demonstration Projects
- RNCMs provide individual visits and facilitate groups focused on Advanced Preventive Care:
  - Physical activity
  - Weight management
  - Healthy eating
  - Social engagement
  - Home safety
  - Vaccinations

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Health Outcomes of HQP RN Care Management Program

- Reduced hospitalizations 24%
- Lowered hospital costs $255 per person per month
- Consistently higher ratings of satisfaction by patients

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Empowerment Groups

- **Diabetes Empowerment Education Program** (DEEP)
- Designed to enhance patient goal-setting, use problem solving, stress and coping skills, obtain social support, improve motivation
- Patients met once a week for 6 weeks with diabetes educator trained in an empowerment approach
  - Emphasis on whole patient
  - Patient generates options
  - Build on patient strengths
  - Failures are learning experiences

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DEEP Health Outcomes

- Reduced HbA1c
- Improved self-efficacy

- DEEP has been adapted by multiple state Departments of Health

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Skill Acquisition Groups

Chronic Disease Self-Management Program
(Lorig et al., Stanford)

- Initially based on the Arthritis Self-Help course
- Premises:
  - Patients, no mater what the condition, have similar needs
- Trained lay leaders:
  - Use a manual with mandated activities
  - Provide information
  - Support skill development
  - Improve self-management confidence of others

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- Participants receive 6 sessions, 2 1/2 hours each
- Trained Lay-leaders work in pairs from a script to provide:
  - mini lectures
  - run discussions
  - model new behaviors
  - provide gentle persuasion to help participants learn new things
- Addresses multiple conditions
- Includes planning and problem solving, skill acquisition, modeling behavior and information giving

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Chronic Disease Self-Management Program Health Outcomes:

- Improved health behaviors and health status
- Fewer hospitalizations some sustained for 2 years

- Now
  - Living Well with Chronic Conditions
    - Adapted by many public health departments across the U.S.

  - Better Choices, Better Health Online Program
    - National Council on Aging

BETTER CHOICES better health

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Reinterpreting Symptoms Groups

Open Airways for Schools
(American Lung Association)

AMERICAN LUNG ASSOCIATION. | OPEN AIRWAYS FOR SCHOOLS

- 6 sessions, 1 hour each
- Focuses on children ages 8 to 11
- School Nurses or Teachers deliver a set curriculum including pictures and worksheets
- Children go home and teach their parents what they have learned
- Program focuses on:
  - Information
  - Emotional support
  - Symptom monitoring
  - Problem solving
  - Physical activity planning

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Open Airways for Schools Health Outcomes

Children report:
- Reduced asthma episodes
- Decreased symptoms
- Improved self-efficacy

Program results:
- Fewer and less severe asthma flare-ups
- Improved academic performance
- Fewer urgent medical visits

- Recognized by the National Association of School Nurses, CDC, Environmental Protection Agency
- https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/health-professionals-educators/open-airways-for-schools

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Peer Support Groups

- Often used in relation to life events
  - Initially began and successful with life related events
    - i.e. grief/loss, pregnancy/newborn, etc.
  - Have expanded to include chronic illnesses
- Can occur in groups face to face and online
  - Offered in communities

- **Patients Like Me**
  - https://www.patientslikeme.com
  - Focus on the Shared Experience of Learning to Live with Chronic Illness
  - Uses Online Digital Platform

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Seven Essential Activities of Self-Management Support

1. Giving information
2. Teaching disease specific skills
3. Negotiating healthy behavior change
4. Providing training in problem-solving skills
5. Assisting with the emotional impact of having a chronic condition
6. Providing regular and sustained follow up
7. Encouraging active participation in the management of the disease

RNCMs provide leadership on the health care team by communicating & advocating patient engagement, activation and self-management support strategies that can improve health outcomes

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Next Steps

- Watch the videos that accompany this lecture
- Review the posted Resources. Download any you would like to keep.
- Complete the Practice Development Activity
- Take the Test Your Knowledge Self-Assessment Quiz.
- When you're ready move onto the next topic
- Questions? Let me know:
  - Kelly.kruse@nationalrn.com
  - (608) 437-6035 CST

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