Self Management Overview

What is self-management?

"People with chronic conditions having greater control in looking after themselves, with the support of their families (where desired) and in partnership with health professionals and community resources."

(National Health Committee, 2005)

To have greater control, people need:

- Self care skills
- Knowledge & understanding
- To know what their early warning signs are, action to take

'Give a man a fish and you feed him for a day, teach him to fish and you feed him for life.'

Self Management Support

- **Is what we, as clinicians and a health system** (along with whanau, community and peers) **do to support, encourage and enable** people to manage the often complex medical, psychological and emotional roles of living with a long-term illness/condition more effectively.

It is about person and whanau centred care

- **It requires:**
  - **Paradigm shift in control** – patient/client/whanau have **central role** in managing their health day to day, expert about their values, priorities, roles and preferences
  - **Multilevel system changes** to facilitate patient self-management
  - **Structured approach,** with a range of tools & resources to match stage of change, values & priorities of patient/family
  - **Collaboration** between patient and care provider,
  - **provider is a coach** as well as clinician and,

•Includes health literacy

•Builds on resilience & development of life skills

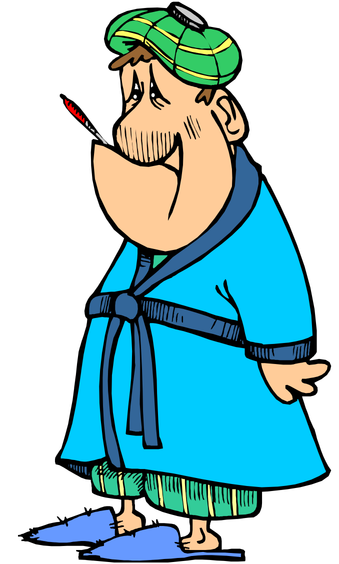
•Most needed for high needs populations

Successful self-management support

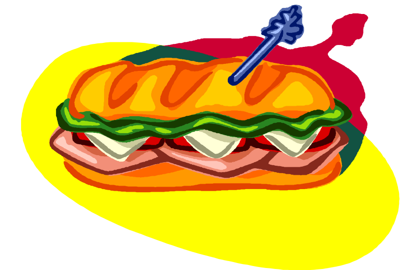
- **Assessment** of self-management (learn what the client knows, their actions, strengths & barriers)
- **Collaborative problem definition** (between client & their health practitioners)
- **Targeting, goal setting & planning** (target issues of greatest importance to client, set realistic goals & develop personalised care plan)
- **Self-management training & support services** (instruction on disease management, behavioural support, & address physical & emotional demands of chronic condition)
- **Active & sustained follow-up** (reliable follow-up leads to better outcomes).

Von Korff et al 1997; Lawn & Battersby 2009

Self-care is not optional



- Over 80% all medical symptoms self-diagnosed and self-treated (David Sobel, Kaiser Permanente)
- 99.9% of diabetes care decisions made independently of medical team (www.diabetes.org.nz/managing/)



Virtually everyone can be encouraged & supported to self care/manage some aspect of their health more successfully

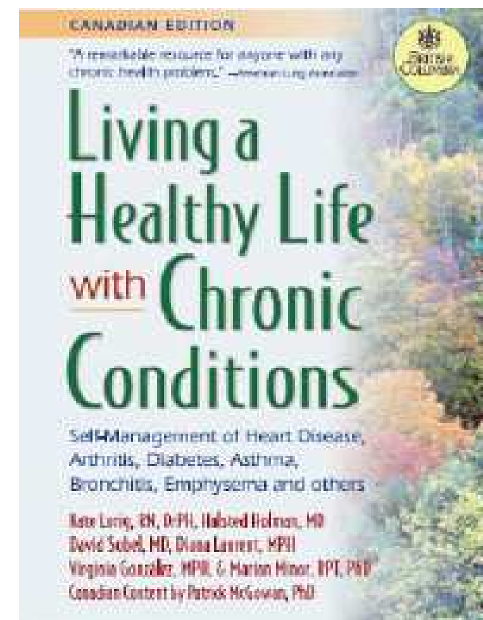
An Integrated Approach to Supporting Self-Care

The integrated resource for supporting self care

Supporting Self Care: A Practical Option UK Dept Health, 2005

Range of interventions

What do people learn in self-management programs?



Information

- From the program
- From other participants

Practical Skills

- Getting started skills (e.g., exercise)
- Problem-solving skills
- Communication skills
- Working with health care professionals
- Dealing with anger/fear/frustration

- Dealing with depression
- Dealing with fatigue
- Dealing with shortness of breath
- Evaluating treatment options

Cognitive Techniques

- Self-talk
- Relaxation techniques

Participants love it – often find it “life changing”

Key lessons learned from implementation programmes
Changing roles, behaviours and mindsets is vital, challenging, but not impossible
Train whole teams, not just individuals
Work with the voluntary and community sector
Engage health care professionals as change agents
Local context is a vital factor in implementation
Use a whole system approach to implementing change
Start with a change strategy that has clear goals, but be flexible on implementation
Consider sustainability from the outset
Design evaluation into change processes from the start
Tools alone are not enough
Offer people a range of support options
Recognise that people are different and tailor interventions appropriately

It's all about helping you to help yourself to help others

Your health is tapu - well done on taking steps to look after your health.

Our gift to you is to help you stay well, so that you can help to look after your family and community.

Day 1: visit doctor
Have a heart health check. Find out your risk of having a heart attack or stroke in the future.

Day 1: visit nurse
Explore what you can do to reduce your risk. Together make a plan to help you stay well.

2 weeks: phone call/text from nurse/community health worker See how you are going with your plan.

1 month: visit nurse/community health worker
Review your plan. Talk about progress, barriers and support.

2 months: phone call/text from nurse/community health worker
See how you are going.

3 months: visit nurse/community health worker
Have a repeat heart health check and review progress.

Build your support team

My support team

Who will help you achieve your goal? How will they help?

Name:

Helps by:

Name:

Helps by:

Name:

Helps by:

Family Work Whanau Community Hospital Friends Health Clinic

Name:

Helps by:

Name:

Helps by:

Name:

Helps by:

Name:

Helps by:

My progress

How will you track your progress? ✏

My follow up plan

By whom?

How?

When?

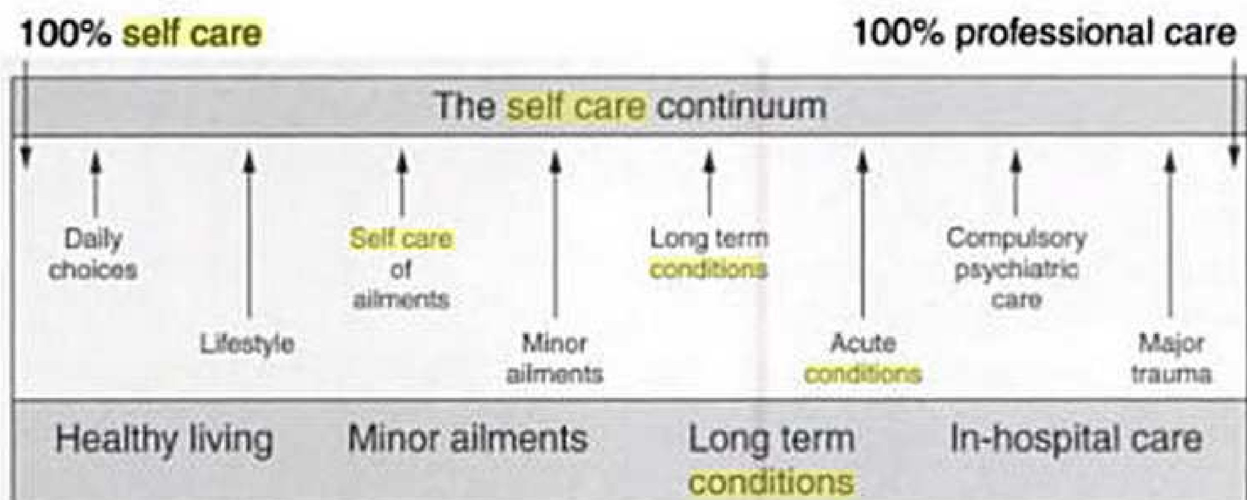


Figure 2.2: The self care continuum.

Components of self care

The aims of promoting self care among your patients or the local population are to encourage individual people to:

P: **P**revent the condition developing
A: **A**wait resolution of the symptoms
R: use self care skills for **R**elief of symptoms
T: learn to **T**olerate symptoms that do not resolve or cannot be reasonably alleviated.[1]

The size of each PART quadrant in Figure 2.4 will depend on the specific level and range of self care skills for a particular condition.

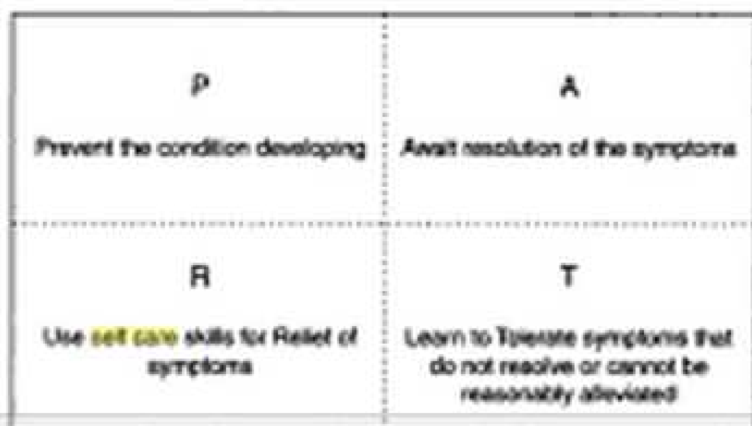


Figure 2.4: The PART model to illustrate pathways for self care.

Enhance the level of self care skills of individuals and self care support provided by the

involving patients in decision making. Examples are given in Box 5.9.

Box 5.9: 'Catchphrases' and open questions that health professionals might use to involve patients in decision making

Exploring patient expectations

'What do you want to get out of our appointment today?'

'What would you like to see happen here?'

Exploring patient ideas

'What are your thoughts as to what is going on here?'

'Do you have any ideas as to what this might be?'

Exploring patient concerns

'Is there anything else you would like to know about?'

'Is there anything in particular that worries you?'

'Have you had any bad experiences with this kind of thing in the past?'

Identifying options

'Have you thought about any alternatives?'

'There are several options here that we could try'

Determining patient preferences for information

'What do you know about it?'

'Would you like to know more?'

'What do you want to know about it?'

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Context - why is self management important and why now?

10 characteristics of high performing chronic care systems

1. **Universal coverage**
2. **Low cost or free care**
3. Focus on **prevention** of ill-health and not just the treatment of sickness
4. Priority is given to **self-management support** for patients to self manage their conditions with support from carers and families
5. Priority is given to **primary health care,** particularly **multi-disciplinary team work** in chronic care **led by nurses**
6. **Population management, risk stratification** by clinical risk and supporting them commensurately
7. **Integrated care** with **easy access to specialist advice** and support for primary care
8. **Information technology** is used to improve chronic care (e.g. to facilitate communication between different professionals and to enable people to be supported at home through telecare and telehealth)
9. **Care is effectively coordinated across health and social sector** and people given **own budgets** or allowed to make direct payments for services particularly for people with multiple conditions who are at greater risk of hospital admission
10. **Whole system approach**

Ham, C, 2010 as presented by Prof Nicholas May in Report To Treasury Jan 2013

Why is self care important?

When people self care, and are supported to do this, they are more likely to:

- ✔ experience better health and well-being
- ✔ reduce the perceived severity of their symptoms, including pain
- ✔ improve medicines compliance
- ✔ prevent the need for emergency health and social services
- ✔ prevent unnecessary hospital admissions
- ✔ have better planned and co-ordinated care
- ✔ remain in their own home
- ✔ have greater confidence and a sense of control
- ✔ have better mental health and less depression.

NHS – Supporting people with LTC to Self Care – Department of Health, UK.

- “Effective self-management support means more than telling patients what to do.
- It means acknowledging the **patients' central role** in their care, one that **fosters** a sense of responsibility for their own health.
- It includes the **use of proven programs** that provide basic information, emotional support, and strategies for living with chronic illness.
- Self-management support **can't begin and end with a class.**
- Using a **collaborative approach**, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.”

Source: http://www.improvingchroniccare.org/index.php?p=Self-Management_Support&s=22

Partnership

- What can we do (as health providers and a health system) to support, enable and facilitate this person and their family and whānau to manage more effectively, safely and appropriately at home?

RCT Results of Stanford Model, CDSMP

Compared health behaviors, health status, and health services use in patients age 40 to 90 years.

After 1 & 2 years:

- Significant improvements in energy, health status, social and role activities, and self-efficacy
- Less fatigue or health distress
- Fewer visits to ED or afterhours
- No decline in activity or role functions

(Lorig et al, 2001, n = 952)

Worldwide: Used in >22 countries,

Format: 2.5 hours, weekly for 6 weeks

Principles of self-management

1. **K**now your condition
2. Be actively **I**nvolved with the health practitioners to make decisions & navigate the system
3. Follow the **C**are plan that is agreed upon with the GP & other health practitioners
4. **M**onitor symptoms associated with the condition(s) & **R**espond to, manage & cope with the symptoms
5. Manage the physical, emotional & social **I**mpact of the condition(s) on your life
6. Live a health **L**ifestyle
7. Readily access **S**upport services.

Battersby, Flinders Programme 2013

Provide Skills Training – Self-Management Education

- Skills based rather than disease information
- Systematic reviews shown disease education doesn't lead to improved health outcomes whereas self management education does.

Self-management programmes

- Stanford Model – generic SME – RCT studies sustained benefit
- Diabetes SME
- Pulmonary Rehab
- Cardiac Rehab

- Auckland: English, Te Reo, Hindi, Samoan
- Refer all: ARI patients, sickness benefit clients, long-term ACC, elderly, carers, **O/P clinics, especially rheumatology, heart failure, respiratory and orthopaedic clinics or** waiting lists

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