CPC+ FAQ Sheet

Name: Self-Management Support

Date: August 4, 2017

Link to Recording

What?

- Supporting patients in managing chronic conditions
  - Self-management tasks individuals take to live well
  - Self-management, support-providing education and support intervention in managing patient problems
  - Shared decision-making – Patient values guide all clinical decision
  - Effective goal setting – Choosing goals the patient wants (ex. Being able to play with their kids without getting short of breath)
  - Smart goals – Specific, measurable, attainable, relevant and timely
  - Action plans – The framework for the patient when they are out of the office

Remember: Patients only spend between 4 and 12 hours with their provider all year. Care teams need to focus on bridging the gap between the treatment plan and the patient's home life.

How?

- Choose a patient engagement tool
  - Patient activation measure – These are available through multiple vendors online
  - Adverse childhood experiences survey (ACES)
  - Agenda-setting tools
  - Rescue pack – This is an example of patient instructions an Arkansas clinic developed to support patients in self-management support
- Use effective goal setting to create goals that are meaningful to the patient (playing with their kids will always be a better goal than an A1C of 7)
- Follow up with patients frequently to follow up on action plans

When?

Before the visit (MA, nurse, support staff)

- Gather clinical information
  - Screenings, labs, specialist reports
- Gather patient experience information
  - Symptom monitoring, medication adherence, life stressors, depression screenings, etc.
  - Prepare visit tools – Questionnaires, screening tools, etc.

During the visit (MD, NP, RN, LPN)

- Front desk
  - Provide assessment tools and ease the patient in to the visit by being patient-centered and focused on their needs
- Provider
  - Collaborate with the patient on the agenda
  - Review together clinical and patient information
  - Collaboratively set self-management goals
- Nurse/MA/Behaviorist
  - Additional coaching or support
  - Create an action plan
  - Provide education
  - Schedule a follow-up

After the Visit

- Proactive follow-up – **Communicate when this will happen to the patient**
- Support the patient if he/she was referred to a specialist
- Connect the patient to community resources

Small or rural practice tip:

Practice tip: Remember not all patients will want to take part in self-management. Work with the patients who are interested, but always make sure every patient with chronic conditions knows it's an option.

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