BC Renal Agency

An agency of the Provincial Health Services Authority

Self-management and Self-management Support

Design Template and Discussion Document

Dr. Chris Rauscher

Commissioned by
Kidney Summit
Core Group
BC Renal Agency

Final
February, 2007

Preface

This discussion paper has been some months in preparation which reflects my evolving understanding of what a practical approach to self-management support could be. I wish to acknowledge the people who have helped me with this evolving understanding.

First and foremost are the patients who allow me to visit them in their homes where they are often struggling to maintain their dignity and independence in the face of declining health. They continually show me their graciousness and hope which I incorporate into my work with them, their network of support and their health care providers.

Connie Sixta, an internationally recognized expert in self-management and self-management support who is close to finishing her Doctorate of Nursing with a focus on self-management, has been my friend and mentor as we, in BC, have gone through our quality improvement journey. Connie has reviewed the drafts and has graciously allowed me to align this discussion paper with her work that she is doing with the BC College of Family Practice Self-management Program.

In BC, we are fortunate to have people who are committed to improving the system of care. The following people have reviewed drafts of this discussion paper: Connie Davis, Geriatric Clinical Program Development Specialist, Abbotsford and Mission, Fraser Health Authority; Sylvia Robinson, Director, Primary Health Care, Medical Services Division, Ministry of Health; Dr. Alan Best, Senior Scientist, Centre Clinical Epidemiology and Evaluation, Vancouver Coastal Health Research Institute.

I have been well supported by the Kidney Summit Self-management Support Working group who have tirelessly reviewed the drafts and engaged in discussions which have increased all our understanding of this very important area. Many thanks to them.

It is my hope that this discussion paper will provide the basis for improvements at multiple levels in providing self-management support, particularly for health care providers who are working directly with patients day to day. This discussion paper will be promoted through the BC Academic Health Council, the VCH Self-management Support Curriculum Development Initiative, through the Kidney Summit Initiative and its members and through

the implementation of the MOH Primary Health Care Charter. It will be made freely available through the website of the BC Renal Agency and can be posted on other websites and freely circulated with my permission.

It is my hope that engaging in effective self-management support will provide us the satisfaction of achieving our primary goal as health providers—helping people to stay as healthy as they would like to be and to lead fulfilling lives.

Dr. Chris Rauscher
Physician Lead, Chronic Disease Management,
Vancouver Coastal Health and, Medical Consultant,
Primary Health Care, Medical Services Division, BC Ministry of Health

Self-management and Self-management Support Project Team

Helen Roberts, *Project Facilitator*
Bev Holmes, *Communications Support*
Christopher Finlay, *Research*

Committee Members

Angela Micco, *Project Manager, MoH*
Diane Ollinger, *Account Manager Disease Management, Baxter*
Diane Shendruk, *Acting Manager of Nursing for Chronic Kidney Disease, Saskatoon Health Region*
Fran Hensen, *IHA*
Jim Dunsmore, *Patient*
Karen Mahoney, *FHA*
Linda Church, *Renal Social Worker, Kidney Care Clinic*
Lisa Hutcheon, *Manager, Patient Programs, Heart and Stroke Foundation of BC & Yukon*
Lydia Drasic, *PHSA*
Maggie Aronoff, *Regional Coordinator, Integrated Self-management Support, Primary Care and Chronic Disease Management*
Maylene Fong, *Clinical Nurse Specialist, Chronic Disease Management, VCHA*
Patricia LaCroix, *Clinical Resource Nurse, Renal Unit VGH*
Patrick McGowan
Sharon Farrish, *Director of Programs, Kidney Foundation*
Sharon Read, *VIHA*
Sherri Kensall, *Renal Care Coordinator, FHA*
Victoria Stewart, *NHA*
Ileana Ciurea, *Chief Medical Officer, Canadian MedicAlert Foundation*
George Eisler, *Chief Medical Officer, BC Academic Health Council*
Claire Skjelvik, *Social Worker – Renal Program, Vancouver General Hospital*

Project Advisor/Resources

Claire Lightfoot, *Outpatient Dietitian, Diabetes Educator, VIHA* (at a later stage)

Project Material Review

Alice Gelpke, *Area Director, VIHA*
Claire Lightfoot, *Outpatient Dietitian, Diabetes Educator, VIHA*

Table of Contents

Section I
Purpose

This document is developed to provide a clearer "picture" of how self-management and self-management support fits into the practice of healthcare providers for chronic disease management. It was developed in response to a perceived lack of clarity as to how to understand and approach self-management support in the clinical context. The generation of this document was commissioned by the Kidney Summit Core Group and the associated working group examining self-management support that providers could deliver to people living with a combination of chronic kidney disease, diabetes and cardiac disease. Although the information and approaches outlined in this document are directed at people living with chronic conditions, it can generally be applied to supporting people at any stage of the health trajectory. This document could be partnered with the report on self-management support commissioned by Dr. Rauscher through the VCH Research Institute and prepared by Dr. Alan Best and his group (see reference 6).

Section II
Definitions

For the work that the kidney self-management working group is doing to understanding self-management support in relation to provider practice, we have adopted the following definitions proposed by Dr. Patrick McGowan in the paper that he prepared for delegates to the "New Perspectives: International Conference on Patient Self-management." Patrick acknowledged that there are many ways that people view self-management and self-management support depending on the context and with no gold standard, he proposed definitions that he felt were most helpful for the conference:

Self-management

Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management.

Self-management Support

Self-management support is defined as the systematic provision of education and supportive interventions by healthcare staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

Section III
Principles

1. For people living with a long term condition, self-management can become a more fundamental part of their everyday lives, to ensure independence, self-worth, and the ability to lead as near a normal life as possible.

2. The person is at the centre of the self-management process making the choices, decisions and taking the actions themselves. For the person, self-management most likely means change for themselves and sometimes for people around them, which may not be easy to achieve. In health care, fostering change has traditionally been seen as an external process, an "outside" view of behavior change, where providers "educate," "try to fix," advise what to do, cajole and sometimes threaten the patients with negative consequences. Self-management support that works is based upon change that is internal to the person, an "internally motivated person," with principles of belief that people change when it is *their decision* to change, when they have confidence (self-efficacy) that they can change, and where change involves the support people being part of the change journey. Developing confidence and self-efficacy is fundamental and can best be achieved through small incremental steps towards an achievable goal.

3. Self-management is an under-utilized resource as people with long term conditions are experts in themselves and how their condition affects them and their lives. Self-management support is not just about a change in service provision, but about a cultural and attitudinal change, supporting people to be partners in their own care and supporting them to decide what support they need, when they need it and how. It is important to recognize that not all people may want to have the responsibility for self-management or will be ready to actively self-manage when this is first proposed by others and they may require considerable support. Health literacy considerations are also very important. The person is supported through their personal network of support and within the wider community that they live as well as through partnerships with their healthcare providers. Providers need to be supported to develop the competencies to provide self-management support and to have options for self-management support available to match the needs of the patients.

Section IV
Providing SM Support: The Overall Goal

From the provider perspective, the overall goal of providing self-management support could be stated as 'providing self-management support for people living with chronic disease so that they can live a healthy and fulfilling life as defined by the person.' There needs to be a collaboration around setting self-management goals between people living with chronic disease and health providers that supports the preferences of the person while improving the health for the individual and the population.

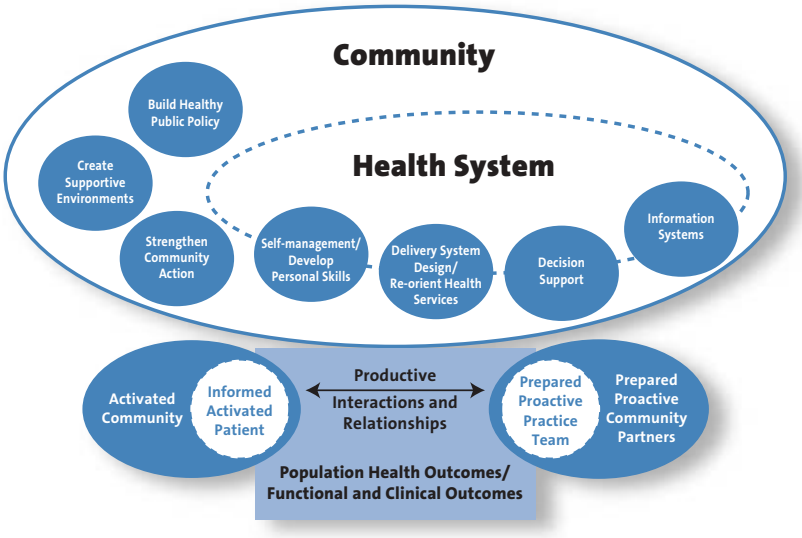
Benefits for people—they are more likely to:

- Experience better health and well-being
- Reduce the perceived severity of their symptoms, including pain
- Improve medication management, including decreased expenditures
- Reduce the need for health services: emergency care (up to 50%), unplanned hospital admissions, GP visits (up to 40%)
- Have better planned and coordinated care
- Remain in their home
- Have greater confidence and a sense of control
- Have better mental health and less depression

Section V
The Practice Model: The Expanded Chronic Care Model

The "Expanded Chronic Care Model," now called the "Care Model," has been adopted in BC as the practice model to support chronic disease management and prevention. This document will start the design from the perspective of the Care Model and break out, more specifically, the elements of *self-management* and *self-management support*.

The Expanded Chronic Care Model: Integrating Population Health Promotion



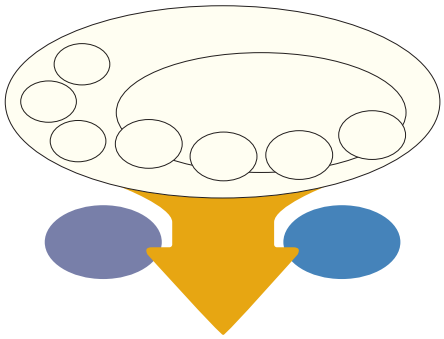
Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002). Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly,* 79,(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

Care Model

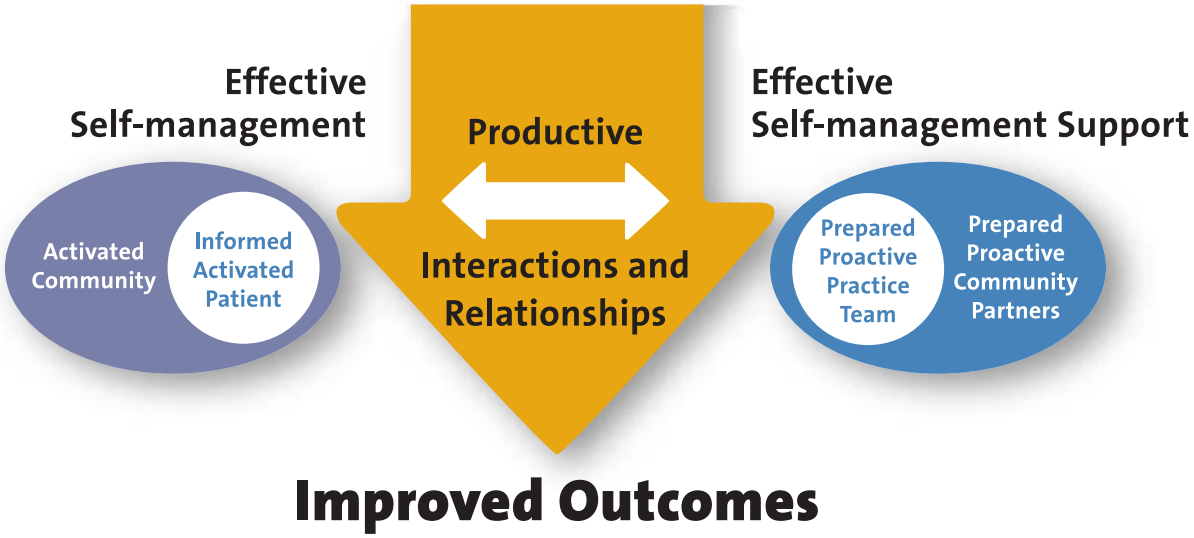
Kidney Summit Core Group, BC Renal Agency

Section VI
Focus on Outcomes

Care Model and Collaborative Self-management Support



The overall goal of providing self-management support should be on improving "outcomes" as defined by the person within their context and network of support. The initial goal chosen by the person may not directly relate to a medical condition of concern to the provider: *eg* a woman living with diabetes may need to be supported to address her concerns around an issue of family dynamics (marital strife) or health of another family member, before she can participate in self-management of her diabetes. However, experience has shown that, over time, the persons' ability to self-manage their own health conditions will improve once their life situation improves overall. The provider needs to be supportive of whatever goal is chosen and may need to arrange support for issues that are not within their own area of expertise while the provider continues to provide medical support. The system needs to support the provider in this person-centered approach.



Section VII

Activated Person/Patient in the Activated Community

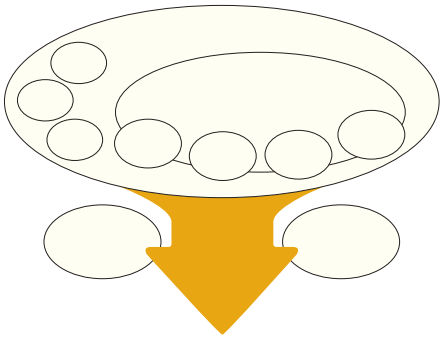
The people manage their long term conditions in the context of their every-day lives. Some people may not be ready to engage in self-management when this is first discussed with them and the concept can be reintroduced in a supportive way through further encounters. People need to develop the self-efficacy and confidence that they can balance the management of their medical conditions, maintaining a stable emotional state while functioning in their roles. When difficulties occur that upset this balance, these can occur in any or all of the areas of medical, emotional and role management and the person may need support from others in their network of support, from the wider "activated" community and from providers. Providers will need the competencies and support to work in this broader context of person, the person's network of support and the wider "activated" community.

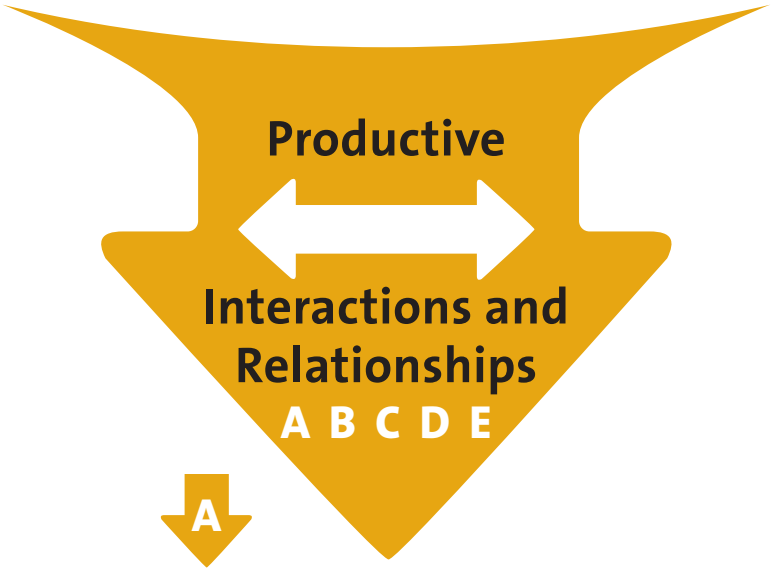
Section VIII

The Prepared, Proactive Practice Team in the Prepared, Proactive Community

Medical management goes hand-in-hand with providing self-management support. Providers need to have the competencies to provide both medical management and self-management support in a related way. For example, to support a person living with heart failure, the provider needs to be able to assess and monitor the heart failure by following the patient's weight and needs to partner with the patient on understanding why it is important to do daily weights and how to respond to an increase in weight.

Section IX
Productive Interactions and Relationships





A

Focus on productive interactions and relationships

B

The Approach

- Based on the 5 A's
- The 3 Questions is an alternative
- Tools to support assess: Flinders, PAM

C

Strategies to support the approach

- Motivational interviewing
- Mastery learning
- Problem-solving
- Readiness to change
- Ask-tell-ask
- Closing the loop

D

Techniques to carry out SM support

- 1-1 interaction
- Group interaction
- Computer-assisted training

E

Capturing and monitoring the goal(s) set

- Healthy changes plan
- Personal health record

Productive Interactions and Relationships

There are many potential strategies, tools, and techniques that have been suggested for providing self-management support. This can be confusing so this document organizes the provision of self-management support in a logical manner. However, it is important to remember that whatever the approach used, it is following the principles that will achieve the desired results whereby it is not the health professional providing the direction but it is the people who decide that they want to change and are confident enough to change.

Overall, it is important to keep things as simple as possible by focusing on the pivotal elements: supporting the person to problem-solve, set a goal and develop and carry out an action plan. Everything else is done in support of these elements.

A. Focus on Productive Interactions and Relationships

The provision of healthcare and support involves interactions that will produce the desirable relationship. For self-management support, the relationship is that of a partnership between the person (and their network of support) with their expertise in what is important in their life and how best to maintain their health and manage their health conditions and the providers with their expertise in disease management and in providing self-management support. This relationship is potentially augmented and supported through the "activated community" and the "prepared community partners."

Each person is different and may be at different stages in their willingness and capability to self-manage and although the aim for the interaction for self-management would be to have the interaction patient-directed, in the early stages the interaction may be "guided" or even somewhat "directed" by the provider. However, the relationship is still the same, a partnership relationship, and the productive interactions need to be supported by the culture of the organization and the attitudes and values of all involved and approached with "humility, graciousness and hope."

The Approach
- Based on the 5 A's
- The 3 Questions is an alternative
- Tools to support assess: Flinders, PAM

B. The Approach

There needs to be a basic approach that captures the pivotal elements of problem-identification, setting a goal, developing an action plan with a confidence level, reporting back on the action plan and problem-solving to move forward (all these elements together are called mastery learning). This triad of goal setting, action planning, and problem solving are viewed as the most important elements for improving health-related behaviors and clinical outcomes, when combined with follow-up. (Bodenheimer and Grumbach, 2007). From the literature and experience in other jurisdictions and from evolving experience in BC, the basic, brief intervention tool called the "5A's" appears to capture these pivotal elements in the most practical and effective way.

It is recommended that the 5As approach be the basic approach adopted in BC for provider self-management support.

Although developed to support smoking cessation (initially as "4A's": ask, advise, assist, arrange, then agree was added) the 5As approach was adapted for self-management support by Glasgow et al (2002) as: 1) **Assess** (assessing patient beliefs, behaviors and knowledge); 2) **Advise** (education about the disease; 3) **Agree** (goal setting); 4) **Assist** (help with problem solving); and 5) **Arrange** (follow-up evaluation). This 5 As approach, adapted by Glasgow et al, has been used in a number of studies that have examined the efficacy of self-management support in improving health outcomes, particularly in people living with diabetes. This is presented diagrammatically in *Appendix 1* and discussed further in *Appendix 5* with the SM support scenarios. In *Appendix 2,* the 5As approach is related to evidence-based principles for providing self-management support as viewed by Connie Davis and the group in Seattle, Washington who developed the US Chronic Care Model.

In BC, Connie Sixta, an internationally recognized expert in self-management and self-management support, working with the BC College of Family Physicians has developed a curriculum with a study manual supporting patient self-management. This curriculum is an adaptation of the pivotal research-based work on self-management of Dr. Kate Lorig from Stanford University and follows the 5As approach adapted by Glasgow et al. The approach is captured in a "Personal Action Plan" when working with the patient on setting a self-management goal (see *Appendix 3*). A pilot study was done in Dec. 2004 that demonstrated that this self-management approach can

be incorporated into the usual practice of a busy GP office and support setting patient-centered self-management goals. A second-phase roll-out of the approach is currently underway involving GPs, their office staff and Health Authority staff across BC. A train-the-trainer approach is being carried out to support further spread of the approach. There is therefore, the opportunity for each Health Authority and other health care agencies to spread this approach in support of people that are living with chronic disease. The approach with the 5As is further elucidated in *Appendix 5* (scenarios) based largely on the BC College of Family Physicians study manual.

The Primary Health Care/Chronic Disease Management group in the Northern Health Authority has gained experience with self-management support through their quality improvement Collaboratives and they realized that it was important to get the culture shift from the current directive approach with the agenda set by change the provider to the person-centered approach supporting the person to develop the skills and confidence for change. They were concerned that providers were using the "advise" step in Glasgow's adapted approach to still direct the change agenda even while being trained on the 5As approach overall. Therefore, they have removed the advise step and are following the 5As from the smoking literature: ask (what concerns you?), agree (agree to talk about the person's concerns about their health), assess (readiness to change), assist (in problem solving what might help, setting a goal), and arrange (support, follow-up). They have developed these 5As into a wheel (as the 5As don't necessarily need to be followed as consecutive steps, depending on where the person is at) and they have scripted their approach plus developed an assist menu for options of strategies that may help people decide what goal they might set *(see Appendix 6)*. This NHA approach to the 5As has created some concern as it moves away from the Glasgow 5As approach which is recognized for use in healthcare in the US and is being introduced into BC through the BC College of Family Physicians program. This has generated discussion amongst the experts and more experienced providers in BC as to the utility of adaptations of the 5As approach and this discussion will continue as we gain more experience in BC. It is recognized that we are all working from the overall goal for self-management support as expressed earlier in this discussion paper: 'providing self-management support for people living with chronic disease so that they can live a healthy and fulfilling life as defined by the person.'

The 5As approach has also been used for interpersonal communication and as an approach to enhancing a culture of change for self-management support in the Northern Health Authority (personal communication from Marvin Barg, Alice Domes and Victoria Stewart). The self-management support trainers in the NHA use the 5As approach to help staff set goals around how they would want to learn about and get engaged in providing self-management support for their patients (*ie* fostering behavior change in the staff on how they provide self-management support). This is a novel approach but shows the adaptability of this approach in supporting behavior change through a person-centered approach. The Northern Health Authority is also developing a computer-assisted 5As approach to self-management support. Also, please see *Appendix 3* for a sample action plan.

A much briefer "3 Questions" approach has also been used in the primary care physician office which when combined with the personal action plan and then with follow-up evaluation, appears to capture the pivotal elements of the 5As. The 3 questions are:

The Three Questions

What worries you the most about your condition?

What would you most like to change?

How do you think you might do that?

There are a number of tools proposed for use to support self-management support. The two main tools that have been considered for use in BC have been the Flinders suite of tools from Australia and the Patient Activation Measure from the US illustrated in *Appendix 4*. These tools could prove useful but may have some limitations:

1. They ask scripted questions focusing mostly on identifying issues that are in the medical context and may miss broader issues that a person may wish to/need to deal with first.
2. The Flinders suite of tools is quite extensive and may be time intensive (although they were developed for and tested in GP office settings supported by advanced practice nurses).
3. The Patient Activation Measure needs to have the action plan process added to it.

More experience with these tools is needed in BC before recommendations can be made about their utility.

Strategies to support the approach
- Motivational interviewing
- Mastery learning
- Problem-solving
- Readiness to change
- Ask-tell-ask
- Closing the loop

C. Strategies to Support the Approach

You may want to incorporate (some of) the strategies listed in the diagram to support the approach. These strategies support but do not replace the approach using the 5A's or the 3 Questions and all these strategies can be built in to 5A's approach. Mastery learning is the basic and fundamental strategy supporting the approach and goes through the steps of goal setting, action plan development, setting a confidence level, and reporting back and problem solving: *ie* the pivotal elements. Problem-solving to identify issues important to the person and set goals and then to work on reducing the barriers is also fundamental and tied to learning to master making changes. Motivation has been shown to be fundamental to achieving and sustaining change and relates to readiness to change, *ie* confidence. Imparting information to support informed decision-making is also important supported by the ask-tell-ask and the closing the loop strategies. These strategies are all part of clinical professional practice for which competencies can be further refined.

See the scenarios in *Appendix 5* that illustrate the use of the approach and these strategies.

Techniques to carry out SM support
- 1-1 interaction
- Group interaction
- Computer-assisted training

D. Techniques to Carry Out SM Support

There are three main techniques used to deliver the approach: one-to-one interaction, group interaction and computer-assisted training, and they may be used in combination The one-to-one clinical interaction is the usual technique in practice through which self-management support can be provided. This is particularly important early in the provision of self-management support, especially with the person who may require more support. Specific visits to provide self-management support are generally more effective than taking time out from a short clinical interaction but monitoring the action plan can be achieved during the course of a usual visit. That being said, provision of self-management support through group interactions has been demonstrated to achieve the same or better outcomes as the group process can be very supportive to the person who is trying to make changes that can be positive for their health. Internet-based computer training has been shown to improve clinical outcomes, although experience is limited in BC. A combination of these techniques can work to support the ongoing achievement of the desired goals/ outcomes.

A complimentary option for self-management support is the standardized group process delivered by the Chronic Disease Self-management Program (the Stanford model) developed by Dr. Kate Lorig and lead in BC by Dr. Patrick McGowan. This is a well established and researched program that captures all the pivotal elements of self-management support including goal setting, action planning (with the confidence and importance models), problem solving and follow-up. It is a lay-led program delivered by people living with chronic disease to people living with chronic disease as a generic scripted curriculum (not focused on a particular condition, in general) and delivered over a six week period. Much of the research on the benefits of self-management are based upon the CDSMP. The population that attends this course offering tends to be people who are somewhat more motivated, not having a high burden of chronic conditions and able and willing to go out of the home to attend these sessions. There is a preponderance of women. However, for people who are less motivated to engage in self-management or are at earlier stages, they may wish to attend the CDSMP once they gain greater mastery of their self-management so this program should always be considered as another self-management support option. As experience has increased with the CDSMP, courses have been delivered to more complex populations, such as aboriginal populations, with adequate support that may come from within a community, and in BC, this innovative work has been led by Dr. Patrick McGowan. The CDSMP is an important option in a menu of self-management support options that need to be available to address the needs of a diverse population.

There is increasing experience in BC in providing self-management support in GP offices and other community settings through involvement of Medical Office Assistants (MOAs) and community health providers working in new ways.

Capturing and monitoring the goal(s) set
- Personal action plan
- Personal health record

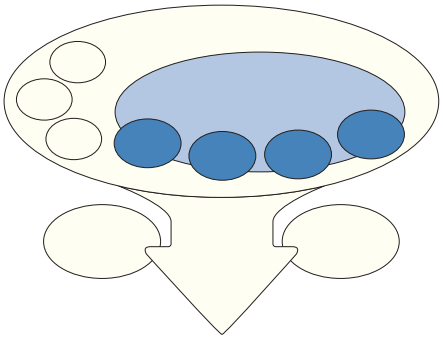
E. Capturing and Monitoring the Goal(s) Set

Throughout this paper, the importance of capturing the goal to be worked on and monitoring the goal achievement related to the desired outcome(s) has been mentioned. This is the pivotal step to closing the loop, moving forward and incrementally setting new goals and achieving the desired health outcomes. This step needs to be worked in to the work process of the providers and there needs to be proactive appointments set for this active review and ongoing action. For example, in a GP office, the one-to-one encounter between the patient and the GP may need to be supported by other team members such as an MOA or nurse, in order to achieve this step which may take more time

than the traditional visit or need to be done over a series of visits. The group setting with meetings over time supported by a variety of health providers is an effective way of achieving this step. A very useful tool for capturing and monitoring the goal(s) set is the Personal Action Plan which incorporates the elements of the 5A's approach. Its use is further illustrated in scenarios in *Appendix 5*. A more extensive tool is the Personal Health Record which the patient carries with them to the various health encounters and which can include the health history, drug list, record of diagnostics as well as the Personal Action Plan. Experience using the Personal Action Plan and also the Personal Health Record is increasing in BC, particularly in the Northern Health Authority.

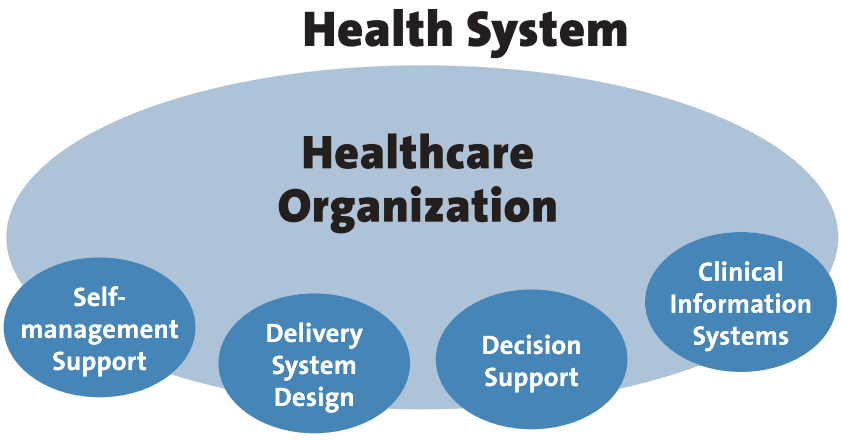
Section X

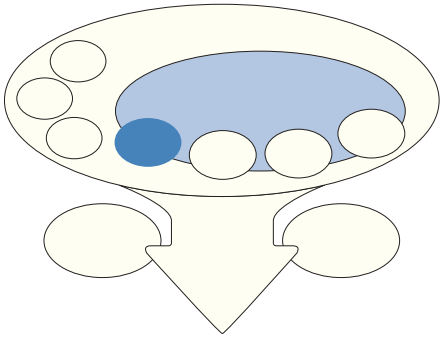
The Upper Part of the ECCM: Relationship to SM and SM Support



Health System

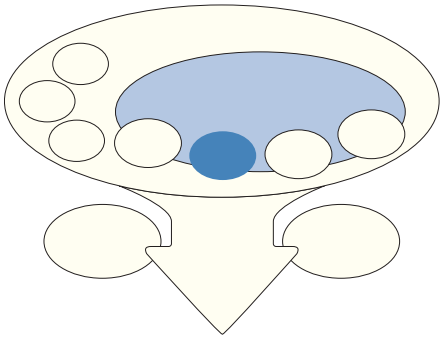
- Set policy to support involving people and the general public in health system development, particularly in developing self-management support systems
- Resource self-management support networks across BC, to collate and develop standardized support information within and across conditions and generically and with a menu of options to provide self-management support
- Invest in people and resources to support partnership-building across health and social care communities
- Develop skills and training for both people living with chronic conditions to carry out self-management (*eg* the CDSMP) and for providers to deliver self-management support (*eg* BC College of FP of BC SM Program for physicians; HA training programs)
- Explore ways of making available more self-management tools, self-monitoring equipment and assistive technologies plus information, access and support for their use
- Set self-management support into a systems quality improvement approach that would promote incremental improvement of the ability to provide effective self-management support





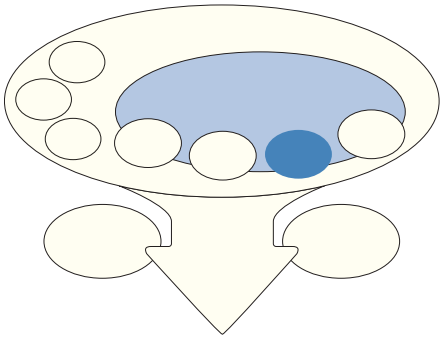
Self-management Support

- Assess patient self-management attitudes, skills, preferences, confidence
- Provide essential information
- Use evidence-based strategies to set goals, motivate, develop an action plan with confidence level and problem solve
- Encourage self-monitoring
- Arrange effective external interventions to support basic skills or behavior change



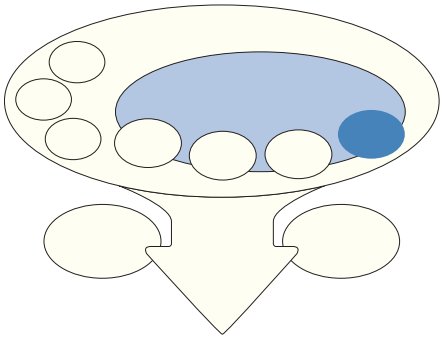
Delivery System Design

- Delegate 5A tasks to relevant member of practice team
- Use planned encounters to assure ongoing SMS
- Assure regular follow-up
- Provide clinical case management services to high risk patients



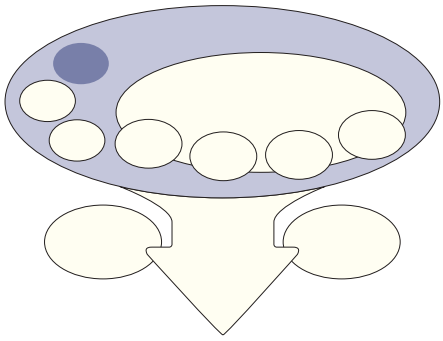
Decision Support

- Select evidence-based counseling approach and intervention protocols
- Train staff who provide counseling
- Give patients evidence-based guidance that support self-management
- Remind patients and clinicians of steps that support care plan and goal attainment
- Provide feedback to patients and clinicians on goal attainment and disease control



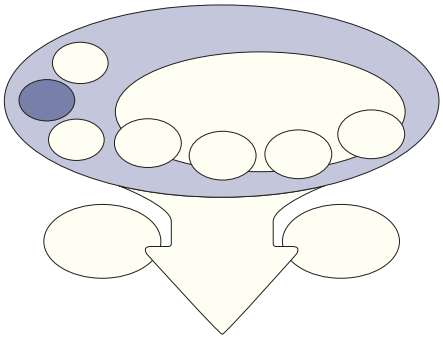
Clinical Information Systems

- CIS includes key information supportive of SMS
- CIS provides feedback about goal attainment and disease control
- CIS provides reminders of goals and needed services



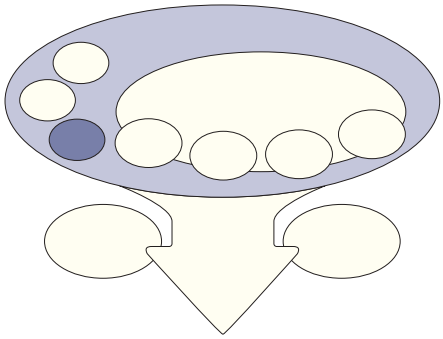
Building Healthy Public Policy

- Set policy that will support partnership-building for involving the public in developing systems for healthy living, including self-management support across health, social care and the broader communities



Create Supportive Environments

- Build a network for self-management support by identifying what currently exits in the community, partnering for further development of options to support self-management and linking people and providers with these options



Strengthen Community Action

- Advocate for options for self-management support for disadvantaged populations which would include addressing the broader determinants of health as fundamental to a person being able to address the more medical goals for self-management as well as access to options appropriate to the population needs and capabilities

Section XI
Creating the Culture for Provision of Self-management Support

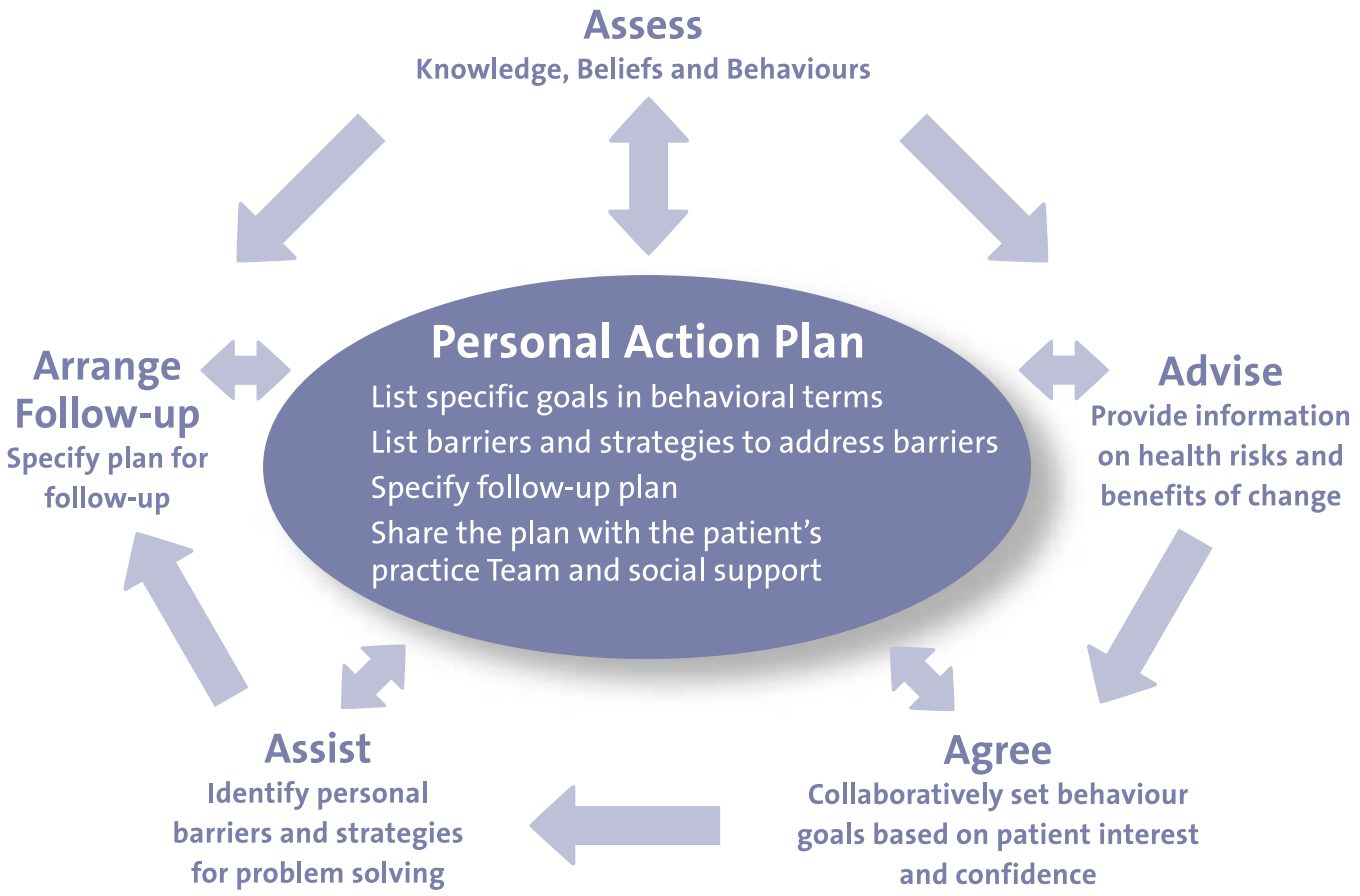
There is a culture shift happening in healthcare in BC and elsewhere from care focused on episodic conditions to greater emphasis on care for chronic conditions and from provider direction to partnerships for care between patients and providers supported by the wider community. This shift is captured in the adoption in BC of the "Expanded Chronic Care Model." Although this document has emphasized the logical approach that providers can take in providing self-management support, it is recognized that the culture of organizations and the wider system has to evolve to support the providers and the people living with long-term conditions. Developing a culture that values self-management and the provision of self-management support needs to be part of the strategic and operational directions of the Health Authorities and other partners in healthcare. This can be linked with the practical provision of self-management support as this new way of working can be introduced and developed in an incremental way using the approach outlined in this document and following the Plan-Do-Study-Act process for improvement. It should be noted that much work has gone on in the past few years in various Health Authorities to create the supportive culture and the practice competencies that has set the stage for the more widespread and comprehensive supports needed for people living with multiple and complex chronic conditions.

Section XII
Summary

This document has attempted to present how self-management support can be viewed and provided by healthcare staff in a logical way in the context of the new way of organizing care through the "Care Model." Self-management support is seen as more than education and strives to increase a person's skills and confidence so that in managing their health problems and includes regular assessment of progress and problems, goal setting and problem-solving support. A systems/organizational culture that values a person's ability to self-manage, trains healthcare providers to provide the requisite support and resources options that match person needs is essential. A practical approach is outlined within the context of and supported by the Care Model which advocates following the 5 A's supported by various strategies through one-to-one or group interactions to produce personal goals set and monitored within a healthy changes plan. Various providers can provide this self-management support and to develop the required competencies, an incremental approach using PDSA cycles is advocated. Experience is accumulating in BC to support this recommended approach in a variety of care environments.

Appendix 1
The Approach

Self-management in the Chronic Care Model



Adapted from Glasgow, RE et al (2002). Used with permission of Connie Sixta and the BC College of Family Physicians, Supporting Self-management Program

The steps in the self-management process are not necessarily linear; each step does not necessarily follow the other sequentially. When you are seeing a new patient or working with a current patient on a new area of behavior change, you will probably use the self-management process sequentially, starting with assess and moving clockwise around the circle. In a follow-up session, the self-management session may go counterclockwise if the goal is not met as you would assist the patient to problem solve on how to reach the goal and may revise the goal (agree) and then arrange follow-up. The self-management process is captured in the Personal Action Plan which aids in supporting the patient as they work towards their goal and is used for the review at the time of follow-up (see *Appendix 3*).

Appendix 2
The Approach

Evidence-Based Principles for Self-management Support (SMS) Care

The Five "A's"

- **Assess**
- **Advise**
- **Agree**
- **Assist**
- **Arrange**

Delivery Models Organized by the Five "A's"

1. Multi-faceted interventions are stronger than single component interventions (Chronic Care Model).
2. Assessing clinical severity, functional status, patient goals and preferences, and self-management behaviors is typically an integral part of SMS interventions *(Assess)*.
3. Effective multi-component interventions provide information that guides self-management, but information alone generally shows negligible effects on important patient outcomes *(Advise)*.
4. Clinicians more effectively support patient self-management when they provide evidence-based information with a non-judgmental approach *(Advise)*.
5. Interventions that involve collaborative identification of priorities, goal-setting and defining specific plans for goal achievement improve self-management and outcomes *(Agree)*.
6. healthcare that employs collaborative problem-solving improves self-management and outcomes *(Assist)*.
7. Diverse professionals and lay persons can effectively deliver SMS interventions if they have clearly defined tasks and roles, and are trained to use evidence-based interventions *(Assist)*.
8. Self-management interventions can be effectively delivered via diverse modalities including individual, group, telephone and self-instruction formats *(Assist)*.
9. Enhancing patient confidence and self-efficacy regarding key chronic illness management tasks improves the process and outcomes of care *(Assist)*.
10. Ongoing follow-up, supported by feedback and reminders to both clinicians and patients, helps sustain self-management behaviors and improves patient outcomes *(Arrange)*.
11. Case management can improve self-management and patient outcomes if (and only if) it is goal-directed and guideline-based *(Arrange)*.
12. Self-management support in healthcare settings should utilize community-based self-management intervention programs that are evidence-based *(Arrange)*.

Michael Von Korff, Judith Schaefer, Evette Ludman, Greene, Melissa Parkerton, Connie Davis, & Ed Wagner. *The Evidence-Base for Collaborative Self-management Support (SMS)*

Appendix 3
The Personal Action Plan

My Personal Action Plan

Name _____ **Date** _____

Long-term Goal

Specific Plan

How:

What:

When:

Where:

Frequency:

Barriers to Changing Behaviour

Plan to Overcome Barriers

Confidence in Meeting My Goals

1	2	3	4	5	6	7	8	9	10
Not at all Confident		Don't feel I can do it right now		Maybe I can do the plan			Think I can do the plan		Absolutely know I can do it

People Who Will Support Me

Follow-up Plan

Used with permission of Connie Sixta and the BC College of Family Physicians, Supporting Self-management Program

British Columbia College of Family Physicians Supporting Patient Self-management: A Study Manual for the MD

Patient Self-help Guide to Changing Behaviors

Most of us have something that we want to improve or change about ourselves. It might be that we want to lose weight or get on an exercise regime. Most of us have tried many times to change or improve, but we just haven't been able to do it. Others of us just want to start feeling better and we don't exactly know what we need to do to "feel better." This approach will help you learn to improve how you feel and change your own behavior one small step at a time.

1) Long-term Goal
First of all, what would you like work on? What do you want to change? For example, do you want to: Lose 30 lbs? Exercise five days per week? Have more energy to play with your grandchildren? Remember your long-term goal is something that will take time, maybe as long as six months or more to achieve.

2) Specific Plan
Now you need to decide specifically how you want to go about achieving your long-term goal. It's important that you plan very small steps that you feel you can be successful in achieving. Your plan needs to be very specific, a step-by-step plan that will help you reach your long-term goal. Answer each question to plan your small steps.

a. How? How do you want to go about losing weight? Do you want to exercise more to lose weight? Do you want to change what you are eating?
"I want to change what I eat."

b. What? What foods do you want to change? What foods shouldn't you be eating? What size portion should you eat?
"I need to stop eating so many desserts."

c. When? When do you want to stop eating so many desserts?
"I want: to stop eating so many desserts after dinner in the evening."

d. Where? Where do you want to limit the eating of desserts?
"I want to stop eating desserts when I'm eating dinner at home."

e. Frequency? How frequently, how many times per week do you want to not eat desserts?
"I want to eat desserts after dinner only on Saturday and Sunday."

3) Identify Barriers
"To be most successful I need to think about what might get in the way of me meeting my plan."
If you can identify those things that might get in the way, you can plan around them. Let's say your barrier is that on two nights during the week you have activities (*ie* Church meetings, card games) where food is always present. What can you do to prevent eating the desserts at those outings?

4) Plan to Overcome Barrier
What can you do to prevent eating desserts at those activities? You need to brainstorm – you can skip the meeting. You can go with Lucy who is on a diet too; you can help each other keep from eating desserts. You can eat dinner right before you go to the activity so that you are not hungry. Choose one of those ideas and try it.

5) Confidence
Do you think you can achieve this goal? If you don't think you can, you need to plan differently—should you only limit desserts three times/week instead of five?

6) Who Can Help You Accomplish This Goal?
Who will help you (family member, friend, or significant other)?

Use the Personal Action Plan to help you develop your goal.

Constance Sixta, RN, MSN, MBA, DSNc

Appendix 4

1. Flinders Suite of Tools
2. Patient Activation Measure

1. Flinders Human Behaviour and Health Research Unit Self-management Program Suite of Tools

The Flinders approach is a generic comprehensive approach to chronic condition self-management which is complimentary to the Stanford Chronic Disease Self-management approach. The Flinders includes a Partners in Health Scale supported by a Cue and Response Interview that then leads to a Problems and Goal Assessment (care plan). This approach is targeted at identifying 12 areas of chronic disease management where increasing patient knowledge and skills would be beneficial. It could, however, direct a course of action that could miss the patient-identified goals for self-management that was done in a more open-ended way and also, it takes more time to do. Therefore, the 5As approach is preferred and recommended until more experience is gained in BC using the Flinders (*eg* the Flinders may help with care planning in certain settings where other providers support the patient and physician in chronic disease management and self-management). For more information on the Flinders approach see *Reference #8*.

2. Patient Activation Measure

The Patient Activation Measure is similar to the Flinders in that it is targeted at areas where increasing patient knowledge and skills for self-management of chronic diseases could be beneficial with the addition of a section called "staying the course under stress." Like the Flinders, it may miss patient-identified goals that the patient would want to work on for self-management. It could be used at the assessment stage but would need to be combined with the approach captured in the Personal Action Plan. Until more experience is gained with the PAM (*eg* as an aid to care planning), the 5As is the recommended approach.

Believes Active Role Important

1. When all is said and done, I am the person who is responsible for managing my health condition.
2. Taking an active role in my own healthcare is the most important factor in determining my health and ability to function.

Confidence and Knowledge to Take Action

3. I know what each of my prescribed medications do.
4. I am confident I can tell my healthcare provider concerns I have even when he or she does not ask.
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.
6. I know the lifestyle changes like diet and exercise that are recommended for my health condition.
7. I am confident that I can follow through on medical treatments I need to do at home.
8. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.
9. I am confident that I can find trustworthy sources of information about my health condition and my health choices.
10. I am confident that I can follow through on medical recommendations my healthcare provider makes, such as changing my diet or doing regular exercises.
11. I understand the nature and causes of my health condition(s).
12. I know the different medical treatment options available for my health condition.

Taking Action

13. I have been able to maintain the lifestyle changes for my health that I have made.
14. I know how to prevent further problems with my health condition.
15. I know about the self-treatments for my health condition.
16. I have made the changes in my lifestyle like diet and exercise that are recommended for my health condition.
17. I am confident I can figure out solutions when new situations or problems arise with my health condition.
18. I am able to handle symptoms of my health condition on my own at home.

Staying the Course Under Stress

19. I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress.

20. I am able to handle problems of my health condition on my own at home.
21. I am confident I can keep my health problems from interfering with the things I want to do.
22. Maintaining the lifestyle changes that are recommended for my health condition is too hard to do on a daily basis.

Adapted from: Development of Patient Activation Measure (PAM)
Figure 2: Final Patient Activation Measure with Item Calibrations

Appendix 5
Self-management Support Scenarios

The approach described in the body of this document and centered around the 5As will be further elucidated in this Appendix, including the presentation of three scenarios for the same patient (living with diabetes): 1. The usual general approach with the 5As, 2. Using the 3 questions and 3. When a goal is identified that does not directly relate to the medical condition. The information in this document can only provide a brief glimpse of what the new approach would be. The necessary next step would be providers supported by their organizations to learn from a curriculum designed to support this new approach to providing self-management support. As mentioned previously, Connie Sixta, working with the BC College of Family Physicians, has developed a self-management support program with a study manual and the associated skills development is being mentored for family physicians, their office staff and targeted health authority staff (who would then act as trainers). The BC Academic Health Council is examining the opportunities and challenges of developing self-management curricula for students and providers. Since we are in the early stages of curriculum development and implementation in BC, people who read this report are encouraged to contact the people supporting chronic disease management improvement in their organizations to see what currently exists, what is being planned, or what may need to be developed/adopted.

The table, immediately below, that outlines the old and new approaches summarizes the commonalities and differences.

Self-management Support: Old vs New Approach

Example: Patient living with diabetes

Steps	Old	New
	Focus is providing education	Focus is on setting and supporting patient-centered goal
Assessment	Clinical assessment with labs	Knowledge, beliefs, behaviors: "What concerns you most about having diabetes?"
Advise	Provide info on health risks and benefits of change – general info, a lot of info	Provide info on health risks and benefits of change but tailor to patient's concerns
Agree	Patient instructed on what to do *eg* exercise 30 min 5 x per week	"What would you like to work on that would decrease your sugar?" (Importance)
Assist	May give a "brochure"	Identify personal barriers and strategies for problem-solving. How/what/when/where frequency plus Confidence – Personal Action Plan
Arrange Follow Up (f/u)	Incorporated into next visit which is often not a planned visit	Specific f/u and review of achievement of goal with problem-solving if did not achieve or generating a new goal. F/u by visit or telephone

Much of the content of this Appendix is based upon the study manual developed by Connie Sixta for the BC College of FP Supporting Self-management Program whose generous support has contributed to the development of this document.

As stated in the study manual, 'to be successful in supporting patient self-management, the Provider must:

- Give up the agenda
- Let the patient take control of his/her life
- Help the patient feel success
- Let the patient feel in control of some aspect of self-care he/she can control.

Furthermore, provider support for patient self-management is dependent on the provider:

1. Having a relationship with the patient
2. Maintaining continuity of care for the patient; seeing the patient on a consistent basis
3. Finding an opening to the patient, that portal of openness, concern, and real need that allows the partnership and the support to occur
4. Letting the patient guide the process, take control
5. Tailoring the advise, making the advise relevant to the patient and not overwhelming
6. Supporting the development of behavioral goals that are realistic, specific and measurable for the patient
7. Helping the patient develop self-efficacy through the setting and meeting of small goals that build self-confidence and the feeling of some ability to manage the disease
8. Assisting the patient in problem solving for goal success
9. Making a verbal pact with the patient about a behavioral goal
10. Showing that the behavior change is important to both of you by writing it down and following it up.

The scenarios presented next are adapted from the work of Connie Sixta and the study manual of the BC College of Family Physicians Self-management Program.

Scenario 1
Using the 5A's

Mrs. Collins is a 50 year-old married woman who has recently been diagnosed with Type II diabetes. She has come to see you for her first visit after her diagnosis.

The 5A's are: assess, advise, agree, assist and arrange. In applying the 5A's, it is important to remember that it isn't necessarily a linear approach and in particular, advising may happen through much of the process. Also, the opportunities to motivate the patient are acted on throughout the process. The 'readiness to change model' is used whereby: **readiness = importance x confidence** (behind this model is the 'stages of change' theory: pre-contemplation, contemplation, preparation, maintenance, action, termination).

Assess: The focus is on assessing the patient's knowledge and beliefs about their disease and its management; and to assess the level of patient adoption of healthy behaviors. Beliefs and values have a huge impact on patient behaviors. Also, the patient's experience with the disease, either personally or within the family, defines the patient's reality of the disease and the small test incremental approach to successful goal achievement will be very important to overcome negative perceptions about what can be accomplished. Ethnicity and culture also affect beliefs, values and behavior patterns. Assessing the patient's level of health literacy would also be important. Eliciting information through an interview or a patient questionnaire (which the patient could fill out while waiting to see the doctor or other provider) is helpful and can be done through asking questions:

- Do you or anybody else in your family have diabetes or another chronic illness?
- What has it been like for you or your family member living with diabetes or another chronic illness?
- What do you know about managing diabetes or another chronic illness?
- What worries or fears do you have about you or your family member managing diabetes or another chronic illness?

Mrs. Collins might indicate that her mother and sister both have diabetes and that her mother has gone blind and that she is worried about that happening to her.

Determining what the patient knows about his/her disease and how he/she is currently managing (knowledge and skills) is the first step in building an effective educational plan (into the advise step). Questions can be asked that generate information for behavior areas that could be important to both the patient and provider- *eg* diet, exercise, weight, medication management. Questions could also be asked determining the patient's educational and self-management needs:

- Does the patient have any religious or cultural practices that may interfere with the adoption of health behaviors (*eg* diet)?
- How does the patient prefer to learn?
- What is the patient currently doing for self-management and does the patient want to take responsibility for self-management?

Mrs. Collins indicates that she has gotten some information from her sister about diabetes. She has concerns that her diet is not correct and that she is not exercising regularly.

Advise: In this step, the patient is advised about the disease, healthy behaviors that are important for the overall management of the disease and health care risks that can result from poor management of the disease. The information should be targeted to where the patient is at, is concerned about and wants to know. It is important to remember that this step is not used to promote the agenda of the provider but to provide the information specific to the person's needs so that, in the next step, 'Agree,' they can establish a goal that makes sense to them in their context and that they think that they can achieve. The following questions help to centre advice-giving around the educational needs of the patient:

- What is it about your disease that concerns you the most?
- What part of managing your disease are you the most worried about?
- What would you like to learn about diabetes today?

Mrs. Collins indicates that although she got some information from her sister, she is concerned that she won't be able to manage and she doesn't know where to start. She has heard that it is important to diet and exercise and she wonders whether she will have to take medication. She would like to learn how doing all these things can prevent her from going blind like her mother has. In particular, she wants to learn about diet.

Giving too much information may overwhelm the patient and will not lead to their understanding and goal-setting plus could create stress and frustration. Keep the advice as clear and simple as possible and in small doses depending on the patient's current knowledge. As well, the patient's readiness to learn and also to engage in behavioral change will need to be determined at this stage as some patients will require more time and support. Advice may need to be given over a few visits. Providers other than physicians, such as a MOA or nurse in a GP office trained to give the advice, could be involved while coordinated with the content and role through the physician. For each condition, there is basic advice that should be shared with the patient- *eg* for diabetes this would be: 'in order to manage your diabetes, patients need to take their medications, reduce dietary intake and increase the amount of exercise they get.

So at this stage of giving advise, it is important to remember that effective advice is relevant (targeted to what the patient is concerned about, wants to learn), understood and heard by the patient. Giving brief information material, which the patient can read at home, will increase their uptake of the necessary information and facilitate their understanding which leads into the next stage of agreeing on a goal for behavior change.

Agree: The patient should now have a basic understanding of the disease and why they would want to engage in a behavioral change and wish to explore doing so. Now the provider can work with the patient to determine what behavioral change they would like to work on and how to help the patient set a reasonable and attainable goal which is important to the patient and for which the patient is confident in reaching. Set only one goal at a time as it can be more difficult to achieve than people may think and success in achieving the goal is very important. This work can be captured on the Personal Action Plan (*Appendix 3*) and is done in the following steps (capturing the **how, what, where, when and how often**):

- Determine the overall behavioral objective/goal (ask 'What (behavior) would you like to work on?')- *eg* may be 'increasing my activity level' or 'lose weight'
- **How** Help the patient determine how he/she would like to go about achieving that behavioral objective. Determine current state, usual activity or intake leads to what might be reasonable and attainable in order to achieve success and build self-efficacy- *ie* through small, incremental goals. Then the **how** might be walking or decreasing food intake

- The small goal statement should answer **what, where, when, and how often.** Example: Mrs. Collins wants to lose weight as she understands that being overweight makes it harder for her body to control her blood sugar and increases her blood pressure. She wants to decrease her food intake (**how**), decreasing the amount of pop that she drinks from 8 to 2 bottles per day (**what**), at home (**where**), when she plays cards with friends plus when she is watching TV (**when**) and every day (**how often**)
- Ask the patient to rate the *importance* of the goal on a scale of 1–10 with 1 being low in importance and 10 being high importance. If the patient rates the goal at 7 or above, the goal is important enough to work on but if less than 7, ask the patient to select a goal that is more important
- Ask the patient to rate how *confident* they are that they can achieve the goal on a scale of 1-10 with 1 being low confidence and 10 being high confidence. If the confidence level is rated by the patient is 7 or above, he/she is confident enough to work on the goal but if less than 7, help the patient revise the goal making it realistic and achievable.
- Mrs. Collins rates the importance of her goal of weight reduction as an 8 but she is unsure about her confidence and would rate it as a 6. On discussion, she indicates that she is not sure that she can cut down from 8 to 2 bottles of pop per day but she thinks that her confidence level would be 7 if she cut down to 5 bottles per day as she could still have a pop when she is playing cards or watching TV.

Assist: When setting a new goal with the associated confidence level or reviewing the achievement status of a goal that he/she has been working on, the patient is assisted in identifying barriers or problems that would make it/have made it difficult to achieve the goal. The role of the providers at this point is to assist the patient in problem solving the barrier or problem by encouraging the patient to identify solutions and in finding resources that can help. Although not wanting to push certain solutions, the provider can help model the problem-solving process with the patient while encouraging the patient to look for solutions."

Arrange It is important to arrange a follow-up within one to two weeks of setting a goal even though behavior change can be slow as the patient needs to be supported during the process of changed. A follow-up visit or telephone call can show the patient that the providers think that working

on self-management goals is important and can help them identify barriers/problems before they get too frustrated. Ask the patient how she/he did with the goal-if achieved, work on a new goal (agree) and if not achieved, support the patient to problem-solve around identified barriers/problems. Arrange another follow-up session.

HCP Hello Mrs. Collins. We last met 2 weeks ago and you had identified your goal at that visit as decreasing the intake of pop from 8 to 5 bottles per day. How has that been working?

Mrs. C. I have found it hard to decrease the amount of pop that I have been drinking-the best that I have done is down to 6 per day

HCP What do you think prevented you from going down to 5 bottles per day?

Mrs. C. Well I like the taste of the pop and I don't like water too much.

HCP Have you thought of anything else that you might do?

Mrs. C. My sister has suggested that I try diet-pop and maybe I could do that

HCP How would you do that?

Mrs. C. Well I wouldn't want to switch all my pop over to diet right away as I don't know whether I would like the taste but I could try to drink 3 bottles of diet and 5 bottles of the regular pop.

HCP How confident are you that you can do that?

Mrs. C. I think that I would an 8.

HCP Yes, that sounds good, work on that and I will see you in 2 weeks."

Following this approach, the BC College of FP self-management program has been able to demonstrate that self-management support can be built into the usual workflow of a GP office (and therefore could be built into the practice of other providers) without taking more time than the usual encounter if focused this way (it make look longer written in this linear way but the conversation can actually happen fairly quickly with most patients). This approach worked with patients who had complex issues and who had not been able to participate effectively in self-management activities previously. Provider and patient satisfaction was high. Visits became more focused and effective. This 5As approach done in this way incorporates the strategies such as motivation,

problem-solving and mastery learning and patients are supported with information materials pertinent to their goals and are encouraged to make small changes that build their sense of self-efficacy.

Scenario 2
Using the 3 Questions

There has been another approach tried by some of the physician offices in some of the BC Chronic Disease Collaboratives using 3 questions to start the conversation around self-management support. The 3 questions are:

- What worries you the most about your condition? (assess/advise type question)
- What would you most like to change? (agree)
- How do you think you might do that? (agree)

The 3 questions would relate to the assess, advise and agree stages and would need to be done with the Personal Action Plan in order to capture all the 5As adequately. The providers that have used these 3 questions have observed that they had a different interaction with their patients in that they elicited quite different responses than the usual clinical interaction-responses that indicated that the patients were bringing up issues that were important to them and that related to the issues in their lives that affected their ability to self-manage. In one audit by a lead GP, it was found that it took 3–20 minutes to have this discussion (using the 3 questions) which averaged out at 8 minutes. The Personal Action Plan would need to be incorporated as well and consideration needs to be given to having another staff member in a GP office such as a Medical Office Assistant or practice nurse to support or indeed carry out this encounter. In other provider environments, the 3 questions could be considered as well as a way of introducing self-management support practice. However, if providers (in a GP office) or other practice environments, are going to learn an effective self-management approach, it is recommended that they start with the 5As approach now that there is more experience with the 5As approach as described in the first scenario.

Using the 3 questions approach, the encounter could be:

HCP Mrs. C., what worries you most about your condition? (assess/advise)

Mrs. C. My mother has diabetes and she has gone blind and I worry that I will as well. I have read about diabetes as my sister also has diabetes

and she has given me some information but I am concerned that my diet is not correct and that I am not exercising enough.

HCP What would you most like to change? (agree)

Mrs. C. I would like to work on my diet as I would like to lose weight as I realize that that will help control my sugar and my blood pressure.

HCP How do you think that you might do that? (agree)

Mrs. C. I could reduce the amount of pop that I drink each day from 8 bottles to 5 bottles.

The provider would use the Personal Action Plan to include the what, where, when and how often as well as the importance and confidence aspects. In addition, follow-up would need to be **arranged**.

Scenario 3
The Patient Goal Does Not Directly Relate to the Medical Condition

There are a number of approaches that can be taken in a clinical setting that could elicit patient goals for addressing issues that they have in their lives, issues that may or may not relate directly to their health conditions. More directive approaches that start from the context of a specific disease, *eg* diabetes, and also from something specific to that disease, HbA1C, generally obtain disease-specific goals. Approaches like the Flinders and the Patient Assessment Method are set up *a priori* to get at specific areas for illness management. The 3 questions approach also starts in the context of a "condition" but the first question is general enough that the providers found that they elicited responses about psychosocial issues that affected a person's ability to self-manage more often than in their usual clinical encounter.

There is a growing consensus that the provider should start with an open-ended approach when exploring issues for the patient that may affect their ability to self-manage their health. This is being suggested not just because of the patient-centered philosophy but in a more practical way, it has seen that unless such issues are addressed, the patient's ability to self-manage will be significantly compromised. Examples could include:

- With Mrs. Collins, she might have to spend a lot of time and mental energy dealing with a sick husband so the provider(s) would have to help with that situation. She may be significantly depressed and this would have to be dealt with first (indeed, in the Collaboratives, it was found that many of the patients who had difficulty with self-management were depressed

so depression assessment was introduced in GP offices and also in the Diabetes Education Centres)

- Many adult patients (especially women) have to deal with providing transgenerational support (children and parents), marital disharmony, serious mental illness in family members, etc. and these adult patients have to be supported in those situations, often before they can look after their own health.

This can create a dilemma for the providers in that they may not have the mandate, expertise and/or time to provide this type of support. The "system" needs to support the providers to work in new ways, with new team relationships (*eg* mental health involved), and within the broader context of the community. This document provides some direction on how to achieve this with the discussion of the necessary culture of care and support and through using the Care Model which highlights the new ways of working and supports necessary to provide effective self-management support.

Appendix 6
The Northern Health Authority 5As Approach

Tobacco Assist Menu
- Support person/group
- NICC Consult
- CCS Booklets
- NRT
- Quitnow.ca
- Quitbyphone 1-877-455-2233
- Stop date

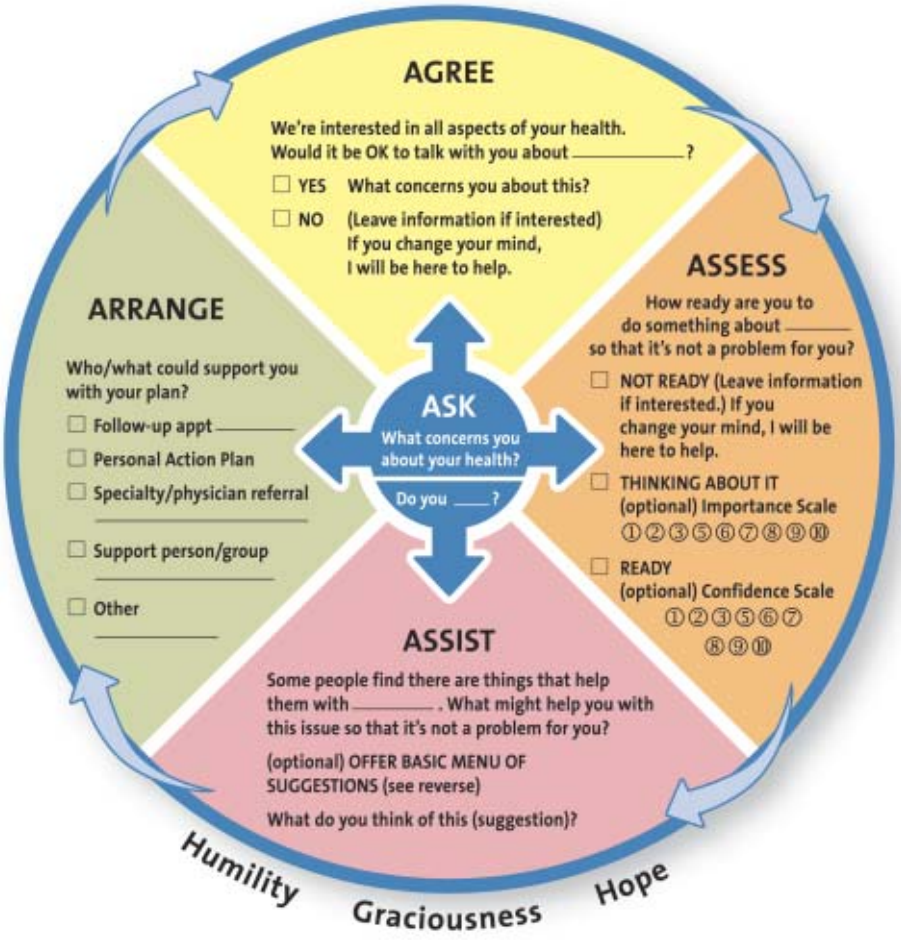
Nutrition Assist Menu
- Shopping tour
- Dial-a-dietician 1-800-667-3438
- RD consult/groups
- Exercise group
- Nutrition sessions
- Good food box
- Other

Activity Assist Menu
- Pedometer/10000 steps
- Walk with friend/dog
- Local fitness centres
- Good shoes
- Set small goals
- Other

Weight ↓ Assist Menu
- Pedometer/10000 steps
- Dietary interest (high fiber/low carb/low fat)
- RD consult/groups
- Local fitness centres
- Regular meals
- Weight Watchers
- Other

Depression Assist Menu
- PHQ-9 screening
- Talk to doctor
- Local AMH services
- Rediscover "spirit"
- Walking
- Other

The Five "A's"



Kidney Summit Core Group, BC Renal Agency

Resource Links and References

1. Kidney summit website: http://www.bckidneysummit.com/
2. Chronic care model website: http://www.improvingchroniccare.org
3. Chronic disease self-management program: http://www.coag.uvic.ca/cdsmp
4. McGowan, P. Self-management: A background paper. http://www.coag.uvic.ca/cdsmp/downloads/What_is_Self-Management.pdf
5. BC College of Family Physicians: http://www.bccfp.bc.ca/SelfManagement.htm
6. Best, A., et al. "A Population-Based Framework for Chronic Disease Self-management Support." Vancouver Coastal Health/Vancouver Coastal Health Research Institute (on Kidney Summit website): http://www.bckidneysummit.com
7. "Essential Elements of Self-management Interventions." The Center for the Advancement of Health (Project funding by Robert Wood Johnson Foundation): http://www.cfah.org/pdfs/Essential_Elements_Report.pdf
8. Flinders Human Behavior & Health Research Unit: http://som.flinders.edu.au/FUSA/CCTU/Self-management.htm
9. Bodenheimer, T. et al. "Patient self-management of Chronic Disease in Primary Care." *JAMA* 2002;288(19):2469-2475
10. Bodenheimer, T. and Grumbach, K. *Improving Primary Care: Strategies and Tools for a Better Practice*. New York: Lange Medical Books/ McGraw-Hill (2007)
11. Chodosh, J. et al. Meta-analysis: "Chronic disease self-management programs for older adults." *Annals of Internal Medicine* 2005;143(6):427-438
12. Clark, N. "Management of chronic disease by patients." *Annu Rev Public Health* 2003;24:289-313
13. Glasgow, R. et al. "Self-management aspects of the improving chronic illness care breakthrough series: Implementation with diabetes and heart failure teams." *Ann Behav Med* 2002;24(2):80-87
14. Glasgow, R. et al. "Physician advise and support for physical activity: Results from a national survey." *Am J of Prev Med* 2001;21:189-196

15. Glasgow, R et al. "Translating what we have learned into practice: Principles and hypotheses for addressing multiple behaviors in primary care." *Am J of Prev Med* 2004;27:88-101
16. Glasgow, R. et al. "Implementing practical interventions to support chronic illness self-management." *Joint Commission J on Quality and Safety* 2003;29(11):563-574
17. Glasgow, R. et al. "A practical randomized trial to improve diabetes care." *J of General Int Med* 2004;19:1167-1174
18. Glasgow, R. et al. "Randomized effectiveness trial of a computer-assisted intervention to improve diabetes care." *Diabetes Care* 2005;28(1):33-39
19. Goldstein, M. et al. "Multiple health risk behavior interventions in primary care: Summary of research evidence." *Am J of Prev Med* 2004;27, (2 Suppl): 67-79
20. Hibbard, J. et al. "Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation." *Health Services Research* 2004, Part 1;39(4):1005-1026
21. Lorig, K.R., Sobel, D.S., Stewart, A.L., Brown, B.W. Jr., Bandura, A., Ritter, P., Gonzales, V.M., Laurent, D.D., Holman, H.R. (1999). "Evidence suggesting that chronic disease self-management program can improve health status while reducing hospitalization: A randomized trial." *Medical Care* 37 (1), 5–14.
22. Lorig, K. "Self-management education–More than a nice extra." *Medical Care* 2003;41(6):699-701
23. Lorig, K.R., Ritter, P.L., Gonzales, V.M. (2003). "Hispanic chronic disease self-management: A randomized community-based outcome trial." *Nursing Research* 52 (6), 361–369.
24. Lorig, K.R., Ritter, P.L., Jacquez, A. (2005). "Outcoomes of border health Spanish/English chronic disease self-management programs." *The Diabetes Educator* 31 (3), 401 - 409.
25. Lorig, K. "Action planning: A call to action." *J of the Am Board of Fam Med* 2006;19(3):324-325
26. Serdula, M. et al. "Weight loss counseling revisited." *JAMA* 2003; 289: 1747-1750

27. Von Korff, M. et al. "Collaborative management of chronic illness." *Ann Int Med* 1997;127(12):1097-1102
28. Wagner, E. et al. "A survey of leading chronic disease management programs: Are they consistent with the literature?" *J of Nursing Care Quality* 2002;16(2):67-80
29. Wheeler, I. "Can a disease self-management program reduce health care costs?" *Medical Care* 2003;41(6):706-715
30. Whitlock, E. et al. "Evaluating primary care behavioral counseling interventions: An evidence-based approach." *Am J of Prev Med* 2002; 22(4): 267-284