Bridging Goal Setting and Skill Building Lessons from the Co-Management Learning Network

Doriane C. Miller, MD
Program Director
Co-Management Learning Network
Health Research and Educational Trust

Bridging Goal Setting and Skill Building: Objectives

- Overview of Co-Management Learning Network Pilot Collaborative
- 3 project examples
- Lessons learned

Bridging Goal Setting and Skill Building: Collaborative Goal

- Test the feasibility of implementing self-management support using change packages nested within the 5A's framework and the chronic care model

Collaborative Self-Management Support: Definition

- Collaborative goal setting and shared decision making
- Regular follow-up, monitor and assess progress towards goals, relating plans to patient's social and cultural environment
- Tracking and ensuring implementation, including linking support programs to the individual's regular source of medical care and monitoring their effects on a patient's health

Co-Management Learning Network Pilot Collaboratiave: Site Overview

- 3 Federally Qualified Health Centers, 2 Integrated Delivery Systems, 1 Kaiser Permanente site
- Geographic diversity: Northeast, South, Midwest, Pacific Northwest
- Diabetes, Asthma with Health Literacy and Obesity as subthemes
- 3 IHI IMPACT members, Health Disparities Collaborative, Kaiser Care Management Institute linkage

Pilot Collaborative: Learning Session Content

- Change packages, motivational interviewing, model for improvement, assessing the business case
- Cultural competence, community context, mental health co-morbidity, accelerating improvements, enhancing implementation spread and sustainability
- Patient voice, holding the gains, data collection, implementation and spread, mental health co-morbidity

The 5A's of Health Behavior Change: An Ecological Approach

	Patient Level	Office Level	Community/ Policy
Assess	Beliefs, behaviors, knowledge, conviction	Health Risk Assessment, Tracking registry	Needs assessment, Community Partnerships
Advise	Personally relevant, specific	Prompts, Decision Support Tools	Incentives Purchaser /payer
Agree	Collaborative goal setting	Staff Patient Centered training	Community Partnerships Reimburse

The 5A's of Health Behavior Change: An Ecological Approach (cont'd)

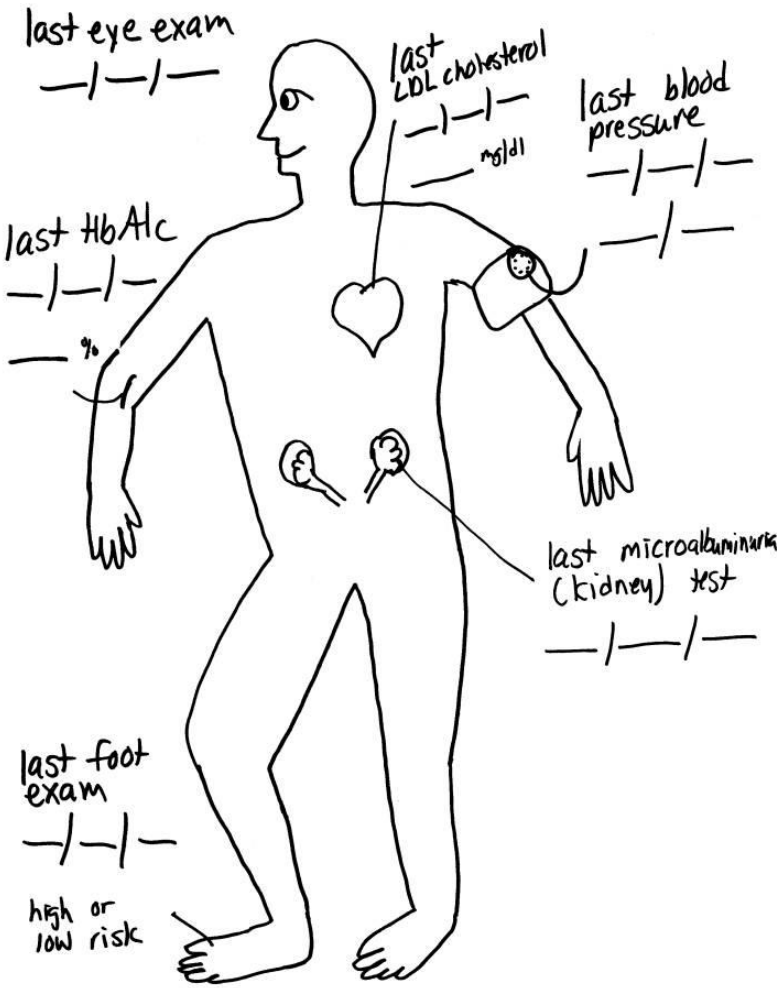
	Patient Level	Office Level	Community/ Policy
Assist	Action plan and problem solving	Provide action plan forms	Resource sharing, Staff incentives
Arrange	Follow-up on plan and referrals	Check-lists, Facilitate referrals	Reimburse Community Partnerships

Self-Management Support and The Chronic Care Model

- Delivery system redesign: assure delivery of effective and efficient clinical care and self-mgt
- Decision support: promote SMS consistent with scientific evidence and patient preferences
- Clinical information systems: organize pt and population data to facilitate SMS
- Health care organization: create a culture, organization and mechanisms that promote SMS
- Community: mobilize community resources to promote SMS

Bridging Goal Setting and Skill Building: GA Carmichael

- Federally qualified health center
- Mississippi Delta
- 96% African American
- Diabetes with youth obesity subtheme
- BRFSS data >25% of population considered obese



If you have DIABETES, here are some things you can talk about with your health care provider

→ ***Choose to talk about changing any of these and add other concerns in the blank circles.***

- Blood Pressure monitoring
- Taking medications to help control blood pressure
- Skin care
- Avoiding strokes or heart disease
- Diet
- Losing weight
- Depression ☹
- Daily foot care
- Smoking

Bridging Goal Setting and Skill Building: Iowa Health Systems

- Integrated delivery system serving >1 million patients in the Des Moines area
- Homogenous urban/suburban population with large number of diabetics, av age 62
- IHI IMPACT members
- Diabetes/Health Literacy as target condition and subtheme

Bridging Goal Setting and Skill Building: Iowa's Health Literacy Objectives

- Enhance assessment techniques
- Create a shame-free environment
- Improve interpersonal communication with patients
- Create and use patient-friendly written materials

Bridging Goal Setting and Skill Building: Iowa's Health Literacy Approach

- Building trust and open communication
- Staff training for identification
- Staff training for teach-back techniques
- Public signage and patient education materials
- Model patient involvement throughout system

Bridging Goal Setting and Skill Building: CareSouth Carolina

- Federally qualified health center
- Poor, rural population in NW South Carolina
- 63% African American, 36% Caucasian
- Member of Bureau of Primary Health Care Collaborative and IHI IMPACT network
- Strong integrated services, including mental health
- Participation in Co-Management as part of spread strategy

CareSouth Carolina: Depression Self-Care Action Plan

http://www.collaborativeselfmanagement.org/uploads/ManagingDepression.pdf

Depression Self-Care Action Plan

DEPRESSION IS TREATABLE!

- **Stay Physically Active.**
  Make sure you make time to address your basic physical needs, for example, walking for a certain amount of each time each day.

  Every day during the next week, I will spend at least _____ minutes(make it easy, reasonable) doing _____
  _____.

- **Make Time For Pleasurable Activities.**
  Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activity each day– for example doing a hobby, listening to music, or watching a video.

  Every day during the next week, I will spend at least
  _____ minutes (make it easy, reasonable) doing _____.

- **Spend Time With People Who Can Support You.**
  It's easy to avoid contact with people when you're depressed, but you need the support of friends and loved ones. Explain to them how you feel, if you can. If you can't talk about it, that's OK– just ask them to be with you, maybe accompanying you on one of your activities.

  During the next week, I will make contact for at least _____
  minutes (make it easy, reasonable) with
  _____(name) doing/talking about _____
  _____(name) doing/talking about _____
  _____(name) doing/talking about _____

- **Practice Relaxing**.
For many people, the change that comes with depression– no longer keeping up with our usual activities and responsibilities, feeling increasingly sad and hopeless– leads to anxiety. Since physical relaxation can lead to mental relaxation, practicing relaxing is another way to help yourself. Try deep breathing, or a warm bath, or just a quiet, comfortable, peaceful place and saying comforting things to yourself (like "It's OK").

  Every day during the next week, I will practice physical relaxation at least _____ times, for at least _____ minutes each time. (make it easy, reasonable)

- **Simple Goals And Small Steps.**
It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and not thinking clearly. Try breaking things down in to small steps. Give yourself credit for each step you accomplish.

The problem is _____

_____

My goal is _____

_____

Step 1: _____

Step 2: _____

Step 3: _____

How Likely Are You To Follow Through With These Activities Prior To Your Next Visit?

Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

Things To Know About Your Antidepressant Medication

- Your antidepressant medication is **NOT ADDICTIVE OR HABIT FORMING.** They are NOT uppers or downers. It is safe for you to take according to your provider's orders. If you are using alcohol or other drugs, please discuss this with your provider.

- Target symptons for antidepressant medications are sleep, appetite, concentration, mood and energy.

- It takes time for your medication to work. Most people begin to feel better in 1-4 weeks. Don't give up if you don't feel better right away.

Important things for you to do:

- **Keep all your appointments**
- **Take the medicine exactly as your provider prescribes– even if you feel better**
- **If you forget a dose DO NOT DOUBLE DOSE - take your next dose at the regular time**

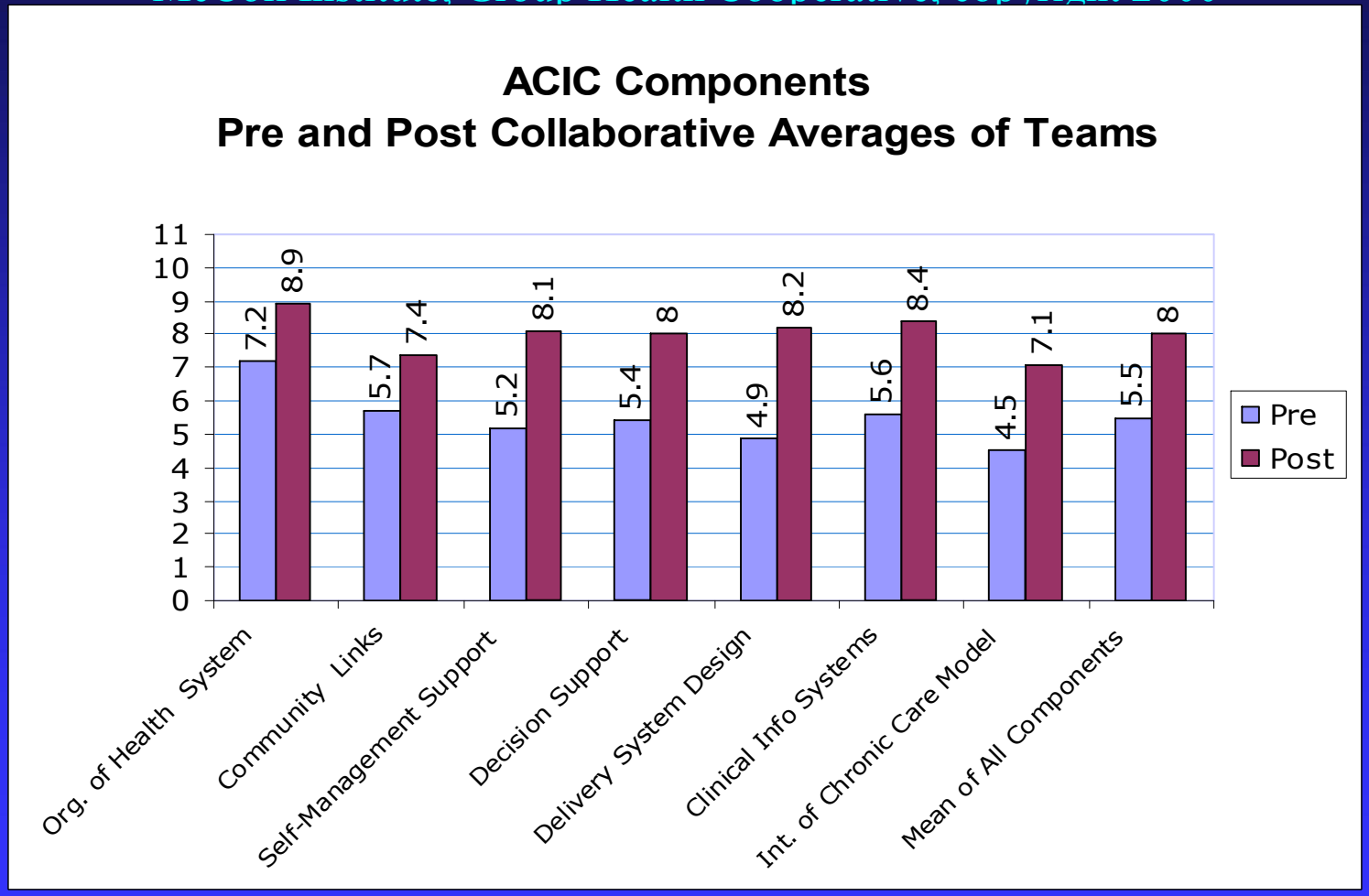
Text courtesy of Ted Amann, RN,C at CareOregon

CareSouth Carolina is a private health and human services corporation which combines the best of traditional, patient-centered health care with the most progressive medical practice. At CareSouth Carolina, you don't have to choose between excellent care and personal attention. We believe you deserve both!

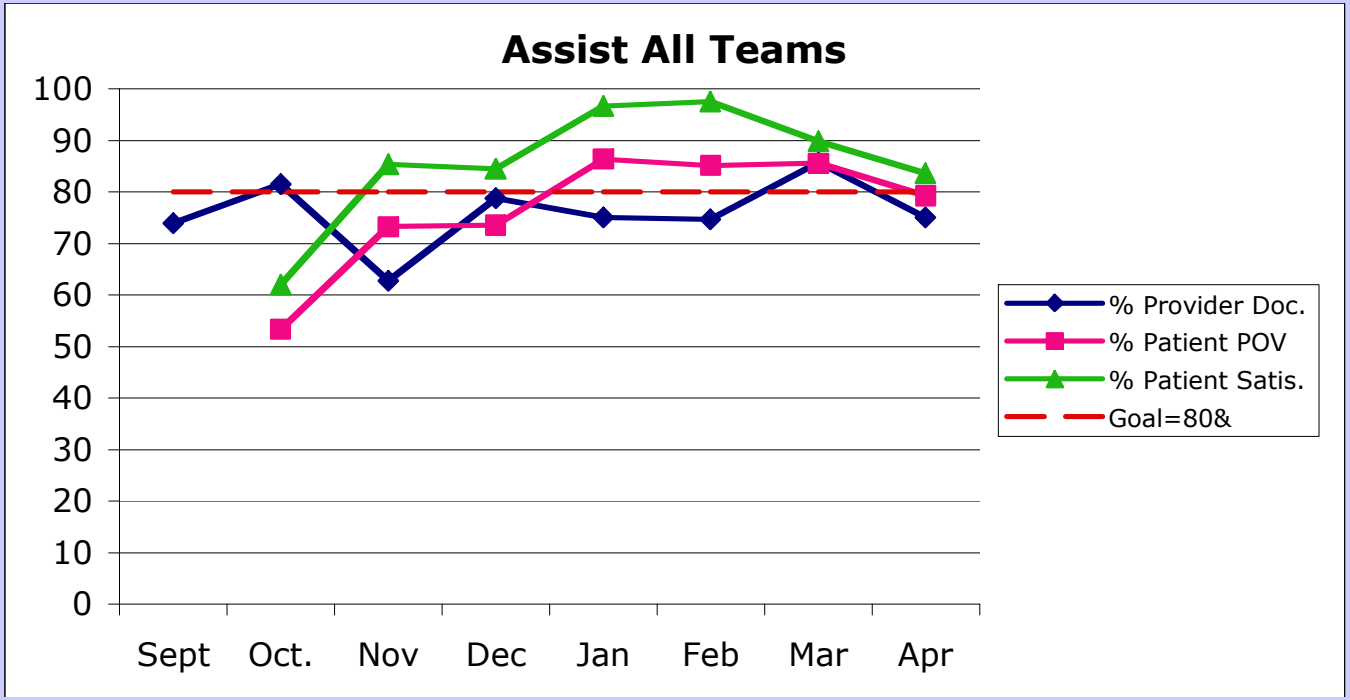
Bishopville Center 803-484-5317	Hartsville Center 843-332-3422
Rosa Lee Gerald Center 843-378-4501	Cheraw Center 843-537-0961

Implementing Collaborative Self-Management Support: Assessment of Chronic Illness Care Survey v 3.5

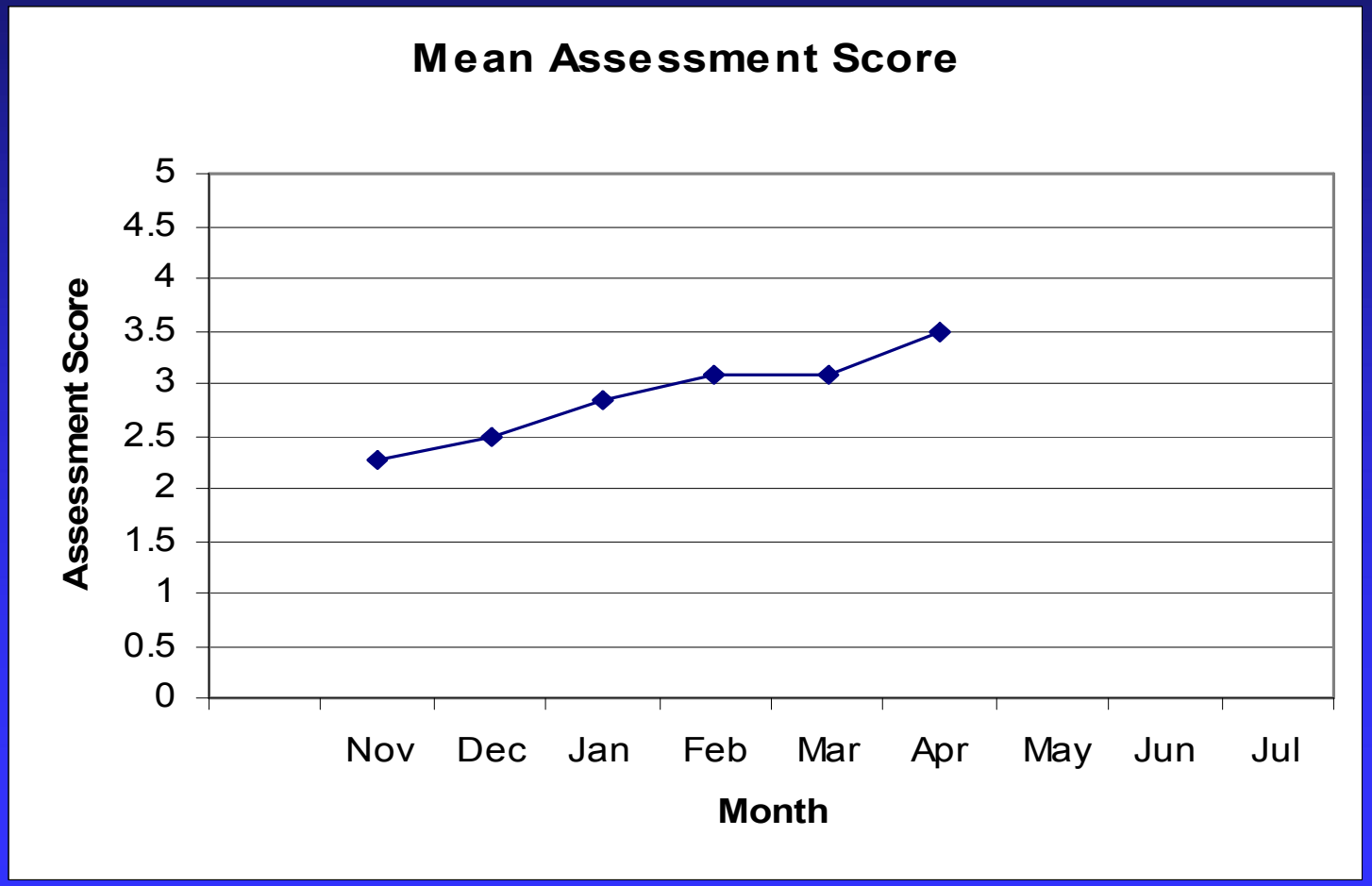
McColl Institute, Group Health Cooperative, copyright 2000



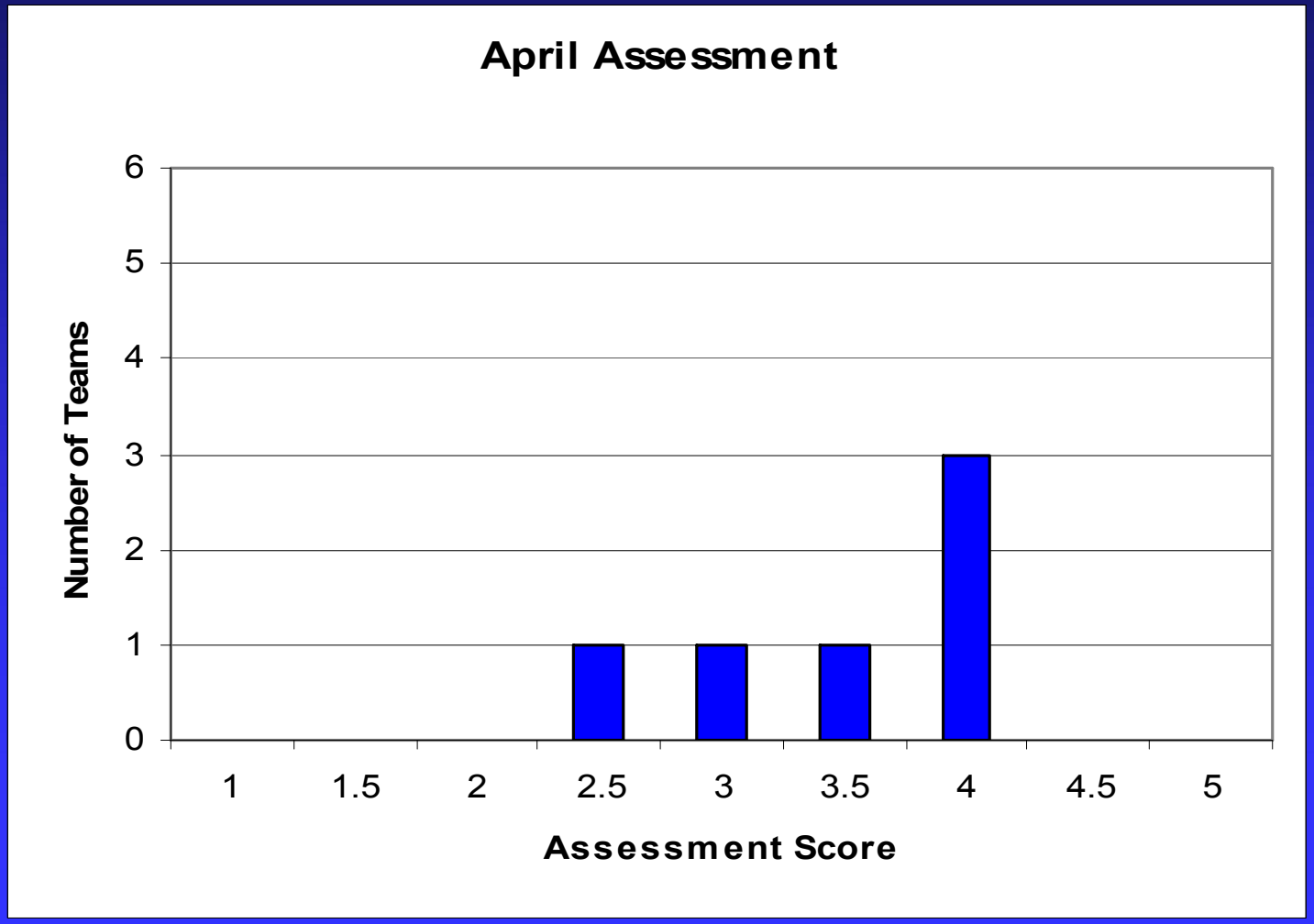
Month All	% Provider Doc.	% Patient POV	% Patient Satis.	Goal=808	n Provider Doc.	n Patient POV	n Patient Satis.
Sept	74			80	72	0	0
Oct.	82	53	62	80	83	183	182
Nov	63	73	85	80	37	75	75
Dec	79	74	85	80	77	72	71
Jan	75	86	97	80	80	88	88
Feb	75	85	97	80	99	81	78
Mar	86	86	90	80	65	96	78
Apr	75	79	84	80	28	168	159



Pilot Collaborative on Self-Management
Collaborative Assessment
Average Assessment by Month



Pilot Collaborative on Self-Management
End of Collaborative Assessments



Bridging Goal Setting and Skill Building: Questions and Discussion

- www.collaborativeselfmanagement.org