Objectives

- **Define** and illustrate the role of *self-management, shared decision making and patient engagement* in promoting best patient outcomes

- **Describe** current *Federal initiatives* that direct the use and implementation of self-management, shared decision making and patient engagement

- **Provide** examples on how self-management, shared decision making and patient engagement can influence *quality measures* for the quality payment program
Expanded Chronic Care Model

The Care Model

Community
Resources and Policies

Health Systems
Organization of Health Care

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Patient-Centered

Timely and Efficient

Evidence-Based & Safe

Coordinated

Services

Informed, Empowered Patient and Family

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
Definition - Self-Management (SM)

Capability to detect and manage the symptoms, treatments, physical and psychosocial consequences, and lifestyle changes inherent in living with multiple chronic conditions (MCC)

Barlow, Wright, Sheasby, Turner & Hainsworth, 2002
Evidence to Support SM

- SM can reduce risk factors, promote adherence to meds and therapy, increase activity and decrease hospital admission rates

- Manage escalating costs of chronic disease in aging populations

(Kuebler, 2015; Redman, 2013).
Management Components

- Medical: Taking meds and treatments and attending appointments as prescribed
- Role: changes in lifestyle, behaviors and life roles
- Perceived quality of life
- Complex regimens with MCC
- Emotional

Schulman-Green et al, 2012
Process of Self-Management

- Enhanced knowledge and beliefs (self-efficacy, outcome expectations)

- Self-regulation skills (goal setting, self-monitoring, decision making, planning and action, emotional control)

- Social facilitation - support/collaboration

(Ryan, 2009; Ryan & Sawin, 2009, Schulmen-Green et al, 2012, Self-Mgmt Science Center, nd)
Concepts Associated with SM

• Internal and External factors that influence a patient’s ability to implement and maintain health behaviors (Evans, 2013).

• Self-efficacy and empowerment

• Therapeutic Relationships

• Move away from compliance to adherence and finally SDM (AHRQ, 2015; Burson & Moran, 2015).

• Motivation - intrinsic (supportive coaching with evaluation of patient readiness to change)
Self-Management Challenges

- Patient demographics (SDH)
- Education/Information/Literacy
- Barriers to behavior change
- Perceptions of providers
- Complex health system/complex regimens/coordination
Self-Management Support

- Engage Patient
- Ongoing assessment and evaluation
- Education - patient specific (goal setting, SDM, problem solving, self-monitoring)
- Solving Patient Identified problems - increases self-efficacy
1. In the era of value based health care and empowering patient self-management of his or her chronic conditions, what are some of the most important tools for use when individualizing a patient care plan for the effective management of concomitant chronic conditions?
Self-Management

a. Patient access to his/her electronic medical record
b. Assess literacy levels
c. Evaluate patient support system
d. Referral to a community support team
e. All the above
E. All the above, patients should be able to monitor their health and outcomes through their electronic medical record. Literacy levels are an important assessment. Use of family and community support are important tools to promote engagement and activation.
Self-Management

“Patient self-management is at the heart of value-based care and achieving many of the MACRA performance measures that are dependent on changing patient behavior”

Chris Delaney, CEO Insignia Health
Activated Patient

- Believes the patient role is important
- Confidence and knowledge to act
- Takes action to improve health
- Sustains action even with stress
Definitions

**Activated Patient**

• Willingness and ability to take independent actions to improve their health

**Engaged Patient**

• Interventions designed to increase activation and the resulting patient behaviors
Increasing Engagement

- Ability to measure activation (PAM)
- Use of evidence to increase activation
- Accountability for support
- Ethical considerations
True or False

Empowering the patient to self-manage his or her diabetes and/or hypertension requires patient and provider communication in the form of shared decision making.

Providers have the responsibility to ensure that the best evidence is shared with the patient so he/she can make informed decisions about their own health and wellness.
Patient Empowerment

True
False
True

Shared decision making between the patient and provider will improve and promote self-management. Self-management empowers patients to take control of their health care management.
Shared Decision Making

- Occurs when a provider and a patient work together to make the best healthcare decision for that patient at the clinical encounter (Gionfriddo et al, 2014).

- Benefit is an increased knowledge of options with accurate expectation of benefits and risks.
Shared Decision Making

- Consistent with patient values and increases participation.
- Reduces conflict, increases patient engagement
- Improved clinician satisfaction (Ferrer & Gill, 2013).
National Quality Forum

- Establishing measurement criteria for SM
- Guidance to improve shared decision making between patients and healthcare providers
- Developed NQP Playbook - making SDM a standard for patient centered care
- Enhance patient education and engagement
- Patient Decision Aids
The joint plan of care should be developed and include education and resources that are:

- Appropriate language and literacy levels
- Community support programs taught by qualified instructors
- Patient preferences
- Readiness to change
Federal Initiatives

• ACA - Value over volume/quality measures (US Dept. of Health and Human Services (DHHS), 2016).

• Chronic Disease Self-Management program (CDSME)/National Council on Aging (NCA)
MCC Strategic Framework

- Maximize use of prove SM practices by:
  (US Dept. of HHS, 2010)
- Develop and improve evidence-based, SM activities and program
- Enhance sustainability
- Improve efficiency, quality and cost-effectiveness
- Facilitate home and community services
CMS Self-Management

The Strategic Framework for Multiple Chronic Conditions released from the Centers of Medicare and Medicaid in 2010, is a result of the Affordable Care Act.

Self-management is a foundational cornerstone in the effective management of chronic conditions leading toward individualized patient-centered outcomes.

Self-management awareness and implementation occurs through:
CMS Self-Management

a. Community trained lay-persons in group settings
b. Provider and patient shared decision making
c. Families and caregiver participation
d. Collaboration with the entire healthcare team (provider, nurses, pharmacist, social worker, e. All the Above
E.
Providers should consider the role that families, caregivers, and communities play in different cultures. Better patient outcomes are achieved through use of evidence-based techniques that emphasize patient activation or empowerment, collaborative goal setting, and problem-solving skills.
Current Initiatives

Medicare Access and CHIP Reauthorization Act (MACRA) includes:

• Merit Based Incentive Program (MIPS)

• Advanced Alternative Payment Models (APMs)
MIPS Improvement Activities

• Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting, teach back, action planning or motivational interviewing.

• Provide condition-specific chronic disease self-management support programs or coaching or link patients to resources in the community.

https://qpp.cms.gov/mips/improvement-activities
• Provide peer-led support for self-management.

• Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).
Provider Engagement

Other side of the coin...
Provider

- Assess your own personal beliefs and professional attitudes
- Identify skills needed for patient approach and encouraging self-management
- Transition systematic approach
Assess Personal Beliefs
Develop Skills
Personal System Changes

Action
Changes
Things
Your approach...

- What’s important to you
- What keeps you from doing what’s important
- Ask permission to share information
- Does any of this information seem to relate to you
- What can be done to move forward
- Set a goal
Patient Education

- Provide education at appropriate literacy levels
- Refer to community programs with qualified educators
How to Get There...

- Start with end in mind
- Collaborative partnership
- Regular meetings
- Tools
- Resources
- System Changes
Utilize Resources

- Michigan Dept of Health and Human Services
- http://www.michigan.gov/mdhhs/0,5885,7-339-71550_63445_83292---,00.html
- Diabetes Self-Management Education and Support (DSMES)
- PATH - Personal Action Toward Health
- Diabetes Prevention Program DPP
- Enhance Fitness
Resources

- Certified Diabetes Educators
- Lay support
- Support Groups
- Shared Medical Appointments
- Diabetes Apps