Section 6.2 Optimize

# Coaching Patients in Self-Management

This tool provides techniques and example scripts for care coordinators (CCs) to use in encouraging patient engagement in self-management in a community-based care coordination (CCC) program. For a general overview of patient self-management concepts, see *Promoting Patient Self-Management* in this Toolkit.

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**Time required**: 3 hours

**Suggested other tools**: Approaches to Patient Communications; Promoting Patient Self-Management; Supportive Communications; Patient Action Plan; Patient Health Diary; Establishing the Care Team: Roles & Communications

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## How to Use

1. **Review** the advantages to patients by actively engaging them in the management of their own health, and the community's role in patient self-management.
2. **Review** the techniques for engaging patients in self-management, as well as the example scenarios in how the techniques might work.
3. **Recognize** that patient self-management doesn't happen overnight and that it might take time to engage some patients. Consider using community resources to help patients with self-management issues.

## Advantages to Patient Self-Management

There are many advantages to encouraging patients to manage their health and health care, ranging from improving their personal well-being to reducing cost of care. Patient self-management is a process that includes monitoring patients' perceived health and then helping them manage their symptoms, treatments, medications and successes. For a comprehensive description of patient self-management, see *Promoting Patient Self-Management*.

Patient self-management is not always easy to accomplish. It is difficult to change a long-entrenched lifestyle, even when there is motivation to do so. Psychosocial and financial factors are key barriers. Many older persons are fiercely independent, may be embarrassed about the need for help, may lack resources to make changes or think they cannot afford some of the desired interventions, and may fear failure and the associated perception that they are incompetent. There has often not been a strong support system within the medical community to help patients manage on their own, nor in the community at large or even sometimes within the family.

The successful CC is one who can be supportive, low-key, and gentle in approach, as well as being non-judgmental and non-confrontational. Counter to the typical directiveness of most providers, the CC achieves the most by serving as a coach or navigator, helping patients understand how they can help themselves and allowing patients to make their own choices and determinations about when and how to change. (See *Approaches to Patient Communications.*)

## Community Role in Engaging the Patient in Self-Management

Two paradigm shifts are necessary for the community to recognize and for the patient to understand. Both revolve around moving away ***from*** the notion that health care occurs only in a structured health care setting and only by a provider ***to*** recognizing that health care also occurs in the home, and that patients are capable of and can be interested in managing their own health.

- **The care delivery process does not end when the patient goes home**, whether from an ED visit, hospitalization, or even a clinic visit. Because of how the current health care delivery system has been structured, most health care professionals often do not think of health care as extending into the home (except when provided by a structured home health care delivery mechanism), or at least have not taken responsibility for making the connection between the structured care setting and the home. Continuity of care in the broadest sense, however, is essential to helping patients regain or stabilize their health conditions. Every health care professional needs to recognize their role in the health care continuum and make the appropriate handoffs.

- **The community-based CC is the health care professional who fills the gaps between each handoff.** As such, the CC should be explicitly called upon by each health care professional at each transition of care to ensure the connections happen successfully. Not only does this help the CC do his or her job on a timely basis and with the appropriate information, but signals to the patient that there is a continuum of care and that the CC is one element of that care process, not a separate piece of the process for which separate payment is involved. The CC is an integral part of the total health care delivery system. The health care professional, when operating in the role of CC, is not the patient's direct treatment provider, but should be viewed by the patient and other health care professionals as part of the patient's care team. (See *Establishing the Care Team: Roles & Communications*.)

## Techniques for Engaging Patients in Self-Management

1. ***Prepare for the visit***

   It is important for both the patient and CC to prepare for the visit. Research has shown that patients who have the opportunity to share their concerns with a care coordinator or provider[1] are less anxious and show more improvement, even if they just provide a written list of those concerns.

2. ***Develop an agenda together***

   At the start of your visit with the patient, make a list of the things that each of you hopes to achieve during the visit, and prioritize the items so that you are able to address the most important things first. Working together to build the agenda demonstrates that the patient's concerns are valued and that you will make time to hear them.

3. ***Ask open-ended questions***

   Encourage the patient to share their experience with you by asking questions that require more than a yes/no response. This can also be done in the form of a statement such as "Tell me more about that."

4. ***Practice reflective listening***

   In order to build a trusting relationship with the patient, it is important to show that you hear and understand what they are telling you. Give the patient time to share their story without interruption and respond by rephrasing what you heard from them without adding meaning or judgment.

5. ***Recognize and elicit "change talk"*** [2]

   Change talk is any statement that expresses a desire to change. It could be as simple as "I wish I could stop smoking" or "At one point in my life I was able to eat better." Listen for these types of statements and ask for more information in a way that will encourage the patient to think more specifically about the change, such as "How might your life be different if you stopped smoking?" or "What is it about your eating that concerns you now?"

6. ***Affirm and celebrate what works***

   During your visit with your patients, make time to acknowledge and talk about what has worked and what success will look like. Ask the patient how they are celebrating their accomplishments. Spend time discussing how it will look and feel to accomplish their goals.

7. ***Make a specific and realistic plan***

   Working in partnership with the patient, identify concrete steps that will be taken to address a particular health concern. Talk about the different options and select one that is consistent with the patient's lifestyle and that the patient is confident they can implement. Set a timeline and talk about how you will monitor progress together. (See *Patient Action Plan*.)

8. ***Follow up***

   After the visit be sure to spend time arranging for support services that will help the patient be successful in achieving his/her goals. Make a plan to follow up with the patient

as needed to check on their progress. For some this may mean a phone call in the next 24-48 hours, while for others, a follow-up call in 1-2 weeks may be sufficient.

As with other improvement efforts, all of the skills above take practice. Rather than trying to do all of them at once, pick one or two to start with and become comfortable with your ability to use those skills before trying others.

## Scenarios for Practicing Patient Self-Management Coaching Techniques

### SCENARIO 1

Mrs. Smith is a 68-year-old patient with congestive heart failure who smokes. She has tried to quit smoking on several occasions, and now believes that she is unable to quit and that she has every right to smoke. She takes care of her two grandchildren a couple of days a week and does her best not to smoke when they are around.

1. ***Prepare for the visit***. Ask Mrs. Smith to make a list of her health care concerns and questions and bring them with her to the visit. Review Mrs. Smith's chart and notes from previous visits so that you have a good understanding of her health, health care experience, lifestyle, and home environment. Make a list of the things that you would like to talk about at the visit: how she is feeling, medications, smoking, support system, physical activity.

2. ***Develop an agenda together*.** At the start of your visit ask Mrs. Smith for her list of questions and concerns and share yours as well. Given the amount of time that you have available for the visit, prioritize the items from both of your lists and decide which items you want to be sure to talk about at this visit.

| Your list | Mrs. Smith's list |
|---|---|
| 1. How she is feeling today | 1. Doesn't like her doctor |
| 4. Medications | 2. Wants to be able to play with her grandchildren |
| 2. Smoking | 3. Having a hard time sleeping |
| 3. Support system | |
| 5. Physical activity | |

Agenda for the appointment

1. How you are feeling today
2. Recent appointments (Mrs. Smith's experience with her doctor)
3. Plan to stop smoking
4. Physical activity/playing with grandchildren

**3.** ***Ask open-ended questions.***

a. How do you feel today?
b. Tell me more about your experience with your doctor.
c. What kinds of things would you do with your grandchildren if you could?
d. What is preventing you from being able to play with your grandchildren?
e. What do you do when you aren't able to sleep?

4. ***Practice reflective listening.*** Simple example:
    a. *Patient:* I've tried to cut back on smoking, but I gain weight and then I always end up starting again. I try to do it less when my grandchildren are over, but it's still hard.
    b. *CC:* So it sounds like you're concerned about gaining weight and smoking around your grandkids, and that you've tried to quit before, but it has been difficult.
    c. *Patient:* My doctor just keeps telling me over and over that I need to do this and I need to do that, but he doesn't listen to me. I try to ask questions and tell him things, but he's always rushing out of there after 10 minutes.
    d. *CC:* You've tried talking to your doctor about your concerns, but he doesn't hear you and keeps repeating the same instructions.

5. ***Recognize and elicit "change talk".*** Acknowledge that Mrs. Smith has tried to quit smoking in the past and that she tries not to smoke around her grandchildren. Both of these actions indicate a willingness to change. Ask questions to get her to say more about the potential for change.
    a. When you have tried to quit smoking in the past, what has been most difficult?
    b. How does your smoking affect your grandchildren?
    c. How would your life be different if you weren't smoking?

6. ***Affirm and celebrate what works.*** Tell Mrs. Smith that you are proud of her for trying to quit smoking in the past and for her efforts to limit her smoking around her grandchildren.

    *CC:* "I'm proud of you for trying to quit smoking and for working so hard not to smoke around your grandchildren. I know it is hard to do."

    Talk about the importance of recognizing and celebrating the small steps toward achieving her goals. Ask Mrs. Smith how she will celebrate her accomplishments on her own and discuss how the two of you could celebrate together as she makes progress toward her goals.

7. ***Make a specific and realistic plan.*** Ask Mrs. Smith if she is willing to consider quitting smoking. Discuss options that are available to her (patch, medication, QuitPlan, gradual reduction, etc.) Identify manageable steps that Mrs. Smith will take to implement the plan, such as:
    a. Build a support system – tell friends and family that you want to quit smoking.
    b. Identify triggers for smoking – describe the circumstances when you are most likely to smoke.
    c. Decide on a quit date – make it a day that will be stress-free and when support will be available.
    d. Make a plan to stay busy in the first week after you quit.

8. ***Follow up.*** Tell Mrs. Smith that you will contact her at key points in her timeline: one week from today, on her quit date, and 2 days after her quit date.

**SCENARIO 2**

Mr. Jones is a 71-year-old patient with diabetes who loves to eat sweets. He is about 25 pounds overweight. He knows that it is important to manage his blood sugar and he doesn't want to be on insulin. A nurse showed him how to read a food label, but it just seems like too much work and he can't ever remember which number to check. Besides, his wife makes such good desserts and they don't come with a label.

1. ***Prepare for the visit***. Ask Mr. Jones to make a list of his health care concerns and questions and bring them with him to the visit. Review Mr. Jones' chart and notes from previous visits so that you have a good understanding of his health, health care experience, lifestyle, and home environment. Make a list of the things that you would like to talk about at the visit: monitoring his blood sugar, medications, nutrition, blood pressure, physical activity.

2. ***Develop an agenda together*.** At the start of your visit ask Mr. Jones for his list of issues and share yours as well. Given the amount of time that you have available for the visit, prioritize the items from both of your lists and decide which items you want to be sure to talk about at this visit.

| Your list | Mr. Jones' list |
|---|---|
| 4. Monitoring blood sugar | 3. Wants to lose weight |
| 2. Medications | 1. Tired a lot |
| 3. Nutrition | 2. Blood pressure |
| 1. Blood pressure | 4. Insurance |
| 5. Physical activity | |

Agenda for the appointment
1. Blood pressure
2. Nutrition/losing weight
3. Fatigue

**3.** ***Ask open-ended questions.***
   a. What do you eat on a typical day?
   b. How often do you feel tired and what does that feel like?
   c. What do you think it will take for you to lose weight?
   d. Who is available to support you when you need help?

**4.** ***Practice reflective listening.*** Simple example:
   a. *Patient:* I know I shouldn't eat dessert every day, but my wife loves to bake for me and what does it really matter at this point in my life.
   b. *CC:* Your wife enjoys baking for you, so you usually eat dessert and don't know if it would make a difference to stop eating desserts.
   c. *Patient:* The nurse told me that I am supposed to read the labels on food when I go grocery shopping, but there are so many numbers and the print is so small. I can't ever tell what's good for me and what's bad for me.

d. *CC:* You have tried to read the labels on the food that you buy at the grocery store, but you aren't able to find the right information so you are unsure about what to buy.

5. ***Recognize and elicit change talk*.** Acknowledge that Mr. Jones wants to lose weight and knows that it is important to manage his blood sugar. Both of these actions indicate a willingness to change. Ask questions to get him to say more about the implications of change**.**
    a. What do you think it will take to get your blood sugar under control?
    b. What are some things that you could do instead of having dessert?
    c. What do you think your life would be like if you had to take insulin?

6. ***Affirm and celebrate what works.*** Tell Mr. Jones that you appreciate his willingness to consider some changes and that he is already making a difference by meeting with you today. Prompt him to think about how things may be different when he achieves his goals.
    a. How do you think you would feel if you lost 20 lbs?
    b. What is your vision of your best self?

    Talk about the importance of recognizing and celebrating the small steps toward achieving his goals. Ask Mr. Jones how he will celebrate his accomplishments on his own and discuss how the two of you could celebrate together as he makes progress toward his goals.

7. ***Make a specific and realistic plan*.** Ask Mr. Jones what he would most like to change about his health. Let's assume that he would like to eat fewer desserts. Discuss ways that he might do this (stop altogether, consider other types of desserts, cut back on the number of desserts, eat smaller portions, etc.) Identify manageable steps that Mr. Jones will take to implement the plan.
    1. Talk to his wife about the importance of eating less sugar and how that will improve his health.
    2. Cut back to 2 desserts per week by the end of the month.
    3. Make a list of activities that he could do in the evening when he usually craves dessert.
    4. Identify healthier alternatives to dessert that may help to satisfy his cravings for sugar.

8. ***Follow up*.** Tell Mr. Jones that you will contact him at key points in his timeline: one week from today, two weeks from today, and at the end of the month.

## Recognize When Time is Not Right for Patient Engagement/Self-Management

While the more patients that can be engaged in the CCC program the better, it is important to recognize when the time may not be right for the patient to engage themselves, or he or she may be somewhat willing to engage but has not fully bought into self-management. It is best to take it slow and pace communications with the patient than to turn them off CCC services entirely.

*For example*, even if a patient declines help in an initial outreach, you can determine when the patient's next scheduled clinic appointment is that may be feasible for you to attend, have the provider introduce you as the CC, and stress how helpful others have found the program. This may re-open a closed door. If the patient is hospitalized or is seen in the ED, those are also opportunities that may be more natural for engaging the patient.

If the patient seems willing to take calls, meet, etc., but unwilling to complete a Patient Action Plan or take other self-management steps, determine if there is ***one*** thing the patient needs the most for which CC help can be provided. Do not require a formal plan to be documented. Simply achieve success with helping the patient manage that one thing and proceed forward from there.

It is also possible that the patient may have been engaged and potentially was even doing some self-management but suddenly seems to stop or becomes less interested. Attempt to determine if there is a change in the patient's condition, a family or caregiver issue, or some other factor that has had an impact upon his/her motivation or ability to participate. Put aside other action plan topics and address this issue to the extent possible.

## Utilize Community Resources to Help Overcome Issues

In addition to focusing on the patient and his/her needs, reach out to the community to:

- Provide feedback to the PCP on how a patient is doing. The patient may need additional help from the PCP, may need a specialist, or may need other/additional special services.
- Use the care team communication strategies described in *Establishing the Care Team: Roles and Communications*. Urge the patient to agree to those services. Explain why they may be helpful. Offer to help make arrangements and follow up afterwards to answer questions.
- Solicit feedback on how others see the patient. Are others seeing a decline in interest, or was there an incident with someone that scared the patient, caused anger or anxiety, etc.? Follow up with the patient on problems identified by community resources.
- Learn about new community offerings or urge new community offerings that support patients in self-management to be instituted if needed.

## Resources

Partnering in Self-Management Support: A toolkit for clinicians, Institute for Health care Improvement. Available at: http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx

Motivating Change: Innovative Approaches to Patient Self-Management. Available at: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MotivatingChangeSelfManagementIB.pdf

Primary Care Resources and Support for Chronic Disease Self-Management. Available at: http://improveselfmanagement.org/pcrs_resource_page.aspx

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## References

[1]Source: Activation of Patients for Successful Self-Management. Available at: http://journals.lww.com/ambulatorycaremanagement/Fulltext/2009/01000/Activation_of_Patients_for_Successful.4.aspx

[2]Source: Coaching the difficult patient. Available at: http://www.dphhs.mt.gov/publichealth/cardiovascular/documents/2011SummitMichaelBurkeCoachingtheDifficultPatient.pdf

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