

# Helping Patients Take Care of Themselves in 20 Minutes or Less

(OK, maybe 30 minutes!)

Ryan White All Grantee Meeting

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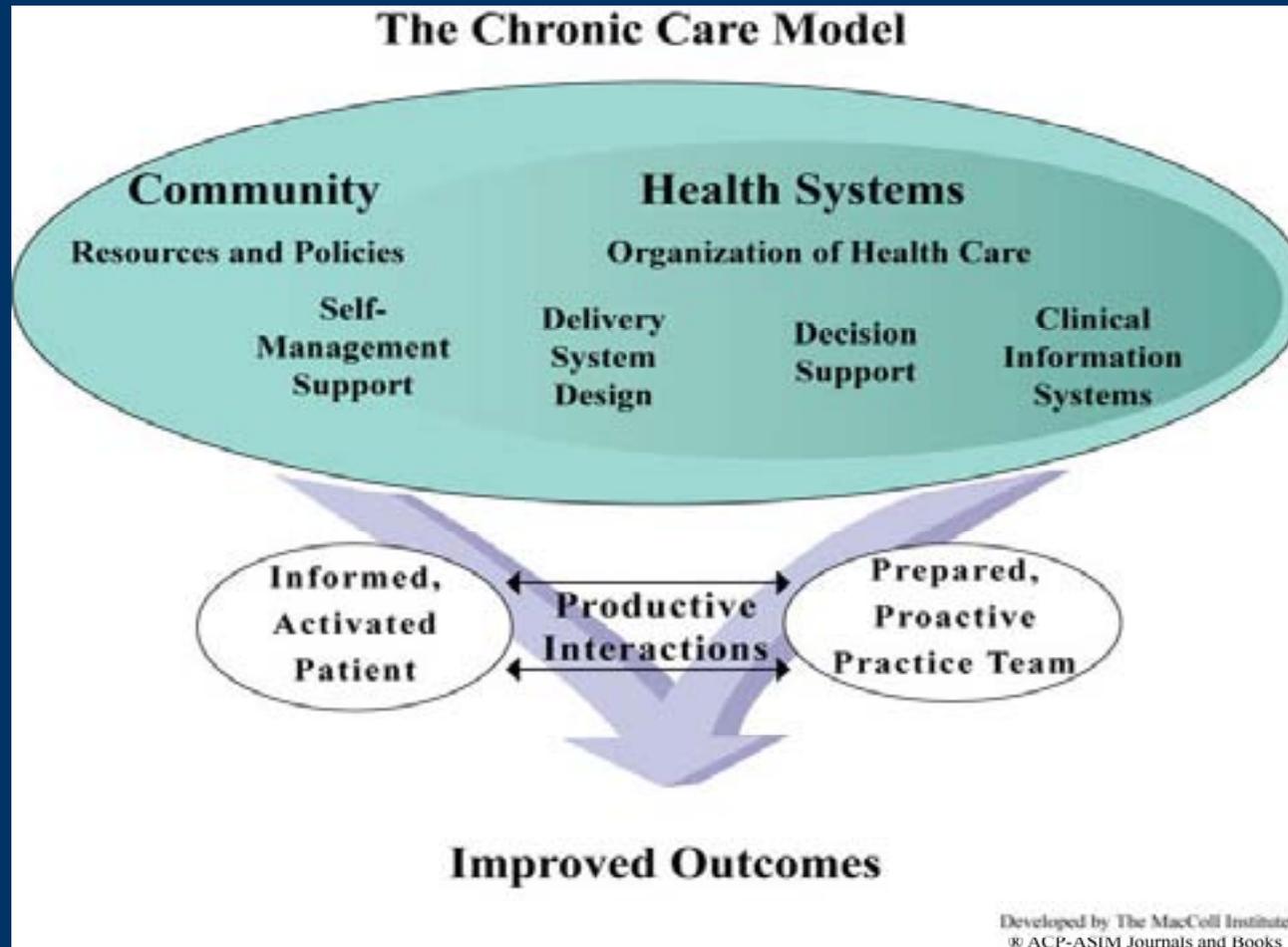
# Objectives



## Providers will:

- Briefly review the chronic care model
- Apply the CCM with an emphasis on self management using the 5 As of self-management support
- Learn to use techniques to enhance a patient's self management skills in the context of a short office visit
- Learn ways to measure effectiveness of self-management support

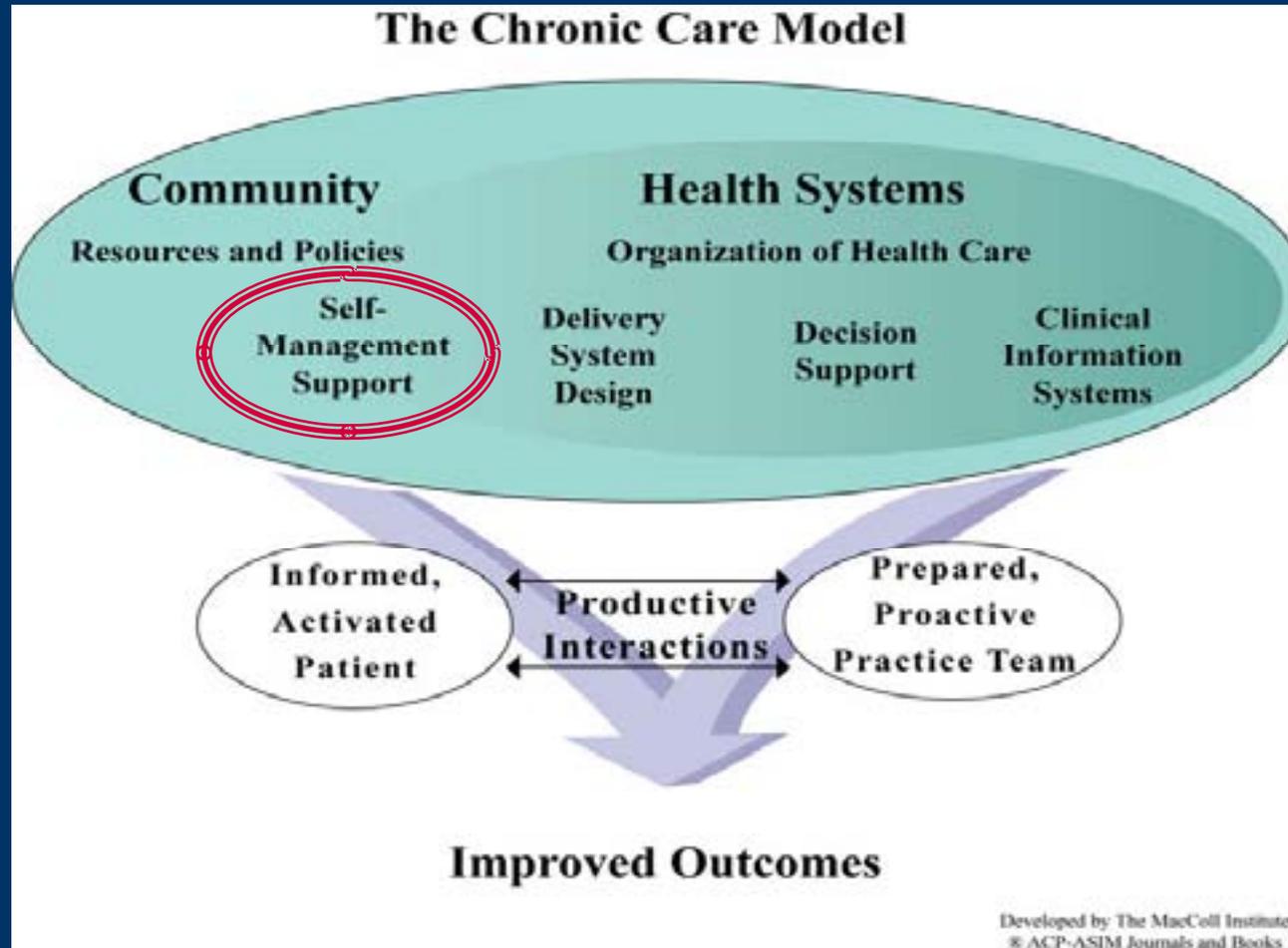
# Chronic Care Model



# Key Tenets of Chronic Care Model

- Create a culture, organization and mechanisms that promote safe, high quality care
- Assure the delivery of effective, efficient clinical care and self-management support
- Promote clinical care that is consistent with scientific evidence and patient preferences
- Organize patient and population data to facilitate efficient and effective care
- Empower and prepare patients to manage their health and health care
- Mobilize community resources to meet needs of patients

# Chronic Care Model



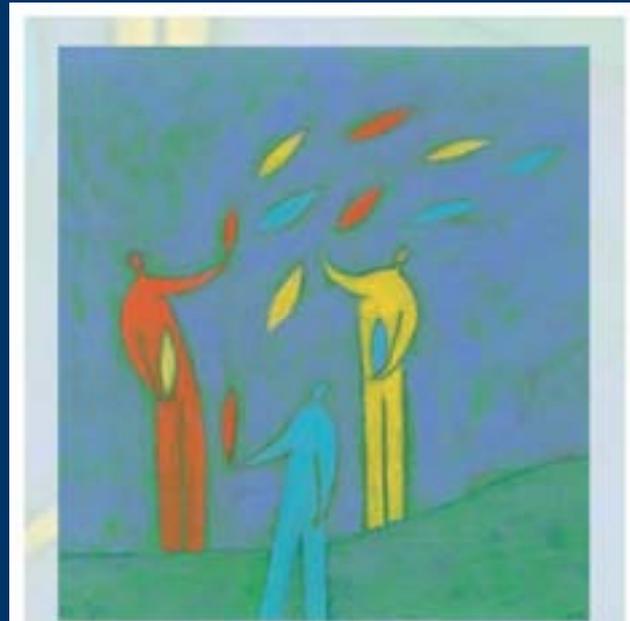
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## Self Management Support

- **Empower and prepare patients to manage their health and health care**
- Mobilize community resources to meet needs of patients

# Self Management Support (within the chronic care model)



Self-management support is the care and encouragement provided to people with chronic conditions and their families to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviors.

“Self-management support is the assistance caregivers give to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes.

Self-management support may be viewed in two ways: as a **portfolio of techniques and tools** that help patients choose healthy behaviors; and as a **fundamental transformation of the patient-caregiver relationship into a collaborative partnership...** The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.”

Tom Bodenheimer, Helping Patients Manage Their Chronic Conditions [www.chcf.org](http://www.chcf.org), 2005

# Self Management Support (within the chronic care model)

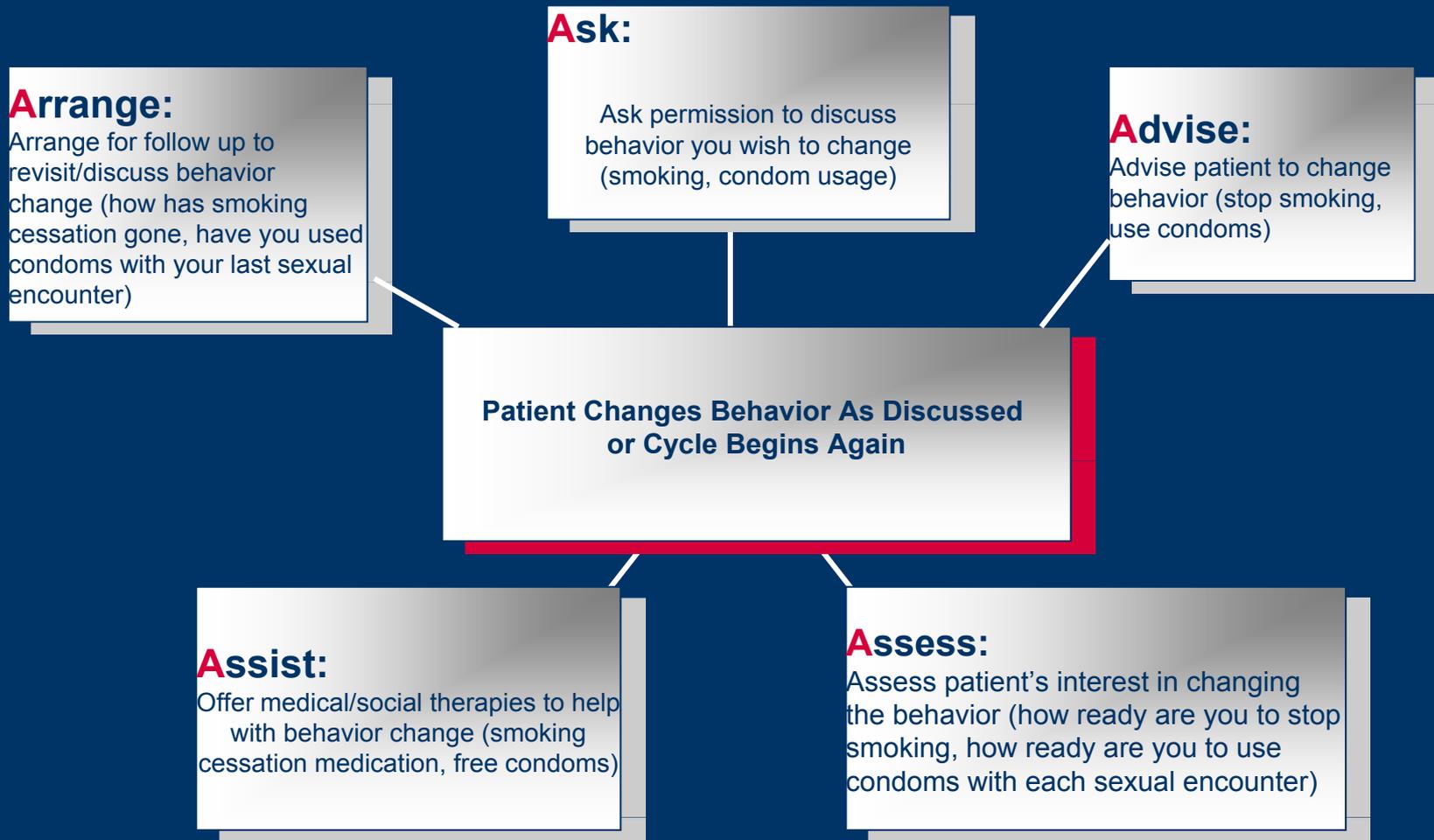
## Evidence for Self Management Support

- Increase utilization with involvement of multidisciplinary teams (Sequist et al, 2009)
- More effective when provided by multidisciplinary teams (Sequist et al, 2009)
- Can improve health outcomes in patients with chronic disease (multiple authors)
- Tailoring interventions to patient's level of activation can produce improved outcomes (Hibbard, et al 2009; Mosen et al, 2007; Johnson et al, 2007)

# How Do We Provide Self Management Support Effectively (and quickly)?

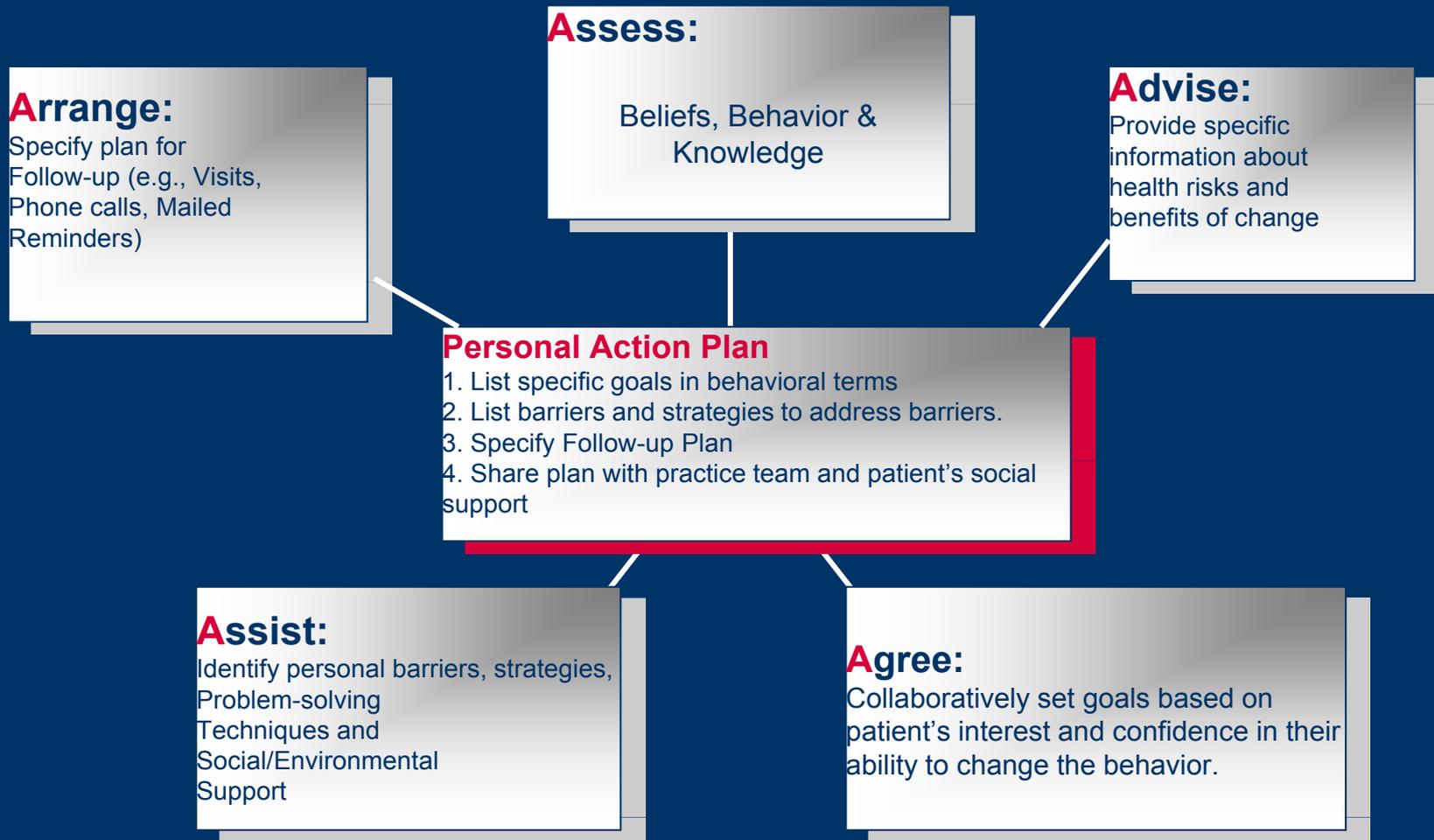
- Self Management support is a process, not an event
- Patient activation is key (meet the patient where they are)
- Utilize resources outside the visit time (phone, email, texting)
- Use of decision support aids can help
- RESPECT PATIENT AUTONOMY to work towards behavior change

# 5 A's of Behavior Change

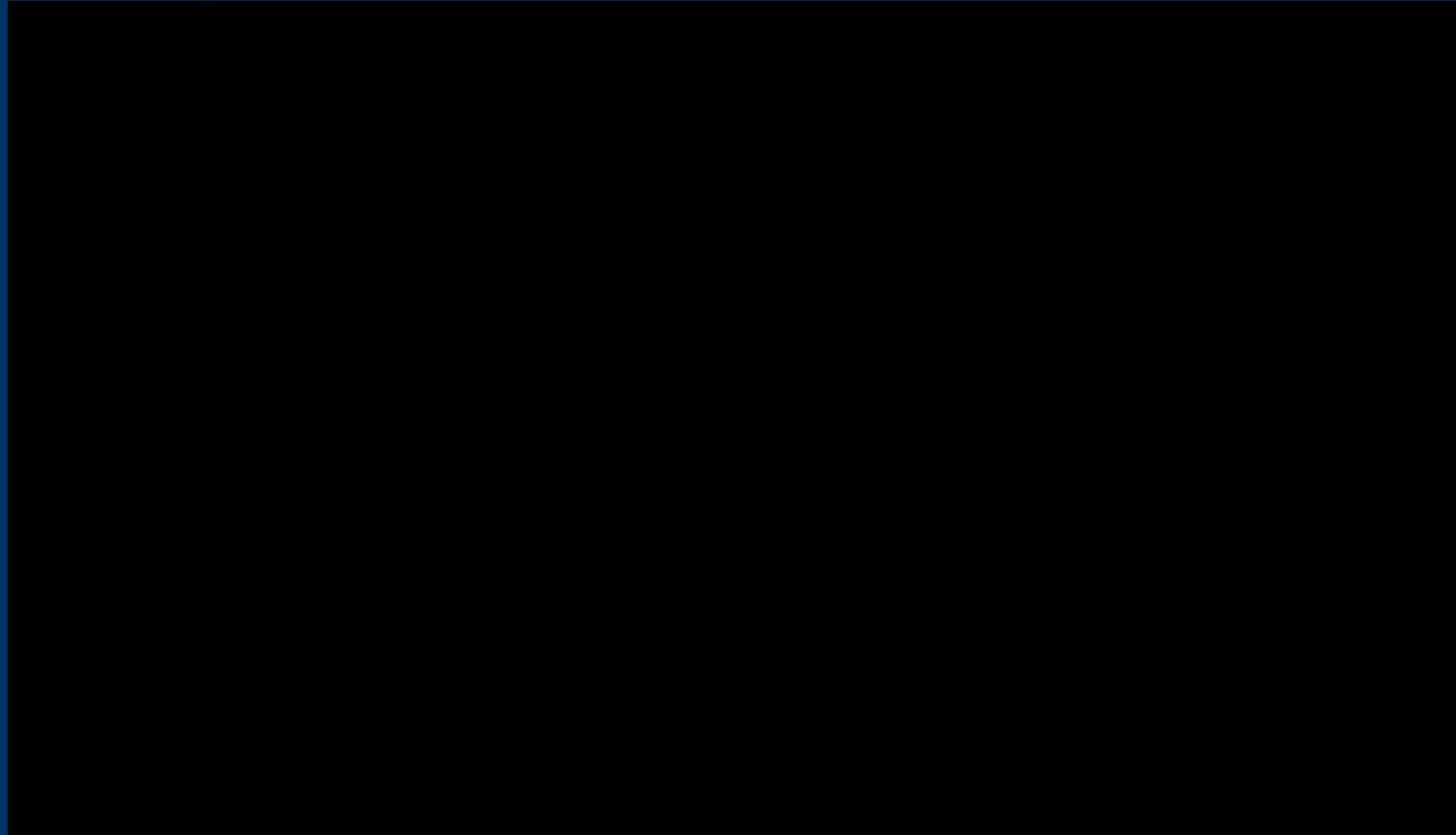


# 5 A's of Self Management Support

(adapted from the Pilot Collaborative for Self Management Support)



# Partnering with Patients for Self Management



“Coaching Patients for Successful Self Management” presented by Tom Bodenheimer, M.D., UCSF/San Francisco General Hospital. 2008.  
California HealthCare Foundation

# Providing Self Management Support is a Collaborative Process

- Collaboration is a hallmark of Ryan White Programs
- Peer, Family and Medical Team Support
- Chronic disease patients (including those with HIV) benefit from a collaborative process (Sequist, et al 2009)
- Case Management occurs outside the medical encounter and is effective in changing behaviors
- This process needs to include both medical and social support

# Collaborative Care Model



# Evaluation Techniques

- Feedback is important to gauge success for both patient and providers
- There are various evaluation tools to gauge success of self management support techniques

- **Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS).**

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# PCRS

- Designed for multi-disciplinary teams to evaluate the effectiveness of their self management support
- Designed to be discussed and can be used as a method to follow progress within an institution

# Case of Collaborative Self Management Support at Work

- CM is a 39 yo female with HIV presenting for management of HIV
- PMH: Diabetes, multi-drug resistant HIV
- Meds: Metformin, Maraviroc, Ritonavir, Tenofovir/Emtricitabine, Fosamprenavir, Abacavir
- Allergies: Amoxicillin
- Pertinent Social History: She currently cares for her 9 yo son who has autism and takes up much of her time and energy. She also has 1 other child and a household to take care of. Her husband has a job which causes him to be gone from the household often.

# C.M. continued

- Labs: presenting viral load= 87,500; CD4= 208
- C.M.: “I’m changing doctors because I’m not happy with my doctor. I’m having trouble remembering to take my medication”

# Self Management Support with C.M.

- Ask: Beliefs, Behaviors, Knowledge
  - CM is devoted to her family, especially her son, and often puts his needs above hers. She is close to her mother and talks to her everyday. She wants to take her medications correctly but often forgets if she gets busy.
- Advise: Discuss benefits of change
  - We discussed the need to take her medication in a way that would get her viral load undetectable. This would help prolong her life and allow her to continue to take care of her family.

# Self Management Support with C.M.

- Agree: Collaboratively set goals
  - To get to the eventual goal of achieving an undetectable viral load, we set a goal of adhering to a schedule of medication administration that worked with her life
- Assist: Problem Solving
  - She was often forgetting morning doses because she would talk to her mom and get side tracked.
  - She was having daily diarrhea which also made her less excited to take her medication
  - She did not have a consistent area where all of her medications were stored
  - Based on her genotype, once daily dosing was not an option

# Group Breakout

1. How would you approach the Arrange portion of this encounter to provide self management support for patient?
2. How would you approach engaging the patient to come up with a personal action plan based on the information above?

# Group Reports



# What We Did

- Arrange: Set Follow up

- She scheduled to follow up via phone and in person with the pharmacist and with the physician in 3 months. She also followed up with the social worker and child life specialist.
- She was concerned about interference in her busy life. Appointments were short and scheduled around her children's schedule.

# What We Did

- Personal Action Plan: identify goals, barriers and possible solutions, follow up and involvement of team and social support
  - Scheduled administration: she was provided with a pill tray which divided her medications appropriately. She also got her medication filled at our pharmacy in 90 day supplies and picked up her refills at her appointments for convenience
  - She recruited her mother to cue her to take her medications during their phone call, which kept her from missing her morning doses
  - She arranged for additional help for her autistic son and connected with support groups
  - She discussed with her family the need for others to help out

# What We Did

- Personal Action Plan: identify goals, barriers and possible solutions, follow up and involvement of team and social support
  - We adjusted her medications to decrease her diarrhea (decreased ritonavir from 200 mg bid to 100 mg bid)
  - We treated her diabetes and hypertension to goal which improved her overall quality of life and decreased her fatigue
  - She continued to take this new regimen and was able to demonstrate adherence via self report and improved laboratory studies
  - Since she had multi drug resistant virus, once she was more adherent to her less potent therapy, she was changed to a more potent regimen and her less effective therapy was stopped
  - She has maintained an undetectable viral load for 8 months.

# Provider Comments

## First Visit

- Pharmacist MTM:
  - “Advised patient that she should set a personal time so she will have a chance to take her medications. (...)
  - Also asked patient to get mom to remind her to take her medications. (...)The problems identified today were reviewed with patient and noted on her personal health action plan.
  - Patient given a copy and asked to try at least one of them for the next two weeks. Patient stated understanding and willingness to try. Will follow up with patient at her next visit ”
- Social Work
  - “Pt's son was referred in the past for assessment (2-2008) and resource referrals and has not followed up with the Autism Clinic due to insurance coverage per pt's report. Pt's son is involved in therapies. Mother reporting today that she is dealing with son's behaviors and does not feel that she has adequate support.
  - She is interested in her son being assessed (...).
  - SW faxed in a new referral to the Autism Center and mailed mother a copy of the referral. “SW spoke with pt about a referral I made for her son to the Autism Clinic (...). Pt has started the process and is collecting information from her son's school in order to begin the program.”

# Provider Comments

## Follow up visit (pharmacist, SW, CM)

- “Reviewed Action plan with patient from last visit: Patient states she is doing better, but has not set up a personal time. Did not ask her Mom to help. Does not use a pill tray. States only 1 missed PM dose in the last 2 weeks. Advised patient that a pill tray may be helpful, but patient was not willing to commit.”
- Next visit 2 wks later “After much discussion, patient stated she wanted to work on adherence by using a pill tray.”

# Provider Comments

## Follow up physician visit: most recent

### ■ Pharmacist:

- “Taking all medications adherently. States one missed dose in the last month. Is using a pill tray and that has improved adherence.”

### ■ Social Work

- “Pt completed a Depression Screen because of her past struggles with depressive symptoms and scored a 24 (normal). SW asked pt how she felt about the score. Pt said she isn't feeling hopeless, overwhelmed and sad anymore.
- SW asked pt what has changed for her and why she feels less depressed. Pt said her husband was assigned a stable run every week, so his schedule is dependable. Crystal stated that she is getting more support from him and that is really helping her.
- SW checked in with pt about her supports for her autistic son. Pt reported that she is receiving extra services from the Autism Clinic such as therapy. Pt reported being more assertive in asking for support for herself and her son. She has a parent advocate at her son's school as well who assists her. SW congratulated pt on her improved supports.”

### ■ Child Life

- “Pt expressed she would like to meet more parents who have children with autism which would help her feel supported. Provided pt with family/parent support groups and resources in the community and volunteer opportunities with autism organizations.”

# Most Recent Physician Visit 18 months from arrival into clinic

- CD 4=625
- HIV RNA < 40
- LDL cholesterol=78 (down from 107), HDL 75 (up from 55)
- HgA1c= 6.4 (down from peak 8.3)
- BP=131/73 (down from 166/99 at presentation)
- Weight=122.8 kg (up from 121.3 kg at presentation)

You can't have everything!!!



# Lessons Learned

- Often the work involved in self management support feels seamless to patients (but not to providers!)
- When it works, patients begin to feel empowered to change many aspects of their lives
- Self management support won't fix everything but it's worth a try
- Puts the patient first and in charge of the plan (feels right to patients)

# Interactions: Use of the 5 As

- Pick a difficult patient from your own panel and practice using the 5 As to offer self management support
- Switch so that everyone gets a chance to be the provider



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# Thank You!

## Questions?

