Self-Management Support

Collaborating with patients to co-create goals, plans, and action steps that address patient needs and are rooted in the desired outcomes of the patient.

Key Changes

- **Develop** a comprehensive self-management support (SMS) system for the practice.
- **Establish** who on the practice team will be given the time and skills to work with patients on self-management plans that include goals and action plans.
- **Develop** workflow strategies to address self-management at every encounter.
- **Train** staff to help patients use problem-solving skills to improve health.
- **Use** the EHR to co-create and document the SMS goals and plan.
- **Identify** and **develop** relationships with self-management resources in the community.

Examples

- Train providers and staff on time-efficient goal setting and action planning.
- Create scripts that guide the conversation with patients.
- Use the methodology of agenda setting to protect time for self-management plan creation
- Practice goal setting, identifying barriers and scaling of importance and confidence skills in role plays for clinicians, nurses, behavioral health, RN care managers and MAs.
- Generate a document from the EHR for the patient to take home and/or receive by email that includes goals, strategies for barriers.
- Build electronic infrastructure to support SMS. Create documentation systems that alert all users of SMS plans, and that include simultaneous population of the care plan in appropriate EHR sections: patient centered care plan section, progress note, and after visit summary or patient instructions.
- Patient centered care plans should be visible on the sign-in page for each patient's chart.
- Develop workflow where MAs open the self-management goal template so it is easy for the rest of the team to access during the course of the visit.
- Develop registry or reporting technique to identify patients due for follow-up on goals.
- Identify CDSMP programs in the community & link patients to them (e.g. Consortium for Older Adult Wellness (COAW) in Colorado at https://coaw.org).
- Send a task from a new self-management goal to an identified staff person who can call the patient 10 days to two weeks later and inquire if patients need any support with self-management goal.
- Ensure all staff are trained and achieve core competencies in active listening skills, health literacy and cultural competency.
- Make time for a team member to phone, email, or text patients and families to support follow through on self-management goals after a primary care or specialist visit.
- Measure patient self-efficacy around goal setting using a scaling question for importance and confidence and adjust goal accordingly.

Primary Care Team Guide Assessment-Related Question

Self-Management Support

	Components	Level 1D	Level C	Level B	Level A
14	Self-management support…	is limited to the distribution of information (pamphlets, booklets). 1☐ 2☐ 3☐	is accomplished by referral to self-management classes or educators. 4☐ 5☐ 6☐	is provided by goal setting and action planning with members of the practice team. 7☐ 8☐ 9☐	is provided by members of the practice team trained in patient empowerment and problem-solving methodologies. 10☐ 11☐ 12☐

How Primary Care Teams Achieve the Quadruple Aim