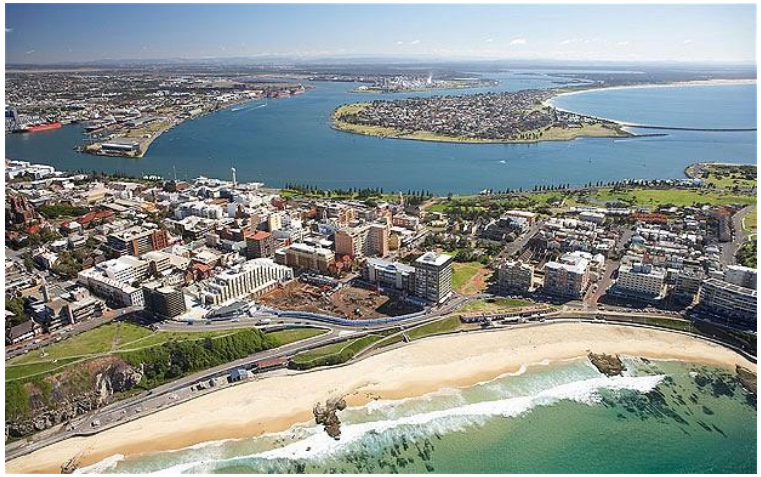
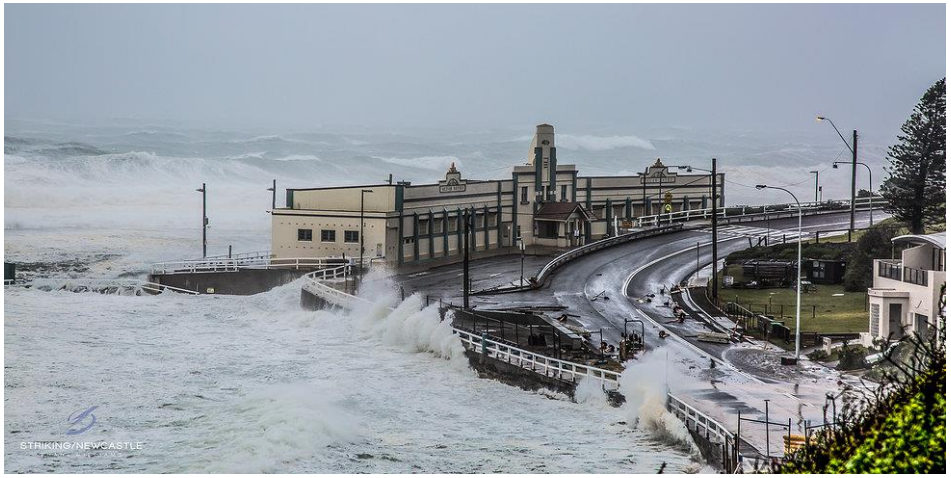
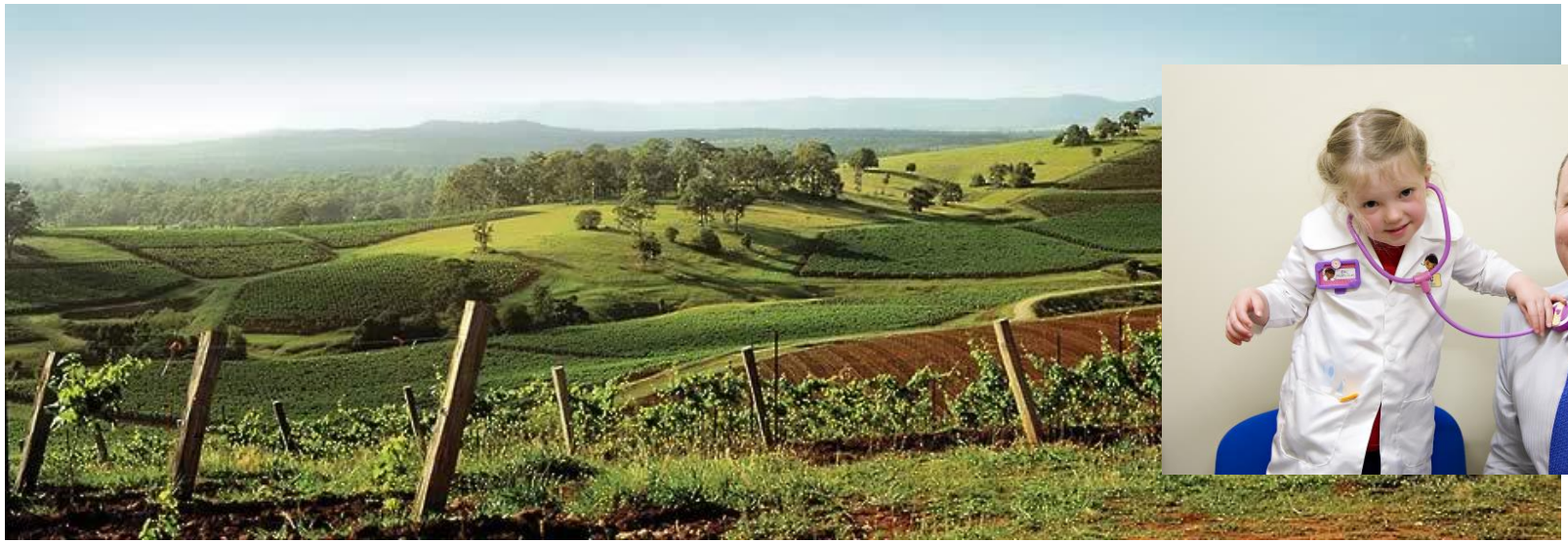
A WHOLE-SERVICE APPROACH TO SUPPORTING PATIENT SELF-MANAGEMENT

KIM ISAAC – KOTARA FAMILY PRACTICE

A LITTLE BIT ABOUT US







CHANGE PRINCIPLE 3

Implement Self-Management Principles and Support Patient Self-Management

CHANGE IDEAS:

1. Establish clear definitions of self-management and what self-management support involves
   - Team education
   - Practice policy
2. Ensure a holistic view of the patient's perspective is embedded in care, including the needs of harder to reach people
   - Ask patient about their perspective and understanding of disease and what goals are important/relevant to them – embed this in clinical processes (eg care planning)
   - Who are hard-to-reach patients – minority groups, full-time workers, non-compliant or resistant patients
3. Organise internal and external resources to provide patient-centered self-management support
   - Individual or group education
   - Patient health records
   - Integration with other care providers
   - Information resources
4. Implement a strategy for self-management support to empower patients and carers to better understand and manage their condition and risk-factors
   - Ongoing education – patient-specific or group
   - Coordination of regular reviews to support patient self-management

FIRST STEP…

To understand the principles of Patient Self-Management

- how it relates to General Practice
- then educate the team…

Where to look for information:

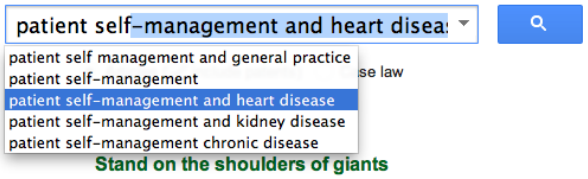
- Collaborative Handbook – Section 7 – Change Principle 3
- Google Scholar – search “patient self-management” (and chronic disease) (and General Practice)

APCC

Australian Primary Care Collaboratives

Pioneering Change

Google scholar



WHAT WE FOUND OUT…

- Over a 12-month period most patients with a chronic disease only spend about 2-3 face-to-face hours with their GP targeting their CD Management
  - The other 8000+ hours they are on their own!
  - Empowering patients to self-manage is critical
- Patient self-management in General Practice includes:
  - Providing care that builds your patient's knowledge about their condition and builds their skills and confidence in managing it
  - Recognising the patient's perspective of their health, their health goals and the health management
  - Providing holistic care that recognises the medical and psycho-social impacts of their disease
  - Improving access to care for marginalised groups and hard to engage groups
  - Improving access to resources so patients can effectively self-manage – establishing support systems, integrated care approaches, education programs and access to educational material…

WHAT TO CONSIDER IN ESTABLISHING AND SUPPORTING PATIENT SELF-MANAGEMENT

THE PATIENT

What do they know? Are they ready for this? What support do they have?

THE CLINICIAN

Do they understand the principles of patient self-management?
Do they have the skills / knowledge /resources to facilitate patient self-management?

THE HEALTH CARE SETTING

Does the practice culture support self-management principles?
Are the resources available to facilitate and support patient self-management?

- human resources
- clinical resources
- financial resources

Does broader government policy and financial support make implementing patient self-management strategies viable?

WHOLE TEAM MEETING

- What is Patient Self-Management?
- How does it relate to our core practice values?
- How do we already do this?
- How can we do it better or differently?

WHAT WE WERE ALREADY DOING…

- GPMP/TCA for chronic disease BUT usually opportunistic without time for comprehensive engagement with the patient; goals were typically very clinical in nature; patient usually left without taking a copy of their plan.
- Basic patient education on new diagnosis BUT wide range of patient information handouts and little consistency in use.
- Skilled nurses available to provide patient education BUT only some patients referred
- Good patient access to information resources via web links, web and Facebook posts BUT not targeted at specific audience.

IDEAS FOR IMPROVEMENT…

- To engage patients in the development of their GPMP/TCA and include goals and strategies that are specific, achievable and relevant to the patient (eg. “to lose 10kg” vs “to be able to fit into my old biker’s jacket”
    - Comprehensive CD appointment with nurse and GP
    - Using patient-centered questioning and interviewing
    - Giving the patient a copy of a standard GPMP template for their specific condition and asking them to identify which goals/targets are important to them and to add their own self-specific goals and targets – opportunity to understand the patient’s perspective, to educate the patient about clinical goals they don’t understand, to produce a plan that empowers and motivates them.

IDEAS FOR IMPROVEMENT…

- To provide patients with the tools to engage in self-management through education about their disease, disease risk-factors, and strategies to reduce risk and disease progression
  - Standardising patient information handouts for newly diagnosed patients
    - Consistent, up-to-date and relevant information about their disease and care pathway
  - Patient and community education series
    - Aim to provide relevant education on health issues, allowing patients and the community to engage more fully with their health and health care
    - Better Health Series – teamed-up with local bowling club
    - Lifestyle education for patients with Diabetes

- Develop Action Plans for disease which can be individualised for each patient's needs and which include a recommended pathway for care and actions to take if disease changes
  - Great way to empower patients to take control of their disease management

IDEAS FOR IMPROVEMENT…

- Employ a CD coordinator to coordinate care and timely review for patients with CD
  - Administrative role
  - Cost and space needs to be considered

- Develop individualised Patient Health Folders for patients with CD
  - My Health Summary
  - My Health Calendar
  - My Health Targets
  - My Health Goals
  - My Management Plan
  - My Referrals
  - My Pathology and Imaging Requests
  - My Action Plan
  - My Health Information

- Investigate other Risk Ax Tools available for use with other disease groups (other than CV Risk and Diabetes Risk)
  - Found Westcare Combined Risk Ax Tool
  - Useful for showing patients their risk and motivating lifestyle change and compliance.

OVERALL AIM OF PATIENT SELF-MANAGEMENT…

- To engage and empower patients to take on a more active role in their care
- To give patients the knowledge and confidence to self-manage for the 8000+ hours of the year when they are not in direct contact with their care team
- To give patients the motivation and support to comply with health goals and treatment plans

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