Self Management Goals Made Simple

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The Joint Commission
Self Management Goals

- Take a walk
- Grow vegetables
- Set goals
- Use positive imagery
- Have a rest
- Pace yourself
- Volunteer
- Help someone else
- Take your own measures
- Use correct bench height
- Support your friends
- Get text alerts
- The Joint Commission
  Accreditation
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Self Management Goals Requirements

- **PC.01.03.01 – EP 44**
  - Patient self management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan

- **PC.02.03.01 – EP 28**
  - The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs

- **RC.02.01.01 – EP 29**
  - The clinical record includes the patient’s self management goals and the patient’s progress toward achieving those goals
Implementation of Self Management Goals

- Self-Management Goals are expected “when warranted by the patient’s condition”

- These goals may be behavioral in nature (smoking cessation or weight loss), compliance-oriented (adherence to medication), or follow-up related (completion of referrals)
Implementation of Self Management Goals

Based on types of visits, patients, services, and settings, an organization should determine when and how the three self-management goal-related requirements should apply.

Surveyors will be expecting to see consistent application across an organization’s settings and services, otherwise they may inquire about relevant policies, procedures, training, and monitoring practices.
Patient Self Management Goals

**Patient-centered not Paper-centered**

- Goals need to be something the patient wants to do, not something they are told they should do. It’s their wanting that gives them the motivation to follow through.

- You might say “What one thing would you like to work on to improve your health?” We might be tempted to simply have patients choose from a list of behaviors changes. Paper Centered.

- Self-management “tools,” (pieces of paper) can help educate patients and give them choices of things that would be good to work on, but the goals need to come from the patient, the person who’ll be making the change!
Patient Self Management Goals vs Clinical Goals

**Clinical goal** – provider’s medical goal for the patient, usually long term.

- **Example:** “Patient’s A1C will be less than 9.0”

**Patient Self Management Goal** – patient’s goal to achieve the clinical goal, usually short term and identifies behavior changes.

- **Example:** “I will drink water in place of a can of soda twice a day”
Self Management Goals Worksheets

SMART Goals
People who choose their own goals with support of our office do better with long-term diseases. What is the one thing you would like to do to improve your health?

Examples of things you can do include...

- Eating Plan
- Take Medication Properly
- Quit Smoking
- Exercise
- Reduce Alcohol Intake
- Reduce Stress
- Reduce Salt
- Weight Reduction
- Self-Monitoring
- Other

WHAT will you do? WHEN will you do it?

WHERE will you do it? HOW will you do it?

On a scale from 0 to 10:

How important is this to you? ______ How confident are you that you can achieve your goal? ______

Things that could make it difficult for you to reach your goal:

My plan for overcoming these difficulties:

Checking your progress toward reaching your goal is important for your success. Our plan to follow-up with you is:

Everyday is a new chance to do something good for yourself!

Specific Measurable Action-oriented Realistic Time-specific (SMART goals)

METAS INTELIGENTES
Las personas que eligen sus propios metas con el apoyo de su doctor y su equipo médico pueden llevar mejor las enfermedades a largo plazo. ¿Qué es la una cosa que usted querría hacer para mejorar su salud?

Ejemplos de las cosas usted puede incluye...

- Dieta
- Tome Su Medicina Apropiadamente
- Deje de Fumar
- Ejercicio
- Reduzca La Ingestión de Alcohol
- Reduzca La Tensión
- Reduzca La Sal en Su Dieta
- Pierda Peso
- De AutoControl
- Otro

¿QUE haría usted? ¿CUANDO lo haría usted?

¿DONDE lo haría usted? ¿COMO lo haría usted?

¿En la escala de 0 a 10, con que seguridad puede usted conseguir su objetivo?

Las cosas que podrían hacer difícil para usted alcanzar su objetivo:

Tu plan para vencer estas dificultades:

Verificar su progreso hacia alcanzar su objetivo es importante para su éxito. Nuestro plan al seguimiento con usted es:

¡Diario es una nueva oportunidad de hacer algo bueno para usted mismo!
Tips for Creating a Successful Action Plan

- Begin with something the **patient** wants to do
- Make the goal **reasonable** (something the patient can reasonably expect to be able to accomplish this week)
- Strive for a change that is **behavior-specific** (losing weight is not a behavior; not eating in the evenings while watching television is a behavior)
- Ensure that the plan answers these questions: **what; how much; when** (think about – which days, what times, how often etc.)
Tips for Creating a Successful Action Plan

- Start when the patient has a **confidence level** of 7 or greater (this is the belief that they can, and will, complete the goal)

- Identify **potential difficulties** to achieving their goal

- Help the patient brainstorm ways to **overcome potential difficulties**

- Ask the patient if there is someone that **can help** them in achieving their goal

- Share your plan to follow up with patient

- Follow up, follow up, follow up
Sample Self Management Goals

**Goal 1:** Patient identified a goal of drinking water in place of soda twice a day

- **Difficulty identified by patient:** There is a soda machine at her place of employment

- **Plan for overcoming difficulty:** Patient will not carry loose change at work
Sample Self Management Goals

Goal 2: Patient identified a goal of walking up the stairs to her office.

- Difficulty identified by patient: The elevator comes before the stairs.
- Plan for overcoming difficulty: Patient will come in through a different entrance that has the stairs before the elevator.
**GOOD HABITS!**

**Trial #1:**
- Mark off a # for each day you accomplish your goal.
- If you miss a day, start over. When you have successfully completed 21 days in a row your goal will have become a good habit.

1 2 3 4 5 6 7
8 9 10 11 12 13 14
15 16 17 18 19 20 21

**Trial #2:**
- Mark off a # for each day you accomplish your goal.
- If you miss a day, start over. When you have successfully completed 21 days in a row your goal will have become a good habit.

1 2 3 4 5 6 7
8 9 10 11 12 13 14
15 16 17 18 19 20 21

**Trial #3:**
- Mark off a # for each day you accomplish your goal.
- If you miss a day, start over. When you have successfully completed 21 days in a row your goal will have become a good habit.

1 2 3 4 5 6 7
8 9 10 11 12 13 14
15 16 17 18 19 20 21

By Rachel Woods, LDS Guide
http://lds.about.com

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Active Support Works Best


Providing information is helpful, but it is not sufficient: without the confidence and skills to use information, information alone will not lead to better health outcomes. Methods that improve people’s activation and self-efficacy are the most effective ways of improving self-management and supporting healthy behaviour change.
Commitment to Change Foundational to Success

Achievement of Goals’ at Six Months

n=282

People making a formal commitment to change 10 times more likely to report meeting goal at six months

Study in Brief

- Six-month study of 282 people: 159 making a formal commitment to change and 123 contemplating a specific behavior change; most common goals were weight loss, exercise, and smoking cessation
- Study participants contacted via phone at two weeks, four weeks, three months and six months to assess progress toward goal
- Study participants 10 times more likely to report meeting goal at 6 months if formal commitment made
Self-Management Support Toolkit

Health Navigator

<table>
<thead>
<tr>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Video explaining Diabetes</strong></td>
</tr>
<tr>
<td>Excellent video explaining diabetes, HbA1C and why taking your medicines as directed can help manage your diabetes.</td>
</tr>
<tr>
<td><a href="http://www.youtube.com/watch?v=rBKSutgPXCY&amp;feature=player_embedded">http://www.youtube.com/watch?v=rBKSutgPXCY&amp;feature=player_embedded</a></td>
</tr>
<tr>
<td><strong>Diabetes Section – Health Navigator NZ</strong></td>
</tr>
<tr>
<td>Factsheets, educational resources, videos, tools</td>
</tr>
<tr>
<td><strong>ADHB Diabetes Centre</strong></td>
</tr>
<tr>
<td>Referral, services and staff information. <a href="http://www.healthpoint.co.nz/default.38695.sm">www.healthpoint.co.nz/default.38695.sm</a></td>
</tr>
<tr>
<td><strong>Diabetes Auckland - Support Groups &amp; Nurse Educators</strong></td>
</tr>
<tr>
<td>Wide range of resources, support and educational programmes</td>
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<tr>
<td>• <a href="http://www.dpt.org.nz">Diabetes Conversations Maps Series</a></td>
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<tr>
<td>• <a href="http://www.dpt.org.nz">Support Groups across Auckland</a></td>
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<td>• <a href="http://www.dpt.org.nz">Information Centre</a></td>
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<td>• <a href="http://www.dpt.org.nz">Shop</a></td>
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<tr>
<td>• <a href="http://www.dpt.org.nz">Supermarket Tours</a></td>
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<tr>
<td><strong>Diabetes Project Trust</strong></td>
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<tr>
<td>Wide range of resources, information sheets – see services directory at the end for information on group programmes</td>
</tr>
<tr>
<td><a href="http://www.dpt.org.nz">www.dpt.org.nz</a></td>
</tr>
<tr>
<td><strong>Health Mentor Online</strong></td>
</tr>
<tr>
<td>An online self-management programme for people with pre-diabetes</td>
</tr>
<tr>
<td>Also has a log in to access resources for Health Professionals</td>
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Self Management / Health Literacy and Referrals – Bringing it all together

- Clearly communicate, in a method that meets the patients identified health literacy needs, the reason for the referral.
- Assess on a scale of 1 to 10 how important the referral is to the patient.
- Assess on a scale of 1 to 10 how likely the patient is to go to the specialist.
- Identify things that would make it difficult for the patient to go to the specialist.
- Work with the patient to identify ways to overcome difficulties (transportation / funding).
- Collaborate with patient to set a goal of attending the referral appointment or document patient’s noninterest.
Self Management Additional Resources

- Self Management Toolkit:
  http://www.healthnavigator.org.nz

- Set & Document Self Management Goals Collaboratively
  http://www.ihi.org/resources/Pages/Changes/SetandDocumentSelfManagementGoalsCollaborativelywithPatients

- AHRQ Self Management Support

- SMART Goals a Patient Self Management Tool
  https://www.bcbsm.com/pdf/OSP-SMART_Goals

- Physician Resource Guide for Patient Self Management
  http://www.gpsccbc.ca/system/files/phys_resource_guide