Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Chronic Care Model

Community

Health System

Resources and Policies

Health Care Organization

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Improved Outcomes

inspiring achievement
Self-Management: Who is Responsible?

**Self-management** - is what the person does by taking action to manage their health and lifestyle.

**Self-management support** - is what others such as services, health professionals, family and friends do to support the person to self-manage. They may do this by providing physical, social or emotional support.
Self management...

a vital component across the continuum

<table>
<thead>
<tr>
<th>Continuum of Prevention of Illness or Disability and Promotion of Health and Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who are well</td>
</tr>
<tr>
<td>People at risk of a health problem or disability</td>
</tr>
<tr>
<td>Early detection and intervention</td>
</tr>
<tr>
<td>People with a health problem or disability</td>
</tr>
<tr>
<td>Treatment/early intervention/prevention of problem increasing or associated problems arising</td>
</tr>
</tbody>
</table>

Promotion of physical, emotional, spiritual and mental health and wellbeing
Similarities between chronic condition prevention/management and cancer survivorship?

- Move from acute care to long term care
- Lack of urgency
- Target behaviours are identical for prevention/disease management and cancer survivorship.
- Requires active personal involvement.
- Complex and multifaceted
- Evidence based interventions are identified but not consistently delivered
- Providers often not trained in the skills required.

(Glasgow et al 2001)
Coordinated Care

• SA HealthPlus controlled trial 1997-2000
• 3100 intervention, 1500 controls
• Aim: ‘behaviour change to improve self-management and health outcomes’
Learning

- Self-management capacity is affected by
  - the illness
  - personal attributes
  - attributes of health providers
  - cultural and social factors
- Self-management skills need to be assessed before the right intervention is offered
- Not all consumers need self-management support and those who do will respond to a wide range of learning methods, some group, some individual

(Battersby et al, Milbank Quarterly, Dec 2006)
Care Planning

Should

• Facilitate the persons engagement in their own healthcare and treatment
• Enhance the client / provider relationship
• Enhance the clients self-efficacy for self-management and health outcomes
• Enhance the clients ability to maintain changes / improvements.
Care Planning

Should enhance clients skills in

- Problem definition
- Goal setting
- Action Planning
- Problem solving
- Emotional management

- Pain management
- Psychosocial skills
- Cognitive change skills
- Goal attainment skills
The Flinders Program

Assess Self-Management + Problems and Goals

- Self-Management
- Healthcare Management
- Community / Family Support
- Psychosocial Support

Action Plan
Agreed Issues
Agreed Interventions
Shared Responsibilities
Review Process
Principles of Self-Management

L
Learn about your risk factors
I
Active Involvement
V
Vary actions
W
Weigh up the costs
E
Engage
L
Healthy L
THE LIVING WELL SCALE  v1 April 2008

Name: ___________________________ ID: [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Assessment Date: / /  Review Date: / /

You have been asked to fill in this form because you have the ‘risk factor(s)’ of
...................................................................................................................... which can lead to long term health problems.

Please circle the number that most closely fits for you

1  Overall, what I know about .................................................................
and how it could affect my health is:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>Something</td>
<td>Very little</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2  Overall, I know what I need to do about this:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<td>Very little</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
THE LIVING WELL CUE & RESPONSE INTERVIEW

Name: .................................................. Assessment Date: .................. Review Date: ..................
Identified Risk Factor(s): ..................................................................................................................

<table>
<thead>
<tr>
<th>CUE QUESTIONS</th>
<th>Notes</th>
<th>HP's Score</th>
<th>Client Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. KNOWLEDGE OF RISK FACTORS(S):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What do you know about ........................................ and your health? e.g. causes, effects?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What could happen to your health in the future because of this?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What do the people in your life understand about this? (note: if this is relevant for the client)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. KNOWLEDGE OF REDUCING RISK FACTOR(S):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What can you do about ........................................ (to stay well)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are there any other things you can do to keep yourself healthy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What do the people in your life understand about this? (note: if this is relevant for the client)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Problems and Goals Approach

A motivational tool

• What does the client see as being the biggest problem?

• What goal(s) could he/she work towards that might impact on the problem?
## Problem Measurement

### Problem Statement

“Because I’m so tired from looking after my grandkids, I don’t do the exercise I should and I feel like a failure.”

### Rating Scale

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
</tr>
<tr>
<td>1</td>
<td>Very little</td>
</tr>
<tr>
<td>2</td>
<td>Somewhat</td>
</tr>
<tr>
<td>3</td>
<td>A fair bit</td>
</tr>
<tr>
<td>4</td>
<td>a lot</td>
</tr>
</tbody>
</table>

Rating: 8
Goal Statements

Repeated and S.M.A.R.T.

Specific
Measurable
Action based
Realistic
Time-framed (how long / how often)
Goal Measurement

Goal Statement

“I will walk the 3 kms to the local shopping centre on Monday, Wednesday and Friday to look at the fashions.”

Rating Scale

My progress towards achieving this goal is:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete success</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No success</td>
</tr>
</tbody>
</table>

Flinders University

inspiring achievement
## Client Problem Statement:

<table>
<thead>
<tr>
<th>How much of a problem is this for me</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My progress towards achieving this goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>complete success</td>
</tr>
</tbody>
</table>

## Client Goal Statement:

<table>
<thead>
<tr>
<th>IDENTIFIED ISSUES</th>
<th>MY AMS</th>
<th>STEPS TO TAKE</th>
<th>WHO IS RESPONSIBLE</th>
<th>DATE TO BE REVIEWED</th>
<th>PROGRESS NOTES</th>
</tr>
</thead>
</table>

## Sign Off - client

I ...........................................(client name) agree with the information contained within this plan. I consent to information relevant to my care being released to my health providers.

Signature: ........................................ Date: .........................

## Sign Off – health worker

I ...........................................(healthworker name) agree that the information contained within this plan is correct at the time of development but is subject to review based on the person’s needs and/or my professional opinion.

Date: .........................
“Well it’s a reality check, isn’t it? You’ve got to think about the question and then... You’ve got to be honest with yourself, I think that’s the key because it would be so easy to lie. But because BL did it herself on what she thought and then I had to do it as well, you have to be honest because she explains what she put and then we changed...”
What a CNAHS worker said

“You think you are covering all the bases, but this gives you a sort of checklist to make sure you don’t miss things, or assume things. You can assume you know what they will think is the problem, but often you are coming from different angles, and that’s why it sometimes doesn’t work. You can be missing half the picture and not really know it.”
Flinders Centre for Cancer Innovation self-management pilot study

• Aim: test feasibility, acceptability, prelim efficacy of the Flinders Program to improve nutrition, exercise and quality of life in cancer survivors

• Inclusion: in treatment or remission from cancer

• Intervention: 12 week study beginning with Flinders care plan, with tailored nutrition and exercise program
Results

• 25 of 65 approached enrolled (38%)
• 80% women with breast cancer
• ‘lifestyle change not a priority’
• G1 in treatment – 11, G2 – 14 remission
• 22 received Flinders Program
• 20 followed up at 12 weeks (84% retention)
Results

‘knowledge about changing improvement in risk factors’ (p=0.047)

• Quality of life: EORTC QLC c30 improved emotional functioning (p=0.03)

• 74 nutrition goals, 37 physical activity goals

• Small reductions in BMI, hip circumference, small increases in hand grip and 6 minute walk
• 21 (84%) found the Flinders Program acceptable or totally acceptable

• 21 (84%) found the Problems and Goals acceptable or totally acceptable

• Living well tool scored across all 3 time points suggests the tools is feasible as
Implications

• A semi-structured one to one clinician guided self-management support program is acceptable and feasible for cancer patients in treatment and remission

• Training of health professionals to deliver patient centred motivational programs tailored to the patient is required

• System issues of coordination of care between primary, secondary and tertiary care could be facilitated by a self-management care plan
Thank you!