

5 Diamond Patient Safety Program

Patient Self Managed Care

2010

** This presentation was collaboratively developed by the Mid-Atlantic Renal Coalition (MARC) and the ESRD Network of New England for the 5-Diamond Patient Safety Program.*

The 5-Diamond Patient Safety Program is endorsed by the Renal Physicians Association (RPA) and American Nephrology Nurses' Association (ANNA).

Patient Self-Management

- Defined as the patient's ability to deal with all aspects of their chronic illness:
 - Symptoms
 - Treatment
 - Physical and social consequences
 - Lifestyle changes

Patient Self-Managed Care

- Self-management skills are an important part of living with chronic illness.
- Chronically ill patients require:
 - Planned, regular interaction with their caregivers
 - A focus on prevention and intervention, and
 - A shift from a provider-centered model to one that is patient- and family centered

Patient Self-Managed Care

- Patients who are involved with their healthcare decisions and management have better outcomes than those who are not.
- Staff who offer effective self-management support will help motivate and inform patients to better cope with the challenges of living with and treating chronic illness.
- This is an opportunity for the health worker to learn from the patient their perceptions and concerns about living with chronic illness.

Important Components of a Self-Management Support Program

- Patient education
- Problem solving
- Monitoring care and taking action
- Symptom management
- Communicating with the physician and other providers
- Utilizing community resources to promote success and continuation of self-management

Patient Education

- Understanding of their chronic illness and treatment
 - Options
 - Dialysis: duration & frequency
 - Best access
 - Labs
 - Medications
 - Diet

Patient Education: Example

Healthcare worker: Mr. Williams, tell me what you know about your kidney disease.

Mr. Williams: They say my kidneys don't work and I have to do dialysis, but I think they're wrong because I can still pee.

Healthcare worker: It's true the kidneys remove excess fluid from your body, but are you aware that they also remove waste products that become poison to your body? They are also important for....

Problem Solving

- Patients need basic problem solving skills.
 - How to identify their problem
 - How to think of possible solutions to the problem
 - How to put the solution into action
- Encourage patients to manage their care by participating in Plan of Care meetings.

Problem Solving: Example

Healthcare worker: Ms. Martin, as you can see from this record, your Kt/V is 0.98. The goal is 1.3. How do you feel about this?

Ms. Martin: I know that I'm not getting a good cleaning and that I can get sick from it.

Healthcare worker: Can we talk about the options we are aware of to improve this? We can increase your time on the machine, increase your dialyzer size, you can come for all your treatments, and you can watch your diet.

Ms. Martin: I don't want to stay any longer on the machine. I guess I could do better with coming for treatment and not eat so many hotdogs. I could ask my cousin who lives down the street to get my child from the bus stop and watch her until I get home from treatment.

Monitoring Care and Taking Action

- Encourage patients to monitor medical care.
 - Taking medications
 - Adhere to diet
 - Attend dialysis treatments & scheduled appointments
- Assist patients in monitoring their behavior/emotions.
 - Cope with the impact of a chronic condition
- Help patients take action.
 - Encourage patients to participate in care planning
 - Help the patient develop short term goals and reach them

Monitoring Care and Taking Action: Tips

- Provide tools for patient to self-monitor
- Provide feedback with simple visual aids
- Check in with patients regularly to answer questions and ask how they are progressing
- Ensure patient goals are easily achievable! Success is motivating.

Symptom Management

- Patients live day to day with their chronic disease and its symptoms
- Lack of symptom control is a major disruptive force in the patient's life
- Help the patient develop a plan to deal with the symptoms of their disease
- Common symptoms experienced by the dialysis patients:
 - Weakness/fatigue
 - Fluid overload
 - Shortness of breath
 - Cramps
 - Nausea & vomiting
 - Bleeding

Symptom Management: Example

Healthcare worker: Mr. Bergeron, I noticed you have been having difficulty with cramps during your treatment and it has caused you to come off early. Do you know why you are having cramps?

Mr. Bergeron: Yes, I'm being pulled too hard.

Healthcare worker: That's a good point. The machine is programmed to pull fluid that you have put on since your last treatment. The more you have on, the more it has to pull in the time you are here. Can we discuss some of the options? Do you agree that it's important to get the fluid off?

(options discussed)

Mr. Bergeron: I would be willing to do 4.5 hour treatments for two weeks at a slower speed to try and get some more fluid off. I will also let staff know when I'm starting to feel cramps coming on so they can turn it down a bit and maybe I can deal with staying on for my whole treatment.

Communicating with Physicians and Other Providers

- Patients should be able to report changes in their condition.
- Patients should be able to discuss this information with their healthcare workers.
- Healthcare workers should listen carefully to the patient.
- Informed patients will make informed choices about their treatment.

Communicating with Physicians and Other Providers

- Encourage patient participation in care planning.
 - Adopt a practice of presenting care options to allow patients to decide their course of treatment.
- Determine what the patient is interested in learning more about; adult learning is largely driven by what is of interest to the individual.

Start a Self-Care Program in Your Facility!

- Encourage patients to:
 - Self-weigh
 - Wash/clean access area
 - Set up/monitor machines
 - Monitor blood pressure
 - Self-cannulation
 - Independent self-care (in-center and/or home)

Utilizing Community Resources to Promote Success and Continuation of Self-Management

- MASSPRO www.masspro.org
- California Healthcare Foundation www.chcf.org
 - Offers several resources for self-management with chronic illness
 - Free DVD that provides 14 minutes of role play on the self-management approach
www.chcf.org/topics/chronicdisease/index.cfm?itemID=133717
- Fistula First <http://fistulafirst.org>
 - New Self-Management Change Concepts

Motivating Patients

- Assess the patient's readiness to change behaviors and assume responsibility.
- Avoid giving advice, and instead elicit from the patient experiences, beliefs, and ideas that will motivate them
- The patient should have a level of confidence to implement and sustain behavior changes .
- The healthcare worker can support changes through the use of direct, open-ended questions and reflective listening to establish agreed goals.
 - Exercises for these techniques can be found in DPC materials

Essential Principals in Motivation

- Healthcare workers should:
 - Empathize with the patient's feelings to help facilitate behavior change.
 - Assist patients in identifying and understanding differences between their current situation and their goals.
 - Adjust to patient resistance rather than opposing it, recognizing that patients choose how to behave.
 - Support patient commitment towards achieving goals.

Self-Management Support Program

- The process begins with the healthcare worker's commitment to actively engage patients in taking responsibility for their health.
- Healthcare workers focus on moving the patient from a dependant to independent role.
- A partnership is established where the healthcare worker and the patient move through stages of responsibility.
- Each stage has easily identified goals.
- An action plan should be created that lists detailed steps, and potential barriers, to achieve the identified goals.

Support Program Framework

- Stage I: Individualized Plan and Goal Setting
(Goal: Patient Safety and Stabilization)
 - The healthcare worker's role is to educate and assist the patient.
- Stage II: Collaboration *(Goal: Problem Solving & Accountability)*
 - The healthcare worker's role is to coach the patient as they accept more responsibility for their own health and well-being.
- Stage III: Patient Autonomy *(Goal: Autonomy)*
 - The focus is on the patient's ability to self-manage their disease with limited assistance.

Stage I:

Individualized Plan and Goal Setting

- An individualized Plan of Care is developed that meets the patient's needs, lifestyle, and priorities. It identifies barriers that the patient may experience.
- The patient uses their Personal Health Record (PHR) when they meet with their primary care physician or nephrologist to discuss the developed Plan of Care.
- The patient can verbalize what signs and symptoms to report, when to contact the dialysis unit or physician, or when to seek emergency care.
- At the end of this stage, the healthcare worker and patient will be able to:
 - Establish at least three mutually defined goals
 - Use the *Self-Management: Healthy Changes Plan* and verbalize a confidence level of at least seven on the 1-10 scale, for attainment of two of the three goals set
- The patient is ready to progress to the next stage when the above are completed and the patient indicates willingness to move ahead.

Stage II: Collaboration

- The patient's efforts to achieve goals identified in their *Self-Management: Healthy Changes Plan* in Stage I are supported by accessing relevant community and educational resources:
 - NKF
 - AAKP
 - Fistula First
 - ESRD Networks
- With healthcare workers' support, the patient uses problem-solving techniques to overcome identified barriers
- The patient manages physician appointments with minimal assistance
- The patient understands the relationship between their PHR, their Plan of Care, their health status, and what actions to take based on this

Stage III: Patient Autonomy

- A patient reaches Stage III when:
 - They understand their illness,
 - Know how to monitor and manage symptoms,
 - Know how to obtain assistance when needed,
 - Will follow through in management of their care.
- At the end of this stage, the patient will be able to:
 - Demonstrate their ability to carry out the self-management plan every day
 - Deal with challenges as they arise
 - Utilize support groups, Internet, and community resources to sustain self management

Patient Self-Managed Care Outcomes

Patients with strong self-management skills will:

- Self-reporting their health status and symptom management
- Follow through on appointments
- Take medications as ordered
- Follow their dialysis schedule
- Reduce the need for emergency care services and have fewer hospitalizations
- Be able to understand and discuss their care, their medications and their dialysis with healthcare workers
- Be proactive about receiving appropriate care

Acknowledgement

A special thank you to

MASSPRO

<http://www.masspro.org/>

for providing materials and resources
to support this module.