Best Practice Intervention Package
Patient Self-Management

HHQI
Home Health Quality Improvement
Table of Contents

Table of Contents .................................................................................................................. 1
Acknowledgements .................................................................................................................. 1
Focus on Patient Self-Management ......................................................................................... 2
PDSA CHECKLIST ................................................................................................................... 7
Patient-Clinician Interaction Level Tips ................................................................................ 10
My Action Plan ....................................................................................................................... 12
Patient Self-Hospitalization Risk Assessment ..................................................................... 13
Motivational Interviewing Tool ............................................................................................. 16
Putting It All Together: Tool Guides and Tips ..................................................................... 17
Putting It In Practice: Clinician Guide .................................................................................. 20
References ............................................................................................................................... 21

Acknowledgements

The Home Health Quality Improvement National Campaign would like to thank the HHQI Stakeholder Work Committee for input in this Focused Best Practice Intervention Package.

HHQI would also like to thank the Centers for Medicare & Medicaid Services’ (CMS) Cynthia Pamon, Government Task Leader for the Home Health Quality Improvement National Campaign and Marie Wagner-Clarke, Contracting Officer's Technical Representative (COTR).

Focused Best Practice Intervention Packages (BPIPs) are succinct intervention packages designed to support or enhance best practices. The patient tools in the Patient Self-Management Focused BPIP are made patient friendly to improve health literacy.

All of the tools and resources in the BPIPs may be modified and used in the most effective manner to promote patient care and efficient staff implementation.
Focus on Patient Self-Management

All patients with chronic conditions must self-manage, but health care professionals have an opportunity to advance patient self-management efforts by providing self-management support.

Self-management support is the care and encouragement provided to people with chronic conditions and their families to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviors.

---Improving Chronic Care

There are four concepts every clinician should understand and use together to fully comprehend patient self-management. To support implementation of the four concepts, this BPIP provides turnkey, or easy to implement, tools. The tools are in this BPIP and on the HHQI Web site. In addition, the BPIP has a checklist with links to helpful turnkey resources (such as bulletin board ideas) to help implement tools and interventions (pages 7-8).

There is also a tool guide (Putting It All Together, page 17-19) and a 1-page clinician guide (Putting It In Practice, page 20). The 1-page clinician guide is also available on the HHQI Web site so it can be downloaded as a separate document. Consider sharing the 1-page guide with clinicians along with one or two of the tools from this BPIP.

The four concepts:

1. Patient Self-Management
2. Individual Motivation
3. Patient Activation
4. Action Planning

Patient Self-Management

“The term self-management assumes and encourages a particular definition, but the truth is that self-management of a chronic condition goes with the territory. How someone defines
that, *how* they feel about it, *what* they do about it, *how* health systems and healthcare professionals support them is another matter entirely”
--Lawn, McMillan, and Pulvirenti, 2011, p.e5-e6

**Some Definitions…**

**Self-care**

- “The ability to care for oneself and the performance of activities necessary to achieve, maintain, or promote optimal health (including activities specific to acute and chronic health conditions)”

**Self-management**

- “The ability of the individual, in conjunction with family, community, and healthcare professionals, to manage symptoms, treatments, lifestyle changes, and psychosocial, cultural, and spiritual consequences of health conditions (particularly chronic diseases)”

**Self-monitoring**

- Awareness and measurement of specific physiologic parameters or symptoms of a health condition that are indicators of the need to take action or consult with a healthcare provider”

**Symptom Management**

- “The awareness of and response to subjective physiologic, cognitive, or functional changes or sensations.

**Self-efficacy**

- “The level of confidence in one's ability to perform self-care activities.”

--Richard and Shea, 2011, p. 261

**How does your staff include patients in care-planning?**

Patient-Clinician Interaction Level Tips is a one-page guide to help your staff understand how to promote self-management (p. 10).

**TIP:** Share this tool with staff and ask them to provide descriptive examples of patient interactions they’ve had, using “what works” tips (See p. 9 for an Application Example).
**Individual Motivation**

**Motivation** is essential for optimum patient self-management. Three necessary principles are required for individual motivation:

1. First, a patient must feel *competent*. Competence means that “I feel capable of performing the task and am provided both adequate time and resources to complete it.”

2. Second, *autonomy* or a sense of internal self-control is essential. “I know the task at hand and feel a sense of ownership toward completion.”

3. Third is a *sense of relatedness*. “By feeling related and engaged in the process, I become emotionally tied to the outcome.”

--Mari Lou Keberly, 2011, Cross Setting II BPIP, Focus Section, p. 15.

**TIP:** This tool is also available as a [pocket card here](#). Pocket cards are a handy staff educational tool.

---

For more ideas and examples on bulletin boards [visit the Focused BPIP page](#).
**Patient Activation**

**Patient Activation** “refers to people’s ability and willingness to take on the role of managing their health and health care.”

--Hibbard and Cunningham, 2008, p. 2

“Studies show that when behavior change interventions are tailored to the patient’s level of activation, that not only do patients gain in activation, they have improvements in adherence, clinical indicators, and have lower rates of hospitalization and emergency department use...”

--Hibbard, Cross Setting II BPIP, Focus Section, p. 2

**Action Planning**

**Action planning** is a way the patient demonstrates *ownership* of his/her health management. “Action planning is a tool or technique that helps people change their behavior over a short period of time”.

--Lorig, Patient Self-Management BPIP, 2007, p. 66

---

**TIP:** My Action Plan is a ‘turnkey’ tool—easy to implement. To maximize effectiveness of use, discuss the tool at an interdisciplinary team meeting. Ask staff to prepare and share a specific example of using the tool with patients at the next meeting. (See p. 11 for an Application Example.)
Reducing Avoidable Hospitalizations

Reducing avoidable hospitalizations is one of the primary goals of the HHQI campaigns in our pursuit of improving the quality of care that patients receive. **Identifying patients who are at risk of hospitalization** is essential in order to reduce hospitalization/rehospitalization rates and improve quality of patient care. Ideally, a tool to identify individual patient hospitalization risk is interfaced with assessment components in an electronic or hardcopy patient record. Whatever method you use, communicate the individual patient hospitalization risk to the interdisciplinary health care team—which includes the patient/caregiver—so the team works together to ensure the plan of care addresses how to reduce the rehospitalization risk.

**But what about patients—are they aware of their hospitalization risk?** One of the HHQI frequently requested tools is the Patient Self-Hospitalization Risk Assessment. This tool will assist patients to actively participate in understanding their hospitalization risk. This tool was adapted from a hospitalization risk assessment, includes a clinician’s worksheet, and Call Me First poster (pp.13-15).

**TIP:** Try role-play to introduce this tool to your staff. (See p. 11 for an Application Example).
# PDSA CHECKLIST

The Model for Improvement, with Plan-Do-Study-Act (PDSA) cycles, provides a framework for testing changes to improve patient self-management. Learn more about the PDSA model: CHAMP presentation, handouts, and worksheet.

## P
- Assess your staff’s understanding of patient self-management and self-management support.
- Review the Patient Self-Management Focused BPIP for best practice ideas, tools and resources.
- Request staff input on how to improve patient self-management.
- Select tools from the Patient Self-Management Focused BPIP and review the resources (Links in this checklist) for ideas to help implement the tools.

## D
- Use role-play or a skit to demonstrate how to use the new tool(s). Click here for a skit example.
- Ask staff to complete My Action Plan on their own health behavior to reinforce understanding of the tool.
- Introduce the Patient Self-Hospitalization Risk Assessment as a tool to help patients understand their risk of being hospitalized.
  - Page 1 - Patient Self-Hospitalization Risk Assessment should be given to the patient on the first visit. Ask the patient to complete it before the next skilled visit (or within the first week of homecare). Review the completed assessment with the patient and discuss concerns and questions.
  - Page 2 of the form helps the clinician identify any additional interventions based on the patient’s self-hospitalization risk assessment.
  - Page 3 - Call Me First poster is an easy way to remind the patient to call the agency first.
  - The Patient Self-Hospitalization Risk Assessment is available in modifiable format (click here). Use page 1, 2, or all 3. Adapt the tool so it works for your agency.
- Motivational Interviewing Tool is also available as a pocket card. Easy directions for downloading, printing, and laminating are included. Click here. Share cards with your staff by placing them on a ring with other pocket cards (i.e. cards on pain scales, wound stages, etc.). Motivational Interviewing will require some practice—provide time during a staff meeting for staff to pair up and practice.
- Ask staff for specific feedback on the tools—before and after implementation.
- Confirm how your patients are informed of their risk for hospitalization (is there a standard place in the medical record where staff document this communication?).
Introduce a **Personal Health Record** for patients to take ownership of their health record and provide a communication tool that can be used across all settings. An example of a personal health record can be found [here](#).

- Use **Patient-Clinician Interaction Level Tips** on physical or in electronic bulletin boards, newsletters, or bathroom doors to reinforce tips. Enlarge and highlight sections or lines to call attention to specific tip(s).
- Communicate your current hospitalization rate and other significant data to staff *every month* by posting the data report on physical or electronic bulletin boards or newsletters.

Include a short quiz in a newsletter or a “Did you know…” on a bulletin board describing what your agency has done to reduce avoidable hospitalizations (which tools have been adopted, which community providers you are partnered with, etc.). ([Click here for a template for bulletin boards and quizzes](#))

- Make a bulletin board to display the tools and share some short excerpts from staff on how the tools have improved their practice. Add staff pictures with quotes to make it personal. ([Bulletin board example 1 — Bulletin Board example 2](#))
- Meet with staff and patients to evaluate effectiveness of self-management support.
- Has your hospitalization rate improved?

**PLAN** — Plan a change or test of how something works.

**DO** — Carry out the plan.

**STUDY** — Look at the results. What did you find out?

**ACT** — Decide what actions should be taken to improve.
Application Example:
Patient-Clinician Interaction Level Tips

As part of an educational focus on patient self-management, Sharon, a home health supervisor, shared Patient-Clinician Interaction Level Tips (p. 10) at a staff meeting. She asked that each staff member read the tips and begin incorporating them into daily practice. Sharon provided examples to demonstrate a few of the tips. To challenge them, she requested staff members share their experiences at the next staff meeting. After the meeting, she sent a reminder e-mail about the new tool and the expectation for staff to share how it is working.

At the next staff meeting, Sharon asked Greg, RN, to share his experience. Greg said “At first I thought I would do one of the tips just to make Sharon happy, but I’ve found that using the tips benefited my patients. I’ve reviewed the tips and add a couple of the ‘what works’ tips into my day-to-day practice.”

Greg continued, “I like to think I encourage my patients to self-manage, but sometimes it is just easier to decide things for them. However, deciding for patients isn’t the best way for them to learn. Instead, I’ve starting asking my patients to tell me what they would like to review and how much they want to review. Most patients pick the high-priority items that I would have chosen anyway--such as high-risk meds. Those tips (self-directed and learner directed) came from the tool under ‘Philosophy’ and ‘Advise’. I’ve noticed that my patients do better remembering what we’ve gone over when they have some choice in what they want to learn. There are a few more tips that I am going to work on this month.” (Tool found on next page.)
# Patient-Clinician Interaction Level Tips

<table>
<thead>
<tr>
<th></th>
<th>What Works</th>
<th>What Does Not Work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Philosophy</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|  | ▪ Patient-centered, acknowledging patients expertise in their own lives  
▪ Responsibility to patients  
▪ Self-directed, iterative, and ongoing support  | ▪ Clinician knows best, care based on clinician needs  
▪ Responsible for patients  
▪ One-time educational sessions  |
| **Strategies and Techniques** |  |  |
|  | ▪ Evidence-based programs that patients can choose to participate in  
▪ Group interactions following tested models  
▪ Various SMS* methods (group, individual, electronic, telephonic, in person)  | ▪ One-time referral  
▪ No clear clinical care or behavior change support  
▪ Only one program or approach  |
| **Assess** |  |  |
|  | ▪ Brief standardized assessments with feedback to both patient and team on progress/status  
▪ Assessment of patient’s view of progress and how behaviors relate to risk/benefits, goal attainment, and values  | ▪ Trying to do behavior change work without any assessment or baseline information  
▪ Assuming patient shares same goals, values, and understanding of condition as the professional  |
| **Advise** |  |  |
|  | ▪ Personalized feedback on lab values, exam findings, or functional status related to risk/benefits and ways behaviors can affect outcomes  
▪ Participatory decisions making with patient-determined level of involvement  
▪ Learner directed, tailored to person and environment  
▪ Problem-based learning  
▪ Listening to patients  | ▪ Rushed or overly complicated feedback that patient cannot understand or that does not appear to be relevant to patient  
▪ Clinician-imposed interaction style  
▪ Imposed regimen or didactic curriculum  
▪ Didactic, standardized recommendations  
▪ Lecturing to patients  |
| **Agree** |  |  |
|  | ▪ Collaborative goal setting based on patient priorities and data review  
▪ Action planning for specific behavior changes  | ▪ Clinician-imposed goals; taking on too many goals at once  
▪ Vague recommendations (e.g., lose weight, exercise more)  |
| **Assist** |  |  |
|  | ▪ Problem solving-based approach; linked to patient social environment and identified barriers  | ▪ Telling patient what to do; lack of awareness of personal, cultural, and community context  |
| **Arrange** |  |  |
|  | ▪ Follow up (in person, by phone, or by e-mail)  | ▪ Failure to follow up  |

*(Glasgow, Davis, Funnell, and Beck). Table used with permission from the Joint Commission Journal on Quality and Safety, November 2003, Volume 29, Number 11. Figure 1 – Table 1. (p.563-574).  
*SMS=Self-Management Support*
Application Example: Self-Management Support

Greg, a home health nurse, is working on self-management support to help his patients improve in self-management. He is looking for a tool or tools that will help motivate his patients. Sharon, the home health supervisor, has introduced two new resources to the staff, “My Action Plan” (p. 12) and “Patient Self-Hospitalization Risk Assessment” (p. 13). Greg decides to try the “My Action Plan” with his 67 year old patient, Brenda, newly diagnosed with Type 2 diabetes. Brenda decides she wants to learn more about her diet. Greg explains that writing goals and actions could help. Brenda completed her action plan and rates herself “Somewhat Convinced” and “A Little Confident” on the ruler scales. She also identifies potential barriers that could cause her to not meet her dietary plan. Brenda said making a plan to overcome the barriers was beneficial, and states that acknowledging barriers actually helps her feel more convinced and more confident.

Greg is also using the “Patient Self-Hospitalization Risk Assessment” tool with many of his patients. He is finding that patients appreciate understanding their hospitalization risk--one patient said it was ‘eye-opening’. Greg is finding that it also helps the patient understand what the health care team is doing to prevent avoidable hospital readmissions. In fact, at a recent staff meeting, Greg shared that by understanding the risk of hospitalization and treatment plan, patients see themselves as a more active member of their own health care team.

HHQI suggests the following toolkits from the Institute for Healthcare Improvement:

Self-Management Toolkit for Patients & Families
Self-Management Toolkit for Clinicians

HHQI suggests the following tools from The Joint Commission’s Speak Up Initiatives.

http://www.jointcommission.org/speakup.aspx
My Action Plan

1. Goal: Something I want to do: __________________________________________________________

2. Describe how: ____________________________________________________________

   Where: ________________________________________________________________________

   When/How often: ________________________________________________________________

3. Barrier(s): ___________________________________________________________________

   Plan to overcome barrier(s): ______________________________________________________

4. Am I convinced that I can do this? Mark on the ruler:

   Totally Unconvinced  Unsure  Somewhat Convinced  Very Convinced  Extremely Convinced

5. Am I confident that I can do this? Mark on the ruler:

   Totally Unconfident  A Little Confident  Somewhat Confident  Very Confident  Extremely Confident

6. Follow-up: ____________________________________________________________________

______________________________________________________________________________

This material was prepared by New Health Partnerships, a National Program of the Robert Wood Johnson Foundation, rulers adapted by the Rhode Island Chronic Care Collaborative 2003, and provided by the West Virginia Medical Institute the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 850W-PA-HHQI7-659 Revised 10/2012
Patient Self-Hospitalization Risk Assessment
Are You at Risk for Going to the Hospital?

Name: ____________________________ Date: ________________
My Top Health Wish or Goal: _________________________________________________________

Check all Boxes that are True for you:

☐ I needed home health care after leaving the hospital.
☐ I have very poor health.

☐ I have been in the hospital or emergency room in the past year.
☐ I need help taking my pills.

☐ I have heart problems/weak heart.
☐ I need help using my inhalers.

☐ I have diabetes.
☐ I have three health problems. They are: ____________________________________________

☐ I feel short of breath often.
☐ I fell down in the last year.

Check all that apply: I need some help every day to:
☐ dress ☐ take a bath ☐ cook
☐ I live alone.

☐ I often feel down, hopeless, or depressed.
☐ I have a: ☐ skin sore; ☐ skin ulcer;
☐ pressure sore on my body, legs, or feet.
☐ I may need help to heal the sore or wound

☐ I sometimes get mixed up or confused.

My total number of checked boxes above is ________.
(5) or more checked boxes could mean a higher chance of having hospital trips.

I’m interested in knowing more about services from:
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy

I’m interested in knowing more about services from:
☐ Social Worker

I’m interested in knowing more about services from:
☐ Hospice care

I’m interested in knowing more about services from:
☐ Nursing

Patient Signature: ____________________________________________ Date: ________________

Home Health Signature: ____________________________________________ Date: ________________

☐ I know how to call for help and have a “Call Me First” home poster.
### Clinician’s Worksheet

**Purpose:** Use this Worksheet based on the patient’s information (page 1). Note: some of the interventions may have already been ordered or in process of being implemented.

#### Checklist of possible patient specific interventions that may be appropriate for this patient for this patient to reduce risk for hospitalization:

<table>
<thead>
<tr>
<th>Referrals:</th>
<th>Medication Management</th>
<th>Patient/family education</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN, PT, OT, ST, MSW, HHA, Dietary Consultant, Other:</td>
<td>Review patient’s medication reconciliation, knowledge, ability, resources, and adherence</td>
<td>Enroll patient into a disease management program e.g. HF, AMI, COPD, Diabetes, HTN, Depression (specify):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice/Palliative Referral</th>
<th>Front-loading Visits</th>
<th>Influenza Immunization, Pneumococcal Immunization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Wound Care Specialist Referral</th>
<th>Add to Case Conference or IDT list related to Risk for Hospitalization</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Emergency Plan</th>
<th>Scheduled Telephone Calls</th>
<th>Care Coordination (Physicians, Hospitals, Nursing Homes…):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fall Prevention Program</th>
<th>Remote Telehealth Monitoring</th>
<th>Other:</th>
</tr>
</thead>
</table>

**Notify the following when appropriate for the patient at risk for hospitalization:**

- Notify Physician:
  - Fax this HRA
  - Or contact physician contact regarding interventions for the Plan of Care

- Interdisciplinary Team Members

- On Call Staff

- Agency Case Manager

- Patient and/or Family/Caregiver

- Case Conference

**Payer (if requires authorization):**

- Other:

**Clinician Signature:** ___________________________ **Date:** ____________

### Notes:

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy.

Stay safe and well at home.
Avoid unneeded trips to the hospital.
Tell me when you have health changes:
  • Get sick
  • Just don’t feel right
  • Find it harder to stand up from a chair
I can help you if I know you need help!

Call Me First!
Because I Care!

Name: _____________________________

Local Number: ____________________

(Anytime: 24 Hours/7 Days a Week)
Motivational Interviewing Tool

Motivational Interviewing (MI) is a scientific patient-centered approach for building motivation and helping patients resolve ambivalence about change. MI is effective in building engagement, readiness and motivation to change, such as for increased medication adherence. MI is effective with patients labeled as “non-compliant” or “resistant”.

--Cross Settings I BPIP—Focus Section 2010, pp. 26-28

Click here for a MI pocket card template. Click here for a brief video on MI, created by HealthTeamWorks in Lakewood, CO. For more information about HealthTeamWorks visit www.healthteamworks.org.

<table>
<thead>
<tr>
<th>Motivational Interviewing/Health Coaching</th>
<th>Typical Patient Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic care oriented</td>
<td>Acute care oriented</td>
</tr>
<tr>
<td>Behavioral-focus</td>
<td>Disease-focus</td>
</tr>
<tr>
<td>Clinician supported, patient-led</td>
<td>Clinician-led</td>
</tr>
</tbody>
</table>

Motivational Interviewing Principles

1) Express Empathy

• Where is patient in understanding their illnesses and their impact?
• Build trust and rapport
• Listen and ask patient to reflect on health status
• How hard is it on you and your family when you are in the hospital?
• I am sure it is very hard to control your sugar level with your diet. What types of foods is the hardest for you?

2) Develop Discrepancy

• Assist patient to see where they are and where they want to be
• Start patient goal setting (non-medical goals are appropriate)
• How does being sick so often affect your life?
• What have you tried before that has worked? Has not worked?
• What did you like to do before you got sick? I wonder what it would take so you could do that again?

3) Role with Resistance

• Don't argue or oppose resistance
• Try new approach or find areas of agreement
• Listen for underlying reasons
• Use open ended questions
• Tell me what do you think caused you to go back to the hospital?
• What do you think caused the symptoms to flare up?
• Tell me about the problems you have with taking your medications?

4) Support Self-Efficacy

• Support patient's goals, actions
• Use sense of trust and guide patient
• Use "My Action Plan" or other goal setting tool
• Tell me what you would like to do in the next couple of weeks?
• How do you think you can do it?
• How can I help you reach your goal?
• You did great this week on your goal. How confident are you to do it this week?

Putting It All Together: Tool Guides and Tips

Note: These tools are all available in a modifiable format on the HHQI Web site. You may modify the forms and add your agency logo. All of the tools and resources in the BPIPs may be modified and used in the most effective manner to promote patient care and efficient staff implementation.

Patient-Clinician Interaction Level Tips

- A guide for clinicians to reflect on current practice and provide tips on how to make patient interactions more meaningful.
- The tool can be reviewed in group and individual discussion to improve individual and agency patient interactions.
- Advance users can engage in a more comprehensive discussion on what happens when interactions are not patient centered. Examples include:
  - Lack of follow-up leads to marginalized services and dissatisfaction (e.g. unfavorable HHCAHPS outcomes)
  - Lack of awareness of personal, cultural, and community leads to the patient being devalued
  - Setting too many goals leads to patient and staff frustration
- Definition of Terms
  - Learner-directed: Patient prioritizes what he/she wants to learn
  - Problem-based and Problem solving-based approach: Use of scenarios to help the patient better understand what to do (example: give the patient scenarios regarding when to call the home care nurse versus going to the ED)
  - Participatory decisions: Patient participates with health decisions (example: action planning)
  - Self-directed: Success will depend on patient being the manager of his/her care
  - Iterative (repeat): Clinician must ‘teach’ several times for patients to understand. (example: when to take medications, medication side-effects)

My Action Plan

- Tool assists patients to identify goals and how likely he/she is to meet the goal. Patient participation in goal selection is critical!
- It is a patient-centered tool (rather clinician-led) designed to promote patient engagement.
• After completion, leave the tool with the patient, but document in the medical record patient’s goals and level of conviction and confidence. Periodically review the tool with the patient to evaluate how he/she feels about progress toward goal. At discharge evaluate patient’s progress—and encourage patient to keep working toward goal(s).

Patient Self-Hospitalization Risk Assessment

Note: This is a 3-page tool, but can be broken into individual tools depending on agency need. Use as a staff educational tool if similar tools are already implemented at your agency.

• Page 1- On the initial visit, explain to the patient/caregiver that this form will help them understand his/her risk of hospitalization and ask the patient to complete the page before the next visit (or within the first week of home care). At a following visit, review the completed form with the patient/caregiver. Share how the interdisciplinary team is working to prevent a rehospitalization--include the patient’s role in preventing hospitalizations. This tool is used to help the patient understand his/her risk factors and will also help the clinician identify additional any interventions needed to prevent hospitalizations. This is a patient tool, but it is based on a clinician/agency tool---Hospitalization Risk Assessment located in a previous BPIP.

• Page 2-Use Clinician’s Worksheet if you need a form for care planning and care coordination. Many agencies may have a similar electronic or paper form. Whatever method you use--make sure that you review the patient’s tool (page 1) and compare to the patient’s plan of care. The patient may be identifying something that needs addressed. For example, if the patient checks “I need help using my inhalers”—make sure this is addressed as an intervention for the patient.

• Page 3-Call Me First is a visual reminder for patient to call the agency first, to allow agency to triage and attempt to avoid an unnecessary hospitalization. Many agencies are already using a similar tool—if so it is a good time to check your tool for appropriate health literacy language. Are clinicians sharing this tool with patients? It may be a good time to review the tool in a staff meeting.
  o An additional tool to teach patients to know when to call the agency versus 911 is the My Emergency Plan.

Motivational Interviewing (MI) Tool

• This tool introduces motivational interviewing to your staff. The tool can be distributed to staff to review before an educational session on motivational interviewing. A pocket card template is also available with clear directions on printing and laminating – ideally the pocket card will be given to staff during an educational session on MI.
HHQI CONNECTIONS

DO YOU FEEL LIKE YOU ARE JUGGLING TOO MANY QUALITY IMPROVEMENT/ PERFORMANCE IMPROVEMENT PROJECTS?

Patient self-management principles from this HHQI BPIP also CONNECT to your Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) initiatives. Many HHCAHPS questions relate to the patient’s perception of having receiving education related to specific dimensions of care including medications, ambulation, and pain.

Patient-self-management tools and resources involve the patient with:

- Goal setting
- Active learning
- Self-directed care
- Better HHCAHPS responses because they are actively involved with their care

The following page is a 1 page guide, Putting It In Practice, that can be distributed to clinicians. Consider sharing one or two of the tools in this BPIP with the guide.
Putting It In Practice: Clinician Guide

“Self-management support is the assistance caregivers give to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes.”
--Institute for Healthcare Improvement

There are multiple tools available to help you with self-management support in the Patient Self-Management Focused BPIP. Ask your nurse manager or educator about them—or register as a participant of the Home Health Quality Improvement National Campaign at www.homehealthquality.org and download the Patient Self-Management Focused BPIP. (Registration and materials are free.)

Self-management support techniques that can be used with patients:

☐ Establish a Focus
  • Start by asking the patient what is most important to them about their health and what do they want to learn

☐ Share Information
  • Sharing what is most clinically important can help the patient make better decisions

☐ Develop Shared Goals
  • Engage the patient to prioritize what is most important to them, and share with interdisciplinary team

☐ Develop an Action Plan
  • Include the “how, what, when, where and how often”

☐ Use Problem-Solving Techniques
  • What’s the plan for follow-up?

--Planned Care: Self-Management Support in Home Healthcare, p. 12

<table>
<thead>
<tr>
<th>Self-Management: Obstacles and Solutions</th>
</tr>
</thead>
</table>
| Inability to self-manage due to dementia or a mental illness | • Work with family and caregiver to guide ‘self’-management for the patient  
• Include the patient when possible, even with small decisions |
| Limited literacy | • Adapt tools for patients at all reading levels  
• Implement practices such as Teach-Back to improve patient understanding (i.e. ask patient to teach you what they just learned)  
• Limit medical jargon |
References


This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number: 10SOW-WV-HH-BK-11112. App. 11/2012.