SMART-CHATS

Developing Effective Physical Health Goals and Health Action Plans

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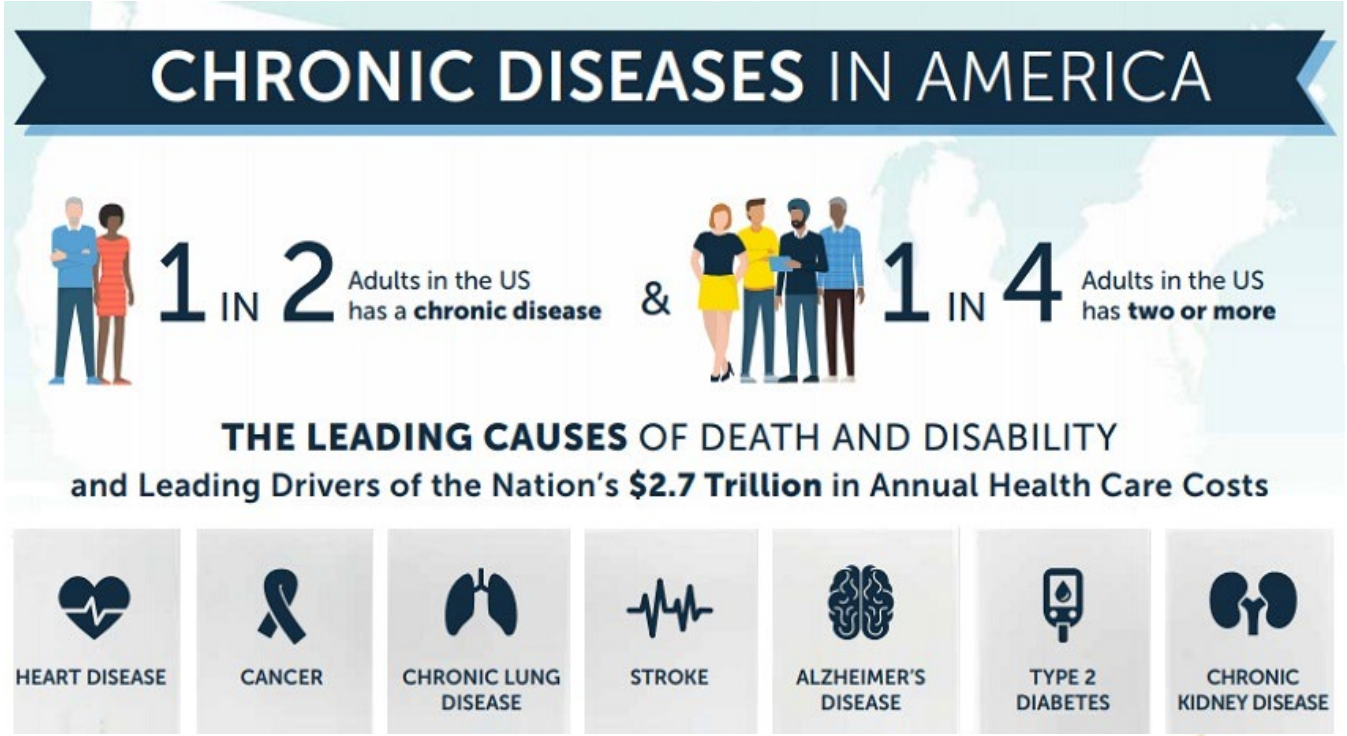
Agenda

- Brief overview of chronic disease
- Concepts of self-management, activation, motivational interviewing, behavior change, goal-setting, and brief action planning
- Model for developing a physical health goal/health action plan in collaboration with the healthcare home member – and ideally their CPRC staff
- Examples of Action Planning

Chronic Disease Prevalence



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Chronic Disease Prevalence

- 7 out of 10 top leading causes of death are due to chronic diseases
- Treating chronic diseases accounts for 90% of the nation's healthcare costs (CDC)
- People with chronic diseases have a lower quality of life
- The majority of persons enrolled in the Behavioral Health Healthcare Home in Missouri have multiple chronic health conditions that require collaborative self-management*

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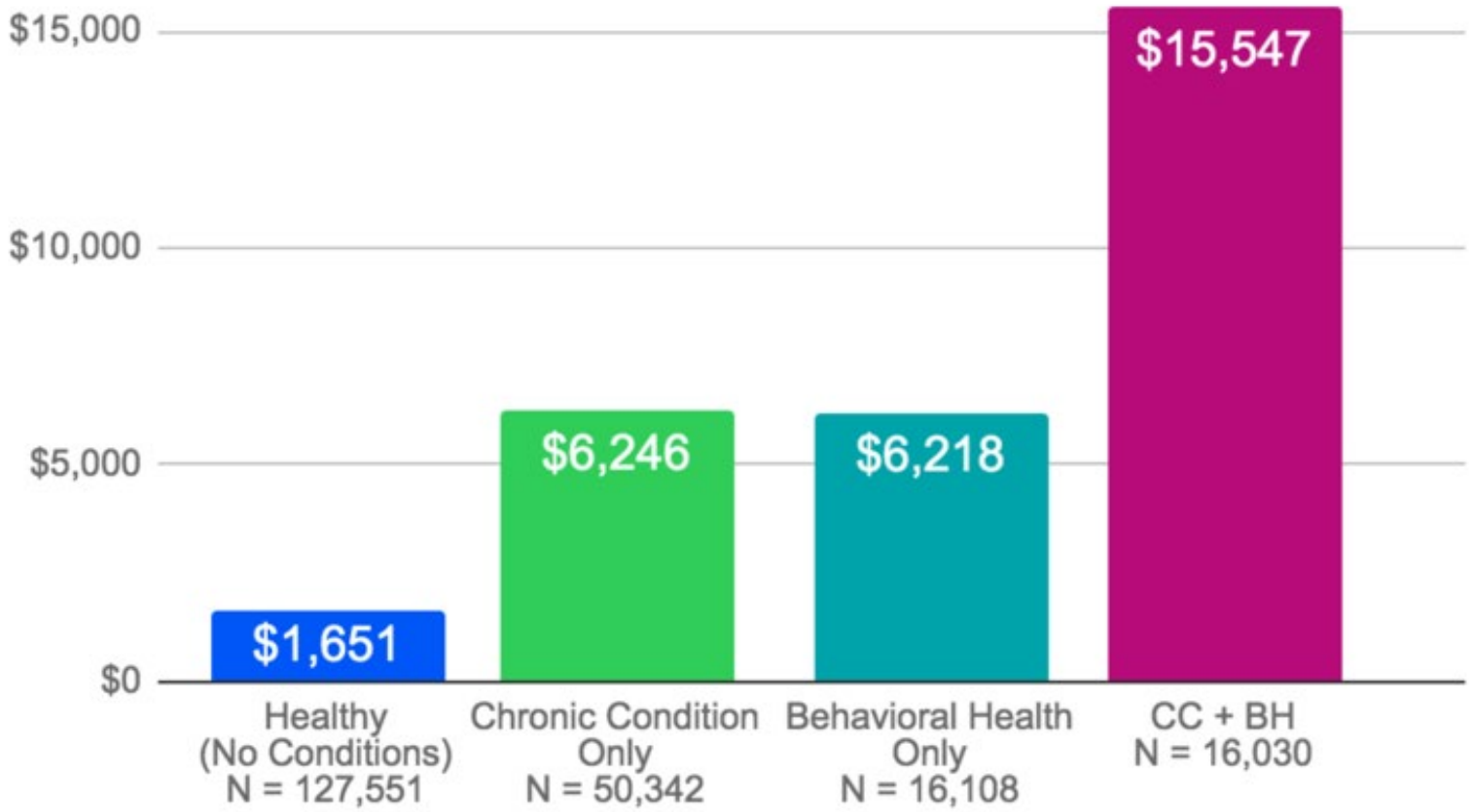
Costs: 1 + 1 = 3



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Key Lifestyle Risks

- Tobacco Use/Secondhand Smoke
- Poor Nutrition
- Lack of Physical Activity
- Excessive Alcohol use

- Persons with behavioral health diagnoses have a higher prevalence of engaging in these behaviors - and have additional risk factors

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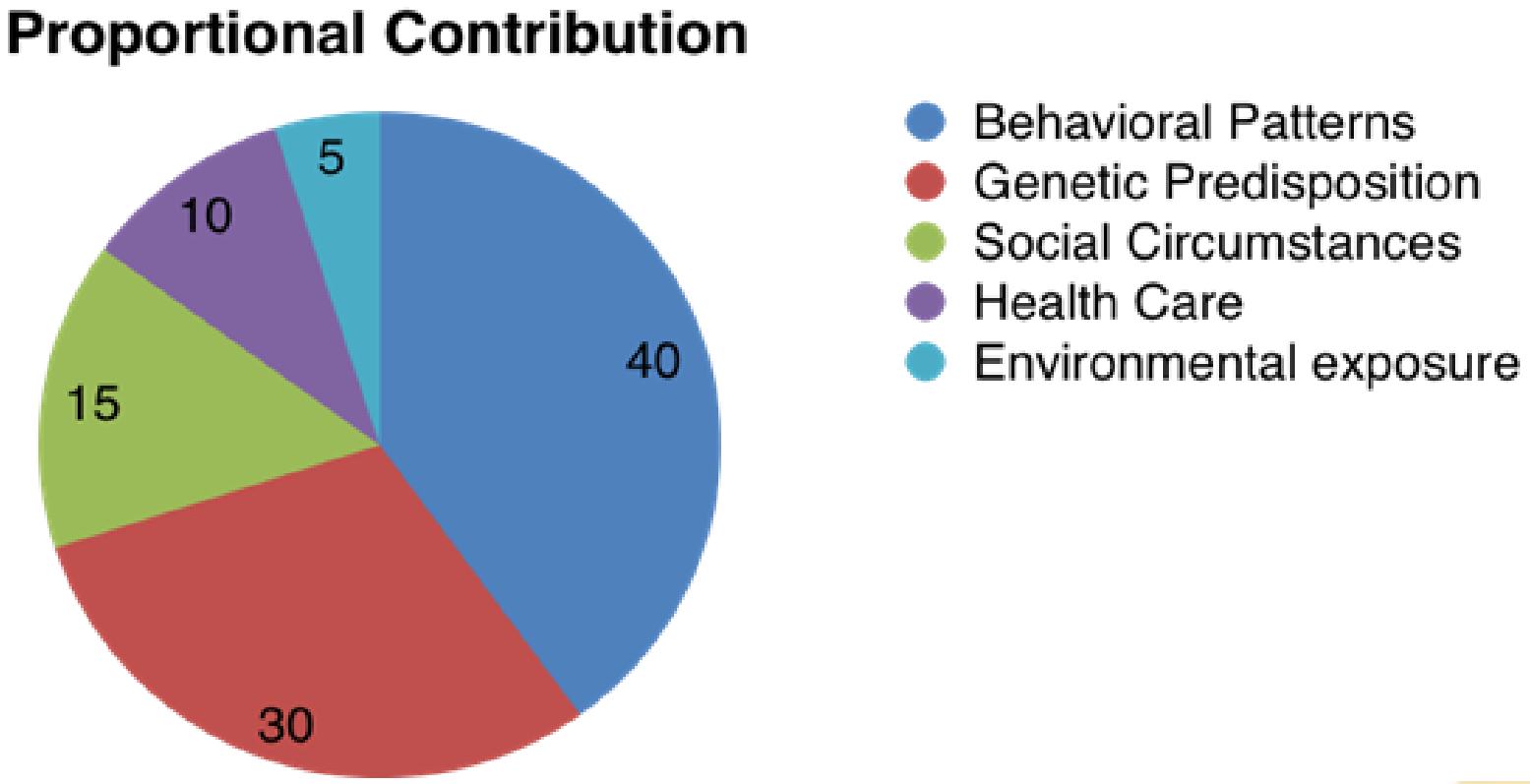
Factors Impacting Health



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Primary Care Model

- Our country's predominant model of Primary Care was designed to treat acute problems, not chronic conditions
- Given the prevalence of Chronic Diseases, Primary Care practices are shifting focus to the treatment of patients with chronic illnesses
- Medications alone do not typically lead to the best outcomes possible for chronic conditions; patient's play a large role in determining their outcomes
- The best system is one that *improves* health, not just *manages* conditions

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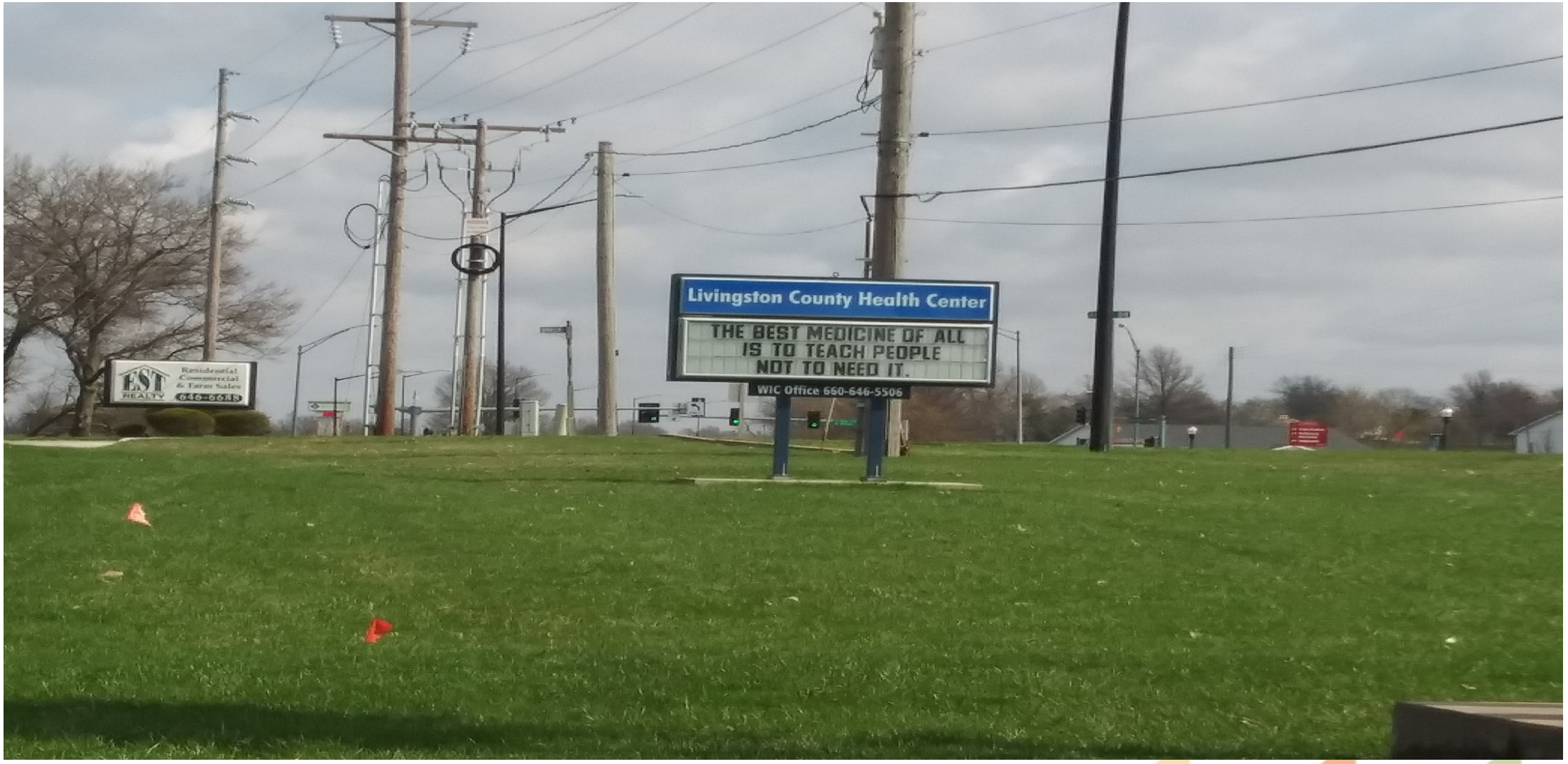

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Managing a Chronic Condition

- There is no way around managing a chronic condition
  - Choosing to do nothing is one way of managing
    - This can lead to progression of the illness and often leads to other symptoms and diseases
  - Medication only is another way
  - Positively managing is learning how to function to the highest level possible, given the chronic condition by:
    - Seeing a Primary Care or Specialty Provider regularly
    - Taking part in treatments available
    - Being proactive in day-to-day management by learning strategies
    - Controlling one's own life instead of allowing the illness to control it

    - Referred to as Self-Management

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Self-Management

- Many patients want to make changes that will improve their health, but they need support
- A major component of treating chronic illness is supporting patients in self-management of their conditions
- Self-management is different than traditional patient education
- In addition to providing education, self-management involves engaging patients in making behavioral changes and create appropriate action plans based on their level of activation

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Engagement

- "Patient experience" is a popular term and has been a part of the Triple Aim - now the Quadruple Aim
- To achieve the best outcomes, it's important for people to be engaged in their own care
- Low levels of patient engagement can present a challenge

- "Patient Engagement" is an umbrella term that includes patient activation

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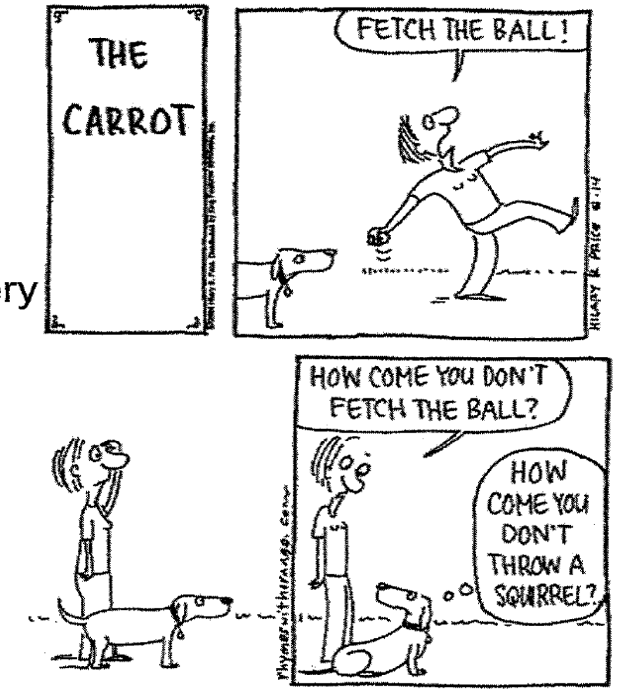
Activation

The Art of Activation/Self Care

- Built on trust
- Starts with the consumer's strengths
- Based on *Stage of Recovery*
- In synch with consumer's own recovery goals and personal preferences
- Exploration of the best self care/activation tools is done by the consumer themselves often in partnership with a trusted other (especially in the early stages of recovery)



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Activation

- Patient Activation is different than patient engagement
- Understanding their role in the care process
- Having the motivation, knowledge, skills, and ability to take action to manage their healthcare
- Can be measured
  - Patient Activation Measure (PAM)
  - Patient Health Engagement Scale

  - Has shown success in low-income, underserved communities

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Activation

- PAM - 4 levels of activation
- 13 items that have statements on confidence, beliefs, knowledge, and skills about managing one's health
- Determining the level is a critically important step
- Some Patient Centered Medical Homes are using the level of activation as a "vital sign"

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Activation

- Tailoring coaching to the person's activation level has been shown to improve outcomes
- Activation level is changeable - developmental
- Behaviors encouraged for each action level - or based on data indicating what is realistic at each stage
- Asking people to do things they could succeed at in order to build confidence

Activation

- Level 1:
  - Person may be disengaged, or overwhelmed and unprepared to play a role in their own health
  - ***"My Doctor is in charge of my health"***
  - Corresponds to the Pre-Contemplative Stage
  - **Action: build self-awareness and understanding of behavior patterns. Provide education**
  - Clinician-led patient education can drive activation levels

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Activation

- Level 2:
  - Person may lack knowledge and confidence - becoming aware but still struggling
  - ***"I could do more"***
  - Corresponds to the Contemplation/Preparation Stage
  - **Action: implement small changes to existing behavior**

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Activation

- Level 3:
  - Person has been taking action
  - ***"I'm part of my healthcare team"***
  - Corresponds to the Action Stage
  - **Action: adoption of new behaviors/development of problem-solving skills**

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Activation

- Level 4:
  - Person is maintaining behaviors and pushing further
  - ***"I'm my own advocate"***
  - Corresponds to the Maintenance Stage
  - **Action: relapse prevention and handling new situations as they arise**

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Activation

- Higher activated people are:
  - More likely to receive preventative care
  - Less likely to smoke
  - Less likely to have a high BMI
  - Less likely to use the ED or have been hospitalized

Self-Management/Chronic Care Models

- 5 A's Behavior Change Model
- Motivational Interviewing
- Teach-back method
- Ask-tell-ask
- Patient Activation
- Brief Action Planning**
- Goal-Setting with confidence scaling

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Self-Management/Chronic Care Models

- Stanford Model
- Whole Health Action Management (WHAM)
- Wellness Recovery Action Plan (WRAP)
- Self-Management Education (SME)

- The trend is towards patient-centered chronic care management vs a condition-centric model
- https://www.youtube.com/watch?v=z6Rdut9rew8&list=PLvrp9iOILTQaIGDl85dhLUE7F8jf5qCZz&index=7&t=0s

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Goal-Setting for Success

- Tailor to level of activation/readiness for change
- Keep in mind the principles and practice of Motivational Interviewing

  - Partnership with the patient vs a prescription for change
  - Resist the urge to give advice or examples
  - Elicit ideas from them using open-ended questions
  - The ultimate choice to change resides with the patient
  - Roll with resistance*

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SMART Goals - Expanded

- **S** - **S**pecific, **S**mall, **S**tage-Matched
- **M** – **M**easurable, **M**onitor-able
- **A** - **A**chievable, **A**ccountable
- **R** - **R**elevant, **R**ealistic, **R**eadiness
- **T** - **T**imely, **T**ime-Specific

- **C**- **C**onfidence, **C**alls for Action
- **H** - **H**ope-filled, **H**elper (to monitor and to follow-up)
- **A** - **A**dds Something, Positively Stated
- **T** - **T**weakable
- **S** - **S**alutes **S**uccess

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SMART CHATS -> Action Plans

- My Health Action Plan - the client can fill it in – assist if needed – client to take with them
- From that you will have the health goal for the treatment plan/wellness plan
  - I will walk my dog for 20 minutes in my neighborhood at least 3 days/week after dinner
  - I will drink one glass of water with each meal at least three days/week

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Action Planning

- Brief Action Planning Model
- Goal is to assist an individual to create an action plan for a self-management behavior they feel confident that they can achieve
- Evidence-informed
- Integrates principles of MI with goal setting and action planning concepts from self-management support, self-efficacy, and behavior change literature

Action Planning

- Two evidenced-based constructs from behavior change literature:
  - Action planning - has been shown to mediate the intention-behavior relationship thus increasing the likelihood that the person's intentions will lead to actual behavior change
  - Self-efficacy – this is the person's confidence in their ability to enact a behavior. There is a strong relationship between self-efficacy and the adoption of healthy behaviors
- Three parts: eliciting a goal, scaling for confidence, and monitoring and follow-up

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My Health Action Plan: Eliciting a Focus Area

- Ideally done after their health screen
- "Now that we've talked about your health, is there any area of your health you would to focus on for the next week or two?"
- "We've been talking about your diabetes, is there anything you would like to do for that?"
- Although technically a closed question, it can generate discussion about change
- Encourages the client to see themselves as engaged in their own health

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My Health Action Plan: Eliciting a Focus Area

- Have an idea
  - Use the elements of SMART CHATS to turn into an Action Plan
- Not Sure
  - Ask permission to share with them some examples (Other client examples or the Menu) If they are able to choose, proceed as above
- No - or – Not at this time
  - "It sounds like you're not ready/interested to make a plan for your health right now – can I check back in with you"
  - Can enlist the assistance of their CPRC Staff to use MI
  - Can ask permission to share educational material with them
  - Roll with "resistance"

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My Health Action Plan: Scaling for Confidence

- "On a scale of 1-10, with 10 being the most confident, how sure do you feel that you can carry out your plan?"
- Assesses self-efficacy and facilitates discussion about potential barriers
- If below a "7", collaboratively explore ways to improve confidence
- Recognize that low confidence is greater than no confidence
- If the client has no ideas, ask permission to share some examples from other clients
- May also want to consider scaling for readiness and importance

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My Health Action Plan: Monitoring and Follow-Up

- Ask about how they can track or monitor – offer assistance or work with their CPRC staff if they need a chart or some other form of tracking; may want to consider digital assistance (smart phone apps, etc.)
- Ask who they can enlist to be their helper or supporter
- Discuss how they will tweak their plan, if needed
- Arrange for follow-up - either by you or their CPRC staff
  - Encourages reflection on barriers as well as successes
  - Presents an opportunity to tweak the plan vs giving up on it

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Action Plan Examples

- https://cepc.ucsf.edu/action-plans-video 6

- https://www.youtube.com/watch?v=r8-O0Q6hkiw 5:39
- https://www.youtube.com/watch?v=w0n-f6qyG54 BAP 4:41

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Questions/Discussion

Inspire Hope. Promote Wellness.

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Resources

- https://www.cdc.gov/learnmorefeelbetter/index.htm
- https://www.cdc.gov/physicalactivity/activepeoplehealthynation/index.html
- https://www.selfmanagementresource.com/
- https://med.stanford.edu/coordinatedcare/better-choices--better-health.html
- https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia/he.personal-action-plan.zx3175

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Resources

- https://www.chronicdisease.org/
- https://health.gov/
- https://www.insigniahealth.com/products/pam-survey
- https://www.mdedge.com/jcomjournal/article/147101/endocrinology/brief-action-planning-facilitate-behavior-change-and
- https://www.ncbi.nlm.nih.gov/pubmed/19514801
- https://www.integration.samhsa.gov/health-wellness/wham

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Resources

- https://mentalhealthrecovery.com/ WRAP

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