SMART-CHATS

Developing Effective Physical Health Goals and Health Action Plans
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

**CHRONIC DISEASES IN AMERICA**

1 in 2 Adults in the US has a chronic disease & 1 in 4 Adults in the US has two or more

**THE LEADING CAUSES OF DEATH AND DISABILITY**
and Leading Drivers of the Nation’s $2.7 Trillion in Annual Health Care Costs

- Heart Disease
- Cancer
- Chronic Lung Disease
- Stroke
- Alzheimer’s Disease
- Type 2 Diabetes
- Chronic Kidney Disease

Compass Health Network
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*
Costs: 1 + 1 = 3
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
Factors Impacting Health

Proportional Contribution

- Behavioral Patterns: 40
- Genetic Predisposition: 30
- Social Circumstances: 15
- Health Care: 10
- Environmental exposure: 5
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.
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
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
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
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)
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
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”
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
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
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
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
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
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=PLvp9iOlLTQalGDI85dhLUE7F8jf5qCZz&index=7&t=0s
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*
SMART Goals - Expanded

• **S** - Specific, Small, Stage-Matched
• **M** – Measurable, Monitor-able
• **A** - Achievable, Accountable
• **R** - Relevant, Realistic, Readiness
• **T** - Timely, Time-Specific

• **C** - Confidence, Calls for Action
• **H** - Hope-filled, Helper (to monitor and to follow-up)
• **A** - Adds Something, Positively Stated
• **T** - Tweakable
• **S** - Salutes Success
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
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
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.
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
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”
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
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
Action Plan Examples

• [https://cepc.ucsf.edu/action-plans-video](https://cepc.ucsf.edu/action-plans-video) 6

• [https://www.youtube.com/watch?v=r8-O0Q6hkiw](https://www.youtube.com/watch?v=r8-O0Q6hkiw) 5:39
• [https://www.youtube.com/watch?v=w0n-f6qyG54](https://www.youtube.com/watch?v=w0n-f6qyG54) BAP 4:41
Questions/Discussion

Inspire Hope. Promote Wellness.
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
Resources

- https://www.chronicdisease.org/
- https://health.gov/
- https://www.mdedge.com/jcomjournal/article/147101/endocrinology/brief-action-planning-facilitate-behavior-change-and
- https://www.integration.samhsa.gov/health-wellness/wham
Resources

• https://mentalhealthrecovery.com/  WRAP