



Self-Management Support

Section Contents

- BCBSM PCMH self-management support criteria
- Tool 11-1 — What's a motivational interview?
- Tool 11-2 — Simple steps to assess health literacy with REALM and sample TOHFLA
- Tool 11-3 — Patient assessment of chronic care survey (PACIC)
- Tool 11-4 — PowerPoint™ on motivational interviewing
- Tool 11-5 — Flow chart on patient action plans and goals
- Action plans and goal sheets for asthma, diabetes and kidney disease

Self-Management Support

Overview: The purpose of the self-management support initiative is to implement a comprehensive program that will utilize patient education tools, informative sessions, and life skills training to offer support to chronic care patients, and help them to manage their condition.

These Blue Cross Blue Shield of Michigan criteria pertain to the self-management support initiative:

Criteria

Met 

- 11.1 Member of clinical care team or PO is educated about and familiar with self-management support concepts and techniques and regularly works with appropriate staff members at the practice unit to ensure they are educated in and are able to actively use self-management support concepts and techniques
- 11.2 Self-management support is offered to all patients with the chronic condition selected for initial focus (based on need, suitability, and patient interest)
- 11.3 Systematic follow-up occurs for all patients with the chronic condition selected for initial focus who are engaged in self-management support to discuss action plans and goals and provide supportive reminders
- 11.4 Regular patient experience/satisfaction surveys are conducted for patients engaged in self-management support, to identify areas for improvement
- 11.5 Self-management support is offered to patients with *all chronic conditions* (based on need, suitability, and patient interest)
- 11.6 Systematic follow-up occurs for patients with *all chronic conditions* who are engaged in self-management support to discuss action plans and goals and provide supportive reminders
- 11.7 Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients
- 11.8 At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques

11.0 Self-Management Support

Self-management *support* is a systematic approach to empowering the patient with chronic illness to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.

11.1

Member of clinical care team or PO is educated about and familiar with self-management support concepts and techniques and regularly works with appropriate staff members at the practice unit to ensure they are educated in and able to actively use self-management support concepts and techniques.

Guidelines:

- Self-management support uses a team-based, systematic, model-driven (including behavioral and clinical dimensions) approach to actively motivating and engaging the patient in effective self-care for identified chronic conditions; must extend beyond usual care such as encouragement to follow instructions
- Level, type, and intensity of training, education, and expertise may vary, depending upon team members' roles and responsibilities in the Practice Unit
 - o Education must be substantive and in-depth and focus on a particular model of self-management support and not consist of only a brief introduction to the concept
 - o California Healthcare Foundation (Bodenheimer) has a list of recommended self-management support training materials at: <http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=134065>
Information is also available at the Institute for Healthcare Improvement website: <http://www.ihl.org/ihl/search/searchresults.aspx?searchterm=self-management+support&searchtype=basic&Start+Search.x=0&Start+Search.y=0>
Self-management tool kit can be referenced at: <http://www.selfmanagementtoolkit.ca/>
- Education of practice unit staff members may be provided by PO staff person if the PO staff person has adequate time to provide comprehensive, meaningful education; otherwise, practice unit is responsible for identifying a member of the practice's clinical care team to receive education in self-management support concepts and techniques
- Appropriate team members should have awareness of self-management concepts and techniques, including:
 - o Motivational interviewing
 - o Health literacy / Identification of health literacy barriers
 - o Use of teach-back techniques
 - o Identification of medical obstacles to self-management
 - o Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
 - o Systematic follow-up with patients



11.2

Self-management support is offered to all patients with the chronic condition selected for initial focus (based on need, suitability, and patient interest)

Guidelines:

- Physicians may provide self-management support (but would not be eligible to bill T-codes for such services)
- Self-management support services may be provided in the context of a planned visit

11.3

Systematic follow-up occurs for all patients with the chronic condition selected for initial focus who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

Guidelines:

- Follow-up may occur via phone, email, or in person.

11.4

Regular patient experience/satisfaction surveys are conducted for patients engaged in self-management support, to identify areas for improvement in the self-management support efforts

Guidelines:

- Surveys may be administered electronically, via phone, mail, or in person
- Self-management support survey questions may be added to regular patient satisfaction surveys providing sampling is structured to ensure adequate responses from those who actually received self-management support services

11.5

Self-management support is offered to patients with all chronic conditions prevalent in the practice's patient population (based on need, suitability and patient interest)

11.6

Systematic follow-up occurs for patients with all chronic conditions prevalent in the practice's patient population who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

Guidelines:

- Follow-up may occur via phone, email or in person.

11.7

Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients



11.8

At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques.

Guidelines:

- Training for self-management techniques should include:
 - o Motivational interviewing
 - o Health literacy / Identification of health literacy barriers
 - o Use of teach-back techniques
 - o Identification of medical obstacles to self-management
 - o Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
 - o Systematic follow-up with patients
- Practices should seek structured information/approaches/processes, which can be from any legitimate source

What's a motivational interview?

Motivational interviewing helps patients move along the continuum of change by enhancing motivation for change and decreasing resistance to change. It establishes a working partnership and a deeper commitment from the patient. Creating steps towards the accomplishment of a long-term goal gives patients guidance and ownership. By rating the level of confidence, the patient expresses their belief in accomplishing a certain task. The motivational interviewer:

- Collaborates rather than confronts
- Evokes rather than educates
- Allows autonomy rather than invoking authority.

Ambivalence and resistance have important roles in the change process. Rather than viewing them as blocks, just understand they are a normal part of the change process and work with them. Very few decisions in life are made with 100 percent certainty.

People weigh the costs and benefits of change against the costs and benefits of staying the same. A person's decision may not make sense unless you understand what they see as the costs and benefits of change vs. staying the same.

Understand how **ready** (what are their priorities), **willing** (how important do they feel the change is) and **able** (how confident they feel of making a change) someone is for change before starting.

Develop and hone listening and empathy skills for motivational interviewing to be successful. Assess how important the change is to the person and how confident they feel about making the change. Avoid telling patients what you think they should do or how they should do it. Also avoid making them fearful as it will lead to more resistance.

Prescription Step Questions

1. What would you like to change? or Have you thought about (behavioral change)?

Help patient to focus on one long-term goal at a time.

2. What are some things you can do to make that change?

Be specific - in the next week, 2 weeks, month, 3 months, what, when, where, how long, with whom, how often.

3. What might get in the way of accomplishing this goal?

Discuss some potential barriers.

4. What can you do to overcome these barriers?

5. Is there any other help you need to accomplish this goal - friends, family, professional, information?

6. How confident are you of achieving this step at the present time on a scale of 1-10?

Behavioral Prescription/Prescription Steps is based on the Self-efficacy Theory of Professor Albert Bandura and Stages of Change (Prochaska and DiClemente)

Simple steps to assess health literacy

Illiteracy may be hard to detect because people are ashamed and cover it up. Most people with limited literacy are masters of concealment! Be non-threatening in your approach.

1. Incorporate questions into casual conversation. Use your mental and visual acuity – look for physical disorders, advanced age, medications that disrupt the ability to concentrate and ask about reading ability.
 - Do you like to read?
 - What kinds of things do you read? (newspapers 10th grade level, new magazines 12th grade level)
2. Asking a patient how far they went in school is **NOT** a good indicator of reading ability. Even most people who can't read have been through the 10th grade because they attend until they can legally drop out. Most research shows a 2-5 year gap between grade level and reading ability. It is better to ask in this manner: *"A lot of people have trouble reading and remembering this information. Is this a problem for you?"*
4. Invite the patient to bring in all of their prescription and over the counter medications and have them explain them to you – Observe how they refer to or review their meds.
5. Look for clues to low literacy:
 - React to complex learning situations by withdrawal / avoidance
 - Use excuses of being too tired, too busy, not interested, not feeling well
 - Show signs of frustration when trying to read
 - Have difficulty following directions
 - Become anxious when asked to read
 - Listen and watch attentively to try to memorize information
 - Don't ask questions
 - Ask someone to read information for them
 - Act confused or talk out of context about the information
 - There is a discrepancy between what they hear and what is written
 - Insist on reading the information at home or with spouse/friend present
 - Resist filling out forms or reading material you give him.
 - Resists changes in routine. Functionally illiterate people learn to cope by following same routine and using same services all the time.

Literacy tests

1. Listening tests: Comprehension skills test

1. Prepare the patient that questions on the material will be asked.
2. Select a passage from currently used material
3. Read the passage aloud to the patient at a normal rate
4. Ask the patient questions about what was read
 - The percent of correct answers is equal to the number of right divided by total number of possible right answers
 - 80% = easy material; 70% about right, but may need help to fully understand; less than 70% = too difficult for effective use

2. **REALM (Rapid Estimate of Adult Literacy in Medicine)**

- Measures a person's ability to read and pronounce medical and health-related vocabulary from three lists graduated from the simple to the more complex words
- The REALM is a list of 66 written words in three columns. Only takes a few minutes to administer
- Explain that you only want to get an idea of how best to provide information. Have them read as many words aloud as they can from list 1. If they cannot read a word say blank and go to the next word
- Count as error any word not attempted or mispronounced. Record the number of correct words for each list in box
- Total the number and match total score with grade equivalent

3. **TOFHLA (Test of Functional Health Literacy in Adults)**

- The TOFHLA is a 50 item reading comprehension test and 17 item numerical ability
- Takes 20 minutes to administer
- Done orally and uses real materials (prescription bottle, appointment cards) to see if patient can understand and get important points

RAPID ESTIMATE OF ADULT LITERACY IN MEDICINE (REALM)

Terry Davis, PhD, Michael Crouch, MD, Sandy Long, PhD

Chart #

Examine date:

Name:

Birth date:

REALM generated reading level:

Grade completed:

List 1	List 2	List 3
Fat	Fatigue	Allergic
Flu	Pelvic	Menstrual
Pill	Jaundice	Testicle
Dose	Infection	Colitis
Eye	Exercise	Emergency
Stress	Behavior	Medication
Smear	Prescription	Occupation
Nerves	Notify	Sexually
Germs	Gallbladder	Alcoholism
Meals	Calories	Irritation
Disease	Depression	Constipation
Cancer	Miscarriage	Gonorrhea
Caffeine	Pregnancy	Inflammatory
Attack	Arthritis	Diabetes
Kidney	Nutrition	Hepatitis
Hormones	Menopause	Antibiotics
Herpes	Appendix	Diagnosis
Seizure	Abnormal	Potassium
Bowel	Syphilis	Anemia
Asthma	Hemorrhoids	Obesity
Rectal	Nausea	Osteoporosis
Incest	Directed	Impetigo
#	# of (+) Responses in List 2: _____	# of (+) Responses in List 3: _____

LEGEND: (+)=Correct (-)=Word not attempted (/)=Mispronounced word

Raw Score:

RAPID ESTIMATE OF ADULT LITERACY IN MEDICINE (REALM) Examiner's Instruction Sheet

Terry Davis, PhD, Michael Crouch, MN, Sandy Long, PhD

The Rapid Estimate of Adult Literacy in Medicine (REALM) is a screening instrument to assess an adult patient's ability to read common medical words and lay terms for body parts and illnesses. It is designed to assess medical professionals in estimating a patient's literacy level so that the appropriate level of patient education materials or oral instructions may be used. The test takes two to three minutes to administer and score. The REALM has been correlated with other standardized tests (Family Medicine, 1993: 25:391-5).

Directions to the Examiner:

1. Examiner should say to the patient:
"This survey is to help us figure out the best type of patient education materials to give you. The survey only takes 2 to 3 minutes to do"
2. Give the patient a laminated copy of the "REALM" Patient Word List.
3. Examiner should hold an unlaminated "REALM" Score Sheet on a clipboard at an angle so that the patient is not distracted by your scoring procedure.
4. Examiner should say:
"I want to hear you read as many words as you can from this list. Begin with the first word on List 1 and read aloud. When you come to a word you cannot read, do the best you can or say "blank" and go on to the next word."
5. If the patient takes more than five seconds on a word say "blank" and point to the next word, if necessary, to move the patient along. If the patient begins to miss every word; have him/her pronounce only known words.
6. Count as an error any word not attempted or mispronounced. Score by:
 - ◆ (/) after each mispronounced word.
 - ◆ (-) after each word not attempted.
 - ◆ (+) after each word pronounced correctly.
7. Count the number of correct words for each list and record the numbers in the "SCORE box. Total the numbers and match the total score with its grade equivalent in the table below.
8. Record the "Realm" generated reading level on the Examiner's Score Sheet and in the Education/Learning History section of the Social and Patient Education History assessment form in the Medical Record.

GRADE EQUIVALENT

Raw Score	Grade Range	
0-18	3rd Grade and Below	Will not be able to read most low literacy materials; will need repeated oral instructions, materials composed primarily of illustrations, or audio or video tapes.
19-44	4th to 6th Grade	Will need low literacy materials; may not be able to read prescription labels.
45-60	7th to 8th Grade	Will struggle with most patient education materials.
61-66	High School	Will be able to read most patient education materials.

PASSAGE A

Your doctor has sent you to have a _____ X-ray.

- a. stomach
- b. diabetes
- c. stitches
- d. germs

You must have an _____ stomach when you come for _____.

- | | |
|-----------|--------|
| a. asthma | a. is. |
| b. empty | b. am |
| c. incest | c. if |
| d. anemia | d. at |

The X-ray will _____ from 1 to 3 _____ to do

- | | |
|---------|-----------|
| a. take | a. beds |
| b. view | b. brains |
| c. talk | c. hours |
| d. look | d. dies |

THE DAY BEFORE THE X-RAY

For supper have only a _____ snack of fruit, _____ and jelly,

- | | |
|-----------|-----------|
| a. little | a. toes |
| b. broth | b. throat |
| c. attack | c. toast |
| d. nausea | d. thigh |

with coffee or tea.

Motivational Interviewing

Tool 11-4 Initiative 11.1



What is motivational interviewing?

- It's a way to talk to patients that helps move them along the continuum of change
- It establishes a working partnership and a deeper commitment from the patient
- It gives patients guidance and ownership in completing long-term goals
- It helps patients build and express their belief in accomplishing tasks



Keys to success

To be successful at motivational interviewing, you will need to understand how the patient feels:

- **Are they ready to change** (what are their priorities)
- **Are they willing to change** (how important do they feel the change is)
- **Are they able to change** (how confident do they feel of making a change)



Stages of change

(DiClemente & Prochaska, 1991)

(Freeman & Dolan, 2001)

- **Pre-Contemplation** – not considering change, often unaware there's a problem (*"I don't think I need to change"*)
 - **Anti-Contemplation** – actively avoids, resists or opposes change; blames others for current difficulties (*"I'm fine just the way I am ... I refuse to change and you can't make me!"*)
- **Contemplation** – actively considering change in the next 6 months, but ambivalent; knows where to go but not quite ready yet; weighing pros and cons of the problem and the solution (*"I think I need to change"*)



More stages of change

(DiClemente & Prochaska, 1991)

(Freeman & Dolan, 2001)

- **Preparation** – intends to take action in the next month and is actively planning what the change will look like; has shifted from neutral to drive and has had some success (*“I think I need to change and have to figure out how to do it”*)
- **Action** – actively working at implementing change; has successfully altered the problem behavior (reached a criterion such as abstinence for a drinking problem) for a period of from 1 day to 6 months (*“Change is hard, but I have to do it”*)

More stages of change

(DiClemente & Prochaska, 1991)

(Freeman & Dolan, 2001)

- **Prelapse** – engages in thoughts, desires, cravings for the old times and old behaviors (*“This is too hard, is it worth it?”*)
- **Lapse** – working on changing but starting to revert to previous patterns of behavior; becomes careless, no longer monitoring, no longer using techniques learned, re-experiencing the difficulty (*“I don’t know why I’m slipping back”*)
- **Relapse** – reverts to old behaviors, regresses to an earlier stage (contemplation or preparation); starts considering plans for next attempt, tries to learn from recent efforts; relapse is the rule rather than the exception (*“I need to get out of this hole”*)

More stages of change

(DiClemente & Prochaska, 1991)

(Freeman & Dolan, 2001)

- **Redirection** – working to overcome the relapse; willing to work on change and continue to move ahead (*“How can I get back on track?”*)
- **Maintenance** – abstinence for more than 6 months, actively working to maintain and build upon what has been learned; sensitive to the cues of relapse; has become own therapist (*“I need to always keep my eye on the need to change”*)

Why use motivational interviewing?

(Can't we just tell people what they need to do?)

- ☺ Brief physician advice can be effective ...
- ☹ But many patients ignore this advice or are resistant to the idea that they have a problem
- ☹ Repeated attempts to simply advise these patients has been shown to **increase**, not decrease resistance to behavioral change
- ☺ Brief motivational interventions have been developed and tested with greater success

Motivational interventions

- **Confrontational**

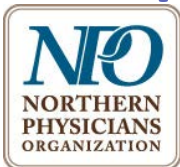
“If you don’t stop drinking, you’re gonna kill yourself!”
(leads to resistance)

- **Cognitive-behavioral therapy**

“We can teach you how to manage the triggers that make you want to drink”
(most effective for depression & anxiety)

- **Patient-centered**

Motivational interviewing (Miller & Rollnick, 1991)



Why use motivational interviewing?

(Can't we just tell people what they need to do?)

- 😊 Brief physician advice can be effective ...
- 😞 But many patients ignore this advice or are resistant to the idea that they have a problem
- 😞 Repeated attempts to simply advise these patients has been shown to **increase**, not decrease resistance to behavioral change
- 😊 Brief motivational interventions have been developed and tested with greater success

Underlying beliefs of motivational interviewing

- ✓ *Motivation is enhanced when patients verbalize their thoughts and feelings about the changes they need to make*
- ✓ *Patients are more likely to change when they feel in control of their own progress*
- ✓ *How physicians ask questions and respond to patients' views about behavioral change are powerful influences on their motivation to change*

Getting Started

- Before you can facilitate motivation in a patient, you need to know how motivated she is so you're both on the same page
- **Bad news:** Motivation to change is a complex construct, consisting of more than just the willingness to change or will power
- **Good news:** Behavioral change doesn't require 100% motivation – *ambivalence* (“I want to, but I don't want to”) and *resistance* are normal parts of the process



Assessing Motivation to Change

Assess the three key components:

 **IMPORTANCE**

 **READINESS**

 **CONFIDENCE**

Basic motivational strategy

“On a scale from 1-10 ...

(1=least motivated, 10=most motivated)

- 1) how **IMPORTANT** is it for you to ...
change any aspect of your drinking?”
- 2) how **READY** are you to ...
change any aspect of your drinking?”
- 3) how **CONFIDENT** are you that you can ...
change any aspect of your drinking?”



Basic motivational strategy continued

*The patient gives a number and you say,
“Why not LOWER?”*

- 🔒 If you ask patients to tell you why they're not **MORE** motivated (why the number isn't higher), **they'll comply and tell you why they aren't more motivated** ... so you're essentially asking for excuses!
- 🔓 When you ask why the number isn't **LOWER**, patients **can't help but give you some clues** about their degree of motivation

Motivational interviewing skills

Use **OPEN-ENDED QUESTIONS** to ask about the patient's responses to your assessment questions:

 ***“Alice, how has alcohol interfered with other things that are important to you?”***

NOT “Is alcohol a problem for you?”

Motivational interviewing skills continued

RESPOND REFLECTIVELY when the patient tells you *“why not lower”*. Restate what she said, even if it’s something resistant. Conveys your desire to understand her perspective and builds a working alliance. *Don’t judge, criticize or blame.*

 *“Alice, it sounds like you’re saying ...”*

“So the way you see this problem is ...”

What is a productive interaction?

ASK FOR CLARIFICATION using neutral, open-ended questions:

💡 *“What do you mean exactly?”*

“Tell me more about that, Alice.”

AFFIRM/EMPATHIZE using compliments and statements of understanding that help the patient recognize her strengths, abilities and successes:

💡 *“It took courage for you to speak about this”*

“I can sense how difficult this is for you”

What to do when it's tough getting through

- ↔ Use **DOUBLE-SIDED REFLECTIONS** (two opposing statements linked with “and” instead of “but”) that can keep an interaction neutral, without hint of criticism or astonishment.
- ↕ **DEVELOP DISCREPANCY** by exploring the ***PROS AND CONS*** of change. Discrepancy increases awareness of the gap between where the patient is and where she wants to be, and zeroes in on the negative consequences of the behavior while highlighting the positive consequences of change.

What else to do when it's tough getting through

- **RESIST THE “RIGHTING REFLEX”** your urge to solve the problem for the patient, and set things straight.
- **ROLL WITH RESISTANCE** and stop if you hear yourself say “you should” or “you must.” The patient’s resistance is a signal that you need to change your strategy.

What to do when it's time to bunt

Give your recommendation and tell the patient that, while you've shared your strongest medical opinion, **IT'S UP TO HER TO DECIDE HOW TO PROCEED.**

Arguing only breeds resistance, defensiveness and stubborn negativism.

AGREE TO DISAGREE if resistance is very high, and leave the issue/door open by asking for the patient's commitment to re-address the issue next time.



Motivational interviewing DON'TS



- ✗ Assume a patient is motivated and ready to change
- ✗ Prescribe solutions or a certain course of action
- ✗ Take an authoritarian or expert role
- ✗ Argue, lecture or try to persuade with logic
- ✗ Tell the patient that he/she has a problem
- ✗ Order, direct, warn or threaten
- ✗ Make moral statements, criticize, preach or judge
- ✗ Give expert advice (especially at the beginning)
- ✗ Ask close-ended questions
- ✗ Respond to a patient's answer to your open-ended question with another question
- ✗ Ask a series of three questions in a row

What to do when they agree to try

Document the decision by writing a prescription

BEHAVIORAL PRESCRIPTION

FOR: _____ DATE: _____

PRESCRIPTION STEPS

On a scale of 1-10, how confident are you that you can do each step?


1 2 3 4 5 6 7 8 9 10
(Not at all (Totally Confident)
Confident)

STEPS	NUMBER
1.	—
2.	—
3.	—
4.	—

Long Term Goal: _____

Patient Signature: _____

Practitioner Signature: _____



Prescription Step Questions

1. What would you like to change?

Help patient to focus on one long-term goal at a time.

2. What are some things you can do to make that change?

Be specific - in the next week, 2 weeks, month, 3 months, what, when, where, how long, with whom, how often.

What to do when they agree to try continued

Prescription Step Questions continued

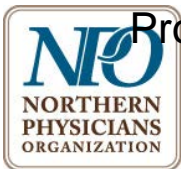
3. What might get in the way of accomplishing this goal? Discuss some potential barriers.

4. What can you do to overcome these barriers?

5. Is there any other help you need to accomplish this goal - friends, family, professional, information?

6. How confident are you of achieving this step at the present time on a scale of 1-10?

Behavioral Prescription/Prescription Steps are based on the Self-efficacy Theory of Professor Albert Bandura and Stages of Change (Prochaska and DiClemente)



Prescription writing tips

- If the patient rates their confidence at “7” or greater, write the steps out along with the confidence level
- If they rate confidence below a “7”, then redefine the step so as to make the step more achievable
- Write the steps out clearly in the active voice/first person (“I will”) using action verbs and complete sentence at the 5-6th grade level

More prescription writing tips

- Use correct spelling, no abbreviations, symbols or signs
- Be specific (include duration and frequency)
- Use short simple language (action verbs and complete sentence)
- Complete the prescription form, have the patient sign it and give them a copy

What to do for follow-up visits

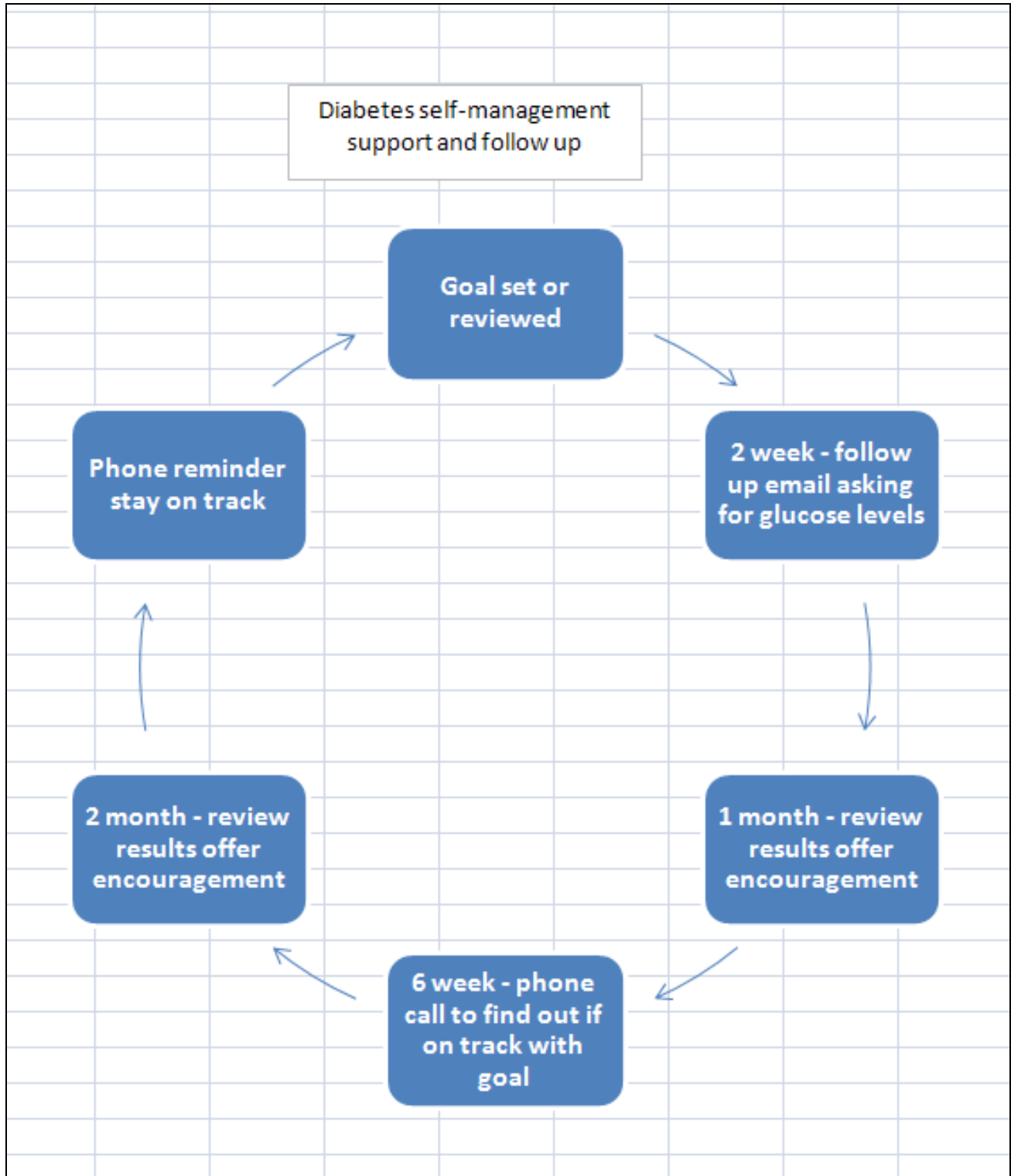


At the follow-up visit, review the steps and make a note on the previous prescription, what percent of the time they complied with the steps.

If necessary, redefine the long-term goal, and follow the process again for defining the steps. The patient may decide to continue working on the previous goal **and** want to define a new goal, or may want to keep the same long term goal, but define new steps because they were either too hard and not achieved or achieved.

It's all progress!

Flow chart from Excel



Name: _____ Date of Birth: _____ Date _____

During the past month, have you often been bothered by:

1. Little interest or pleasure in doing things? YES NO
2. Feeling down, depressed, or hopeless? YES NO

S.M.A.R.T. DIABETES GOALS

WHAT ARE S.M.A.R.T. GOALS?

Specific: For example, "Walk more" is too general. "I'll walk three times a week for 20 minutes" is more specific.

Measurable: How will you measure your progress? For example, "I'll eat three servings of carbohydrates for dinner three days a week" is better than "I'll eat less bread."

Action-Oriented: "Lower my blood sugar" doesn't say how. Your goal should have some action to go with it like: "Test my blood sugar twice a day for a month."

Realistic: You want to set a goal you can succeed at. You probably can't lose 40 pounds by the end of the month. But you may be able to lose 4 pounds. That's a more realistic goal.

Time-Limited: Set a time to look at your goal again. Try it for a week or a month. Then have another look. Did you do it? Maybe you need to set a new or a more realistic goal. The idea is to have a goal and keep at it. **GOOD LUCK!**

Self-Management Goal: Choose one or two areas that you would like to work on to improve your overall health and manage your Diabetes. Write down your goal in the space provided below. You will receive a copy of this form to take with you. Place it in an area that is visible (ex. Refrigerator, night-stand, mirror) to remind you of your goal/goals.



Exercise

My Goal is _____



Nutrition

My Goal is _____



Foot Checks

My Goal is _____



Blood Sugar Testing

My Goal is _____

Medications _____













My Own Goal _____

This is how sure I am that I will be able to reach my goal: 1 2 3 4 5 6 7 8 9 10

1 = not sure at all 5 = somewhat sure 10 = very sure

*It's your life...your body...your Diabetes...
We're here to help you to healthier outcomes!*

GOALS FOR KIDNEY CARE SELF MANAGEMENT

Goal 1 <input type="checkbox"/>	I know my GFR (% kidney function remaining) and I will let my healthcare providers know my GFR whenever I receive care for any reason (especially emergency room or out-of-province)		Date
Goal 2 <input type="checkbox"/>	I will take all the medicines prescribed by my doctor and remind myself by: ___ Keeping the medications in a pill box. ___ Writing out a list of what I need to take, how much and when		Date
Goal 3 <input type="checkbox"/>	I will keep an updated list of all the medications I take and bring the list with me when I see my doctor or any healthcare provider		Date
Goal 4 <input type="checkbox"/>	I will follow the diet that has been recommended for me: ___ reduce protein (meats, dairy products) ___ reduce phosphorus (limit milk, eggs, baked goods) ___ reduce potassium (fruits, nuts, soy products)		Date
Goal 5 <input type="checkbox"/>	I will work towards being at my ideal body weight, which is: _____ lbs/kgs.		Date
Goal 6 <input type="checkbox"/>	I will get a flu shot this fall and get a pneumonia vaccine (if I haven't had one done)		Date
Goal 7 <input type="checkbox"/>	___ I will know my blood pressure goal: ___/___ ___ I will measure and record my blood pressure		Date
Goal 8 <input type="checkbox"/>	I will work on quitting smoking. I will be down to ___ cigarettes a day by my next visit to the doctor		Date
Goal 9 <input type="checkbox"/>	I will learn more about kidney disease by: ___ attending a learning session ___ reading information from the Kidney Care Clinic		Date
Goal 10 <input type="checkbox"/>	I will exercise ___ days a week for ___ minutes ___ days a week The exercise I choose to do is:		Date
Goal 11 <input type="checkbox"/>	I will monitor my mood. If I am feeling down, I will: ___ talk with a friend or family member ___ do an activity I enjoy		Date
Goal 12 <input type="checkbox"/>	I will check my blood sugar as instructed by my doctor or nurse: My goal is: _____ 2 hrs. after a meal		Date