

## Handout: Self-management support – more strategies

As health professionals/health coaches get more experienced at providing SMS to people with LTCs, the health professionals/health coaches will use more complex SMS strategies instead of just action planning, problem-solving and decision-making. This Handout has nine additional strategies and examples from primary care practices in New Zealand.

### Strategy 1. Be willing to share the decision-making process.

#### Example

Jack, whose HbA1c is 120mmol, comes in to see you. Jack doesn't want to discuss anything about his diabetes at this session because Jack's grandson's 21<sup>st</sup> is coming up in four weeks and Jack has to finish off the stamp album he is giving his grandson as a present. You agree that finishing the stamp album will be Jack's goal for the next four weeks and Jack agrees to test his blood sugars and take his insulin during that time. Five weeks later, Jack comes back in to see you and says the 21<sup>st</sup> went really well and his grandson really liked his present. Jack says he is now ready to focus on his diabetes.

#### Example

You work with Steve who has Type 2 diabetes. When Steve was diagnosed, he started to be much more active and he and his wife changed the way they ate. As a result, Steve has lost a lot of weight and reduced his HbA1c to 70mmols. However, Steve has a lot of problems trying to get his HbA1c any lower. He experiences hypos and generally feels unwell and often has to have time off work. Steve comes to see you and asks if everyone can agree that his HbA1c target is 70mmol. You ask Steve to explain why this is important to him and he gives lots of examples, including how his hypos and feeling unwell affects his time with his wife and grandchildren.

Steve's GP joins you and looks at your detailed notes and agrees that in Steve's situation, his HbA1c target can be 70mmol.

After the GP leaves, you congratulate Steve on coming in and talking about his target. You ask Steve what his plan is to keep at that target. He says:

- Checking blood sugars.
- Taking his insulin.
- Staying active.
- Eating healthy food.
- Checking his feet all the time.

Making sure he has his diabetes review each year.

You acknowledge that all those things are great. Plus Jack will need to have a blood test every three months as well as have his eyes checked every two years.

#### Example from your practice



## Strategy 2. When setting goals with people focus on a small, achievable goal that is important to the person at the moment and can be achieved quite quickly.

Sometimes setting future goals can be overwhelming for people especially if they have never had a care plan before or they are stressed and are finding it hard to see a future.

### Example

Jenny has high blood pressure and cholesterol, and suffers from stress incontinence. She and her husband will have been married 50 years in three years' time and their children have offered to pay for their parents to travel to Europe and see all the places they have dreamed about. Jenny's goal on her care plan is to be more active so she can be fit to travel and do a lot of walking to see all the sights. However, this is a really long-term goal and Jenny is finding it hard to see progress. Jenny sends you a message through the portal to cancel her next appointment to see you in a month. She says she is going to Perth to visit her sister. You think about how she is struggling with her long-term goal. You realise that her trip to Perth might provide her with a short-term goal that she could achieve within four weeks. You message her back and suggest she comes to see you to talk about her trip to Perth.

Jenny comes in and you ask her about her trip. She tells you straight away she is worried about the long flight and how she will cope. She is thinking about really cutting down on her fluids the day before and on the trip. You show her the article about stress incontinence on the Health Navigator website and leave Jenny to read it. She tells you she is really surprised about the concept of 'bossing your bladder'. She hasn't done pelvic floor exercises for years and maybe this is the time to do them.

You ask Jenny if she has tried any incontinence pads and she hasn't. You write on a sheet of paper possible mini goals for the trip to Perth.

- Try out incontinence pads to find one that works.
- Boss my bladder
- Do pelvic floor exercises 4-5 times a day.

You ask if there is anything else Jenny thinks is important. Jenny says she realises she needs to keep drinking 5-6 glasses of water and make sure she isn't constipated. So, you add those things to the piece of paper.

You ask Jenny if it is okay if you make a suggestion. She says yes. You suggest that her goals for the next four weeks focus on:

- finding the right incontinence pads
- doing pelvic floor exercises 4-5 times a day
- drinking 5-6 glasses of water.

Jenny looks at the previous list and suggests adding in "boss my bladder". You say that makes sense as it is about being conscious of making her bladder work.

You show Jenny the pelvic floor app on the Health Navigator website and ask her if she needs help to load it on her phone. Jenny says she will get her granddaughter to do it tomorrow. You also tell Jenny that the companies that sell incontinence products offer free samples on their websites.

You suggest Jenny writes out her goals again for the next four weeks before she goes to Perth. Jenny is really excited to have some goals she can focus on for a short period of time which will really help her enjoy her trip to Perth. She thanks you for asking her to come in. You ask her to message you through the portal to say how she is getting on and to have a great trip.

**Example from your practice**

**Strategy 3. Map the person’s journey. Look back to see what progress they have made.**

**Example**

You are working with a 24-year-old Tama who has high blood pressure. When he first had his blood pressure measured it was 150/180. Tama’s mother has high blood pressure and as a result she has CKD. A couple of Tama’s siblings also have high blood pressure.

Tama finds it really difficult to get his head around having to take long-term medicine at his age and has told you he forgets to take his medicines a couple of times a week. You take his blood pressure and show him how his blood pressure has come down to 140/170. You point out that is a really good start because it is really hard to get into a routine taking long-term medicines if it is not something you are used to.

You ask Tama what he remembers the GP said to him about his high blood pressure and why he needed to take his blood pressure medicines every day. Tama says he doesn’t really remember why his blood pressure is important to his kidneys and his mum couldn’t explain it either. She just told him he must keep taking his medicine so he didn’t end up with CKD like her. You apologise to Tama that he isn’t clear about the links between high blood pressure and kidney disease. You explain the link and say his mother is right about needing to take his medicine.

You ask him if he thinks setting an alarm on his phone would help. He says his mother made him do that. Before Tama leaves, you remind him that he is making good progress.

**Example from your practice**

## Strategy 4. Develop a list of strategies the person can use when they are stressed or going through tough times.

Care plans often include what to do when LTCs get worse. This strategy is about providing other ideas that don't relate to LTCs specifically, but are about what people with LTCs can do when things get tough for a lot of reasons.

### Example

Maria is the live-in caregiver for her elderly mother who has a number of LTCs, including early dementia. Maria works part-time for a children's charity and really enjoys her job. Maria has recently been diagnosed with osteoarthritis in her back.

You and Maria worked on a care plan for her osteoarthritis when she was diagnosed. Maria comes back in to see you. She says her mother and she both have stuff in their care plans about when their conditions worsen, but there is nothing in there about what to do when things start to get Maria or her mother down. You say to Maria that that is a very good point.

You ask Maria what sort of things make her feel good. She thinks for a while and says "Walking on the beach or walking in a park, watching birds in the garden, listening to her favourite music, playing with her great nieces and nephews". You ask Maria if she wants you to add those things to her care plan and she says yes. You suggest Maria makes a goal for herself now. Maria decides that every day she will take at least 20 minutes to do something that she enjoys such as the things she identified, that will help when she is stressed or feeling down. .

As you add the goal and the list of activities you ask her what has happened recently that made things get tough. Maria said the wheel on her mother's walker broke and when she took it back to the supplier, they lent her mother a different walker while they fixed the wheel. For a week, her mother has complained non-stop about the walker. Maria realised she was getting really stressed and that is why she came in today.

Maria thanks you for reminding her that she does know a whole lot of things that she can do to relieve her stress. And, best of all, she is going to pick up her mother's repaired walker when she leaves you.

### Example from your practice

**Strategy 5. Acknowledge the person is the expert in their LT Cs as they live with them every day.**

**Example**

You are working with Jason who has a rare blood condition. Jason is doing really well – taking his medicine, being active and eating well. He also has a positive mindset and is managing to keep on working full-time because his employer lets Jason work from home when he needs to. You don't know anyone else who has the same condition as Jason and you have read up on Jason's condition since you have been working with him.

Sometimes, when Jason comes to see you, he describes doing things to keep well that seem odd based on what you have read, such as intermittent fasting. However, the letters from Jason's specialist show that Jason is doing very well. The last time you saw Jason you said to him that you were surprised about the intermittent fasting, but it seems to be working for Jason and he is the expert on his condition. Jason says he has done a lot of reading about his disease based on websites and support groups his specialist referred him to, so he feels confident in what he is doing and his specialist is happy about what Jason is doing. You acknowledge his expertise in his condition and thank him for sharing what he has learnt with you.

**Example from your practice**

## Strategy 6. Praise the person's effort to increase their self-efficacy (confidence they can do things).

### Example

Lana wants to take part in a 10km walk/run to support breast cancer and to honour her friend who died from breast cancer eight months ago. Lana has never done a lot of walking/running, she has always preferred swimming, so she is not very confident about how she will get on.

Lana has diabetes, high blood pressure and cholesterol, and knows that doing this walk/run will help her LTCs, but that isn't the reason she wants to do it – she really wants to honour her friend.

Lana has a training plan developed by the organisers of the walk/run and she shows it to you at her most recent appointment. She mentions she is not that confident. You ask if you can have a copy of the training plan and you add it to Lana's care plan.

You ask Lana to message you through the portal each week to tell you how she has got on. Lana says she is also tracking activity on her Fitbit which her son bought her for her birthday. Every week, when you get a message from Lana, you go back and acknowledge her efforts. In the weeks where she hasn't been able to complete her training plan, you praise her for not giving up and keeping going.

### Example from your practice



## Strategy 7. Share knowledge of local community groups and what might work for people with LTCs.

It can be a big job keeping an up-to-date directory of local groups and community organisations, but it is something that can be shared. Practice meetings could include an agenda item about any new community groups that people had become aware of. An admin person could be responsible for checking and updating the directory every month.

Local groups and community organisations can provide really valuable SMS for people with LTCs, particularly people who are socially isolated.

### Example

Sam's wife died 10 months ago after a long illness. Sam has high blood pressure and high cholesterol as well as COPD. You have noticed the last three times you have seen Sam that he seems to be getting quieter and quieter. You know that Sam was a very keen home handyman until he and his wife moved into their modern small unit. You ask Sam how often he is getting out and seeing people. Sam says he goes out and does the shopping every couple of days. You ask him if he still does any home handyman work. He says there is nothing to do in their unit. He kept all his tools, but he hasn't used them for a while and he misses it.

You ask him if it is okay if you make a suggestion. He says okay. You ask him if he would be interested in joining a group who volunteer their time helping out with community projects. Sam says that sounds okay but he doesn't know anyone and he is a bit shy. You give Sam the phone number of Tim, who is a widower too. Tim works with a group of other men to do building projects in the community.

You don't hear back from Sam but you see an article in the local newspaper a month later about a group who are building a playground at a local playcentre. And there, in the photo smiling broadly, is Sam.

### Example from your practice

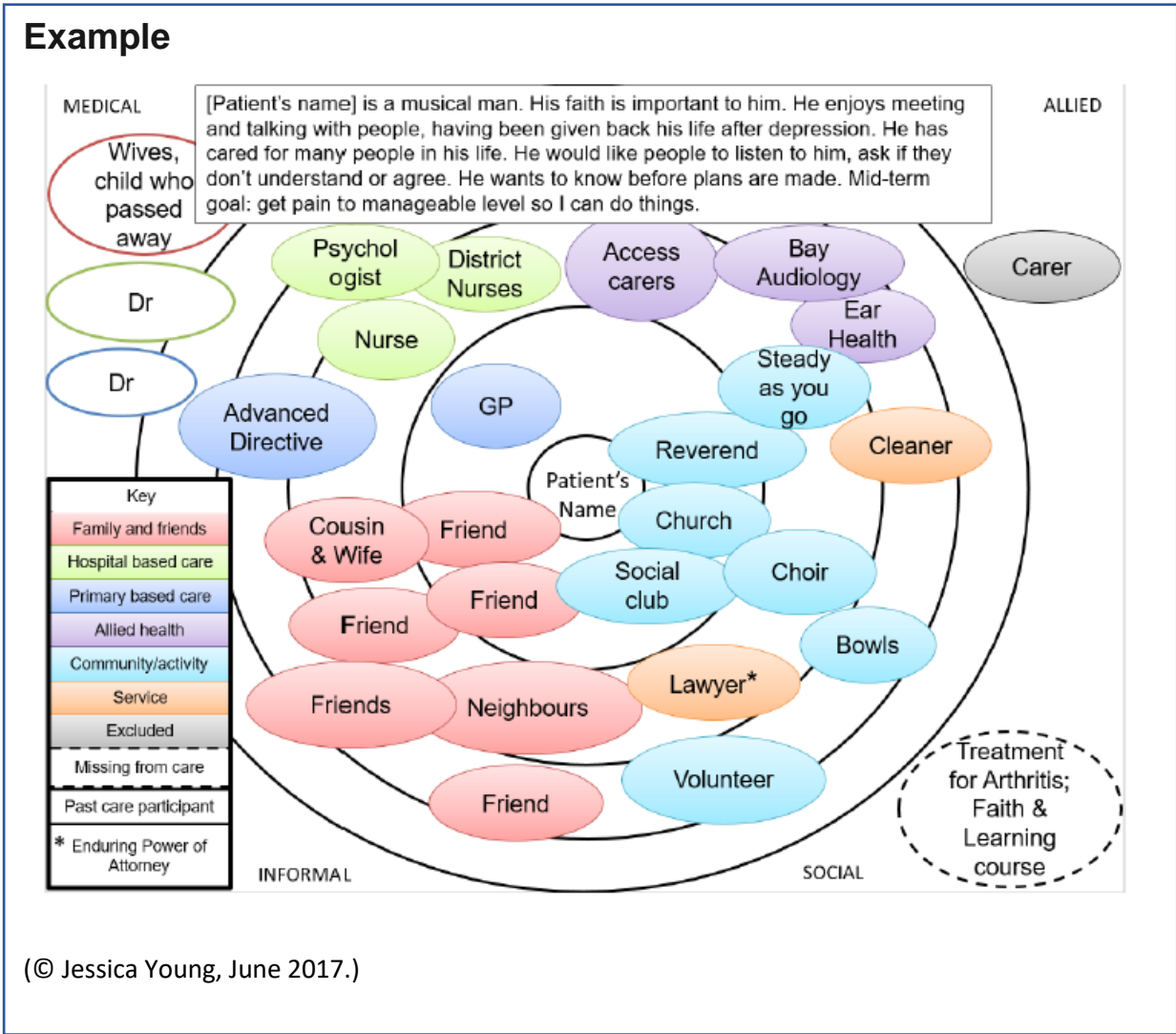
### Strategy 8. Know the person with LTCs.

How well do you know the people with LTCs you are working with? Do you know what is really important to them and why? Could you complete a care map for them showing the social networks that support them? (see Handout: Social networks and supports for people with long-term conditions).

Are you also aware if the person belongs to a group that is affected by health inequities e.g. Māori, Pacific peoples, people living in areas of high social deprivation. Being aware of equity issues assists you to focus your approach when working with this person.

For example, if you are aware that Māori and Pacific peoples with gout receive inequitable treatment in terms of being prescribed allopurinol, this would encourage you to check how the person’s gout was being treated and congratulate them if they were taking allopurinol.

If the person has not been prescribed allopurinol then you could have a discussion with the person about their gout and how it is affecting their daily life, their family, their employment and their involvement in their community. You could also talk about how gout is about their genes and kidneys, and not food, and encourage them to think about using allopurinol.



**Example from your practice**

## Strategy 9. Know yourself.

Remember, we talked about everyone having biases. Sometimes, unwittingly, you can allow those biases to influence how you react to a person with LTCs. Your biases might cause you to disagree with a person's decision and act in a way which makes the person feel judged, and they lose confidence in your ability to support them.

1. Try and work out what your implicit and explicit biases are. Make notes about the things that trigger feelings of discomfort or unease, or when you stop listening.
2. Stop for a moment and acknowledge what is happening.
3. Actively move past the discomfort and focus on what the person needs and thinks is important.
4. Remember that your biases are more likely to take over when you are under stress or when you are short of resources.

### Example

You realise that you react negatively to people with tattoos. Thinking back to your parents, they always said that men who had tattoos (such as sailors) were common and weren't nice people. None of your relatives or your parents' friends had tattoos. However, things are really different now. A lot of your patients, including women, have tattoos and a lot of them are extensive and cover a lot of their body.

You work with Briar a young woman in her 20s who has Type 1 diabetes. She has one full sleeve tattoo on her arm and seems to be working on getting her other arm covered. You know Briar is a student and you have often wondered how she affords to pay for all the tattoos.

At your last appointment, Briar notices you looking at her tattoos as you take her blood pressure and asks you if you like her tattoos. You take a deep breath and say to her that you don't know anyone with a tattoo so you haven't had the chance to talk to people about what the tattoos mean, and how they decide what tattoo to have and where.

Briar asks if you want to ask her about her tattoos. You apologise and say that you don't mean to be nosy. Briar says she always laughs inside when I talk about self-management because that is what her tattoos mean to her. The tattoos honour her name, Briar, and her grandmother, also called Briar, who was very important to her. Briar says she was diagnosed with Type 1 as a child and her parents were always very anxious about her. Briar said when she was a teenager, she didn't take care of herself, resulting in a number of admissions to hospital. These made her parents even more anxious. As soon as Briar was old enough, she left home and got her first tattoo.

All her tattoos are about things that are meaningful to her and the tattoos help her when she is stressed and upset. Her boyfriend's cousin is a tattoo artist and is always entering competitions, so Briar acts as his model. They have already agreed on a design for the rest of her arm.

You ask Briar what is her favourite tattoo and she shows you the picture of her grandmother surrounded by roses and thorns, which Briar says are to keep away bad things.

You thank Briar for explaining about her tattoos and ask her if she wants to add a goal in her care plan about completing her arm tattoo. Briar laughs and says she will stick to her existing goals.

She says she is glad you had this talk as she always thought you didn't like her tattoos. You say you are really sorry that you made her feel like that. You realise how it was your problem. You didn't have an open mind and appreciate how special the tattoos were and you thank Briar again for telling you about her tattoos. After Briar leaves, you write on a post-it note 'Tattoos = SMS duh' and stick the note on your wall.

**Example from your practice**