HealthChange® Personal Self-Management Plan

Whilst the HealthChange® Goal Hierarchies/Menus of Options show what a person might *do* to optimally manage their health or quality of life and provide options for doing so, the HealthChange® Personal Self-Management Plan (PSMP) records the topics and outcomes of a *conversation* about these self-management tasks. The term 'self-management' refers not only to chronic condition or disease self-management, it also may refer to general health self-management or general life self-management activities (e.g. in a social services context).

This document has been designed to be used as a conversation record for service providers, clients and other care team members. The context of the conversation or consultation could be multiple condition-oriented, disease-specific or professional domain-specific. Regardless of the context, the PSMP documents the outcomes of Steps 2 to 10 of the HealthChange® 10 Step Decision Framework in one simple table.

Step 1 of the Decision Framework (Identify, discuss and summarise clinical issues), will usually be documented separately in a care plan, treatment plan or clinical notes (preferably with a copy provided to the client). If the PSMP is to act as a record for the health service, the service provider will need to fill it out. In other circumstances, such as a group education program, the client may fill out the PSMP under guidance.

The first three columns of the PSMP document outcomes from the following HealthChange® processes *above* the decision line:

Column 1

(Outcomes of Step 2)

Documents *all* of the relevant general self-management categories of action that are recommended for *any* person with a particular condition or set of conditions to take action *over time* in order to achieve the best possible health and quality of life outcomes given their particular situation.

These are the general treatment, lifestyle and/or referral categories shown in the purple 'above the line' boxes in the HealthChange® goal hierarchies/menus of options. Documenting these general recommendations shows that a discussion has been held between the service provider and service user about the *general* recommendations for the management of their condition/s. In discussing these general recommendations, specific examples of management activities relevant to the client's health issues should be given to illustrate the types of things they would need to do within each category. For example: understanding the nature, timing and dose of cardiovascular, diabetes and osteoarthritis medications and how they relate to each other; doing sputum clearance and breathing exercises for COPD; monitoring blood glucose, cholesterol and blood pressure levels; attending pathology and specialist appointments specific to a particular set of conditions; managing triggers such as stress and infections to avoid blood sugar spikes, and managing diet, exercise, fatigue and/or social support for better lifestyle-related outcomes (see HealthChange® Manage Health Conditions Menu of Options).

Filled out in this way, Column 1 ensures that the service provider has discussed all of the treatment, lifestyle and referral categories required to provide the client with sufficient knowledge and understanding (health literacy) to make informed decisions about what they will do to manage their health.

Notes:

- If a client already has a good level of knowledge and understanding of these categories and has already been managing their condition/s reasonably well, *it may not be*

necessary to use a PSMP to document their ongoing self-management activities. For example, a disease-management PSMP may have already been completed with a different service provider. A PSMP will be most useful when a person is newly diagnosed or when they are being assisted to consolidate and prioritise what actions to take in relation to one or a number of different health issues (e.g. care coordination or care planning).

Column 1 continued

- A pre-populated PSMP (with the first column already filled in) can be very useful to use with clients where it is considered preferable to discuss *all* the necessary self-management tasks for a condition or set of conditions. Using a pre-populated PSMP can normalise the need to raise the various discussion topics for any particular condition and can reduce any perceived personal judgement of the client's current decisions and behaviours. For example, it can make it easier to inquire about lifestyle risk factors or personal triggers that may be acting as barriers to effective self-management.

- By recording *all* of the treatment, lifestyle and referral categories that anyone with a particular condition needs to act on over time, the information in Column 1 acts as a prompt for the client or patient to consider what else they could do in the future to help their situation, whilst acknowledging that they may not yet be ready to do this at the time that the PSMP is filled out.

- In the case where a consultation focuses only on a specific subset of categories (such as nutrition or exercise), the categories written into column 1 may relate only to that specific consultation context. Nonetheless, if the client has complex conditions and needs, an overarching PSMP for all their health issues should ideally have been compiled first (by another service provider).

Column 1 documents the *outcomes of Step 2* of the HealthChange® 10 Step Decision Framework: Identify and discuss *all* relevant treatment, lifestyle and referral categories (relevant to the consultation context)

Column 2

(Outcomes of Step 3)

Documents the collaboratively agreed *priority* in which a client or patient plans to take action within these categories.

These priorities will depend upon what the person is already doing and what they agree to do in the short term and longer term.

Whilst Column 1 promotes health literacy, Columns 2 and 3 acknowledge the client's choice and control over what they choose to do, the order in which they choose to do it and what they choose not to do. The purpose of the PSMP is to help the service provider to guide the conversation to enable the client to make responsible decisions about their actions to manage their health.

Notes:

- If a client is already taking sufficient action within a category, it need not be included in the prioritization. E.g. the service provider could simply place a tick (✓) in Column 2 and write the client's current actions in the comments column.

- If a particular category is not relevant to the client's condition/s (e.g. they have not been prescribed any medications), then the service provider can place a dash (-) or NA

in column 2 for that category, particularly where a pre-populated PSMP is being used.

Column 2 documents the outcomes of Step 3 of the HealthChange® 10 Step Decision Framework: Prioritise and choose categories to work on in this consultation

Column 3 (Outcomes of Step 4)

Documents the client's *agreement or otherwise* with taking action in each generally recommended category (agree, disagree, unsure or not applicable to them).

This is to ensure that a patient's or client's readiness is taken into account and documented for each broad recommendation (treatment, lifestyle or referral category) and that any non-applicable categories are recognised as such.

Column 3 documents the outcomes of Step 4 of the HealthChange® 10 Step Decision Framework: Check RICk and make a decision

Columns 4 and 5 of the PSMP document outcomes from the following HealthChange® processes *below* the decision line:

Column 4 **Documents the agreed planned time frames for specific actions to be taken by the client within particular categories.**

Column 5 **Documents the key specific agreed actions that the client plans to take.**

Options for action can be generated by discussing the relevant condition-specific green 'below the line' boxes in the goal hierarchies.

Together, Columns 4 and 5 document the outcomes of Steps 5 to 10 of the HealthChange® 10 Step Decision Framework

Column 6 **The last column on the PSMP is provided to document any other comments that are relevant to either the above the line or below the line processes**

The HealthChange® PSMP is a *person-centred* document that is meant to accompany more system-centric clinical care plans or treatment plans. It is a simple to read and understand document for clients or patients to take home with them to prompt them regarding:

1. *All* of the treatment, lifestyle and referral categories or broad areas relevant to the current consultation in which the client needs to take action *over time* to achieve the best possible health and quality of life outcomes, given their particular health issues and situation.
2. The areas in which they have *agreed* to take action in the *short term* and the specific actions and time frames that they have committed to.

The PSMP also provides valuable information about a person's current *readiness, actions and intentions* that can be shared among that person's health care team.

General Recommendations	Priority	Decision	Action time frame	Agreed actions	Comments
		Agree Disagree Unsure NA			
		Agree Disagree Unsure NA			
		Agree Disagree Unsure NA			
		Agree Disagree Unsure NA			
Step 2	***Step 3***	***Step 4***	***Steps 5-10***		