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Essential Components of Chronic Disease Patient Self-Management

Ronald D. Deprez, PhD, MPH

The Center for Health Policy, Planning and Research
College of Osteopathic Medicine
University of New England
www.chppr.org

Agenda

- Need and Justification
- What is Patient Self-Management (PSM)
- Current Limitations
- Implemented Self Management Components
- PSM Components
- The Practice Partner Model
- Pending Research

Who We Are

CHPPR is a department of the University of New England College of Osteopathic Medicine, specializing in health policy, program and services planning through population need studies, best practice research, and the design and evaluation of health system reforms for the private and public sector.

Need and Justification

"Today, Chronic Diseases – such as cardiovascular disease, cancer, and diabetes – are among the most prevalent, costly, and preventable of all health problems" (CDC 2007)

"The medical care costs of people with chronic diseases account for more than 75% of the nation's $1.4 trillion medical care costs" (CDC 2007)

Need and Justification

- The need to improve patient adherence is the issue
  - "…in developed countries, adherence among patients suffering chronic diseases averages only 50%" (WHO 2003)
  - "There is growing evidence that effective adherence interventions have a far greater impact on the health of the population than any improvement in specific medical treatments" (WHO 2003)
  - "Too often, caring for chronic illness features an uninformed passive patient interacting with an unprepared practice team, resulting in frustrating, inadequate encounters" (Bodenheimer 2002)

Need and Justification

- Traditional Practice Systems and views on patient behavior
  - Focus on acute illness care
  - Physicians are experts and patients bring little to the table
  - Behavior is changed through external forces
  - Patients are not motivated to change
  - Professionals solve problems for patients

What is self-management?

Self-management is defined as the tasks that individuals must undertake to live with one or more chronic conditions.

What is the Role of the Patient?

- Patients accept (some) responsibility in managing their health condition/disease (s)
- Patients must maintain their life roles
- They must deal with the emotional consequences of the disease (s)
- They are sometimes the only person with vital information required for maintaining their health

Criteria for Successful Self Management

- **READY TO CHANGE. The patient must be interested in and committed to self-management**

- **KNOW WHAT TO DO. The patient must have a clear and achievable plan for self-management (written preferred but no essential)**

What is self-management support?

Self-management support is defined as the systematic provision of education and supportive interventions by health care system to increase patients' skills and confidence in managing their health problems including regular assessment of progress and problems, goal setting, action planning and problem solving support.

Key Change Concepts in Self-Management Support

- Set and document self-management goals and action steps collaboratively with patients
- Appreciate and consider the culture the patient lives in
- Understand potential barriers to patient behavior
- Use self-management tools that are based on evidence of effectiveness
- Don't expect large changes—this is a slow and deliberate business

Source: The Planned Care Change Package, IHI

Key Change Concepts in Self-Management Support

- Train staff and providers on how to help patients with their goals (e.g. Motivational Interviewing)
- Follow up and monitor patient goals
- Implement group visits w/providers
- Use community resources (e.g. support groups, web sites, ALA written materials, rehabilitation programs)

Source: The Planned Care Change Package, IHI

Some Limitations of Current PSM

- PSM efforts (CCM/IHI) are primarily Practice Focused—little happens outside the primary care office
- PSM is often limited to distributing information to patients—literacy issues are big as are means of communication
- Some programs, such as the Stamford Self Management Program, while patient focused, are not easily accessible to patients living in rural areas.

Patient Self Management: Evidence

Stanford Chronic Disease Self Management Program

- Patients with one or more chronic diseases were recruited from various Kaiser Permanente hospitals and clinics.
- 7 week, small group intervention attended by people with different chronic conditions.
- Taught largely by peer instructors from a highly structured manual
- Based on self-efficacy theory and emphasizes problem solving, decision making, and confidence building.
- At 1 year, participants in the program experienced statistically significant improvements in health behaviors, self-efficacy, and health status and had fewer visits to the emergency department.

Source: Lorig, Kate et al. Effect of a Self-Management Program on Patients with Chronic Disease, 4 2001; 256-262

Patient Self Management: Evidence

Physician Communication, Participatory Decision Making, and Patient Understanding

- Study assessed the influence of patients' evaluation of their physicians' participatory decision-making style, rating of physician communication, and reported understanding of diabetes self-care on their self-reported diabetes management
- Surveyed 2,000 patients receiving diabetes care across 25 Veterans' Affairs facilities.
- Measured patients' evaluation of providers
- Patient understanding of self-care behaviors was associated with both provider decision-making style and provider communication on self-management
- Provider styles enhance self-management through increased patient understanding or self-confidence

Source: Heisler M, et al. The Relative Importance of Physician Communication, Participatory Decision Making, and Patient Understanding in Diabetes Self-Management. Journal of General Internal Medicine 17(4) 2002. 243-52.

Patient Self Management: Evidence

AIDES to Improving Medication Adherence

Assessment: Completing a comprehensive medication assessment

Individualization: Partnering with patients to ensure individualization of the regimen

Documentation: Choosing appropriate documentation to assist with communication between patient and provider

Education: Provide accurate and ongoing education tailored to the needs of the individuals

Supervision: Continuing supervision of the medication regimen

No evidence of efficacy provided in this paper.

Source: Bergman-Evans, Brenda. AIDES to Improving Medication Adherence in Older Adults. Geriatric Nursing 27 (3) 2006:174-182.

Patient Self Management: Evidence

Group Visits

- Uninsured and inadequately insured patients with uncontrolled type 2 diabetes were randomly assigned to receive care in group visits or usual care.
- Lead by both primary care provider and a diabetes nurse educator.
- Groups met monthly for 6 months with 19 to 20 participants.
- Each visit lasted 2 hours including: warm-up, presentation, questions and answers, and one-on-one consultations with the physician.
- Patients who received care in group visits showed an improved sense of trust in their physician compared with patients who continued to receive usual care.
- Patient attendance at the groups indicated good acceptance of this form of healthcare delivery.

Source: Clancy D, et al. Evaluating Group Visits in an Uninsured or Inadequately Insured Patient Population with Uncontrolled Type 2 Diabetes. The Diabetes Educator 29 (2) 2003: 292-302.

Patient Self Management: Evidence

Clinical Microsystems: Planning Patient Centered Services

- Clinical Microsystems are the small, functional frontline units that provide most health care to most people
- Evaluation of patient subpopulations that are served, the people who work together in microsystems, the process the microsystem uses to provide services, and the patterns that characterize the microsystem's functioning
- Patient Self-Management support, clinical decision support, delivery system design, and clinical information systems must be planned to be effective, timely and efficient for each individual patient and for all patients.
- Well-planned, patient-centered care results in improved practice efficiency and better patient outcomes

No evidence of efficacy found in the literature.

Source: Wasson et al. Microsystems in Health Care: Part 3 & 4: Journal on Quality and Safety, 29(4)

Patient Self Management: Evidence

The Action Plan

- 43 primary care clinicians at 8 sites participated in the Action Plan Project
- An agreement between a patient and a caregiver that the patient will attempt a concrete, specific behavior change. Designed to accomplish a small behavior change with high likelihood of success rather than a large change that is difficult to achieve.
- Behavior change discussion with patients is a desirable addition to the primary care enterprise, but clinicians cannot be expected to add these documents to an already overfilled plate of responsibilities.
- The results of the clinician questionnaires completed indicated that the majority of the clinicians found the action plan concept helpful as a guide to discussing behavior change with their patients.
- The major barrier to initiating action plan discussions with patients was lack of time in the multiagenda primary care visit.

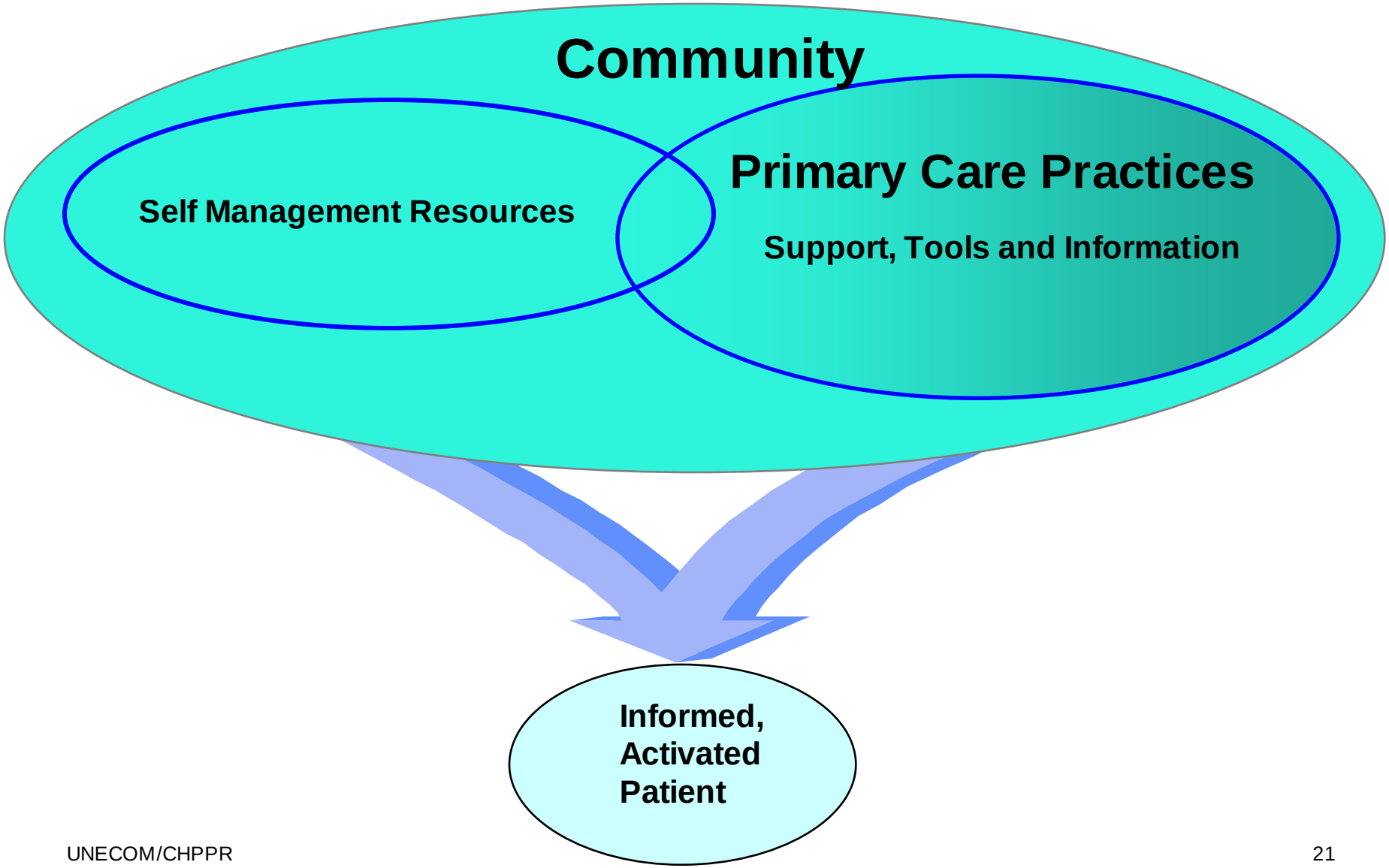
Source: MacGregor, Kate et al. The Action Plan Project: Discussing Behavior Change in the Primary Care Visit. Annals of Family Medicine 3 (2) 2005: s39-s40

Findings from 2006 CHNA

Findings from 2006 Community Health Needs Assessment (CHNA) of Northern, Eastern, and Central Maine:

- Level of physician compliance with disease care guidelines is high
- Patient involvement in treatment plans is low
- Provider knowledge of patient barriers is low
- Risk factor levels in patient w/chronic disease is high (smoking, obesity, sedentary life style)
- Use of the ER for patients with Chronic conditions is high

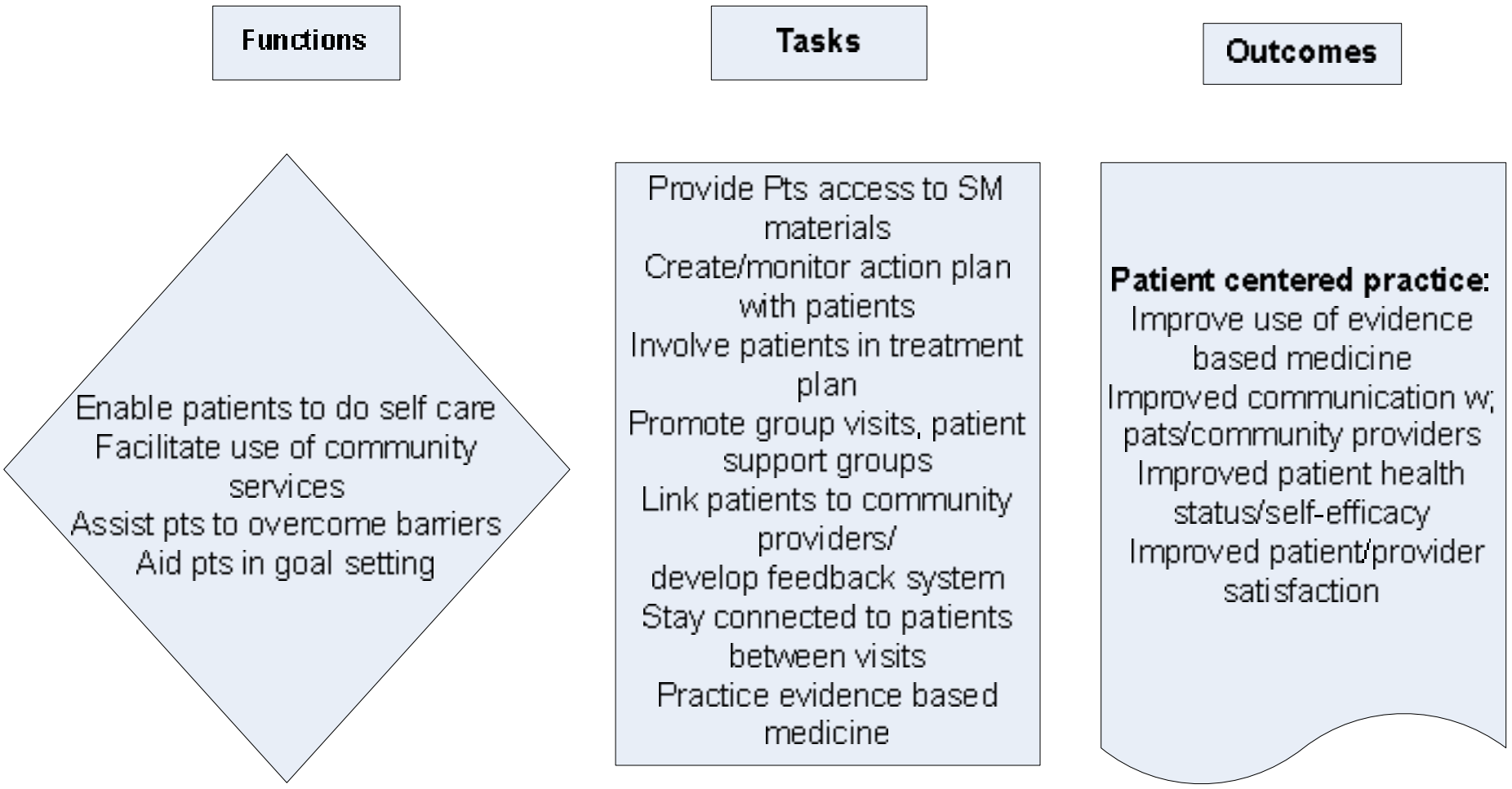
PSM Overview



Practice PSM Objective

- Practice assessment and re-design to align process to:
  - Educate/empower patients on self care
  - Link patients to appropriate community services
  - Assist patients to overcome barriers to self care
  - Aid patients in specific goal setting/action plans and follow-up

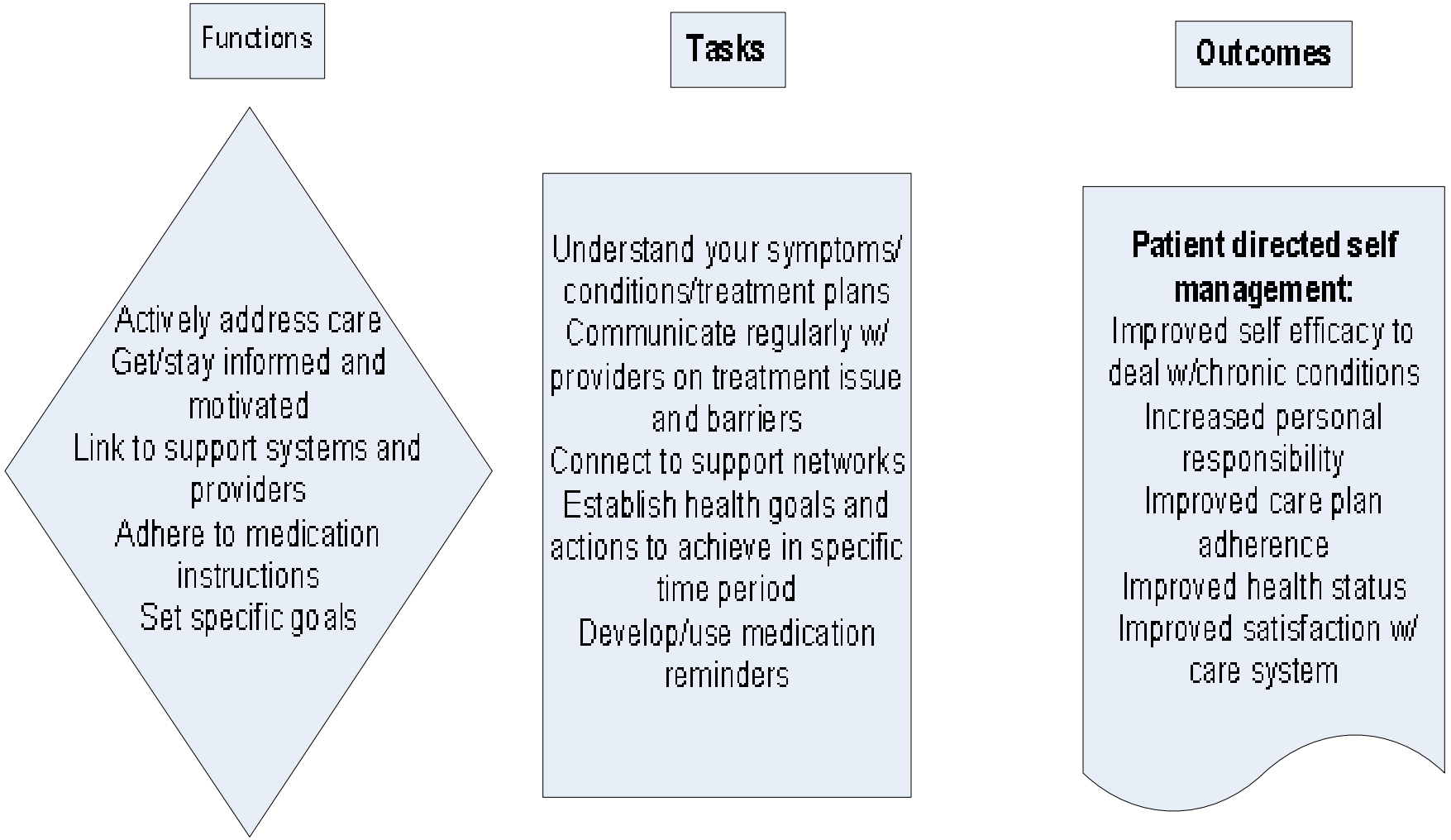
Practice Functions, Tasks & Outcomes



Patient/Family Objectives

- Communicate effectively with providers on self care and treatment issues
- Get/ stay informed about health conditions, treatment plan, and steps required to comply
- Understand resources/supports are useful and how to access them
- Understand and adhere to medication instructions
- Set specific goals and action steps

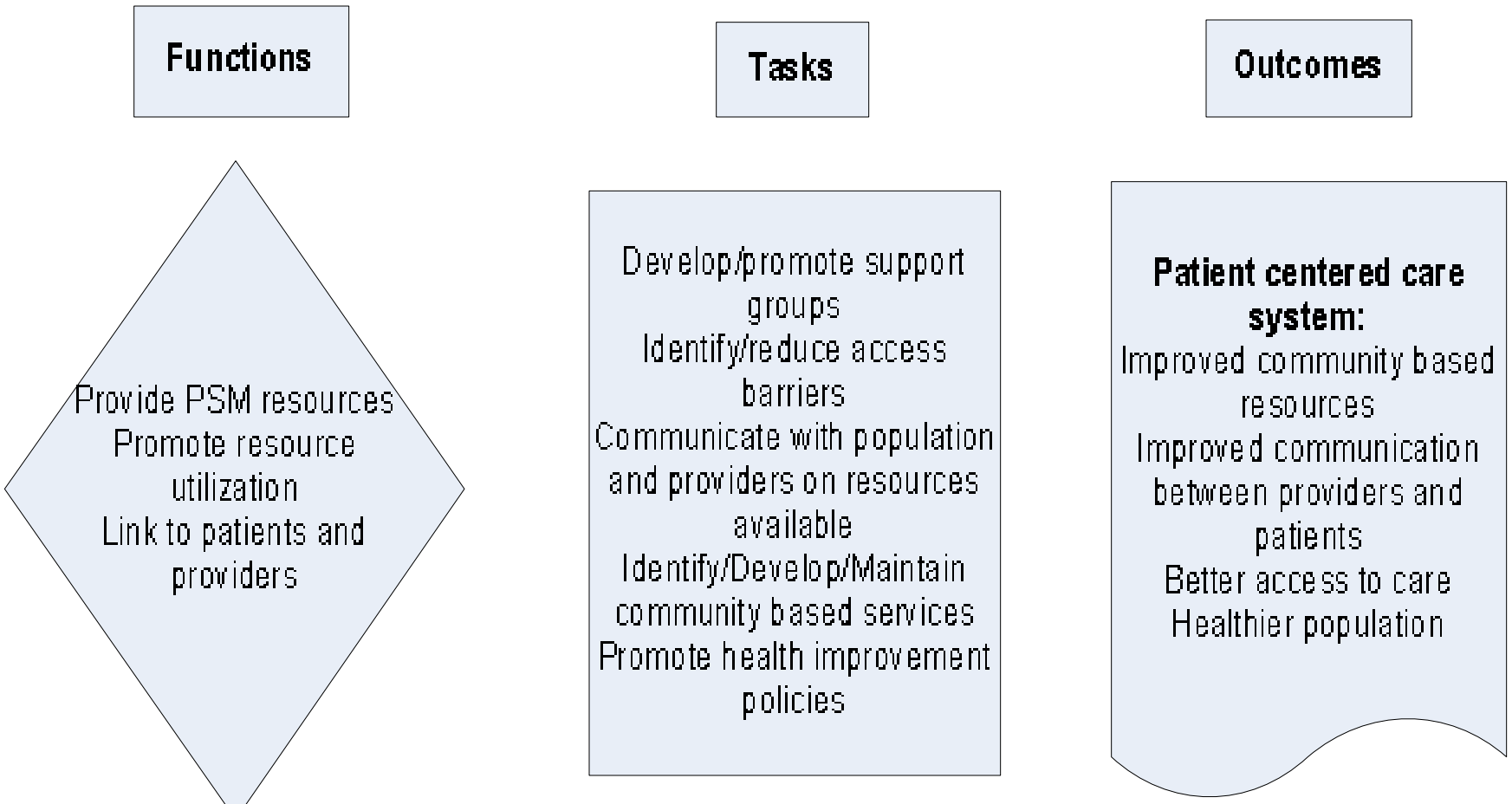
Patient Functions, Tasks & Outcomes



Community PSM Objectives

- Provide PSM resources—use of a template helps
- Promote resource utilization—marketing and communication
- Link resource information to patients and providers

Community Functions, Tasks & Outcomes



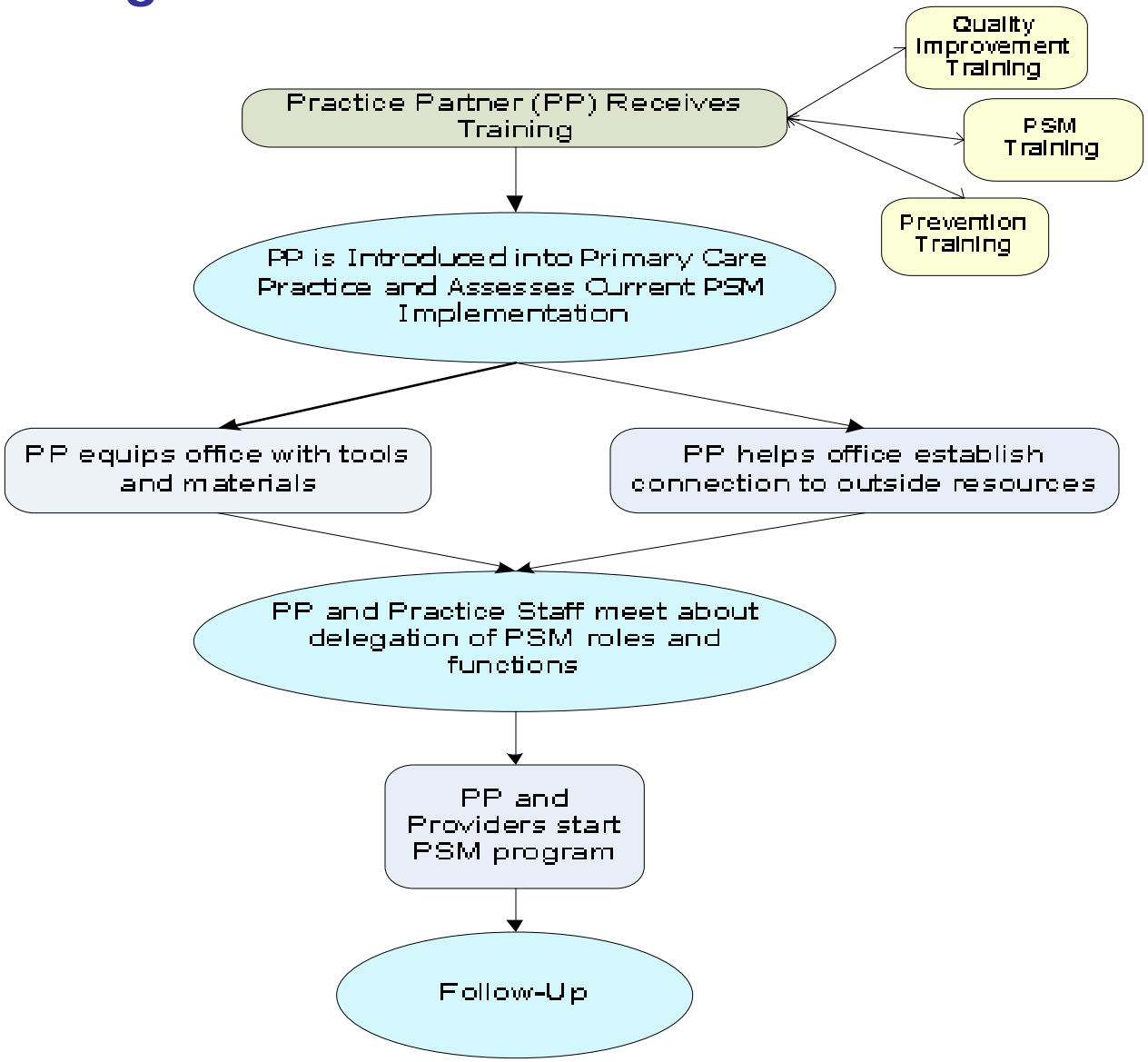
The Practice Partner Model

The model is designed to implement best practice approaches to improve patient self management of chronic conditions, in particular with primary care practices and communities in rural settings

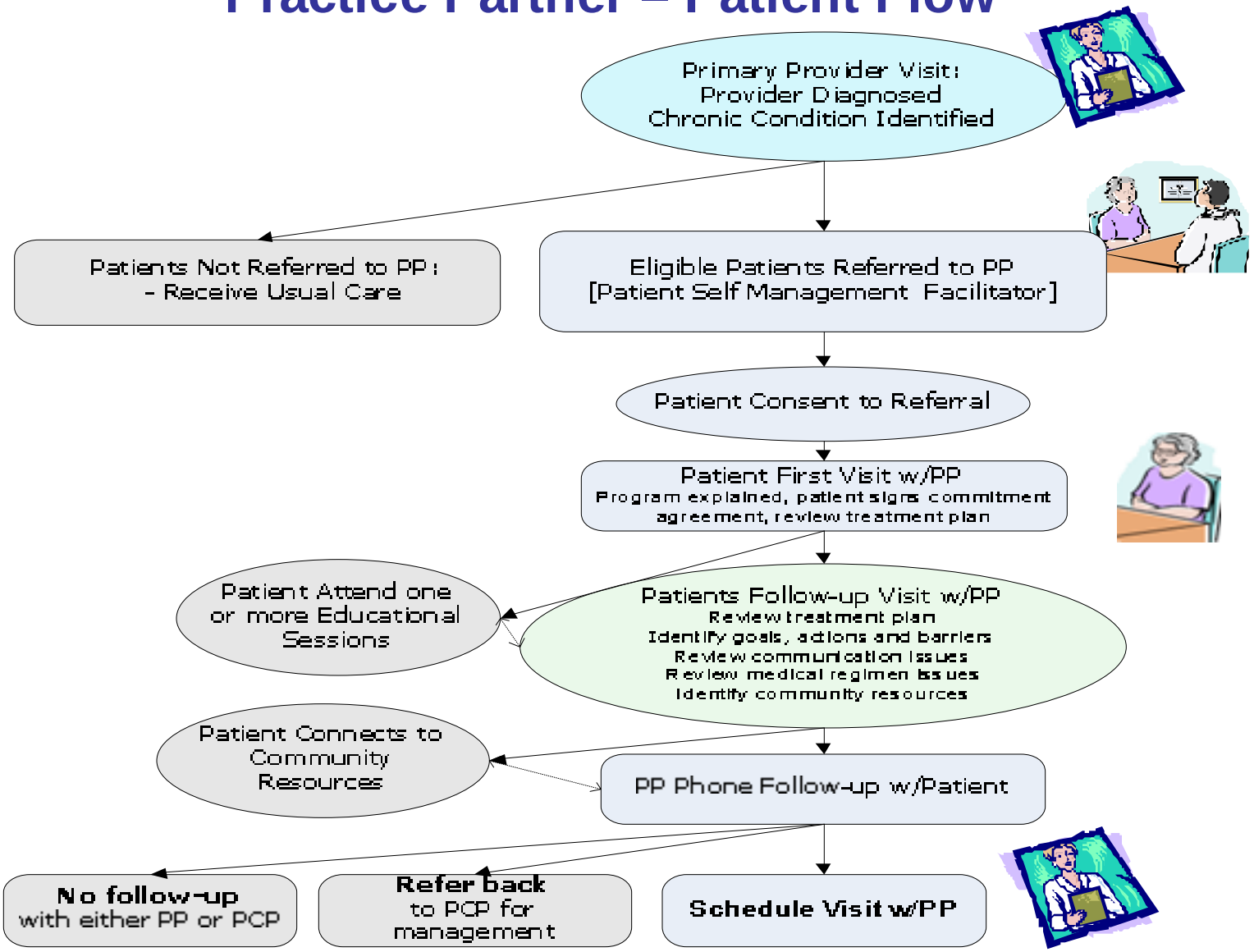
Activities of the Practice Partner

- Practice Level
  - Assess PSM capacity and functions
  - Assist practice in re-design
- Patient Level
  - Schedule health/social resource appointments for patients and follow up on patient's usage of the resource.
  - Educate/assist patient in finding/accessing appropriate/necessary outside the practice.
  - Assist patients in completing and implementing action plans.

Design of the Practice Partner Model



Practice Partner – Patient Flow



Pending Project

Hancock County Chronic Disease Patient Self Management Network

- Proposal Submitted to US Department of Health and Human Services Health Resources and Services Administration for a Rural Health Network Development Grant.
- The Network is dedicated to improving patient-self management strategies and chronic disease outcomes in Hancock County, Maine.
- The Network consists of local providers, community organizations, and regional and statewide resources/experts.
- Individuals will benefit from the Network by gaining access to information, tools and resources that have demonstrated value in the management of chronic conditions.