

Section 4.15 Implement

Promoting Patient Self-Management

This tool provides background on the concept of patient self-management, identifies key factors in supporting effective self-management, and provides some concrete steps to initiate patient self-management. Techniques and example scripts for engaging patients in self-management can be found in *Coaching Patients in Self-Management* in this Toolkit.

Time required: 3 hours

Suggested other tools: Approaches to Patient Communications; Coaching Patients in Self-Management; Supportive Communications; Patient Action Plan; Patient Health Diary

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How to Use

1. **Review** the overview of patient self-management and understand how it differs from traditional provider-directed care.
2. **Understand** the key tools to help patient to actively manage their care, and the critical factors in supporting effective patient self-management.
3. **Consider** how to implement the recommended steps to engage patients in self-management.

Overview of Patient Self-Management

Patient self-management is similar to patient engagement and patient activation. These terms refer to the actions individuals take to obtain the greatest benefit from the health care services available to them. The idea is that individuals who are more knowledgeable about their health conditions and have the skills to make health-related decisions, can use their knowledge and skills to improve their health outcomes. The result is a higher quality of life for those with chronic conditions and lower costs for managing acute exacerbations and complications.¹

Patient self-management is not the same as compliance. *Compliance* means an individual obeys a directive from a health care provider. *Self-management* means that a patient is involved in taking advice from the health care provider and actuating it in a manner that fits his or her own needs, preferences, and abilities. This difference is significant for both the provider and the patient:

- **Providers are accustomed to giving directives.** Although they recognize that patients do not always follow their directives, providers have traditionally taken little responsibility for working with the patient to ensure compliance. In patient self-management, the provider is expected to both assume some responsibility for helping the patient incorporate the advice into his or her lifestyle, and share responsibility with the patient to ensure that the patient has the knowledge, skills, and confidence to make choices that accomplish health care goals the patient wants to achieve.
- **Patients have become accustomed to receiving directives from their providers** and making choices about those directives. Sometimes these choices are conscious “I don’t want to do that,” and other times they are less conscious “Oops, I’ve forgotten to take this medication” or “An extra helping of fried chicken won’t hurt.” In some cases, patients do not realize the potential harm for not taking the medication or eating the extra fried chicken, and they may not have had this clearly explained to them in an environment that is conducive to learning.

In other cases, the traditional health care environment has allowed patients to abdicate their responsibility for improving their health. It has become such that “the doctor will cure me” or “I can eat all the fried chicken I want because this pill will keep me from having a heart attack.” A critical component of self-management is acknowledgement by the patient that they share responsibility for their health care goals.

The Agency for Health care Research and Quality (AHRQ) has conducted an evaluation of patient self-management support programs.² Some of the key findings and recommendations are included in this tool. This work and others describe the purpose of self-management support programs as “aim[ing] to change patient behavior.”

Patient self-management support programs are important and very useful, but they must recognize the need for both patients *and* providers to share responsibility for patient self-management. Both providers and patients need to reset their behavioral norms in order to achieve patient self-management.

Patient Self-Management Tools

There are two key tools to help patients to actively manage their care. These tools include:

- Patient action plan (see *Patient Action Plan*)
- Patient health diary (see *Patient Health Diary*)

The care coordinator should help the patient incorporate these tools into a self-management plan.

Resetting Provider and Patient Norms to Support Patient Self-Management

Support for patient self-management is a relatively new concept. The health care delivery system is just beginning to conduct studies on what works and what doesn’t. The following have been shown to be critical factors in supporting effective patient self-management:

- **Trust** – Providers must accept the fact that many patients will self-manage; as such they need to be engaged in making appropriate self-management choices. This will take time and effort by the provider.
- **Positive Reinforcement** – Providers must recognize that a patient who makes a limited number of “right” choices, even if not all of the desired choices are made, will still be better off than the patient who makes the choice not to follow any of the advised choices. A small number of “right” choices that yield success and are applauded by the provider generally lead to more “right” choices and further success.
- **Communication** – Providers must learn to motivate the patient as part of a shared responsibility for the patient’s health among the care team and with the patient. Providers (themselves *and* through their care coordinators) have ongoing interactions with the patient to reinforce desired behaviors. New skills of supportive (not directive) communications, new and very specific patient-tailored tools with which to deliver key messages, and a transparent partnership with the patient are elements that need cultivating.
- **Shared Responsibility** – Patients must desire a healthier lifestyle and to “feel better.” They must move from being a “can’t do” patient to a “can do” person. They must understand their provider is there to help them along the way, but they have a shared responsibility for their health.
- **Partnership** – Patients must be willing to accept help with making choices. This partnership requires time to build and may require different tactics for different patients.
- **Active Management of the Transition** – Patients must be given the tools to help them make appropriate choices. These tools include coaching, care system navigation, motivational support, action planning, follow up, and others. Initially, “green prescriptions” – prescriptions for exercise, nutrition, etc. – can help the patient make the transition from the directiveness of “old” provider to the supportiveness of the “new” provider.

Steps to Engage the Patient in Self-Management

The following are steps abstracted from *The Self Care Toolkit* from the Bradford Pain Rehabilitation Programme in New Zealand.³

1. ***Persuade the patient to accept the persistence of his or her health condition*** – and the fact that a healthier lifestyle really does help make a person feel better and reduces risk for future setbacks and complications.
2. ***Encourage the patient to get involved in developing his or her own action plan.*** Reinforce that the action plan should be paced. Only one goal with a couple of action steps is much more effective than too many goals that no one can accomplish. Encourage the patient to find the ***one*** goal that is easiest to accomplish. Early wins are keys to future wins. Pacing also refers not only to one goal at a time, but just a few steps toward that goal. For example, improving nutrition may need to include fried chicken once a week, just not every day!

3. **Encourage the patient to include a support team in the action plan.** This support may be a caregiver, friend, pastor, or neighbor and could extend to a support group online, or a regular telephone or Skype call with a remote family member. (Remember, the provider and care coordinator are there to support the patient as well, but the patient must ultimately move to a more personal set of team members.)
4. **Help the patient learn to plan a healthy day or healthy week.** Again, pacing is important; patients should not be over-achievers. For example, if exercise is on the agenda and that is something the patient has done in the past, and thinks he/she can do now, set appropriate expectations for what can be accomplished. It may only be a ten minute walk on sunny days for the next month, or when a friend is available. Encourage the patient to keep a health diary of what beneficial things they want to achieve, which is often more motivating than the things they *must* do or *not* do.
5. **Acknowledge that it is important to have a set-back plan.** Urge the patient to recognize that set-backs are normal but can be minimized. Make sure the patient recognizes a set-back and knows what to do if it occurs. Documenting what might have triggered the set-back helps avoid such triggers in the future. As the care coordinator, do not criticize the patient for having a set-back. Acknowledge that it happens and move forward.

References

¹ Greene, J. and J.H. Hibbard (Nov. 30, 2011). Why Does Patient Activation Matter? An Examination of the Relationships Between Patient Activation and Health-Related Outcomes. *Journal of General Internal Medicine* (27)5:520-526. Available at: <http://www.commonwealthfund.org/Publications/In-Brief/2012/Feb/Why-Does-Patient-Activation-Matter.aspx>

² Patient Self-Management Support Programs: An Evaluation: Final Contract Report. November 2007. Agency for Health care Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/research/findings/final-reports/ptmgmt/index.html>

³ Moore, P and F. Cole (July 2011) The Self Care Toolkit ...for People Who Live with Persistent Health Problems, Bradford Pain Rehabilitation Programme, NHS Kirklees Primary Care Trust (UK), and Health Navigator New Zealand. Available at: <http://www.nhs.uk/Planners/yourhealth/Documents/Self%20Care%20Toolkit%20Booklet%20-%20Oct%2010%20-%20READ.pdf>

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