Incorporating self-management support into primary care

A fact sheet for Primary Care Partnerships

This fact sheet provides information and links to further resources to assist clinicians, agencies, and Primary Care Partnerships (PCPs) to incorporate self-management support into practice and delivery systems.

1. The necessity of self-management support

Self-management support is essential for effective chronic care, but dependent on providing quality clinical care and systemic improvements.

'Increasing the effectiveness of adherence interventions *[self-management support]* may have a far greater impact on the health of the population than any improvement in specific medical treatments.'

– World Health Organization [1(p.xiii)]

Chronic diseases and their management present many new challenges for health care provision (see Box 1). These challenges highlight the limitations of approaching chronic disease care purely from a medical perspective and from within a traditional health care framework that historically developed to address acute illness. In response, health care services are increasingly being called upon to adopt a more client-centred, collaborative, and long-term approach that includes embedding support for self-management in standard practice alongside and integrated with high quality clinical care.[2,3,4,5]

Box 1: Challenges for providing health care to the chronically ill

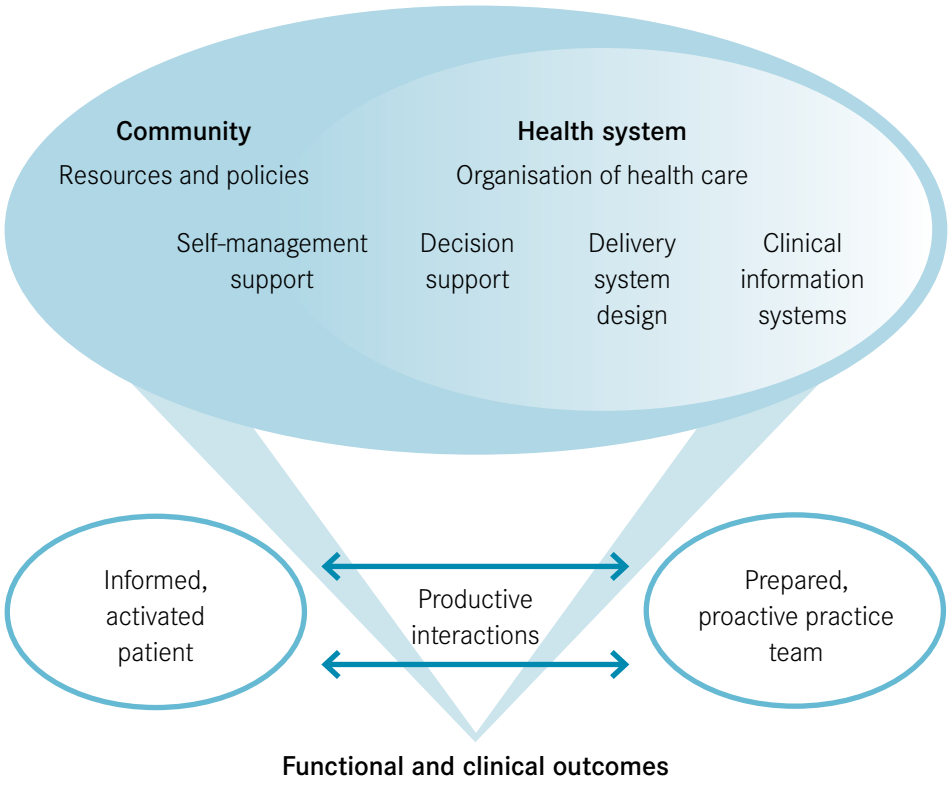
- Chronic disease management is primarily the responsibility of the person with the chronic disease. This is in contrast to acute illness, where health care providers assume the majority of responsibility for illness management.[2,8]
- Many people with chronic disease struggle to follow treatment recommendations. The World Health Organization (WHO) suggests adherence to long-term treatment for chronic diseases averages 50 per cent.[2]
- The quality of chronic disease management significantly contributes to incidence of comorbidities, exacerbations, and to the rate of disease progression.[2,8]
- Chronic disease management is required long term.[8,9]
- Requirements for chronic disease management are likely to change over the course of the illness.[2,9,10]
- The prevalence of chronic disease is increasing. WHO reports chronic disease as the world's leading cause of burden of disease, and increasing dramatically.[2,8]
- Most skills required for disease management are not disease specific, but life and behaviour change skills.[11]
- Consideration of individuals' personal and social contexts are central, given the importance of behavioural factors.[2]

In Victoria, PCPs are expected to develop local service systems and enhance the capacity of their local workforce to provide best practice clinical care and support for self-management.[6] The Wagner chronic care model (CCM) has been endorsed by the Victorian Department of Health as a framework to guide these quality improvement efforts.

The CCM[7] articulates six interrelated elements that should be considered when redesigning care: (1) community; (2) health systems; (3) self-management support; (4) delivery systems design; (5) decision support; and (6) clinical information systems. The six CCM elements interact with one another to influence clients and providers, either enabling and enhancing interactions, or acting as barriers to productivity.[8]

There is no central element within the CCM; however, self-management support often receives particular attention given its relative novelty. The self-management support element of the CCM is dependent on providing quality clinical care and quality improvement in the remaining five CCM domains.

Figure 1: Wagner chronic care model



(Source: Wagner EH. *Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice.* 1998;1:2–4)

2. Self-management support versus traditional care

There are a number of key distinctions between a self-management approach and traditional care.

Self-management support requires: (1) a collaborative and active partnership between the client and service provider; (2) a client-centred approach to care; (3) shared responsibility for care outcomes between client and provider; (4) a focus on client empowerment and enhanced capacity to engage in activities that promote health and care; and (5) an ongoing, lifelong approach to care.[12,13] (See Box 2.)

Box 2: Key principles of self-management support

1. Collaborative and active partnership between client and service provider	
Traditional care Service provider is expert and the client passive.	*Self-management support* Expertise is shared between client (expert on their life) and provider (expert on chronic *illness care*).[12,13]
2. Client-centred care	
Traditional care Care is disease and/or service centric and often standardised.	*Self-management support* Care is planned around the client's individualised circumstances, needs and preference.[12,13]
3. Shared responsibility for outcomes	
Traditional care A single service provider is the principle caregiver and therefore responsible for outcomes.	*Self-management support* Responsibility for outcomes is shared between the client and often multiple service providers.[12,13]
4. Empowerment and enhanced capacity as goals of care	
Traditional care The goal is client compliance with recommendations, the mechanism being the administration of treatment(s) and the provision of information and advice.	*Self-management support* The goal is to empower the client and enhance their capacity to engage in activities that will improve their health and care.[12,13]
5. Care is lifelong	
Traditional care Immediate needs are addressed and care is a one-time activity.	*Self-management support* Long-term change and impacts are addressed and care is an iterative and self-corrective process.[12,13]

3. What does self-management and self-management support involve?

The objective of self-management support is to enhance clients' capacity to engage in activities that improve their health and care.

Chronic disease self-management involves a raft of activities and responsibilities (see Box 3 and Figure 2) that often require clients develop or change patterns of behaviour, and manage their emotional and physical experiences. In order for clients to achieve this, they often need to develop or strengthen their:

- **knowledge** (of what, why and how to engage in activities that will improve their health and care)[2,5,7]
- **skills** (in particular, skills for problem solving, decision making, resource utilisation, formation of a client–provider partnership, action planning and self-tailoring)[5,10,14]
- **resources** (such as social supports, financial resources and health care services)[2,7]
- **self-efficacy** (confidence in their capacity to engage in specific activities that will improve their health and care)[2,7,15,16]
- **motivation** (interest and willingness to engage in specific activities that will improve their health and care).[2,17,18]

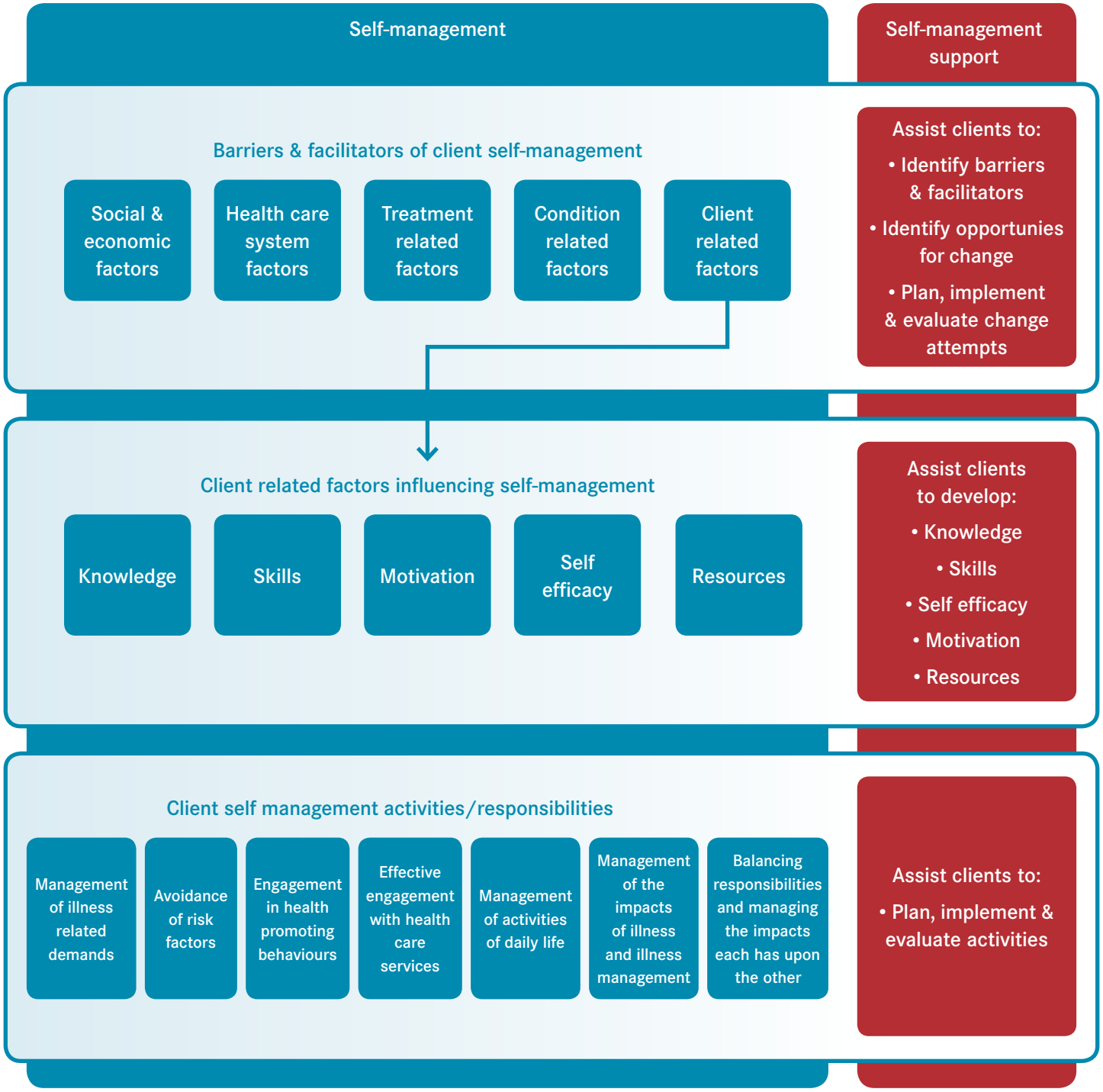
Box 3: Self-management activities and responsibilities

1. **Managing illness-related demands.**[2,5,7] For example: managing medications and other therapies, and monitoring and managing signs and symptoms.
2. **Avoiding risk factors** for secondary disease development, and disease progression or exacerbation.[2,5,8] For example: alcohol misuse, obesity, high blood pressure and high cholesterol.
3. **Engaging in health-promoting behaviours.**[2,5,7,8] For example: adhering to dietary recommendations and engaging in physical activity.
4. **Engaging with health care services.**[2,5,7] For example: seeking assistance when required, attending appointments, and communicating information and concerns effectively.
5. **Managing the activities of daily life around illness-related demands.**[7,14] For example: managing the personal, social, familial, functional and occupational facets of life in a way that accommodates illness-related factors and minimises any impacts on health or care.
6. **Managing the impacts of illness and illness management.**[5,7] For example: monitoring and managing psychosocial impacts that result from ill health or illness-management responsibilities.
7. **Balancing these tasks and responsibilities**, and managing impacts each has upon the other.[14]

The role of service providers therefore becomes, in part, geared towards supporting clients to self-manage. **The focus of self-management support is** (see Figure 2):

1. assisting clients to develop: (a) knowledge; (b) skills; (c) resources; (d) self-efficacy; and (e) the motivation they need to engage in activities that improve their health and care
2. providing the support clients may require with planning, implementing, monitoring and evaluating self-management activities[2,7,14]
3. assisting clients to identify opportunities, barriers and facilitators to change.[2,7,14]

Figure 2: Elements of self-management and self-management support



4. Self-management support core competencies

In order to provide self-management support, service providers require particular core competencies *(see Box 4),* and service systems must be designed and function in ways that respect inclusion of self-management support as a key objective of care.[2]

Box 4: Self-management support core competencies

1. Communicate and engage effectively with clients and service providers[2,19,20]

Synthesising and providing information; communicating and asserting care boundaries; making clients feel comfortable and confident in the care; eliciting, reading and responding to client cues; promoting motivation and self-efficacy; encouraging active participation in care; and listening and responding actively and empathetically to questions and concerns.

2. Conduct comprehensive, holistic assessments[20]

Including assessment of: client health risk factors; psychosocial concerns and supports; and self-management capacity (enablers and barriers for their self-management).

3. Plan and provide care collaboratively[2,20]

Collaborating with clients and other service providers to define problems, set goals and actions, and problem solve.

4. Support and empower clients[19]

To: (i) access appropriate information; (ii) develop skills required for their self-management; (iii) develop and maintain health-related behaviours; (iv) use available technologies to support self-management; (v) access and use available self-management tools; (vi) access support networks; (vii) manage health risks; (viii) communicate their needs and choices; and (ix) understand their strengths, areas for development, and capacity and willingness to self-manage.

5. Deliver care using a variety of approaches[20]

Including group services, individual sessions, telephone-based support, and the use of other communication technologies to support care.

6. Possess chronic care knowledge[19,20,21]

Awareness of: (i) the interaction between factors that influence client behaviour;[2] (ii) the importance of personal, religious and cultural beliefs, and their impact on individual choices;[19,20] (iii) the impact of one's own beliefs on one's ability to support clients;[19,20] (iv) the range of services and treatments available;[19] (v) the range of self-management support tools available to clients;[19] (vi) the range of support networks available to clients;[19,20] (vii) health promotion approaches;[20] (viii) models of health behaviour change;[20] (ix) evidence-based guidelines for clinical care; (x) the roles of other members of the health care team; and (xi) how to access and incorporate knowledge into practice.[2]

7. Use decision supports, information and communication management systems effectively[20]

8. Identify and respond to clinical risks[21]

9. Engage in continuous quality improvement activities[21]

5. Opportunistic and planned self-management support

While there is no panacea, there are a range of strategies that, when combined, show promise for supporting self-management.[2,22]

'There is no single intervention, strategy, or package of strategies that [is] effective across all patients, conditions and settings.'

– World Health Organization[(2, p.33)]

Opportunistic self-management support

Each encounter a client has with any provider, in any setting offers opportunities to contribute to that client's capacity to self-manage. Self-management support therefore is not the exclusive domain of 'self-management support providers'.[13,23,24,25] Box 5 provides examples of opportunities for self-management support that exist across the continuum of care that are not dependent on particular delivery system designs.

Box 5: Opportunistic self-management support examples

- Using effective and empathetic communication techniques to enable clients to feel comfortable and understood, enhancing the likelihood they will express their concerns and preferences and actively engage in care[2]
- Using motivational interviewing techniques to enhance client motivation and self-efficacy to engage in activities that improve their health and care[2]
- Providing clients with tailored information in a simple format, at appropriate times, in appropriate amounts, to enable them to make informed decisions about their health and care and engage actively in care processes[2]
- Documenting and sharing information relevant to clients' capacity to self-manage, ensuring all members of the care team remain apprised of efforts to enhance self-management and are therefore in a position to support these efforts and reinforce key messages[13]
- Inviting family members and carers to be involved in care, ensuring the clients' key supports are empowered in their role[13]
- Facilitating clients' access to local health and community services that support their efforts to self-manage[13]

Planned self-management support

In addition to opportunistic self-management support, many services provide structured or planned support to assist clients to engage in activities that enhance their health and care. Research suggests seven key components to effective planned self-management support interventions (see Box 6).

These components can be built into existing systems, and/or can be delivered in a range of innovating formats and systems. Available 'models' of self-management support (such as the Flinders model and health coaching; see *Common models of chronic disease self-management support: A fact sheet for primary care partnerships* for more details) typically provide some, yet not all components listed in Box 6. However, these models can be effectively coupled with other models and systems. When partnerships exist across organisations, a range of self-management support opportunities can be offered to meet the needs and preferences of clients.[2,22,26]

'The wider the selection of evidence based service and supports available, the higher the likelihood that [clients] will choose approaches that will help them successfully change and maintain change over time.'[22]

Box 6: Planned self-management support interventions

1. Individualised assessment

To be of value, recommendations and support must be matched to the needs and preferences of the client, and the realities of their social and personal world.[2,7,14] Therefore, the way a client is supported to enhance their self-management should be decided on a case-by-case basis following an individualised and comprehensive assessment, and discussions with the client regarding the range of options available. Furthermore, circumstances, needs and preferences are not static, and regular reassessment is important.[2,22]

2. Personalised advice and information

When clients are provided with personally relevant, appropriate, accurate, clear and specific information about their health and care they possess the first ingredient required for decision making and change—knowledge and understanding of what, how and why to change.[7] The assessment process provides an opportunity to establish the understanding of the client required to tailor advice and information to their needs.[13]

3. Collaborative goal setting

The process for deciding the focus of care should be largely driven by the client. A client's commitment to change can be strengthened by ensuring care goals and plans are aligned with their needs, circumstances and preferences and their readiness to change,[7] and by ensuring they feel ownership for decisions made with regards to their care.[2,14,27]

4. Skill enhancement

Common skills required for self-management include: problem solving,[7,10] decision making,[7,10] goal setting, action planning,[10,14] resource utilisation,[10,14] health care provider engagement,[7,10] emotional coping,[10,14] self-tailoring information and responses,[7,10] and monitoring.[14] Individual clients may have other skill gaps, or may have adequate skills in some of these areas.

5. Follow-up and support

During initial decision making, goal setting, planning, and skill development, clients usually require considerable support to identify and overcome barriers, and seek advice about strategies and approaches. Clients also benefit from having someone to reflect back their experiences and challenges, provide encouragement, keep them accountable to the goals they have set, and assist them to monitor and evaluate their progress. Following care, clients benefit from ongoing (but less intensive) access to support when problems arise.[2,14,28,29,30]

6. Resource access

Throughout their contact with health services, clients benefit from support to identify and access resources that may support their efforts to self-manage. These resources may take the form of additional health and community services, social supports, information, financial support, or equipment. Again, these resources should be matched to client needs, circumstances and preferences to have best effect.[2,14]

7. Quality clinical care

Self-management support and quality clinical care are highly dependent upon one another.[11] Clinical care often both enables and drives self-management activities and, where clinical care is poor, self-management efforts may be misdirected. In turn, clinical care is highly dependent upon clients' successful self-management.[2]

6. Self-management support for everyone

All clients self-manage to some extent and all clients can be supported to improve their self-management.

The goal of self-management support is to assist the client to reach *their* self-management goals and move along the continuum (as far as they are willing and able) towards optimal health and wellbeing.[7,21] The goal is *not* ensuring clients achieve a pre-determined, clinician-driven 'gold standard' of self-management.

Self-management support is challenging, given the difficulties clients face in developing or changing entrenched behaviours under demanding circumstances. The key is ensuring: the care goals negotiated and approaches adopted are appropriately matched to the needs, circumstances and preferences of each client; and clinicians have the necessary skills to facilitate and support clients to enhance their capacity to self-manage.[21]

'[Self-management] is a complex behavioural process determined by several interacting factors. These include attributes of the patient, the patient's environment (which comprises social supports, characteristics of the health care system, functioning of the health care team, and the availability and accessibility of health care resources) and characteristics of the disease in question and its treatment.'

– World Health Organization[2, p.136]

While most clients willing to engage with support for self-management can be assisted to make progress, there are a number of factors that influence their capacity to develop or strengthen the qualities required, and to develop or change health-related behaviours. WHO suggests **five interrelated factors impact clients' capacity to self-manage** (see Box 7).

A client's capacity to self-manage is frequently impacted by more than one barrier, usually related to different aspects of the problem in question.[2] Client complexity and level of support needs therefore often have little to do with disease severity or complexity.[2,31] Comprehensive assessment of client needs, circumstances and preferences, including examination of client capacity to self-manage various aspects of their care and life, become important to ensure the best match of service to client.[2,31] Some of the factors identified may be amenable to intervention, while others will be static.[2]

Particular challenges are often cited for some client groups, for example, Aboriginal and Torres Strait Islander clients, culturally and linguistically diverse (CALD) clients, and mental health clients. The underlying principles of self-management support apply equally to these client groups. Again, the challenges experienced in the provision of self-management support underscores the importance of taking an individualised approach and providing support that is culturally and personally appropriate for each client. The likely requirements of client groups served by primary care agencies should drive the design of services, group programs, educational materials, and support strategies offered, in addition to the knowledge and skills of the practitioners providing care.[2,14]

Box 7: Factors impacting on a client's capacity to self-manage

1. Social and economic factors

For example, familial relationships and characteristics,[2,14] income status, social isolation and support levels,[2,14,31] stressful life events,[32] unemployment, unstable living conditions, distance from services, lack of transport and treatment costs.[2]

2. Health care team and system-related factors

For example, the quality of the client–provider relationship, poorly developed or inappropriate service systems,[33] inadequately trained staff,[2] high clinical case loads, lack of incentives and feedback regarding performance, and clinical service time limitations.[2]

3. Condition-related factors

For example, the severity of symptoms, the level of disability experienced (physical, psychological, social and vocational), the rate of progression and disease severity, the availability of effective treatments, and the presence of comorbidities.[2,32]

4. Therapy-related factors

For example, the complexity of the medical regimen, the duration of treatment, the success or failure of previous treatments, the frequency of changes to treatments, the immediacy of beneficial effects, any treatment side effects, and the availability of support to manage treatment.[2]

5. Client-related factors

This factor essentially represents the clients (a) knowledge, (b) skills, (c) resources, (d) self-efficacy and (e) motivation to engage in particular activities to improve their health and care.[2] There are a number of client-related issues that can influence these, for example: quality of life;[14,34] emotional state;[2,35] stress levels;[2,31] cognitive function;[2,36] literacy levels;[2,31] religious, cultural and health-related beliefs;[31,37] level of time pressure;[31] age;[2] and gender.[2]

7. Organisational change and self-management support

A number of organisational changes are required to support self-management.

Self-management support is one ingredient of quality chronic illness care. In order to have the desired impact of improving outcomes for clients with chronic disease, self-management support needs to be embedded within routine care and integrated with other efforts to reform health care.

There are a number of key resources that provide useful insights into what is required to transform the way care is currently provided (see Box 8), so as to ensure 'consumers with chronic disease consistently experience safe, effective, client-centred, timely, efficient, and equitable heath care delivered by an integrated and coordinated health system'.[6]

Box 8: Frameworks for ICDM

- ***Improving chronic disease care: Learnings from the integrated disease management projects***[39]
- ***It takes a region: Creating a framework to improve chronic disease care***[40]
- ***Integrating chronic care and business strategies in the safety net***[10]
- ***Model for improvement***[41]

Among the key messages in these resources is the importance of ensuring the following.

- **Engagement of senior leaders within organisations** and their explicit recognition and expression of the importance of the change being sought (in this case, the provision of self-management support as a key objective of care for clients with chronic disease).
- **Integration of the new approach** (in this case, self-management support) into existing systems. In relation to self-management support, each interaction a client has with a health service provides an opportunity to support their self-management. Services should ensure the roles of their providers are optimised and coordinated, and systematic barriers for providing self-management support are minimised. Another key challenge for evolving services is ensuring each service provider is prepared to provide opportunistic self-management support.
- **Planned delivery of care** (in this case, self-management support). Available 'models' of self-management support (such as the Flinders model and health coaching; see *Common models of chronic disease self-management support: A fact sheet for Primary Care Partnerships* for more details) provide a valuable starting point, however, they typically do not provide all components of planned self-management support (listed in Box 6). These models can be effectively coupled with other models and systems. Organisations should be mindful they needn't view themselves as responsible for providing the full range of required group, one-on-one, and other (such as phone and web-based) supports. A local-area approach, whereby local agencies collaborate to ensure an adequate mix of services, could allow the establishment of a broad range of clinical and self-management supports for clients with chronic diseases. PCPs provide a valuable platform in Victoria to progress this integration work.
- **Systemic barriers to change are addressed.** A number of barriers to incorporating self-management support into routine practice are commonly cited (see Box 9). It is expected that the impact of efforts of providers and clients will be limited unless systemic barriers are addressed.[2]
- **Workforce capacity is enhanced** to enable: effective planning, implementation and measurement of service system improvements (including evaluation of impacts and outcomes for consumers); and provision of coordinated, best practice clinical care and support for self-management. Repeated or ongoing opportunities to establish skills over time are more effective in enhancing providers practice than one-off training.
- **Capitalising on existing enablers of change.** In the case of self-management support these have been demonstrated to include:
  - using organised, specific and focused approaches to the implementation of change initiatives[38]
  - embedding self-management support within existing services[25,38]
  - using self-management approaches that parallel the models used for system improvement (including PDSA cycles)[38]
  - using of self-management approaches that are practical, relatively brief, and can be integrated into a variety of care settings[2,25]
  - targeting multiple levels—addressing all elements of the Wagner chronic care model in attempts to embed self-management support[23,30]
  - having leaders support and reinforce the importance of self-management[23,25]
  - providing opportunities for sharing learnings between peers and services[38]
  - training providers in effective communication approaches, the use of effective self-management support strategies, and in continuous quality improvement methods.[23]

Box 9: Health service system barriers to self-management support

- Lack of awareness (at all levels of the organisation) regarding the challenges associated with chronic disease management and self-management support[2,38]
- Misconceptions that self-management support is an alternative to clinical care or equates to chronic disease management, client education, or a particular model[2,23,38]
- Lack of decision supports to assist providers assess, plan and intervene in self-management problems[2,23]
- Lack of tools to help clients develop adaptive health behaviours or change maladaptive ones[2,13,14]
- Service gaps—inadequate opportunities for clients to receive coordinated evidence-based clinical care and self-management support[2,23]
- Suboptimal communication between clients and providers, including inadequate communication regarding expectations for care[26,32]
- Inappropriately designed delivery systems, that do not allow adequate time for the effective provision of planned self-management support interventions, or inhibit continuity of care[2,13,23,26]
- Inadequate demand management that contributes to reduced access or provider workloads that compromise client safety or the provision of effective, proactive care[20]
- Inadequately trained providers who don't possess the knowledge and skills required to provide opportunistic and planned self-management support[19,20]
- Inadequate linkages and pathways between local services providing services offering clinical care and support for self-management. This is contributed to by inadequate articulation of the role and scope of services in the provision of self-management support and clinical care, and by resistance to integrate services across traditional service, discipline and organisational boundaries[20]
- Lack of adequate processes for service access, assessment, care planning, monitoring and review, recall and follow-up[20,23]

Where to begin?

1. Audit your organisation's self-management practice

Tool: *Assessment of primary care resources and supports for chronic disease self management (PCRS),* Diabetes Initiative of the Robert Wood Johnson Foundation, 2006; *http://diabetesinitiative.org/build/PCRS.html*

2. Choose a small process to change and use a continuous quality improvement framework to test the change, assess the experience, problem solve and build on successes.

Tool: For example, *Change report worksheet and change summary report for assessment of PCRS for chronic disease self-management and change http://diabetesinitiative.org/build/PCRS.html*

Endnotes

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