Implementation of the Self-Management Programs in British Columbia 1986 - 2010

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Patrick McGowan PhD
University of Victoria
Centre on Aging

A health education program that was delivered by peer leaders and could be widely disseminated.

The Innovation

Acute and Chronic Disease

	ACUTE DISEASE	CHRONIC DISEASE
BEGINNING	Rapid	Gradual
CAUSE	Usually one	Many
DURATION	Short	Indefinite
DIAGNOSIS	Commonly accurate	Often uncertain, especially early
DIAGNOSTIC TESTS	Often decisive	Often of limited value
TREATMENT	Cure common	Cure rare
ROLE OF PROFESSIONAL	Select and conduct therapy	Teacher and partner
ROLE OF PATIENT	Follow orders	Partner of health professionals, responsible for daily management

Overview of the Chronic Disease Self-Management Program

1. Persons with any type of chronic health conditions
2. Self-referral
3. Spouses and significant others may participate
4. Led by pairs of lay persons with chronic health conditions
5. Leaders receive a 4-day training workshop

6. Leaders follow a scripted Leader’s Manual
7. Course is given once a week for 2 ½ hours for 6 weeks
8. Ideal class size is 10 to 12 persons
9. Participants receive *“Living a Healthy Life with Chronic Conditions”* workbook
10. No cost to participants

What do people learn in self-management programs?

Information

- From the program
- From other participants

Practical Skills

- Getting started skills (e.g., exercise)
- Problem-solving skills
- Communication skills
- Working with health care professionals
- Dealing with anger/fear/frustration

Practical Skills (cont'd)

- Dealing with depression
- Dealing with fatigue
- Dealing with shortness of breath
- Evaluating treatment options

Cognitive Techniques

- Self-talk
- Relaxation techniques

Self-efficacy Enhancing Strategies

Self-efficacy: Health outcomes

- Mastery Learning
- Modeling
- Reinterpreting Symptoms
- Persuasion

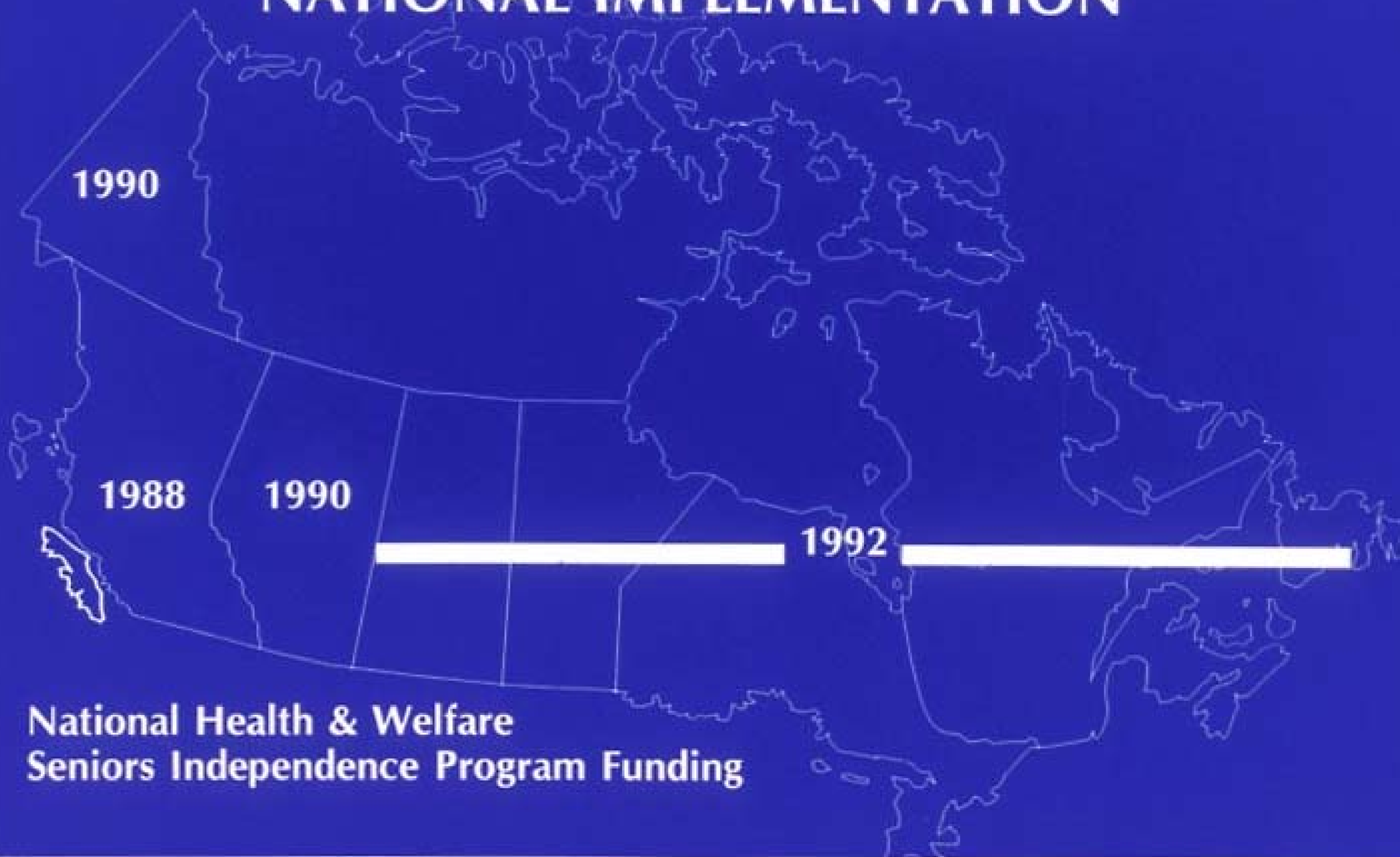
Patient Skills

Wagner and colleagues identify five self-management skills that form the core of self-management programs. These skills are:

- Problem Solving
- Decision Making
- Resource Utilization
- Patient-Provider Relationship
- Taking Action

Wagner et al 1996

ARTHRITIS SELF-MANAGEMENT PROGRAM NATIONAL IMPLEMENTATION



The Osteoporosis Prevention and Self-Management Program

- Led by pairs of trained volunteer leaders
- Led to groups of 10 - 12 persons
- 4 series (2 - 2½ hours per session
  - 4 weeks in a row)

During the two year project period

- 217 persons were trained as leaders
- Program was given 68 times
- In 46 community selling
- 855 program participants

Community lay-led Self-Management Programs in BC

Chronic Disease
Punjabi Chronic Disease
First Nations Chronic Disease
Online Chronic Disease
Youth Self-Management
Chronic Pain
Diabetes
Active Choices
Matter of Balance

Percentage of English-speaking British Columbians with chronic health conditions that have access to self-management education programs within a year.

Goal: 75% by 2010

Access = the program is offered at least once a year within a 50 km radius.

CDSMP is a Minimum Intervention

Minimal interventions are defined as those interventions that yield varied therapeutic effects with little expense in time or money and have few side effects.

Rose, 1985; Hovell et al.,1986; Geller et al., 1991.

Therapeutic services that…

1. Result in either small effects in a large proportion of the population or large effects in a small proportion of the population
2. Do not require much money; and
3. Involve little or no risk of side effects.

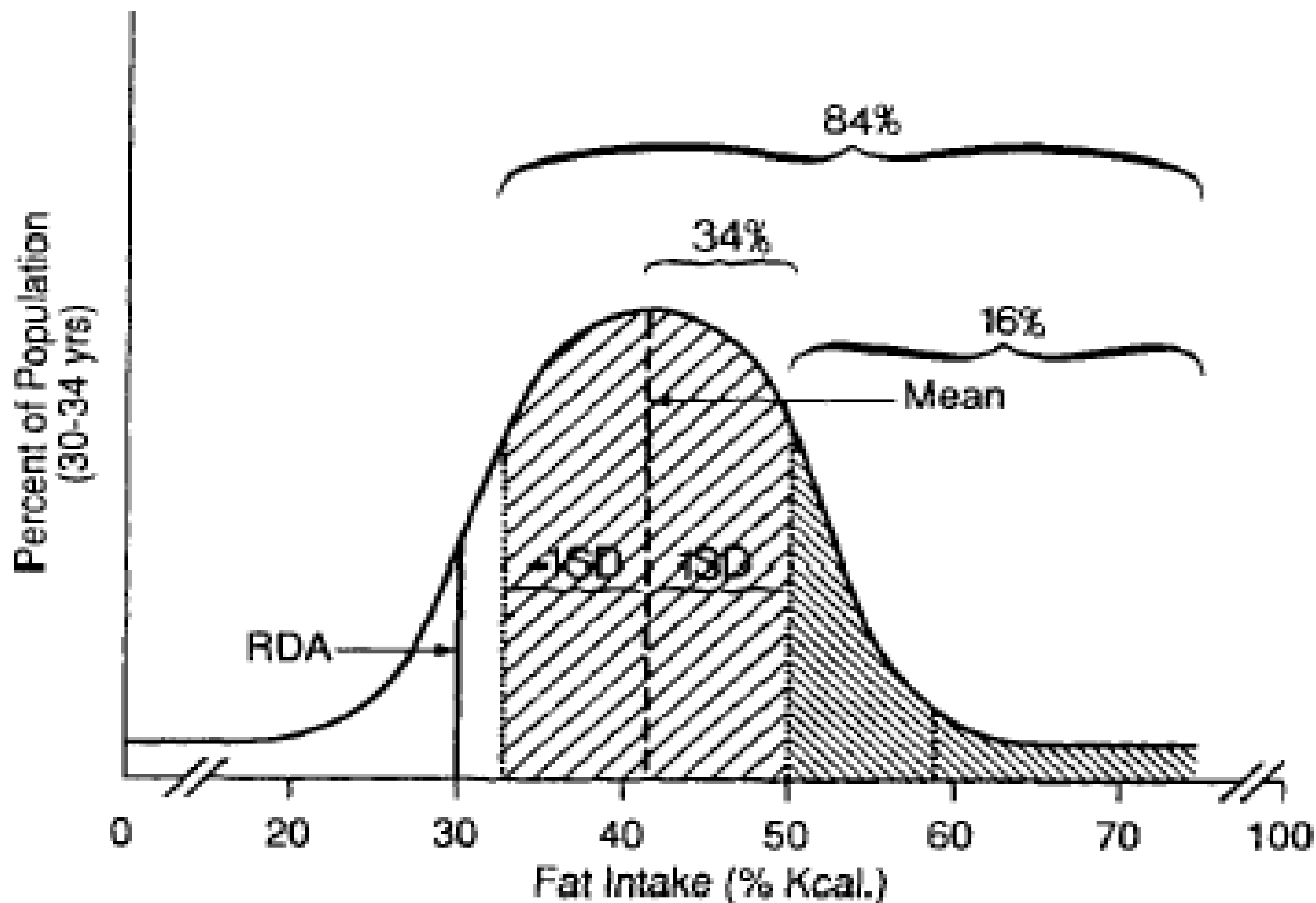
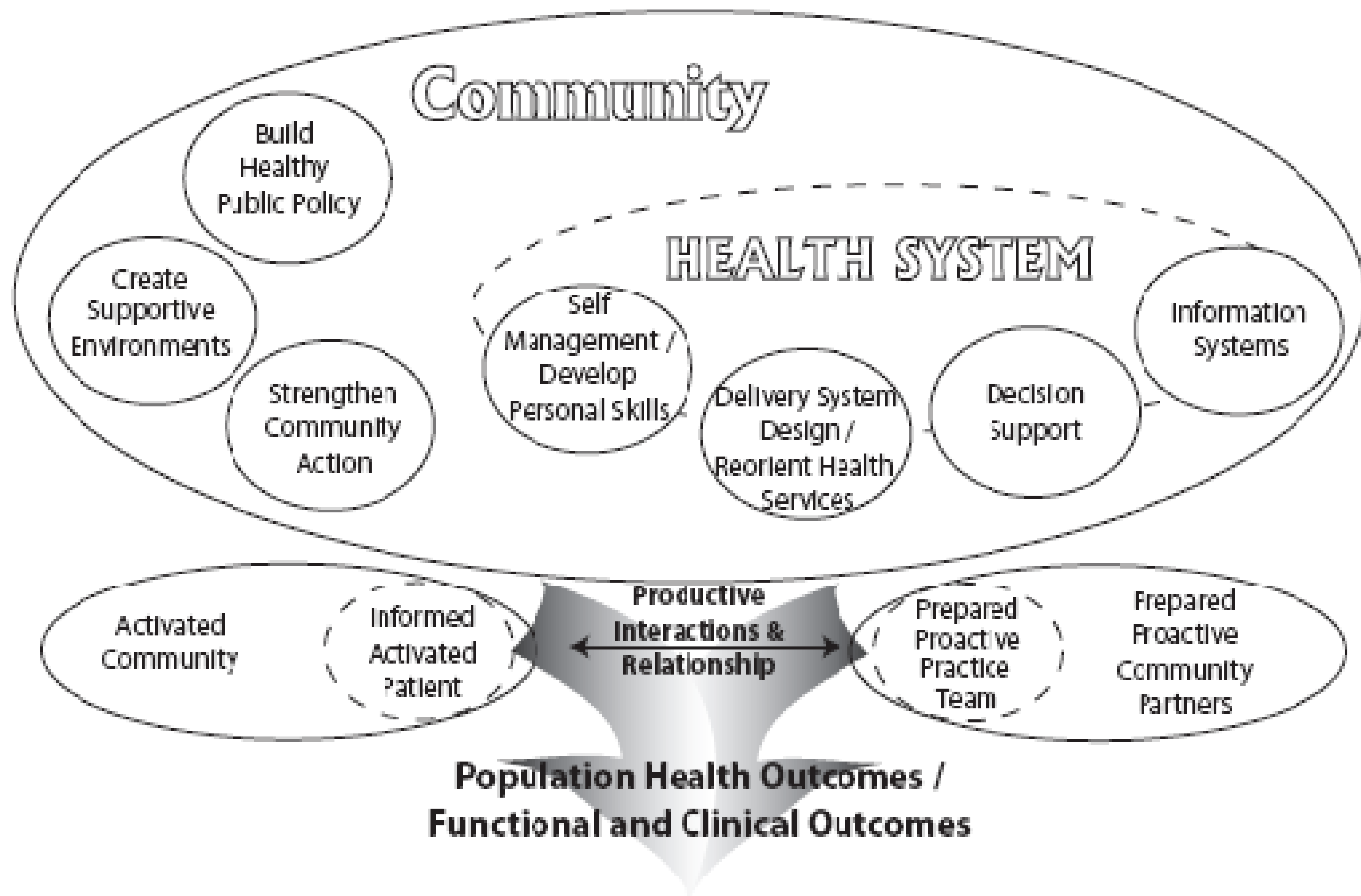


Figure 1. Distribution of fat intake in young adults.

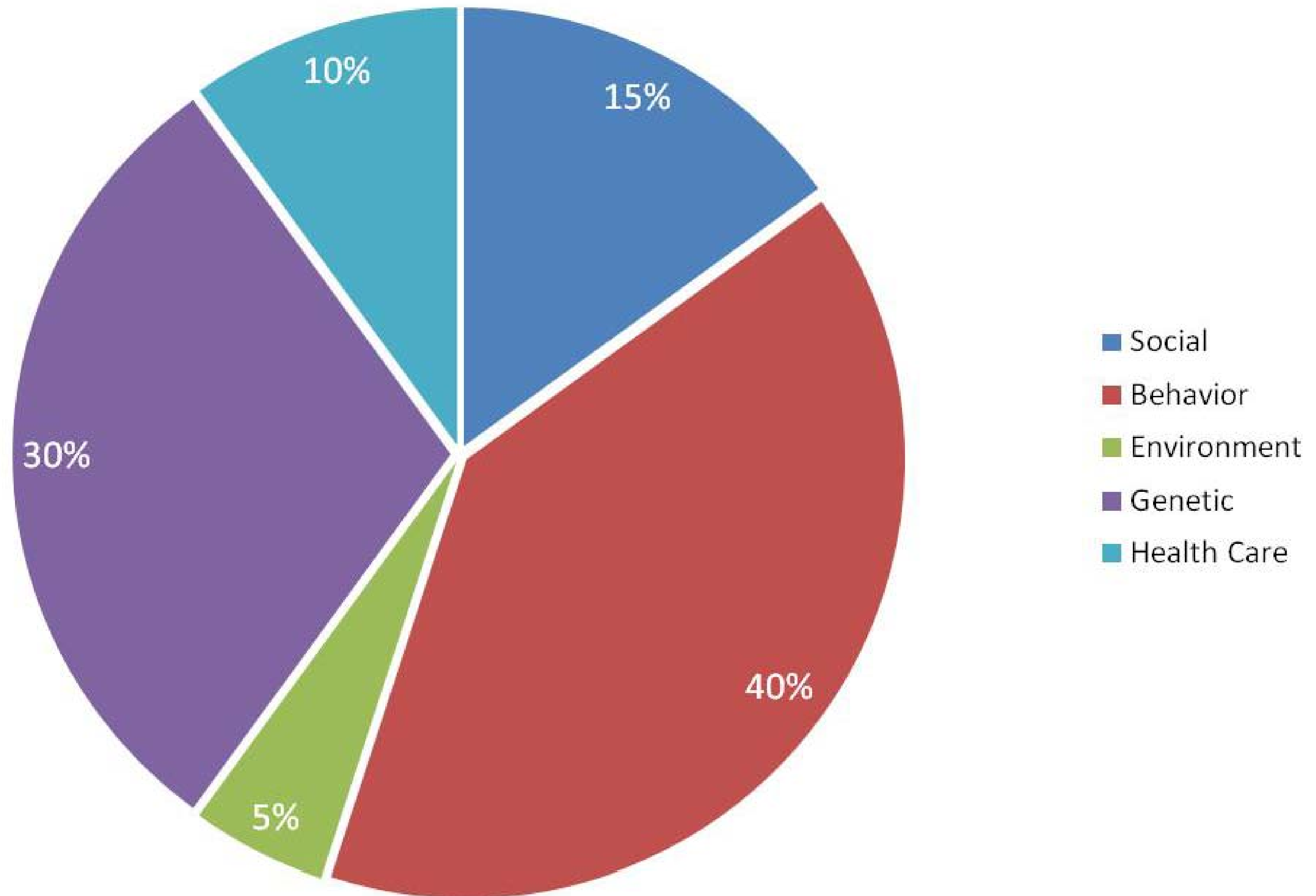
THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION



- Clinicians are present for only a fraction of the patient's life.
- Motivation is not enough. People also need self-confidence and certain skills that we can model and teach.
- Nearly all outcomes are mediated through the patient's behavior.

Considerations

The Leading Determinants Of Health



Source: McGinnis , JM et al Health Affairs Apr2002

Primary Health Care Charter

A Collaborative Approach

http://www.primaryhealthcarebc.ca

The tasks that individuals must undertake to live well with one or more chronic conditions.

These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions.

The US Institute of Medicine 2004

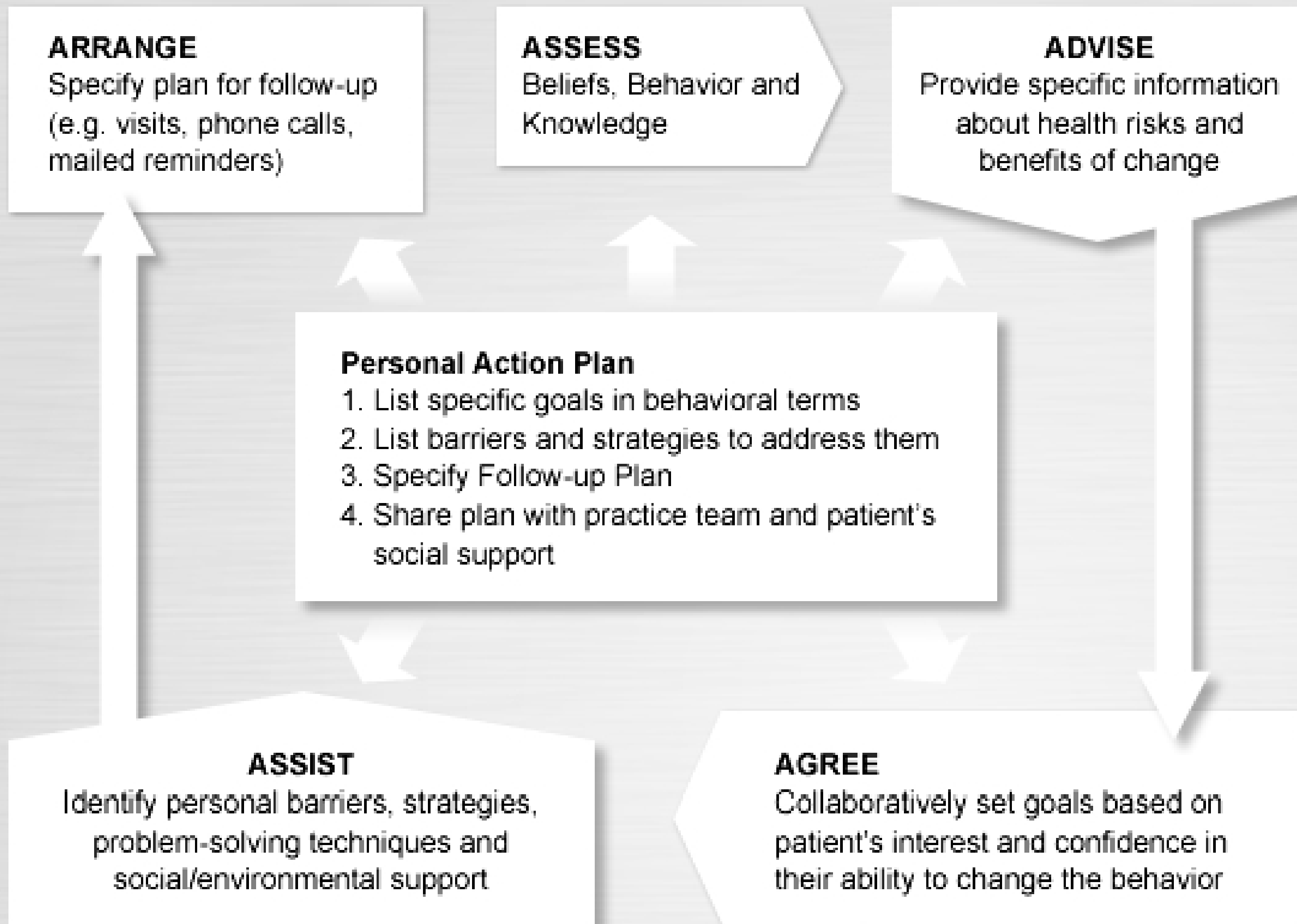
Definition of Self-Management

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

What health care providers do…

Essential Elements of Self-Management

- Both people are Experts
- Two-way information exchange
- Both state preferences
- Consensus to decide treatment
- Collaborative relationship


ARRANGE
Specify plan for follow-up (e.g. visits, phone calls, mailed reminders)
ASSESS
Beliefs, Behavior and Knowledge
ADVISE
Provide specific information about health risks and benefits of change
Personal Action Plan
1. List specific goals in behavioral terms
2. List barriers and strategies to address them
3. Specify Follow-up Plan
4. Share plan with practice team and patient's social support
ASSIST
Identify personal barriers, strategies, problem-solving techniques and social/environmental support
AGREE
Collaboratively set goals based on patient's interest and confidence in their ability to change the behavior
Glasgow RE, et al (2002) Ann Beh Med 24(2):80-87

Assess
Advise
Agree
Assist
Arrange

- Used lay leaders to teach the program?

- Used a minimal intervention strategy to deliver the program?

- Implemented a program that attempted to change the relationship between the health care professionals and patients?

- Delivered education that helped people manage their health conditions?

What was the Innovation?

Ongoing Challenges

- Definition of self-management
- Integration of patient education and self-management education
- Interface of "*Informed activated patients*" and the "*Prepared, proactive practice team*"
- Operating at arm's length from primary care physicians

Greatest Challenge

The greatest challenge for SM and SMS intervention is not at the individual level – where there are effective, evidence-based strategies – but at the systems level, where the optimal mix of clinical, community, and informal/personal strategies is difficult to manage.

What can be done?

- *"If you hold it where they are at …they will come"*.
- Offer programs on a continual basis with varying schedules (over 20 years, 40% of a closed cohort of persons with arthritis attended).
- Offer the community a menu of programs.
- Provide self-management support training to health care professionals.