

# Activation of Patients for Successful Self-Management

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**Abstract:** Patients, not healthcare providers, are the primary managers of their health conditions. Current healthcare falls short of providing the kind of support that patients need to optimally manage their conditions. But there are simple and effective self-management support tools and methods that are easy to learn and can be used within the time constraints of the office visit. In addition to tools and methods, supporting self-management requires practice redesign to reliably deliver optimal care to all patients. Whether the care team consists of a solo physician or a large, multiphysician organization, applying basic principles and using simple tools can enable patients to take a more active role in improving their health. **Key words:** *action planning, goal setting, patient activation, patient-centered care, planned visit, self-care, self-management support*

## RATIONALE AND BACKGROUND

Patients, not healthcare providers, are the primary managers of their health conditions. However, current healthcare falls short of providing the kind of support that patients need to optimally manage their conditions. Many patients do not understand what their doctors have told them (Schillinger et al., 2003), nor do they feel included in decisions about their care (Schoen et al., 2004). Others are not yet even aware that taking an active role in managing their condition can have a big impact on how they feel and what they are able to do.

Changing health behaviors is not an easy task. Patients often manage difficult treat-

ments within a complex psychosocial context. Clinicians need to create a collaborative relationship that addresses patients' priorities, circumstances, and goals. The health provider thus becomes a colleague, offering guidance and support instead of solely telling patients what to do to manage their health.

In the context of a collaborative relationship with shared decision making, clinicians can provide the elements of self-management support, including self-monitoring and problem solving, goal setting, and action planning. When patients receive collaborative self-management support, they have fewer hospitalizations, improved quality of life, and improved clinical outcomes in several ambulatory sensitive conditions (Lorig et al., 1999; Norris et al., 2002).

Such a collaborative framework for patient care is a fundamental transformation of the patient-caregiver relationship (Bodenheimer et al., 2005). Making this shift seems daunting in the face of existing time and resource constraints in ambulatory care practice. This article describes the authors' experience over the last 5 years in projects that helped provide some answers to the following questions:

1. Are there brief interventions to effectively enhance collaborative care that any provider could implement with minimal training?

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2. What practice and systems redesign elements are necessary for optimizing care for all patients?

**METHODS**

The experience we offer is based on 2 initiatives:

1. *New Health Partnerships: Improving Care by Engaging Patients*, an initiative of the Institute for Healthcare Improvement, funded by the Robert Wood Johnson Foundation, has worked with 35 teams in 3 different projects to identify best practices in collaborative self-management support. Patients and family members have been involved at every level of the project.
2. The Institute for Healthcare Improvement Learning and Innovation Community on Redesigning the Clinical Office Practice has brought together teams from a variety of healthcare organizations to explore how best to implement patient-centered, collaborative care. The community has tested tools and meth-

ods stemming from both the New Health Partnerships initiative and ideal medical practices, an ongoing project to develop patient-centered care within very small and solo practices (Moore & Wasson, 2007).

**TOOLS AND METHODS FOR PATIENT COLLABORATION AND ENGAGEMENT**

The following tools and methods are selected on the basis of our experience that they are relatively easy to learn and can generally fit within time constraints of office visits. We know that even brief interventions to enhance the collaborative relationship can be effective (Von Korff et al., 1997). These tools and methods are just a start. Honing skills and knowledge in collaborative care is an ongoing endeavor. Table 1 summarizes many of the following tools.

**Preparation for the visit**

In a systematic review of studies on provider-patient interaction, Griffin and colleagues (Griffin et al., 2004) concluded that

**Table 1. Resources\***

Tools, methods, resources	Purpose
Bubble Diagram	Enable collaborative agenda setting
Ask-Tell-Ask-Close the loop	Ensure patient understanding and recall
Readiness for Change Sample Dialogue	Enable collaborative agenda setting
Importance/Confidence Rulers	Support and initiate behavior change
Goal Setting/Action Planning Forms	Support and initiate behavior change
Problem Solving Form	Address patients' barriers to achieving success with behavior change
Follow-up Checklist	Design a process for patient follow-up
<i>www.How'sYourHealth.org</i>	Support patient problem solving and evaluate patient self-management
Communications skills reference	Remind providers of good communication techniques using a simple reference
Planned visit checklist	Design efficient self-management support visits using all staff
Ottawa Decision Aid Web site	Provide patients with evidence-based decision support

\*A wealth of free tools and resources for collaborative self-management support are available for download at Institute for Healthcare Improvement's New Health Partnerships Web site (<http://www.newhealthpartnerships.org/PatientActivation>).

“complexity is not necessary for success; patients who simply provided practitioners with written information about needs, emotional concerns and functional status prior to consultation were less anxious or showed improvement in functional status afterwards.” A short form that elicits patient concerns or needs, either mailed in advance of the visit or completed in the waiting room, can be sufficient.

### Agenda building

In collaborative care, patients and providers work together to create a list of agenda items for discussion during the visit. A simple visual aid such as the “bubble diagram” (Table 1) is a way to focus both the patient and the provider on the range of issues that are important to the patient. Providers are often concerned that the patient will have a long list of items that cannot possibly be covered during the office visit. However, patients can be engaged to help prioritize agenda items for the time available (Epstein et al., 2008).

### Ask-Tell-Ask-Close the loop

Patients often leave the office visit without understanding or remembering important care instructions and medication information (Roter & Hall, 1989), which may lead to worse outcomes such as higher hospitalization rates (Safeer & Keenan, 2005). Twenty percent of patients read at a fifth-grade level or below for which written healthcare information is not often tailored. Physicians cannot expect that patients will spontaneously reveal their lack of understanding. Also, physicians may not provide basic information that patients need. In one study, physicians explained the adverse effects of medications or instructions about one third of the time (Tarn et al., 2006). Using a simple method such as Ask-Tell-Ask-Close the loop can help improve communication and patient understanding.

- *Ask permission:* The provider asks permission to give information about a topic of importance to the patient (“Would you like to hear more about . . .?”). This establishes a respectful tone with the patient.

- *Tell:* Explanations and written material are most effective when given in response to the patient’s expressed agenda and tailored to their ability to understand. Simple visual aids can be very effective (See the CareSouth Carolina case example). Patients can also be referred to online decision support such as *How’s Your Health*.
- *Ask for understanding:* The physician asks the patient if he or she understands the instructions and provides additional information or clarification as needed.
- *Close the loop:* The physician asks the patient to restate the information as the patient understands it. The provider can then tailor the information for the patient’s needs and level of understanding. In one study with diabetes patients, patients recalled and comprehended only 12% of new concepts introduced during the visit. Those patients whose recall and comprehension were assessed were more likely to have hemoglobin A<sub>1c</sub> levels below the mean (Schillinger et al., 2003). In this study, use of the closing the loop technique was not found to add time to the visit duration.

### Readiness for change assessment

Patients are more likely to succeed with a health behavior change when the change can be related to a matter that is important to them and when they are confident that they can achieve the change. Simple ratings of level of importance and confidence using a scale of 0 to 10 can give a quick indication of readiness and next steps. Ratings of less than 7 on either measure signify less likelihood of success and the need to explore concerns and barriers with the patient, or even to select a different topic for health behavior change (Miller & Rollnick, 1991).

### Goal setting, action planning

Once a health goal is chosen that is important and meaningful to the patient, the next step is collaborative work to create an action plan, framing small steps that have high likelihood of success. In one study, action planning was found to take as little as 1 or 2 minutes or as long as 20 minutes. The

average was 6.9 minutes (MacGregor et al., 2006). Some patients may require a longer visit or additional contacts to help achieve their self-management goals. Most patients are best served by a short process that is revisited, improved, and modified over time. Participating organizations in the New Health Partnerships initiative created 1-page “action planning forms” to facilitate self-management support.

### **Problem solving**

The physician can use a step-by-step process to assist the patient in identifying problems and testing solutions to overcome barriers. Problem solving is a skill generic to a large cross-section of issues in managing chronic illness.

### **Follow-up**

Collaboratively set goals, creation of an action plan, and high patient confidence for making behavior changes are not enough to guarantee healthy change. Follow-up with patients, during subsequent visits and between visits, to assess progress and adjust plans as needed is an essential part of self-management support (DeBusk et al., 1994; Wasson et al., 1992; Weinberger et al., 1995). Inter-visit follow-up occurs 1 week after the visit and nurses, medical assistants, and trained lay volunteers can often provide the necessary support. Practices with secure Internet portals can provide additional patient support by e-mail and updates to online patient records. A follow-up checklist may make this task quicker and more reliable.

## **PRACTICE REDESIGN**

Establishing a system of support for patients often requires practice redesign to make efficient use of staff time and other resources, to ensure appropriate training, and to reliably deliver and document care. Ideally, redesign also leverages community and family resources and identifies new ways for patients to interact with a variety of healthcare providers.

### **Redesign in very small and solo practices**

In the ideal medical practice model (Moore & Wasson, 2007), which is focused on very small and solo practices, overhead and panel size are reduced so that the physician can spend more time with patients. In this design, a public domain information system, *How's Your Health*, offers practices and patients ready access to patient-reported data and outcomes to tailor self-management support. Information and tools available through *How's Your Health*, telephone counseling, and group visits all provide a menu of options to tailor support to patient needs. The changes for redesign described in this article, however, primarily focus on larger practices.

### **Key changes for practice redesign in multiphysician practices and larger organizations**

#### ***Train the entire care team for effective communication***

All staff can be trained in the simple tools described above. More comprehensive training is important for key members of the care team who specialize in coaching patients. Organizational teams participating in the New Health Partnerships initiative received intensive training in motivational interviewing communication skills, which they reported was essential to their success with collaborative self-management support.

#### ***Optimize roles and develop the care team***

All care team members are part of the collaborative relationship with patients. Many patients will require more than a single contact to establish an action plan and receive follow-up support. The physician alone cannot do all of this work. With training and a team-based care approach, care team members can help fulfill patient support needs, thereby making the physician's role and time more focused and efficient.

#### ***Plan the visit***

Involving the whole care team in the patient visit requires close coordination to

sustain consistency and collaboration. This process can begin with identifying the essential tasks of the clinical visit, designing efficient workflows, and training staff to fill new roles. Flow mapping a planned visit for diabetes care is one method that can be used for such processes as previsit planning, laboratory testing and results, registry checks, self-management support coaching, and other essential elements.

### ***Document self-management activity***

Documentation of patient needs and priorities and action plans is just as necessary for follow-up and care coordination as recording traditional clinical data. Expectations and requirements for documentation have to be built into office practice policies and care team responsibilities.

### ***Link to community resources***

Patient self-management is a 24/7/365 activity. It is important to link patients and family members to support resources in the community. Patients participating in the New Health Partnerships initiative report that they value referrals from their care providers. Begin by seeking and establishing collaborative connections with select community-based resources. Identify 2 or 3 relevant, high-quality community programs and maintain a list of these programs, along with current phone numbers, that care team members can use to refer patients as appropriate.

### ***Offer patient decision support***

An increasing number of patient medical decision aids are available to patients and providers online. For example, *How's Your Health* offers information to patients that they can use independently or with their providers (Wasson & Benjamin, 2006).

## **CASE EXAMPLE: CARESOUTH CAROLINA**

CareSouth Carolina is a rural healthcare system in Hartsville, South Carolina, serving more than 31,000 patients, many of whom are low income. There are high rates of chronic illness in the population. The system has worked since 1999 to improve chronic ill-

ness care through adoption of evidence-based guidelines and the chronic care model.

Dr Scott Anders, Medical Director, had achieved steady improvements in rates of hypertension control. However, he felt his results were still suboptimal. About the same time, Mr B, a 50-year-old patient with diabetes and hypertension, came in for a visit. Over the last 2 years, Mr B had been steadily gaining weight and required ongoing adjustment to his antihypertensive medications. Nothing they tried seemed to work, including giving Mr B many written materials about hypertension.

On reviewing the patient record Dr Anders noted that, several years earlier, Mr B had been able to lose 100 lb and no longer required hypertension medications as a result. Over the course of conversation during the office visit Mr B blurted out, "I can't read or write and I've never told anyone." Mr B's previous improvement was the result of remembering instructions to lose weight and exercise given to him by an endocrinologist. These instructions were no longer helpful to Mr B because he could not remember them. He also could not read the new handouts he received, and the blood pressure numbers he and Dr Anders talked about did not make sense to him.

This moment changed Dr Anders's practice and, ultimately, all practice at CareSouth Carolina. CareSouth began to realize the high prevalence of issues with health literacy in their population and other barriers to improving chronic illness care. For example, providers often heard patients make statements such as "My blood pressure has never and can never be controlled" or "It runs in my family and something I just have to live with." Also, there was a belief that "if it doesn't hurt, it doesn't need to be fixed," making it difficult to create a shared sense of urgency about treatment.

In January 2005, Dr Anders and CareSouth Carolina introduced the "high blood pressure thermometer," a visual aid to help patients better understand how to control hypertension (Fig 1). Over the next 6 months, Dr Anders saw an increase in the number of his patients who had control of their hypertension, from 54% to 65%. Patient ratings of

## CareSouth Carolina, SC High Blood Pressure and Diabetes (sugar) Patient Education Thermometers

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Hello: \_\_\_\_\_

Today your blood pressure is:

\_\_\_\_\_ / \_\_\_\_\_

(Please draw a line on thermometer to show patients where their blood pressure reading scores.)

It is important that we get the top number of your blood pressure to below **130**. **120 is perfect**

The closer we get your blood pressure to 120/70, the less chance you'll have of having a **heart attack, stroke, or kidney disease**. You can help by eating less salt (called sodium on food labels) and walking 30 minutes a day.

Your Last HbA1c was: \_\_\_\_\_

On: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(Please draw a line on thermometer to show patients where their blood pressure reading scores.)

This is how we keep track of your diabetes (just like blood pressure for hypertension). It is important that we get this number **under 6.0** if possible. It should be checked **every 3 months**. The closer to 6.0 your number is the less chance of **blindness, stroke, heart, or kidney problems, or damage to your nerves (causing chronic pain)**.

**Please ask how we can work together to help you to reach this goal. Thanks for bringing all your medications to your doctor appointments**

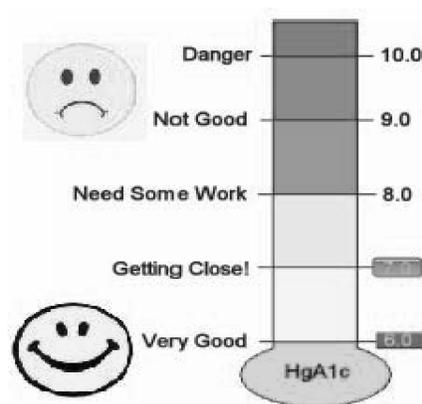
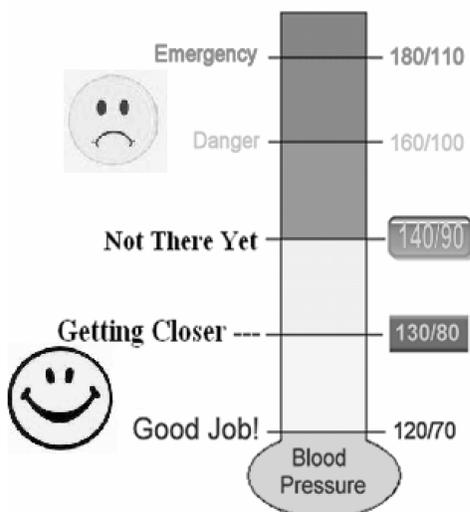


Figure 1. CareSouth Carolina high blood pressure thermometer visual aid.

confidence in managing their conditions rose from 42% to 88%.

The thermometer helps providers, staff, and patients have a shared understanding of desired care management and makes closing the loop much easier. CareSouth Carolina expects all staff who interact with patients to review the thermometer at each encounter so that there are repeated chances to ensure and improve patient understanding. Patients know the whole care team is on board with them. Now, even when patients feel good,

control of blood pressure makes some sense. And they are less likely to face the embarrassment of saying “I can’t read or write.” Dr Anders set all of this change into motion by closing the loop with one patient.

### CASE EXAMPLE: UNITE HERE HEALTH CENTER

UNITE HERE Health Center is a primary and specialty care center run by the UNITE HERE labor union that treats immigrant workers in

New York City. More than 90% of patients' income is less than 200% of the poverty level. Most patients' primary language is Spanish, Chinese, or French Creole and many of the center's staff is bilingual or multilingual.

The clinical improvement team led by Dr Heidi Frances decided to focus on weight management, an important issue in the patient panel. Given the doctor's limited time, the team piloted a new role, care manager/coach, with Julie Kaye, the clinic nutritionist. Julie began to reach out to Dr Francis' patients whose body mass index was more than 30 kg/m<sup>2</sup>, offering to coach them in weight management. Initially, many patients were unused to such proactive contact and did not agree to a coaching visit.

Ms L, one of Dr Francis's patients, wanted to lose weight for some time and tried multiple diets without any lasting success. When Julie contacted her to offer a coaching appointment, she was surprised but decided to give it a try. Julie listened to Ms L's past difficulties with weight management and engaged her in looking for a possible next step. Ms L felt it would be a manageable increase in exercise to walk 3 additional blocks to a different subway stop during her commute. This also meant she could avoid changing trains and save time.

Dr Francis's team learned that patients were more likely to focus on obesity issues once they met with Julie. To meet demand and expand the coaching role to other conditions, the improvement team needed to involve additional clinic staff. Using tools supplied by the New Health Partnerships initiative, Julie developed a staff-training curriculum for self-management support. Initial trainings were with volunteers (mostly medical assistants) who expressed an interest in learning the role. The training was designed to be fun, model the coaching process, and encourage staff to experiment with their own behavior changes. The trainees quickly learned basic skills for goal setting and action planning. The medical assistants reflected the ethnic and language background of the patients and related particularly well to them.

Ms L's journey to greater health is still unfolding. As she experienced the benefits of

walking she wanted to do more but felt bored simply walking alone in her neighborhood. She and Julie brainstormed possible ways to solve that problem, and now she talks on her cell phone with her favorite cousin who feels good about supporting Ms L in her new healthy habits. Ms L has now taken on a new role as patient advisor to the clinic's improvement team and she is involved in training new coaches. Her story is an inspiration to staff and other patients alike.

To make self-management support even more accessible, Ms L, Julie, and other coaches have begun outreach through the union to bring information and support to the worksites, offering lunchtime group programs on healthy eating, goal setting, and action planning.

Dr Francis's patients have now become accustomed to being in regular contact with the clinic staff. Their coach may call to see how an action plan is going or to tell them about new opportunities for actively managing their health conditions. Some patients, like Ms L, come to the clinic frequently because they have become valued collaborators in helping other patients and in improving the quality of care at UNITE HERE.

## SUMMARY AND CONCLUSION

Bringing together the medical expertise of the clinician and the experience of the patient in applying that expertise to effectively manage health is the biggest challenge of collaborative care. It is also the promise of improved health for the 100+ million people in the United States with a chronic health condition who account for approximately 75% of healthcare costs in the United States (University of California, San Francisco Institute for Health Aging, and the Robert Wood Johnson Foundation, 1996).

In both case examples, single providers employed very simple techniques and worked together with patients to significantly improve their health. These experiences led to larger practice and system changes, enabling providers to tailor interactions to patient needs. In the authors' experience,

making changes to promote collaborative self-management support by first testing new tools and methods can promote a successful shift in staff attitudes and organizational culture.

To meet the challenge of implementing collaborative self-management support, the healthcare delivery team or clinical microsystem (Batalden et al., 2003) takes on new im-

portance in performing the variety of roles and tasks required to offer truly patient-centered care. Whether this microsystem consists of a solo physician or a large, multiphysician organization, applying basic principles and using simple tools can enable patients to take a more active role in managing their chronic conditions and improving their health.

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