

# Collaborative Self-Management and Behavioral Change

Kathryn Rice, MD<sup>a,\*</sup>, Jean Bourbeau<sup>b</sup>,  
Roderick MacDonald, MS<sup>a</sup>, Timothy J. Wilt, MD, MPH<sup>a</sup>

## KEYWORDS

- Chronic obstructive pulmonary disease • Collaborative self-management • Behavioral change
- Pulmonary rehabilitation

## KEY POINTS

- Behavioral change is critical for improving health outcomes in patients with chronic obstructive pulmonary disease.
- An educational approach alone is insufficient; effective collaborative self-management (CSM) to promote adaptive behaviors is necessary.
- CSM should be integrated with pulmonary rehabilitation programs, one of the main goals of which is to induce long-term changes in behavior.
- More research is needed to evaluate the effectiveness of assimilating CSM into primary care, patient-centered medical homes, and palliative care teams.

## INTRODUCTION

According to the World Health Organization (WHO), chronic noncommunicable medical conditions, including chronic obstructive pulmonary disease (COPD), comprise more than half of the total global burden of disease. People who suffer from chronic diseases have complex medical, emotional, and social needs during the changing trajectory of their illnesses. These needs cannot be met by education alone; changes in behavior, especially the acquisition of self-care skills, are also required.<sup>1</sup> Chronic disease management, also termed collaborative self-management (CSM), is defined by the Disease Management Association of America as “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.”<sup>2</sup> There is mounting evidence that embedding CSM within existing health care systems provides an effective model to meet

these needs. The Joint Commission on Patient Safety and Quality in the United States has recently set out an evidence-based framework to improve self-management support for people with chronic conditions.<sup>3</sup> For people suffering from COPD, CSM is a multicomponent model of health care delivery that guides self-management behaviors to help patients lead lives that are as healthy and functional as possible.

Regarding COPD, the first Cochrane review in 2003 found insufficient evidence to demonstrate the effectiveness of CSM.<sup>4</sup> The next Cochrane review of 14 randomized controlled trials (RCTs) reported that COPD CSM improved dyspnea scores and reduced respiratory-related hospitalizations.<sup>5</sup> In 2013, a new Cochrane review of 26 RCTs found that COPD CSM not only improved disease-specific health status and exercise capacity but also reduced hospital admissions and hospital days per person.<sup>6</sup> This meta-analysis found no difference in mortality, although more

<sup>a</sup> Minneapolis VA Health Care System, One Veterans Drive, Minneapolis, MN 55417, USA; <sup>b</sup> Montreal Chest Institute, McGill University Health Centre, Montréal, Québec, Canada

\* Corresponding author.

E-mail address: [kathryn.rice@va.gov](mailto:kathryn.rice@va.gov)

recent studies were not included. There was insufficient evidence to either refute or confirm the long-term effectiveness of COPD CSM.

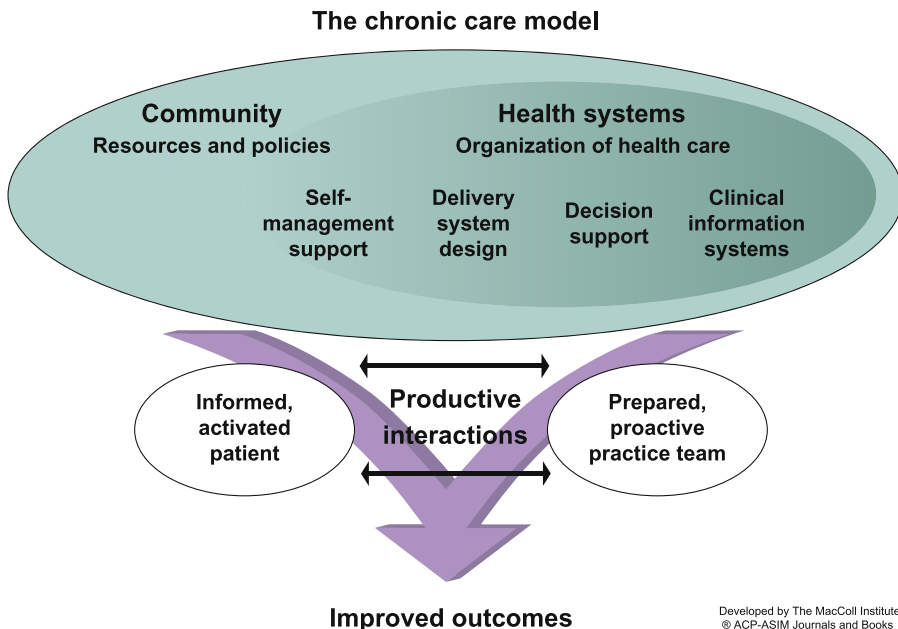
### CHALLENGES TO PROVIDING HIGH-QUALITY COPD CARE

Health care systems face major challenges in reducing the burden of illness and improving the functional status of people with chronic health problems.<sup>7</sup> Challenges for patients include the complexity of behavioral changes they are asked to make, communication problems, such as the fear of asking questions or “white-coat silence,”<sup>8</sup> a lack understanding of the disease and the severity of its symptoms, and nonadherence to medication.<sup>9</sup> Provider challenges include knowledge deficits and pessimism about COPD,<sup>9–14</sup> and acquiring the skills needed to guide behavioral changes. Challenges to health care systems are the availability of resources, including sufficient provider time to elicit and answer questions and ensure understanding<sup>8</sup>; role clarity for members of the health care team<sup>15</sup>; and systematic evaluation of the effectiveness of interventions.

Team-based models of care such as COPD CSM provide a framework for overcoming many of these challenges. The theoretical frameworks

for these systems have been previously described in some detail.<sup>16</sup> CSM is based on Wagner’s Chronic Care Model as shown in **Fig. 1**,<sup>17</sup> which emphasizes patient self-efficacy and behavior change. An additional framework for behavioral change is provided by the precede-proceed model.<sup>18</sup> According to this model, it is important to identify participants’ learning needs based on the evaluation of factors that can influence their behavior, as follows. (1) The predisposing factors that refer to existing health-related knowledge, beliefs, attitudes, and values, and expected changes in behavior; in addition, the level of self-efficacy is an important predisposing factor to behavioral change. (2) The facilitating factors or barriers that are based on patients’ past life experiences, knowledge, and skills already acquired, and the accessibility to services and financial resources. (3) The reinforcing factors that depend on patients’ social support network and their successful past life experiences. Behavioral interventions must be planned in relation to identified learning needs that are meaningful for the patient and applied through methods enhancing self-efficacy to achieve the expected behavioral changes and outcomes.

Evidence supports the integration of CSM into routine health care for several chronic diseases,



**Fig. 1.** The Chronic Care Model. Notes: The Improving Chronic Illness Care Program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health Cooperative of Puget Sound’s MacColl Institute for Healthcare Innovation, and its relationship to the Patient-Centered Medical Home. (From Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract* 1998;1(1):2–4; with permission.)

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