

Supporting self-care in general practice

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ABSTRACT

There is both a clear need and a political will to improve self-care in long-term conditions: demand for self-care support interventions is rising. This article discusses current approaches to supporting self-care in primary care, evidence in favour of self-care support, and issues for GPs to consider in planning self-care support systems. In planning care pathways, important choices need to be made about whether to use individual or group-based approaches and what intensity of intervention is appropriate to match patient needs. Investment may also be needed in both health professional competences and practice systems to optimise their ability to support patient self-care. Self-care support is a key approach for the future of UK health care. Practices that are well trained and well organised to support self-care will respond better to the complex challenges of achieving improvements in the outcomes of long-term conditions.

Keywords

chronic illness; intervention; self-care.

INTRODUCTION

How many health professionals does it take to change a lifestyle? The issue of behaviour change and how to achieve it is an important challenge for GPs. Changing the self-care behaviour of patients is relevant not only for preventing future health problems, such as heart disease and lung cancer, but also in mediating the course of long-term conditions. Supporting self-care and increased efforts at prevention are both major aspects of the government's current health policy.^{1,2} However,

achieving patient behaviour change is a major source of frustration for many health professionals. This article seeks to draw together and discuss some of the complex issues around supporting improvements in self-care in general practice.

WHY DOES SELF-CARE MATTER?

Long-term conditions affect millions of people in the UK and account for around 80% of GP consultations.³ It is widely acknowledged that patient self-care is a major determinant of health outcomes for these patients. Poor glycaemic and blood-pressure control in diabetes is a primary source of cost⁴ and morbidity,⁵ and around half of the patients on oral therapy do not achieve adequate glycaemic control.⁶ Poor control of asthma symptoms results in 74 000 emergency admissions and 4 000 000 primary care consultations per year.⁷ Only a minority of people with hypertension achieve target levels for control.⁸ The way that patients cope with illnesses in terms of stress and emotional consequences is also a crucial aspect of patient wellbeing.^{9,10} In summary, the effects on patients' quality of life and the costs to society of poor self-care are considerable.

Self-care affects health outcomes through several pathways:¹¹

- adherence to treatment regimes;
- maintenance of good physical health through lifestyle choices (for example, diet, not smoking);
- monitoring symptoms to inform treatment/self-care decisions;
- monitoring and managing stress and/or emotional consequences of illness;
- interacting effectively with health professionals to ensure that patients' needs are expressed and addressed; and
- using social support networks to help to achieve the above.

From the above, it is clear that self-care is something patients do all the time and that, in most cases, the majority of care received by patients with long-term conditions is self-care.¹⁰ However, there is considerable scope for improving self-care.^{1,3,11-14} Adherence to medication recommendations is

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considered to be at around 30–50%^{15–17} and it is estimated that 75% of admissions for both asthma and diabetes are avoidable through self-care actions.^{18,19} In addition, the majority of patients do not engage in recommended levels of physical activity or follow dietary guidelines.²⁰

As well as being a crucial element of illness management, self-care in the form of day-to-day 'lifestyle' behaviours (such as diet, physical activity, smoking, and drug use) is also the basis of much preventative health care.^{1,21} Major initiatives now exist on preventing diabetes and its complications,²² stopping smoking, and preventing the progression of hypertension and hyperglycaemia and other heart disease risk factors.^{22,23} The drive to prevent more illness by promoting healthy behaviour further increases the need for effective systems of self-care support.

INTERVENTIONS TO IMPROVE SELF-CARE

There is a wide range of self-care support interventions. These have varying levels of intensity, differences in content, and a range of theoretical underpinnings (from didactic education to the use of behavioural counselling techniques and theories of behaviour change).^{24–26} Interventions may include information-giving, addressing motivations and barriers to change, teaching coping strategies, designing action plans, dealing with emotional sequelae of illness, ongoing monitoring/support, or engaging family and social support. They may be based in healthcare settings, in the community, or at home. They may use individual, group, or self-mediated delivery and may be led by patients, nurses, GPs, or other specialists. The range of options is expanding rapidly with intensive case-management approaches at the highest level and a plethora of referral options for people with less complex needs (for example, pulmonary rehabilitation, exercise prescriptions, structured group education).

Despite this heterogeneity, trials and systematic reviews indicate that self-care interventions can be (but are not always) effective for a range of long-term conditions.^{9,24,25,27–32} Recent reviews have identified that 11 of 18 interventions were effective in improving clinical diabetes outcomes,³⁰ eight of 14 interventions improved lung function in asthma,²⁴ around 40% of interventions improved self-reported pain and disability in arthritis, and that six out of 17 interventions statistically significantly improved blood pressure in hypertension.²⁵ Other positive outcomes from such interventions include better self-monitoring and disease control, reduced symptoms, improved psychosocial outcomes

How this fits in

In current general practice, supporting patient self-care is arguably more of an art than a science. Primary care professionals recognise this as a central part of their work. However, GPs, nurses, and other allied health professionals often receive little or no formal training in self-support skills and may have limited knowledge of the emerging evidence base. This article attempts to demystify self-care support, providing a brief overview of the field and offering some pragmatic advice on how to appraise and choose between the wide range of options available. It is argued that practices that are well trained and well organised to support self-care will achieve greater improvements in outcomes for patients with long-term conditions.

(including patient satisfaction, health-related quality of life, and self-efficacy), and reduced healthcare use.

Attempts have been made to identify the key components that separate successful and unsuccessful interventions. Following a critical review (not a meta-analysis) of over 400 intervention and review studies,³³ Wagner *et al* in the US identified four key components for supporting patient self-care:

- collaborative problem definition involving patients and care providers;
- targeting issues and goal setting;
- active and sustained follow-up; and
- high-quality education/training (including training in the support of behaviour change).¹²

There are indications that sustained monitoring or review^{30,31,34,35} and more intensive or multifaceted interventions^{36–39} may increase the likelihood of effectiveness. However, meta-analytic reviews have neither confirmed the other principles mentioned above, nor have they established alternative key components.^{24,25,37} This, perhaps, suggests that there is no single best approach. However, the evidence base is not yet good enough to allow such complex analysis, as these same reviews highlight the lack of trials comparing interventions based on different theories. They also highlight a need for more thorough description and evaluation of intervention processes, which would facilitate the kind of component analysis desired.

Hence, although there is evidence that strong benefits are possible from supporting self-care and there are some suggestions about best practice, the key processes for delivering changes in self-care behaviours are not yet firmly established. So where does this leave the poor beleaguered GP? As ever, the job seems to require the making of pragmatic decisions based on incomplete information. The following sections outline some of the issues that might be considered in making such decisions.

GROUP OR INDIVIDUAL INTERVENTION

The mode of delivery of self-care interventions is an important issue. Group interventions are often used due to their (assumed) lower cost per person.⁴⁰ They are also attractive in that they enhance the possibilities for intragroup support and the sharing of coping strategies.^{40,41}

However, a number of patients do not wish to attend groups. In the recent Cornwall Heart Attack Rehabilitation Management Study when patients were offered a choice, 57% chose an individual rather than a group setting.⁴¹ Reasons given for preferring individual therapies included a desire not to have to share personal problems with others. The patient's right to confidentiality should be respected in such cases.

The peer support networks established in group education are temporary and are not usually designed to be sustained beyond the short intervention period. Group sessions can be hard to organise, especially in rural settings,⁴² and people who miss sessions can lose touch with the developing group agenda. Opportunities to tailor the intervention to individual needs are also inevitably diluted compared with individual (one-to-one) interventions.

It is not necessarily the case that group interventions are cheaper per patient than individual interventions, and there are trade-offs between the numbers of patients treated and the 'amount' of intervention an individual gets. It is questionable whether six sessions of 1 or 2 hours (as with the UK's flagship lay-led self-care support intervention, the Expert Patients Programme,⁴³ or diabetes structured education)^{44,45} with a group of 6–8 people is more or less effective than one or two individual 1-hour sessions. The latter involves similar resource use per person, but a more individual focus and much less time input from the patient's perspective.

Only a few studies or reviews have sought to compare the effectiveness or cost-effectiveness of group and individualised approaches,^{24,40,46–48} and it is not yet clear if one mode of intervention is generally preferable. Despite this, in the UK structured group education and group rehabilitation programmes for diabetes,⁴⁵ arthritis,²⁸ and chronic obstructive pulmonary disease,⁴⁹ as well as generic group support interventions,⁴³ are being widely implemented. Group intervention, therefore, seems to be the dominant paradigm. Once again, policy races ahead of the evidence base.

However, the choice of individual or group mode intervention can also be made on a pragmatic basis and there are circumstances where one approach might have clear advantages. The following are offered as pragmatic, rather than evidence-based, criteria for selecting the mode of intervention (group or individual) required in different circumstances. Evidence has, however, been cited wherever possible.

Individual approaches may be more suitable when:

- the condition is complex;
- outcomes are influenced by multiple psychosocial factors;
- individual context is important — if self-care depends heavily on contextual variables, such as the patient's social or physical environment, as well as other life stressors, then it makes sense to tailor self-care and coping strategies to address each person's situation.^{14,50} Although the health messages may be similar for many patients (for example, 'eat less saturated fat'), the way these can be realistically implemented may vary greatly depending on the context of a patient's day-to-day life (for example, baseline diet, preferences, attitudes to food, understanding of the problem, social context, cultural influences);

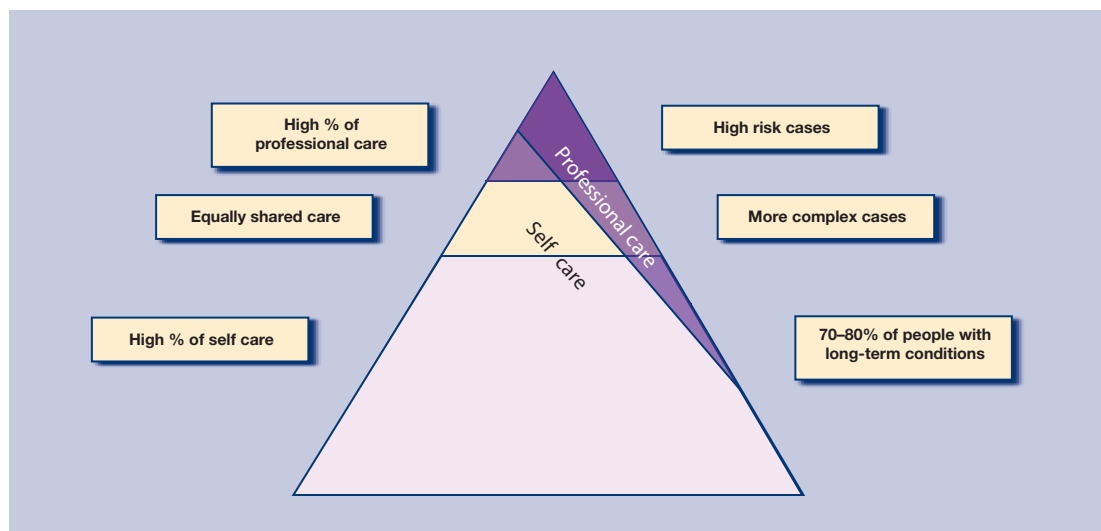


Figure 1. The NHS model of care for empowering and enabling individuals to take control of long-term conditions (source: Department of Health, ©Crown Copyright 2006).¹

- patients resist taking part in group interventions, or do not wish to discuss sensitive issues in groups;⁴¹
- achieving the aims of the intervention requires a high level of personal interaction or individually-adapted advice.

Group approaches may be more suitable when:

- the messages are simple and a more standardised one-size-fits-all approach is sufficient (for example, basic education about treatments and illness);
- peer support, albeit temporary, may be beneficial (it should be noted that some individual interventions also involve peer support);⁵¹
- the patient expresses a preference for this type of intervention; and
- group intervention offers a lower cost/higher throughput and similar effectiveness.

Cultural factors may also affect patients' preference for group or individual approaches, and resource availability may also be an issue (for example, space, suitably trained staff, or volunteers).

TARGETING: MATCHING INTENSITY TO NEED

Targeting methods may be useful to identify patients with a level of risk or health outcomes that justify a more intensive approach; for example, those with 30% or more cardiovascular risk,²³ a high frequency of asthma attacks,¹⁴ or people with type 2 diabetes who are not achieving glucose management targets.⁵ There is some evidence that appropriate targeting of self-care interventions can improve effectiveness.⁵² However, it is worth noting that applying a targeted approach may necessitate developing practice systems to identify patients and to provide interventions matched to need.¹²

The concept of 'taking the low-hanging fruit' is familiar to GPs and adopting a stepwise approach is a pragmatic idea that may help to guide decisions. Some patients do respond to simple verbal advice and instructions, so this should always be attempted,⁵³ but when this doesn't work a more intensive approach might be considered. In some situations more than one level of intervention intensity may be available. In obesity management, for instance, there is a whole range of options including simple advice-giving, exercise prescription schemes, extended counselling sessions (for example, nurse-, counsellor-, or dietician-led), commercial weight-loss programmes, and an increasing range of drug and surgical approaches. The following are offered as pragmatic criteria for selecting the intensity of intervention required in different circumstances.

Intensive interventions (whether group or individual) may be justified if:

- the patient has particularly poor existing outcomes or increased risk, or if the scope for benefit justifies a more intensive approach;
- the condition is complex and outcomes depend on multiple self-care factors; and/or
- previous, less intensive approaches have failed.

Less intensive interventions (whether group or individual) may be justified if:

- the prevalence of the condition is high and resource availability is low (for example, preventative interventions for people with high diabetes risk);
- the scope for benefit is less (medium rather than high risk or less severe consequences); and/or
- simple verbal advice-giving and/or patient information resources have failed.

There is evidence that more intensive or comprehensive interventions can increase effectiveness in some circumstances.³⁶⁻³⁸ However, there is also a self-evident relationship between intensity of intervention and cost, which reinforces the argument for focusing more intensive intervention on those at the top of the 'pyramid of need'. This is a central feature of the NHS strategy for the management of long-term conditions¹ (Figure 1).

PATIENT CENTREDNESS AND SHARED DECISION MAKING

There is a strong political and philosophical drive towards adopting self-care approaches that are responsive to patient agendas and patient choice.^{1,43,46,54,55} Although there is some evidence suggesting that lay-led self-care interventions may improve health outcomes^{27,28,56,57} and disease prevention behaviours, such as immunisation uptake and breastfeeding,⁵⁷ this is by no means conclusive.^{57,58}

The effectiveness trial of the Expert Patients Programme found that the intervention produced only small benefits in terms of patients' self-efficacy (that is, confidence about being able to manage their condition) and quality of life.⁵⁹ The intervention was cost-neutral due to small savings in self-reported health service usage. However, this is far from the Department of Health's high expectations at the launch of the programme, which included 40% or more reductions in hospital admissions and GP consultations.⁴³ This figure was based on trials of the parent intervention in the US.^{56,60} Hence, as with the wider self-care literature, the evidence base for lay-led self-care interventions is

mixed; although there is clearly potential for benefit, it is unclear what the essential components for success or effectiveness are.

Putting politics aside, it is worth considering whether approaches that are purely lay led are the best form of patient-centred support. Optimal care may be better achieved by finding ways in which health professionals and patients can work together to maximise the expertise of both parties, rather than having one party or other lead the process. A concordance-based approach requires both parties to respect and acknowledge the other's expertise and remit, and to work together to manage the condition.⁶¹ In the concordance model, the health professional's role is to make diagnoses, provide expert advice and opinion as needed, and act as a gatekeeper for medications and other health-related interventions. Patients are acknowledged as an expert on what is feasible in the context of their own lives and as having control over treatment implementation.

This provides a sensible basis for negotiation and, intuitively, seems like a good approach to delivering self-care support. There is good evidence that partnership in primary care is desirable and acceptable for most patients,⁶²⁻⁶⁴ but there is only limited evidence about the clinical effectiveness of approaches that follow a model of shared decision making and concordance. This evidence suggests that patient satisfaction, communication, and wellbeing can improve without detriment to health outcomes.⁶⁴⁻⁶⁷ It should be noted, however, that there was evidence in one study that a focus on greater participation may have distracted from the achievement of secondary, preventative disease management aims.⁶⁶

Some health professionals are concerned that giving patients more autonomy within the context of the consulting room could lead to poorer patient outcomes when patient choices conflict with best medical practice, for example, non-adherence with medication regimes.^{68,69} However, this objection is based on the false premise that patients somehow do not already have the freedom to make such choices. Patients are the main decision makers during the time spent outside of NHS premises, so they already have almost complete autonomy over their self-care behaviours. Despite this, there is a legitimate concern about patients being encouraged to develop autonomy about self-care to the point where they no longer involve the health professional, such as through increased use of self-monitoring devices and over-the-counter treatments.⁷⁰

PRACTICE SYSTEMS

Most self-care interventions focus on the patient as

the agent of change. However, good care of long-term conditions requires both 'activated patients' and a 'prepared' practice team.¹² Primary healthcare providers need to be able to assess the needs of patients, specify appropriate interventions, design and coordinate care pathways (including targeting processes), and reinforce self-care support processes during their own patient interactions if they are not the intervention provider. There may also be a need to integrate efforts with wider public health or community health promotion initiatives, particularly if the focus is on illness prevention.

There is a need for training health professionals in how best to support self-care interventions. A recent review of self-care support²⁴ suggested that health-provider training in skills of group facilitation, problem solving, goal setting, and consultation techniques for supporting behaviour change needs to be enhanced. Attention should also be paid to developing practice information, referral and review systems, staff awareness of the nature of interventions available, and practice team competences to deliver or support self-care interventions.^{11,12,71} This kind of training is not common, although the recent launch of the NHS Working In Partnership Programme's training materials on self-care support may help to change this.¹⁰ Training in self-care support, including the teaching of consultation skills for motivating behaviour change, should be a core element of medical education programmes for almost all UK health professionals.

The importance of the coordinating role of general practice should not be underestimated. Self-care strategies for individual patients are developed and modified over time. Hence, where external self-care interventions are used, primary-care providers have a crucial role in reinforcing the self-care messages given, and in providing consistent, ongoing support beyond the brief period of the intervention. It is worth noting that, both in the US and the UK, researchers have highlighted the dangers of fragmentation of care due to increasing outsourcing.^{12,72} This issue may become increasingly relevant in the UK as the number of referral-based options for treatment expands.

The developers of self-care interventions also need to consider how their interventions will be integrated into the wider process of patient care. Although some self-care interventions have training components to address intervention support,^{9,12,73} or seek to train health professionals as intervention providers,^{71,74} many interventions — such as the Expert Patients Programme, computerised cognitive behavioural therapy, and pulmonary rehabilitation — are designed to be delivered independently outside the general practice setting.

A prerequisite to the development of practice systems around a self-care intervention is that the initiative has the full support of the healthcare team. Most GPs generally support the principles of health promotion and supporting self-care; however, a wide range of practitioner views is evident. Some argue that supporting behaviour change would be too resource intensive and that 'treating risk' is over-medicalising the situation, whereas others see clear benefits for early prevention input.⁷⁵

Many are sceptical that putting significant resources into these areas will be effective, and point to their lack of skills in promoting behaviour change^{69,76} and the existing time pressures on consultations.^{69,76,77} Others are reluctant to relinquish control over patient care and highlight the need to balance increased patient responsibility with professional monitoring.^{69,78} Health professional attitudes and workload or resource issues may, therefore, affect the development of systems to support self-care.

LETTING GO

Applying a stepwise approach to self-care support, designing practice systems to facilitate it, and applying pragmatic criteria to the choice or commissioning of self-care interventions will take things a long way. However, one sticky question remains: at what point should we stop trying? There will always be some patients who do not respond to intervention. Even the most effective interventions will result in behaviour changes for only 30–50% of patients.^{79,80}

A refusal or inability to engage with self-care may stem from personal stressors, strongly held beliefs or attitudes, or other over-riding priorities. However, in a publicly funded, socially accountable healthcare organisation, continuing investment of limited resources in unresponsive patients is ethically unjustifiable. So, is there a point at which we should cut our losses?

The motivational interviewing paradigm⁸¹ offers some useful ideas about when to let a case go. The principle is that of 'informed choice': if you are confident that the patient is aware of the risks or consequences of their existing self-care behaviours and the advantages and disadvantages of changing them, and they decide that they do not wish to change at this point in time, then that is their choice to make. At this point, the model proposes that the therapist or caregiver summarise the situation, acknowledging that this is the path that the patient wishes to take.

The patient then leaves with the understanding that the door is still open for further support if desired. This approach is not only therapeutic for patients (who have at least had a chance to explore

their self-care issues and to make a considered decision) but also for health professionals who can reassure themselves that they have taken all reasonable steps for their patient. The seeds for future change may also have been planted.

CONCLUSIONS

Self-care support is a key technology for the future of UK health care. However, careful planning is needed to establish self-care support mechanisms and care pathways in general practice. Practices that are well trained and well organised to facilitate self-care support will respond better to the complex challenges of achieving improvements in patient self-care behaviour. These changes are needed to stem the rising tide of resource use associated with long-term conditions and to help prevent the future burden of lifestyle-related illness.

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Competing interests

The authors have stated that there are none.

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