Patient-centred care and self-management support in primary health care

Patient-centred care (PCC) is prominent in current healthcare, particularly in relation to the care of people with chronic diseases/conditions. Self-management by patients, in tandem with self-management support (SMS) provided by medical/health professionals, is a key strategy in chronic disease management. Patient-centredness is viewed as central to SMS.

This *RESEARCH ROUNDup* discusses PCC and SMS in primary health care (PHC) settings, including a brief outline of the history, policy context, and evidence base.

Chronic conditions account for an increasing proportion of the burden of disease, particularly among elderly people.[1] Comorbidity (the coexistence of two or more diseases or conditions) is common,[1,2] and patients with chronic conditions often have additional vulnerabilities and disadvantages.[1] Management of chronic conditions imposes substantial demands on general practitioners (GPs)[1] and PHC more broadly. PCC is widely accepted as an important principle, and SMS is recognised as an important strategy.

There is a considerable literature on PCC and related concepts such as patient experience of health care, but much of it is beset by conceptual and methodological issues.[3,4,5]

Patient-centred care

PCC focuses on patients' experience of health and illness and healthcare. Similar terms include "person-centered","consumer-centered", "personalized", and "individualized" care.[6] Lawn and Battersby defined PCC in detail:

> *Patient-centred care places the patient as the focus of any health care provision. The focus is on the needs, concerns, beliefs and goals of the patient rather than the needs of the systems or professionals. The patient feels understood, valued and involved in the management of their chronic condition. Patients are empowered by learning skills and abilities to gain effective control over their lives versus responsibility resting with others* (p. 7).[2]

The needs of patients extend beyond clinical needs, and include issues such as housing, transport, and social support, i.e. social determinants of health. One important aspect of PCC is cultural competence—the capacity of health professionals, agencies, and systems to integrate culture into health service delivery.[7] Cultural safety—patients' experience of receiving culturally competent care – has been compared in importance to clinical safety.[7]

Self-management

Self-management is what patients do, in order to manage the impact of chronic conditions on their lives. It includes "a broad set of attitudes, behaviors and skills", and it encompasses self-care and sometimes prevention (p. 206).[8]

Lorig and Holman identified six self-management skills: problem solving; decision making; resource utilization; formulation of a patient-provider partnership; action planning; and self-tailoring.[9] In addition, health literacy is an important foundation for self-management.[10] Self-management and health literacy are forms of patient empowerment that are congruent with, and facilitate, PCC.

Coventry et al. identified three factors that are necessary for patients to fully engage in self-management:

- capacity (availability of socioeconomic resources and time; knowledge; emotional and physical energy)
- responsibility (the degree to which patients and practitioners agree about the division of labour about disease management, including self-management)
- motivation (willingness to engage in self-management).[11]

All three factors are negatively affected by socioeconomic deprivation, underscoring the need for a PCC approach to recognise the importance of social determinants of health.

A few criticisms of self-management have been articulated in the literature, suggesting that it can work against PCC. For example, Lawn et al. have argued that self-management "encourages a particular conception of responsibility and self-management that may not fit with all patients' experience" and that "Providing services without reflecting on the meaning of self-management for the person with chronic conditions creates unintended assumptions about responsibility, engagement and care provision" which may alienate and stigmatise some patients, particularly those with complex needs (p. e5).[12] In addition, self-management is sometimes problematically equated with compliance.[13]

Self-management support

SMS is provided by health care professionals (and often relatives and/or friends). It is considered integral to good care of people with chronic conditions.[10,14]

According to Bodenheimer et al., "Self-management support involves collaboratively helping patients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools (eg, blood pressure cuffs, glucometers, and referrals to community resources), and routinely assessing problems and accomplishments" (p. 1776)[15]

Battersby et al. identified twelve evidence-based principles for implementing SMS in primary care: 1) brief targeted assessment, 2) evidence-based information to guide shared decision-making, 3) nonjudgmental approach, 4) collaborative priority and goal setting, 5) collaborative problem solving, 6) diverse providers, 7) diverse formats, 8) patient self-efficacy, 9) active follow-up, 10) guideline-based case management for selected patients, 11) linkages to evidence-based community programmes, 12) multifaceted interventions.[16]

Models of SMS

There are varying models of SMS. Some have been influenced by Wagner's Chronic Care Model[17], which focuses primarily on

systems of care. Lawn and Schoo compared several prominent models,[8] including:

- the Flinders Program
- the Stanford Chronic Disease Self-Management Program
- the 5As Model
- motivational interviewing
- health coaching.

They concluded that all models have advantages (e.g. flexibility) and disadvantages (e.g. time-intensiveness), and they are often complementary.

History and policy context of PCC and SMS

PCC was first articulated in the 1960s by US psychologist Carl Rogers.[4] Its importance in PHC was affirmed in the Declaration of Alma Ata: "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care"[18]. Subsequently PCC has extended much more broadly into healthcare practice and policy, including the Australian *National Primary Health Care Strategic Framework*.[19] In the US, PCC is one of six aims for improvement (along with safety, effectiveness, timeliness, efficiency, and equity) identified in the Institute of Medicine's *Crossing the Quality Chasm: A New Health System for the 21st Century*.[6]

SMS also has a decades-long history.[17] It also features prominently in health policy; for example, it is one of four action areas in the Australian *National Chronic Disease Strategy*.[20]

Evidence base for PCC and SMS

There is increasing but inconsistent evidence about the effectiveness of PCC[5] and SMS[13] in terms of health outcomes. A 2003 review found stronger evidence for PCC in studies in which health professionals sought to activate patients to take some control (e.g. asking questions and providing information) rather than when they merely took the patient's perspective.[3]

A recent systematic review found varying evidence of effectiveness of different SMS interventions for different chronic conditions and patient groups.[14] The most successful interventions were multicomponent. Core components include 1) education about conditions, recognising the importance of patients' pre-existing knowledge and beliefs; 2) psychological strategies to support adjustment; 3) strategies to support treatment adherence; 4) practical support, action plans, and training tailored to specific conditions; and 5) social support as appropriate.[14] It is often assumed that self-management programmes will decrease health service utilisation. However, there is limited and contradictory evidence about this.[21]

Training health professionals

A Cochrane review found that training for doctors and nurses in PHC and hospital outpatient settings was effective in transferring PCC skills to providers.[22] However, the impacts on patient satisfaction, health behaviours, and health outcomes were mixed, and data were often limited. In relation to shared decision making, most training programmes have reported outcomes for doctors rather than impacts on patients.[13]

Conclusions

PCC is an important principle in PHC, but is not a panacea. Similarly, SMS can be beneficial, but there can be tensions between professional expectations and patient preferences and capacities.

Links

- The Health Foundation (UK) person-centred care resources
  W: personcentredcare.health.org.uk/resources
- The Flinders Program, Flinders Human Behaviour and Health Research & Unit (FHBHRU)
  W: flinders.edu.au/medicine/sites/fhbhru/self-management.cfm

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