pharmacy practice

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Self-management support of patients with chronic diseases

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LEARNING OBJECTIVES

Upon successful completion of this lesson, you should be able to:

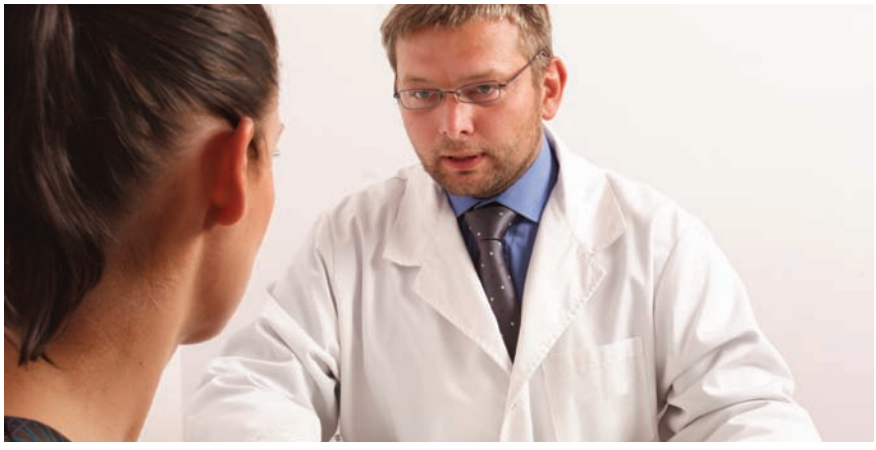
1. explain the currently recommended multi-faceted approach to chronic disease management
2. describe the concept of patient self-management and its role in chronic disease management
3. discuss the role of the pharmacist in self-management support of patients with chronic diseases
4. utilize mastery learning and problem-solving strategies to support patient self-management

INSTRUCTIONS

1. After carefully reading this lesson, study each question in the post-test and select the one option you believe is the best answer. Although more than one option may be considered acceptable, only one option is the *best* answer.
2. To pass this lesson, a grade of at least 70% (14 out of 20) is required. If you pass, your CEU(s) will be recorded with the relevant provincial authority(ies). (Note: some provinces require individual pharmacists to notify them.)

ANSWERING OPTIONS

A. For immediate results, answer online at www.pharmacygateway.ca.
B. Mail or fax the printed answer card to (416) 764-3937. Your reply card will be marked and you will be advised of your results within six to eight weeks in a letter from *Pharmacy Practice*.



An estimated 16 million Canadians live with chronic diseases, with an increased prevalence among vulnerable communities such as First Nations and socioeconomically disadvantaged groups.[1] Chronic disease in Canada accounts for an estimated 87% of disability, 67% of direct healthcare costs and 60% of indirect healthcare costs.[1] It is estimated that the cost of chronic disease to the Canadian economy is $80 billion annually.[2] The World Health Organization estimates that 60% of all deaths worldwide result from chronic diseases.[3] Clearly, the burden of long-term illnesses impacts not only individuals and their families, but entire countries.

While some risk factors for chronic disease such as age, gender and genetic composition cannot be changed, others can be modified. These include personal behaviours (e.g., tobacco use, alcohol use, physical inactivity, unhealthy diet) and health status indicators (e.g., hypertension, hyperglycemia, dyslipidemia, obesity).[4]

Effective chronic disease management programs can improve patient care and the quality of services while, at the same time, reduce healthcare costs. The Health Council of Canada has identified the following elements of good chronic disease management:[5]

- identifying patients with chronic disease
- having access to data on individuals and populations through high quality information systems
- organizing patients by risk
- involving patients in their own care
- using case managers to co-ordinate care
- using interprofessional teams
- integrating specialist and generalist practices
- minimizing unnecessary health visits and admissions
- providing care in the least intensive setting

Many of these elements are already being addressed through health-system redesign initiatives, but one area all frontline healthcare professionals need to embrace and incorporate into their practices is supporting increased

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patient involvement in their own care—a practice known as patient self-management.

This lesson will enable pharmacists to understand the correlation between self-management and chronic disease management, as well as how to incorporate self-management support into their practices.

Patient self-management

People with chronic diseases require more than traditional patient education and technical knowledge to adequately manage their own illnesses. Most of these patients live at home and want to remain independent, despite their chronic disease. To accomplish this, they must learn self-management skills that enable them to change their behaviour, manage their health risks and improve their health status by becoming actively engaged in their own care. They must learn how to:[6,7]

- recognize and act upon their symptoms
- make the most effective use of their medications and treatments
- deal with acute attacks or exacerbations (manage emergencies)
- make healthy choices related to tobacco, alcohol, exercise and food
- use stress reduction techniques
- interact effectively with their health providers
- use community resources
- manage work and the resources of employment services (adapt to work)
- manage relations with significant others
- manage their emotional responses to illness

Patient self-management is defined as tasks individuals must undertake for themselves to live well with one or more chronic conditions. The development of problem-solving and goal-setting skills is essential for patient self-management.

Self-management support is defined as the systematic provision of education and supportive interventions by healthcare staff to increase patients' skills and confidence in managing their health conditions.

Self-efficacy is defined as the confidence individuals have in their ability to deal with an aspect of their health condition. Self-efficacy affects every phase of behavioural change including initial consideration of a change, how much change happens, how much benefit comes from the change, how well change is maintained and how vulnerable a person is to relapse after a change.[8]

Healthcare professionals, including pharmacists, are an integral part of self-management education. As noted above, patients with chronic diseases require more than traditional patient education and technical knowledge. Table 1 summarizes specific differences between traditional patient education and self-management education.[9]

Incorporating the self-management approach into chronic disease management requires a paradigm shift—for both patients and healthcare professionals. Patients must accept the role they play in their own care, have access to useful information and develop skills to become more informed and engaged. And healthcare professionals must take on the dual role of providing useful information and also providing supportive interventions that enable the patient to achieve better functional and clinical outcomes.[10]

table 1

Traditional education versus patient self-management education[9]

	Traditional patient education	Patient self-management education
What is taught?	The patient is taught information and technical skills about the disease.	The patient learns skills regarding how to act on problems.
How are problems formulated?	Problems reflect inadequate control of the disease.	The patient identifies problems experienced that may or may not be related to the disease.
How does the education relate to the disease?	Education provides information and technical skills specifically related to the disease.	Education provides problem-solving skills relevant to the consequences of chronic conditions, in general.
What is the theory underlying the education?	Disease-specific knowledge creates behavioural change, which in turn produces better clinical outcomes.	Greater patient confidence in capacity to make life-improving changes (self-efficacy) yields better clinical outcomes.
What is the goal?	Compliance with behavioural changes is taught to the patient to improve clinical outcomes.	The patient will have increased self-efficacy to improve clinical outcomes.
Who is the educator?	A health professional, often one-on-one, is the educator.	A health professional or peer, often in group settings, is the educator.

PHARMACISTS AND PATIENT SELF-MANAGEMENT

Most people living with chronic diseases take medication to control symptoms or to delay disease progression. This means community pharmacists are one of the most frequently encountered health professionals in these patients' lives.

This prime position in the chronic disease-management milieu has a number of practice implications for community pharmacists. Pharmacists tend to establish ongoing relationships more often with their "regular," chronic-disease patients than their occasional patients. Chronic disease patients often have complex drug therapy regimens that need to be followed indefinitely. These patients have many health responsibilities and can feel overwhelmed, stressed, anxious and angry about their health status. Each time a chronic disease patient comes to the pharmacy, the community pharmacist has a professional opportunity to support patient self-management efforts.

ESSENTIAL ELEMENTS OF PATIENT SELF-MANAGEMENT SUPPORT

Self-management support by community pharmacists involves providing two general types of care for patients:

- provision of useful information
- assistance in collaborative decision-making through supportive interventions

Techniques for the provision of useful information

The techniques discussed in this section have universal application and are particularly useful when working with a person living with a chronic disease.[11]

Information-giving is an art, as well as a science. The goal is not to impart as much information as possible, but rather to provide the right information in the right format at the right time in a way that makes the information useful to a patient.

Three problems can occur in any information-giving scenario between a pharmacist (or other healthcare professional) and a patient:

- The patient does not get the information he or she wants.
- The patient does not understand the information.
- The patient is overwhelmed by the information.

Unfortunately, some patients may be reluctant to admit when they are having a problem with information they have received. They may not have understood technical words or their emotional response may have interfered with comprehension. They may be embarrassed to speak up or be concerned about bothering the pharmacist who looks too busy. Instead of clarifying their understanding, they go home confused, frustrated or anxious, and then make the best decisions they can under the circumstances.

Two simple techniques to maximize the effectiveness of any information-giving effort are:

- ask-tell-ask
- closing the loop

Ask-tell-ask

The ask-tell-ask approach involves three steps. It is always helpful to initially ask patients' permission before going through this process. That way they are more likely to understand why questions are being asked and ready to receive the information given.

- Ask patients what is important to them. You may be surprised to find that the issues they think are important are different than what you thought they would or should be.
- Tell patients relevant information that specifically incorporates the issues that are important to them.
- Ask patients to describe what they are going to do now that they have the new information.

This dialogue is a springboard to more discussion and frames the conversation in terms of issues important to the patient. Remember that patients will not automatically change their behaviour just because their doctor or pharmacist tells them they should. People generally need to perceive sufficient benefit for themselves to make a change, and the way a patient is engaged in a discussion can be as important as what you say during that discussion.

In each information-giving session, always encourage patients and invite them to translate the information they receive into practical action.

Here is a sample conversation:

Pharmacist: *What would you like to know about your diabetes?*

Patient: *What do I have to do to keep all my toes?*

Pharmacist: *Give information about blood sugar control and foot care. Then ask…What are you going to do now that you know this?*

Patient: *I'm going to check my feet every day and try not to forget my medication.*

Pharmacist: *Those are two great goals to set for yourself. How do you plan to accomplish these goals?*

Closing the loop

Closing the loop is a technique that helps the communicator assess a person's understanding of information he or she has received. This technique also involves three steps:

- Provide information.
- Ask listeners to tell you what they heard.
- Confirm, clarify and correct information as needed.

Again, keep in mind these conversations often lead to more discussion and the pharmacist's goal is to help support a patient in translating information into realistic behavioural changes. Always close by letting the patient know you are available if he or she has more questions or concerns.

Here is a sample conversation:

Pharmacist: *Three things that help prevent diabetes complications are choosing suitable foods, being more physically active and taking medicines as prescribed. Can you repeat these back to me so I know it's clear?*

Patient: *Eat less, walk more and take my pills.*

Pharmacist: *Great. Now what could you do at home to eat less?*

Techniques for self-management support

In addition to providing useful information, self-management support involves four important strategies:

- mastery learning
- problem-solving
- readiness to change
- tapping into community resources

Mastery learning

A person living with a chronic disease cannot escape from being a self-manager. Some people may try by withdrawing from life, staying in bed, socializing less or making their disease the focus of their life. Other people with the same symptoms somehow manage to get on with life. They may need to change some of the things they do or the way they get things done, but life continues to be full and active for these people. The difference between these two extreme examples is not the disease, but rather how the person with the disease decides to manage it.[12]

How to self-manage a disease can be decided only by the patient, since each patient is an expert on him- or herself. Patients are the ones who best know their own values, likes and dislikes, motivation, past experiences and all other issues unique to their lives. The pharmacist, on the other hand, is the expert on the medication, health information and disease management involved in the patient's condition. Mastery learning involves the meeting of these two experts, each bringing his or her own expertise to the discussion and each taking on specific responsibilities. The patient is the one who ultimately has to make behavioural changes at home. The pharmacist is responsible for support, followup and respectful intervention when needed.

Mastery learning is the process of setting a goal, devising an action plan to move closer to achieving the goal, and then regularly following up to support continued effort and revisions along the way as needed.

A ***goal*** is something a person wants to achieve in three to six months that would generally be too big to accomplish all at once (e.g., follow the diabetic diet).

The hardest part of self-management for some patients is to determine which goals are important to them and decide what goals to work on. In fact, one problem is that goals may often seem unattainable. Other patients may have a goal in mind but not be able to identify ways to achieve the goal, or reject alternatives without knowing much about them.

The pharmacist's first responsibility in self-management support is, therefore, to help the patient identify a goal.

Here is some sample scripting to help a patient identify a goal:

Introductory statement:
A health goal is anything you decide you want to improve or achieve with your diabetes (or other condition).

Question to start the patient thinking:
What would you like to be able to do that you can't now because of your condition?

Once a goal has been chosen, the next step is for the pharmacist to support the patient in identifying an action plan. For example:

Introductory statement:
An action plan is a small step you can work

on to help you move toward reaching your goal.

Question to start the patient thinking: *What can you do to move yourself closer to your goal?*

An ***action plan*** is a small doable step that a patient can realistically expect to accomplish within the next week. Action plans need to be something patients want for themselves and not just to please friends, family or doctors.

A realistic action plan helps a patient get started and is probably the most important self-management tool. The plan also needs to be reasonable, related to a change in behaviour and specific. Table 2 describes these requirements along with good and poor examples of action plans.

For example, a patient may choose a goal of improving physical fitness and break the goal into smaller action plans that address some of the following steps:

- Decide what type of exercise to do.
- Decide where to do it (e.g., community centre, gym, at home, the park).
- Determine at what level to exercise comfortably.
- Read up on specific details of the exercise.
- Find a friend with whom to exercise.
- Set a start date to begin exercising.
- Set a weekly target for exercising.

If an action plan is well-written and realistic, the patient will generally find it possible to achieve success.

An important step in the process of determining which action plan patients will work on is identifying patients' ***level of confidence*** in their ability to realistically complete the entire action plan.

Question to start the patient thinking: *Now, ask yourself, how confident are you, on a scale of 1–10, that you can implement this action plan, with 1 being "not at all confident" and 10 being "totally confident."*

A person needs a minimum 7 out of 10 level of confidence in a specific action plan before attempting the plan. The goal is to have patients experience success (which in turn helps improve confidence) so it is inadvisable to attempt a plan unless they are pretty sure they can complete it. Otherwise, the pharmacist needs to help the patient identify a different action plan or make modifications to the existing one to the point where the patient's confidence level reaches 7 or more.

table 2

Parts of an action plan[12]

Part	Good examples	Poor examples
Realistic *something the patient wants to do (not what someone else thinks he or she should do)*	Walk at lunch.	Walk at 3 a.m.
	Measure blood sugars twice daily.	Measure blood sugars before and after each meal.
Reasonable *something that can be accomplished in the next week*	Walk at lunch.	Run a marathon.
	Eat carrot sticks for an afternoon snack.	Become a vegetarian.
Behaviour-related *something that requires a change in behaviour to accomplish*	Listen to a relaxation tape.	Relax each day.
	Don't snack after dinner.	Lose weight.
Specific *answers the questions: What? How much? When? How often?*	Walk 4 blocks at lunchtime on 5 of the next 7 days.	Get outside. Start walking next week.
	Eat 2 servings of vegetables with dinner 5 nights this week.	Eat more greens.

table 3

Steps in the problem-solving process[12]

Step	Comments	Example
Identify the problem and describe it.	This is often the hardest step. Patients may think one issue is the problem, when the problem is actually something else.	A patient might feel that poor performance at work is the problem, whereas fatigue is affecting his or her ability to concentrate on the real problem.
List possible ideas to solve the problem.	Patient provides ideas. The pharmacist may suggest ideas too. Ask the patient if any of the ideas could work.	Ideas could include taking a short walk at lunchtime, seeing if there's a place the patient can take a short nap at lunchtime, checking if any medications could be causing fatigue and researching whether the fatigue may be due to depression.
Ask the patient to pick one idea to try.	This can be the basis for a new action plan. Support the patient in trying the new idea.	Taking a walk at lunchtime may help her become fit, as well as energized.
Assess the results.	Follow up after a pre-set time (usually 1–2 weeks) and provide feedback.	The walk did help but the patient is worried because she is also depressed.
Substitute another idea or use other resources.	Do more problem-solving if the chosen idea didn't work. Ask friends, family and other professionals for more ideas.	Try avoiding coffee in the evening and ask for a thyroid test at the next doctor appointment.
Accept that the problem may not be solvable now.	Don't give up. Tackle another goal and plan to revisit the current problem at a later time.	Perhaps stress is contributing to the fatigue. Working on the stress issue may help.

The final step in the mastery learning process is ***followup***. Followup is the responsibility of the pharmacist providing self-management support, and is a critical link between action plans. Followup enables a patient to continue moving forward and

table 4

Information and tools on patient self-management for healthcare professionals

Website	URL
Chapter 5: Patient self-management support. The 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities (2004), USA	books.nap.edu/openbook.php?record_id=11085&page=57 (accessed August 2, 2007)
Self-management support tools. Texas Association of Community Health Centres, Texas, USA	www.tachc.org/HDC/Tools/Self-Management.asp (accessed August 2, 2007)
Self-management tools. Institute for HealthCare Improvement, Cambridge, Mass., USA	www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/Tools/ (accessed August 2, 2007)
Patient self-management reports and initiatives. California HealthCare Foundation, USA	www.chcf.org/topics/chronicdisease/index.cfm?subtopic=CL613 (accessed August 2, 2007)
Background paper on patient self-management. First International Conference on Patient Self-Management, Victoria, BC, September 2005	www.coag.uvic.ca/cdsmp/downloads/What_is_Self-Management.pdf (accessed August 2, 2007)
Institute for Healthcare Improvement, Cambridge, Mass., USA	www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/ (accessed August 2, 2007)
The expert patient—a new approach to chronic disease management in the 21st century. UK	www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018578.pdf (accessed August 2, 2007)
Australian Better Health Initiative	www.aodgp.gov.au/internet/wcms/publishing.nsf/Content/feb2006coag03.htm (accessed August 2, 2007)

achieve success. Knowing a pharmacist will be following up on how a patient is managing with his or her plan is an excellent motivator for a patient to keep working on the action plan. Followup can be hard to maintain over time and many patients' health initiatives go off the rails when pharmacists don't continue monitoring progress.

Followup involves a scheduled time where the patient can discuss progress with their action plans with the pharmacist—what worked and what didn't. This naturally leads to a discussion about any challenges, problems or barriers that arose, ways to address them, and patient plans for next steps to keep the momentum going.

Questions to facilitate followup include:
Did anything happen with your health or medication since we last spoke?
How did it go for you with your action plan last week?
How do you feel about your results? Did you get closer to your goal?

Success is measured over a period of a week or more at a time and patients should be reminded not to worry if they do not see measurable changes each day. Small changes can produce big results when they are allowed to accumulate, and patients should not adjust their action plan prematurely.

Problem-solving

Many patients find their biggest challenges with action plans are figuring out exactly what problems they are having and what they can do to resolve them. When faced with obstacles, patients need to realize that the first action plan they tried may not always be the most workable plan and that they should not give up. The process of making mid-course changes in patients' action plans involves problem-solving and, ultimately, the identification of new or modified action plans on which to work.

Problem-solving is a way of working out issues that get in the way of patients' success with their goals and action plans. The problem-solving process can be used for any problem a patient faces now or in the future.

Questions to facilitate problem-solving:
What worked and what didn't work for you?
What could you have done differently to make it work better for you?

The problem-solving process flows into the mastery learning process to create a continuous loop of interaction between the patient and the pharmacist.

Steps in the problem-solving process include identifying the problem, listing ideas that could solve the problem, picking one idea and trying it (as an action plan), assessing the results (followup), trying another idea or using other resources (another action plan) and, if need be, accepting that the problem may not be solvable at the present time. These steps are described in Table 3.

The rationale behind problem-solving is to seek opportunities for success. If one idea doesn't work, the pharmacist's role is to support the patient in trying another one, choosing a smaller problem or taking a different approach. Something will eventually work to assist the patient in moving forward; however, now may not be the right time to keep working on a particular problem. In this case, the patient should be encouraged to work on another goal until the time is right to come back to the original problem.

Along the way, patients gain experience with mastery learning and problem-solving processes. The pharmacist's goal is to help patients experience the self-management cycle enough times that they can go forward and use the same processes to set future goals and tackle future health problems on their own.

Readiness to change

Sustained change is necessary for successful chronic disease management. Finding out what areas of behaviour a patient is ready to change is essential for identifying specific goals to work on in the self-management process.

A simple way to determine patients' readiness to change involves identifying how important the specific change is to them and how confident they are in their ability to make that change.[13]

Readiness to change = importance x confidence

The 1–10 scale is a useful tool here. The target is to achieve at least 7 out of 10 for importance and confidence for a specific change idea. Otherwise, the risk of failure is high.

Here is a sample conversation:

Pharmacist: *I see your latest HbA1c is 8.5.*

Patient: *It's supposed to be 7 or lower, right?*

Pharmacist: *That's right. What would you like to do about this?*

Patient: *I'm already on a diet, and I'm too busy to exercise. I don't know what to do.*

Pharmacist: *Could we talk about exercise?*

Patient: *OK.*

Pharmacist: *On a scale of 1–10 with 1 meaning it isn't important and 10 meaning it's just about as important as it can get, how important is it to you to increase your exercise?*

Patient: *It's an 8. I know I really need to do it.*

Pharmacist: *OK. Again, using a scale of 1–10 with 1 meaning not at all confident, and 10 meaning totally confident, how confident are you that you can increase your exercise?*

Patient: *It's a 4.*

Pharmacist: *Why did you say 4 and not 1?*

Patient: *I can exercise on the weekends, so it's not completely impossible.*

Pharmacist: *What would it take to raise your confidence from a 4 to an 8?*

Patient: *Maybe if I could exercise with a friend, I'd be more motivated. I have a friend at work with diabetes, too.*

Pharmacist: *Would you like to work on organizing exercise with your friend?*

Patient: *OK.*

Pharmacist: *How could you do this?*

Patient: *I could talk to my friend about setting up a walking schedule at lunch…*

Tapping into community resources

Throughout the self-management process, it's important to remember that patients are not expected to take care of themselves alone. Likewise, pharmacists are not expected to have all the answers for exactly what will work for every patient.

Pharmacists already work collaboratively with other healthcare professionals and community health groups, and pull in health resources as needed. These same resources are useful for patients with chronic diseases who are developing their self-management skills. Examples of resources include written literature, websites, allied health professionals (e.g., dietitians, physical therapists, social workers, audiologists) and community groups (e.g., local chapters of health organizations, community centres, seniors centres, support groups).

Patients living in urban centres often have access to useful resources they may not even be aware of, while patients in smaller communities can also often access resources through the Internet or telephone. Patients can also benefit from self-management support by peers and groups of patients with similar problems and health conditions.

Self-management support in community pharmacy practice

Many patients have problems with their medications and a logical place for the pharmacist to start with a patient is identifying goals to improve drug therapy outcomes. The same drug therapy problems defined in pharmaceutical care are amenable to patient self-management approaches, as well as clinical interventions by the pharmacist.[14]

A recent chronic disease management and self-management support demonstration project in British Columbia called Empowering Patients Through Integrated Care (EPIC) showed that a community pharmacist needs to practise providing self-management support with up to five patients before gaining a level of comfort and confidence in this approach.[15]

Strategies that can be helpful in expediting the learning curve include:

- sample wording (scripts) to help illustrate self-management concepts and processes
- checklists of icebreaker phrases and starter questions
- using in-person, telephone and email communication, as appropriate
- time-management approaches (to control interaction time)
- case-management approaches (to log followup appointments)
- documentation (of goals, action plans and progress)

A number of progressive institutions are actively developing and sharing self-management support tools online to assist health professionals in their own development of self-management support skills (Table 4).

Lessons learned from EPIC, one of the first-ever examples of community pharmacists providing patient self-management support, include:[16]

- ***Practice change is challenging.*** Some of the biggest challenges with practice change for today's pharmacists are integrating new clinical services into existing work environments, juggling multiple roles in new service development (creating, marketing and delivering the service), managing frontline practice change issues and having viable business models. Sustainable practice change requires the full commitment of management, operations, clinical and technician sectors.
- ***Confusion about the term "self-management."*** Many pharmacists use the term self-management to describe tasks associated with monitoring a health condition (e.g., technical training on how to use blood glucose meter). This differs from the modern definition of self-management, which involves patients learning problem-solving, goal-setting and action-planning skills, as well as gaining confidence enabling them to make decisions and adapt their own behaviour at home.
- ***Health professional discomfort in handing over control to the patient.*** Self-management requires a partnership, in which pharmacists help patients identify their health priorities and figure out ways to achieve the priorities that work for them. When adequately informed, most people set clinically logical priorities, but pharmacists find it a challenge to work within this new patient-led healthcare paradigm.
- ***Reconciling self-management support with professional (clinical) responsibility.*** All pharmacists carry responsibility for their patient-care activities, and self-management support does not absolve a healthcare professional of his or her obligations to ensure patient safety. Some pharmacists may worry about the ethical dilemma of supporting a patient's wishes when the patient's priorities are not aligned with their own assessment of the clinical priorities. However, in most cases, patients' priorities do not put them at risk of immediate danger; as such, pharmacists may rest assured in continuing with self-management support for the patient's priorities first.
- ***Need for a new mindset.*** Most pharmacists have been trained in the acute-care model of health delivery. Chronic disease management requires new partnerships between patients and pharmacists, planned proactive care, and community-based primary healthcare teams, all of which are in the early stages of practice development.

Summary

The fundamentals of chronic disease management and self-management can be summarized as follows:

- Individuals are experts on their own lives, experiences, beliefs and motivations.
- Healthcare professionals are experts on specific aspects of healthcare service delivery.

- Patients and pharmacists must collaborate on problem-solving and address concerns of both parties.
- Goals and action plans must reflect the patient's contributions, preferences, and assessments of feasibility, not mere acquiescence to a pharmacist's recommendations.
- Action plans must relate to a patient's unique social and cultural environment.
- Ongoing followup and problem-solving support is important for success and can occur via one or more modalities.
- Pharmacists have a responsibility to identify patients who are not managing well and assist them in modifying their actions to achieve desired drug therapy outcomes.
- Patients need to learn how to connect with resources and support in their own communities, since their need for these resources will change over time.
- Patients who develop mastery learning and problem-solving skills become more informed and engaged in their own care, which leads to better functional and clinical health outcomes. pp

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Questions

To answer online, go to www.pharmacygateway.ca, CE section, CE Online, Pharmacy Practice

1 What is the annual cost of chronic disease to the Canadian economy?
a) $80 million
b) $800 million
c) $8 billion
d) $80 billion

2 According to the World Health Organization, what percentage of deaths worldwide result from chronic diseases?
a) 6%
b) 16%
c) 60%
d) 66%

3 Which of the following has been identified by the Health Council of Canada as an element of good chronic disease management?
a) ensuring that patients are followed by a specialist physician
b) involving patients in their own care
c) providing care in the most intensive setting
d) developing cost-effective, sustainable programs

4 Which of the following is the correct definition for self-management support?
a) the tasks individuals must undertake to live well with one or more chronic conditions
b) the management support provided to healthcare practitioners that is necessary to create risk-stratified patient registries
c) the systematic provision of education and supportive interventions by healthcare staff to increase patients' skills and confidence in managing their health conditions
d) the confidence individuals have in their ability to deal with an aspect of their health condition

5 Which of the following is the correct definition for self-efficacy?
a) the tasks individuals must undertake to live well with one or more chronic conditions
b) the management support provided to healthcare practitioners that is necessary to create risk-stratified patient registries
c) the systematic provision of education and supportive interventions by healthcare staff to increase patients' skills and confidence in managing their health conditions
d) the confidence individuals have in their ability to deal with an aspect of their health condition

6 Which of the following statements is *true* for patient self-management education?
a) The goal of patient self-management education is increased efficacy to improve clinical outcomes.
b) Patient self-management education is disease-specific and teaches information and technical skills related to the disease.
c) The underlying theory behind patient self-management education is that disease-specific knowledge creates behavioural change that, in turn, produces better clinical outcomes.
d) Problems identified through patient self-management education reflect inadequate control of the disease.

7 Which of the following scenarios is correct and best enables a pharmacist to maximize any information-giving effort?
a) Tell patients relevant information. Ask patients to describe what they are going to do. Ask patients what is important to them.
b) Ask patients what is important to them. Ask patients what they are going to do. Tell patients relevant information.
c) Tell patients relevant information. Ask patients what is important to them. Ask patients what they are going to do.
d) Ask patients what is important to them. Tell patients relevant information. Ask patients to describe what they are going to do.

8 What is the "closing-the-loop" technique?
a) a way for a pharmacist to end a counselling session by summarizing the major points the patient should have learned
b) a way for the communicator to assess a person's understanding of the information he or she has received
c) a written education sheet that is provided to patients so they can refer to the information at home
d) a written test patients are asked to complete to verify their understanding of the information

9 What are the four broad strategies for self-management support?
a) goal-setting, action-planning, confidence levels and followup
b) mastery learning, problem-solving, readiness to change and liaising with acute-care resources
c) mastery learning, problem-solving, plan-do-study-act and followup

d) mastery learning, problem-solving, readiness to change and tapping into community resources

Joan is a 57-year-old woman with diabetes, osteoarthritis and hypertension (for which she now takes metoprolol). You've just received her lab results and her HbA1c is 9.8. She knows exercise is important for helping to control of her glucose levels but her arthritis makes it difficult for her to exercise. She is in a great deal of pain. She can't go to the pool as was suggested by the physiotherapist, because she can't swim but, more importantly, she doesn't want people to see her in a bathing suit since she has gained so much weight. Your main concern is Joan's glycemic control.

10 Today, Joan brings you a new prescription for a diuretic to be added to her metoprolol. What is the most supportive strategy to start a conversation with her?

a) Hi Joan. I'm concerned about your blood sugar levels. We need to figure out a way to get them down to a safer range. What are you willing to do to accomplish this?
b) Hi Joan. I understand you have a lot going on with your health. What are the biggest problems you are having right now? Maybe I can help.
c) Hi Joan. Here is a new prescription for your blood pressure. The doctor says you need to start taking this now because your blood pressure is still too high and that is hard on your heart.
d) Hi Joan. I noticed you are having trouble with weight control. Has your doctor talked to you about this?

11 Joan tells you her arthritis pain is her number one problem and she frankly doesn't care about her blood pressure or blood sugar levels. A supportive response(s) would be:

a) I'm thinking we should spend time talking about eating right and exercising. People with arthritis need to exercise even though it hurts, and exercise helps the diabetes and blood pressure too.
b) We have a brochure on pain management here. Would you like to read it?
c) I really appreciate you taking the time to talk with me today and sharing with me your biggest concern. What are you doing to manage your pain now?
d) What options can you think of that may help relieve your pain?
e) Both c) and d)

12 What is the minimum threshold confidence level that is necessary for a specific action plan?

a) 5
b) 6
c) 7
d) 8

13 Which of the following statements is true for problem-solving?

a) Problem-solving can only be used for immediate problems patients are facing.
b) Problem-solving creates a one-way flow of information as the pharmacist educates patients on how to resolve their situation.
c) Problem-solving is a way of working out the problems that can get in the way of patients' success with their goals and action plans.
d) Problem-solving is a way to illustrate to patients the consequences of failing to follow the advice of a healthcare professional.

14 What are the steps in the problem-solving process?

a) brainstorming ideas to solve multiple problems, prioritizing the problems and choosing the one that is the most clinically urgent, as determined by the pharmacist
b) identifying the problem, choosing the most clinically sound alternative, as determined by the pharmacist, and assuming the patient complies
c) identifying the problem, listing ideas that could solve the problem, picking one idea and trying it, assessing the results and trying another idea, if necessary
d) identifying the problem, listing ideas that could solve the problem and giving up when the patient states that the problem cannot be solved

15 What is often the most difficult step in the problem-solving process?

a) assessing the results
b) accepting that the problem may not be solvable now
c) communicating effectively with physicians
d) identifying the problem and describing it

16 Which of the following is indicative of a patient's readiness for change?

a) importance only
b) confidence only
c) importance and confidence
d) importance, confidence and problem-solving ability

Beth is a 46-year-old married mother of two teenage boys. She has type 2 diabetes. Her doctor said she needs to change her diet and do some exercise to lose weight. She is upset about this and very worried. She tells you she has tried to cook some recipes suggested by the dietitian, but her family complained. "They like their meat and potatoes and apple pies for dessert." Beth prides herself on being a great cook, and her husband tells everyone she is the best. She tells you she is too tired after work to cook a separate meal for herself, plus it's too much time and money. She tried an exercise program at the community centre on Saturdays, but the pace was too much for her, and she was too tired afterward to clean the house.

17 Which of the following is the most likely cause of Beth's problems?

a) pressure from her family to maintain her image as a great wife and mother
b) financial problems
c) not making her own health needs a priority
d) fatigue due to lack of exercise

18 How can you most help Beth?

a) Provide a sympathetic ear while Beth continues to vent her frustrations.
b) Tell Beth that if she doesn't take care of herself she will be not be healthy enough to take care of her family properly.
c) Ask Beth what worries her the most about her health.
d) Recognize Beth may be feeling overwhelmed and tell her changes don't have to be all at once. Instead, you can help her take small steps every week or two over the course of a year to help with things like food choices and exercise.
e) Both c) and d)

19 Which of the following best describes what goals and action plans must reflect?

a) the patient's contributions, preferences and assessments of feasibility
b) the healthcare professional's contributions, preferences and assessments of feasibility
c) the patient's contributions and preferences
d) the healthcare professional's contributions and preferences

20 Which of the following statements regarding ongoing followup and problem-solving support is true?

a) Ongoing followup and problem-solving support is not important for success.
b) Ongoing followup is important for success, but problem-solving support is not necessary.
c) Ongoing followup and problem-solving support can only occur during a scheduled one-on-one session in the pharmacy.
d) Ongoing followup and problem-solving support can occur via one or more of many modalities.

ce faculty

THIS MONTH
Self-management support of patients with chronic diseases

AUTHORS
Ms. Gobis was the pharmacist lead for the Empowering Patients Through Integrated Care (EPIC) demonstration project where community pharmacists, in collaboration with the British Columbia Ministry of Health, Fraser Health, Northern Health and the BC NurseLine, provided medication management and self-management support to people living with diabetes or congestive heart failure in B.C. At the time of writing, **Dr. Chong** was a Clinical Services Specialist at Network Healthcare and Clinical Mentor for the EPIC project. Dr. Chong is now a postdoctoral research fellow at the Centre for Health Services and Policy Research (CHSPR) at the University of British Columbia.

All lessons are reviewed by a minimum of six pharmacists for accuracy, currency and relevance to current pharmacy practice.

This lesson is valid until January 9, 2011. Information about self-management support of patients with chronic diseases may change over the course of this time. Readers are responsible for determining the most current aspects of this topic.

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