



Motivating Change: Innovative Approaches to Patient Self-Management

Introduction

Chronic disease care continues to evolve as physicians adopt practice guidelines to improve their care of patients. But beyond a certain point, what matters most is a patient's own ability to manage his or her disease. Behavior change is one of the most difficult of human endeavors, and success is nearly impossible without conscious effort and the use of specific skills. Those skills are not inherent in most people and need to be taught.

The acknowledgment of the importance of patient self-management is a relatively new phenomenon, as is the idea that teaching patients the necessary skills may be within the realm of primary care. Among the safety-net population, lifestyle barriers such as a lack of money, transportation, free time, or access to care make changing patients' behavior particularly challenging.

In recognition of the need for innovation to overcome these barriers, the California HealthCare Foundation established an initiative to fund the work of safety-net providers who are trying out new and better ways to support patients' ability to manage their own conditions. The six selected projects took varied and creative approaches to the problem. Two started at the provider level to ensure that residents and primary care doctors (and their staffs) understood the importance of self-management and knew how to teach it. Two others focused on one-on-one connections with safety-net patients in their communities, one of which sent out Spanish-speaking peer educators to provide diabetes patients with support whenever

and wherever they needed it. Another sought out a difficult-to-reach population of asthmatic adolescents, supplying them with cell phones to keep track of their illness.

Along the way, the projects generated useful information about the potential for these innovations to work and the nature of the barriers that stand in the way. During the course of the 18-month initiative, it became clear that developing a new idea takes time. Several projects contributed knowledge to the field by working out solutions to logistical problems they encountered, bringing safety-net providers a little closer to having better tools for teaching self-management.

Background

As recently as 1950, the seven leading causes of death in the United States were all managed as acute conditions: People either got better or they died. In contrast, five of the seven leading causes in 2004 required long-term management of chronic disease. Today, approximately 45 percent of people in the United States have at least one chronic condition; of these, 43 percent have two or more chronic conditions. More than 80 percent of health care costs are expended on the care of patients with chronic disease.

For the most part, this shift in the patient population has not been addressed by a corresponding shift in how the health care system handles chronic disease. For physicians treating acute conditions, it is reasonable to tell patients what to do: Take antibiotics for ten days to cure pneumonia; go to the surgeon to have cancerous

tissue removed. The alternative might be a relatively quick death. Treatments last a short time, allowing patients to follow the instructions without permanent changes in their lives. This is the directive model. Physicians are the experts, they make the decisions, and they instruct the patients about what to do.

In the treatment of chronic disease, telling patients what to do doesn't work very well. People have chronic conditions for the rest of their lives; physicians cannot cure them. In fact, patients have the power in chronic disease. Most spend a tiny percentage of their lives in the health care system and the vast majority of their time either by themselves, with their families, at work, at school, or within their communities. Patients decide what to eat, whether to exercise, and how often to take their medications. As chronic disease care self-management expert Kate Lorig says, "If people don't want to do something, they won't do it."

The new approach to caring for patients with chronic disease is one of collaboration—creating a partnership between caregivers and patients. To respond to the change in the makeup of today's patient population, the collaborative model needs to replace the directive model. Yet physicians make decisions collaboratively with patients a mere 9 percent of the time.¹ Most physicians have not accepted that they are practicing in a different world. When patients are involved in decisions affecting their health—when they are informed about their chronic condition and actively involved in managing it—they are more likely to make healthy behavior choices and to take prescribed medications.² The goal of the collaborative model in managing people with chronic disease is the informed, "activated" patient—one who takes an active role in his or her own care.

Self-Management Support

In pursuit of that goal, a new concept has arisen in medical care—one that most caregivers do not yet understand—"self-management support." Self-management support means the concrete actions caregivers take to implement the collaborative model and thereby encourage patients to be informed and activated to manage their chronic condition themselves.^{3,4}

The Institute of Medicine defines self-management support as "the systematic provision of education and supportive interventions to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal-setting, and problem-solving support."⁵ This support is delivered in the form of seven primary components:

1. Providing information to patients;
2. Teaching patients disease-specific skills;
3. Encouraging patients to choose healthy behaviors;
4. Training patients in problem-solving skills;
5. Assisting patients with the emotional impact of having a chronic condition;
6. Providing regular and sustained follow-up; and
7. Encouraging patients to participate actively in the management of the disease.

A number of these components have been thoroughly studied, and evidence is available demonstrating their effectiveness. Others have not received much study, but experts in chronic disease believe strongly that they work.⁶

Most physicians have not been trained in the collaborative approach and do not practice it on a regular basis. Moreover, most health care institutions have not re-organized themselves to provide the seven components of self-management support, nor are most payers reimbursing health care institutions for offering them. In spite of these difficulties, a number of health care institutions, such as those involved in CHCF's initiative,

are attempting to provide self-management support to their patients with chronic conditions.

In addition to determining how best to provide patients with information, teach them the skills to monitor and manage their specific disease, and guide them toward healthy behaviors, institutions making this leap must grapple with two difficult issues: Who delivers the support? And when it should take place?

The “who does it?” question is often a major barrier because the clinicians who are reimbursed for their time often have no time to spare, while other caregivers who may have the time typically must provide services without pay. However, caregivers without professional degrees, such as medical assistants and community health workers/*promotoras*, can often be trained in providing information for a limited number of chronic conditions, as well as how to teach self-management skills and encourage healthy behaviors. In general, it is clear that health care institutions can provide self-management support only by forming teams, training team members who are interested in doing the work, and giving those trained team members time to engage in self-management support activities.

As for the question of when such support should occur, many organizations have followed the dictates of the Chronic Care Model and organized scheduled visits as the place to provide self-management support. It is virtually impossible to provide a sufficient level of information-giving, skills training, and goal-setting in an acute care environment. Success at organizing scheduled visits that are separate from acute visits, however, has been spotty. While Chronic Care Model devotees can cite many reasons to have separate, planned visits, patients often don't want them. By and large, patients want one-stop shopping: Go to the doctor, get lab, health education, x-ray, and pharmacy services all in one trip, and then get away from the health care system as quickly as possible.

The Initiative

In 2005, the California HealthCare Foundation sent out a request for safety-net practices in California to apply for grants to improve the delivery of self-management support to patients with chronic conditions. This “Promoting Consumer Partnerships in Chronic Disease Care: Strategies for the Safety Net Initiative” provided support for six projects implementing innovative strategies to help people with diabetes or asthma become more active partners in their own care. The project ran from January 2005 to September 2006. The expectation was these interventions could be sustained after the grant period and would benefit low-income populations with the highest rates of chronic illness, the lowest health literacy rates, and the least access to comprehensive services. These populations, for the most part, receive their care from safety-net providers such as community clinics, county clinics, public hospital systems, and physician offices that contract with Medi-Cal plans.

The goals of the initiative were to:

- Identify innovative and effective strategies that involve interaction between the health care provider (or organization) and the patient;
- Support implementation of these strategies in specific settings; and
- Evaluate their success—including identifying those strategies that have the greatest potential to be replicated by a range of providers and consumers in the safety net.

After an application process, six projects were funded with up to \$200,000 each over two years. Each project was required to undergo an evaluation, including an analysis of the costs of providing the innovation.

The Projects: Results and Lessons

Alameda Alliance for Health, Oakland

ATTACK PROGRAM: TRAINING PROVIDERS IN ASTHMA CARE

The Alameda Alliance for Health is a not-for-profit Medi-Cal health plan providing comprehensive health care services to about 89,000 low-income residents of Alameda County. The Alliance partnered with Children's Hospital and Research Center in Oakland to implement the Asthma Tools and Training, Advancing Community Knowledge (ATTACK) program for 18 months, training primary care physicians and their office staff in caring for patients with asthma. An RN asthma specialist from Children's Hospital and the health educator from the Alliance traveled to each practice to conduct the training sessions.

The training program reached nine primary care practices and 146 staff, which included 86 clinical staff and 60 non-clinical staff. These practices care for about 30 percent of Alliance-enrolled children with asthma (about 1,770 children) and also care for children with asthma who are not covered by the Alliance health plan.

Each practice received four to eight one-hour training sessions over the period of a month or two. The sessions were held during the lunch hour or very early in the morning prior to the start of the clinic day. Because both clinical and non-clinical staff play important roles in the delivery of patient education and the implementation of system changes to improve asthma care, the effort was made to include all staff members in the training. Incentives were offered for participation—including Starbucks coupons, lunch, and continuing medical education credits for clinical staff—plus one larger gift for the entire practice, such as a spirometer (a device used to measure lung function) or TV/DVD player. The incentives worked well in attracting participants to the training sessions.

Results

To determine whether the training resulted in better care and outcomes, the Alliance surveyed children and families being cared for by the private practices both at baseline and follow-up intervals. However, because of sampling problems, the asthma of children in the follow-up survey was found to be less severe than the cases in the baseline survey, so a clear comparison was not possible.

The training program was well-attended and participants rated the sessions as extremely useful. It expanded the use of spirometry and prompted some practices to start using medical assistants and licensed vocational nurses to provide education to children with asthma. The practices improved their educational materials for patients and started using a more team-based care model. The most effective methods they learned were spending time on education, demonstrations, asthma management plans, written reinforcement of information presented during office visits, and follow-up care.

At the same time, project leaders heard from providers that they needed more help with how best to change their practices to accommodate what they learned from the training, as well as more hands-on training about how to use asthma medication delivery devices.

Key Lessons

Health plans can support providers in improving the care of patients with asthma by arranging for training sessions that include licensed and non-licensed staff. Using a well-respected local expert—the RN asthma specialist—to travel to the practices at a mutually agreed upon time worked well. Providing free meals and other incentives helped to sustain participation. Training must focus on teaching staff members to be able to instruct patients in disease-specific skills—how to use inhalers, spacers, and asthma action plans, as well as the differences between controller and rescue medications. The biggest challenge for practices has been in establishing clinic procedures

and changing clinic flow patterns to advance educational objectives.

Clinica Monsenor Oscar A. Romero, Los Angeles

SU SALUD EN SUS MANOS PROGRAM

Clinica Monsenor Oscar A. Romero is a community health center that serves 15,000 residents of the Pico Union neighborhood in downtown Los Angeles. About 2,000 of those patients have diabetes, and many are immigrants from Central America or Mexico who lack health insurance.

The health center built upon an established program that helped diabetes patients manage their disease using three methods: collaboration with primary care providers to develop action plans to change their behavior, counseling from a peer health educator, and participation in a nutritionist-led class. When the organization found these methods were not meeting the self-management needs of their patients, it developed a program called *Su Salud en Sus Manos*. The program improved the existing services and added several new ones, specifically:

- A diabetes registry;
- The inclusion of individualized help with goal-setting from the patient's primary care provider and a community health educator as part of each clinic visit;
- A diabetes education class given by a nutritionist;
- Depression screening and referral to a mental health counselor for treatment if needed;
- Follow-up from a case manager; and
- An intensive 15-hour self-management skills training workshop led by a health educator.

The 15-hour workshop was the most important new service offered by the clinic. Called *Tomando Control de Su Salud*, the six-session workshop is based on a model

developed by Kate Lorig at Stanford University.⁷ It is a peer-led course focused on building self-confidence through problem-solving, decision-making, and creating and carrying out short-term action plans. While the Stanford program usually mixes patients with different chronic conditions, the Oscar A. Romero program focused exclusively on patients with diabetes.

Results

About 800 patients were enrolled in the *Su Salud en Sus Manos* program. The group received an average of 5.6 hours of direct services, including time with a health educator, phone calls from the case manager, a diabetes education class, a visit with the mental health counselor, and, for those who attended the intensive workshop, time with a peer health educator. Workshop participants received far more support (13.4 hours) than other patients (2.2 hours).

Participants in the *Su Salud* program saw their HbA1c levels drop from an average of 9.1 to 8.4. The cost of the intervention was relatively low, with much of the expense coming from staff time spent working with patients. Many interactions were carried out by community health educators, who are less expensive than other staff.

The evaluation found that nearly all program participants were entered into the registry and screened for depression; about 3 percent had a high depression score and were referred to mental health services.

Su Salud's leaders considered the workshop the most successful piece of the program. Other useful innovations included an action-plan tool that provides a simple approach to help patients set goals for such behaviors as walking, eating, and taking medications; a nurse case-manager tool that facilitates chart review and the ordering of lab tests for patients who miss appointments or fall out of care; and the use of a health educator both during and following the clinician visit to complete follow-up care and improve continuity across providers.

Given the improved lab results of participants, program leaders considered the *Su Salud* program an overall success. They found that while clinicians were eager to participate, they need more training to help with goal-setting. The program's leaders also found that case management and data entry are both essential and costly.

Key Lessons

This program was successful in involving many members of the staff—professional, nonprofessional, and lay people—in engaging patients to become better self-managers. As a result, patients heard similar messages from all the different people they encountered in the clinic, and clinic staff was imbued with a new self-management support culture, which could build on itself as staff members collaborated in providing self-management support. In a number of organizations, the *Tomando Control* classes have been unable to attract participants; Oscar A. Romero's success in getting patients to take part may have been due to many different people in the clinic recommending the workshops.

Community Health Alliance and the Humboldt-Del Norte IPA

CREATING CONFIDENCE IN CHRONIC CARE PROJECT

The Humboldt Diabetes Project is a community-wide effort to improve care for the 10,000 people with diabetes in the mostly rural Northern California counties of Humboldt and Del Norte. The project, known as Creating Confidence in Chronic Care, focused on improving support for self-management in diabetes patients, with an emphasis on the patients who use the five safety-net clinics known as the Open Door Community Health Centers (ODCHC). Within that network, about 35 primary care providers serve 1,700 diabetes patients.

The Creating Confidence program included clinician education, patient action plans, depression screening, patient education classes and community-based services. An all-day conference was attended by 140 clinicians;

lunchtime presentations were held at four of five ODCHC's attended by 40 staff; and work continued with clinician champions. The educational effort focused on helping clinicians deliver care that is more patient-centered, teaching techniques for motivating patients, and helping them create action plans.

Safety-net clinics in the project trained medical assistants in administering the PHQ-9 checklist tool to screen diabetes patients for depression. Because depression is commonly associated with diabetes, and because patients with depression have a far more difficult time controlling their diabetes, depression screening and treatment is an important part of self-management support for the control the disease.

Results

A four-session diabetes education class was in place prior to this project. The classes were improved by holding them at the safety-net clinics rather than a hospital, targeting patients with high HbA1c levels, and allowing patients rather than instructors to set the agendas for the classes. Patients were also offered a class called "Take Charge" that empowered them to get more involved in their medical care or participate in a support group. While patients expressed strong satisfaction with the classes, the number of patients who took them did not increase significantly. However, depression screening increased over the 18 months from 1 percent of patients to 33 percent.

As a result of the project, 50 percent of patients with diabetes in the five community health centers agreed on self-management goals and action plans, compared to an average of 20 percent for other primary care clinics in the community.

Key Lessons

This project built upon the foundation of previous diabetes improvement work, with a focus on depression screening and behavior-change action plans. While it

was successful in increasing the depression screening rate substantially, the impact of that success on patients' depression symptoms or their diabetes control was not determined. However, the first step in treating depression is recognizing it, and the project was successful in greatly increasing the awareness of this problem. The project also demonstrated that medical assistants can take on new functions, such as depression screening—a task that can be incorporated into the assistants' role in the clinic visit process with relative ease.

Latino Health Access, Orange County

EXTENDED CARE PROGRAM—*PROMOTORES*

Latino Health Access (LHA) is a center for health promotion based on the *promotor* model, which emphasizes intensive case management by Spanish-speaking peer health educators. It is a community organization, not a health care provider. Its clients receive care in several Orange County facilities.

The program enrolled 255 patients who had graduated from its 12-week diabetes class. Each *promotor* closely managed 14 to 42 patients, depending on the *promotor's* availability. Participants received a large amount of one-on-one support, totaling about 15 hours.

To support their clients' efforts to become more active in controlling their diabetes, the *promotores* visit them at their homes, meet them at LHA, or call them on the phone. The *promotores* also remind patients to pursue needed medical care and teach them how to interact with doctors and obtain information. Sometimes such support includes helping clients with their transportation, setting up appointments, and accompanying them to medical visits. This one-on-one intensive support is particularly important for patients who speak only Spanish, have no insurance, and have a difficult time navigating the health care system.

Results

Program leaders concluded that the relatively high cost of the program resulted from the large amount of one-on-one support that participants received. The amount of effort it took to enroll and train patients was high, averaging about ten contacts per patient.

However, there were also measurable improvements in participants' health. The percent of clients with an HbA1c below 7 increased from 19 percent to 29 percent; the percent with an LDL level below 100 went from 55 percent to 62 percent, and those with blood pressure below 130/80 increased from 34 percent to 44 percent.

The program also affected how patients kept track of their health. The greatest improvement was in the percent of participants who monitored their glucose levels through HbA1c tests—the number of patients who had been tested at least twice within the past year increased from 41 percent to 80 percent. There was also a significant increase in the percent of clients who reported writing down test results or asking their doctor for a copy of results—a figure that jumped from 10 percent to 80 percent. More patients learned to keep track of their lab results and other clinical services, with some using a personal folder provided by LHA called a *Carpeta Roja* (Red Carpet). However, clients reported little change in their self-care knowledge or confidence levels.

Program leaders learned through the initial groundwork phase of the project that this planning period required more time than expected, as well as extra attention to documentation and developing a database.

During implementation, it became clear that training patients is very time consuming because of the patients' inflexible schedules, the constant changes in their lives, and financial difficulties. The *promotores* adapted their own schedules to connect with clients during nights and weekends, and maintained a 90 percent retention rate.

Those clients who dropped the program often did so because they were leaving the country.

Key Lessons

In an extremely vulnerable population, this project achieved great success—though the intensity of effort given to each patient was at times extreme and would be difficult for many organizations to sustain. LHA has shown that with intense effort, excellent results can be achieved outside the confines of a medical practice. The project demonstrated the value of *promotores*, who are trusted because they are very much like the patients they are assisting. In situations in which many organizations would have given up on a patient or simply not tried very hard, LHA persisted and the persistence paid off. However, resource use per patient was high. Programs may want to consider further stratifying patients, placing their initial focus on those with high HbA1c counts, LDL cholesterol levels, or blood pressure readings as a way to effectively manage scarce resources.

San Mateo Medical Center, San Mateo

CELL PHONE PROJECT FOR ASTHMATIC CHILDREN

San Mateo Medical Center is the public hospital and safety-net provider for San Mateo County. Along with services provided at the main hospital, the county operates a network of nine outpatient primary care clinics.

This project focused on improving asthma care for school-age children in three of the outpatient clinics. As part of a multifaceted program, the clinics gave 30 patients cell phones loaded with a software application that allowed them or their parents to interact daily by phone with a clinic case manager and medical provider. The children chosen for the cell phone project were between the ages of 5 and 18 and had severe or persistent asthma. Most were Latinos, Pacific Islanders, or African Americans, and most qualified for Medi-Cal or other public health insurance programs.

The clinics worked with a mobile technology software firm to tailor a care management application to meet the needs of providers and patients, creating screen instructions, information, and graphics in both Spanish and English. This allowed patients to enter daily measurements—such as peak air flow, symptoms, inhaler use, missed school days—and receive feedback on the cell phone screen. The entries were uploaded to the software firm's Web portal for monitoring by the clinic team, and also to the clinics' asthma registry for trend analysis and care planning.

The goal of the cell phone self-management project was to help this group of young patients better understand how to manage their asthma and to reduce asthma exacerbations, emergency room visits, and hospitalizations.

Along with the use of the cell phones, the project focused on developing asthma action plans for each child. A case manager and community worker directed the program. Case management was considered crucial to the program's success. Two asthma teams composed of primary care physicians, nurses, and case managers were trained. Group medical visits were also instituted, with patients offered two visits of one hour each, facilitated by a case manager or community worker.

Results

The intervention involved a number of components, including group medical visits, case management services, an asthma registry, and a cell phone application. Twelve group medical visits were held in the two clinics with 50 children attending. To address turnout issues, a physician was added towards the end of the visit, which helped boost participation rates from 20 percent to 50 percent. Case management was primarily provided via telephone and in-person visits. However eight children had home visits to assess environmental factors.

In developing the registry it was discovered that 600 children aged 5 to 18 were eligible for inclusion due to their asthma diagnosis. Case managers and community workers used the registry reports and tools to help organize patients. However, by the end of the intervention, the data was still not being used to actively manage patients because the data entry and implementation logistics were still being worked out.

The majority of the grant period was spent co-developing a user-centered cell phone interface (in English and Spanish) for children with asthma. Due to challenges with providing cell phones and cell phone service, only 30 children made use of the phones during the grant period. Despite the typical start-up problems inherent to any new technology, the cell phone intervention showed a great deal of promise and worked well for children who received the cell phones. No children who were part of the cell phone project needed emergency room visits or hospitalization during the entire study period.

Key Lessons

This program brought asthma self-management skills to children and teens through a medium central to their culture—the cell phone. Since many teens are not interested in going to health clinics, this approach seemed to work for them. However, it also turned out to be a challenge: numerous technological glitches slowed down the program, which meant that it yielded only minimal results. Eventually the cell phones did what they were supposed to do in helping children and teens manage their asthma, adding a useful tool to the growing list of telemedicine interventions for chronic disease care.

UC Davis Chronic Disease Management Center

ASSESSING THE READINESS OF DIABETES PATIENTS TO CHANGE THEIR BEHAVIOR

The Chronic Disease Management Center at the University of California, Davis worked with hospital-based internal medicine and endocrinology clinics to reach both medical resident trainees and patients to

improve self-care for patients with diabetes. Internal medicine residents were provided with instruction on self-management concepts that they could use with their patients. Meanwhile, patients were assessed for their readiness to change health behaviors with the help of a clinical psychologist and health coach. The psychologist and coach developed individualized action plans for each patient, with the coach providing follow-up and support.

The physician training involved 66 residents and fellows in the university medical school's internal medicine residency program. They attended at least one of three 40-minute group training sessions. Thirty of the residents had at least one individual consultation with the health psychologist in the internal medicine clinic. The clinical psychologist also developed and introduced new curricular content on self-management.

Results

One hundred patients were enrolled, and were seen for two to three months, receiving about one-and-a-half hours of additional services. It was difficult to enroll as many patients as the project's leaders had intended because pool of diabetes patients who are seen by residents turned out to be smaller than they had expected.

Diabetes patients with HbA1c levels above 8 were assessed using a questionnaire asking about self-care behaviors, readiness to change, depression, and quality of life. The psychologist reviewed the questionnaires, met with the physician to discuss them, explained the physician's recommendations to the patients, and collaborated with the patients to develop an action plan to address the patient's own goals. The patient meeting was sometimes held by or with the health coach.

While surveys before and after the intervention offered no statistical evidence of improvement in the patients' skills (possibly because of a small sample size), the doctors reported that they appreciated the help of the health coach and availability of tools such as a depression

screening questionnaire. At the same time, the feedback made clear that it is difficult to fit another training obligation into residents' already full schedules.

Project leaders concluded that the best way to reach residents is in small groups, and the best way to reach a struggling patient is one-on-one interaction with both the health psychologist and doctor. They also found that shorter assessment tools work better.

Key Lessons

Improving care in a teaching clinic is both important and challenging. Integrating a health psychologist into the clinic workflow proved difficult. Continuity of care was a problem as residents rotated in and out of the clinic. Using a psychologist also proved to be an expensive way to add a self-management component to a clinic.

Summary and Conclusions

In delivering each of the seven components of self-management support, primary care practices need to decide three things: How do we do it? Who does it? When should it happen? To accomplish all this within 12 to 18 months is extremely difficult. Yet the six projects described here did provide some lessons that allow some answers to emerge on how to tackle this daunting task.

All six projects provided information to their patients. The Alameda Alliance project on asthma is an excellent example of the need to train clinic staff to assist patients in learning the disease-specific skills of using inhalers and spacers and asthma action plans. A number of the grant recipients, particularly those working with diabetes patients, emphasized healthy behavior change using goal-setting and specific action plans. The Humboldt-Del Norte and UC Davis programs focused on the emotional impact of having a chronic condition as part of their work on depression. The Oscar A. Romero clinic, Latino Health Access, and San Mateo Medical Center were perhaps the most persistent in encouraging patients to take an active role in the management of their chronic

condition and in providing intensive follow-up, spending a considerable amount of time with some of their patients. To initiate and integrate all seven components of self-management support into the clinic culture in the course of a 12- to 18-month period is more than can be expected.

The solution to the problem of how best to provide self-management support varied widely among the programs, with the extremes being the high-tech approach of San Mateo County's cell phones versus the high-personal-touch philosophy of Latino Health Access. Different patients will respond to different modes of interaction. In some cases, such as the Oscar A. Romero and San Mateo projects, many patients responded well to a group setting, but this mode of providing self-management support does not work well for all patients. A spectrum also exists between programs that emphasize concrete disease-specific skill development (Alameda Alliance, for example) and those that emphasize assisting patients in learning to live with their chronic condition (e.g. Oscar A. Romero).

The question of who provides self-management support was answered differently by different projects. A number used peer educators/*promotores*. Others relied on medical assistants, nurses, coaches, or professional caregivers. Generally, physicians alone could not integrate self-management support activities into their demanding clinical priorities; someone else is needed to take that responsibility. Often, the issue of "who" is answered by determining who is available in a particular setting, who is interested in doing this kind of work, and who is provided with the necessary training. Sometimes the best way to start to integrate self-management support into a primary care clinic is to focus on training, then see who comes forward with enthusiasm during the training sessions.

The answer to the question of when to provide self-management support also varied greatly among the six projects. San Mateo County, to some extent, allowed

the patients to determine when an interaction would take place; patients responded to the messages from the software application or would call the case manager on the cell phone. The Alameda Alliance program, concentrating on training of office staff, did not confront that issue, but offices implementing the training would likely have office staff teach asthma skills immediately before or after a physician visit. Humboldt-Del Norte IPA trained medical assistants to perform depression screening as part of a provider visit, while also offering the option of separate education classes. Latino Health Access, which is not a provider-based program, brought self-management support into patients' homes or incorporated it into the process of accompanying patients to medical appointments. Oscar A. Romero may provide the most important lesson regarding both who should do self-management support and when should it be done: The answer is that everyone should do it and it should happen as frequently as possible.

While patient self-management is essential for improving health and quality of life, health systems continue to struggle with the problem of identifying systematic, sustainable interventions. However, the results of the six projects summarized here demonstrate that it takes a team of providers and peers to help patients gain the skills, confidence, and knowledge to be successful in managing a chronic condition.

FOR MORE INFORMATION CONTACT

California HealthCare Foundation
1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org

AUTHOR

Thomas Bodenheimer, M.D., adjunct professor in the Department of Family and Community Medicine at the University of California, San Francisco.

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