Objectives

1. Present an overview of the concept of self management
2. Differences between SM education and traditional patient education
3. Discuss the Stanford model and programs
4. Describe the CPSMP and evidence from research studies
What is Self-Management?

“The individual’s ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition”.

(Barlow et al, 2002)
History of self-management

- First coined in the 1960’s by Tom Creer, a pediatrician in Denver, to denote a patient’s active participation in day-to-day treatment.
- Emerged as a major research priority in the 1980’s following prevalence studies of the rapid rise in chronic illness in the two previous decades.
- Realization that standard health care delivery models of acute care were too narrow in scope to address chronic conditions.

Holman & Lorig, 2004
Critique of traditional patient education

- Scope of education: focuses on technical self-care skills & specific disease-related information. This is not enough to handle complexity of impact of chronic disease.
- Client is a passive recipient of information – little active involvement
- Lacks adequate complexity to address the multiple tasks of long term conditions and co-morbidity
Tasks in all chronic conditions

- Individuals will need to self-manage day-to-day:
  - medical treatment
  - symptoms
  - physical, emotional & social impacts
  - lifestyle changes
Impact

- Deep distress
- Functional limitations
- Depression
- Sleep problems
- Low self esteem
- Job change or job loss
- Change in social relationships
- Effects on the family

Brevik et al. (2006); Boulanger et al. (2007)
Five Core Self-Management Skills

- Problem-solving
- Decision-making
- Using resources
- Partnerships HCPs
- Taking action for change
What is Self-Management Education?

- Programs, based on adult learning principles, that provide patients/clients with the five core skills needed to live an active and meaningful life.

- The goal is to maintain a wellness focus in the foreground, even in the midst of a chronic condition, to improve quality of life (Lorig, 2003).
Why is self-management so important?

- Patient SM is **inevitable**.
- Outcomes are better when patients are **actively involved**, have skills to deal with the consequences of chronic conditions, and believe in their ability to do so (self-efficacy).
- The professional’s role is to be in **partnership with the patient**.
  - Professionals are experts about diseases and treatments; patients are experts about their own lives.
Self-Management Education: Underlying Principle

Active self managers are willing to learn about and take responsibility for daily management of their chronic condition and its consequences and are able to:

- Take care of overall health
- Carry out normal activities and roles in life
- Manage emotional changes
Types of Stanford SM Programs

- ASMP – arthritis only
- CDSMP – chronic diseases (respiratory, heart disease, hypertension, diabetes, and arthritis)
- DSMP - diabetes only
- Positive SMP – HIV/AIDS
- CPSMP – chronic non-cancer pain (LeFort, 1996; 2006, LeFort & Webster)
Theoretical base for Stanford Model - Theory of self-efficacy

- Developed by Albert Bandura, a social psychologist, at Stanford

- “The exercise of human agency through people’s beliefs in their capabilities to produce desired effects by their actions”

- not just knowing ‘what to do’, but belief in one’s ability to organize and integrate cognitive, social, & behavioral skills to achieve control over everyday circumstances
Self-efficacy enhancing strategies

- **Skills Mastery** - the opportunity to practice skills in a supportive environment

- **Modelling** - peers are role models for other - "If they can do it, I can do it"

- **Reinterpretation of symptoms** - cognitive reframing; examination of illness-related beliefs

- **Social Persuasion** - gentle support and encouragement from peers, family, friends, HC providers
Process elements of all Stanford Programs

- Mini-lectures
  - information sharing

- Self-reflection — sharing of feelings
  - about how chronic illness affects their lives, how it affects communication, etc.

- Quiz
  - addressing common mis-beliefs

- Brainstorming
  - about benefits of exercise, symptoms of depression
Process (cont.)

- Setting weekly action plans
  - learning the process of setting short term goals
- Feedback
  - about how well they are doing (verbal & written)
- Group problem-solving
  - dealing with difficult emotions, solving problems that arise with the action plan
- Telephone support mid-week
Chronic Pain
Self Management Program

- Standardized program
- Community-delivered
- 10-16 people per group
- 2.5 hrs /wk for 6 weeks
- Train-the-trainer model of dissemination
- Leaders – Peers or HCPs
- Pain workbook and exercise audio CD
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<th>CPSMP Program</th>
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## PAIN SELF-MANAGEMENT TOOLBOX

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<tr>
<th>Physical Activity/Exercise</th>
<th>Problem-Solving</th>
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<tr>
<td>Managing Fatigue</td>
<td>Using your Mind</td>
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<td>Pacing &amp; Planning</td>
<td>Healthy Eating</td>
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<td>Relaxation &amp; Better Breathing</td>
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<td>Medications</td>
<td>Understanding Emotions</td>
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<td>Working with Health Professionals</td>
<td>Finding Resources</td>
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110 people, randomized to the SM CPSMP treatment group (N=57) or the wait-list control group (n=53)

- Mean age: 40 yrs (24 – 60 yrs)
- % female: 73 %
- % working: 38 %
- Neck/back pain: 68 %
- Pain duration: 6.5 yrs
- Recent visit to HCP: 62% in past 30 days
Results at 3 months

- Statistically significant improvement in health status measures (pain, disability, dependency on others, self-efficacy and resourcefulness, social and physical functioning, mental health, and life satisfaction)
- Results comparable to studies of other pain programs in the literature
- Results supported the role of confidence building and problem solving
RCT #2 (2003)

- Larger study in varied rural and urban sites (Ontario, Newfoundland and Saskatchewan)
- Facilitators were community-based nurses and allied health professionals
- Baseline, 3 and 12 month data collected on major study variables and monthly Pain Care Diaries to track economic costs
Participant characteristics (n=207)

- Mean age: 48 yrs
- % female: 80%
- % Working: 31%
- Mean pain duration: 9 yrs
- % back or neck pain: 75%
- Recent visit to a health care provider: 90%
At the end of the CPSMP
What they said

- Having their voice heard
- Knowing they are not alone
- Sharing with others who understand
- Being in a ‘safe’ environment
- Taking ownership of their pain
- Learning from others/helping others
- Hope/direction
Dissemination and other research

- CPSMP being delivered in parts of Canada, the USA, Denmark and Australia
- Supports results from pilot studies done at Queen’s University, Canada
- Evaluation of first 71 Danish participants found significant reductions in pain catastrophizing and functional limitations & perceived overall benefit.
- Danish health department conducting an RCT across 25 municipalities (n=500) in 2011/2012 with peer facilitators
Acknowledgments

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- Dr. Kate Lorig, Stanford Patient Education Research Centre ([http://patienteducation.stanford.edu](http://patienteducation.stanford.edu))


