SELF-MANAGEMENT:
A Background Paper

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Self-Management often means different things to different people – and sometimes different things at different times even to the same people.

This handout for delegates at the *"New Perspectives: International Conference on Patient Self-Management"* provides background on use of the term *self-management* and describes how it was used in the planning. Throughout this background paper, the term will be used in the context of persons living with one or more chronic health conditions and will focus on what various stakeholders can do to facilitate self-management.

This paper will further clarify *self-management* by addressing a few of the common ambiguities that have contributed to confusion, specifically: self-management as process or outcome; similarities and differences between patient education and self-management education; engaging patient self-management; and effective training techniques.

DEFINING SELF-MANAGEMENT

To date there is no "gold standard," universally accepted definition of **self-management**. Rather, several terms are used, sometimes interchangeably, depending on the context and focus of the discussion. These include: self-management preparation/training; patient empowerment; and self care. Although generally they are meant to describe a similar phenomenon, the terms imply varying specification regarding attributes, roles and responsibilities of both people with chronic health conditions and health care providers.

To illustrate the scope of "self-management related concepts", self-management is said to take place when the individual participates in treatment (Creer, 1976), or when the individual participates in a certain type of education, such as interdisciplinary group education based on principles of adult learning, individualized treatment and case management theory (Alderson, Starr, Gow, & Moreland, 1999).

Others have defined self-management as a treatment intended to bring about specific outcomes: "a treatment that combines biological, psychological and social intervention techniques, with a goal of maximal functioning of regulatory processes" (Nalagawa-Kogan, Garber, Jarrett, Egan, & Hendershot, 1988).

Redman (2004) defines self-management preparation as referring to the

> training that people with chronic health conditions need to be able to deal with taking medicine and maintaining therapeutic regimes, maintaining everyday life such as employment and family, and dealing with the future, including changing life plans and the frustration, anger, and depression. (p. 4)

Lorig (1993) defined self-management as "learning and practicing skills necessary to carry on an active and emotionally satisfying life in the face of a chronic condition" (p. 11). Lorig further emphasized that self-management is not an alternative to medical care. Rather, self-management is "aimed at helping the participant become an active, not adversarial, partner with health care providers".

The Expert Patient Approach (National Health Service, UK, 2001) uses the term self-management to refer to "any formalized patient education programme aimed at providing the patient with the information and skills necessary to manage their condition within the parameters of the medical regime" (p. 22). Further, these programmes "are based on developing the confidence and motivation of the patient to use their own skills, information and professional services to take effective control over life with a chronic condition" (ibid).

Alternatively, self-management has been defined as practicing specific behavior and having the ability to reduce the physical and emotional impact of illness, regardless of the degree to which the individual participates in the education/treatment or the type of education/treatment received: Gruman and Von Korff (1996) write that "the individual engages in activities that protect and promote health, monitors and manages symptoms and signs of illness, manages the impacts of illness on functioning, emotions and interpersonal relationships and adheres to treatment regimens (p. 1). Or, according to Glasgow, Wilson, and McCall (1985), self-management is used to describe the cluster of daily behaviors that patients perform to manage their chronic condition.

Further, self-management is said to take place when the individual engages in particular behaviors that control or reduce the impact of disease but in collaboration with healthcare providers. Self-management is understood as:

> the day-to-day tasks an individual must undertake to control or reduce the impact of disease on physical health status. At-home management tasks and strategies are undertaken with the collaboration and guidance of the individual's physician and other health care providers. (Clark, Becker, Janz, Lorig, Rakowski, & Anderson, 1991, p. 5).

In another vein, self-management is referred to as individual abilities, regardless of how they were acquired and does not specify a relationship with healthcare providers:

> self-management refers to the individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and life style changes inherent in living with a chronic condition. Efficacious self-management encompasses ability to monitor one's condition and to effect the cognitive, behavioral and emotional responses necessary to maintain a satisfactory quality of life. Thus, a dynamic and continuous process of self-regulation is established (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002, p.178).

As illustrated, self-management has been defined as:

- participating in education/treatment or treatment designed to bring about specific outcomes;
- preparing people to manage their health condition on a day-to-day basis;
- practicing specific behaviors; and

- having the skills and abilities to reduce the physical and emotional impact of illness with or without the collaboration of the health care team.

The definitions of the terms **empowerment** and **self-care** are also relevant to the definitions of self-management.

Robbins, Chatterjee, and Canda (1998) define empowerment as the "process by which individuals and groups gain power, access to resources and control over their own lives" (p. 1). Zimmerman (2000) sees empowerment as a multi-level construct involving participation, control and critical awareness. Processes are empowering if people are able to develop skills that allow them to problem solve and make decisions. Outcomes refer to the operationalization of empowerment, and can include situation-specific perceived control, skills and proactive behaviors.

Funnell, Anderson, Arnold, Barr, Donnelly, Johnson, Taylor-Moon, and White (1991) see empowerment as a vision or philosophy, rather than a technique or strategy. Health professionals cannot empower a patient, but can use strategies that will assist patients to achieve this. Empowerment is a patient-centered collaborative approach where professionals and patients are equals. They define patient empowerment as helping patients discover and develop the inherent capacity to be responsible for one's own life. An empowered patient is one who has the knowledge, skills, attitudes and self-awareness necessary to influence their own behavior and that of others to improve the quality of their lives (ibid). The role of the patient is to be well-informed active partners or collaborators in their own care, while the role of the professional is to help patients make informed decisions to achieve their goals and overcome barriers. Empowerment is fundamentally an outcome of patient education. Self-management education is a patient empowerment strategy, "the essential foundation for the empowerment approach" (Funnell & Anderson, 2004, p. 124).

The term **self-care** is also problematic. Some define it as the actions and decisions an individual takes to capture or maintain a desired level of health independent of interaction with a health professional (Clark et al., 1991), while others view self-care as interactive with the health care system rather than being independent of professional care (e.g., Hickey, Dean, & Holstein, 1986). In any case, even if the term self-care has a similar definition to self-management, Clark (2003) believes that "it is not an appropriate term for chronic disease management given that most conditions demand the full involvement of medical practitioners and of accepted therapeutic regimes" (p. 292).

Definition for this Conference

As shown above, defining self-management is strategic within different contexts, and therefore one needs specificity in usage. In planning the *New Perspectives: International Conference on Patient Self-Management,* we found the definition provided by Adams, Greiner, and Corrigan (2004, p. 57) to be most helpful. Therefore the definition, as adapted for use at this conference, is:

Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management.

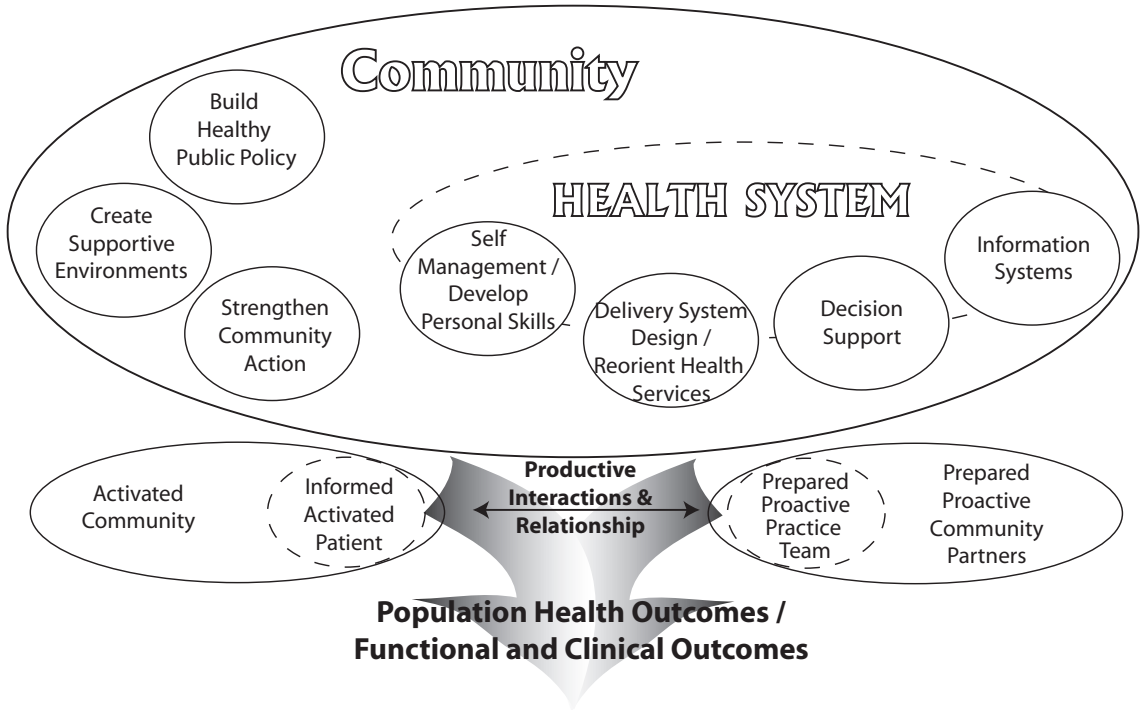
This definition envisions self-management as behaviors, but includes the notion of "confidence" and embraces medical management (a primary concern of healthcare providers) as well as role and emotional management by the individual. It provides greater clarity in that the definition focuses on the person with the chronic condition, and further introduces Adams, Greiner, and Corrigan's (2004) concept of "self-management support," which specifies what health care providers can do to encourage self-management.

> "Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support" (p. 57).

By articulating "self-management" as behaviors and confidence to deal with medical, role, and emotional management and by using the term "self-management support" to describe what health care providers can do to facilitate it, Adams, Greiner, and Corrigan (2004) have brought greater clarity to the picture.

Another factor supporting the decision to use this definition of self-management is that it is congruent with the concept of "self-management support" incorporated into the Chronic Care Model (Wagner, Austin, & Von Korff, 1996). The model has been implemented through the Chronic Illness Breakthrough Series conducted by the Institute for Health Care Improvement (Wagner, 1998). In British Columbia, the model has been modified and re-named The Expanded Chronic Care Model (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).

THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION



The model involves two overlapping realms, the community and the health care system, with self-management support as one of the four essential components within the health care system. "Self-Management / Develop Personal Skills" refers to "the support of self-management in coping with a disease, but also to the development of personal skills for health and wellness" (Barr et al., 2003, p. 77).

Ultimately, the model posits that when "Informed Activated Patients" interact with a "Prepared, Proactive, Practice Team" the result is improved "Functional and Clinical Outcomes". To encourage these outcomes, health authorities provide inputs to strengthen and maximize the efficiency of each component – including Self-Management Support.

In addition to local and provincial health departments, Self-Management Support is also provided by other constituents. The diagram places the definition of self-management in the middle and locates several bodies with responsibility for self-management support around the circumference. Several initiatives are currently underway involving family physicians, provincial telehealth services, community lay-led programs, universities and health professional training associations.

OTHER RELEVANT TERMS

Four other commonly used terms in relation to self-management have ambiguities that contribute to confusion, specifically: self-management as a process or outcome; similarities and difference between patient education and self-management education; engaging patient self-management; and effective training techniques.

Self-management - process or outcome

Self-management can be either a process or an outcome. With process, the term is used to describe the type of training (e.g., self-management education, self-management preparation) provided to people with chronic health conditions. Essential elements of the training should include Mastery Learning and Problem Solving (The Robert Wood Johnson Foundation and The Centre for Advancement of Health, 2001). A range of tutors deliver self-management training, the majority being health professionals (Barlow et al., 2002). However, the Stanford self-management programs are delivered by trained lay persons.

When self-management is referred to as an outcome, it usually connotes people with chronic health conditions having achieved the knowledge, skills, and confidence to manage their health and engage in particular behaviors relating to medical, role, and emotional management. These "outcome" behaviors and confidence are brought about through the training process.

Patient education and self-management education

One aspect of "Self-Management Support" (Adams et al., 2004) focuses on the educational strategies and techniques used by health professionals and lay-persons. Within this area, the distinction between the type of patient education delivered by health professionals and educators is sometimes blurred with the type of education known as self-management education. Both types of education are essential in assisting the individual achieve the best quality of life and independence; the intent is to compare and contrast their attributes.

In some instances, self-management education has been defined as meaning the same as patient education. For example, Clement (1995) argued that "the term self-management education emphasizes the need for people with diabetes to manage their diabetes on a day-to-day basis. For this reason the terms *diabetes education* and *self-management education* will refer to the same process" (p. 1204). Therefore, Clement considered "treatment behaviors," which are the major focus of traditional patient education, to be synonymous to self-management behaviors because it was the individual (i.e., the self) who would practice them. Treatment behaviors for diabetes include: self-injection of insulin; self-monitoring of glucose levels; eating properly; smoking cessation; exercising; and taking medications properly. By practicing these behaviors there is an expectation that intermediate goals will be achieved (i.e., metabolic control, optimal blood glucose levels, blood lipid control, and achieving and maintaining a healthy weight). And, if these intermediate goals are achieved, there should be better diabetes outcomes: a reduction in morbidity (retinopathy, neuropathy, nephropathy), fewer hospitalizations, a reduction in diabetes-related health care costs, and reduced mortality.

One cannot minimize the benefits of this type of education, whether it is referred to as patient education or self-management education, in that there is strong evidence linking these behaviors to diabetes outcomes. (Corabian & Harstall, 2001; Peyrot, 1999; McLeod, 1998; Brown et al., 1996; Brown, 1992; Brown, 1990; Brown, 1988; Padgett, Mumford, Hynes, & Carter, 1988).

More recently, the major differences between patient education and self-management education have been delineated by Bodenheimer, Lorig, Holman, and Grumbach (2002).

- Traditional patient education provides information and teaches technical disease-related skills whereas self-management education teaches skills on how to act on problems.
- Problems covered in traditional patient education reflect widespread common problems related to a specific disease whereas the problems covered in self-management education are identified by the patient.
- Traditional patient education is disease-specific and offers information and technical skills related to the disease. In comparison, self-management education provides problem-solving skills that are relevant to the consequences of chronic conditions in general.
- Traditional patient education is based on the underlying theory that disease-specific knowledge creates behavior change which in turn produces better outcomes. Self-management education, in contrast, is based on the theory that greater patient confidence in his/her capacity to make life-improving changes yields better clinical outcomes.
- The goal of traditional patient education is "compliance" whereas the goal in self-management education is increased self-efficacy and improved clinical outcomes.
- In traditional patient education the health professional is the educator, but in self-management education educators may be health professionals, peer leaders, or other patients.

Engaging self-management

Both health care providers and persons with chronic health conditions can engage in self-management. Health care providers engage by learning and then practicing strategies and techniques that are effective in promoting self-management. Persons with chronic health conditions engage by participating in community self-management programs and by working collaboratively with their health care providers.

It follows that the chances of getting persons with the chronic health conditions to a state where they engage in healthful behaviors and have the confidence to manage the medical, role, and emotional aspects of their condition are maximized when both partners are involved. This constitutes the ultimate objective of self-management training.

Effective self-management training/education techniques

Using the definition of self-management developed by Adams et al. (2004), the goal of self-management training/education is that people will have the confidence to deal with medical management, role management and emotional management of their condition. To achieve this goal, the training should teach people:

- ways to access the information they seek;
- ways to ensure they are proficient in carrying out both medically-related behaviors (e.g., insulin injection, using an inhaler) and non-medically related behaviors (e.g., interacting with one's doctor, exercising);
- ways to enhance their levels of confidence (i.e., perceived self-efficacy) in their ability to engage in these behaviors; and
- ways to ensure they are proficient in problem-solving.

Self-management training can take place on a one-to-one basis between the individual and his/her health care provider, or in group settings led by either health providers or lay persons. This training should encourage people to: identify problems, figure out their barriers and supports, generate a solution, and develop a long and short-term goal (i.e., an action plan). Ways to monitor and assess progress (e.g., personal contact, telephone, mail, e-mail) towards reaching goals need to be developed, and if the person is not successful, the problem-solving process can be repeated and new or re-adjusted short term goals can be developed.

The work of Albert Bandura has made a significant contribution to the field of self-management, particularly by articulating strategies and techniques that influence beliefs in people's capabilities to engage in behaviors. Bandura defined self-efficacy as "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances" (1986, p. 391). The key contentions regarding the role of self-efficacy beliefs, defined in human functioning is that *"people's level of motivation, affective states, and actions are based more on what they believe than on what is objectively true"* (Bandura, 1997, p.2). The process of developing long and short-term goals is known as "Guided Mastery" experiences and serves as the major means for developing and expanding behavioral competencies (Bandura, 1986), and is an effective technique for raising individuals' self-efficacy. Findings from diverse lines of research reveal that perceived self-efficacy affects every phase of health behavior change, whether people even consider changing their health behaviors, how much they benefit from treatment programs, how well they maintain the changes they have achieved, and their vulnerability to relapse (Schwarzer,1992; Holman & Lorig, 1992; Maddux 1995). Evidence also exists that self-efficacy mediates the effects of psychosocial programs on health status (O'Leary, Shoor, Lorig, & Holman, 1988; Bandura, 2000).

In conclusion, this background paper illustrates the differences in the ways the term self-management is used and implemented. These variations, however, should be considered as a positive and an expected trend, just as this happens in any area of growth. The objective of the paper is to clarify the use of the self-management by addressing the common ambiguities that have contributed to confusion and suggest a more functional definition for general use at this conference. A general consensus on terminology provides a more efficient framework for interaction and collaboration among administrators, health care providers, researchers, and people experiencing chronic health conditions.

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