Hva bør primærhelsetjenesten gjøre for å støtte pasientenes egenmestring?

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Teaser

- Korte opplæringstiltak i spesialisthelsetjenesten eller i kommunene er ofte ikke nok.
- Mange pasienter trenger lengre strukturerte opplegg for mestringsstøtte og forholdene ligger best til rette for det i kommunene.
- Men hvordan kan helsepersonell og pasienter samarbeide best mulig på en evidensbasert og strukturert måte? Og hvordan kan dette arbeidet integreres i kommunal klinisk praksis?
- Funnene fra en artikkel som har oppsummert forskningen på dette feltet vil bli gjennomgått, og det vil bli rom for diskusjoner om samarbeid mellom spesialisthelsetjenesten og primærhelsetjenesten.

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Bakgrunn

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Bakgrunn: Antallet kroniske sykdommer øker med alder

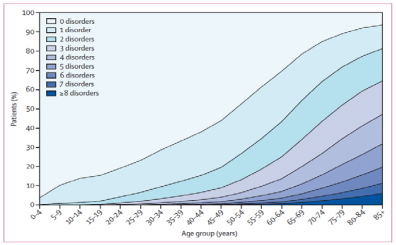
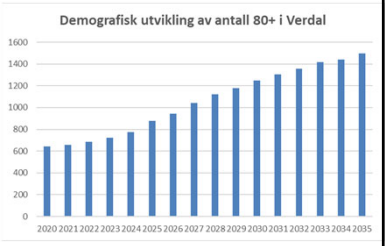


Figure 1: Number of chronic disorders by age-group



Barnett et al. Lancet 2012

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Likevel friskere?

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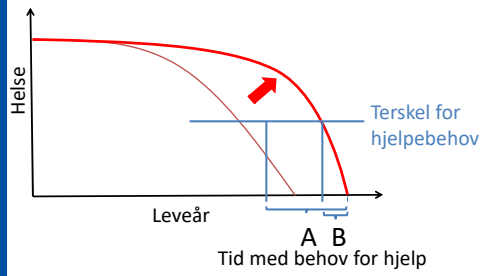
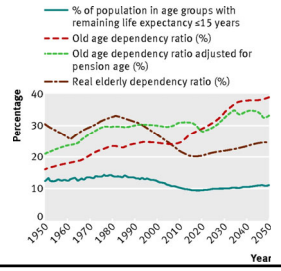
Hjelpebehov kan utsettes



Tid til død sier mer om hjelpebehov enn alder

Andelen med <15 år forventet livslengde går ned



Spijker J, MacInnes J. Population ageing: the timebomb that isn't? BMJ 2013 2013-11-12 23:30:47;347

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Referanse til artikkel:

Dineen-Griffin S, Garcia-Cardenas V, Williams K, Benrimoj SI (2019) **Helping patients help themselves: A systematic review of self-management support strategies in primary health care practice.** PLOS ONE 14(8): e0220116.
https://doi.org/10.1371/journal.pone.0220116

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Self-management support (SMS)

- Definition SMS (støtte til egenmestring)
  1. A portfolio of techniques and tools that help patients choose healthy behaviours, and
  2. a fundamental transformation of the patient-professional relationship into a collaborative partnership
- Objective is to change behaviour within a collaborative arrangement to produce sustainable effects.
  - Increasing patients' skills and confidence in managing their disease state,
  - through regular **assessment** of progress and problems, **goal setting**, and **problem-solving** support

Bodenheimer T, Wagner E, Grumbach K. Improving Primary Care for Patients With Chronic Illness. The Journal of the American Medical Association. 2002a; 288(14):1775–9. https://doi.org/10.1001/jama.288.14.1775

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Generic self-management skills

- Lorig & Holman:
  1. Problem-solving
  2. Decision making;
  3. Resource utilization;
  4. Forming a patient-health care provider partnership;
  5. Taking action.
- Acquisition of these skills leads to increased self-efficacy. Self-efficacy refers
- to beliefs in one's capabilities to execute a behaviour or course of action necessary to reach a desired goal

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Guiding principles for SMS

1. **Informed by evidence** and evolve in response to the needs of the chronic condition population
2. **Centred on the person** or family and reflect the differing goals, needs and preferences of individuals and their differing social contexts
3. **Focused on improving an individual's capacity to be healthy and live well according to their values**
4. Created to be **equal**ly available, appropriate and accessible to all persons with chronic conditions
5. Developed to **promote benefits** and **minimize potential harms**
6. Implemented in ways that **respect an individual's choice, autonomy and rights** to determine their own goals and participation in SMS
7. Embedded in the management and treatment of **chronic conditions**
8. **Integrated** across the continuum of health and community services from prevention to palliative care

Susan L Mills, Teresa J Brady, Janaki Jayanthan, Shabnam Ziabakhsh, Peter M Sargious, Toward consensus on self-management support: the international chronic condition self-management support framework, *Health Promotion International*, Volume 32, Issue 6, December 2017, Pages 942–952, https://doi.org/10.1093/heapro/daw030

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Mål artikkelen

- To summarize the evidence of effectiveness for SMS interventions
- **delivered face-to-face**
- **in primary care practice,**
- and identify evidence-based strategies with active **components facilitating positive** clinical and humanistic patient **outcomes**.
- ***(kun voksne, individuell-ikke gruppe, bare profesjonelle-ikke brukere, sammenlignet vanlig praksis)***

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Definisjon av self-management intervensjoner

- "*Interventions that aim to equip patients with skills to **actively participate and take responsibility** in the management of their chronic condition*.
- *This includes **knowledge acquisition**, and a combination of at least two of the following*:
- *(1) stimulation of independent sign and/or symptom **monitoring**;*
- *(2) **medication** management;*
- *(3) enhancing **problem-solving** and **decision-making** skills for treatment or disease management;*
- *(4) or changing **physical** activity, **diet**ary and/or **smoking** behaviour*".

Jonkman N, Schuurmans M, Jaarsma T, Shortridge-Baggett L, Hoes A, Trappenburg J. Self-management interventions: Proposal and validation of a new operational definition. Journal of clinical epidemiology. 2016; 80:34–42. https://doi.org/10.1016/j.jclinepi.2016.08.001

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Om SMS intervensjonene

- 58 RCT (i 80 publikasjoner)
- 8 land, flest fra UK and US
- Hyppigste tilstander: T2DM (38%), COPD (21%), depression (14%)
  - **Ingen spesifikt på multisyke**
- Steder: general practice (48%), primary care clinics (26%), community pharmacies (10%).
- Personnel: general practitioners or nurses, commonly specialising in areas such as respiratory, diabetes and mental health.
  - 24% primary care teams involving more than one health care professional from different disciplines.

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Multisykdom

	COPD	Heart failure	Stroke	Hip fracture
Antall kroniske sykdommer per pasient (målt som organsystem med kronisk diagnose)	3,6	3,8	3,5	3,6
Andel med to eller flere kroniske sykdommer (%)	91%	91%	89%	85%

Grimsmo A, Løhre A, Røsstad T, Gjerde I, Heiberg I, Steinsbekk A. Disease-specific clinical pathways - are they feasible in primary care? A mixed-methods study. Scand J Prim Health Care. 2018 Jun;36(2):152-160. doi: 10.1080/02813432.2018.1459167

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Opplæring helsepersonell

- 71% of studies included upskilling of HCPs to deliver the intervention.
- Training aimed at enhancing aspects of patient self-efficacy
  - mastery achievements, positive learning, adjustment to stress, verbal encouragement and outcome expectations.
- Core communication skills to build trust and rapport in the patient-provider relationship
  - active listening, non-verbal communication, reflection, empathy and affirmation.
- Provision of HCP resources to support self-management,
  - written material or manuals, feedback on care reports, video demonstrations or case studies, and tools to assess patient support needs and priorities.

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93 different outcome measures

(1) disease specific indicators;
(2) self-efficacy;
(3) health-related quality of life;
(4) functional status and disability;
(5) psychological functioning;
(6) disease knowledge;
(7) behaviours and self-management activities.

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Resultat

Antall studier som har målt, og antall studier med klare positive eller blandede resultat

Komponent	Ant studier	Positive	Andel
self-management activities	9	7	78 %
disease knowledge;	10	7	70 %
disease specific indicators;	45	26	58 %
psychological functioning;	26	12	46 %
health-related quality of life;	24	10	42 %
self-efficacy;	15	5	33 %
Behaviours	9	3	33 %
Physical and social functioning	13	4	31 %

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Components of SMS interventions

1. condition or treatment **knowledge** acquisition;
2. active stimulation of symptom **monitoring**;
3. self-treatment through the use of an **action plan**;
4. enhancing **resource utilization**;
5. enhancing **problem-solving** and/or **decision-making** skills;
6. enhancing **stress** management or **emotional coping** with condition;
7. enhancing **physical** activity;
8. enhancing **diet**ary intake;
9. enhancing **smoking** cessation; and
10. **medication** management or adherence.

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Komponenter brukt

Components	Number of studies in which this strategy is mentioned N (%)
Providing **knowledge** about condition or treatment	58 (100.0)
Stimulation of **physical** activity	27 (47.4)
Enhancing **problem-solving** and/ or **decision-making** skills	27 (47.4)
Self-treatment through use of self-management or **action plan**	26 (45.6)
Active stimulation of symptom **monitoring**	25 (43.9)
Emotional coping with condition or **stress** management	25 (43.9)
Enhancing **diet**ary intake	24 (42.1)
Medication management or adherence	21 (36.8)
Encouraging use of other health services or support **resources**	13 (22.8)
Enhancing **smoking** cessation	13 (22.8)

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13 studier med klar effekt på alle resultatmål

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De mest effektive intervensjonene

- Varighet 4 – 52 uker
- Første konsultasjon 62 minutter
- Oppfølgingskonsultasjon 57 minutter
  - 85% ansikt til ansikt, resten telefon
- I 92% fikk deltagerne støttemateriell
  - manuals, information or educational booklets to work through at home, personalized treatment or action plans, devices and diaries for self-monitoring, goal setting forms or individualized dietary plans.

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I gjennomsnitt 5 komponenter i hver intervensjon

Innhold	Antall	Andel
Transfer of information (**knowledge**)	13	100 %
Enhancing **problem solving/ decision making**	7	54 %
Active stimulation of symptom **monitoring**	6	46 %
Stress or **psychological** management	6	46 %
Enhancing **diet**ary intake	6	46 %
Enhancing **medication** adherence	6	46 %
Self- treatment through use of an **action plan**	5	38 %
Enhancing **physical** activity	5	38 %
Enhancing **smoking** cessation	5	38 %
Resource utilization	1	8 %

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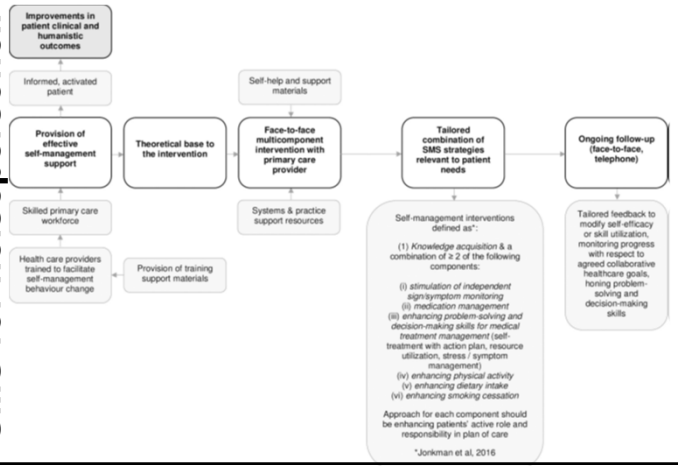
Praktisk tilnærming til SMS for helsepersonell



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Takk for oppmerksomheten

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