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 strukturerede 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.

Bakgrunn

Bakgrunn: Antallet kroniske sykdommer øker med alder

Barnett et al. Lancet 2012
Likevel friskere?

Ny uke... Nye muligheter!

http://www.hjertestrikk.no/2015/02/styrke‐trening.html

Hjelpebehov kan utsettes

Tid til død sier mer om hjelpebehov enn alder

Andelen med <15 år forventet livslengde går ned

Referanse til artikkel:

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

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.

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 equally 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

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)

Definisjon av self-management intervansjoner

- “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, dietary and/or smoking behaviour”.

Om SMS intervensionene

- 58 RCT (i 80 publikasjoner)
- 8 land, flest fra UK and US
- Hyppigste tilstander: T2DM (38%), COPD (21%), depression (14%)
  - Ingen spesifikt på multisyk
- 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.

Multisykdom

<table>
<thead>
<tr>
<th>COPD</th>
<th>Heart failure</th>
<th>Stroke</th>
<th>Hip fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,6</td>
<td>3,8</td>
<td>3,5</td>
<td>3,6</td>
</tr>
</tbody>
</table>

Andel med to eller flere kroniske sykdommer (%)

- 91% 91% 89% 85%


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.

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

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

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 dietary intake;
9. enhancing smoking cessation; and
10. medication management or adherence.

Komponenter brukt

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

13 studier med klar effekt på alle resultatmål
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.

I gjennomsnitt 5 komponenter i hver intervensjon

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

Praktisk tilnærming til SMS for helsepersonell

Takk for oppmerksomheten

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