

# Building Patients' Capacity for Self-management

Promoting self-confidence, sense of control and social support leads to improved patient outcomes and a better doctor-patient relationship.

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**T**he importance of good self-management in determining diabetes outcome is well accepted.<sup>1</sup> The overall decisions patients make about food, exercise, stress reduction, medication use and self-monitoring make a large difference in the course of their disease. Helping patients succeed at self-care is a critical skill for diabetes professionals, one we need to improve upon if we want better results, less frustration and a more rewarding relationship with our patients.

Everyone would take better care of their bodies if they could. But, society puts formidable practical, socioeconomic and psychological barriers in our way.<sup>2</sup> Self-care is not something children always learn in school, and as they grow many do not have appropriate role models for healthy living. Because self-care does not pay bills or get the housework done, most people have other priorities for daily living.

## A MAJOR FOCUS

A chronic illness like diabetes, however, calls on people to make self-care a major focus of their lives. Patients need to make a series of challenging life changes. Most patients do not jump to these changes enthusiastically. They face internal and external barriers such as:

- Competing demands such as long hours of work, care of children, parents and home, financial worries and concerns about safety.
- Lack of access to healthy food, exercise opportunities, places to relax; good medical care from people who treat patients with respect; self-management equipment or dental care. These problems concentrate in lower socioeconomic groups who are hardest hit by diabetes.
- Psychosocial problems, of which stress is the most important, but also lack of support, low self-confidence, low self-esteem, lack of positive goals and reasons to live.

Building patients' capacity for self-care is a long-term process that requires a team approach.

Although these issues also tend to be more pronounced in people of lower socioeconomic status, they can affect anybody.<sup>3</sup>

Given these difficulties, most patients need more than warnings about diabetes complications to motivate them and more than a food exchange list to support them. We need to consciously help them build their capacity for self-care. This is a long-term process and will usually require a team of physicians, additional health professionals and others to meet patient needs.

## ELEMENTS OF SELF-CARE CAPACITY

To succeed at self-care, patients need self-confidence, social support and positive goals. In health education, we often use the term self-efficacy, which is self-confidence applied to a particular area/behavior. Self-efficacy is the belief in one's ability to achieve a desired outcome or accomplish a valued task. Self-efficacy is the strongest predictor of adoption of a new behavior.<sup>4</sup>

Patients need social support, or the assistance of friends, families, other patients, professionals or social agencies. Positive goals are self-care motivators; something a person can work toward and know when they have accomplished. Goals are personal and can only be chosen by the patient.

Other important areas of self-care capacity are knowledge and assertiveness, but self-efficacy and support have been shown to have the greatest impact on self-management

## ACTION PLANNING

An action plan is one specific activity that you are going to do in the coming week. An action plan must be:

- something you WANT to do;
- something you reasonably CAN do. It's better to say you'll walk 3 days this week and do it, than to plan for 5 days and do 4;
- behavior-specific – "I will stop eating ice cream," not "I will lose weight." What, where, how often, when, with who? The more specific the better;
- something you are very confident of doing – on a scale of 1 to 10, your confidence should be at least 7, preferably 8 or higher that you will complete the whole plan. If your confidence level is lower, re-work the plan, perhaps making it easier or getting more help with it, until your level reaches seven.

*Example: This week I will walk four times for 30 minutes at a time, around the block, after dinner, with my dog.*

## SAMPLE ACTION PLANNING FORM

Date: \_\_\_\_\_

This week I will \_\_\_\_\_ (type of activity) \_\_\_\_\_

I will do this \_\_\_\_\_ times for \_\_\_\_\_ (time or amount of activity)

I will do this when, where, with whom? The more specific the better.

\_\_\_\_\_

On a scale of 1 – 10, my confidence that I will complete the entire plan is \_\_\_\_\_

Things that might get in the way of this plan are

\_\_\_\_\_

Ways I might overcome these problems are

\_\_\_\_\_

LOG — I carried out my plan on the following days

MON TUE WED THU FRI SAT SUN

NOTES (anything interesting that happened):

Figure 1. An example of an action planning guide.

behaviors and diabetes outcomes.<sup>56</sup> Using our expertise, we want to help patients build self-efficacy and find support.

How do we help build self-care capacity? First, know what not to do. Patients with diabetes who are overweight may have low self-efficacy about healthy behaviors, so prescribing a large number of challenging alterations at once will likely overwhelm his/her confidence. Threatening patients with kidney failure or blindness is not a useful motivational tool because the patient is probably already scared, and fear is only a motivator if people feel confident that there something can be done to counteract the threat.

Further threats will only increase their stress. When patients are stressed, they tend to medicate themselves

with sugar, fats, alcohol or other unhealthy behaviors. Giving patients orders places power in the hands of the physician, when it is the patient who desperately needs a sense of control.

## HELPING PATIENTS SET GOALS

How do we avoid these traps? Rather than giving orders, we want to form a relationship where the patient is in charge. We should support goals the patient has chosen. Ask open-ended questions and listen carefully – "How can I help?" "What is giving you the most trouble?" "Where would you like to start in managing your diabetes better?" "What's going on in your life now?" "How is

diabetes affecting you?" You can also ask about strengths: "What's been going well lately? Would you like to build on that?"

The answers to such questions will point patients towards meaningful goals they can actually pursue. The goals may be related to exercise or diet, however sometimes they might be about things that initially do not seem health-related. Individualized goals are key to the patient's well-being, and choosing their own goals builds self-efficacy and sense of control as well as reduces stress.<sup>7,8</sup>

Many practitioners fear that working with patients in this way will be too time consuming. Other practitioners are uncomfortable letting patients take the lead in their own self-care. Studies show that listening to patients' psychosocial concerns actually shorten appointment times.<sup>9</sup> In this setting, patients bring up their real concerns at the beginning of the appointment instead of waiting until the end. If practitioners try to set goals for their patients, it is possible that patients will agree with the goal during the appointment and then revert to a different behavior later.<sup>10</sup>

## ACTION PLANNING

The best way to build self-efficacy is to actually accomplish a goal. We should break large challenges into small, achievable chunks. After setting the goal, it may be useful to complete an action plan (Figure 1) for a single step of the goal. The action plan should be for something the patient wants to do and is confident doing. It should be behavior specific. A typical plan might be, "I will walk for 30 minutes, 4 days this week, after dinner, around the block with my dog."

To maximize chances of success, it is helpful to assess a confidence level. On a scale of one to 10, ask patients how confident they are of completing the entire plan? The confidence level should be at least seven. If their confidence level is less than seven, ask "What would it take to get your confidence up to a seven or eight?"

It's important to ask about the patient's goals and plans at each appointment, and a follow-up call 3 or 4 days after the appointment also lets them know you care and that you consider their plan important. Nobody expects a busy physician to go through action planning and follow-up with each patient. Many practices use nurses, health educators or medical assistants to work on goal setting and follow-up.

## THE SUCCESS OF OTHERS

Another way to build self-efficacy is through vicarious success.<sup>11</sup> When patients see others like them succeed, they build confidence. You can maximize this social support by offering group instead of one-on-one sessions. This works, is cost-effective and well liked by patients.<sup>12</sup> You can refer patients to self-management classes or support groups in a health center or the community. You

can also match patients with each other to act as mentors or sponsors.

Families can be crucial sources of support, and they can also sabotage lifestyle change. Studies show that family cohesion is one of the strongest predictors of glycemic control.<sup>13</sup> Consider including families at appointments, and refer families to therapy if necessary. If one member has type 2 diabetes, other family members are often at risk. A patient's neighbors, friends or congregation may also be possible sources of support.

Patients usually cannot succeed at self-care alone. By working together as partners and getting support from families and communities, we can succeed at chronic illness management.

For more information on building patient's capacity for self-care, consider the following resources:

- Chronic Disease Self-Management Program  
Address: Stanford Patient Education Research Center  
1000 Welch Road, Suite 204, Palo Alto, CA 93404  
Web site: [www.stanford.edu/group/perc](http://www.stanford.edu/group/perc)
- Improving Chronic Illness Care  
Phone: 206-287-2704  
Web site: <http://www.improvingchroniccare.org>. ■

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