5 Communication Strategies to Promote Self-Management of Chronic Illness

How you communicate with your patients can enhance – or inhibit – their ability to manage their chronic illnesses.

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Why is it that patients often do not follow our recommendations? Consider the following scenario, in which Mrs. Jones comes in for a routine office visit and her doctor brings up her high blood pressure:

Doctor: "Hi, Mrs. Jones. How are you today?"

Mrs. Jones: "Fine."

Doctor: "I see that your blood pressure is still high. Are you taking your pills?"

Mrs. Jones: "I was, but I ran out last week."

Doctor: "Oh. Well how are you doing with your diet? Are you avoiding salt like I told you to?"

Mrs. Jones: "Uh, well … I try …"

What goes unsaid in this encounter is that Mrs. Jones is not really "fine." She is very worried about her blood pressure since her aunt recently died of a stroke, but she does not feel confident about changing her diet. She does not understand why she has to take medication because it does not seem to help. Her pressure is always high, even if she does take her medicine for a while.

The doctor also has unvoiced concerns. He feels frustrated because he too knows that Mrs. Jones is not "fine." She is at risk for a stroke if she does not control her blood pressure, and she needs to change her diet. The doctor does not understand why she lacks motivation. He cannot tell if medication helps her blood pressure, because it is always high in the office and she never seems to be on her meds when she comes in for an appointment.

Both Mrs. Jones and her doctor have similar concerns about her health, but their failure to communicate is resulting in poor medication adherence, which may have significant health consequences. They have no mechanism for talking about the management of Mrs. Jones' health in the context of her life.

A new model

In traditional doctor-patient interactions, the physician sets the agenda, defines the health objectives and makes all the medical decisions. The patient is expected to

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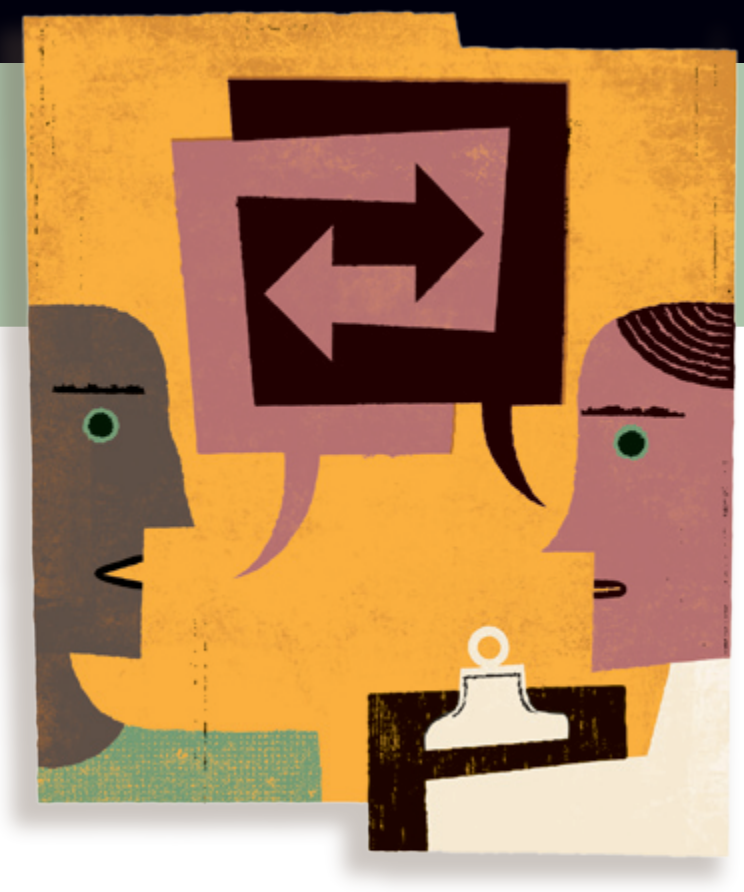

"comply." This model does not take into account the many reasons why patients might decide not to follow a treatment program. For example, in a study of patients with diabetes, researchers found that although patients were well informed about their disease and optimal treatment, they perceived that their quality of life might be more adversely impacted by their treatment than by the diabetes itself.[1]

Chronic health conditions require a new paradigm because treatment is lifelong and requires the patient to be an active participant. That new paradigm is "collaborative care," which emphasizes self-management support, or the need to enhance patients' skills and self-efficacy in managing their chronic illnesses. (See "Collaborative care: promoting self-management," below.) Under this model, physician-patient interactions start with an agenda that focuses on the patient's priorities as well as the doctor's care recommendations. Medical decisions are made collaboratively within the partnership of the patient and medical team.[2]

As part of our residency program's efforts to improve chronic illness care, we sought a model of communication that would enable us to support our patients' efforts to manage their diseases more effectively. Researchers have identified five strategies that can facilitate communication between the patient and physician.[3] (See "Five communication strategies," page 14.)

The first three strategies "set the stage" for collaboration between the doctor and patient:

1. Set a shared agenda. The critical step of setting an agenda for the visit is frequently overlooked. The physician may have a clear idea of what should be discussed but often does not share this information with the patient. Likewise, the patient may be concerned with certain questions but may not feel comfortable asking the physician. Setting an agenda allows important topics to be laid out at the beginning of the visit. Agenda setting can start by asking, "Mrs. Jones, what would you like to discuss today?" The patient and the physician then decide together which issues take priority. This helps to ensure that the issues most important to each are addressed and allows the physician to redirect the discussion back to these topics if necessary. Setting the agenda together conveys interest in the patient's priorities and invites the patient to take an active role in the discussion. While physicians may be concerned that they don't have time for agenda setting, researchers estimate that the process adds just 1.9 minutes to the length of a visit, on average.[4] ➤

COLLABORATIVE CARE: PROMOTING SELF-MANAGEMENT

	Traditional	Collaborative
Interactions	Based on the caregiver's agenda	Based on a shared agenda
Behavior change	Comes from knowledge	Comes from self-efficacy plus knowledge
Goal	Compliance	Self-efficacy
Decisions	Made by the caregiver	Made by the patient and caregiver in partnership

TIMOTHY COOK

In traditional doctor-patient interactions, the physician sets the agenda. The patient is expected to "comply."

For chronic illness to be managed effectively, the patient must participate actively in the care process.

Working with the patient to set an agenda for the visit is a critical first step.

The ask-tell-ask technique can help you tailor information to the patient's needs.

2. Ask-tell-ask. This strategy provides a structure for the physician to tailor information to the patient's needs by 1) asking the patient what he or she already knows or wants to know about his or her illness, 2) telling the patient what he or she needs to know and 3) asking or ascertaining whether the patient understands the information or has additional questions. The first step allows the physician to assess the patient's understanding of his or her condition and its treatment. The physician might ask, "Mrs. Jones, what is your understanding of why you have high blood pressure?" or "What effect do you think diet has on your blood pressure?" The physician then responds by providing focused information relevant to the patient's issues regarding his or her health. A follow-up question such as "Can you repeat that back to me in your own words so I know that it's clear?" helps to assess the patient's response to the information just received and keeps the patient involved in the conversation.

3. Assess readiness to change. Patients will differ in their readiness to change their health habits even if they are well informed about the importance of such changes. (See "Stages of change," page 15.) For behavior change to take place, the individual must feel that the change is important (motivation) and feel capable of making the change (self-efficacy). Two simple questions can assist the physician in addressing these necessary preconditions for change in just a few minutes.

FIVE COMMUNICATION STRATEGIES

Setting the stage	Taking action
Set a shared agenda	Set self-management goals
Ask-tell-ask	Close the loop
Assess readiness to change	

The first question is "How important is it to you to make this change, on a scale of 0 to 10 with 10 being extremely important?" This question puts the physician and patient on the same page with regard to goals. In my experience, patients with diabetes rarely answer that it is any thing less than very important to control their blood sugar.

Self-efficacy is the second point to be assessed by asking "How confident are you that you can make this change, on a scale of 0 to 10 with 10 being extremely confident?" Patients need to feel confident that they can make changes that will positively impact their health. Many patients have only experienced failure in making health changes and are doubtful of their ability to effectively influence their health. Patients who think they must make immediate, extreme changes to their diet or daily routine may prematurely conclude that they cannot make any changes at all. Physicians can increase their confidence by emphasizing how small, incremental steps can improve their health.

The last two strategies invite patients to take action to improve their health.

4. Set self-management goals. Physicians and other staff members can help patients identify incremental changes in health behavior that are realistic for them to achieve. Asking "Is there anything you are ready to do this week to improve your health?" is an effective way to initiate a dialogue about practical next steps. Goals such as "I know I should exercise more," or a physician's statement that "You really should stop smoking," are ambiguous and daunting for patients. Instead, goals should follow the SLAM acronym:

Specific: If a patient's goal is to "exercise more," the physician should encourage the patient to commit to exercise by specifying what type of exercise he or she will do, how often and how long. The more specific the plan, the more likely the patient will follow it. For example, a specific exercise plan would be

to "walk three times a week with my husband for 20 minutes."

Limited: The goal should be limited to no more than a few weeks. It may be too overwhelming for patients to conceive of sustaining these changes over the long term. Goals can be continued or modified at the next visit.

Achievable: It is not reasonable for a sedentary patient to commit to a daily five-mile run, but it may be achievable for that same patient to commit to walking around the block three times a week. Success with an achievable goal can lead to greater confidence and motivation to tackle more ambitious goals down the road.

Measurable: The goal should be measurable so the patient and physician can determine whether the plan was effective. However, it is preferable to develop goals that measure behavior rather than results. Goals such as "lose 10 pounds" or "improve blood pressure by 10 points" may be measurable, but they don't specify what action the patient is supposed to take and, thus, may be difficult to achieve. Goals focused on exercise behaviors, changes in diet or taking medications regularly are both measurable and achievable.

In discussing the self-management goal, it is useful to again assess the patient's confidence that he or she will be able to carry it out. When asking the patient to rate his or her confidence level on a scale of 0 to 10, a rating of 7 or above means it's likely that a patient will follow through with the plan. Early evidence suggests that even patients who had previously been in the pre-contemplation stage of change can and do follow through with goals they set with their physician.[5,6]

5. Close the loop. Research has shown that as many as half of patients have misunderstood some portion of what was discussed at their doctor's visit.[7] Hurried physicians may think they have clearly explained key instructions, especially when a patient's nonverbal signals appear to signify understanding. Closing the loop means asking the patient to repeat the important points and instructions to ensure correct understanding. Having the patient verbalize key instructions allows the physician to correct misunderstandings before they become errors. This simple but powerful strategy has been associated with improved A1C levels.[6] If a physician only has time to employ one of the five strategies, this one is a good choice.

STAGES OF CHANGE

Stage	What the patient is thinking
Pre-contemplation	Patient is not thinking about changing the behavior.
Contemplation	Patient is thinking about changing the behavior but has not taken any action steps.
Preparation	Patient is committed to changing the behavior and may have made an attempt in the recent past.
Action	Patient is in the process of making overt lifestyle change.
Maintenance	Patient has established the new habit. Focus is on maintaining behavior change.
Relapse	Patient returns to problem behavior. May have cycled back into a previous stage.

Practice makes perfect

When our faculty began teaching these strategies as part of our behavioral science curriculum, residents rapidly improved their ability to carry them out with the psychologist present. Unfortunately, there was little carryover when the residents were videotaped at a later time seeing patients on their own. This suggests that communication behaviors learned in medical school and internship are strongly reinforced and not easily changed.

The next iteration of our curriculum had residents share and discuss videotapes of their patient encounters in a small group, which proved to be a powerful learning tool. But again, change did not come easy.

Just as patients often struggle to implement and sustain behavioral change related to their chronic illnesses, physicians may struggle to change their communication skills. Interestingly, the change strategies that work for patients, such as implementing changes in small, incremental steps and setting SLAM goals, can also work for physicians. An initial goal might be "I will try the 'closing the loop' technique with one patient today." Physicians may also benefit from using paper tools that

- Two key questions can help you assess a patient's readiness to change.
- Encourage patients to set realistic goals for changing their health behavior.
- At the end of each visit, ask the patient to repeat back important information to ensure understanding.

Article Web Address: http://www.aafp.org/fpm/20090900/12five.html

As many as half of patients have misunderstood some portion of what was discussed at their doctor's visit.

assist patients in goal setting (such as the worksheet available at http://www.aafp.org/fpm/20080400/a6anew.html#box-a) and involving nurses and clerks, who can assist patients in setting self-management goals and make follow-up phone calls to provide support to patients in fulfilling their goals.

Self-management communication strategies can be effective in helping patients manage their chronic health conditions. These strategies require that the physician move from a traditional model of care to a more collaborative one that emphasizes the patient's central role in managing their own health. While simple in concept, these communication strategies require ongoing attention, learning and practice. FPM

Collaborative care acknowledges that the patient is central to managing his or her health.

Moving from traditional care to collaborative care requires practice.

Send comments to **fpmedit@aafp.org.**

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