Collaborative Self-Management in Pulmonary Rehabilitation

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Collaborative self-management describes the combined efforts of the health care team and the patient/family to meet the needs of the patient in relation to the management of their chronic lung disease. The American Thoracic Society/European Respiratory Society statement on PR[1] says, "The symptom burden, functional impairment, and impaired quality of life in patients with chronic respiratory disease are not simply consequences of the underlying physiological disorder, but also *depend on the patient's adaptation to the illness, its comorbidities, and its treatments*." This is the basis for collaborative self-management – working with the patient to establish a plan of care that is individualized to each patient and their specific chronic lung disease and comorbidities, the treatments specific for that patient, and most importantly the patient's readiness to make behavior changes.

A Cochrane Review published in 2014 reviewed the literature on self-management for patients with COPD.[2] It included 29 studies and 3189 participants. The review concluded that self-management training provided in these studies improved health-related quality of life as measured by Saint George's Respiratory Questionnaire, reduced respiratory-related & all cause hospital admissions, and improved dyspnea as measured by the Modified Medical Research Council Scale (mMRC); however showed no statistically significant effect on mortality. The criticism of self-management training is the lack of consistency in the training. Although the literature supports positive benefits from this type of training, use of alternative approaches that may not be evidence-based, may not have benefit. It is important that we as health care professionals working in pulmonary rehab (PR) programs provide disease self-management training as it is outlined in the literature.

The goal of self-management training is to empower the patient at all stages of disease. The content and components of the training vary depending on the disease itself, the severity of the disease, the presence of comorbidities, and the ease of accessing the health care system.[3] Training must focus not only on behavior change, but on problem-solving and building the patient's self-confidence not only in the ability to problem-solve but also to master the skills necessary to manage their disease. Our role in that process will become more involved as the patient's disease severity worsens, they experience exacerbations, or as they develop more comorbidities. However, the goal is to shift towards more patient self-management by helping them to gain confidence, and to acquire and master the skills needed to successfully manage their disease. To help patients become more engaged and actively manage their own care, PR staff must develop new and improved skills, such as those used in clinical health coaching. The skill of what questions to ask, how to ask them, and how to inspire patients to be more accountable can be acquired through health coach training and practice.

Motivational interviewing (MI) is a form of communication that motivates people to take responsibility for their health, and increase confidence in the ability to manage their health[3] MI falls in the center of the continuum of communication styles, with *directing* on one end of the continuum, and *following* on the other. Directing is the typical means of communication in health care. The patient is given information, instruction or advice. In other words, telling patients what they need to do and how to do it. Following is primarily listening. It is important that we listen to what is important to the patient, and refrain from giving advice. *Guiding* falls in the center of the continuum, incorporating aspects of both directing and following. PR staff should be health coaches, guiding patients to make changes by using MI to support the desire to change.

Although people may want to change, sometimes things get in the way. The desire to change is hindered by ambivalence. In PR, we need to recognize the patient's desire to change, but also their ambivalence.[3] We recognize the desire to change through change talk, but their argument for not changing through sustain talk. For example, a statement such as, "I know I need to quit smoking for my health", is change talk; but when they go on to state, "but I really enjoy smoking", this is sustain talk. The goal in this situation is to move the patient forward out of ambivalence by helping *them* choose a positive direction and follow it. In this situation, we could confront the patient with reality and push them in the right direction because we think we know what is best for them; or we can listen respectfully, withhold our advice and just ask questions to gather more information. The latter, of course, is the most effective way to assist the patient with behavior change.

As health care professionals, we have a desire to make things right for our patients. We want the patient to follow what we think is the right path to health and wellness. We try to fix their problems. In MI, this is called the Righting Reflex, and it can not only be ineffective, but may push the patient farther away from change. MI requires acceptance of the patient and their desires, wherever they are in the stages of change. We have to respect the patient and their wishes, and not place judgment on their decisions. Judging may actually immobilize the patient and change will not happen. We have to keep in mind that *all* patients are self-managers. It is how they decide to manage that makes the difference.

The steps of MI begin with creating an atmosphere of acceptance & trust, and allowing the patient to do most of the talking. This can be a real challenge for many who work in health care! Responding to the patient with empathy rather than jumping in with a solution (the righting reflex) will help the patient learn to problem-solve. We have to be ready to roll with resistance from the patient, and try to avoid letting it become a road block to change.[3]

To be a successful change agent, we must avoid playing the expert; avoid labeling the patient or the problem; and use open-ended questions to gather more information from the patient, rather than narrowing the focus too much and too early. Always keep in mind that blaming the patient for lack of change or a lack of willingness to change will only lead to defensiveness and will become a roadblock to successful change.

Critical to the process of behavior change is identification of where the patient is at that point in time in regards to the stages of change. Is the patient's sustain talk telling you they are either unaware of a problem, or they are unwilling to change a specific behavior? If so, they are likely in the *pre-contemplation* stage of change. Or do you hear both change talk and sustain talk, suggesting they may be seriously considering change, but have not yet made a commitment to take action? This describes the *contemplation* stage of change. The patient is in the *preparation* stage if they are committed to the change, and are taking small steps toward that change in behavior. When the patient is taking clear steps toward behavior change they are in the *action* stage. When they can sustain those changes, they have moved into the *maintenance* stage. However, remember that change is a dynamic process with patient moving forward and backward among the stages. Relapse, a return to the previous behavior, is common. An important role of staff in a PR program is help the patient move through the stages of change and stay on track to successful change. Each stage of change has a goal, and our role is to assist the patient in achieving that goal.

An excellent resource to help you in developing a disease self-management program for chronic lung disease patients is Roberto Benzo's article on the development and feasibility of a self-management

intervention for COPD delivered with motivation interviewing strategies.[4] The study showed patients were engaged and committed to self-management; and reported improved breathing and an increase in their physical activity. Benzo's group identified 3 key behaviors that all COPD patients NEED to know. Day one of the training was devoted to those 3 key behaviors: Use of an emergency action plan, proper use of pursed-lips breathing, and discussion of the importance of daily physical activity. The session focused on discussion, demonstration and practice, and use of teach-back for evaluation. For each of the subsequent sessions the patient was asked to describe their experiences with daily practice of physical activity, and any use of the emergency action plan. The staff responsibility was to listen to the patient and affirm their efforts. They did not attempt to problem-solve for the patient if something didn't work. Rather they listened and guided the patient to identify why something may not have worked, and what they could try the next time. In addition, at each of the subsequent sessions, patients were asked to choose a self-management domain *of interest to them*, and set a realistic goal. If the patient was unable to identify a self-management strategy to work on, a menu of options was provided. The domains included typical types of education/ training provided in a PR program, such as taking medications, tobacco cessation, stress management, improved nutrition, etc. The patient and staff member discussed specific strategies to move the patient toward goal achievement. At each session the patient was asked to discuss their progress toward their self-management goals. This study provides the basics of a COPD self-management plan. This can be modified to develop self-management plans for other chronic lung diseases.

In conclusion, pulmonary rehabilitation is a comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

One of our major challenges in PR, is long-term adherence. We, as PR staff, must focus our efforts on behavior change and independence in not only exercise, but in the patient's ability to manage their chronic lung disease efficaciously. Maintenance of those behavior changes and the ability to manage their disease throughout the various stages of progressive lung disease will be a dynamic process that requires a collaborative effort on the part of the health care team, the patient and the family.

References

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