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EDITORIAL

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QUALITY RESEARCH NEEDED TO EXPAND THE SCOPE AND QUALITY OF SELFCARE

The Case for Stirring the Pot

SOLLER R W
Clinical Professor of Pharmacy, University of California, San Francisco

Imagine a government agency requiring drug labels "*[to] be written only in such medical terms that are not likely to be understood by the ordinary individual.*" In 1938 FDA did just that. Yet, similar views had prevailed for centuries[1]. In the 1500's, the Royal College of Physicians mandated in its ethical statute a similar requirement under an infraction penalty of 40 shillings: "*Let no physician teach the people about medicines or even tell them the names of the medicines, particularly the more potent ones ⋯ For the people may be harmed by their improper use*"[2]. Over the middle decades of the 20th century it became apparent that this approach had serious problems[3]. Usurping individual responsibilities in care and restricting liberty of choice was not advancing 'modern' health care. Under mounting concerns about patient safety, the escalating costs of medical care which did not meet acceptable standards of care, and overutilization of primary care and emergency medical services, gaps in care were documented, unifying concepts articulated, and changes made. Paternalistic approaches to patient care were supplanted by 'patient-centered care' and 'accountability' as new rallying points for empowering people to take a central role in their own health care.

In 1999, the U.S. Congress directed the Agency for Healthcare Research and Quality (AHRQ) to produce annual reports on "national trends in the quality of health care provided to the American people." The first was issued in 2003, and the 2010 edition contained specific steps for health professionals to take "to ensure that their patients are fully informed about their drug regimens and to minimize opportunities for mistakes to occur". The report also enjoined health organizations to "make it a standard procedure to inform patients about clinically significant medication errors made in their care, whether the mistakes lead to harm or not."[4] Over a similar timeframe, parallel efforts were underway by the U.K. authorities (i.e., the National Health Service NHS; and the Department of Health DH,)[5]. Quality, productivity, accessibility, continuity, accountability, and cost-containment were among the new watch words in both U.S. and U.K. efforts to reinvigorate practitioners, stimulate new research, create new technologies (such as electronic medical records), and improve transparency.

A central tenet of the annual AHRQ reports has been the restatement of patient-centered care and partnership, as in the following directive: "Establishing and maintaining strong partnerships between health care providers and patients is crucial to reducing medication error." A more in-depth exploration of this was made by the DH through its backgrounders on the continuum of care, and specifically self care[4, 5].

In brief, self care is about empowering people to take more control of their own health care.

Self care empowerment depends on engendering self motivation and facilitating choice to allow patients to determine workable solutions associated with high self-efficacy which then encourage further behavioral changes. In office visit settings, the practitioner serves as an infrequent 'coach'. Even patients with serious long term conditions will only have the opportunity for limited time spent in interaction with health care professionals. For example, a person with diabetes will spend about 0.04% their annual waking hours in 'face to face' dealings with HCPs (based on a very liberal assumption of 3 hours of total in-person visit time in a year). The limited time physicians and other health professionals have with their patients heightens the responsibility of practitioners to be skilled in motivational interviewing techniques to, create a partnership. Such motivational interviewing must allow the HCP to understand the patient's agenda, drill down for details, and help the patient create a self care action plan for both disease and medication therapy management. Outside the practitioner's office, people bear the responsibility of deploying these self care action plans and self-education on subjects including disease prevention, using medications appropriately, and lifestyle changes. Government and private industry have an important role in supporting self care through patient-centered public education campaigns, product labeling, and web-based information to facilitate the self management of disease.

Yet despite this widely held modern vision of self care, significant challenges remain. In a recent working paper, the United Health Center for Health Reform and Modernization highlighted the size of the opportunity and some potential costs of inaction if evidence-based interventions for medication therapy management and lifestyle improvement are not put in place[6]. The Center estimated that by 2020 in the U.S. 15% of adults will have diabetes and 37% will have prediabetes, compared with 12% and 28% today, respectively. Projecting what effective translation of local projects on a broader scale might achieve, the Center estimates:

- Modeled after proven coaching programs and weight management programs, coordinated low, moderate and intense lifestyle interventions to promote a modest five percent weight loss among healthy adults (i.e., before onset of prediabetes or diabetes) could potentially reduce those with prediabetes by about 10 million by 2020 and a result in $45 billion of cost savings to the health care system.
- Enrolling adults with prediabetes in intensive lifestyle interventions using community-based coaches and an IT tracking system could potentially reduce those who move from prediabetes to diabetes by three million by 2020, with a projected $105 billion savings.
- Focusing on self care through medication therapy management and related self-educational tools, pharmacist counseling could help patients improve compliance with their physicians' treatment program, leading to reductions in the number of diabetes-related complications and improved health status and estimated cost savings, if scaled nationally, of $34 billion.

Herein lies the challenge to academic and private industry researchers. And there can be no doubt that the opportunity is huge. The evidence to support the scalability of many known approaches to optimizing patient participation in lifestyle and medication therapy management is simply limited or lacking entirely. This evidence is essential if large private or government

payers are to insist on their routine application across all settings. Focusing on the eight accepted dimensions of quality (i.e., effectiveness, patient safety, timeliness, patient/family centeredness, efficiency, access, care coordination, and health system infrastructure, with the overarching dimensions of equity and value)[7] can provide a common agenda for government and private-industry funding. Peer-review journals interested in promoting original research that will make a significant contribution to the advancement of clinically-effective and cost-efficient self care within healthcare must have the same focus.

Effective self care is the outcome determinant of any successful patient interaction with a health professional. As such, the journal *SelfCare* is positioned to act as a key stakeholder for international dissemination of original work, review papers, commentary, and solicited papers from academic researchers, their students and government and private industry researchers (Table 1).

Table 1

The broad spectrum of self care served by the journal *SelfCare*

Self care exists across a spectrum of relative involvement of health professionals in consumer/patient decision-making and actions.

1. Self-determined self care which is proactive – e.g., an individual deciding to exercise daily;
2. Facilitated self care– e.g., a consumer choosing to purchase an OTC medicine easier based on the label, or the advice of a pharmacist, or advertising that results in product awareness; increasing the access to care services)
3. Supported self care– e.g., a person with diabetes deciding to participate in pharmacist care services to better self manage their disease, or engaging nurse educators to learn about lifestyle approaches to complement their disease self-management.

Areas needing attention through well-designed prospective and retrospective studies

- Novel approaches to improving adherence, weight control, smoking cessation, disease control/management
- Novel telehealth approaches to improving self care by patients with chronic disease (see definition of self care above)
- Impact of patient and consumer choice on successful adoption of self care plans (e.g., medication or lifestyle action plans)
- Aspects of program design that influence consistent counseling across MTM and/or lifestyle counselors in chronic disease management programs
- Expanded access of self care programs for the underserved
- Full economic analyses of self care programs targeting selected clinical as well as humanistic outcomes (e.g., satisfaction, quality of life, and presenteeism)
- Demonstrated feasibility of novel IT approaches to enhance self care action plans (i.e., medication therapy or lifestyle action plans)
- Scalability of self care programs for medication therapy and disease management over larger populations and/or different settings
- Rx-to-OTC switch including labeling comprehension studies, actual use studies and self selection studies
- Wellness programs for disease risk reduction /prevention, in the home and work settings
- Self care approaches by practitioners to avoid burn-out

Submit your manuscripts! The pot needs stirring! Visit the "For Authors" page for *SelfCare* at: http://www.selfcarejournal.com/index.php

Correspondence to: Professor R W Soller sollerrw@pharmacy.ucsf.edu

REFERENCES

1. Seligman, P. and S. Osborne. Perspectives on Early Communication of Drug Risks to the Public. Clin Pharmacol Ther 2009;85:335-9.
2. Ibid.
3. Institute of Medicine. America's healthcare in transition: protecting and improving quality. Washington, DC.1994. Available at: http://www.nap.edu/catalog.php?record_id=9147
4. Agency for Healthcare Research and Quality. 2010 National Healthcare Quality & Disparities Reports. Available at http://www.ahrq.gov/qual/qrdr10.htm
5. U.K. Department of Health. Self care – a real choice: self care support – a practical option. Janaury 2005. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100717.
6. UnitedHealth Center for Health Reform and Modernization. The United States of Diabetes – Challenges and opportunities in the decade ahead. Working Paper 5. November 2010. Available at http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper5.pdf.
7. Agency for Health Research and Quality. National Healthcare Disparities Report, 2010. Available at: http://www.ahrq.gov/qual/nhdr10/nhdr10ch1.pdf