Key Strategies for Sustained Health Behavior Change in Chronic Disease

Innovative strategies based on shared decision-making can change patient behavior and lead to greater success in chronic disease management

Hospitals and health systems have identified three top chronic health-management goals for patients:

1. Manage chronic diseases such as diabetes, hypertension and obesity better.
2. Reduce costs of avoidable emergency department utilization and hospitalization.
3. Increase patient access and/or convenience beyond the episodic physician visit within a brick-and-mortar setting.

More than half of all Americans live with at least one chronic disease, taking an enormous toll on patients and driving up the cost of health care.

There are many causes, but patient behaviors can play a large role in many chronic diseases. The 3-4-50 Framework, developed by the UK-based Oxford Health Alliance, states that tobacco use, poor diet and a sedentary lifestyle contribute to cancer, cardiovascular disease, chronic lower-respiratory disease and diabetes. Those four conditions cause 50 percent of deaths, many of them premature.

Health care experts say it is crucial to control chronic disease better to meet national goals of improving population health and move toward a system of value-based care.

The top patient groups that would benefit from targeted interventions are those dealing with multiple chronic conditions; early-stage type 2 diabetes (not insulin-dependent); late-stage type 2 diabetes (insulin-dependent); hypertension; mental health issues; smoking-cessation issues; obesity; prediabetes; and sleep disorders.

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How Effective are Chronic Disease Management Programs?

The effectiveness of chronic disease management programs can be measured in a variety of ways, depending on the disease. For example, patients with a prediabetes diagnosis have been identified as a target group to prevent the progression to type 2 diabetes. Prediabetes is reversible with lifestyle changes, and health systems are starting to implement programs to make that happen. The success of these programs is sporadic, however.

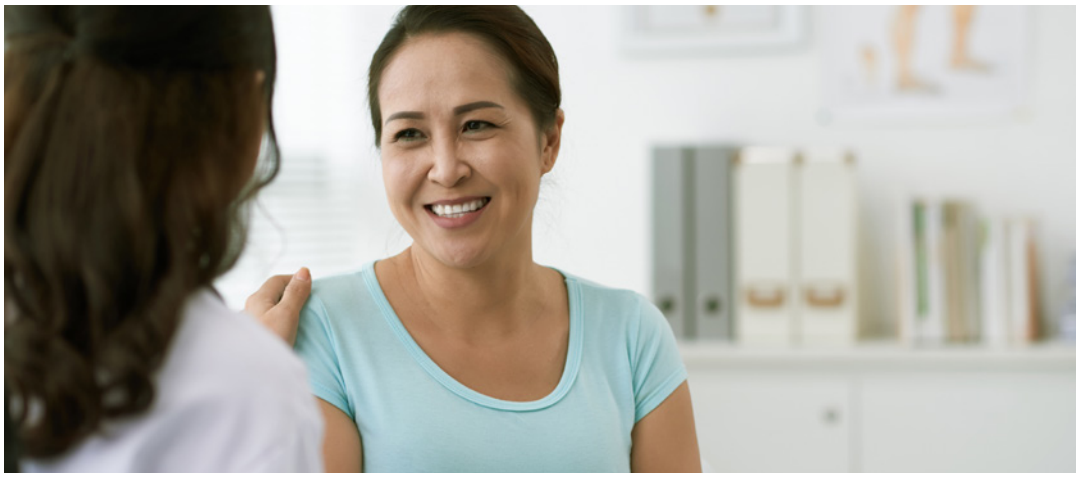
The most successful chronic disease management programs have increased patients' knowledge about their conditions and how to manage them; improved patient-medication compliance; achieved a positive change in patients' diets and other lifestyle factors; and lowered emergency department (ED) visits and hospitalizations.

On a scale of 1 (extremely poor) to 10 (excellent), Eric Hekler, Ph.D., professor and director of the Center for Wireless and Population Health Systems at the University of California San Diego, rates chronic disease management in the U.S. at a 5.

"The reason," says Hekler, whose research focuses on individualized and precise behavior change to foster long-term health and well-being, "is that as you learn more, your perception of how much you actually know becomes less. We're just starting to realize how complex it is to help people help themselves live healthier lives."

Faced with complexity and a sense of urgency, hospitals and health systems are aiming for higher rates of patient engagement in chronic disease management. Such engagement could lead to an increase in exercise, lower cholesterol, lower body mass index and a measurable reduction in health care costs.

Experts say that increasing the level of patient engagement can be extremely challenging. Many programs see only one-third to one-half of patients who actively participate, and it's not unusual for patients to drop out.



Power to the Patient

Hekler says chronic disease management programs as they exist today suffer from an imbalance of power and input between patients and health providers.

"This is not to question the knowledge and expertise of the medical profession," Hekler says, "but population health requires you to have a clear understanding of why people do what they do. Patients understand who they are, what they value and what is going on in their lives. And often, these things are not readily apparent or understood within the clinical context. It's a form of paternalism that undervalues what is known by the patient and undermines systems-level thinking."

For example, Hekler adds, "People have only so much time in their lives, particularly people with complex medical conditions. Sometimes they have to spend hours doing all of this care and, right now, a lot of those care suggestions are provided in a rather fractured way. They also have to work, be with their families, find ways to enjoy their lives and sleep. It's a delicate balancing act to work through."

Overcoming such challenges and attaining the right balance requires plans and solutions that fit better into each patient's unique life; this will augment patient participation and reduce dropout rates.

How to Improve Chronic Disease Management Programs

Experts agree that to reach their full potential for improving population health, chronic disease management programs must attain success in these crucial areas:

- Higher rates of program engagement by patients and families.
- Improved coordination and communication among clinicians, patients and families.
- Appropriate just-in-time care delivery by interprofessional teams.
- Higher percentage of patients who achieve such goals as weight loss, greater mobility or higher quality of sleep.
- Measurable reduction in health care costs.

Health Coaches

Patients with a chronic illness need support and information to become effective managers of their own health. Besides information about their diseases, they frequently need ongoing support, including assistance in building the necessary skills to manage their health.

"In health coaching, it's all about guiding your clients or your patients to move positively toward change."

Melinda Huffman, MSN
Co-founder, National Society of Health Coaches

Health coaching can be a vital tool for better chronic disease management and improved population health.

Health coaches can help patients manage conditions and challenges like diabetes; heart conditions; weight-loss goals; hypertension; mental health issues; smoking cessation; multiple health risks; and multiple chronic conditions.

"In health coaching, it's all about guiding your clients or your patients to move positively toward change," Melinda Huffman, MSN, co-founder of the National Society of Health Coaches, said in an article posted Sept. 19, 2018, on PatientEngagementHIT.com.

For example, Huffman said, "When a clinician says to a patient, 'you have to quit smoking,' it usually leads to the patient going to smoking-cessation counseling and saying, 'I'm only here because my doctor told me to come.'"

"Clinicians cannot force change," Huffman said. "If you try to force, demand, shame the patient or argue for change, it's not going to happen."

Instead, Huffman said that clinicians should ask patients questions about their lifestyles, activities that are important to them and their own overall health goals. These open-ended questions could reveal an unexpected intrinsic motivation that could lead to patient behavior change.

"A clinician doesn't have to come out of clinical practice to be a health coach," Huffman concluded. "You can learn these skills and use them at the point of care … wherever the point of care may be."

And while the typical patient cannot have a face-to-face visit with someone every time he or she needs health coaching, technology-based solutions can help meet that need.

7 Effective Strategies to Achieve Sustainable Results in Targeted Populations

Experts have identified these strategies as some of the most effective methods for attaining the improved health results desired by patients, providers and other stakeholders of the health care system:

1. Involve patients in the co-creation of program goals and/or co-creation of a health plan.
2. Engage family members in the program.
3. Provide individual feedback with health education to support action plans that address the patient's health risks.
4. Review current diet and eating habits and develop a personalized healthful eating plan with guidance from a dietitian.
5. Provide connected devices to measure such biometric data as blood pressure, blood glucose, weight, activity and sleep.
6. Conduct a patient health-risk assessment.
7. Use a platform to track patient engagement and provide incentives.

Despite the challenges confronting effective patient engagement, it is possible and realistic, according to Adrienne Boissy, M.D., Cleveland Clinic's chief experience officer.

"The greatest potential for technology is for it to help clinicians feel more engaged — not less so — with their patients, while helping to artfully engage patients at the same time," Boissy said in a Feb. 6, 2017, post on HealthcareITnews.com. "You'll get the maximum potential if you engage both."

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