

Self-Efficacy and Patient Engagement and Empowerment: Imperative to Improving Health Outcomes

A Perspective By:
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Self-Efficacy and Patient Engagement and Empowerment: Imperative to Improving Health Outcomes and Controlling Costs

The Canadian psychologist Albert Bandura is best known for his work in social learning theory (how we learn from one another). Bandura, a towering figure in the psychology of human learning and behavior, also introduced the concept of “self-efficacy.” By self-efficacy, he meant a person’s confidence to carry out actions needed to reach his or her goals. This concept, which he introduced over 30 years ago, could be a game-changer in health care delivery. That’s because the concept of self-efficacy provides a roadmap for tapping into the power of patients to engage in their own health care. Empowered patients, working in effective collaboration with their providers, can improve their own health outcomes and also become an important force in controlling health care costs.

Health-related behaviors are critical factors

Our own health-related behaviors are critical factors in determining our long-term health. Exercise, seatbelt use, smoking avoidance or cessation, healthy eating and weight control can mean the difference between a healthy longevity or early-onset of chronic disease and disability. Of course, even those of us with great health habits still can have chronic conditions or come down with disease. But even then, good habits and effective engagement in our own health care can make a big difference.

If a person with HIV rigorously follows a daily regimen of effective medicines, he or she can change a once-uniformly-fatal disease into a manageable chronic condition. Such an engaged and empowered person with HIV can now lead a full and long life.

In contrast, if I have only hypertension but don’t fill my prescriptions – or don’t take my pills regularly – I’ll likely suffer the resulting heart attacks and strokes. Unless I make a personal commitment to taking my state-of-the-art antihypertensive medications, their availability provides me with no benefit. Even the best antihypertensives do nothing to prevent damage to arteries, losses of function and quality of life, and associated health care utilization and costs, unless they are taken regularly by the person with the hypertension.

Early in my medical career I witnessed the power of patient engagement and empowerment in what seems an unlikely setting – an acute care teaching hospital. About 20 years ago we were grappling with a dilemma at Deaconess Hospital in Boston – a challenge that still faces hospitals across the country on a daily basis. The dilemma was this: Why do frail older patients who are admitted to the hospital with straight-forward diseases and medical needs, often end up having long, complicated, and costly hospital stays, sometimes with terrible impacts on function and quality of life?

Our findings showed that primary diagnoses usually were treated successfully. Instead, we found that the problem was that chronic conditions and functional vulnerabilities often were under-appreciated. Under the stress of acute illness and hospitalization, there was deterioration of other conditions. What followed included unnecessary suffering, loss of function, and sometimes even death. And the economic costs often were dramatically higher than the primary admitting diagnosis would have predicted.

In response to these findings, we developed the Deaconess ElderCare program, in which an

interdisciplinary team including a physician, nurse practitioner, and social worker engaged patients and families in evaluations and care decisions from the very beginning of a hospital admission.

Medical teams, in partnership with patients and families, were able to develop a more complete and reality-based picture

The partnerships, created between the medical team, patients, families, and consultants, led to a more accurate and complete assessment of medical, functional, and social realities. Interventions and preventive strategies could be targeted at the full range of a patient's needs. And trust and cooperation between patients and providers had unexpected benefits. For instance, engaged patients felt safe to complain. That resulted in detection and treatment of complications before they became crises. This collaborative, patient-empowering model resulted in reduced numbers and severity of in-hospital complications, shorter hospital stays, improved patient outcomes, and lower readmission rates.

If we can empower even frail, ill, older patients in hospitals, shouldn't we be able to empower patients in other settings as well? Yes. But the question is how to achieve this. How do we create empowered patients who work with their providers to improve health outcomes and decrease health care costs?

The "informed health care consumer" would seem to be the answer. But this approach has been a disappointment. Study after study shows that simply providing information to patients doesn't make much difference in outcomes.

Bandura's concept of self-efficacy explains this failure. Knowledge and understanding are necessary but not sufficient. A patient also needs "competence" in the necessary activities, plus the "confidence" to effectively engage and make the needed behavioral change.

This next step has been taken by Kate Lorig, a nurse, health educator, and researcher at Stanford University. Professor Lorig brought a personal perspective to this issue, having been diagnosed with a serious chronic disease at the age of three. Building on Bandura's concept of self-efficacy, Lorig and her colleagues at Stanford created a series of programs for patients to learn how to "self-manage" chronic diseases such as arthritis and asthma.

Patients developed self-management decision-making skills: how and when to use medications, when to seek follow-up care, and how to build collaborative decision-making relationships

In these programs, patients developed self-management decision-making skills: how and when to use medications, when to seek follow-up care, and how to build collaborative decision-making relationships with their providers. They learned the skills necessary to engage in their own health care, to become empowered, self-efficacious health care consumers working in partnership with their providers. Results were encouraging. The programs of Lorig and colleagues, as well as other programs that taught patients similar skills, tended to result in improved health outcomes and decreased costs.

So whether it's the older patient in the hospital, or the chronic disease patient in out-patient care, the available data suggests that health care outcomes can be improved and costs lowered by developing competent, confident individual patients – patients who are empowered and engaged in their own health care in the context of collaborative patient-provider partnerships. Two major changes are necessary for this potential to be realized widely in the U.S.

We need cultural and attitudinal transformation

The first change needed is a cultural and attitudinal

transformation. Providers and patients must leave behind the traditional, romanticized model of the parent-like provider figure (“paternalistic physician-authority”) making all the decisions for the grateful, passive patient who is expected to unquestioningly act on the physician’s orders (“compliant patient”).

This model has failed largely because it is a fantasy rather than a reality. Physicians who don’t respect their patients and don’t create an atmosphere of trust may not get information from their patients necessary for accurate diagnosis or proper course of treatment. And when patients don’t understand their illness or the purpose of a medicine, or don’t feel respected, understood, and cared about by their physician, they may not even fill their prescription. Mutual respect and trust between patient and provider, whether physician, nurse, or other professional, is a first and critical step toward developing effective, collaborative patient-provider relationships.

For the last 30 or so years we’ve been talking about these issues. And we’ve gradually moved away from the ideal of a paternalistic physician/compliant patient toward the ideal of a patient-provider partnership. But many providers – and many patients too – have not yet embraced or put into practice the ideas of patient empowerment or collaborative partnerships.

Secondly, in order to achieve patient engagement and empowerment, health care delivery settings must create a supportive environment. Time is needed to develop effective collaborative patient-provider partnerships. Resources are needed to support patient competence- and confidence-building. But most current health care delivery financing models don’t promote or support these types of changes.

Fee-for-service payment models reward frequency of service over appropriateness, thoroughness, or quality. Fee-for-service provides incentives for seeing more and more patients, and for ordering tests and procedures. The results include overutilization of testing, procedures, and hospitalization, and little time for patient-provider engagement. The 8-minute doctor visit is symbolic of our fee-for-service health

care reimbursement follies. Capitated payment approaches theoretically reward better quality care and outcomes. But the biggest incentive of capitation models is to limit health care choices and services. So there are problems with the models at the two ends of the health care reimbursement spectrum.

We are now transitioning toward payment systems that support effective care and improved outcomes.

We are now transitioning toward payment systems that carry some hope of supporting more effective care and rewarding improved outcomes. Each of the two major approaches builds on existing models. Each attempts to dampen payment model-associated perverse incentives while promoting improved care and decreased costs. One approach, illustrated by Medicare Advantage programs, hopes to promote cost-effective care through capitated payments for all health care services, while adding mechanisms to safeguard access to care and to monitor quality and outcomes. The other approach is to modify the fee-for-service model, attempting to preserve freedom of choice and access, while putting into place mechanisms that promote quality-of-care, care coordination, and improved outcomes.

In the coming year, the move toward more effective payment and delivery models should get a major boost. Starting in 2012, the Centers for Medicare and Medicaid Services (CMS), acting under the Patient Protection and Affordable Care Act (PPACA), will provide mechanisms and incentives for “Accountable Care Organizations” (ACOs). ACOs are vertically integrated provider organizations that include physician groups, diagnostic facilities, hospitals, and other health care service providers. An ACO is meant to provide the total range of health care services for each individual patient. These PPACA-enabled ACOs initially will be reimbursed in a Medicare fee-for-service-like way. Each ACO will be responsible for meeting access and quality-of-care standards and will be rewarded for improved health outcomes. Additionally and importantly, each ACO

will receive a share of cost savings resulting from prevention, early intervention, improved quality of care, and care coordination.

The ACO approach has the attention of many in the health care delivery community. While initial rules for ACOs came under intense criticism and final rules are still being worked out, ACOs are likely to represent a significant force attempting to move us toward decreased health care costs and improved health care quality and outcomes.

We are entering a time of great challenge and major change in health care delivery and financing. In such an environment, health care leaders, physicians, and other providers in the trenches must rethink old models and find new ways to achieve their goals. Self-efficacious patients represent a potentially

major new resource, and the patient-provider partnership an important vehicle, for improving health care outcomes and controlling costs.

ACOs and other delivery organizations will be able to allocate resources in new and creative ways. Effective engagement and empowerment of the health care patient-consumer in his or her own care will be of central importance in meeting the goals of cost containment and improved health outcomes. The opportunity is at our doorstep.

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Dr. John Delfs is a physician educator and health care leader with extensive experience in medical practice, managed care, medical education, health policy, and media communications. Board-certified in internal medicine, geriatric medicine, and neurology, his focus is the use of knowledge in cognitive neuroscience to empower health care providers and patient-consumers.

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