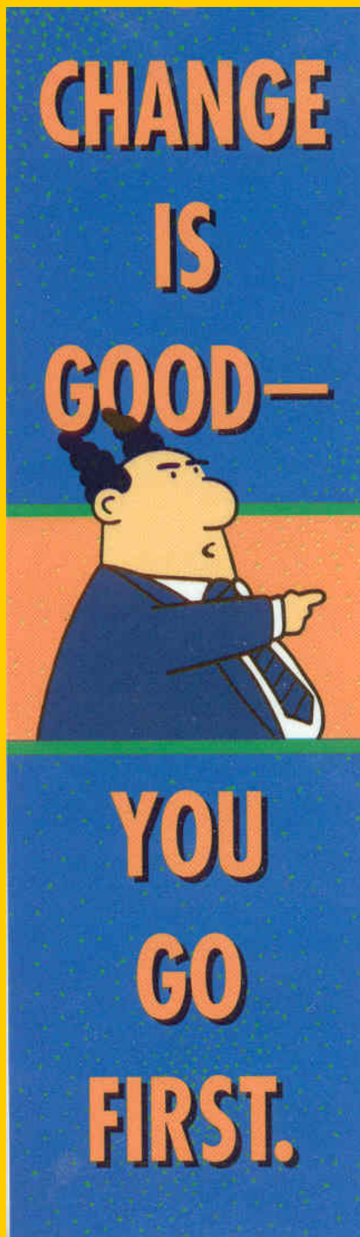


Nephrology Days 2007

Focus on Patient Self-Management: Communication, Education, Motivation

October 11 & 12, 2007
Vancouver, BC

Connie Davis and Patrick McGowan

Objectives

- Share experiences motivating others
- Review science behind behaviour change
- Learn principles of motivating patients for behaviour change
- Learn a brief method to use these principles
- Practice skills
- Discuss how to use skills in practice

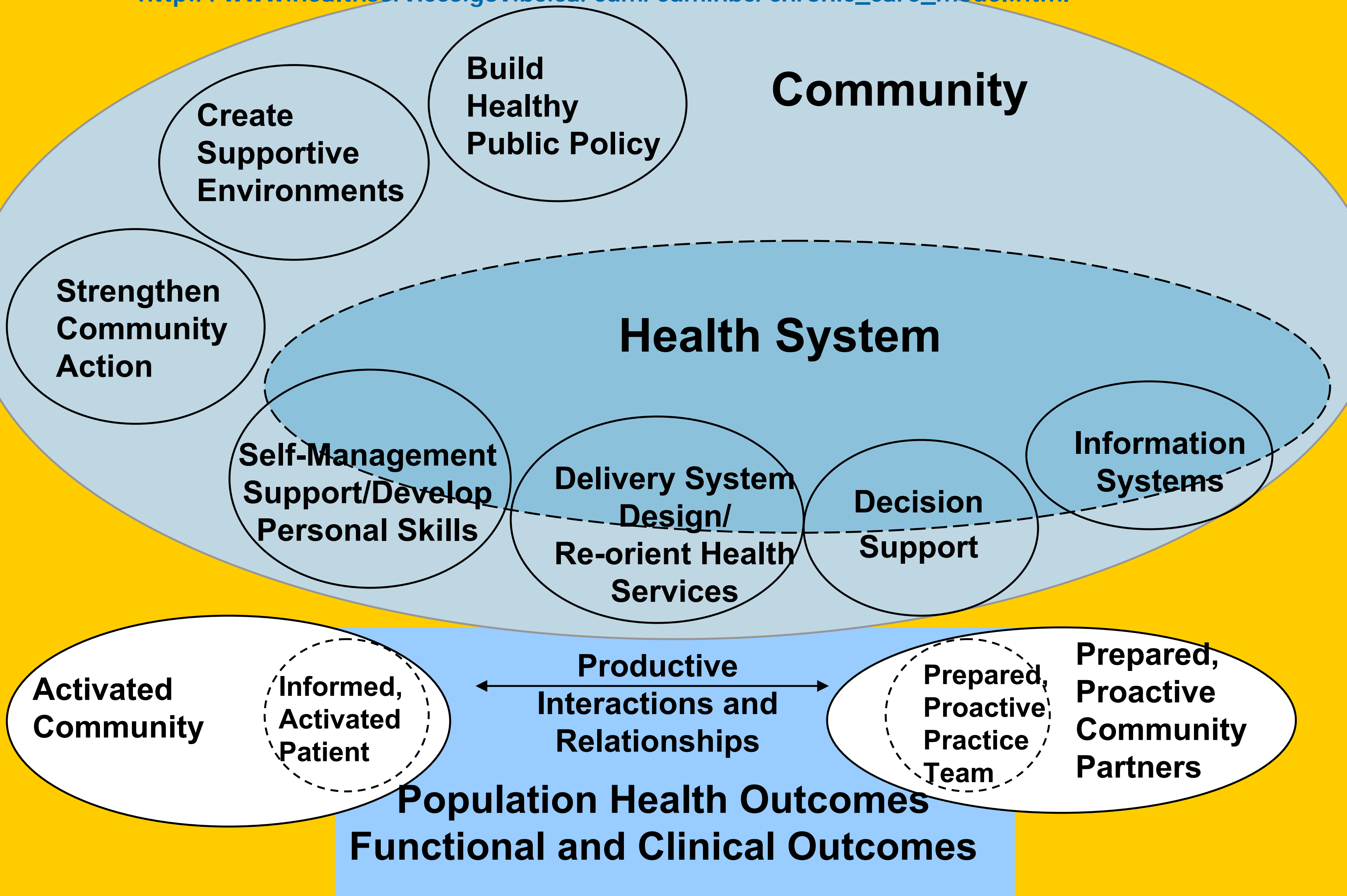
What's the hardest thing for you in working with kidney patients?

Considerations

- Clinicians are present for only a fraction of the patient's life
- Nearly all outcomes are mediated through the patient's behavior

BC's Expanded Care Model

http://www.healthservices.gov.bc.ca/cdm/cdminbc/chronic_care_model.html



Definition of Self-Management

The tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the <u>confidence</u> to deal with medical management, role management and emotional management of their conditions.

***The US Institute of Medicine* 2004**

A “Good” Self-Manager

- Has knowledge of his/her condition
- Follows a treatment plan, (care plan) agreed with health professional
- Actively shares in decision making with health professional
- Monitors and manages signs and symptoms of his/her condition
- Manages the impact of the condition on his/her physical, emotional, and social life
- Adopts lifestyles that promote health

What health care providers do..

Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

“Patients as Partners”

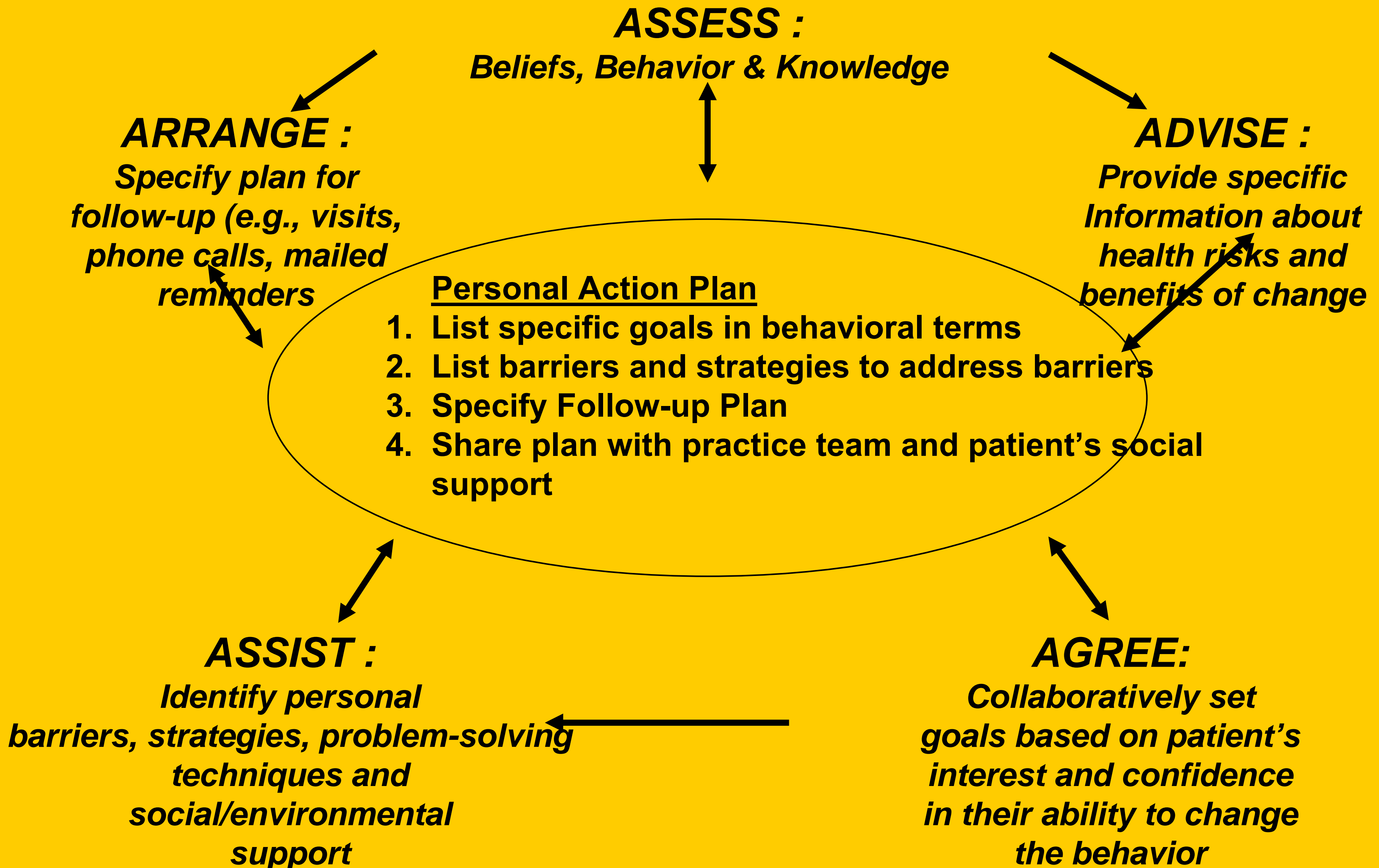
Recommendation

Adoption of the 5A's construct as a unifying conceptual framework for delivering and evaluating health behavior counseling interventions in primary care settings (i.e., minimal contact interventions that can be provided by a variety of clinical staff in primary care settings).

The US Preventative Services Task Force's Counseling and Behavioral Interventions Work Group

1. Assess
2. Advise
3. Agree
4. Assist
5. Arrange

Self-Management in CCM



Glasgow RE, et al (2002) *Ann Beh Med 24(2):80-87*

5 A's

1) Assess

Ask about / assess behavioral health risk(s) and factors affecting choice of behavior change goals / methods.

Assessment Tools

Questions

- What are you doing for fun?
- What trouble are you having with your medications?
- What are the biggest problems you're having?
- Tell me about a typical day.

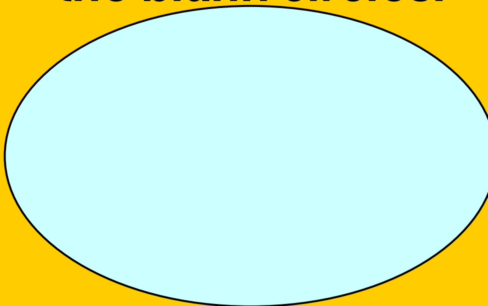
The 3 questions:

- ***What worries you the most about your condition?***
- ***What would you like to change?***
- ***How do you think you might do that?***

If you have a chronic condition, here are some things you can talk about with your health care team

→Choose to talk about changing any of these and add other concerns in the blank circles.

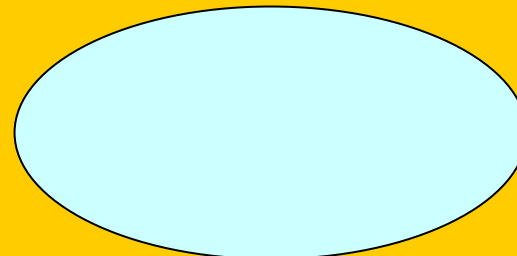
Monitoring your health



Taking medications consistently

Regular exercise

Avoiding health problems

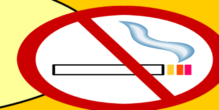


Eating better

Mood

Meaningful Activities

Smoking



Encouraging patients to be activated: agenda setting

- A study of 1000 physician visits found that the patient did not participate in decisions 91% of the time. [Braddock et al. JAMA 1999;282;2313]
- In a study of 264 visits with family physicians, patients making an initial statement of their problem were interrupted after an average of 23 seconds. In 25% of visits the physician never asked the patient for his/her concerns at all. [Marvel et al. JAMA 1999;281:283]

Collaboratively setting the visit agenda is the first step in activating the patient

Readiness to Change Model

Readiness = importance x confidence

How important is it to you to (insert issue here)?

0 1 2 3 4 5 6 7 8 9 10

Not important **Very Important**

(From Keller and White, 1997; Rollnick, Mason and Butler, 1999)

How confident are you that you can (insert behaviour here)? A "0" means you aren't sure at all; "10" means you're 100 percent sure.

0 1 2 3 4 5 6 7 8 9 10

Not sure **Very sure**

What did you observe?

Key points from the dialogue

- **The HCP allows the person to approve the agenda: "Could we talk a bit about the medication?"**

- **If the level of importance is high (7 or above), the HCP moves on to confidence level**

- **If the level of importance is LOW, it might help to provide more information about the risks of not changing the behavior**

More key points from the dialogue

- **If the confidence is low, it is very important to ask the patient to say why it isn't a zero or one so they state why they want to change.**
- **The follow-up question, what would it take to get the confidence level tells you what the barriers are.**
- **If the patient is stuck, the HCP might decide to propose an action plan, it would be something like *"Would you like to read this pamphlet about potassium rich foods and talk about it next time I see you?"***

5 A’s

2) Advise

- **Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.**

- **Provide personally relevant, specific recommendations for behavior change.**

Information Giving

- **Information from assessments**

- **Ask, Tell, Ask**

- **Closing the Loop – a technique of assessing patient's understanding**

Information Giving

The "Ask – Tell – Ask" process
(self-directed learning)

Problems:
- **Patient doesn't get the info he/she wants**
- **Patient doesn't understand the information**
- **Patient gets overwhelmed with information**

Ask – Tell – Ask Script

Ask – HCP asks " *What is your understanding of chronic kidney disease?"*

Patient responds *"I will have go to dialysis."*

Tell – HCP tells patient information.

Ask – HCP asks *"Could you please tell me back what I just said so I can make sure I made it understandable?"*

HCP: ***I just checked your blood tests, and I have to tell you something very important. You have chronic kidney disease.***

Patient: ***I knew I had a problem with my blood pressure, what do you mean kidney disease?***

HCP: ***Do you know what kidney disease is?***

Patient: ***I know someone who had it. She had to go on dialysis and she didn’t live very long.***

HCP: ***Those things can happen in kidney disease, but they can also be prevented. Tell me this: What would you like to know about kidney disease?***

Patient: ***I need to know everything, I don't want to die of this.***

HCP: ***Do you know what caused your kidney disease?***

Patient: ***I think it had something to do with my blood pressure.***

HCP: ***Yes, controlling your blood pressure is important. There are things to watch for in your diet, taking medicine will help with your blood pressure and some side effects of the kidney disease. If it progresses, you may need treatment.***

Can you repeat that back to me so I know it's clear?

Patient: ***Eat differently, control blood pressure, and take pills.***

HCP: ***Good. Where do you want to start?***

Patient: ***What will happen if I need treatment?***

HCP: ***There are dialysis you would do in your home, there is hemodialysis you can do at home or in the community at a clinic or peritoneal dialysis, a kidney transplant or we could do nothing and let nature take it's course.***

Patient: ***You mean I could do treatment at home?***

***HCP**: There are 2 types of treatment we can do in the home*

***Patient**: But right now if I work on my medications, diet and blood pressure I might avoid that, right?*

***HCP**: Yes, which would you like to talk about more?*

***Patient**: What I should eat.*

Providing information: closing the loop

- Study of patients with diabetes: in only 12% of patient visits, the clinician checked to see if the patient understood what the clinician had told the patient
- Asking patients if they understood what was said is called “closing the loop”
- In 47% of cases of closing the loop, the patient had not understood what the physician said
- When closing the loop took place, HbA1c levels were lower than when it did not take place

Closing the loop should be an integral part of advising patients

Schillinger et al. Arch Intern Med 2003;163:83.

5 A’s

3) Agree

Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change a behavior.

The Question…

Is there anything you would like to do this week to improve your health?

- **The patient chooses a behaviour s/he is motivated to change.**
- **The patient chooses a personally meaningful outcome.**

"Is there anything you would like to do this week to improve your health?"

Other things?

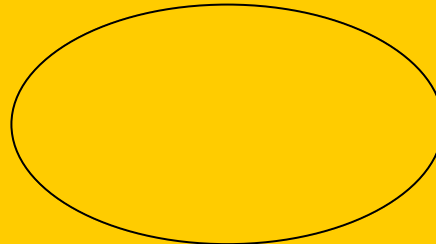
Physical activity

Taking medications

Reducing stress?

Healthy diet

Checking sugars



Mastery Learning

Goal → Action Plan → Follow-Up

Mastery Learning

A. Goal

Something person wants to achieve in 3 to 6 mos.

“Be exercising regularly – say about 5 hours/week”

B. Action Plan

A small doable step he/she wants to take in working toward reaching the goal.

“Between this week and next week I will buy running shoes.”

C. Confidence Level

Person specifies his/her confidence level in achieving the action plan (scale 0 to 10).

D. Reporting Back and Problem Solving

At the next appointment or via telephone or e-mail.

Your Turn

- Think of a health goal for yourself

Encouraging patients to be activated: Goal-setting and action plans

- An important part of activating patients is goal-setting: assisting patients to set goals and make realistic and specific action plans
- Patient chooses goal: to lose weight
- Unrealistic action plan: “I will lose 20 pounds in the next month.” “I will walk 5 miles a day.”
- Realistic and specific action plan: “I will eat one candy bar each day rather than the 5 per day I eat now.” “I will walk for 15 minutes each day after lunch.”

Success in achieving an action plan increases self-efficacy (confidence that one can improve one’s life)

What is Self-Efficacy?

"One's belief that one can perform a specific behaviour or task in the future."

Dr. Albert Bandura

Self-efficacy affects every phase of health behaviour change

- Whether one even considers changing a health behaviour
- How much one benefits from the changed behaviour
- How well one maintains the change achieved
- How vulnerable one is to relapse

Parts of an Action Plan

1. Something YOU want to do
2. Reasonable
3. Behaviour-specific
4. Answer the questions:
   a) What
   b) How much
   c) When
   d) How often
5. Confidence level (0-10) that you will complete the ENTIRE action plan

Your turn…

- Make an action plan for this week.

Usual Weekly Action Plans

1. Exercise
2. Eating
3. Medically related
4. Personal / Emotional
5. Related to relief of stress

The action plan must reflect contributions, preferences, and assessments of feasibility by the patient, not mere acquiescence to physician recommendations.

5 A's

4) Assist

Refers to HCP activities that address barriers to change, increase the patients' motivation and self-help skills, and /or help the person secure the needed supports for successful behaviour change.

1. **Reviewing goals and action plans**
2. **Teaching of self-monitoring skills**
3. **Motivational Interviewing**
4. **Teaching problem-solving skills**
5. **Offering coping skills (CDSMP)**
   - **dealing with pain, shortness of breath**
   - **adjusting to restricted functioning**
   - **dealing with depression and emotions**

Problem Solving Steps

1. Identity the problem
2. List ideas that could solve the problem
3. Select one idea to try
4. Assess the results
5. Substitute another idea
6. Utilize other resources
7. Accept that the problem may not be solvable now

5 A's

5) Arrange

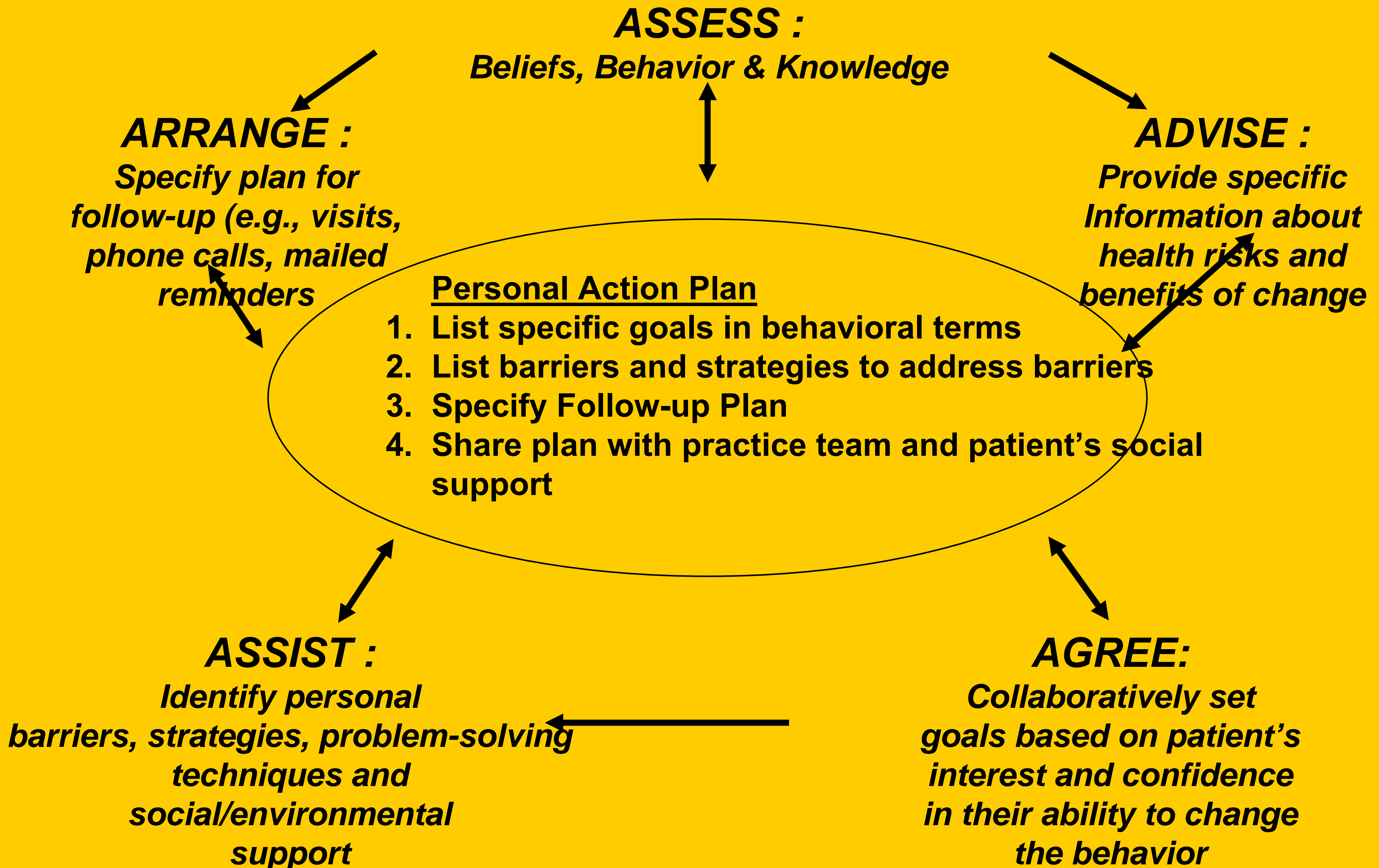
Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance / support and to adjust the treatment plan as needed including referral to more intensive or specialized treatment.

Follow-Up

Follow-Up

- Regular and sustained follow-up is crucial for the success of goal-setting and action-planning
- Follow-up includes problem-solving of barriers to goal achievement
- Follow-up can be done in person, by phone, by medical office assistants, or other patients

Self-Management in CCM



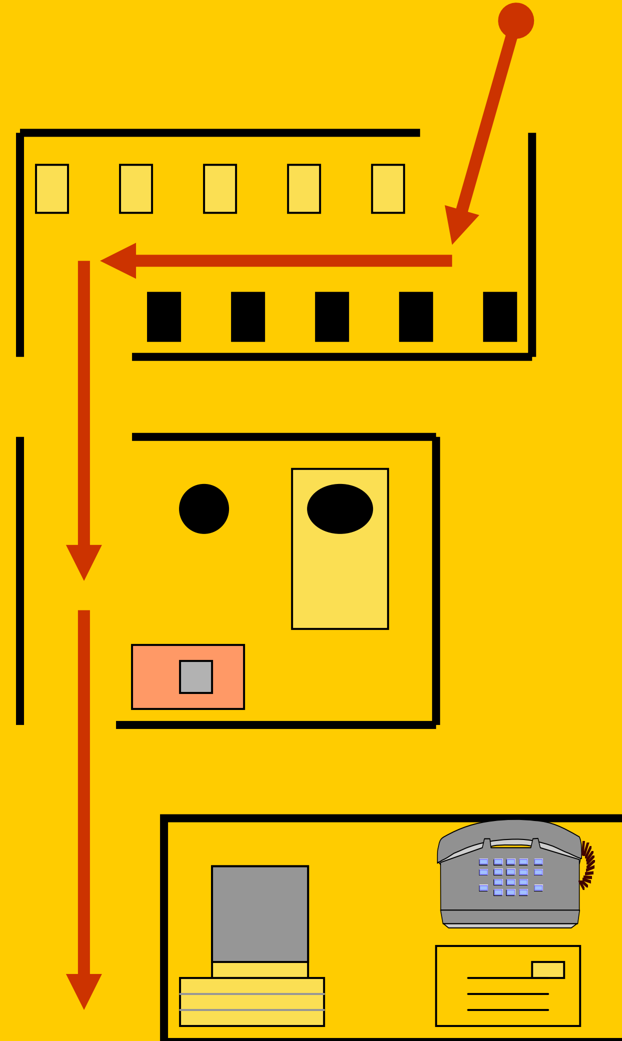
Glasgow RE, et al (2002) *Ann Beh Med 24(2):80-87*

I work in a busy office, how can I possibly do this?

Ideas from you….

Opportunities for SMS

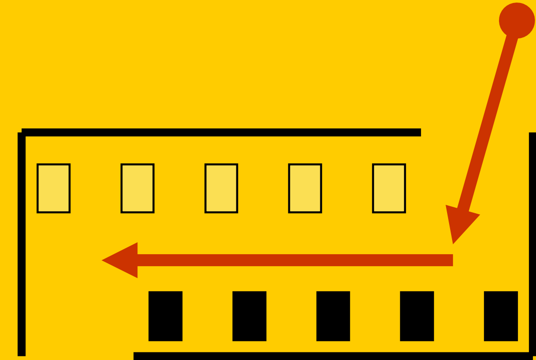
- Before the Encounter
- During the Planned Visit
- After the Encounter



Russ Glasgow, PhD

Opportunities for SMS

Before the Encounter



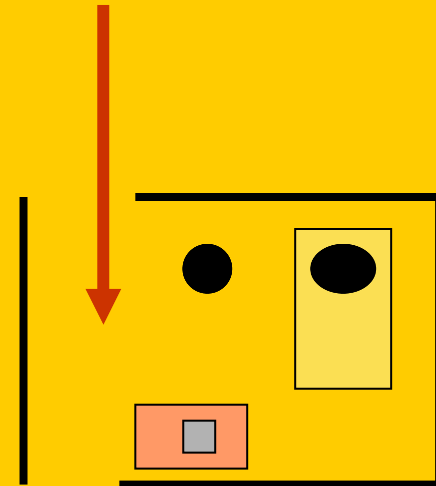
- **Pre-visit contact (phone, mail or e-mail)**
- **Waiting room assessment**
- **Patient education material**
- **Posters**
- **Pamphlets on "Talking to Your Provider"**
- **Community outreach**

(Glasgow, Pt Ed & Couns 1997;32:175-184)

Opportunities for SMS

During the Planned Visit

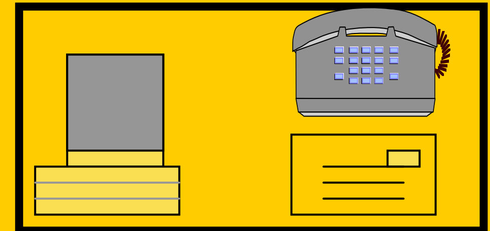
- **Review assessments**
- **Feedback on achievements vs. goals**
- **Identifies priorities for visit**
- **5 “A”s Counseling**
- **Targeted patient education materials**
- **Referral to self-management education**



Opportunities for SMS

After the Encounter

- Referrals (Education, etc)
- Further 5 “A”s counseling
- Phone calls follow-up
- Mailed patient education
- Peer support
- Newsletters
- Follow-up visits
- e-mail/Internet sites



Greatest Challenge

The greatest challenge for SM and SMS intervention is not at the individual level – where there are effective, evidence-based strategies – but at the systems level, where the optimal mix of clinical, community, and informal/personal strategies is difficult to manage.

The combination of good patient clinician communication and shared decision making:

- **Increases patient satisfaction**
- **Higher self-reported health status**
- **More adherence to treatment plans**
- **Improved health outcomes (especially diabetes)**

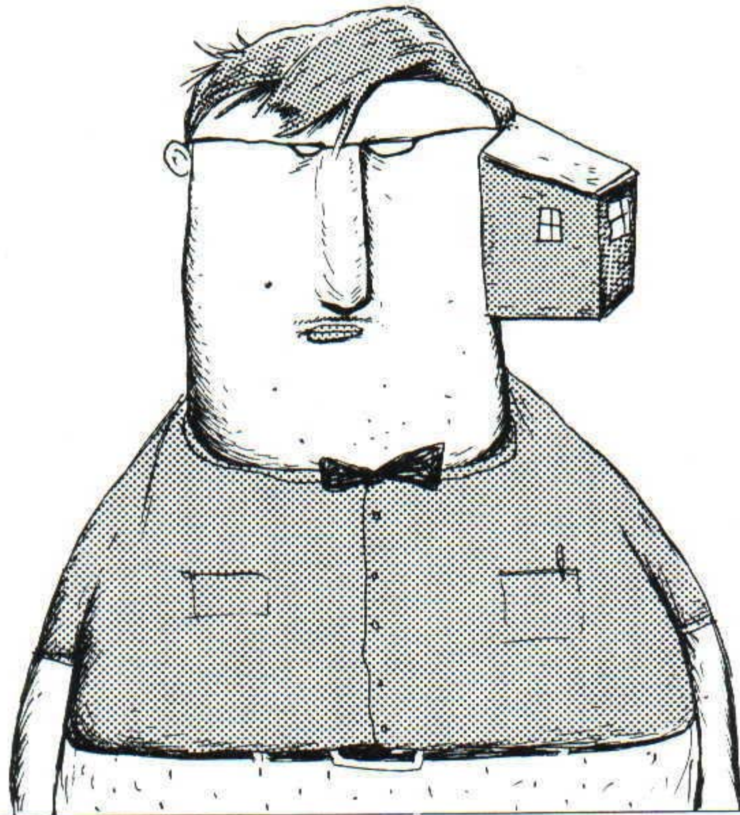
Heisler et al. JGIM 2002;17:243

Conclusion

The triad of goal setting, action planning, and problem solving, while not rigorously evidence based, appear to be important techniques to improve health-related behaviours and clinical outcomes. Regular and sustainable follow-up Is essential.

Bodenheimer & Grumbach. Page 94

Back to where we started…


People were always telling Franz he had room for improvement... so he decided to build on a sun porch.
hickerson

Resources

- Book: Rollnick et al “Health Behavior Change” 1999.
- Book: Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001
- Bibliography on self-management: www.improvingchroniccare.org

Web resources

- www.bayerinstitute.com provides provider training in "Choices and Changes"
- www.motivationalinterview.org has books, videos and training
- http://med.stanford.edu/patienteducation/ home of Chronic Disease Self-Management Programs

Health Risk Assessment Tools

Free

Atlantic Health and Wellness Institute

- http://ohra.ucis.dal.ca

How's Your Health

- www.howsyourhealth.org

Membership Required

- U of Michigan HRA
- www.hmrc.umich.edu/services/hra.html
- Mayo Clinic HRA
- www.mayoclinichealthmanagementresources.com/products/hra.cfm
- My Health Choice
- www.nsaho.ns.ca