Patient Engagement: Optimal Outcomes

Kenneth L Miller, PT, DPT, MA, CEEAA
Laurie A Page, PT, DPT, COS-C, HCS-D

Objectives

Upon completion of this course, participants will be able to:

- Describe Trans-theoretical Model of Change (TTM); Self-Determination Theory (SDT); Motivational Interviewing (MI); and Health Coaching (HC)
- Incorporate TTM, SDT, MI and HC into therapist practice
- Identify barriers and facilitators to improve patient engagement

2

Introduction

Why patient engagement now?

Shift to value-driven system (Affordable Care Act of 2010)

- Vested interest by providers in preventing re-hospitalizations and for patient success in adhering to more healthy behaviors
- To effect health behavior change for better outcomes in less time
- Costly system - 86% of our health care dollars on the treatment of chronic diseases (Centers for Disease Control and Prevention (CDC))
- To meet the Triple Aim (Institute for Healthcare Improvement (IHI))
  - Improve the patient experience (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care

3

Patient Engagement

"much of the real work of improving health outcomes takes place outside of the system, within the patients' daily lives"

Bucher and O'Day

4

The Patient Experience

Patient is referred for home SN/PT s/p TKA and has complaints of uncontrolled R knee pain 8/10. Pt has Rx for oxycodone at pharmacy – pharmacy will not have pain meds x 2 days.

What should be done?

5

The Patient Experience

- Option 1.
  - RN performs SOC in am – "I will call MD." SN. Leaves patients home, calls MD, does not hear back from MD. Goes on to next patient and completes her day. Does not call patient back.
  - PT performs Eval in pm – "Did the nurse call the doctor? She should call you back." Goes on to next patient and completes her day. Does not follow up with patient"
- Option 2.
  - RN states, "I will call your doctor. If you do not hear back in 2 hours, call XXX-XXXX and ask to have the MD, PA or NP paged.
  - PT states, "Did you hear back from the nurse or MD? No? Did you follow up? No? OK. Let me help you call now."

6

Option 1 vs. Option 2

- Option 1. Patient is a passive participant and not educated to advocate for self. PT reinforces behavior established by nurse
- Option 2. Patient is engaged and being educated to advocate for self. PT reinforces behavior established by nurse

7

Engaging the Patient

- At the SOC (Admission Visit) and all follow up visits as appropriate:
  - Discuss roles and responsibilities for agency, clinicians AND patient.
  - Patient-centered goals (what is important to the patient)
  - Address safety risks, medications, etc.
    - Coach rather than instruct
    - Active rather than passive
  - Provide patient marble composition book to take notes
  - Have patient write own med profile, including dose, route, time, side effects
  - Give patient action plan to triage S/Sx to report to agency, MD, 911

8

So, you've included the patient

9

And nothing changes…

WHY?

10

DEPRESSION

PAIN

FEAR

BELIEFS

NO HOPE

ANXIETY

11

Making change starts with beliefs

"My dad died at 60 of a heart attack…I shouldn't be here at 75."

"My mother had diabetes, it is inevitable. I will get diabetes."

"What is the point?"

"I can't."

"Why are you here?"

12

How do we get patients to take ownership of their own health behaviors?

We need to take a look at:

- What do people believe about heath?
- How do people take health actions (or fail to do so?)
- What motivates behavior change?
- When does the scale tip towards adherence to health behaviors?
- How do they maintain behavior change?

13

Behavior Change Models

Beliefs and **Attitudes** are prominent in the constructs of behavior change models.

Beliefs involve ***"Cognitive elements":*** how people evaluate and respond to ideas in order to derive conclusions regarding the truths of something.

Attitudes involve the ***"Emotional or Affective elements"*** or emotional state regarding a person's individual feelings or emotions regarding a belief.

14

Tools for Behavior Change

How do we as healthcare providers "engage" instead of "instruct or tell" patients regarding adoption of healthy behaviors?

- Trans-theoretical Model of Change (TTM) - Prochaska
- Self Determination theory (SDT) – Deci and Ryan
- Motivational Interviewing (MI) – Miller and Rollnick
- Health Coaching (HC)

Health Behaviors addressed

- Smoking cessation, exercise adoption, dietary changes, weight loss

15

Tool Summary

Patient Engagement Technique/Approach	Practical Meaning for Therapists
Trans-theoretical Model of Change ("Stages of Change")	Awareness for need to change
Self-Determination Theory	What motivates the patient? Patient is in the driver's seat
Motivational Interviewing	Person-centered, goal oriented language that is non-judgmental and shows empathy
Health Coaching	Partner with patient

16

TTM

TRANS-THEORETICAL MODEL OF CHANGE

17

Origin of TTM

- Prochaska, Norcross and DiClemente studied how people overcame problems with smoking & alcohol abuse, emotional distress, weight control on their own – Began in late 1970's
- Studied those who made changes that were in formalized psychotherapy vs those making changes on own
  - Both were effective depending on stage of change the person is in

18

Trans-theoretical Model of Change

A model of intentional behavior change which offers a view of when, how and why people change their behavior by incorporating process orienting variables with "stages of change"

- *Six "predictable, well-defined" stages*
  - *Series of tasks that need to be completed before progressing to the next stage*
- *One does not necessarily lead from one stage inevitably to the next, as many times one gets stuck in a stage.*
- *"Decisional balance" (Pros and cons of engaging in the behavior) and "self-efficacy" (person's confidence in performing the health behavior change are also incorporated into this theoretical model.*

Prochaska, DiClemente, and Norcross (1994)

19

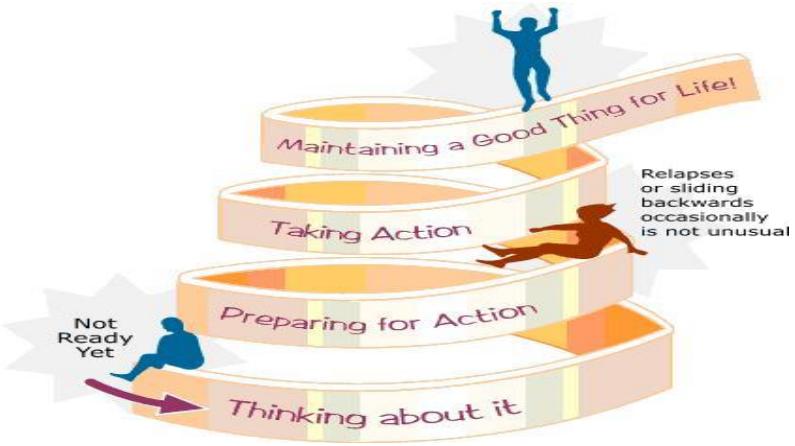
Stages of Change model	
Stage of change	**Patient cognition and behavior**
Precontemplation	Does not think about change, is resigned or fatalistic Does not believe in or downplays personal susceptibility
Contemplation	Weighs benefits vs. costs of proposed behavior change
Preparation	Experiments with small changes
Action	Takes definitive action to change
Maintenance	Maintains new behavior over time

From: Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. *Am J Health Promot* 1997;12(1):38-48.

TERMINATION: This is the stage where, through persistence, knowledge and experience, you feel you are now free from a long-standing problem.

20

TTM



21

What stage is your patient in?

- **Precontemplation:** "What problem? Oh that, I would rather not discuss that right now."
- **Contemplation:** "I'm thinking about it." People in this stage are thinking about starting a change plan within the next month.
- **Preparation:** "I have made up my mind and I am getting ready."
- **Action:** "I am doing the exercises. Do you want to see?"
- **Maintenance:** The individual has established new habit patterns and continues to take actions that reinforce the new behaviors

22

TTM in Action

Precontemplation Stage

Patient says:

"It was an accident. It won't happen again because I am being more careful."

Therapist response:

"Being careful is a good start, but, there are other things you can do to reduce the risk."

23

TTM in Action

Contemplation Stage

Patient says:

"I'd like to exercise but, I don't because I'm afraid I will get too tired."

Therapist response:

"You can reduce your chances of falling by increasing your exercise and activity level without overexerting yourself."

24

TTM in Action

Preparation Stage

Patient says:

"I'm worried about falling. Do you think there's anything I can do to keep from falling?"

Therapist response:

"Let's look at some things you can do to help yourself reduce the risk."

25

TTM in Action

Action Stage

Patient says:

"I know I'd feel better with grab bars in my bathroom."

Therapist says:

"I am glad that you are thinking about your safety."

26

Case Scenario

- Patient is a 67 year old female referred for home care with Dx of DM, HF, OA.
- Recently hospitalized with exac of HF. (3rd hospitalization in past 6 months).
- Patient states, "I don't need nursing or therapy. I forgot to take my medication and did not elevate my legs. I am being more careful now."

27

Case Scenario

- What stage of change is this woman most likely in based on the her comments?
  - Precontemplation Stage
- What is an appropriate clinician response?

  "Being more careful is a good start, but, there are other things I can share with you to make your life safer and less likely to go back to the hospital."

28

SDT

SELF-DETERMINATION THEORY

29

Origin of SDT

- Deci and Ryan - Theory of motivation
- Focuses on process through which a person acquires the motivation for initiating new health behaviors and maintain them over time
- Health behaviors not intrinsically motivated
  - Increasing physical activity
  - Taking medications
  - Quitting smoking

30

Self Determination Theory (SDT)

SDT is a theory of human motivation, emotion and personality in social contexts in which there is ***a natural tendency for humans to be oriented towards physical and psychological health***.

A critical component of this theory is the ***degree in which*** human fulfill their basic psychological needs of:

- AUTONOMY - an informed un-coerced and "respected" decision. **Patient Choice**.
- COMPETENCE - one's **self belief** in their ability to perform well or feel effective in one's actions.
- RELATEDNESS - **feeling safe and cared for** in one's interpersonal relationships.

The more these needs are attained…..the more the behavior is self directed.

31

Promoting Autonomy

- How do PT's influence autonomy with exercising?
- 1.) Offer choices (types). Ask what the individual enjoys?
- 2.) Redefine Exercise by finding out what exercise (or activity) means to the individual.
  - If person does not like to exercise don't even refer to it as such!
    - i.e. redefine exercise through gardening, golfing, cooking or woodworking.
  - Or maybe suggest how short bursts of exercises can be incorporated and remembered during daily ADL's and IADL's, i.e brushing teeth, doing the dishes, watching TV.

32

Promoting Competence

- Tips on administering feedback:
- Positive Reinforcement – be selective or it loses it's value
- Skill - Specific Feedback - give positive feedback immediately when parts of a skill are correct
- The Sandwich Approach – patient feels "personally " responsible (perceived self-belief) for what was done so emphasize what was done well even if their competence is low. (i.e. they feel as if they are not adherent or part of them is weak and they feel incompetent in their actions.
  - 1st slice = mention something done correctly.
  - Filling = offer a solution of what needs to change.
  - 2nd slice = finish with a general positive comment.

33

Promoting Relatedness

The best technique is to put in the time to ***show genuine caring.***

- Ask them what they like, including how much they want to talk during therapy, and adjust accordingly.
- Keep in touch with them with an email or card and thank them in person for working with you.

34

Self Determination Theory

Continuum of motivation:

(absence of motivation) (driven by external forces) (ideal: driven by internal factors)

35

Case Scenario

- Patient is an 95 year old male who referred for home care due to difficulty walking. Dx: PAD in LE's. S/P – L BKA 3 months ago
- PMH: DM, HTN, HF, BPH
- Social: Patient lives with spouse whom is also elderly and disabled. Patient was the primary caregiver prior to hospitalization.
- What is one possible intrinsic motivator?
  - Caring for spouse
- Are there any extrinsic motivators?

36

MI

MOTIVATIONAL INTERVIEWING

37

Origin of MI

- William R. Miller studied behavior therapy for problem drinking
- Empathy was found to be effective approach to achieve behavior change
- Developed empathetic, person-centered style
- Have the client, rather than the counselor verbalize the argument for change

38

Motivational Interviewing

- **Collaborative conversation style**
  - strengthening a person's own motivation and commitment to change.
- **Person-centered counseling style**
  - Addresses the common problem of **ambivalence** about change.
- **Goal-oriented style of communication**
  - Language of change**,** designed to strengthen personal motivation
  - Explores the person's own reasons for change within an atmosphere of acceptance and compassion
- Encourages people to discover their interest in considering and making a change in their lives

39

MI

Express Empathy

- Where is the patient in understanding their illnesses and their impact?
- Build trust and rapport
- Listen and ask patient to reflect on health status
- How hard is it on you and your family when you are in the hospital?
- I am sure it is very hard to control your sugar level with your diet. What types of foods is the hardest for you?

Courtesy www.centerforebp.case.edu

40

MI

Develop Discrepancy

- Assist patient to see where they are and where they want to me
- Start patient goal setting (non-medical goals are appropriate)
- How does being sick so often affect your life?
- What have you tried before that has worked? Has not worked?
- What did you like to do before you got sick?

I wonder what it would take so you could do that again?

Courtesy www.centerforebp.case.edu

41

MI

Roll with Resistance

- Don't argue or oppose resistance
- Try new approach
- Listen for underlying reasons
- Use open ended questions
- Tell me what do you think caused you to go back to the hospital
- What do you think caused the symptoms to flare up?
- Tell me about the problems you have with taking your medications?

Courtesy www.centerforebp.case.edu

42

MI

Support Self-Efficacy

- Support patient's goals, actions
- Use sense of trust and guide patient
- Use "My Action Plan" or other goal setting tool
- Tell me what you would like to do in the next couple of weeks?
- How do you think you can do it?
- How can I help you reach your goal?
- You did great this week on you goal. How confident are you to do it this week?

Courtesy www.centerforebp.case.edu

43

Am I Doing this Right?

1. ✔ **Do I listen more than I talk?**
   ✗ Or am I talking more than I listen?
2. ✔ **Do I keep myself sensitive and open to this person's issues, whatever they may be?**
   ✗ Or am I talking about what I think the problem is?
3. ✔ **Do I invite this person to talk about and explore his/her own ideas for change?**
   ✗ Or am I jumping to conclusions and possible solutions?

Courtesy www.centerforebp.case.edu

44

Am I Doing this Right?

4. ✔ **Do I encourage this person to talk about his/her reasons for *not changing*?**
   ✗ Or am I forcing him/her to talk only about change?

5. ✔ **Do I ask permission to give my feedback?**
   ✗ Or am I presuming that my ideas are what he/she really needs to hear?

6. ✔ **Do I reassure this person that ambivalence to change is normal?**
   ✗ Or am I telling him/her to take action and push ahead for a solution?

Courtesy www.centerforebp.case.edu

45

Am I Doing this Right?

7. ✔ **Do I help this person identify successes and challenges from his/her past *and* relate them to present change efforts?**
   ✗ Or am I encouraging him/her to ignore or get stuck on old stories?

8. ✔ **Do I seek to understand this person?**
   ✗ Or am I spending a lot of time trying to convince him/her to understand me and my ideas?

9. ✔ **Do I summarize for this person what I am hearing?**
   ✗ Or am I just summarizing what I think?

10. ✔ **Do I value this person's opinion more than my own?**
    ✗ Or am I giving more value to my viewpoint?

Courtesy www.centerforebp.case.edu

46

Change Talk

"Change talk is defined as statements by the client revealing consideration of, motivation for, or commitment to change"

Miller and Rollnick

47

MI – Change Talk

Collaboration				
Low				High
1	2	3	4	5
Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration is absent.	Clinician responds to opportunities to collaborate superficially.	Clinician incorporates client's goals, ideas and values but does so in a lukewarm or erratic fashion. May not perceive or may ignore opportunities to deepen client's contribution to the interview.	Clinician fosters collaboration and power sharing so that client's ideas impact the session in ways that they otherwise would not.	Clinician actively fosters and encourages power sharing in the interaction in such a way that client's ideas substantially influence the nature of the session.

48

Four Central Components of MI

- **Acceptance**—interviewer communicates absolute worth, accurate empathy, affirmation, and autonomy support.
- **Compassion**—interviewer acts benevolently to promote the client's welfare, giving priority to the client's needs.
- **Evocation**—interviewer elicits the client's own perspectives and motivation.
- **Partnership**—interviewer functions as a partner or companion, collaborating with the client's own expertise.

49

Case Scenario

- Patient is a 66 year old male referred for home health nursing and therapy for medication instruction and for stair training (difficulty with climbing stairs in and out of home).
- PMH: Obesity, HTN, DM, HF.
- Physical Exam: (+) edema in B LE's. +2 dyspnea with ambulation, vitals WNL.
- Patient is sleeping on couch with LE's in dependent position due to difficulty climbing stairs.

50

Case Scenario

- **Therapist states:**

  "Mr Jones, I would like to see how you climb the stairs."
- **Patient states:** "I don't want to climb the stairs and I don't want therapy."
- **Therapist states:**

  "I am here to help you achieve your goals. What are your goals? What do you think causes you difficulty with climbing the stairs?"

51

Chronic Disease

- Diabetes Mellitus
- Heart Failure
- COPD

- Goal: Increase adherence with Diet.
- Increase activity level.

52

Case Scenario

- 68 year old female referred for PT due to weakness following hospital stay of 5 days due to UTI. Unsteady gait, increased fall risk (TUG = 20 seconds) and patient has low activity tolerance (RPE – 8/10 with amb 55' with cane).
- PMH: DM2 x 10 years, obese, incontinent of urine, OA in B hips.
- Social/Functional: Lives with spouse in 1 floor home. Prior level of function: community ambulator with SPC.

53

Case Scenario

- Upon arrival to home for evaluation, patient reports, " I do not need any therapy." [Precontemplation].
- Using MI, what do you say to engage patient to allow for evaluation?
- Therapist states:

  "It must be hard on you and your family when you are in the hospital." [Empathy]

  "Have you tried home care in the past? Has it worked?" [Developing Discrepancy]

54

Case Scenario

- Purpose of empathy and developing discrepancy statements are to foster power sharing [coincides with SDT – autonomy] and facilitate change talk.
- Patient states, “OK. You can come inside, but, I don’t know that you can help me.”
- Therapist reinforces developing discrepancy by stating, “Have you tried physical therapy in the past? Has it helped you?”
- Be sure to roll with resistance…

55

HC

HEALTH COACHING

56

Health Coaching (HC)

- Background – where, why?
- Current use? By who?

- Move from director to partner
- Redefines the patient/provider relationship fostering behavior change

- Health Coaching is NOT:
  - Counseling; Directing; Managing

57

Teaching and Coaching

- Traditional health teaching - involves directing/managing
  - Gives advice, diagnosis-driven, we do the talking, provider's agenda

- Health Coaching is partnering and engaging
  - Active Listening
  - Empowers
  - Patient's concerns
  - Non-judgmental
  - Uses Motivational Interviewing

  - "Please tell me your concerns about …?"

58

Health Coaching

- Patient is the change agent
- Skillful Conversation
- Clinical Strategies
- Actively engage
- Taps into patients own motivation

Melinda Huffman, BSN, MSN, CCNS, CHC
Co-Founder, National Society of Health Coaches

59

Health Coaching – Tips to engage patients

- Guiding the Agenda:
  - Ask the patient/family what is most concerning to them about the health behavior change they believe they need or want. Consider all concerns mentioned. Guide the patient to drill down to those of utmost personal importance to him/her.
- Addressing Ambivalence:
  - Have the patient list the reasons he/she hasn't changed the behavior and the reasons the behavior needs to change. Have the patient decide which of those behaviors have priority.

60

HC using MI

- Help the patient drill down to the real issue(s) or dilemma by using open-ended questions/statements/responses and empathy.
- Example of open-ended question: "Tell me what concerns you about ____" (taking insulin, quitting tobacco; changing eating habits, losing 35 lbs.)
- *Note: Don't interrogate; but explore.

Miller & Rollnick, 2013

61

Case Scenario

- Patient referred for home care with a diagnosis of Alzheimer's' Disease.
- Rx states: RN Eval, PT Eval and HHA 5xweek.
- Patient is a frequent flier to your agency.
- Caregiver states, "My doctor ordered the services and we need the aide."
- How can you incorporate HC and MI to effect health behavior change in the patient/caregiver?

62

Case Scenario

- Depending on the patient's level of cognition, the patient engagement tools may need to be employed with the caregiver
- Mild Cognitive Impairment – engage both patient and caregiver
- Moderate/Severe Cognitive Impairment – include the patient, but, behavior change is more likely with caregiver

63

Giving Information:

- Traditionally, providers give information based on what we think the patient/family needs to hear without regard for what the patient/client already know or have immediate concerns about.
- Ask for permission and provide information accordingly.
- Example: Patient with a new diagnosis of diabetes... "What do you understand about diabetes? Would you like some more information about it?"

Adapted from http://www.nshcoa.com/qa

64

Facilitators and Barriers

- Address Contextual Factors
  - Environmental Factors
    - Architectural
    - Support System
      - Attitudes of others
  - Personal Factors
    - Belief system
    - Educational level
    - Values of patient

65

Thank You

- Kenneth L Miller, PT, DPT, MA, CEEAA
  - Kenneth.miller.consultant@gmail.com
- Laurie A Page, PT, DPT, COS-C, HCS-D
  - Lpagept@gmail.com

66

References

- Public Law 111-148. Patient Protection and Affordable Care Act. 2010. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf Accessed October 18, 2013
- Cliff B. Patient-Centered Care and Community Engagement. Journal of Health care Management. 2012; 57(4):234-5.
- Frank J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet 2010; 376(10):1923-58.
- Zimmerman GL, Olsen CG, Bosworth MF. A Stages of Change approach to helping patients change behavior. American Family Physician 2000;61(5):1409-1416.
- Institute for Healthcare Improvement. www.ihi.org/engage/initiatives/tripleaim/pages/default/aspx. Accessed 10/20/14.
- Johnson S.S., Driskell M., Johnson J.L. Prochraska J.M., Zwick W.,Prochraska J.O. (2006). Efficacy of a Transtheoretical Model – Based Expert System For Antihypertensive Adherence. Disease Management. 9 (5). 291-301.

67

References

- Bucher A., O'Day R. (2014). The Triple Aim's Missing Link: Meaningful Engagement for Patients with Chronic Conditions. *Managed Care Outlook. 27 (5) : 1-8.*
- Hibbard J., Greene J., & Overton V. (2013). Patient Activation and Health Care Costs: Do More Activated Patients Have Lower Costs? Health Affairs. 32 (2) : 216-222.
- Patrick H., Williams G.C., (2012). *Self- determination theory: its application to health behavior and complimentarity with motivational interviewing.* International Journal of Behavioral Nutrition and Physical Activity. 9 (18): 1-12.
- Williams G.C., Patrick H., Niemiec C.P., Cryan R.M., Deci E.L., Lavigne H.M. (2011). *The Smoker's Health: A self-determination theory intervention to facilitate maintenance of tobacco abstinence.* Contemporary Clinical Trials. 32 (2011): 535-543.
- Williams G.C., Patrick H., Miemiec C.P., Williams L.K., Divine G., Lafata J.E., Heisler M., Tunceli K., Pladevall M. (2009). *Reducing* the Health Risks of Diabetes: How Self-determination *Theory May Help Improve Medication Adherence and Quality of Life.* The Diabetes Educator. 3 (3) 484-492.

68

References

- Palmeira A.L., Teixeira P.J., Branco T.L., Martins S.S., Minderico C.S>, Barata J.T., Serpa S.O. (2007). *Predicting short-term weight loss using four leading health behavior change theories.* International Journal of Behavioral Nutrition and Physical Activity. 4(14). 1-12.
- Lonsdale C., Hall A.M., Williams G.C., McDonough S.M., Ntoumanis N., Murray A., Hurley D.A. (2012). Communication style and exercise compliance in physiotherapy (CONNECT). A cluster randomized controlled trial to test a theory-based intervention to increase chronic low back pain patients' adherence to physiotherapists' recommendations: study rationale, design, and methods. BMC Muskuloskeletal Disorders. (2012)13 (104) 1-15.
- Frerichs W., Kaltenbacher E., Peterrr van de Leur J., Dean E. (2012). Can physical therapists counsel patients with lifestyle related health conditions effectively? A systematic review and implications. Physiotherapy Theory and Practice. 28(8): 571-587.
- Miller WR, Baca LM. Two-year follow-up of bibliotherapy and therapist-directed controlled drinking training for problem drinkers.Behavior Therapy. 1983;14:441–448.

69