A revolution for the traditional healthcare model: How health professionals can better support their patients

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How to better support patients

Self-management

Collaborative care

2 key myths
Myth 1: Behaviour change is easy
ISLAGIATT Principle
-Prof Martin Eccles
Individual-level determinants

Socio-cultural factors

Environmental factors
“What conditions internal to individuals and in their social and physical environment need to be in place for a specified behavioural target to be achieved?”

Michie et al. 2011 (Implementation Science)
Behaviour Change Wheel

Michie, Atkins & West (2014)
Myth 2: Information drives behaviour change
Ecological model
-Sallis & Owen

- Behaviour change does not occur in a vacuum
- Individual/intrapersonal determinants of behaviour
- Interpersonal determinants
- Organizational determinants
- Community-based determinants
- Societal/Public policy
Two key concepts in self-management

1. **Collaborative care**: the collaborative relationship between the health-care professional and patient

2. **Self-management education**: In comparison to traditional education, self-management teaches skills & techniques to allow the patient to overcome barriers
<table>
<thead>
<tr>
<th></th>
<th>Traditional Patient Education</th>
<th>Self-management Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is taught?</td>
<td>Information and technical skills about the disease</td>
<td>Skills on how to act on problems</td>
</tr>
<tr>
<td>How are problems formulated?</td>
<td>Problems reflect inadequate control of the disease</td>
<td>The patient identifies problems he/she experiences that may or may not be related to the disease</td>
</tr>
<tr>
<td>Relation of education to the disease</td>
<td>Education is disease-specific and teaches information and technical skills related to the disease</td>
<td>Education provides problem-solving skills that are relevant to the consequences of chronic conditions in general</td>
</tr>
<tr>
<td>What is the theory underlying the education?</td>
<td>Disease-specific knowledge creates behavior change, which in turn produces better clinical outcomes</td>
<td>Greater patient confidence in his/her capacity to make life-improving changes (self-efficacy) yields better clinical outcomes</td>
</tr>
<tr>
<td>What is the goal?</td>
<td>Compliance with the behavior changes taught to the patient to improve clinical outcomes</td>
<td>Increased self-efficacy to improve clinical outcomes</td>
</tr>
<tr>
<td>Who is the educator?</td>
<td>A health professional</td>
<td>A health professional, peer leader, or other patients, often in group settings</td>
</tr>
</tbody>
</table>

Bodenheimer et al. 2002 (JAMA)
Supporting self-management

- Encouraging people to participate actively in their self-management by acknowledging that they are experts in their own lives
- Using evidence-based information to guide shared decision making
- Non judgemental approach
- Collaborative approach to setting priorities and goals
- Collaborative problem solving
- Active follow-up
- Links to evidence-based community programs/support groups
- Ensuring that self-management is culturally appropriate

(Ministry of Health, 2016)
How to better support patients
The role of the health professional

- Behaviour change occurs when the patient is engaged
- The decision to change behaviour must come from the patient
- The patient must choose goals for themselves
- Discuss how social and cultural factors may facilitate or challenge change to occur
Skills of the health professional

1. Communication skills
2. Establishing rapport
3. Active listening

Client centred techniques
  e.g.
  Healthy Conversation Skills
  Motivational Interviewing
Motivational Interviewing is a client-centered, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

Miller & Rollnick, 2002

(or... helping people talk themselves into changing)
The origins of motivational interviewing

- Originally developed to address substance use disorders
- Therapist effects

Miller, 1983:
- Empathic, person-centred
- Empathic response to “sustain talk”
- The client (not therapist) voices the arguments for change

“the change-promoting value of hearing oneself argue for change”

Miller & Rose, 2009, p.2
What is motivational interviewing?

- Behaviour change is a shared endeavour – supports client autonomy
- MI has been described as a ‘way of being’ with a client
- The ‘spirit’ in which it is delivered is as important as the techniques that are used – warm, genuine, respectful and egalitarian

- Five basic components to enhance motivation:
  1. Development of discrepancy
  2. Avoid argumentation
  3. Rolling with resistance
  4. Expression of empathy
  5. Support of self-efficacy
Foundational skills in MI

- Open-ended Questions
- Affirmations
- Reflections
- Summaries
Levels of reflection

- **Repeating:** the simplest reflection simply repeats an element of what the speaker has said.

- **Rephrasing:** the listener stays close to what the speaker said, but substitutes synonyms or slightly rephrases what was offered.

- **Paraphrasing:** this is a more major restatement, in which the listener infers the *meaning* in what was said and reflects this back in new words. This adds to and extends what was actually said. In artful form, this is like *continuing the paragraph* that the speaker has been developing, saying the *next* sentence rather than repeating the last one.

- **Reflection of feeling:** often regarded as the deepest form of reflection, this is a paraphrase that emphasizes the emotional dimension through feeling statements, metaphor, etc.
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Thank you!

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