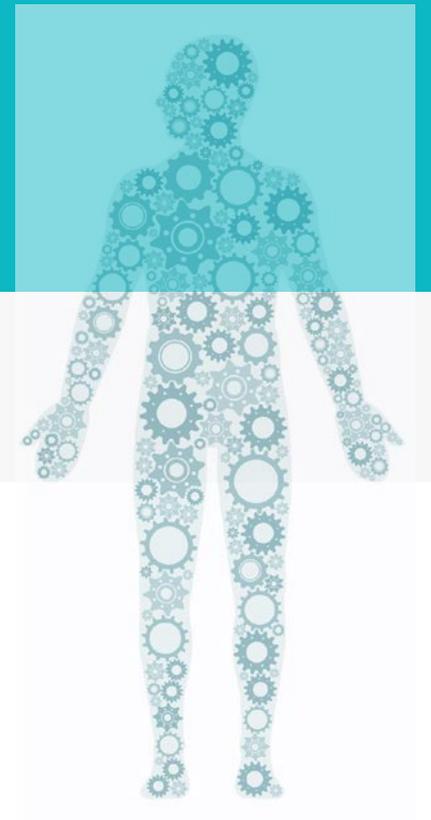


A revolution for the traditional healthcare model: How health professionals can better support their patients



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2 key myths



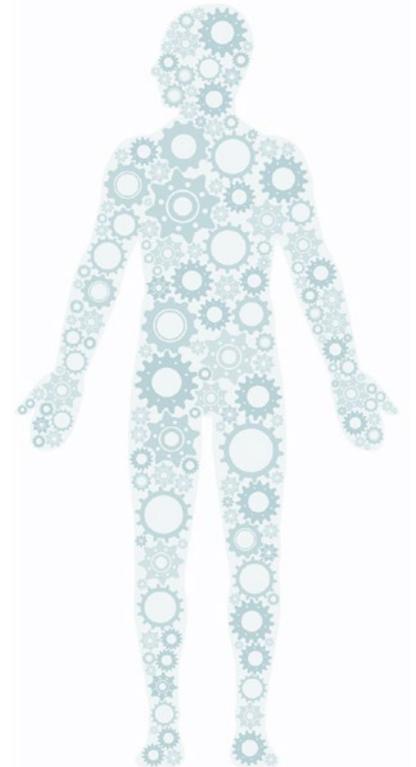
Collaborative care



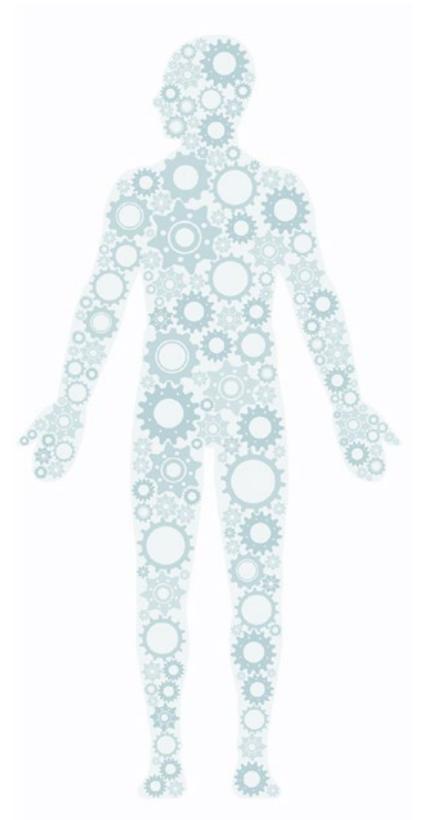
Self-management



How to better support patients

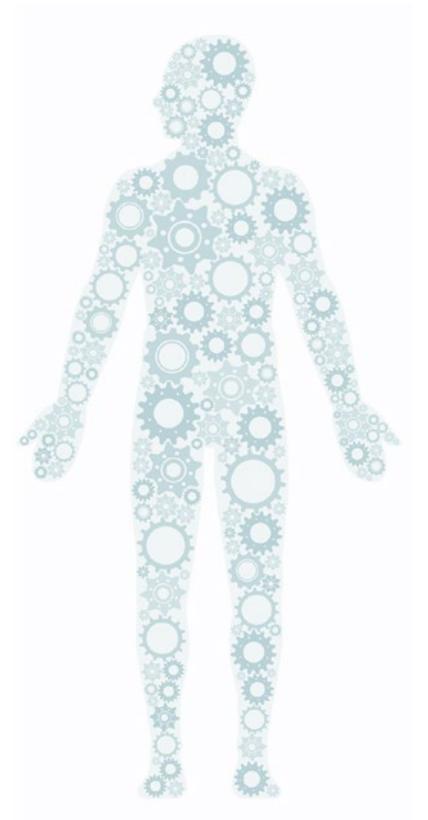


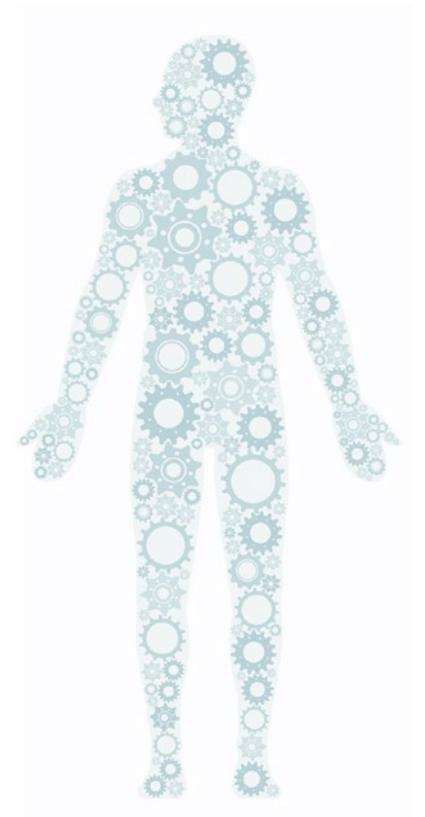
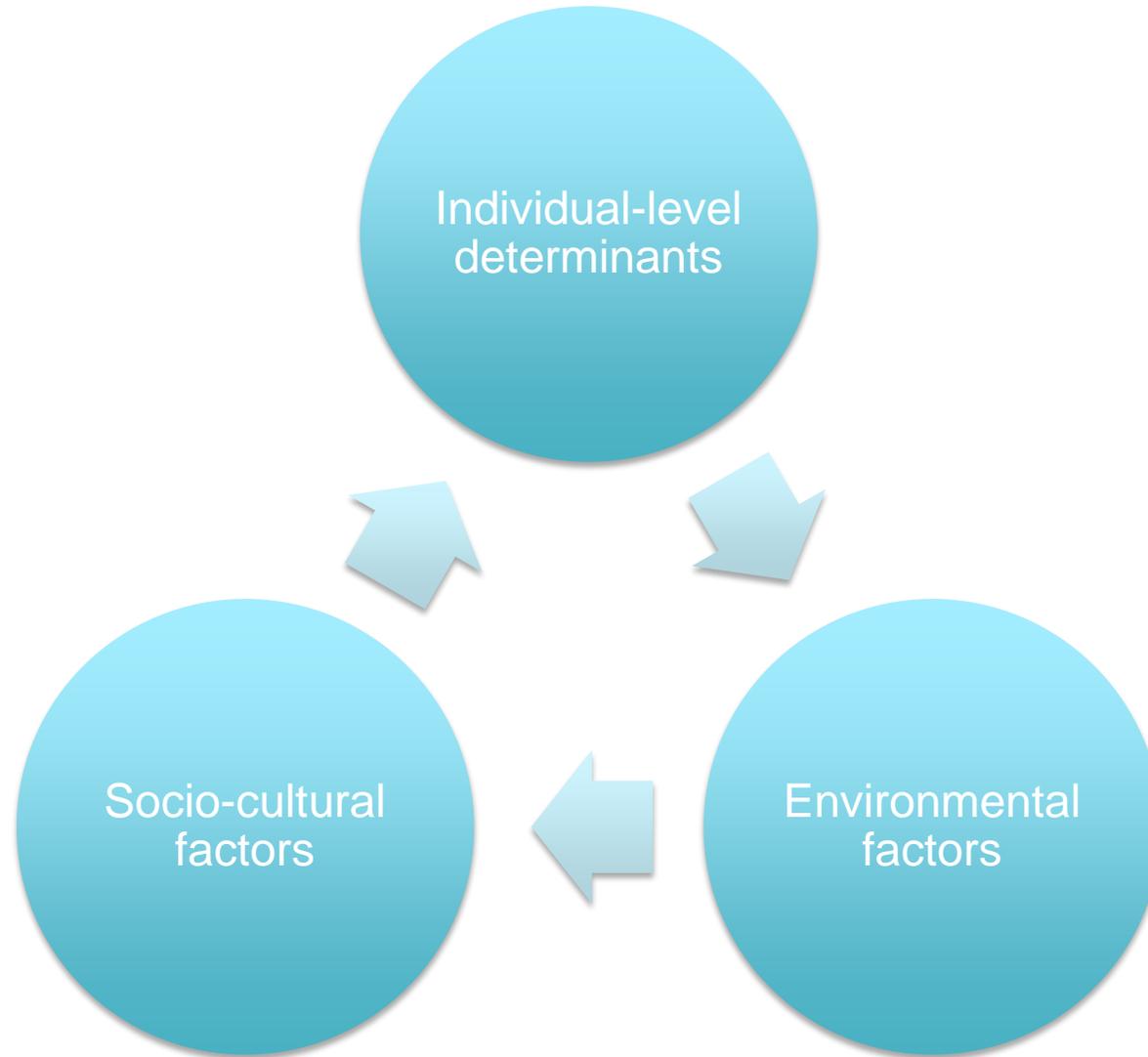
Myth 1: Behaviour change is easy



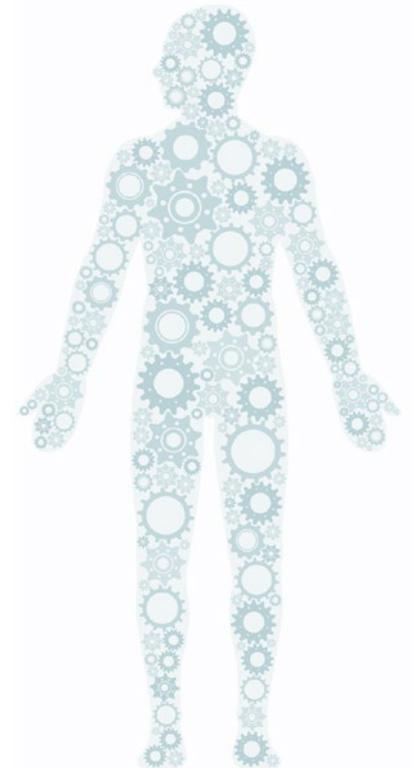
ISLAGIATT Principle

-Prof Martin Eccles

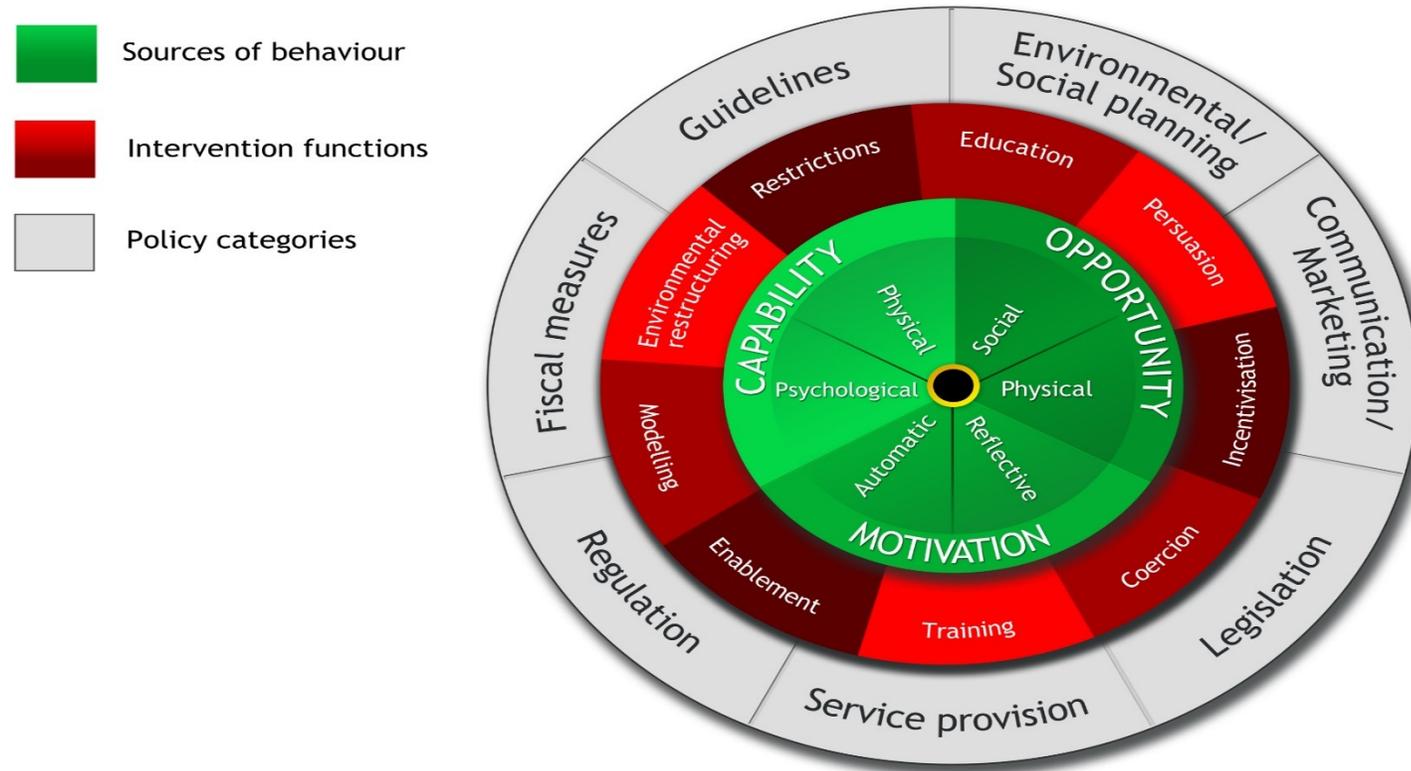




“What conditions internal to individuals and in their social and physical environment need to be in place for a specified behavioural target to be achieved?”

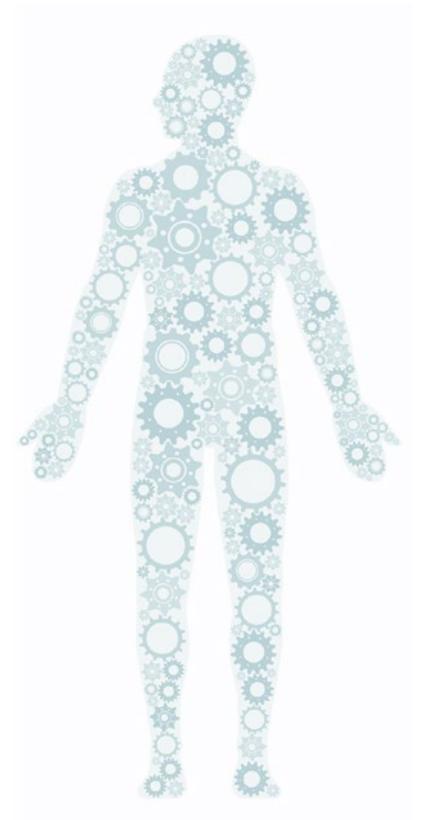


Behaviour Change Wheel



Michie, Atkins & West (2014)

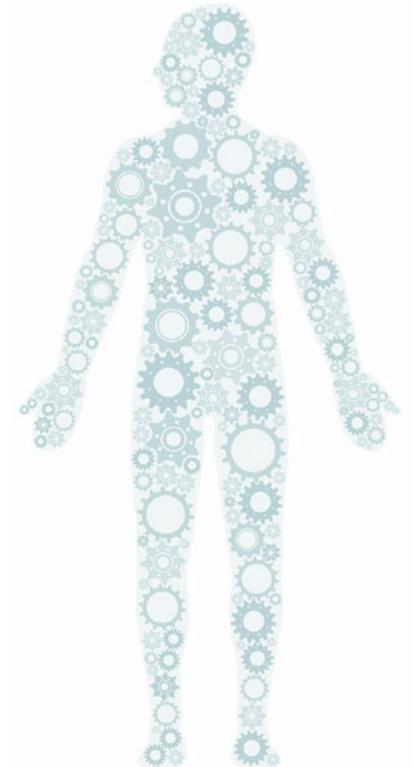
Myth 2: Information drives behaviour change



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

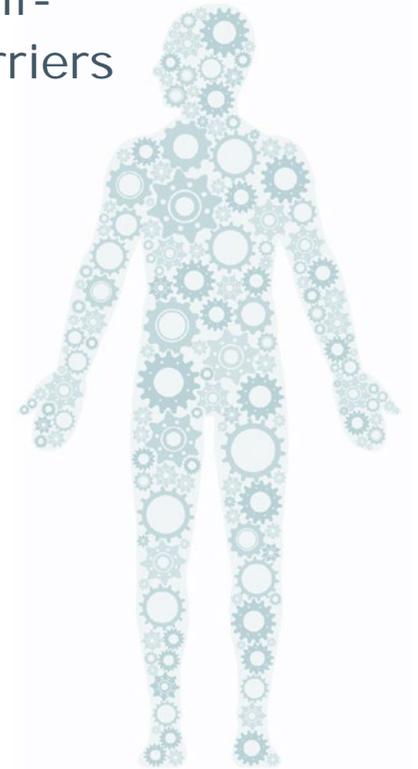


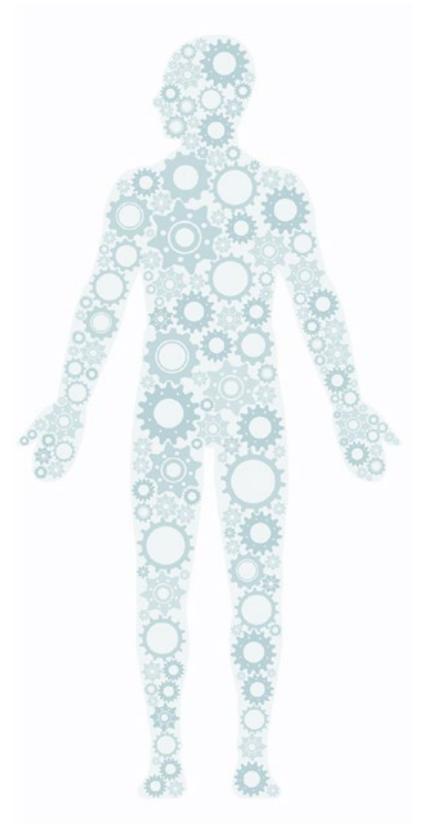
Table 2. Comparison of Traditional Patient Education and Self-management Education

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

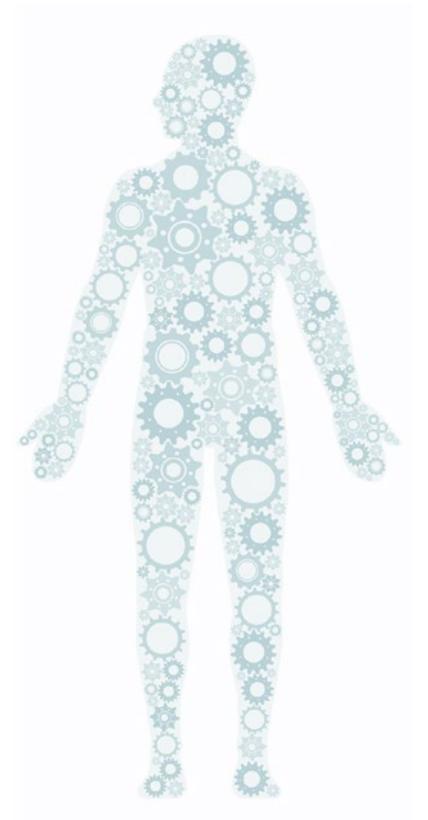
Supporting self-management

- 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)

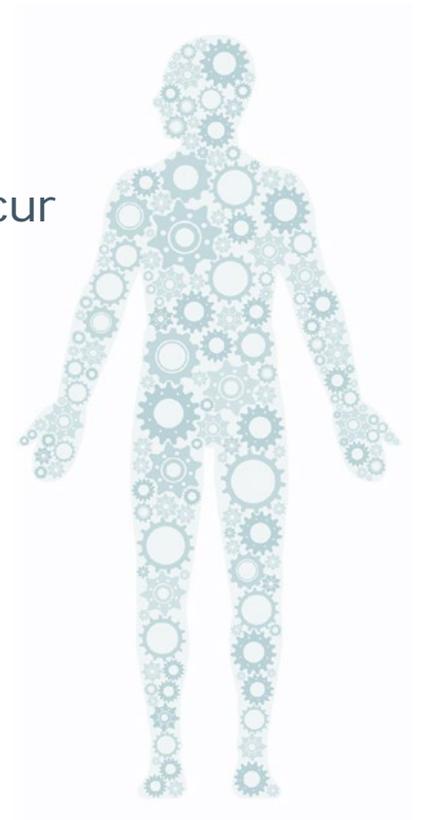


How to better support patients



The role of the health professional

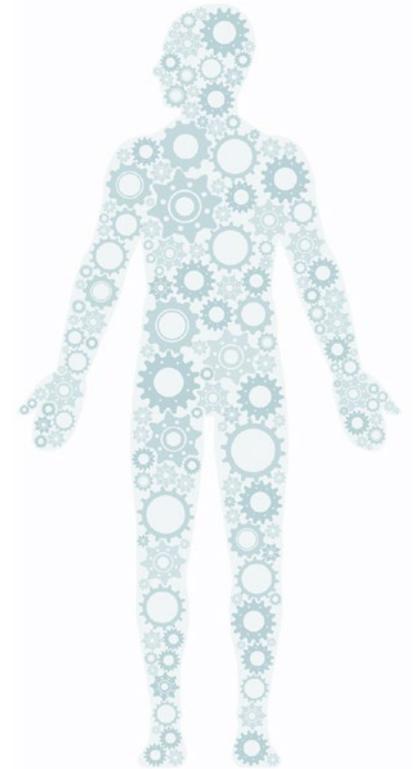
- Behaviour change occurs when the patient is engaged
- The decision to change behaviour must come from the patient
- The patient must choose goals for themselves
- Discuss how social and cultural factors may facilitate or challenge change to occur



Skills of the health professional

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

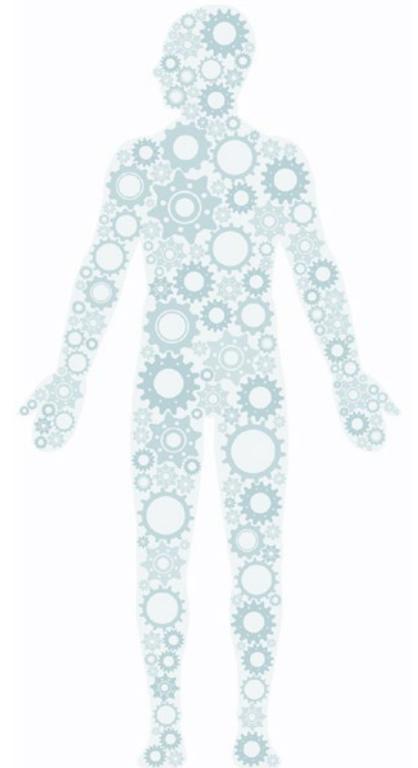
Client centred techniques
e.g.
Healthy Conversation Skills
Motivational Interviewing



*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)



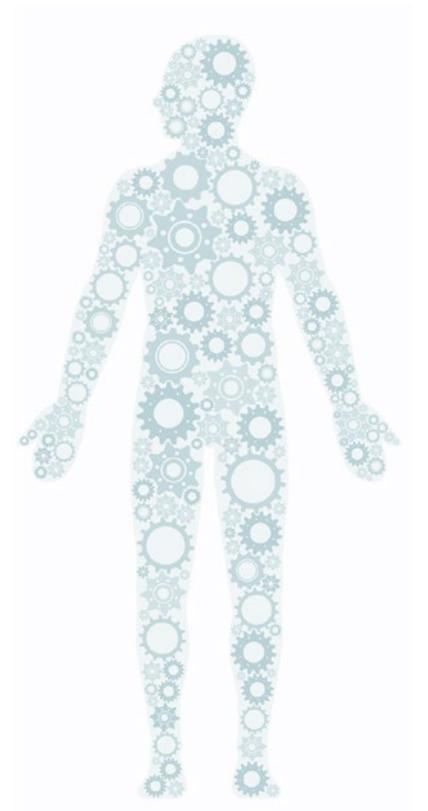
The origins of motivational interviewing

- 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

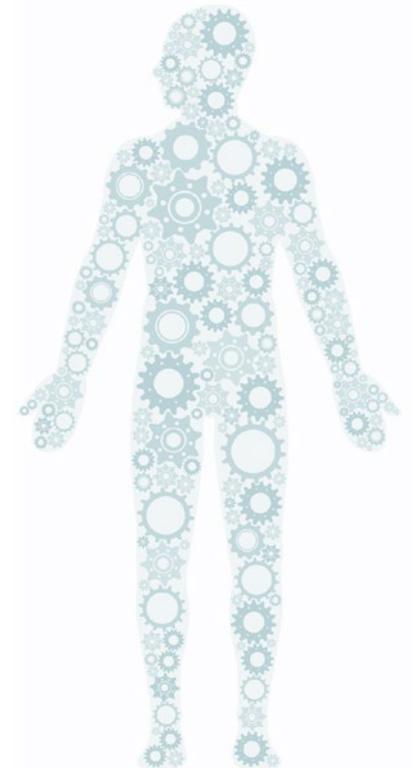
"the change-promoting value of hearing oneself argue for change"

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. **D**evelopment of discrepancy
 2. **A**void argumentation
 3. **R**olling with resistance
 4. **E**xpression of empathy
 5. **S**upport of self-efficacy



Foundational skills in MI

O

Open-ended Questions

A

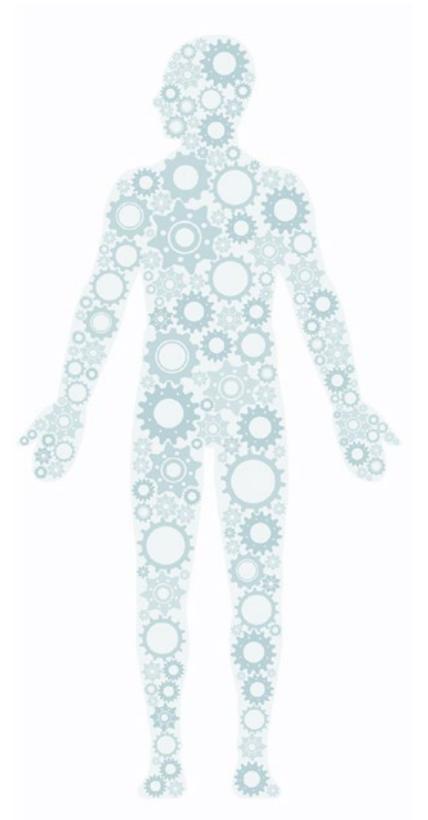
Affirmations

R

Reflections

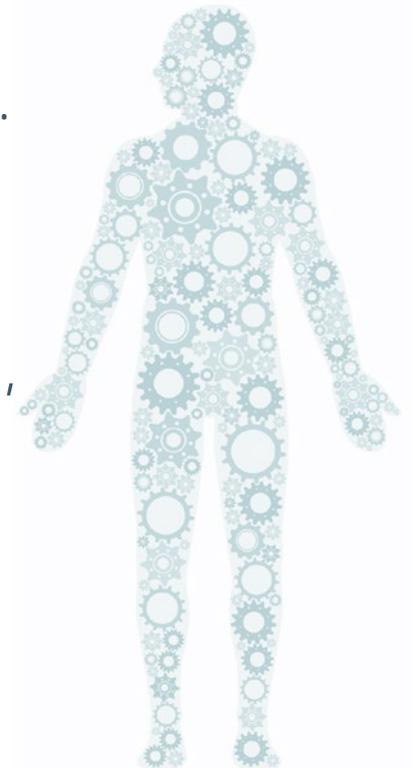
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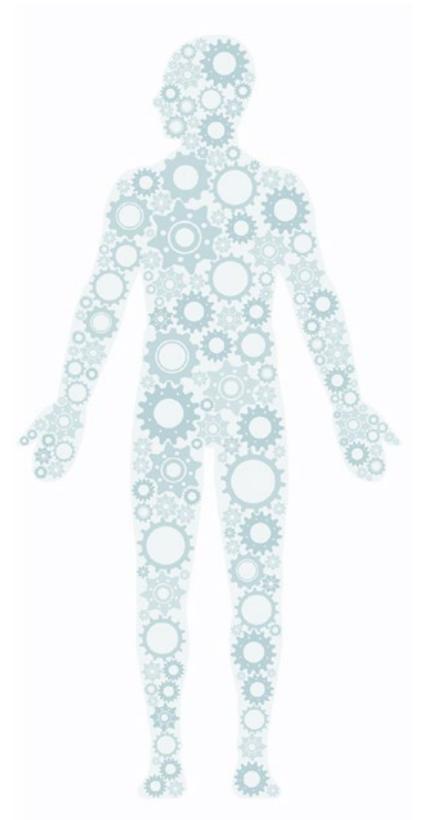
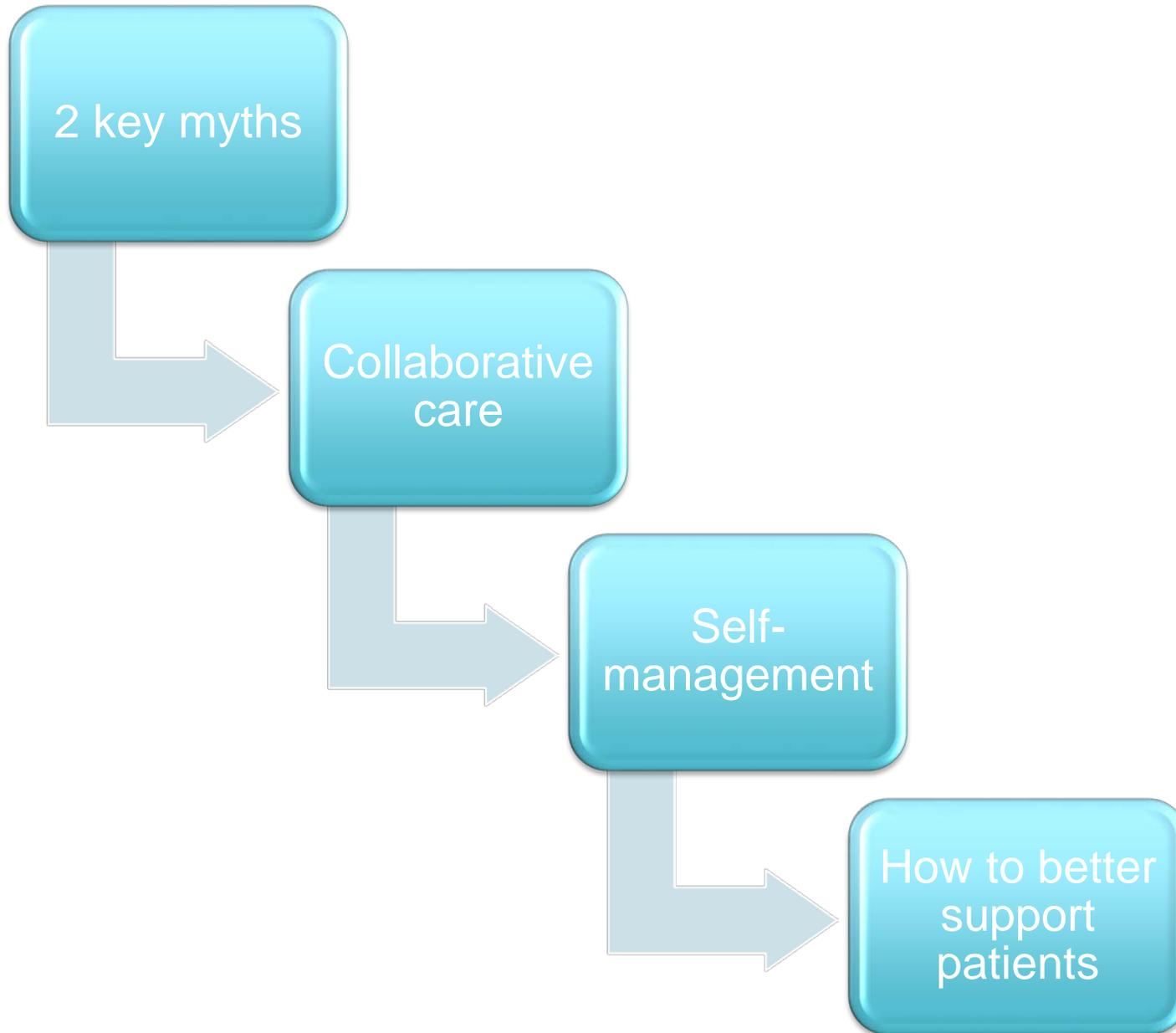
Summaries



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.





Thank you!

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