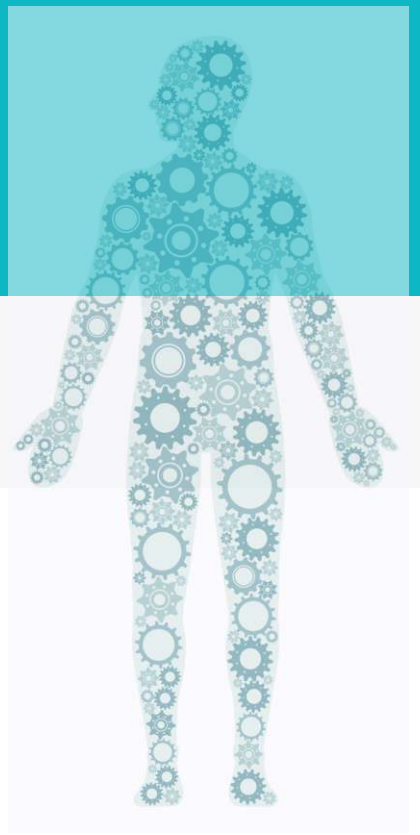
The science of behaviour change: How health professionals can better support their patients



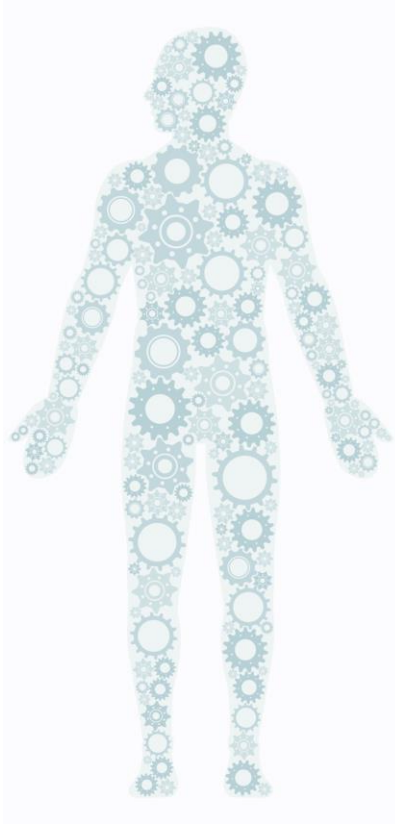
Dr. Anna Serlachius
a.serlachius@auckland.ac.nz

2 key myths

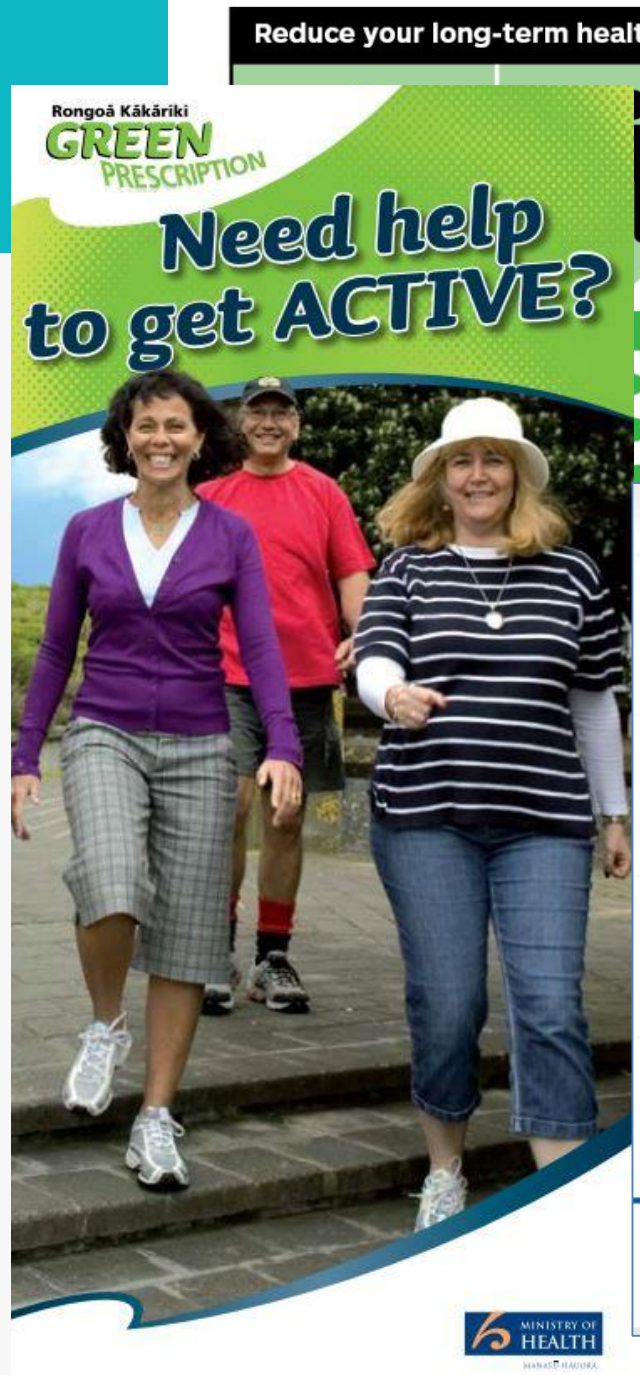
Collaborative care

Self-management

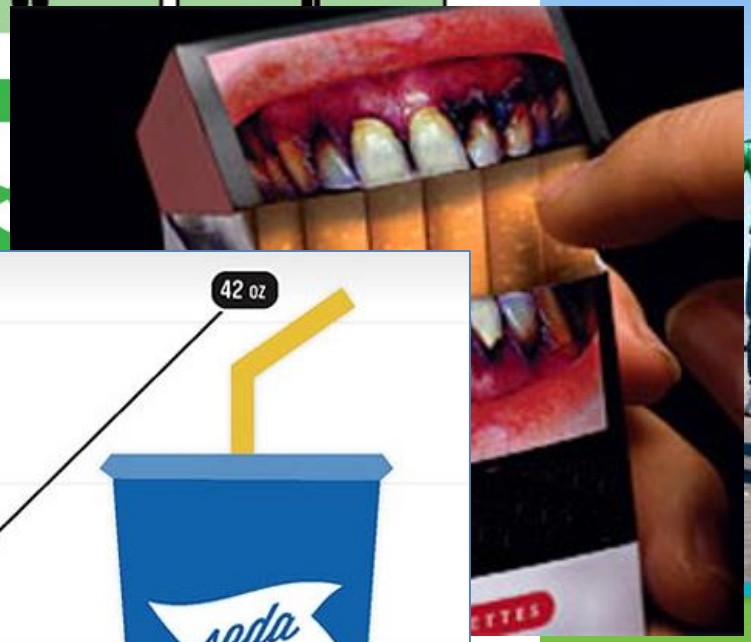
How to better support patients

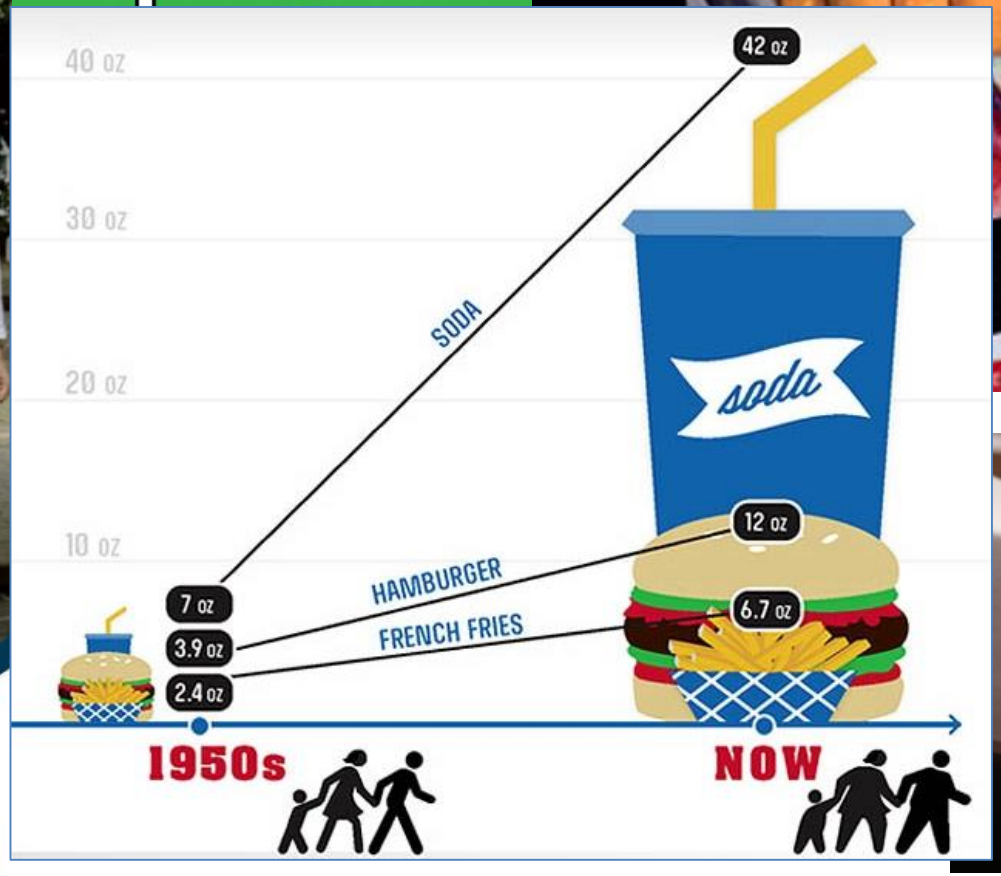


Myth 1: Behaviour change is easy

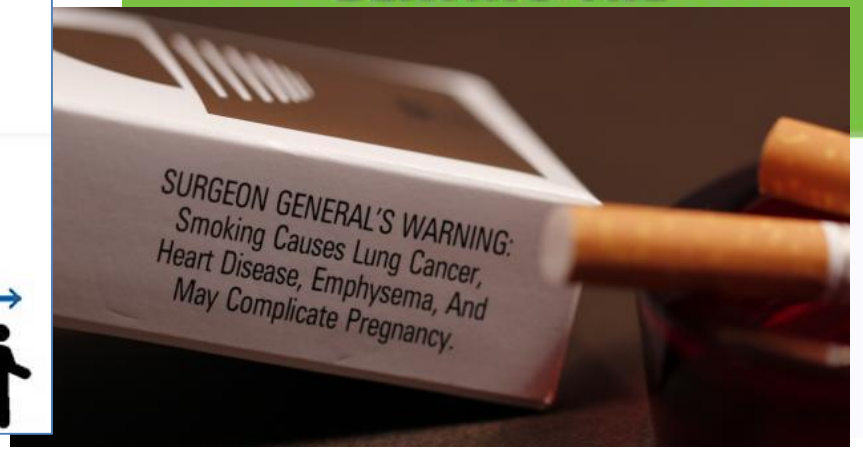

Rongoā Kākāriki
GREEN PRESCRIPTION
Need help to get ACTIVE?
MINISTRY OF HEALTH


Reduce your long-term health risks
Reduce your risk of injury
Pregnant women
No more than...
4

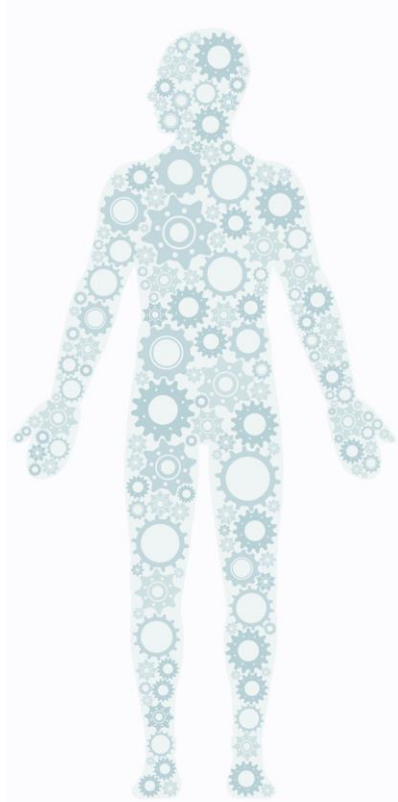


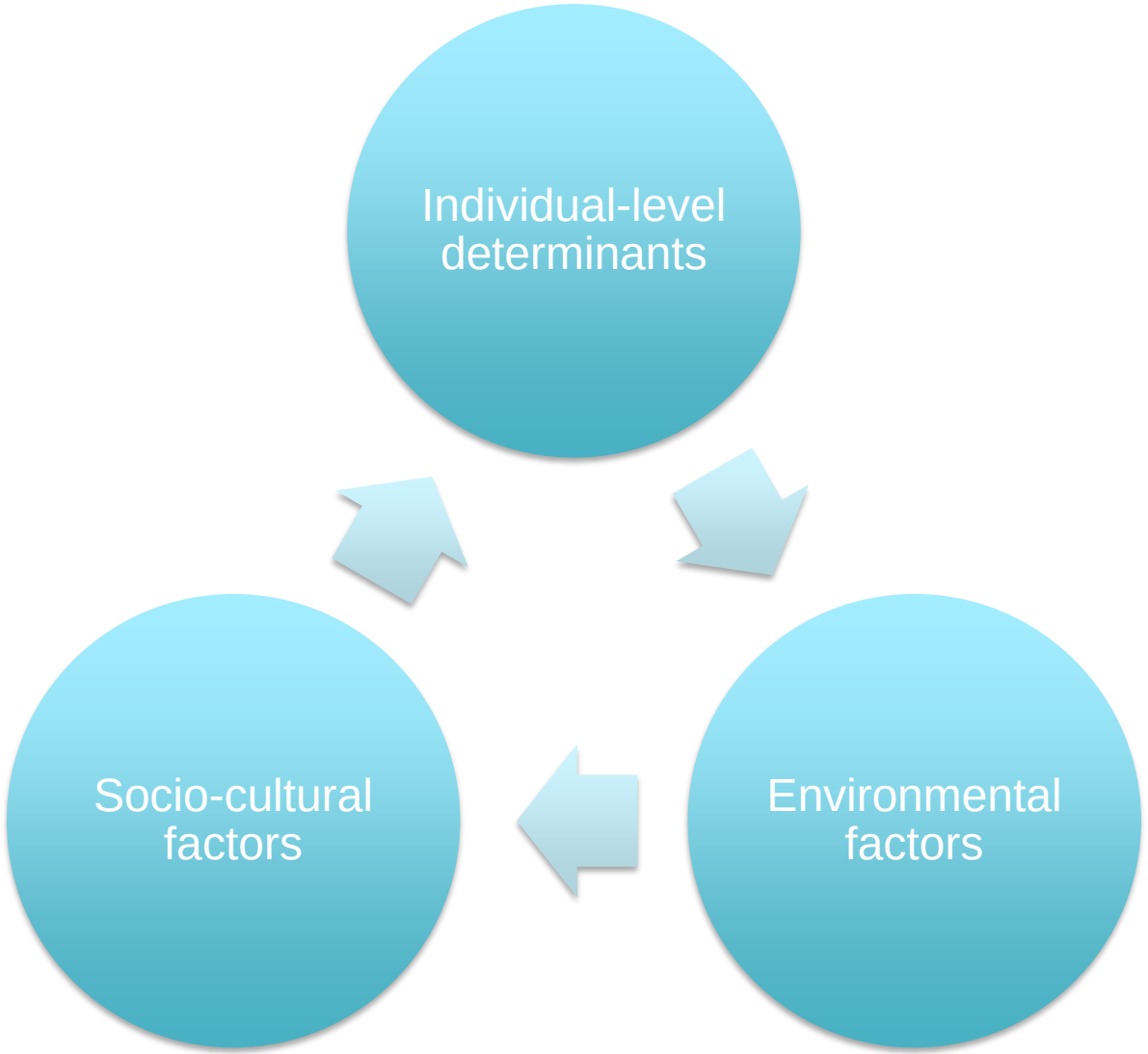

40 oz
30 oz
20 oz
10 oz
SODA
HAMBURGER
FRENCH FRIES
42 oz
12 oz
6.7 oz
7 oz
3.9 oz
2.4 oz
soda
1950s
NOW

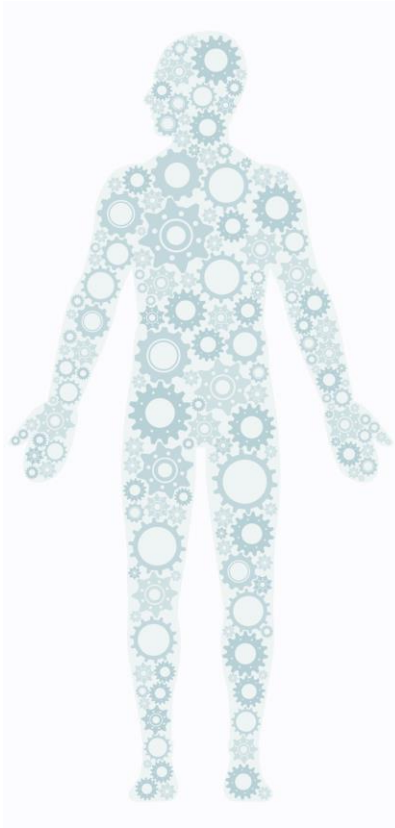

The Quit Book
BEATING THE


SURGEON GENERAL'S WARNING:
Smoking Causes Lung Cancer,
Heart Disease, Emphysema, And
May Complicate Pregnancy.

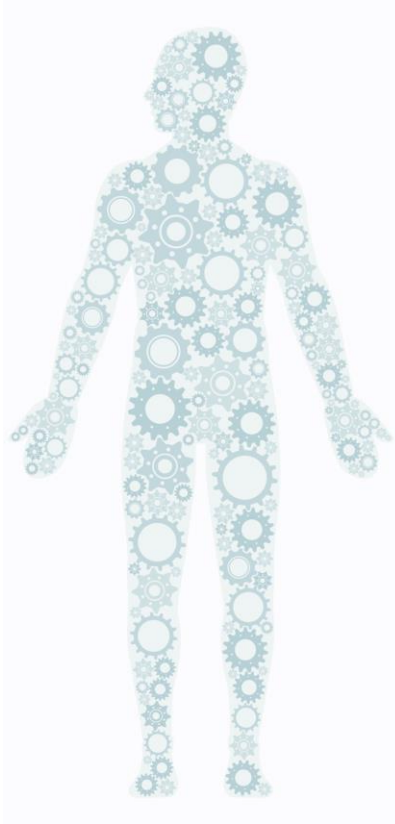
ISLAGIATT Principle
-Prof Martin Eccles




Individual-level determinants
Environmental factors
Socio-cultural factors

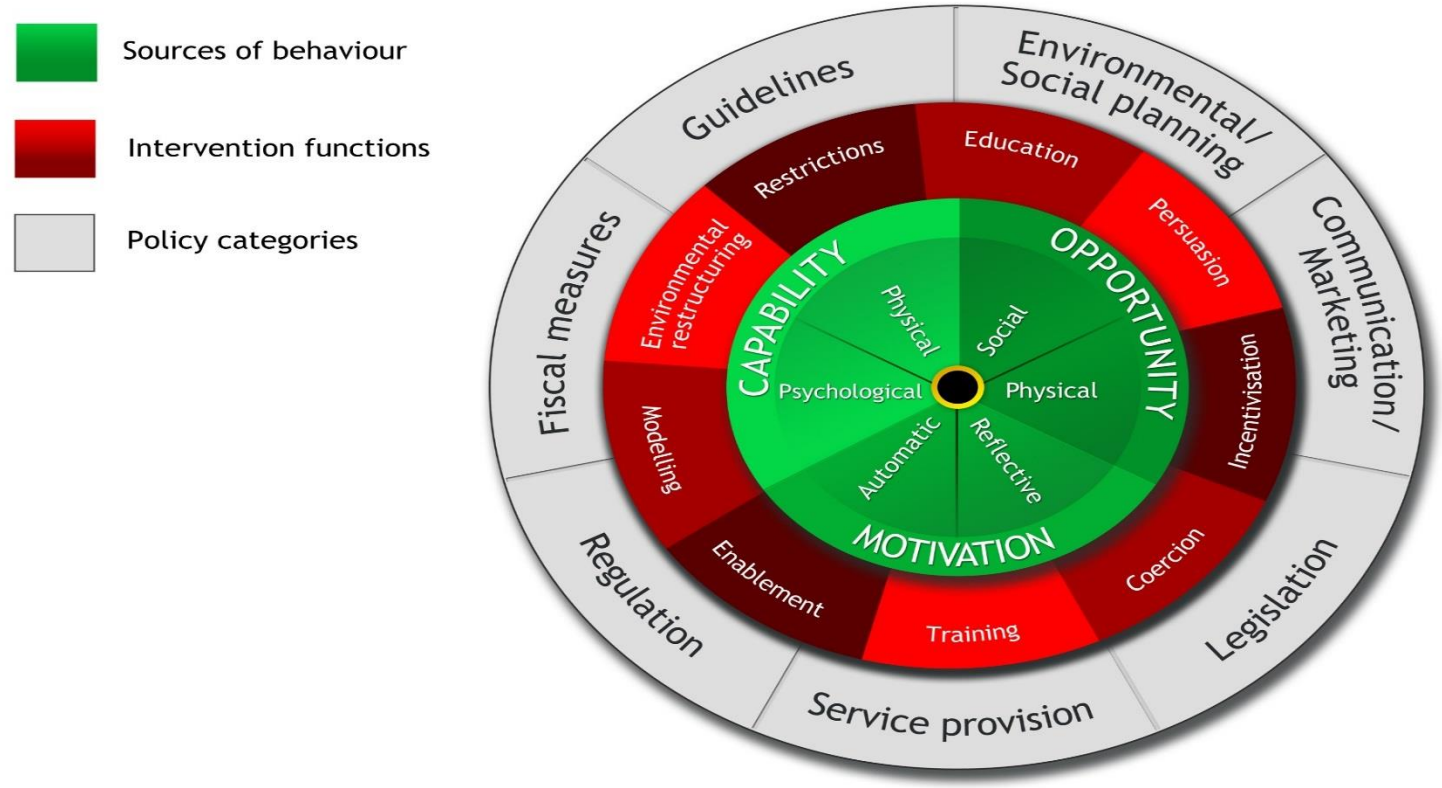


“What conditions internal to individuals and in their social and physical environment need to be in place for a specified behavioural target to be achieved?”



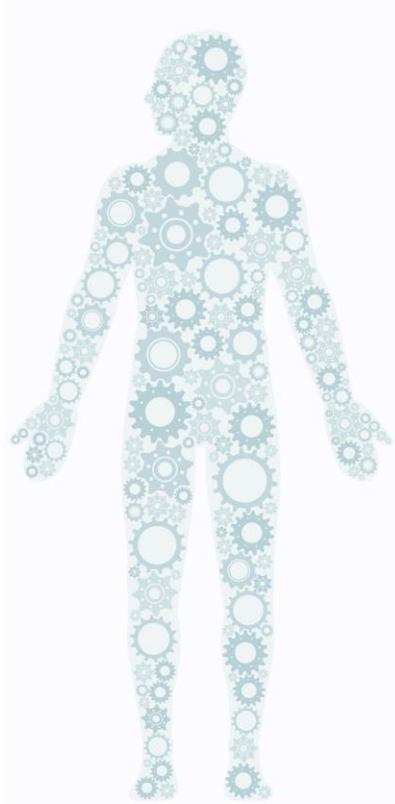
Michie et al. 2011 (Implementation Science)

Behaviour Change Wheel

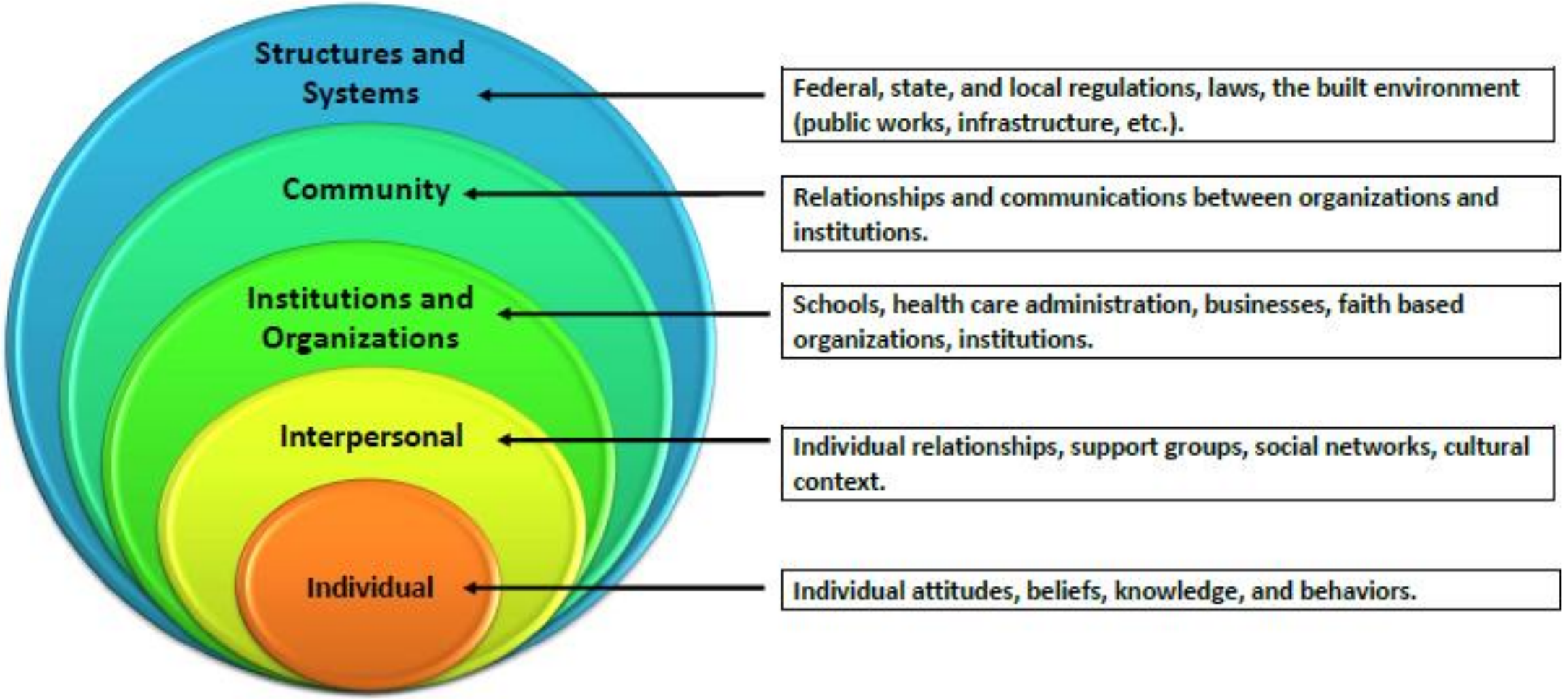


Michie, Atkins & West (2014)

Myth 2: Information drives behaviour change



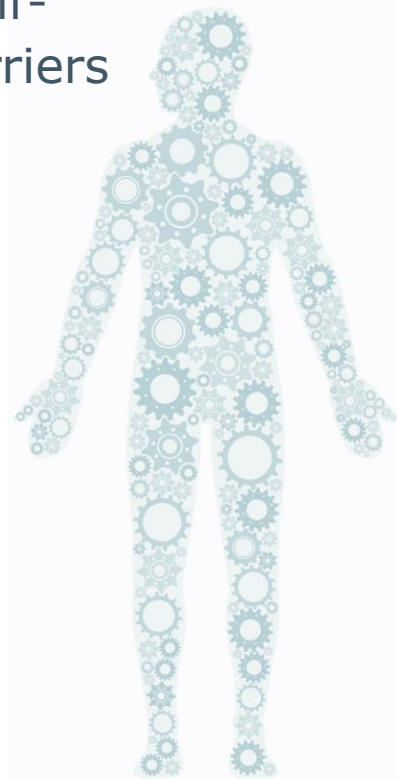
Behaviour is influenced at multiple levels



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



Chronic disease self-management programme

SYSTEMATIC REVIEW Volume 10 — January 17, 2013

A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program

Teresa J. Brady, PhD; Louise Murphy, PhD; Benita J. O'Colmain, MPH; Danielle Beauchesne, MPH; Brandy Daniels, MPH; Michael Greenberg, JD, MPH; Marnie House, EdD, MPH; Doryn Chervin, DrPH, MEd

Suggested citation for this article: Brady TJ, Murphy L, O'Colmain BJ, Beauchesne D, Daniels B, Greenberg M, et al. A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program. Prev Chronic Dis 2013;10:120112. DOI: http://dx.doi.org/10.5888/pcd10.120112 .

PEER REVIEWED

Abstract

Introduction
The Chronic Disease Self-Management Program (CDSMP) is a community-based self-management education program designed to help participants gain confidence (self-efficacy) and skills to better manage their chronic conditions; it has been implemented worldwide. The objective of this meta-analysis was to quantitatively synthesize the results of CDSMP studies conducted in English-speaking countries to determine the program's effects on health behaviors, physical and psychological health status, and health care utilization at 4 to 6 months and 9 to 12 months after baseline.

Methods
We searched 8 electronic databases to identify CDSMP-relevant literature published from January 1, 1999, through September 30, 2009; experts identified additional unpublished studies. We combined the results of all eligible studies to calculate pooled effect sizes. We included 23 studies. Eighteen studies presented data on small English-speaking groups; we conducted 1 meta-analysis on these studies and a separate analysis on results by other delivery modes.

Results
Among health behaviors for small English-speaking groups, aerobic exercise, cognitive symptom management, and communication with physician improved significantly at 4- to 6-month follow-up; aerobic exercise and cognitive symptom management remained significantly improved at 9 to 12 months. Stretching/strengthening exercise improved significantly at 9 to 12 months. All measures of psychological health improved significantly at 4 to 6 months and 9 to 12 months. Energy, fatigue, and self-rated health showed small but significant improvements at 4 to 6 months but not at 9 to 12 months. The only significant change in health care utilization was a small improvement in the number of hospitalization days or nights at 4 to 6 months

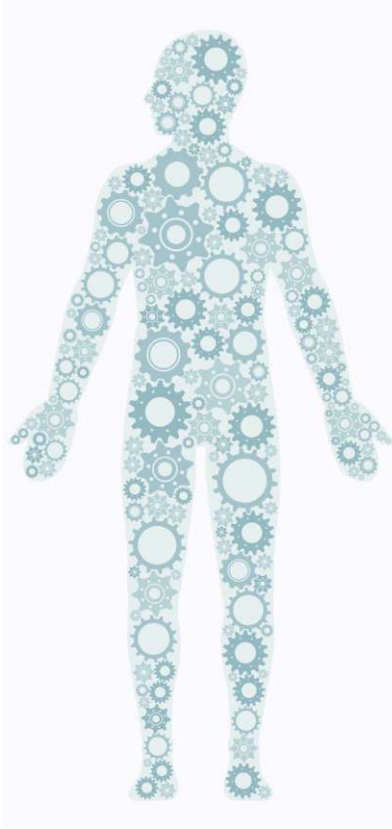


Table 2. Comparison of Traditional Patient Education and Self-management Education

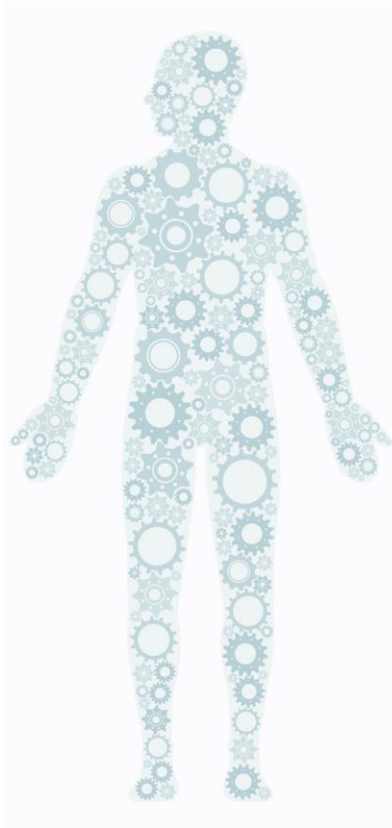
	Traditional Patient Education	Self-management Education
What is taught?	Information and technical skills about the disease	Skills on how to act on problems
How are problems formulated?	Problems reflect inadequate control of the disease	The patient identifies problems he/she experiences that may or may 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

Bodenheimer et al. 2002 (JAMA)

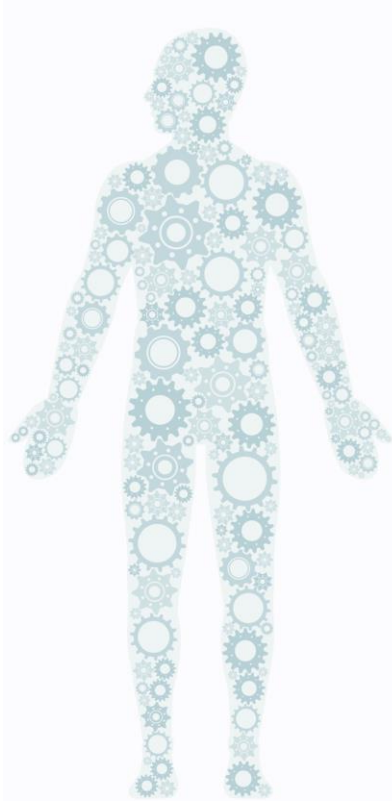
Supporting self-management

- 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



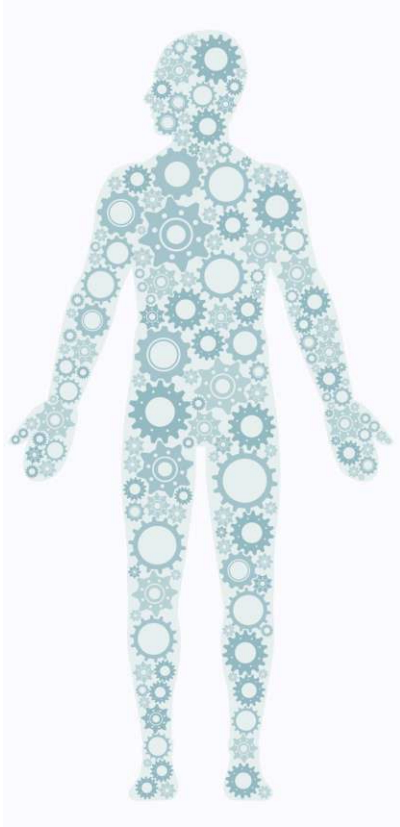
When does real, sustainable behaviour change occur?

Patient/client involvement

- 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

Health professional's skills

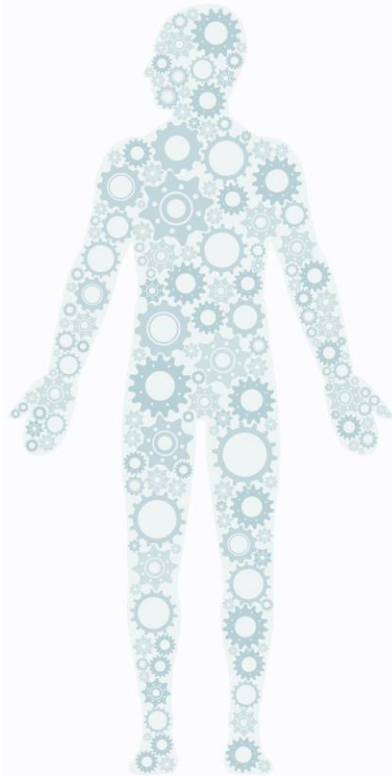
- Establish rapport
- Use active listening
- Discuss how social and cultural factors may facilitate or challenge change to occur
- Use client-centred techniques (e.g. Healthy conversation skills, motivational interviewing)



Motivational Interviewing is a client-centered, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

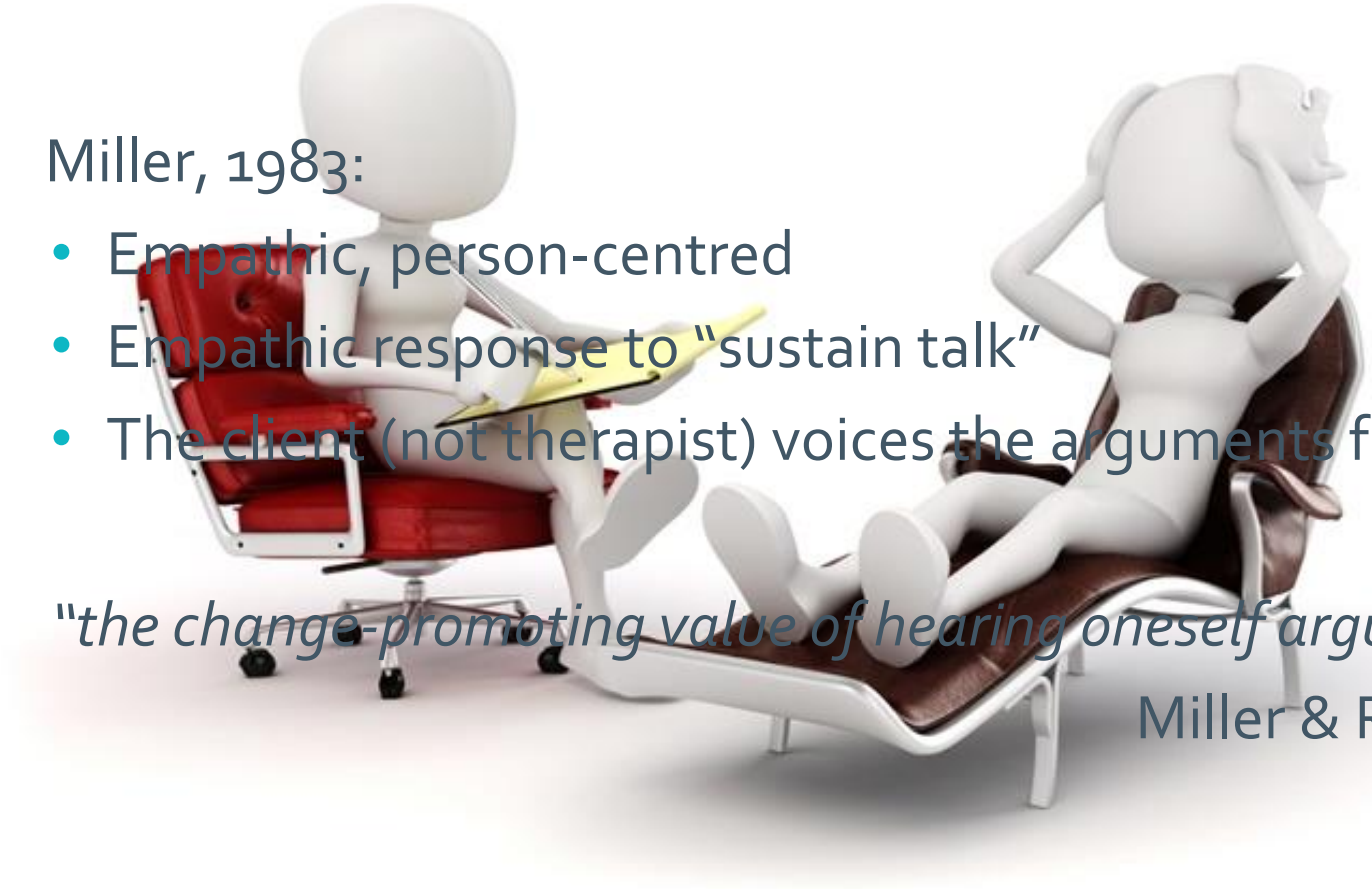
Miller & Rollnick, 2002

(or… helping people talk themselves into changing)



The origins of motivational interviewing

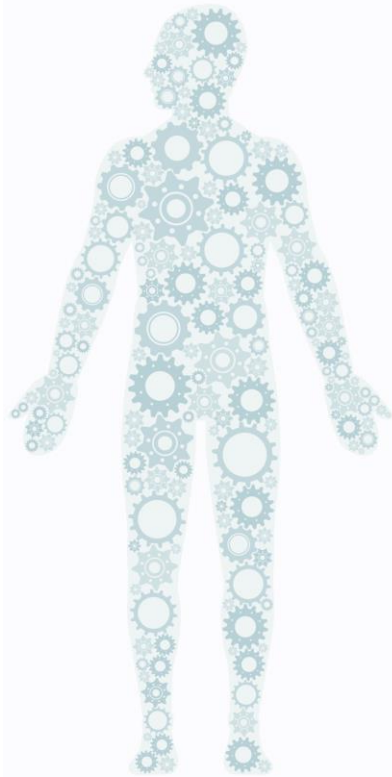
- Originally developed to address substance use disorders
- Therapist effects



- 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"

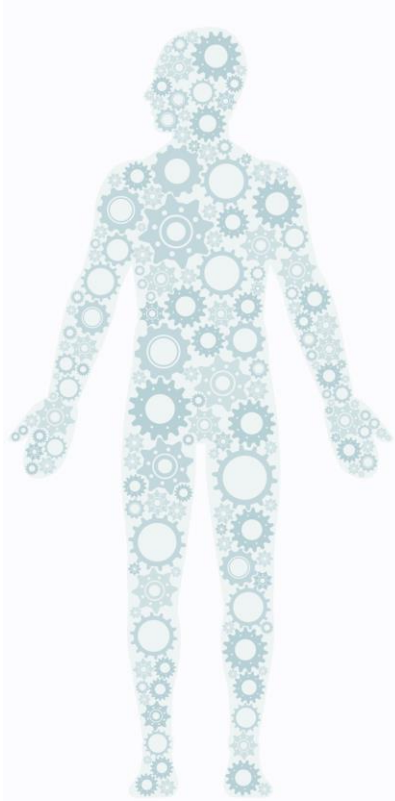
Miller & Rose, 2009, p.2



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



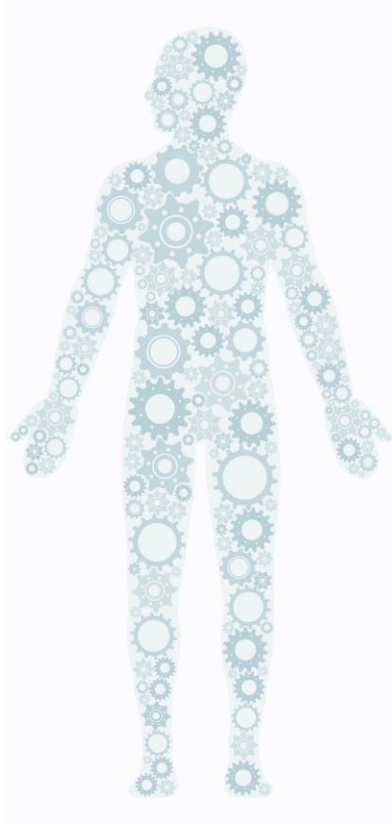
Foundational skills in MI

Open-ended Questions

Affirmations

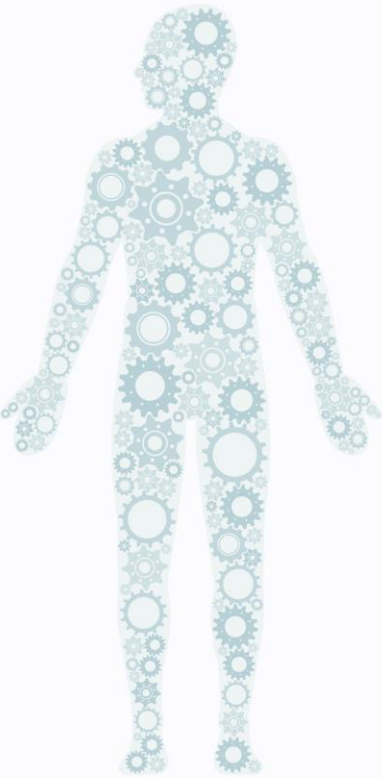
Reflections

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: o**ften 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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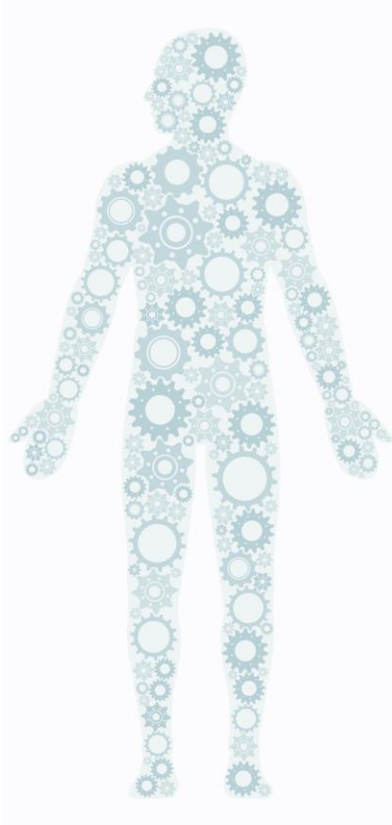
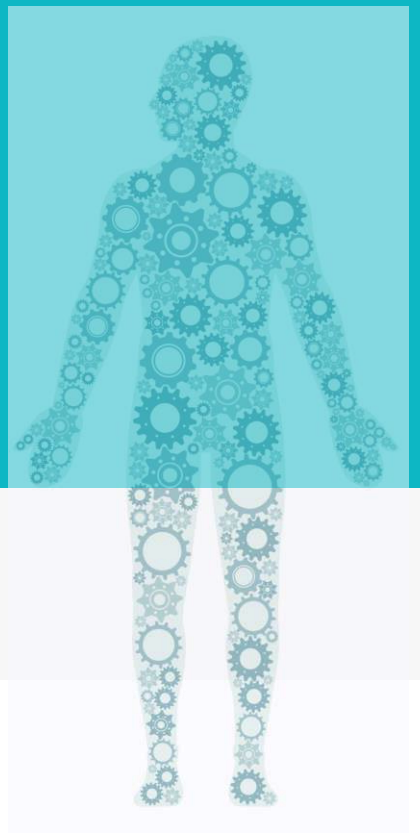


Thank you!



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