Cultivating Behavior Change

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Objectives

Upon completion of this session, participants should be able to…

- describe common provider behaviors in the healthcare setting that represent “seeding without cultivating the soil”
- explain how patient engagement can be cultivated through conversation that focuses on drivers of behavior change
- implement aspects of such “cultivating” conversation with their own patients

None of the presenters has financial or other conflicts of interest to disclose in relation to this presentation.

Case A

You are seeing a patient who is a long-time smoker, and you ask the patient what she/he likes about smoking. The patient responds, “It helps me relax.”

How would you proceed?

Case B

Ms. Kim Jones is 54 yo woman coming to the clinic today because she is concerned about her diabetes. Her blood sugars have been higher than normal for the past several weeks (typically 120-160, but recently more in the 180-225 range). She had a Hemoglobin A1C done last week and it was 8.6 (last visit 6.8)

PMH: HTN, DMII, HLD
medications – metformin 1000 mg bid, lisinopril 20 mg daily,
atorvastatin 20 mg daily
Allergies - none
Surgeries – none
SH: Tobacco - none ever
Alcohol - occasional glass of wine
Work - administrative assistant

As you prepare to enter the room you note that her BP is 168/102 today, and she has gained 5 pounds since her last appointment.

Health Behavior

- Providing education and advice tends to be the default for physicians with respect to addressing patient behavior.
- What is different about physicians and patients?
- How does physician health behavior compare to the health behavior of the general population?

Case A

You are seeing a patient who is a long-time smoker, and ask the patient about what she/he likes about smoking. The patient responds, “It helps me relax.”

- What’s the problem with giving the patient ideas about other ways to relax?

Doctor work: diagnosis, determining treatment options (including medications/dosing, referrals, etc.)

Patient work: decisions about treatment options, adherence, health behavior

Potential Problems with how Patient Behavior is Commonly Addressed

- Knowledge/education may be necessary but is commonly insufficient to motivate behavior change (and patients often already know what we want to teach them).
- Pre-mature seeding (education/advice) on untilled soil.
- Non-adherence.

Knowledge ≠ behavior change

If knowledge itself doesn’t necessarily motivate behavior change, what does motivate change?

change

- Occurs from the desire for consistency between important goals/values and one's behavior.
- Is most likely when the gap between important goals/values and current behavior is large enough to create motivational discrepancy, but not so large as to be demoralizing.
- Emotion is typically a stronger driver of change than is reason.

$$\frac{\text{knowledge x motivation}}{\text{resistance}} = \text{change}$$

Motivational Interviewing

- A collaborative conversational style for strengthening a person's own motivation and commitment to change that involves addressing the common problem of ambivalence about change.
- APPROACH vs technique

MI is characterized by a spirit of…

- COLLABORATION/PARTNERSHIP (vs confrontation)
- ACCEPTANCE (vs judgment) (individual worth/autonomy)
- COMPASSION/EMPATHY
- EVOCATION (vs education)

MI Skills

- **O**pen-ended questions
- **A**ffirmations
- **Reflective Listening**
- **S**ummarizing

- Informing and advising (only done with patient request or permission)

emotion

- Pay particular attention to patient content that carries emotion (e.g., “I’m afraid of…” “I really want to be able to…”).

ambivalence

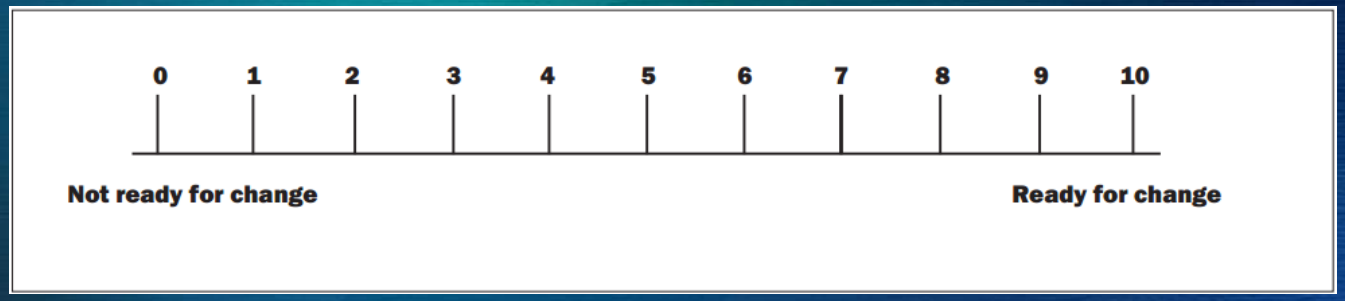
- Ambivalence is about the “buts.”
- “I know I should exercise more but I just don’t have the time.”
- Explore both sides of the “but.”
- “Sustain talk” is about the status quo whereas “Change talk” is about reasons for change.
- Develop the discrepancy between what the patient says is important to her/him, and what he/she is currently doing.

informing and advising

- Only done with patient's request or permission.
- "If it's OK with you, I could share some of the reasons…"
- "Would it be OK with you if I explained…?" (Getting permission is a good time to use closed questions.)
- Good to follow "education" with open-ended inquiry about patient's reaction to the information.
- "How does hearing this affect your thoughts about…?"

0-10 scales

- Ask patients to rate importance, confidence, or readiness to change on 0-10 scales.
- “On a scale of 0-10, with 0 meaning that you aren’t even considering quitting, and 10 being ready to quit right now, how ready are you to quit smoking?”
- If patient says “3”…
- “What makes you a 3, and not a 1 or 2?”
- “What would it take to move you to a 4 or 5?”



"Tilling the Soil" – Examples of Questions

- "What do you like about (behavior)?"
- "What don't you like about (behavior)?"
- "How do you think your smoking (any negative behavior) might be related to your COPD (medical concern)?"
- "What types of consequences have you had from your (negative behavior)?"
- Explore the no change option: "One possibility is for you to continue (negative behavior). From a health perspective, what does this possibility look like to you?"
- 0-10 scales (importance) – a "10" can be a useful reference point (can be contrasted with an effort of "5")

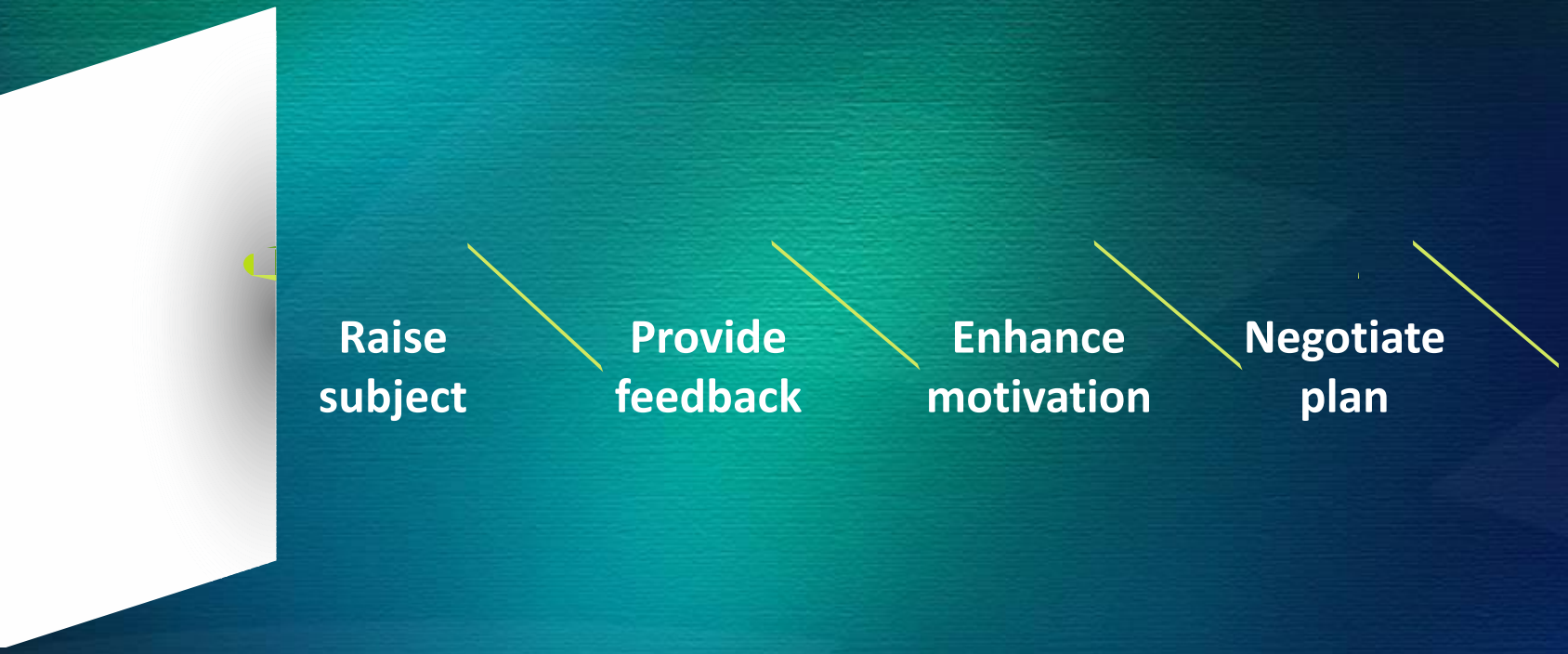
time

- Most common perceived barrier to using MI on the part of providers.
- No evidence that being directive is more effective than MI when there is limited time.
- Instead of “You need to quit smoking” use a 0-10 scale for readiness to quit. This yields a more useful progress note than does just stating that patient was advised to quit smoking.
- New behavior will initially take more time, and likely will feel clumsy. When the approach becomes second nature, time becomes a non-issue.

SBIRT

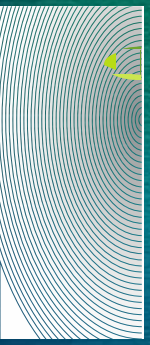
Screening, Brief Intervention, and Referral to Treatment

Steps of the brief intervention



D`Onofrio, et al., 2005

Steps of the brief intervention



Raise subject

- Screening forms act as conversation starters
- Ask permission - “Would it be OK if we review the questionnaire(s) you completed?”
- “Tell me about your substance alcohol/drug use”

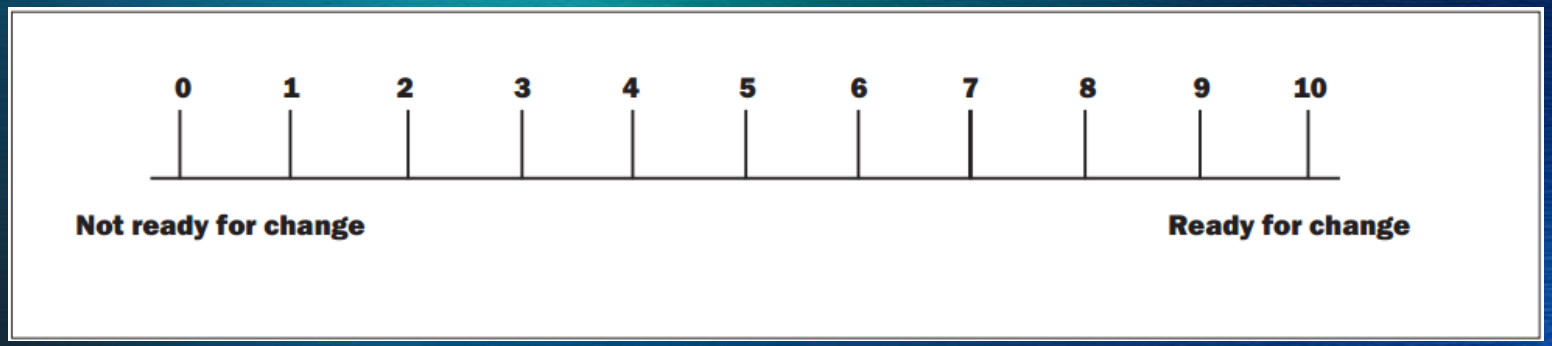
Steps of the brief intervention

- State zone of use
- Ask and explain connection between use and health issue
- State low risk limits
- Give recommendation to reduce use or abstain

Steps of the brief intervention

Enhance motivation

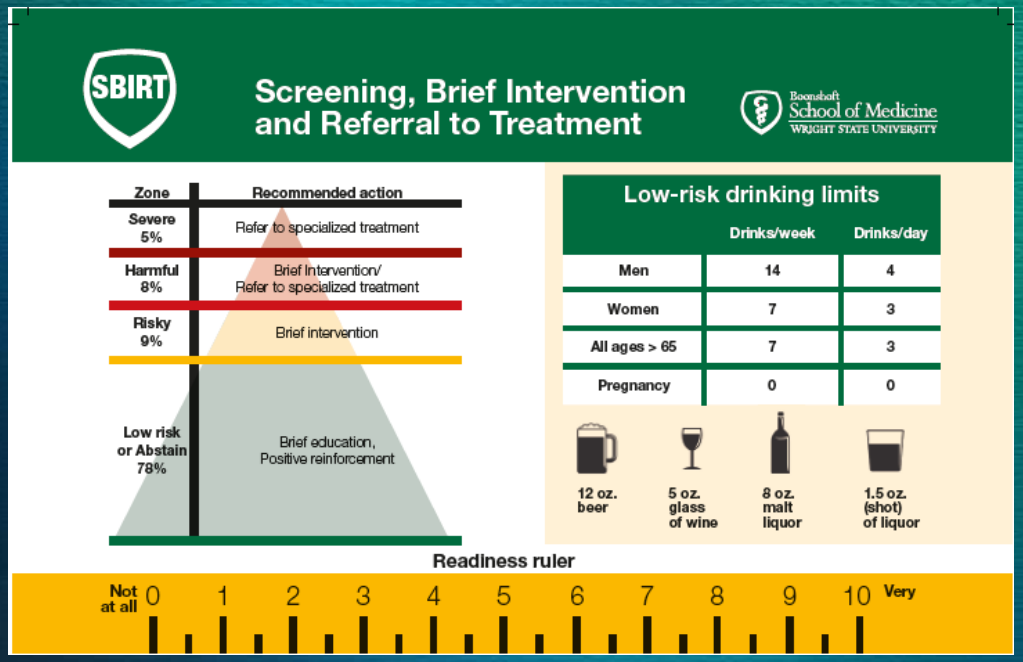
- Ask and reflect about perceived pros and cons of use
- Use a 0 – 10 scale re: readiness to make a change
- “Why not a lower number?”

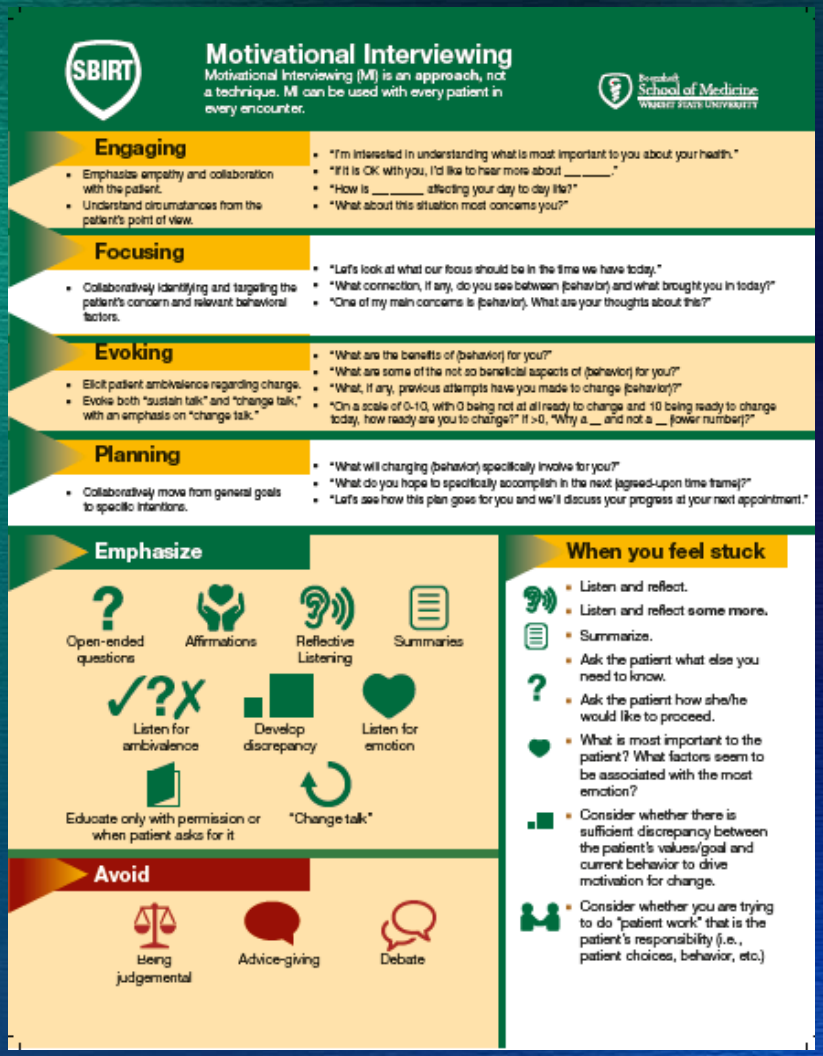


Steps of the brief intervention

- Explore what patient is willing to do (i.e., make a change?, to move higher on readiness ruler?)
- If patient sounds ready, ask, “What would this change look like for you?”
- Re-state your recommendation
- Ask to schedule follow-up

Pocket cards





Physician Health & Well-Being

- MI approach better for physician as well as the patient.
- Less stressful to be collaborative rather than confrontational.
- Physician avoids taking responsibility for what he/she doesn't control --- patient behavior.
- There is enough "doctor work" for the physician to do (diagnosis, determining treatment options, etc.); let the patient do "patient work" (i.e., adherence, lifestyle change, problem-solving).

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