Moving Towards Change: Supporting Your Patients to Self-Manage

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Why are we here?

Lack of motivation to follow through

Patients get overwhelmed and depressed

Lack of family support

Patients start ok but fall off

Lack of access to HCPs

Easier for patients to avoid

Patients say: Just tell me what I should do!

Patients worried about side effects

I get frustrated that patients don’t seem to want to follow through

Patients say: Just tell me what I should do!
Why we are here?

- Health was advanced in the 19th century due to significant advances in hygiene.
- Health advancement in the 20th century is largely associated with advancements in medicine.
- Advancements in the 21st century are based on behaviour change.
WORLD 592 million people living with diabetes

WORLD 387 million

Africa 93%
Middle East and North Africa 85%
South East Asia 64%
South and Central America 55%
Western Pacific 48%
Europe 33%
North America and Caribbean 30%
Association of Body Mass Index With Lifetime Risk of Cardiovascular Disease and Compression of Morbidity

Sadiya S. Khan, MD, MS; Hongyan Ning, MD, MS; John T. Wilkins, MD, MS; Norrina Allen, PhD; Mercedes Carnethon, PhD; Jarett D. Berry, MD; Ranya N. Sweis, MD, MS; Donald M. Lloyd-Jones, MD, ScM

Figure 1. Lifetime Risk of Cardiovascular Disease (CVD) Morbidity and Mortality Among Middle-aged Individuals
Burden of Diseases, Injuries, and Risk Factors Among US States

Introduction: Several studies have measured health outcomes in the United States, but no one has provided a comprehensive assessment of patterns of health by state.

Objective: To use the results of the Global Burden of Disease Study (GBD) to report trends in the burden of diseases, injuries, and risk factors at the state level from 1990 to 2016.

Design and Setting: A systematic analysis of published studies and available data sources estimates the burden of disease by age, sex, geography, and year.

Main Outcomes and Measures: Prevalence, incidence, mortality, life expectancy, healthy life expectancy (HALE), years of life lost (YLL), and disability-adjusted life-years (DALYs) for 333 causes and 84 risk factors with 95% uncertainty intervals (UI) were computed.

Results: Between 1990 and 2016, overall death rates in the United States declined from 74.2 (95% UI, 74.0 to 74.8) per 100,000 persons to 78.0 (95% UI, 76.9 to 78.7) per 100,000 persons. The probability of death among adults aged 20 to 55 years declined in 31 states and Washington, DC from 1990 to 2016. In 2016, Hawaii had the highest life expectancy at birth (83.3 years) and Mississippi had the lowest (74.7 years), a 8.6-year difference. Minnesota had the highest HALE at birth (70.3 years), and West Virginia had the lowest (63.8 years), a 6.5-year difference. The leading causes of DALYs in the United States for 1990 and 2016 were ischemic heart disease and lung cancer, while the third leading cause in 1990 was low back pain, and the third leading cause in 2016 was chronic obstructive pulmonary disease. Opioid use disorders moved from the 11th leading cause of DALYs in 1990 to the 7th leading cause in 2016, representing a 74.5% (95% UI, 42.8% to 95.9%) change. In 2016, each of the following 6 risks individually accounted for more than 5% of risk-attributable DALYs: tobacco consumption, high body mass index (BMI), poor diet, alcohol and drug use, high fasting plasma glucose, and high blood pressure. Across all US states, the top risk factors in terms of attributable DALYs were due to 1 of the 3 following causes: tobacco consumption (52 states), high BMI (10 states), or alcohol and drug use (8 states).

Conclusions and Relevance: There are wide differences in the burden of disease at the state level. Specific diseases and risk factors, such as drug use disorders, high BMI, poor diet, high fasting plasma glucose level, and alcohol use disorders are increasing and warrant increased attention. These data can be used to inform national health priorities for research, clinical care, and policy.
TO THE EDITOR: Different countries celebrate different holidays, but many such celebration periods have one thing in common: an increased intake of favorite foods. How do holidays—such as Thanksgiving in the United States, Christmas in Germany, and Golden Week in Japan—affect weight?
<table>
<thead>
<tr>
<th>Prescriptions</th>
<th>Overall</th>
<th>Switch to New Drug in Pharmacologic Class</th>
<th>New Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central nervous system agents</td>
<td>9035(30.1)</td>
<td>1082(10.2)</td>
<td>7953(32.8)</td>
</tr>
<tr>
<td>Analgesics and antipyretics</td>
<td>3248(27.8)</td>
<td>444(14.0)</td>
<td>2804(30.0)</td>
</tr>
<tr>
<td>Psychotherapeutic agents</td>
<td>2762(32.5)</td>
<td>168(11.3)</td>
<td>2594(33.9)</td>
</tr>
<tr>
<td>Cardiovascular drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypotensive agents</td>
<td>3108(32.2)</td>
<td>862(5.9)</td>
<td>2246(42.3)</td>
</tr>
<tr>
<td>Antilipemics</td>
<td>2794(33.6)</td>
<td>590(8.0)</td>
<td>2204(40.5)</td>
</tr>
<tr>
<td>Anti-Infectives</td>
<td>5087(24.2)</td>
<td>361(11.9)</td>
<td>4726(25.1)</td>
</tr>
<tr>
<td>Antibacterials</td>
<td>4179(23.3)</td>
<td>344(10.8)</td>
<td>3835(24.5)</td>
</tr>
<tr>
<td>Antivirals</td>
<td>271(35.4)</td>
<td>13(46.2)</td>
<td>258(34.9)</td>
</tr>
<tr>
<td>Hormones and synthetics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidiabetic agents</td>
<td>979(29.1)</td>
<td>7(42.9)</td>
<td>972(29.0)</td>
</tr>
<tr>
<td>Thyroid/antithyroid agents</td>
<td>614(49.4)</td>
<td>0(NA)</td>
<td>614(49.4)</td>
</tr>
<tr>
<td>Skin and mucous membrane drugs</td>
<td>3221(27.6)</td>
<td>523(18.2)</td>
<td>2698(29.4)</td>
</tr>
<tr>
<td>Anti-inflammatory agents</td>
<td>1046(27.4)</td>
<td>500(18.2)</td>
<td>546(30.2)</td>
</tr>
<tr>
<td>Gastrointestinal drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-ulcer agents</td>
<td>2410(33.1)</td>
<td>434(12.0)</td>
<td>1976(37.7)</td>
</tr>
<tr>
<td>Antidiabetic agents</td>
<td>2244(33.0)</td>
<td>428(12.2)</td>
<td>1816(37.9)</td>
</tr>
<tr>
<td>Ear, nose, and throat preparations</td>
<td>1752(34.2)</td>
<td>185(20.9)</td>
<td>1567(35.9)</td>
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<tr>
<td>Anti-inflammatory agents</td>
<td>1442(36.3)</td>
<td>161(21.7)</td>
<td>1281(38.1)</td>
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<td>Autonomic drugs</td>
<td>1311(27.1)</td>
<td>276(15.2)</td>
<td>1035(30.2)</td>
</tr>
<tr>
<td>Diuretics</td>
<td>981(33.4)</td>
<td>7(28.6)</td>
<td>974(33.5)</td>
</tr>
<tr>
<td>Other pharmacologic classes</td>
<td>2072(34.3)</td>
<td>181(12.2)</td>
<td>1891(36.4)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37,506(31.3)</strong></td>
<td><strong>4992(11.6)</strong></td>
<td><strong>32,514(34.3)</strong></td>
</tr>
</tbody>
</table>
Treatment persistence: a significant issue in chronic disease, including diabetes

Needs and concerns analysis

Assess the patient’s view of the needs for medication
Assess their concerns about the potential side-effects

<table>
<thead>
<tr>
<th>Needs</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>Low</td>
<td>Sceptical</td>
</tr>
<tr>
<td>High</td>
<td>Accepting</td>
</tr>
<tr>
<td>Low</td>
<td>Indifferent</td>
</tr>
</tbody>
</table>
Your Turn to Practice

Break into pairs:
- To what extent do you think you need this medication to benefit your health?
- To what extent do you have concerns about taking this medication?

<table>
<thead>
<tr>
<th>Needs</th>
<th>High</th>
<th>Low</th>
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<tr>
<th>Concerns</th>
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<tr>
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<tr>
<td>Sceptical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indifferent</td>
<td></td>
<td></td>
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</tbody>
</table>
Decision aid: SURE test

<table>
<thead>
<tr>
<th>Sure of myself</th>
<th>Do you feel SURE about the best choice for you?</th>
<th>Yes [1]</th>
<th>No [0]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td>Do you know the benefits and risks of each option?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-benefit</td>
<td>Are you clear about which benefits and risks matter most to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouragement</td>
<td>Do you have enough support and advice to make a choice?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Yes equals 1 point
No equals 0 point

If the total score is less than 4, the patient is experiencing decisional conflict

What Needs to Change?
(Table 5 in ever employed module and 21.4 modules). A 60.9% completion of 1.3 module, an average of 3.7 module, or national health
What is the difference between Inspiration and Motivation?

• Most of the time motivation is only shortlived. Why?
What is the difference between Reinforcement and Cheerleading?

- Why are clinicians so focused on getting to behaviour so quickly?
I think, I probably should, stop smoking

• What are the typical clinician responses to statements such as this?

• If you had to wager $1000 of your own money, would you predict this person will be successful or unsuccessful?

• If the person were unsuccessful what is the most likely word that they would use to describe this unsuccessful outcome?

• How many times can a person have a failure experience before they conclude that they are incapable – the opposite of self-efficacy
This is what happens when expectations are set too high.
How old is a child when they first declare:  
**YOU ARE NOT THE BOSS OF ME!**

What are amongst a child’s first words:  
NO!  
ME DO!

The more you tell someone what to do, the more they

………..
Psychological Reactance

• The tendency to act the opposite to what one is asked to do
• Reactance is related to the issue of control and self-determination
• If a person feels that control is being taken away from them, or free will is limited it is NORMAL to resist
Core Principles of Behaviour Change Counselling

Within these core principles, what are the knowledge and skills gained?

What do I need to know? What do I need to do?
The HOW of behaviour change: pathway to success

Evidence-based pathway\(^1,2,3\)

Impact of Healthy Lifestyle Factors on Life Expectancies in the US Population

BACKGROUND: Americans have a shorter life expectancy compared with residents of all other high-income countries. We aim to estimate the impact of lifestyle factors on premature mortality and life expectancy in the US population.

METHODS: Using data from the Nurses’ Health Study (1980–2014, n=78,865) and the Health Professionals Follow-up Study (1986–2014, n=44,254), we defined 5 low-risk lifestyle factors as never smoking, body mass index of 18.5 to 24.9 kg/m², ≥20 min/d of moderate to vigorous physical activity, moderate alcohol intake, and a high diet quality score (upper 40%), and estimated hazard ratios for the association of total lifestyle score (0–5 scale) with mortality. We used data from the NHANES (National Health and Nutrition Examination Surveys; 2013–2014) to estimate the distribution of the lifestyle score and the US Centers for Disease Control and Prevention WONDER database to derive the age-specific death rates of Americans. We applied the life table method to estimate life expectancy by levels of the lifestyle score.

RESULTS: During up to 34 years of follow-up, we documented 42,167 deaths. The multivariable-adjusted hazard ratios for mortality in adults with 5 compared with zero low-risk factors were 0.26 (95% confidence interval [CI], 0.22–0.31) for all-cause mortality, 0.35 (95% CI, 0.27–0.45) for cancer mortality, and 0.28 (95% CI, 0.12–0.62) for cardiovascular disease mortality. The population-attributable risk of nonadherence to 5 low-risk factors was 60.7% (95% CI, 53.6–66.7) for all-cause mortality, 51.7% (95% CI, 37.1–62.9) for cancer mortality, and 71.7% (95% CI, 58.1–81.0) for cardiovascular disease mortality. We estimated that the life expectancy at age 50 years was 29.0 years (95% CI, 28.3–29.8) for women and 25.5 years (95% CI, 24.7–26.3) for men who adopted zero low-risk lifestyle factors. In contrast, for those who adopted all 5 low-risk factors, we projected a life expectancy at age 50 years of 63.1 years (95% CI, 61.6–64.5) for women and 57.6 years (95% CI, 55.8–59.4) for men. The projected life expectancy at age 50 years was on average 14.0 years (95% CI, 11.6–16.2) longer among female Americans with 5 low-risk factors compared with those with zero low-risk factors; for men, the difference was 12.2 years (95% CI, 10.1–14.4).

CONCLUSIONS: Adopting a healthy lifestyle could substantially reduce premature mortality and prolong life expectancy in US adults.

<table>
<thead>
<tr>
<th>Body mass index, kg/m²</th>
<th>Person-Years</th>
<th>Deaths Resulting From Any Cause</th>
<th>Cancer Deaths</th>
<th>CVD Deaths</th>
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<tr>
<td></td>
<td></td>
<td>Cases HR (95% CI)</td>
<td>Cases HR (95% CI)</td>
<td>Cases HR (95% CI)</td>
</tr>
<tr>
<td>18.5–22.9</td>
<td>624,140</td>
<td>5337 1.06 (1.02–1.09)</td>
<td>1868 0.96 (0.91–1.02)</td>
<td>1077 1.02 (0.94–1.10)</td>
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<tr>
<td>23–24.9</td>
<td>677,848</td>
<td>7289 1.0 (Referent)</td>
<td>2588 1.0 (Referent)</td>
<td>1716 1.0 (Referent)</td>
</tr>
<tr>
<td>25–29.9</td>
<td>1,381,081</td>
<td>17,903 1.05 (1.02–1.08)</td>
<td>5935 1.01 (0.96–1.06)</td>
<td>4738 1.16 (1.10–1.23)</td>
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<tr>
<td>30–34.9</td>
<td>518,621</td>
<td>7427 1.25 (1.21–1.29)</td>
<td>2371 1.12 (1.05–1.18)</td>
<td>2006 1.66 (1.56–1.78)</td>
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<tr>
<td>≥35</td>
<td>250,013</td>
<td>4211 1.67 (1.61–1.74)</td>
<td>1191 1.24 (1.16–1.33)</td>
<td>1152 2.58 (2.39–2.79)</td>
</tr>
</tbody>
</table>

No. of 5 low-risk factors:

<table>
<thead>
<tr>
<th>No.</th>
<th>Person-Years</th>
<th>Cases HR (95% CI)</th>
<th>Cases HR (95% CI)</th>
<th>Cases HR (95% CI)</th>
</tr>
</thead>
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<tr>
<td>0</td>
<td>458,169</td>
<td>9286 1.0 (Referent)</td>
<td>2785 1.0 (Referent)</td>
<td>2430 1.0 (Referent)</td>
</tr>
<tr>
<td>1</td>
<td>110,1853</td>
<td>16,329 0.79 (0.77–0.81)</td>
<td>5227 0.83 (0.79–0.87)</td>
<td>4143 0.75 (0.71–0.79)</td>
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<tr>
<td>2</td>
<td>1,053,250</td>
<td>10,908 0.61 (0.59–0.62)</td>
<td>3821 0.68 (0.65–0.71)</td>
<td>2719 0.54 (0.51–0.57)</td>
</tr>
<tr>
<td>3</td>
<td>596,784</td>
<td>4408 0.47 (0.45–0.49)</td>
<td>1607 0.53 (0.50–0.57)</td>
<td>1101 0.40 (0.38–0.43)</td>
</tr>
<tr>
<td>4</td>
<td>208,683</td>
<td>1113 0.35 (0.33–0.37)</td>
<td>458 0.44 (0.40–0.49)</td>
<td>270 0.28 (0.25–0.32)</td>
</tr>
<tr>
<td>5</td>
<td>32,964</td>
<td>123 0.26 (0.22–0.31)</td>
<td>55 0.35 (0.27–0.45)</td>
<td>26 0.18 (0.12–0.26)</td>
</tr>
</tbody>
</table>
The Patient Journey

Diagnosis
Initiation of treatment

Adjustment to Disease

Opportunities for TEACHABLE MOMENTS

Periods of adherence and nonadherence

Our Patients’ Journey Starts Here

Ongoing medical touchpoints with multiple providers
Turning Back the Clock: Adopting a Healthy Lifestyle in Middle Age

King, Mainous & Geesy, American Journal of Medicine, 2007, 120, 598-603

Artherosclerosis Risk in Communities Study
15,708 participants

8.5% Healthy
91.5% Not

6 years later

8.4% Became Healthy
91.6% Stayed Unhealthy

Over a 4 year period!

Not Smoking
Healthy Weight
Active
Eat+

Mortality -0.40

Cardiac Events -0.35
Who Needs to Change?
The scientific method

As clinical medicine developed, this led to the clinician taking the role of the expert.

The expert clinician with the uninformed help-seeker

Complexity

- Complex systems
  - Fuzzy boundaries
  - Internalized rules
  - Adaptive systems embedded in other systems
  - Tension/paradox natural not resolvable
  - Interaction leads to continually emerging novel behaviour

- Plsek & Greenhalgh. BMJ. 2003;323:625-628
Testimony to Complexity: Foresight Obesity System Atlas
Outcomes are dependent on how good you are.
Physician weight loss advice and patient weight loss behavior change: a literature review and meta-analysis of survey data

SA Rose1,2, PS Poynter1, JF Anderson1, SW Noar3 and J Conigliaro2

Primary care providers (PCPs) can empower their patients to make health-promoting behavior changes. Many guidelines recommend that PCPs counsel overweight and obese patients about weight loss, yet few studies examine the impact of provider weight loss counseling on actual changes in patient behavior. We performed a systematic review and meta-analysis of published studies of survey data examining provider weight loss counseling and its association with changes in patient weight loss behavior. We reviewed the published literature using keywords related to weight loss advice. We used meta-analysis techniques to compute and aggregate effect sizes for the meta-analysis. We also tested variables that had the potential to moderate the responses. A total of 32 studies met criteria for the literature review. Of these, 12 were appropriate for the meta-analysis. Most studies demonstrated a positive effect of provider weight loss advice on patient weight loss behavior. In random effects meta-analysis, the overall mean weighted effect size for patient weight loss efforts was odds ratio (OR) = 3.85 (95% confidence interval [CI] 2.71, 5.49; P < 0.001). Indicating a statistically significant impact of weight loss advice. There was no significant difference in the effectiveness of advice in studies using obese patients alone versus mixed-obsese patients. In the absence of all obesity patients, mixed sample OR = 3.44, 95% CI 2.37, 5.00; mixed sample OR = 3.98, 95% CI 2.53, 6.26, P = 0.63. PCP advice on weight loss appears to have a significant impact on patient attempts to change behaviors related to their weight. Providers should address weight loss with their overweight and obese patients.


Keywords: physician; counseling; documentation; patient behavior; meta-analysis

INTRODUCTION
Obesity is a major clinical and public health problem associated with an increased risk of morbidity and mortality and is related to many comorbidities treated by primary care providers (PCPs).1,2 Intentional weight loss can potentially mitigate this increased risk.1,3 Studies on tobacco and alcohol use counseling in the clinical setting demonstrate that physicians can have a positive impact on changing patient behaviors, even with brief counseling.4 Advancing similar methods, multiple organizations recommend physician screening and counseling for overweight and obesity, but most physicians do not appear to be advising their patients to lose weight.1,5 Lack of physician counseling may be related to controversy regarding the effectiveness and realistic nature of weight counseling. The United States Preventive Services Task Force (USPSTF) found good evidence to recommend that clinicians screen all patients for obesity through measurement of body mass index. However, they found fair to good evidence that only “high-intensity counseling and behavioral interventions”, defined as more than one person-to-person session during at least the first 3 months, were effective for treatment purposes, and that evidence for less-intensive interventions that may be more feasible in the clinical setting was insufficient.6 The few studies that address health care provider self-efficacy on the topic of weight find that providers face challenges with weight counseling, including a lack of tools, training, reimbursement, staffing, and time, and rely a lack of confidence in their own abilities and in the effectiveness of weight loss strategies in general.1,7-17

The purpose of this study was to examine whether PCP counseling enhances patient engagement in weight reduction efforts. We aimed to systematically review the survey literature regarding the effectiveness of PCP-provided advice related to patient weight loss behaviors, followed by a meta-analysis examining the hypothesis that PCP counseling would enhance patient participation in weight loss efforts.

MATERIALS AND METHODS
Literature review search strategy
We performed an extensive search related to the effect of provider weight loss advice on patient behavior. We conducted a review of published literature in the English language using numerous keywords in combination relating weight loss advice, including physician, counseling, overweight, obese, weight loss, advice, diagnosis, documentation, recording, recognition, screening and cardiovascular risk. We performed searches in PubMed, Web of Science, PsychINFO, Cochrane Library, EMB, Dissertation and Theses and WorldCat, and used PubMed Medical headings and analogous search strategies in other databases. No limitations were made upfront; however, one relevant non-English language article was excluded from the coding. Searches included articles published through November of 2011. An initial search using PubMed alone found five articles with the outcome appropriate for inclusion in the meta-analysis,7,18 with one later removed in favor of an article using the same data set with a large, more generalizable population.7 The list of references for each of these articles was searched for additional potential articles.

OR = 3.85
Foundations of Behaviour

Most Common Coping Strategy
Foundations of Behaviour

Decisional Conflict

The SAFEST thing to do.......NOTHING
Foundations of Behaviour

The Neurobiology of Behaviour

• Feeling and thinking: preferences need no inferences

• Emotions dominate logic

• Communication is the bridge

Behaviour Change Counselling Competencies

Change-Based Relationships

Collaborate & Empower
- Bond, Task Goal Alliance

Motivational Communication
- Dangers of Teach & Tell
  - Ask, Listen, Summarize & Invite
  - Nonjudgmental Curiosity, Ambivalence, Avoid Argument

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- Collaborate & Empower
  - Bond, Task Goal Alliance

- Motivational Communication
  - Dangers of Teach & Tell
    - Ask, Listen, Summarize & Invite
    - Nonjudgmental Curiosity, Ambivalence, Avoid Argument

- Change-Based Relationships
Collaborating with and empowering our patients

**Bond alliance**
Professional, respectful, caring and supportive connections established with patients

**Task alliance**
Distribution of tasks and activities to achieve a specific goal

**Goal alliance**
Agreement on the specific outcome to be achieved
Using the patient–provider relationship

- Ask open-ended questions
- Listen empathetically and reflectively
- Summarise
- Invite

‘Communicate to negotiate’
Motivational Communication

While you ask, listen, summarize and invite, a change-based relationship is facilitated by:

• Nonjudgmental Curiosity
• Expressing Empathy (Ask, listen, summarize invite)
• Avoiding Argument
• Sitting with Ambivalence
Your patient lives with type 2 diabetes and is maxed out on oral agents.
- The MD – recommend insulin
- The Pt – you see the idea of insulin as terrifying and a sign of failure; the last thing you are interested in
READINESS TO CHANGE
Defining Behaviour

• Behaviour is:
  • Observable
  • Measureable
  • Something that the patient does.

• Patients and providers need to agree on a behaviour (i.e. exactly what the patient needs to do) that is highly specific (when, where, what, how) and in the context of the person's life.

• The behaviour should be meaningful to the patient rather than solely the provider.
Assessing Readiness

- Readiness for change is a state that fluctuates over time.
- The purpose of assessing readiness is to tell you how to get started.
Assessing Readiness

A person’s readiness can be categorized as red light, yellow light or green light for a certain behaviour.

1. “Do you consider [the behaviour] a problem?”
2. “Are you bothered by [the behaviour]?”
3. “Are you interested in changing [the behaviour]?"
4. “Are you ready to change now?”
Assessing Readiness

Readiness is a state, not a trait.

1. “Do you consider [the behaviour] a problem?” – Frontal lobe engagement
2. “Are you bothered by [the behaviour]?” – Limbic system engagement
3. “Are you interested in changing [the behaviour]?” – Identifying the goal
4. “Are you ready to change now?” – Action

• You are trying to be transparent with the process in order to give feedback to patients.
• Aim is to obtain buy-in.
Readiness assessment is the beginning, not the end

- **Ready**: Go right to behaviour modification
- **Ambivalent**: Begin working on behaviour and encourage a focus on personal meaningful reasons to change
- **Not ready**: Confirm that the person is not ready and ask permission to keep the conversation going
Assessing Readiness

Proceeding Under a Green Light:

• First step action plans/SMART goals.
• Next step goals (behaviour shaping).
• Personalized re-built environments (stimulus control).
• Turning external into internal motivation (reinforcement management).
Goal Setting:

Create S.M.A.R.T. Goals

- Specific
- Measurable
- Achievable
- Realistic
- Timely
Shaping

• Sequence SMART goals such that the person experiences:
  – Success…followed by
  – Success….followed by
  – Success….followed by
  – Success….followed by
  – Success….followed by

• Following sufficient successes (varies but commonly 5-7) the person develops self-efficacy.
  – This self-efficacy is based on past behaviour
Stimulus Control

• **Stimulus Control** is about recognizing that a strong determinant of behaviour is environmental cues.

• Recognition that the *built environment* is an important determinant of behaviour.

• May want to focus on environmental factors that make it difficult to stay on track.

• Stimulus control is about identifying the cues that elicit unhealthy behaviour.

Example:

• Despite being outrageously priced, many people eat food at a movie when they are not hungry
Reinforcement Management

Behaviour will be repeated when:

• It is reinforced or rewarded.
  - Something valued or desirable is added
  - Something negative is taken away
• It happens at the same time as other behaviour that is rewarded.

Behaviour will extinguish (stop) when:

• A reinforcer or reward is taken away.
• The reward value ends or is faded out.
• A punishment is applied
PROMOTING READINESS

This is what we would do for red and yellow light behaviours
Assessing Readiness

Yellow Light:

- The person is ambivalent. They can see the pros and cons of changing.
- They are pulled in two directions.
- You can have opposite opinions at the same time.
- You will hear “Yes,…But”
- “Yes,…But” actually means “No,…Because” (Avoiding argument).
# Decisional Balance

<table>
<thead>
<tr>
<th></th>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>Of staying the same</td>
<td></td>
<td></td>
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<tr>
<td>Of changing</td>
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</tbody>
</table>
Assessing Readiness

Red Light:

• The clinician needs to communicate that the expectation of change is off the table.

• Keep the conversation going.

• The patient is not receptive to change and is resistant to what you have to say. This does not mean that the relationship stops.
Assessing Readiness

Proceeding Under a Red Light:

• This is the most challenging situation for us.
• Find a way to keep the dialogue going.
• Intervention is maintaining the relationship.
• Take the expectation of change off the table.
Assessing Readiness

Steps for Proceeding Under a Red Light:

• Ask yourself if you notice an urge to fix the problem or set the patient straight.
  • If so, this involves you (as the provider) managing your own reaction so that it doesn’t come off as judgmental). Maintaining the relationship at this point is critical.
  • Managing your own reaction (“righting reflex”).
  • Reminding yourself that patients have a right to make their own choices.
  • Trusting that understanding a patients current choice can be a pathway to discussing alternate choices.
Supporting Sustained Behaviour Change

• This is about emotional, psychological and social issues
  • Provider role and self-efficacy
    • Identify
    • Educate
    • Recommend
    • Support
Supporting Sustained Behaviour Change

• The 4 Ss
  • Self-Image
  • Self-Efficacy
  • Social Support
  • Stress Management (discharge, calming, expression, connection)
Replacing the Function

• Many unhealthy behaviours serve a purpose for the individual
  – Uncovering the purpose or function of the unhealthy behaviour is very important (nonjudgmental curiosity)
    • This function is a strong reason not to change
• Once the function of the behaviour has been understood
  – Focus on healthier alternative behaviours that provide a similar function
• Once a person has an alternative they can choose to give up the unhealthy behaviour
Intrinsic Motivation
Values

The personal strengths or qualities a person most wants to express in his or her life and daily patterns of action.
Values-driven behaviour

• The cookie example
  • Scene:
    • You are asked to choose between 2 cookies – freshly baked, warm and aromatic versus misshapen slightly burned 2-day-old cookies – which would you choose?

• Punch line
  • You are told your 3-year-old granddaughter came up with the idea and worked hard to make this cookie for you, insisting that your son bring it to you so it arrived in time for your dinner tonight. Which cookie would you choose?
‘AWAY’
Moving away from the life outcome you want, acting ineffectively, behaving unlike the person you want to be

‘TOWARDS’
Moving towards the life outcome you want, acting effectively, behaving like the person you want to be

HOOKS
Difficult/unhelpful thoughts, feelings, sensations, and memories that ‘hook’ you

HELPERS
Values, strengths and skills that help you to act like the kind of person you want to be

Challenging Situation

Choice Point
Committed Action

The Bull's Eye

I am living fully by my values

I am acting very inconsistently with my values

Work/Education

Personal growth/Health

Leisure

Relationships
Ask, Assess, Advise, Agree, Assist
Persons with chronic disease spend only a small portion of their life with Healthcare Providers

- Without a health care provider: 525,480 minutes
- With a health care provider: 120 minutes
- With a health care provider in flare ups: 120 minutes
Change is hard: Ambivalence is normal

The impulse to seek pleasure is tempered by human values: “Anything worth having is worth tolerating distress for”

Meaning can balance pleasure
What Do We Know About Those With Chronic Conditions?

• Their symptoms are chronic!

• They function even when they have symptoms

• Healthy people don’t show up when they are ill; those with chronic disease soldier on regardless of symptoms

They are ALWAYS ill!!!

You might as well dress the part even if you feel like S*#t!
Two Take-Aways

• Listen

• Allow flexibility

Why is it easier for a smoker to take smoke breaks in the workplace than it is for someone with, say diabetes, to take care of their diabetes in the workplace??!!!!
What do we know about Diabetes?

• Let’s calculate how many years of experience in diabetes we have as a group

• How many times has a person come to your clinic to say:
  • “I don’t have diabetes but I’d LOVE to test my blood glucose 4-6/day, take insulin and pills multiple times/day, monitor and record everything I eat and drink and do”?
What Do People With Diabetes Experience?

• The behavioural demands of self-care can be **OVERWHELMING**
  • Self-testing, healthy eating, exercise/activity, insulin/medication regimen, general health care (feet, eyes)

• Maintaining glucose control is enormously **COMPLEX**
  • Managing the behaviours in like thinking in 4-dimensional space - “you cant imagine”

• Diabetes self-care demands are **CONSTANT**
  • There are no weekends, summer vacations, retirement packages

• Diabetes can be **UNFORGIVING**

• Diabetes is plagued by **UNCERTAINTY**
Healthy Behaviour is Abnormal Behaviour in the Current Environment We Live In

- Approach pleasure and avoid pain
- Save energy for when we need it
- Make the most of the moment because the future is uncertain

Apple pie or Apple? Elevator or Stairs?

How often did your great, great grandfather go to Goodlife?

A healthy old age requires working hard when you are well and younger