

Are your patient counseling strategies evidence-based?

Overview of effective and ineffective lifestyle counseling strategies for patients with type 2 diabetes

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Disclosures

- No conflicts of interest relevant to the content presented
- I am a primary care physician and not a psychologist – but I have studied behavioral theory extensively as it relates to my research to overcome barriers to physical activity for patients with type 2 diabetes

Overarching Objectives

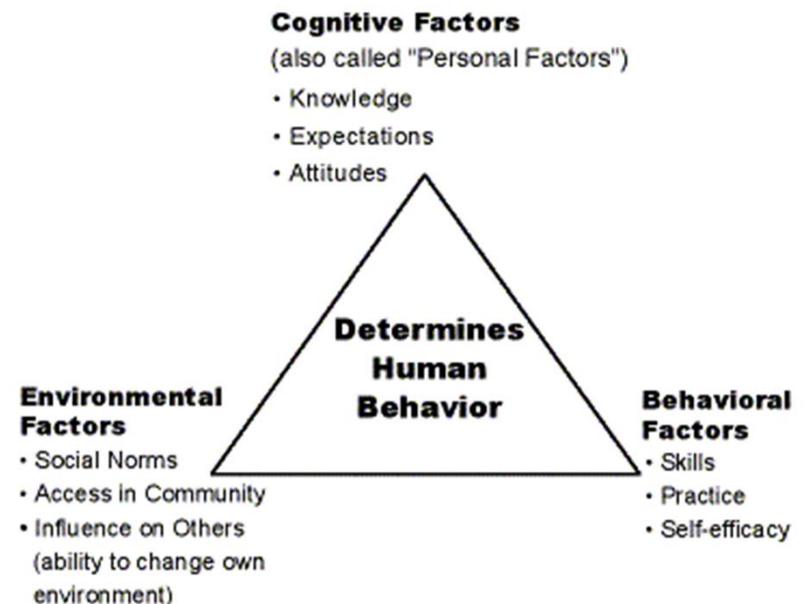
- To identify lifestyle counseling techniques that are generally effective and those that are generally ineffective.
- To develop confidence in the use of effective counseling techniques

Outline

- Provide a brief overview of behavioral theory as it relates to counseling our patients
- Present a rationale for the importance of certain clinical counseling approaches
- Identify “best practices” for lifestyle counseling for clinicians in time-constrained visits
- Present overview of Motivational Interviewing
- Model counseling strategies with Dr. Halliday

Background on Behavioral Theory

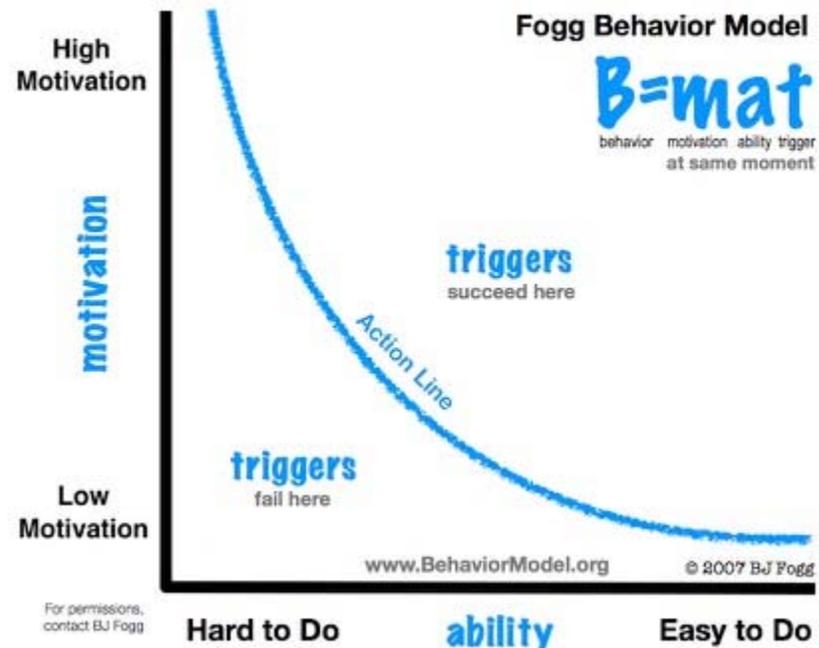
- Human Behavior is influenced by motivation and ability
- Many valid behavioral models have been developed to inform our counseling strategies
- Models vary, but generally identify factors related to motivation and ability:
 - Motivation:
 - Cognitive factors
 - Environmental/Social factors
 - Ability
 - Behavioral factors



Bandura, Social Cognitive Theory, 1986

Background on Behavioral Theory

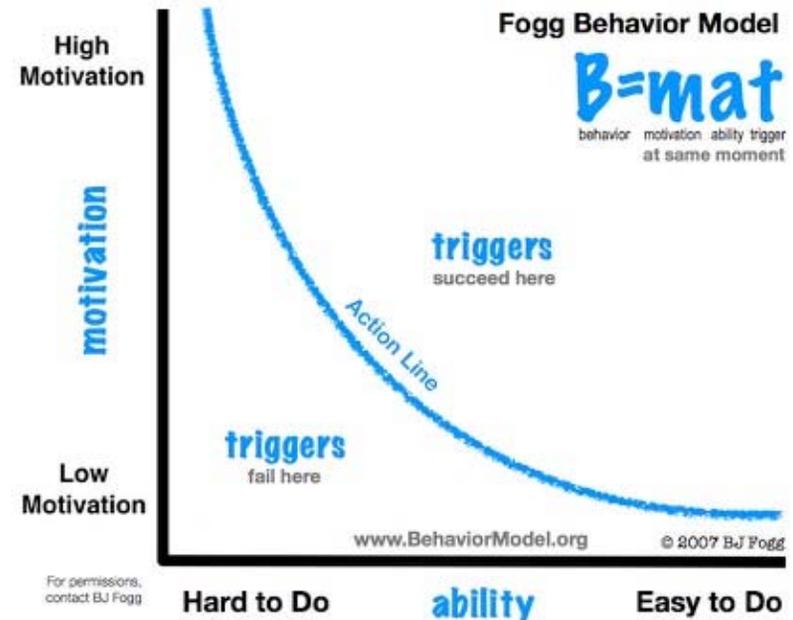
- Dr. Fogg posited that a crucial catalyst to add to motivation and ability is a “trigger”
 - A trigger is a reminder
 - Examples:
 - Push notifications on your phone
 - Prompts to be active from your activity monitor
 - Personal association: when I do X, then I will also do Y



Fogg Behavior Model,
www.behaviormodel.org

Key Point #1 from the Fogg Model

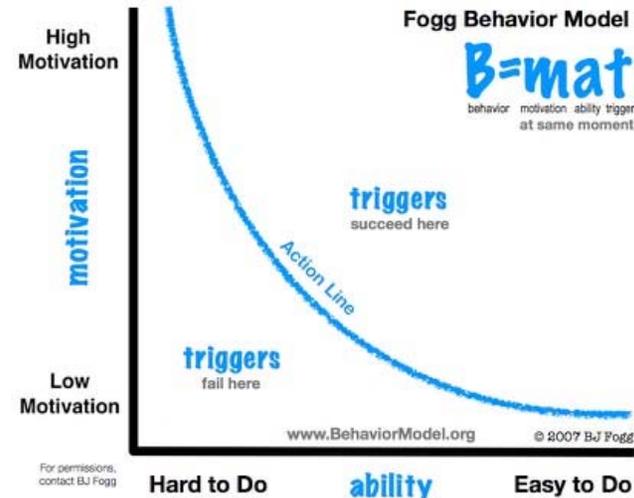
- If patients report high motivation and ability to do a behavior
 - May just need a trigger
 - Examples:
 - I will put my morning pillbox by my coffee pot so I remember to take my morning pills.
 - Accountability “buddy” for weekly check-ins on whether you are meeting a specific goal



Fogg Behavior Model,
www.behaviormodel.org

Key Point #2 from the Fogg Model

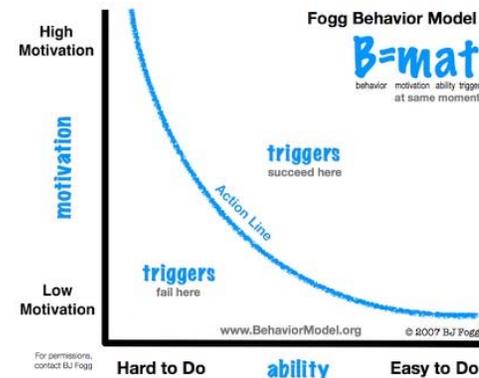
- If patients report high motivation but have low ability, then a trigger will not work
- Dr. Fogg suggests you “simplify the goal” in order to ↑ability to do it
 - Examples:
 - ↓Time: 2-minute walk
 - ↓Money: exercises you can do without a gym
 - ↓Physical effort/pain: water exercise or stationary bike rather than walking/land-based exercise



Fogg Behavior Model,
www.behaviormodel.org

Key Point #3 from the Fogg Model

- If patients report low motivation:
 - Sometimes, they are framing their motivation based on an unrealistic goal (e.g., working out at the gym).
 - Frame your counseling based on their stage of change
 - Precontemplation:
 - Briefly suggest the clinical benefits from a simple change (e.g., 5-minute walk after dinner may ↓ blood sugars)
 - Keep the door open to talk more in the future if their motivation increases
 - Contemplation:
 - Help patients build personal motivation
 - Take baby steps – help them find something they can do easily
 - Not a “one size fits all” prescription
 - **This is not often accomplished in a single visit!**



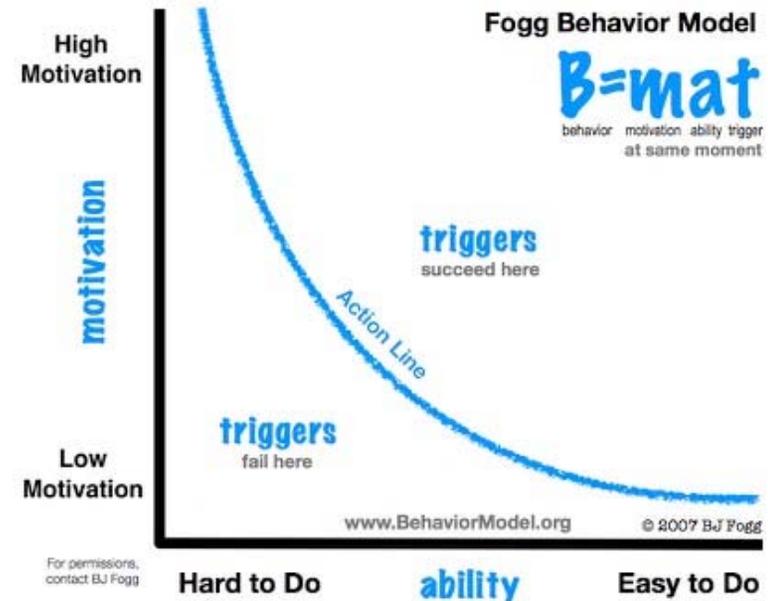
Fogg Behavior Model, www.behaviormodel.org,
 Transtheoretical Model, Prochaska and DiClemente, 1983

Case example

- CD – 55 yr old female
- Type 2 diabetes diagnosed for 5 years
- “I want to exercise more to help prevent my breast cancer from coming back, and to keep my sugars down, but by the time I get home from work I am exhausted”

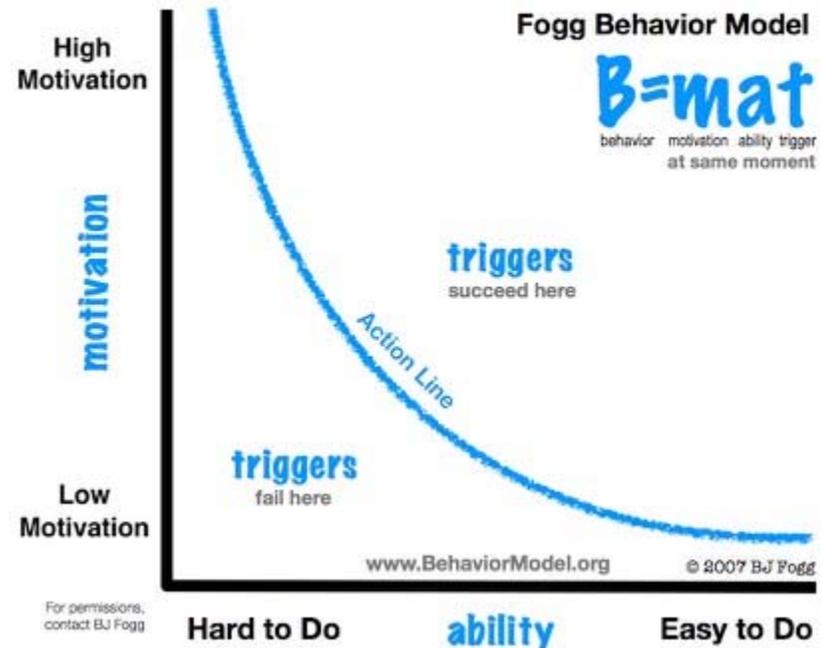
Case example

- CD – 55 yr old female
- Type 2 diabetes diagnosed for 5 years
- “I want to exercise more to help prevent my breast cancer from coming back, and to keep my sugars down, but by the time I get home from work I am exhausted”
 - Working at a desk job
 - Works 12 hours/day, 5 days/week
- Motivation level – high or low?
- Ability – high or low?



Case example

- CD – 55 yr old female
- Type 2 diabetes diagnosed for 5 years
- “I want to exercise more to help prevent my breast cancer from coming back, and to keep my sugars down, but by the time I get home from work I am exhausted”
- Motivation level – **high**
- Ability – **low** – at least after work it is low



Case example

- Fogg model strategies:
 - High motivation/low ability
 - Identify easy ways to be active

Case example

- Fogg model strategies:
 - High motivation/low ability
 - Identify easy ways to be active
 - Before work
 - ~~After work?~~
 - At work
 - On non-work days



Take 30 seconds to brainstorm – talk with others at your table or just write down your own ideas.

Case example

- Fogg model strategies:
 - High motivation/low ability
 - Identify easy ways to be active
 - Before work – too early
 - After work – too tired
 - **At work – this is when the patient thinks it will work best**
 - On non-work days – too many errands

Case example

- Fogg model strategies:
 - Brainstorm opportunities with patient to be active in their preferred setting (in this case – at work)
 - Walk during lunch breaks – perhaps with co-worker to make it more fun/social?
 - Take 2-minute walking breaks every 30 minutes
 - Track daily steps with her pedometer – identify average daily steps and then identify a target daily goal
 - Get a standing desk
 - Desk workouts <https://www.webmd.com/fitness-exercise/features/exercise-at-your-desk#1>
 - Setting a SMART goal (Specific, Measurable, Attainable, Relevant, Time-specific) is often a later step than asking patients to brainstorm and explore options

Case example

- Fogg model strategies:
 - Brainstorm opportunities to be active at work
 - Walk during lunch breaks with co-workers – patient's choice
 - Take 2-minute walking breaks periodically
 - Track daily steps with her FitBit – identify average daily steps and then identify a target daily goal
 - Get a standing desk
 - Desk workout
 - Setting a SMART goal (Specific, Measurable, Attainable, Relevant, Time-specific) is often a later step than asking patients to brainstorm and explore options

Overview of counseling strategies

- Many different evidence-based counseling strategies exist – can seem overwhelming
- Research has identified common elements of effective counseling strategies that are useful in primary care:
 - Collaborative interactions with patients
 - Patients receive support to make **their own decisions**
 - Example: Motivational Interviewing

Assessment of best practices in counseling strategies

- Positive deviance study in a Health Maintenance Organization model
 - Identified doctors whose patients had highest readiness to change (top tier) as compared to doctors whose patients had lowest readiness to change (lowest tier)
 - Compared counseling strategies among doctors in the top tier vs. lowest tier



Greene J, Hibbard JH, et al., *Ann Fam Med*, 2016

Counseling strategies among doctors in the top tier

- Emphasizing patient ownership
- Partnering with patients
- Identifying small steps/goals
- Scheduling follow-up visits to cheer success, problem-solve, or both
- Showing caring and concern for patients

Counseling strategies among doctors in the top tier

- Emphasizing patient ownership
(↑ Motivation/Accountability)
- Partnering with patients (↑ Motivation/Support)
- Identifying small steps/goals (↑ Ability)
- Scheduling follow-up visits to cheer success,
problem-solve, or both (↑ Motivation/Coaching)
- Showing caring and concern for patients
(↑ Motivation/Empathy)

Positive communication - Accountability

- Emphasizing patient ownership
 - “I try to make them as responsible as I can...I want them to take ownership.”
 - “I’m here to coach you, not to make you better – you make yourself better. I can’t do that for you.”

Support

- **Partnering with patients**
 - “How can we work together to help you quit smoking?”

Building confidence

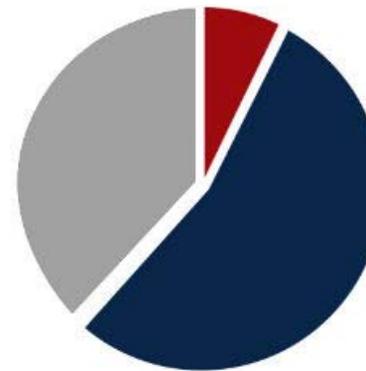
- Identifying small steps
 - “I try to meet them where they’re at – with baby steps.”
 - “If they say, ‘I can’t do anything to make my life better,’ I’ll say, ‘Let’s think of one small thing you can do.’”

Coaching

- Scheduling frequent follow-up
 - “When they come in and they’ve had a success, we celebrate together. I tell them, ‘I’m your biggest cheerleader.’”
 - “We work on problem-solving if things aren’t going well. I ask them, ‘Why aren’t we successful yet? What are you finding is holding you back?’”

Non-verbals are really important

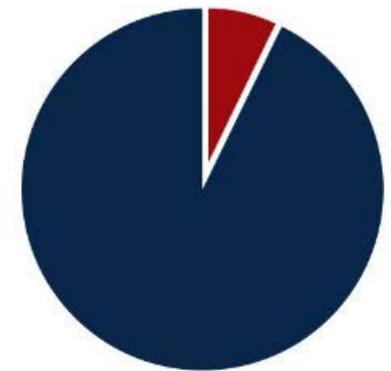
- The words that you say matter (Content)
- How you say things matters much more than the words you say (Face/Body language, Voice/Tone)



Face/Body - 55%

Voice/Tone - 38%

Words - 7%



How You Present
Your Words - 93%

Your Words - 7%

Source: Albert Mehrabian, UCLA

A. Mehrabian, 1971

Empathy

- Show Caring and Concern
 - Positive attitude
 - “Try to have an open mind going into each visit. Smile, be uplifting, and try not to be too judgmental.”

Examples of negative communication content

- Presenting negative health outcomes they may expect if they do not change
 - “Sometimes you just keep reminding people, ‘You’re going to kill yourself this way, you gotta do something.’”
 - This strategy was not successful in enhancing patients’ readiness to change

Motivational Interviewing (MI)

- Encompasses many of the counseling strategies of the doctors whose patients were more ready to change
- Notable and replicated findings
 - Effective to improve many different behaviors for healthy and diseased patients (type 2 diabetes)
 - Physical activity
 - Diet
 - Weight loss
 - RELATIONSHIP MATTERS – better relationship with one’s counselor leads to better outcomes
 - Empathy is a key component of the “spirit” of motivational interviewing - improves outcomes

Miller WR and Rollnick S, Motivational Interviewing: Helping People Change, 3rd ed., New York: Guilford Press, 2012,

Miller and Rollnick's Definition of MI



MI is a **collaborative**, goal-oriented style of communication with particular attention to the *language of change*. It is designed to **strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change** within an atmosphere of acceptance and compassion

What MI is NOT

Motivational Interviewing is NOT a way of tricking people into changing; it is a way of activating their own motivation and resources for change.”

- Miller & Rollnick, 2013

Motivational interviewing 101

Evoking: preparing people to change



The heart of MI: It is in the process of evoking that counseling becomes distinctly MI

Evoking involves eliciting the client's own motivations for change

The expert/ directing approach does not facilitate personal change

Personal change requires the individual's active participation and is a long term process

Component skills in Evoking



- Recognizing ***change talk*** when you hear it
 - × And, knowing how to evoke and respond to it when it occurs

- Recognizing ***sustain talk*** when you hear it
 - × And, understanding what it signifies and how to respond to it

Sustain Talk is the hallmark of ambivalence

Preparatory Change Talk (The DARN's)



Desire, **A**bility, **R**easons, and **N**eed

Each reflect the pro-change side of ambivalence.

They are considered preparatory change talk because **none of them, alone or together, indicate that change is going to happen.**

Mobilizing Change Talk (The CATS)

The CATS signal movement toward resolution of the ambivalence in the favor of change.

- **C**ommitment: signals the likelihood of action
“I will”; “I promise”; “I guarantee”; “I intend to” (decision with a little doubt)
- **A**ctivation: movement toward but not quite a commitment
“I’m willing to try”; “I am ready to”; “I am prepared to”

Mobilizing Change Talk

- **T**aking **S**teps: the client has already done something in the direction of change:

“I bought nicotine patches”; “I didn’t snack any evening this past week”; “I quit smoking inside my house & car”

The DARN CATS: Language that signals movement toward change

Responding to Change Talk



When you hear it, respond to it!

- **O**pen-ended questions: Ask for more detail or examples
- **A**ffirmation: Comment positively about what you heard
- **R**eflections: simple or complex, continuing the paragraph
- **S**ummaries: include change talk content in summaries

Wrong Questions?



- Questions that would be ill-advised from an MI perspective.
 - “Why haven’t you changed?”
 - “What keeps you doing this?”
 - “Why do you smoke?”
 - “Why aren’t you trying harder?”
 - “Why can’t you?”



Transitioning to goal-setting

Transitioning Methods



- **Recapitulation:** A transitional collecting summary of Change Talk, like adding flowers to a bouquet
“I’ve heard you say you want to feel better, live a longer life, be able to do more things with your grandkids and set a better example for them by not smoking. What do you think you need to do to get there?”
- **Key question:** from the bouquet, ask a short and simple question about doing
“What do you think will make that happen?”
- **Pregnant Pause:** waiting for the client to hear themselves or feel the affect associated with their statement, allows them to sit with the discomfort without rescuing them.

Motivational Interviewing from our case example

- **Open-ended:** “Being active after work doesn’t sound like it will work for you – are there other times that would work better to fit in 5-10 minutes of walking? Perhaps before work, during work, or on the weekends?”
- **Affirmation:** “Walking at work does seem wise—you still have the energy while you’re there.”
- **Reflection:** “I hear you saying that walking with a co-worker could help you look forward to walking rather than considering it as a chore.”
- **Summary:** “CD – it sounds like you want to be more active to **keep your breast cancer from coming back and to keep your sugars down**. You picked out walking with a co-worker during lunch as a good way to be active, as you would enjoy the conversation while also getting your steps.
- **Goal-setting (baby steps):** Do you want to set a goal for how many days of the week to take a walk at lunch – maybe once weekly on Fridays as a start?

Challenges to providers who are starting to use Motivational Interviewing

- Not all patients will be ready to set a goal after a single clinic visit, especially if patient is in contemplation phase
 - That's OK – patients need to “own” their goals, so they shouldn't set them if they're not ready.
 - Rome wasn't built in a day!
- Solutions: if patient is interested in further dialogue, set additional follow-up visits to continue the counseling

Review

- Behavioral theories may be distilled down to a patient's motivation, ability, and a trigger necessary to carry out this behavior
- For patients with high motivation and ability, help them identify a good “trigger”
- For patients with high motivation and low ability, help them simplify their options
- For patients with low motivation, identify their stage of change and counsel accordingly
- Use evidence-based counseling strategies
 - Motivational Interviewing
 - Emphasizing patient ownership
 - Partnering with patients
 - Identifying small steps/goals
 - Scheduling follow-up visits to cheer success, problem-solve, or both
 - Showing caring and concern for patients