Patient-Centered Care: Motivational Interviewing and Health Coaching

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PATIENT-CENTERED CARE: MOTIVATIONAL INTERVIEWING AND HEALTH COACHING

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DISCLOSURE

No relevant financial relationship exists for any of the presenters.
LEARNING OBJECTIVES

1. Identify the characteristics of a patient-centered medical homes (PCMH) & accountable care organizations (ACO) as they relate to the home health setting.
2. Describe what is necessary to achieve the Triple Aim of the Institute for Healthcare Improvement (IHI) in the home health setting.
3. Describe motivational interviewing and apply it to the home health setting.
4. Describe health coaching and apply it to the home health setting.
5. Demonstrate how to conduct a motivational interview for a typical home health patient.
6. Demonstrate the proper techniques necessary for health coaching for a typical home health

OUTLINE

5 minutes: Introduction

15 minutes: Discussion of the characteristics of a patient-centered medical homes (PCMH) & accountable care organizations (ACO) as they relate to the home health setting.

15 minutes: Discussion on motivational interviewing and applying it to the home health setting.

20 minutes: Practicing motivational interviewing with a partner

15 minutes: Discussion on health coaching and applying it to the home health setting.

20 minutes: Practicing health coaching with a partner

15 minutes: Group discussion of what worked and what didn’t in their health coaching and motivational interviewing.
Patient-Centered Medical Homes (PCMH)\(^1\)

- Combination of the core attributes of primary care—access, continuity, comprehensiveness, and coordination of care—with new approaches to healthcare delivery, including office practice innovations and reimbursement reform.
- High-quality evidence on the effectiveness is limited, but the data suggest that, under some circumstances, PCMH interventions may lead to improved outcomes and generate moderate cost savings.
- Enjoys broad support by multiple stakeholders, significant challenges to widespread adoption of the model remain.
- Achieve the Triple Aim of the Institute for Healthcare Improvement (IHI)

Accountable Care Organizations (ACO)\(^2\)

- Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.
- Medicare offers several ACO programs:
  - Medicare Shared Savings Program—a program that helps a Medicare fee-for-service program providers become an ACO.
Triple Aim of the Institute for Healthcare Improvement (IHI)³

**IHI Triple Aim Initiative**
Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

When and Why did the focus change?
Affordable Care Act (ACA)\(^{4,5}\)

- Passed into law 2010
- Expanded coverage for managed care and Medicaid
- Changed reimbursement model for health care services
- Medicare Shared Savings Programs
- Bundling demonstrations and projects
- Patient-Centered Medical Home (PCMH)
- Affordable Care Organizations (ACO)
- Comprehensive Care for Joint Replacements (CJR)

Patient-Centered Medical Homes (PCMH) and Home Health
A PERFECT FIT?
PCMH and Home Health

- In the environment that patients prefer to be cared for: their home
- Patient centered approach: one-on-one with the patient and their family/caregivers

Patient-Centered Care\textsuperscript{6,7,8}

- Center stage in discussions of quality.
- Enshrined by the Institute of Medicine’s “quality chasm” report as 1 of 6 key elements of high-quality care.
- A quality of personal, professional, and organizational relationships.
- To promote patient-centered care should consider patient-centeredness of patients (and their families), clinicians, and health systems.
Patient-Centered Care: How to achieve it? 

- Engage patients as active participants. 
- Systems changes that unburden clinicians from the drudgery of productivity-driven care. 
- Train clinicians to be more mindful, informative, and empathic transforms their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration. 

Clinician Training in Motivational Interviewing and Health Coaching

A BRIDGE TO ACTIVE PATIENT PARTICIPATION
Health Behavior Models Effective in Home Health\textsuperscript{10-12}

- Trans-theoretical model
  - Stages
    - Pre-contemplation
    - Contemplation
    - Preparation
    - Action
    - Maintenance
- Self-determination theory
  - Based on patient motivation
  - Designed to support the patient’s intrinsic tendencies
  - Health coaching is used
  - Motivational interviewing (MI)

What does the Research say?\textsuperscript{14,15}

- Huffman\textsuperscript{14} found that using MI and health coaching with patients in their homes helps patients use their own motivation to facilitate them change.
- Coyne and Correnti\textsuperscript{15} found MI to have mixed results when used with patients with cardiovascular disease: If the behavior is not urgent, home healthcare providers can use MI to help patients because they typically see these patients for a longer period of time. MI had an effect on patients with diabetes. Patients with a more serious diagnosis might better benefit from MI compared to patients with a less severe diagnosis.
What does the Research say?\textsuperscript{16,17}

- Huffman\textsuperscript{16} found that MI helped increase participation and follow up appointments, improve medical treatment adherence, and increase exercise activities. When using health coaching in the home, the healthcare provider can talk with the patient face-to-face and it is easier for the healthcare provider to see what is important to the patient in his or her natural environment.

- Pyle\textsuperscript{17} found that after a two hour educational seminar on MI increased communication self-efficacy of nurses, and therefore yields more patient-centered care, instead of nurse-directed care in home health.

What is Motivational Interviewing?\textsuperscript{13}

- A type of conversation used to increase the patient’s motivation and commitment to changing.
The Spirit of Motivational Interviewing

- Collaborative: cooperative and collaborative partnership between patient and clinician
- Evocative: evoke from patients that which they already have, to activate their own motivation and resources for change.
- Honoring patient autonomy: MI also requires a certain degree of detachment from outcomes—not an absence of caring, but rather an acceptance that people can and do make choices about the course of their lives.

Four Guiding Principles of MI

- Resist the righting reflex (Setting everything right): It is the patient who should be voicing the arguments for change.
- Understand and explore the patient’s own motivations,
- Listen with empathy
- Empower the patient, encouraging hope and optimism.
Communication styles in healthcare

- Following
- Guiding
- Directing
- A continuum, with following at one end, directing at the other, and guiding in the middle.
- Use the appropriate style as needed.
- Each of these styles reflects different attitudes about your role in the relationship.
Communication Styles in Healthcare: Following

- Listening predominates
- At the beginning of a PT evaluation, a brief period of following helps you to understand patients' symptoms and how these fit into the larger picture of their life and health.

Communication Styles in Healthcare: Directing

- The directing style signifies quite a different interpersonal relationship.
- Implies an uneven relationship with regard to knowledge, expertise, authority, or power.
- Many health care practitioners will recognize this as one of the cornerstones of their education.
- Seems appropriate for countless situations in which a patient depends on you for decisions, action, and advice.
- Patients often appear to expect and want this kind of take-charge approach from you.
Communication Styles in Healthcare: Guiding

- A guide helps you find your way.
- Role is that of a tutor, who is a resource to help patients in more self-directed learning.
- A good guide knows what is possible and can offer alternatives from which to choose.
- With regard to behavior change, the guiding style communicates, “I can help you to solve this for yourself.”

Communication styles in Healthcare: Mix and Match

- All three of these styles—following, directing, and guiding—are used everyday.
- They are suited to different types of circumstances and relationships.
- A mismatch can cause problems.
Communication Styles in Healthcare: Overuse of Directing

- A disturbing pattern seems evident in health care, with the balance of communication shifting toward directing rather than following and guiding.
- A directing style that compromises quality care, permeates most conversations, and all too often renders patients the passive recipients of care.
- Clinicians are under pressures of time to check off boxes, conduct standardized assessments, adhere to competency frameworks, and reduce costs.
- An action oriented culture sometimes prevails, and directing is the style that expresses this value.

Guiding, MI, and Behavior Change in Healthcare

- Guiding is well suited to helping people solve behavior-change problems.
- MI is a refined form of this guiding style: paying particular attention to how to help the patient make his or her own decisions about behavior change.
A good guide will:

- Ask where the person wants to go and get to know him or her a bit.
- Inform the person about options and see what makes sense to them.
- Listen to and respect what the person wants to do and offer help accordingly.

MI: Category of Questions
### Categories of Questions to ask in MI

- Asking Permission
- Eliciting/Evoking Change Talk
- Exploring Importance and Confidence
- Opened-Ended Questions
- Reflective Listening
- Normalizing
- Decisional Balancing
- Columbo Approach
- Statements Supporting Self-Efficacy
- Readiness to Change Ruler
- Affirmations
- Advice/Feedback
- Summaries

### Asking Permission

Communicates respect for clients. Patients are more likely to discuss changing when asked, than when being lectured or being told to change.

Example: “Can we talk a bit about your frequent falls?”
Eliciting/Evoking Change\textsuperscript{18,19}

- Patients give voice to the need or reasons for changing.
- Rather than the therapist lecturing.
- Example: “What would you like to see different about your current situation?”
- Listening for change talk:
  - “Yes, I will.”
  - “I might be able to.”
  - “I promise I’ll do that for you tomorrow.”
  - “I’ll consider it.”
- Be supportive, what’s the worst thing that would happen without change, What’s the best that would happen with change, What would the future be like with change.

Exploring Importance and Confidence\textsuperscript{19}

- How do patients view the importance of changing?
- To what extent do they feel change is possible, self-efficacy?
- Examples:
  - What would have to happen for you to feel changing is important?
  - What would make you feel more confident in making the change?
Open-ended Questions

- Allows for a richer, deeper conversation that flows and builds empathy with patients.
- Examples:
  - “What makes you think it might be time for a change?”
  - “What can I do to help you to change?”
  - “What is your goal and how can I help you achieve it?”

Reflective Listening

- Involves listening carefully to patients.
- Making a reasonable guess about what they are saying; in other words, it is like forming a hypothesis.
- Then paraphrasing the clients’ comments back to them.
- Example:
  - “It seems as if....”
  - “I get the sense that....”
  - “It feels as though....”
Normalizing  

- Intended to communicate to patients that having difficulties while changing is not uncommon.
- They are not alone in their experience, or in their ambivalence about changing.
- Is not intended to make patients feel comfortable with not changing.
- Help them understand that many people experience difficulty changing.

Examples of Normalizing:
- "A lot of people are concerned about changing their [insert risky/problem behavior]."
- "Most people report both good and less good things about their [insert risky/problem behavior]."

Decisional balancing  

- Can be used anytime throughout treatment.
- Examples:
  - "What are some of the good things about your [problem behavior]? [Client answers] Okay, on the flipside, what are some of the less good things about your [insert problem/behavior]."
  - Use a reflective, summary statement with the intent of having patients address their ambivalence about change.
Columbo Approach

- Deploying discrepancies.
- The goal is to have a client help the therapist make sense of the client’s discrepant information.
- The idea is to get clients who present with discrepancies to recognize them rather than being told by their therapists that what they are saying does not make sense.
- Example:
  - “On the one hand you’re falling every day, and on the other hand you are saying that not using an assistive device is not the reason you keep falling?”

Statements supporting Self-Efficacy

- Having patients give voice to changes they have made, as many have little self-confidence in their ability to change their behaviors, the objective is to increase their self-confidence that they can change.
- Example:
  - “Last week you couldn’t walk up and down any steps, now you can do six steps”
Readiness to Change Ruler

- Assessing readiness to change is a critical aspect of MI. Motivation, which is considered a state not a trait, is not static and thus can change rapidly from day to day.
- Example:
  - “On the following scale from 1 to 10, where 1 is definitely not ready to change and 10 is definitely ready to change, what number best reflects how ready you are at the present time to change your [insert risky/problem behavior]?”
  - “And where were you 6 months ago?”
  - “How do you feel about making those changes?”
  - “What would it take to move a bit higher on the scale?”

Affirmations

- Made by therapists in response to what clients have said,
- Used to recognize clients' strengths, successes, and efforts to change.
- Affirmative responses
- Verify and acknowledge clients' behavior changes and attempts to change.
- Example: “It’s clear that you’re really trying to change your [insert risky/problem behavior].”
Advice/Feedback

- Frequently used MI strategy.
- Can be a valuable technique because patients often have either little information or have misinformation about their behaviors.
- Research has shown that by and large the effectiveness of simple advice is very limited.
- Does not work well because most people do not like being “told what to do.” Most individuals prefer being given choices in making decisions, particularly changing behaviors.
- Example: “Do you mind if we spend a few minutes talking about…? f/b “What do you know about…?” f/b “Are you interested in learning more about…?”

Summaries

- Used frequently to relate what patients have already expressed, especially in terms of reflecting ambivalence, and to move them on to another topic or have them expand the current discussion further.
- Summaries require that therapists listen very carefully to what patients have said throughout the session.
- Summaries are also a good way to either end a session (i.e., offer a summary of the entire session), or to transition a talkative patient to the next topic.
- Examples of Summaries:
  - “It sounds like you are concerned about your frequent falling because you don’t want to break a bone and end up in the hospital.”
Therapeutic Paradox

- Used with patients in an effort to get them to argue for the importance of changing.
- Useful for patients who have been coming to therapy for some time but have made little progress.
- Intended to be perceived by patients as unexpected contradictions.
- It is hoped that after patients hear such statements patients would seek to correct by arguing for change.
- Example: You have been coming to therapy for 2 months, but you are not using your assistive device as prescribed. Maybe now is not the right time to change?”. It is hoped that the patient would counter with an argument indicating that he/she wants to change (e.g., “No, I know I need to change, it’s just tough putting it into practice.”).
- Once it is established that the client does want to change, subsequent conversations can involve identifying the reasons why progress has been slow up to now.

Health Coaching
What is Health Coaching?  
- Helps guide a patient to determine his or her personal uncertainty to behavior change
- Engages the patient to be part of the treatment process.
- Health coaching has several different components including:
  - Active listening
  - Working from the patient’s agenda,
  - Identifying patient beliefs and values,
  - Eliciting change talk.
  - Recognizing patient’s change readiness.

Health Coaching Themes in the Literature
- Health-focused: evident in nursing and non-nursing health professions
- Partnership: Both client and coach are actively involved in the process, working together toward the desired outcome
- Client-centered: Focus remains on the client and that the relationship exists for his or her benefit.
- Goal-oriented: client-centered partnership of health coaching exists as a means to accomplish an outcome.
- Process: Not stagnant, but recurring and evolving.
- Enlightening: For the client, new knowledge from health education is enlightening and often necessary to achieve the desired outcomes of health coaching.
- Empowering: Part of the process and as precursor to achieving the desired outcome or goal of health coaching.
Positive Consequences of Health Coaching

- Improved health: both physical and mental health.
- Health goal attainment: presented as specific to each client's individual health concerns and preferences.

Antecedents of Health Coaching

- A situation in which a client experienced a health concern or a desire for enhanced health or well-being.
- Presence of a health coach with some level of training and a desire to help.
The Process of Health Coaching

Health Coaching Questions: Explore

- Ask open-ended questions that explore options, values, and possible outcomes, without judgement.
- “What things are most important to you? How does your exercise and eating fit into this?”
- “What sorts of things would you like to accomplish in your life?”
- “What would you like to see change?”
- “If things were better with your exercise, what would be different?”
- “What have you already tried? What worked/didn’t work?”
Health Coaching Questions: Imagine$^{21,22}$

- “Imagine you can...”
- “Imagine you are already...”
- “Imagine that you have the body and health you desire. What did it take for you to achieve it?”

Health Coaching Questions: Breed Success$^{21,22}$

- “In the past, when were you successful with this, even just a little bit?”
- “How could we do more of that?”
Health Coaching Questions: Sense Problems

- I get the sense that…”
- “It seems to me like…”

Health Coaching Questions: Speculate

- “I wonder what it would be like if you…”
- “I wonder if we could try…”
Health Coaching Questions: Evoke Change

- “In what ways does this concern you?”
- “If you decided to make a change, what makes you think you could do it?”
- “How would you like things to be different?”
- “How would things be better if you changed?”
- “What concerns you now about your current exercise and eating patterns?”

Health Coaching Questions: Assess Readiness to Change

- If you decided to change, on a scale of 1-10, how confident are you that you could change, when 1 represents not at all confident and 10 equals extremely confident?”
- If they respond with a 9 or 10, great. If they respond with a lower number, ask them how they can make the selected behavior less overwhelming.
Health Coaching Questions: Plan Next Steps

- Instead of directing a client forward, have them generate their own solutions. Examples:
  - “So, given all this, what do you think you will do next?”
  - “What’s next for you?”
  - “If nothing changes, what do you see happening in five years? If you decide to change, what will it be like?”
  - “How would you like things to be different?”

Health Coaching Questions: Give Advice Carefully

- Find out if clients want your advice. Some will, some won’t. If you do give advice, keep it general and experiential. For example:
  - “In my work with clients like yourself, I’ve found that...”
Coaching Examples in the Literature

The Coach2Move Approach

- Developed on the basis of 2 systematic literature studies and expert consultations.
- Multiple focus group meetings and a Delphi procedure were organized to gain consensus on the Coach2Move strategy.
- Acceptability and potential effectiveness were studied in a pilot study with a pre-/postdesign in which 2 physical therapists and 12 patients participated.
- Patients were interviewed, discussion was held with the involved physical therapists, and health records were studied.
- Potential effectiveness was tested measuring the level of physical activity, frailty, quality of life, and mobility before and after treatment.
The Coach2Move Approach

- an algorithm based on the Hypothesis Oriented Algorithm for Clinicians Part II was developed: the Coach2Move approach.
- Key elements of the Coach2Move approach include:
  - an extensive intake using motivational interviewing, clinical reasoning, coaching to increase physical activity and self-management, focusing on meaningful activities, and working according to 3 patient-tailored intervention profiles with a predefined number of sessions.
  - The pilot study showed high appraisal of the strategy by both physical therapists and patients. Moreover, a potential effect on the level of physical activity, frailty, quality of life, and mobility was observed.

The Coach2Move Approach: RCT

- Purpose: The aim of this study was to test the (cost-) effectiveness of a patient-centred physical therapy strategy (Coach2Move) in which individualized treatment (motivational interviewing, physical examination, individualized goal setting, coaching and advice on self management, and physical training) is combined to increase physical activity level and physical fitness and, thereby, to decrease the level of frailty.
- METHODS: A RCT was performed in 13 PT practices with measurements at 3 and 6 months. Eligible patients were aged 70 years or over and had mobility problems (i.e. difficulties with walking, moving, getting up and changing position from bed or chair to standing, or stair climbing). Primary outcome was physical activity (total and moderate intensity) in minutes per day. Secondary outcomes were as follows: frailty, walking speed and distance, mobility, and quality of life. Data were analysed using linear mixed models for repeated measurements. Healthcare costs and quality-adjusted life years (QALYs) were computed and combined using net monetary benefit (NMB) for different willingness to pay thresholds. Data on costs, QALYs, and NMBs were analysed using linear mixed models.
The Coach2Move Approach: RCT\textsuperscript{24}

- **RESULTS:** 130 patients participated in this study. At 6 months, the between-group difference was significant for moderate-intensity physical activity in favour of the Coach2Move group (mean difference: 17.9 min per day; 95% confidence interval (CI) 4.0 to 34.9; \(P = 0.012\)). The between-group difference for total physical activity was 14.1 min per day (95% CI -6.6 to 34.9; \(P = 0.182\)). Frailty decreased more in the Coach2Move group compared with usual care (mean difference: -0.03 (95% CI: -0.06 to -0.00; \(P = 0.027\)). Compared with usual treatment, the Coach2Move strategy resulted in cost savings (€849.8; 95% CI: 1607 to 90; \(P = 0.028\)), an improvement in QALYs, (0.02; 95% CI: 0.00 to 0.03; \(P = 0.03\)), and a higher NMB at every willingness to pay threshold.

- **CONCLUSIONS:** Older adults with mobility problems are able to safely increase physical activity in their own environment and reduce frailty. This study emphasizes both the potential cost-effectiveness of a patient-centered approach in the frail elderly and the importance of physical activity promotion in older adults with mobility limitations.

Walk On!\textsuperscript{25}

- **BACKGROUND:** Physical inactivity is significantly associated with more frequent hospitalizations and increased mortality in COPD even after adjusting for disease severity. While practice guidelines recommend regular physical activity for all patients with COPD, health systems are challenged in operationalizing an effective and sustainable approach to assist patients in being physically active.

- **METHODS:** A pragmatic randomized controlled trial design was used to determine the effectiveness of a 12-month home and community-based physical activity coaching intervention (Walk On!) compared to standard care for 1650 patients at high risk for COPD exacerbations from a large integrated health care system. Eligible patients with a COPD-related hospitalization, emergency department visit, or observational day in the previous 12 months were automatically identified from the electronic medical records (EMR) system and randomized to treatment arms. The Walk On! intervention included collaborative monitoring of step counts, semi-automated step goal recommendations, individualized reinforcement from a physical activity coach, and peer/family support.
Walk On! 25

- RESULTS: The primary composite outcome included all-cause hospitalizations, emergency department visits, observational stays, and death in the 12 months following randomization. Secondary outcomes included COPD-related utilization, cardio-metabolic markers, physical activity, symptoms, and health-related quality of life. With the exception of patient reported outcomes, all utilization and clinical variables were automatically captured from the EMR.

- CONCLUSIONS: If successful, findings from this multi-stakeholder driven trial of a generalizable and scalable physical activity intervention, carefully designed with sufficient flexibility, intensity, and support for a large ethnically diverse sample could re-define the standard of care to effectively address physical inactivity in COPD.

I-Can 26

- The purpose of the Intervention Composed of Aerobic Training and Non-Exercise Physical Activity (I-CAN) study is to determine whether a physical activity program composed of both aerobic training (consistent with public health recommendations) and increasing non-exercise physical activity (3000 steps above baseline levels) leads to enhanced improvements in waist circumference, oral glucose tolerance, systemic inflammation, body composition, and fitness compared to aerobic training alone in obese adults (N=45).

- Commercially available accelerometers (Fitbits) will be used to monitor physical activity levels and behavioral coaching will be used to develop strategies of how to increase non-exercise physical activity levels. In this manuscript, we describe the design, rationale, and methodology associated with the I-CAN study.
Summary

Motivational Interviewing and Health Coaching

- Patient centered
- Collaborative
- Empowering
- Enlightening
- Goal oriented
- Partnership
- Health-focused
REFERENCES


