Falls Prevention: Otago Program and Behavior Change

Combined Sections Meeting 2015

Speaker(s): Mary Altpeter, PhD
Tiffany Shubert, PhD

Session Type: Educational Sessions
Session Level: Basic

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February 4-7, 2015
Indianapolis, IN

www.aptahpa.org

HPA The Catalyst is the Section on Health Policy & Administration of the American Physical Therapy Association
Falls Prevention: The Otago Exercise Program and Behavior Change

APTA Combined Sections Meeting
Indianapolis, Indiana
February 6, 2015

Speakers

• Tiffany E. Shubert, PhD, PT
  Senior Research Scientist
• Mary Altpeter, PhD, MSW, MPA
  Senior Research Scientist

A CDC Prevention Research Center
Acknowledgements

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Objectives

By the end of this session, you will be able to………..

• Describe the impact of an online training program in the dissemination and implementation of an evidence-based fall prevention on physical therapy practice and patient outcomes
• Assess the impact of challenges and facilitators reported by physical therapists
• Evaluate evidence-based theories of behavior change to support patient engagement
• Describe the process of integrating motivation and behavior change theories into clinical care
A FAVOR! Before We Start

Since part of this talk was funded through a grant (see slide #3) it would be very helpful if you complete this demographic form to demonstrate our value to our funders.

http://CSM 2015

The information will be kept into a secure database and will help us justify to our funders the number of people reached by this work.

Disclosures

• Tiffany Shubert is a part-owner of the EIM Fall Screening Mobile Application available for iphone and android
• Tiffany Shubert consults for Reflexion Health, which has received funding to help develop a virtual version of the Otago Exercise Program for older adults to use in the home
• No other disclosures
What is Otago?

- Evidence-based fall prevention program from New Zealand (late 1990’s, early 2000’s)
- Program Design
  - 6 – 8 visits delivered over 12 months
  - Standard set of balance and strength exercises
  - Patient does exercises INDEPENDENTLY
- Best for community-dwelling frail

The Otago Exercise Program US Dissemination Project

The only recognized evidence-based fall prevention program delivered by physical therapists in the clinical setting!
Research & Rollout

- 30-40% reduction in falls in high-risk fallers after 12 months of program (Campbell, 1997, 1999)
- Reduced risk of death (Thomas, 2010)
- Benefits continue for two years for those individuals who continue exercising (Campbell, 1999)
- Otago Exercise Program may improve cognitive function (Liu-Ambrose, 2008)

The Clinical Experience

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<td>PT Management Phase</td>
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<td>Call</td>
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<td>Self-Management Phase</td>
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<td>Visit</td>
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Visit/DC

Call | Call | Call | Call
Leveraging Initiatives

Administration for Community Living - Funding states for evidence-based fall prevention programs

PCORI/NIA – Funding 10 centers in 10 states to do fall risk management – referrals to Otago

CDC - State Driven Fall Prevention Project

The Challenges

• Reach
• Effectiveness
• Adoption
• Implementation
• Maintenance
The Strategy - Reach

- Real time presentations 2012
- Online training launched March 2013
  - Partnership with UNC Center for Aging and Health and Centers for Disease Control
  - 3-hour online-training for physical therapists in implementation
  - $25 registration fee; 0.3 CEUs
- Monthly implementation webinars
- Crowdsourced database to track outcomes

Resources for Therapists

- $25/2 CEUs
- Program is FREE to DPT programs
- Otago Exercise Program Training for Physical Therapists
- Otago Outcomes Database
Resources for Patients

Video Translations in:
- English
- Spanish
- Dutch

Who are we reaching? - Adoption

- Over 2000 physical therapists enrolled in online training
- All 50 states and 6 other countries
- Over 100 patients in the database
### Online Trainees Demographics (n = 944)

<table>
<thead>
<tr>
<th>Age</th>
<th>% Sample</th>
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<tbody>
<tr>
<td>20 – 29</td>
<td>32%</td>
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<tr>
<td>30 – 39</td>
<td>19%</td>
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<tr>
<td>40- 49</td>
<td>18%</td>
</tr>
<tr>
<td>50- 59</td>
<td>20%</td>
</tr>
<tr>
<td>60+</td>
<td>6%</td>
</tr>
<tr>
<td>Missing</td>
<td>5%</td>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>% Sample</th>
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<tbody>
<tr>
<td>Male</td>
<td>25%</td>
</tr>
<tr>
<td>Female</td>
<td>75%</td>
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<table>
<thead>
<tr>
<th>Race</th>
<th>% Sample</th>
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<tr>
<td>White</td>
<td>84%</td>
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<tr>
<td>Hispanic</td>
<td>3%</td>
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<tr>
<td>African American</td>
<td>2%</td>
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<tr>
<td>Asian</td>
<td>5%</td>
</tr>
<tr>
<td>Native American</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
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<table>
<thead>
<tr>
<th>Patient Care</th>
<th>% Sample</th>
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<tbody>
<tr>
<td>Full Time</td>
<td>47%</td>
</tr>
<tr>
<td>Part Time</td>
<td>23%</td>
</tr>
<tr>
<td>Not in Practice</td>
<td>30%</td>
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### Online Trainee Practice Characteristics (n = 944)

<table>
<thead>
<tr>
<th>Years in practice</th>
<th>% of Sample</th>
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</thead>
<tbody>
<tr>
<td>&lt;= 3</td>
<td>32%</td>
</tr>
<tr>
<td>4 - 7</td>
<td>8%</td>
</tr>
<tr>
<td>=&gt; 8</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years working with older adults</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 3</td>
<td>30%</td>
</tr>
<tr>
<td>4 - 7</td>
<td>13%</td>
</tr>
<tr>
<td>=&gt; 8</td>
<td>57%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>% of caseload age 65 or older?</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25%</td>
<td>19%</td>
</tr>
<tr>
<td>25 - 49%</td>
<td>9%</td>
</tr>
<tr>
<td>50 - 74%</td>
<td>14%</td>
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<tr>
<td>&gt; 75%</td>
<td>58%</td>
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<table>
<thead>
<tr>
<th>Experience with Evidence-Based Health Promotion Programs</th>
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<tbody>
<tr>
<td>Ever Referred?</td>
<td>27%</td>
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<tr>
<td>No</td>
<td>65%</td>
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<table>
<thead>
<tr>
<th>Which Program? (Select all that apply)</th>
<th>%</th>
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<tbody>
<tr>
<td>N</td>
<td>45</td>
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<tr>
<td>Matter Of Balance</td>
<td>25</td>
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<td>Stepping On</td>
<td>143</td>
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<td>Tai Chi</td>
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<tr>
<td>Other</td>
<td>47</td>
</tr>
</tbody>
</table>
### Facilitators vs. Barriers

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have active support from my Agency’s administration</td>
<td>23</td>
<td>95</td>
<td>155</td>
</tr>
<tr>
<td>The program is low cost; and does not need substantial resources to continue</td>
<td>18</td>
<td>119</td>
<td>131</td>
</tr>
<tr>
<td>The research data helped convince my Agency of the value</td>
<td>19</td>
<td>118</td>
<td>130</td>
</tr>
<tr>
<td>My patients like the program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported by community and state-based fall coalitions</td>
<td></td>
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<tr>
<td>I am able to bill as a Part B provider</td>
<td></td>
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<tr>
<td>Other facilitators (please specify)</td>
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</table>

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>My agency is not set up keep patients on caseload over an extended period of time</td>
<td>66</td>
<td>127</td>
<td>65</td>
</tr>
<tr>
<td>Patients unable or do not want to pay co-pays</td>
<td>38</td>
<td>160</td>
<td>59</td>
</tr>
<tr>
<td>My agency does not have a system for follow up phone calls</td>
<td>94</td>
<td>114</td>
<td>50</td>
</tr>
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</table>
Summary & Anecdotes - Implementation

- Overall, we like this program! BUT…. 
- Clinician Policy Challenges
  - Cook book
  - What is standardized care anyway?
- Medicare Policy challenges
- Agency Policy challenges
  - Productivity
  - Maximizing Medicare visits
  - Documentation/billing/reimbursement
  - Phone calls? POC > 3 months??
- Successful integration into workflow
  - Champion clinician
  - Agency support/mandate

Effectiveness
Potential Solutions - Maintenance

- Think about the Otago Exercise Program as a great excuse to integrate evidence into your practice
  - Chronic disease model of care
  - Structured, progressive strength and balance exercises
  - Low frequency, long duration – better accountability and outcomes

Low-Hanging Fruit

- Bundled-payment
- PACE programs
- Population health
Once we have our side right…

Mary Altpeter

- Evidence-based theories of behavior change to support patient engagement
  - What the intra- and inter-personal theories tell us
  - Applying them to falls work

- Describe the process of integrating motivation and behavior change theories into clinical care
  - How to ask questions
  - Motivational interviewing
  - Dealing with resistance
Two Key Concepts that Behavior Change Theories

1. Behavior is considered to be mediated through cognitions; that is, *what we know and think* affects how we act.

2. *Knowledge is necessary but not sufficient* to produce behavior change. Readiness, perceptions, motivation, skills, and factors in the social environment also play important roles.

Source: Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health

Intra-personal Theories of Behavior Change

- Theories at the individual level focus on intrapersonal (within individuals) factors.
- These are characteristics of individuals such as their knowledge, attitudes, beliefs, motivation, self-concept, developmental history, past experience, skills, and behavior
- Two theories at this level:
  - Stages of Change (Transtheoretical Model)
  - Health Belief Model

Source: Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
Intra-personal Theories of Behavior Change: Stage of Change Model

• 1980’s Prochaska and DiClemente
• Concerns individuals' readiness to change or attempt to change toward healthy behaviors.
• Basic premise - behavior change is a process and not an event; individuals are at varying levels of motivation, or readiness, to change.
• People at different points in the process of change can benefit from different interventions, matched to their stage at that time.

Source: Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health

Stage of Change Model Constructs

• describes the relationships among:
  – stages of change
  – processes of change
  – decisional balance, or the pros and cons of change
  – situational confidence, or self-efficacy in the behavior change
  – and situational temptations to relapse

Stage of Change Model Process

- Six stages have been identified in the model:
  - Pre-contemplation
  - Contemplation
  - Preparation/Decision
  - Action
  - Maintenance
  - Relapse
- When it comes to change efforts, you can tailor messages, strategies, and programs to the appropriate stage.

Pre-Contemplation

- Identified by: NOT READY TO CHANGE
  - Individual is not considering change
  - No action within upcoming 6 months
- Your client may be thinking: “I'll Never Fall!”
- What you can do:
  - Increase awareness of need for change, personalize information on risks and benefits

Sources: Dr. Cherie Rosemond, UNC at Chapel Hill; Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
Pre-Contemplation

- **Techniques:**
  - Validate lack of readiness
  - Encourage re-evaluation of current behavior
  - Encourage self-exploration, not action
  - Explain and personalize the risk

- **Start the Conversation:**
  - “Sounds like fall prevention isn’t of interest to you.”
  - “Can you think of anything that would make you try to exercise?”
  - Tell your story...

Source: Dr. Cherie Rosemond, UNC at Chapel Hill

Contemplation

- **Identified by:** THINKING OF CHANGING
  - Ambivalent about change
    - “On the fence”
  - Not considering a change within the upcoming month

- **Your patient may be thinking:** “Well, I did have a little bit of a fall last week.”

- **What you can do:**
  - Motivate, encourage to make specific plans

Sources: Dr. Cherie Rosemond, UNC at Chapel Hill; Theory at a Glance: Guide for Health Promotion Practice by the National Institutes of Health
Contemplation

• Techniques:
  – Encourage evaluation of pros and cons of behavior change
  – Support opportunities for change

• Start the Conversation:
  – “What do you think you would gain by doing Otago?” “What do you think you would lose by not doing the program?”
  – “Would you consider working with me?”
  – “Would you be interested in customizing a program to your needs?”

Source: Dr. Cherie Rosemond, UNC at Chapel Hill

Preparation

• Identified by: READY TO CHANGE
  – Some experience with change and are trying to change
    • “Testing the waters”
  – Planning to act within one month
• Your patient may be thinking: “My brother’s fall experience has really gotten my attention.”
• What you can do:
  – Assist in developing concrete action plans, setting gradual goals

Sources: Dr. Cherie Rosemond, UNC at Chapel Hill; Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
Preparation

• Techniques:
  – Provide encouragement to evaluate pros and cons of behavior change
  – Encourage small initial steps

• Start the Conversation:
  – Do you think you could try a few things from Otago to get a feel for it?
  – Would you like to try some simple balance and strengthening exercise to see what they’re like?

Source: Dr. Cherie Rosemond, UNC at Chapel Hill

Action

• Identified by: MAKING CHANGE
  – Active work toward behavioral change, including:
    • Modification of environment, experiences and/or behavior
    – Specific, overt modifications over the past 6 months
    – Preventing relapse is important
  – Your patient may be thinking: “I need to join a balance exercise class.”
  – What you can do:
    – Assist with feedback, problem-solving social support, reinforcement

Sources: Dr. Cherie Rosemond, UNC at Chapel Hill; Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
Changing Patient Behavior For Better Outcomes

2/6/15
HPA CSM Session 11 am – 1 pm

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### Action

- **Techniques:**
  - Enhance self-efficacy for dealing with obstacles
  - Guard against feelings of loss and frustration
  - Take measures to prevent relapse

- **Start the Conversation:**
  - Is there anything that could get in your way from doing Otago or make you stop?
  - Do you have concerns about doing exercise? Would you like to discuss that?
  - What ways can I help you be successful?

Source: Dr. Cherie Rosemond, UNC at Chapel Hill

### Maintenance

- **Identified by: STAYING ON TRACK**
  - Focus on ongoing, active work to maintain changes and prevent relapsing
  - Confidence will increase while in this stage

- **You patient may be thinking:** “Boy, I’ll never again want to feel so wobbly on my feet again.”

- **What you can do:**
  - Assist in coping, reminders, finding alternatives

Sources: Dr. Cherie Rosemond, UNC at Chapel Hill; *Theory at a Glance: Health Promotion Practice* by the National Institutes of Health
Maintenance

- Techniques:
  - Plan for follow-up support
  - Reinforce internal rewards
  - Discuss coping with relapse

- Start the Conversation:
  - How about a new pair of tennis shoes?
  - Doesn’t it feel great to be fit?
  - What would help you keep on track with your exercises?

Source: Dr. Cherie Rosemond, UNC at Chapel Hill

Relapse

- Identified by: FALLING FROM GRACE
  - Refers to falling back to the old behaviors after going through other stages
  - Can occur at any time

- Your patient may be thinking: “Oops, I fell off the wagon and it’s hard to get back to exercising.”

- What you can do:
  - Assist in avoiding slips/relapses (as they apply)

Sources: Dr. Cherie Rosemond, UNC at Chapel Hill; Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
Relapse

• Techniques:
  – Evaluate the trigger for relapse
  – Reassess motivation and barriers
  – Plan stronger coping strategies
  – Reassess risk factors and method for addressing and coping with those behaviors

• Start the Conversation:
  – What got in your way?
  – How confident are you that you can get back on track? What would help you?
  – What do you want to accomplish this week?
  – What things support you in being successful?
  – Who else can help?

Source: Dr. Cherie Rosemond, UNC at Chapel Hill

Intra-personal Theories of Behavior Change: Health Belief Model (HBM)

• Developed in the 1950’s to explain why Public Health Service medical screening programs were not successful, particularly for tuberculosis
• Addresses a person's perceptions of the threat of a health problem and the accompanying appraisal of a recommended behavior for preventing or managing the problem.
  – Perceptions are key to behavior change!

Source: Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
**Intra-personal Theories of Behavior Change: Health Belief Model (HBM)**

- HBM based originally on 4 constructs
  - Perceived susceptibility, perceived severity, perceived benefits, perceived barriers

- More recently, 3 more constructs added
  - cues to action, motivating factors, self-efficacy

**Perceived Susceptibility**

- Involves one’s own opinion of the chances of developing a condition
- When someone is worried that they will fall or describe feeling unsteady on their feet, they are identifying themselves as at risk for falling
- What you can do:
  - Correct misinformation client has about health knowledge, health risks and consequences
  - Talk about the patient’s specific vulnerability
    - The greater the perceived risk, the likelihood of engaging in behaviors to lower the risk
    - If perceived risk is misperceived as low, heighten it by emphasizing patient’s risk level
  - Personalize risk based on the patient’s health, behavior

Source: Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health

Perceived Severity (Seriousness)

- One’s opinion of how serious an illness or condition is and the subsequent medical consequences (i.e. pain, disability and death) and social costs (the effect on an individual’s work, family and social relationships)

- What you can do:
  - Specify the medical and social consequences of falling and/or the risk for falling


PERCEIVED SUSCEPTIBILITY + PERCEIVED SERIOUSNESS = PERCEIVED THREAT!!!!

- If the perception of threat is to a serious disease, for which there is real risk, behavior often changes

(Stretcher and Rosenstock, 1997)
**Perceived Benefits**

- One’s belief that undertaking a recommended action could be useful in reducing the risk or severity of potential illness or disease
- What you can do:
  - Determine patient’s goal
    - BEWARE! It my not be stated as a fall prevention goal
  - Define concrete action to take to reach patient’s goal – how, when and where
  - Clarify the positive effects to be expected


**Perceived Barriers**

- One’s belief around the tangible and psychological *costs* of the advised action
- Evaluation of obstacles that get in the way of adopting the new behavior
- Studies of older adults perceptions of physical activity barriers specifically identified pain (related to an existing condition), lack of interest, and facility accessibility as major barriers to participation
- They also expressed need for individualized programs

**Perceived Barriers**

- What you can do:
  - Discuss barriers and how to overcome them
  - Tackle practical issues like transportation, access
  - Educate about physical activity safety
  - Educate about pain management


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**Cues to Action**

- Focus on the readiness of an individual to take action
- Can be events, people or things that motivate to change their behavior
- Can be internal or external
- Internal - Physiological cues (e.g., pain, symptoms)

Cues to Action (cont’d)

• What you can do:
  – Provide “how to” information
  – Promote awareness
  – Provide reminders


Theories of Interpersonal Health Behavior: Social Cognitive Theory (aka Social Learning Theory)

• Assumes that people and their environments interact continuously.
• Addresses both the psychosocial factors that determine health behavior and strategies to promote behavior change.
• Explains human behavior in terms of a three-way, dynamic, reciprocal theory in which personal factors, environmental influences, and behavior continually interact.

Source: Theory at a Glance: A Guide for Health Promotion Practice by the National Institutes of Health
Self-Efficacy: The “I Think I Can” Phenomenon

• Self-efficacy = confidence to take and persist in action
• People don’t try something unless they think they can do it and it will be beneficial
• Concept added to the HBM in the 1980s
• In the 1970s, Albert Bandura – Social Learning Theory, an interpersonal theory that incorporates self-efficacy

Those with High Self-Efficacy are…

– Better caretakers (for themselves)
– Approach tasks as something that can be mastered
– Have feelings of empowerment
– Are not controlled by circumstances
– Able to cope with hardships and setbacks
– Learn from failure
– Channel energy toward success…
Whereas Low Self-Efficacy Is Linked to…

- Helplessness
- Anxiety
- Depression
- Frustration
- Behavior that doesn’t change

- What you can do:
  - Provide training
  - Provide guidance in performing action
  - Support self-efficacy by
    - Individualizing goal-setting, preferred incentives, positive reinforcements
    - Help identify individuals in social network who can be supportive and give cues to action

Enhancing Self-Efficacy

- Messages you can give
  - “Take one step at a time”
  - “See to believe – visualize what it will take”
  - “Draw from your past – what’s worked well before”
  - “Find a role model”
  - “Ask for help”
  - “Accept self-doubt… but put it in its place”
  - “Focus on the positive, not the negative”

Source: Dr. Cherie Rosemond, UNC at Chapel Hill
What is the Purpose of Motivational Interviewing?

It is designed to:

Enhance the client’s own motivation to change using strategies that are empathic and non-confrontational.

How does MI differ from traditional or typical medical counseling?

- People are almost always ambivalent about change – ambivalence is normal
- Lack of motivation can be viewed as unresolved ambivalence.
How does MI differ from traditional or typical medical counseling? (continued)

• AMBIVALENCE is the key issue to be resolved for change to occur.
• People are more likely to change when they hear their own discussion of their ambivalence.
• This discussion is called “change talk” in MI.
• Getting patients to engage in “change talk” is a critical element of the MI process.

*Glovsky and Rose, 2008

Goal of Motivational Interviewing

• Finding out which stage the patient is at, and addressing the concerns specific to their stage
• Have the patient articulate their “pros” and “cons” of taking on a new behavior so they can better process and ultimately resolve the conflict between them.
• Empathizing and empowering the patient to take steps towards change by affirming their strengths as well as the centrality of their initiative in lasting change.

Use of Scales

- A common way of assessing as well as cultivating confidence or importance is the use of scales. Scales can help patients to verbalize and process their ambivalence further. In this case,
  - “On a scale of 1 to 10, how important do you think it is for you to take steps to prevent falling?” (Patient says 9 out of 10)
  - “On a scale of 1 to 10, how confident are you that you can exercise to prevent falls?” (Patient says 5 out of 10)


So, now what do we do?

- Affirmations: recognizing patient strengths and countering a defeatist attitude
  - “Why did you give yourself a 5 instead of a 2?”
  - “I am impressed that you have are willing to give Otago a try, especially since you said you don’t like exercising.”
- Reflecting the pros and cons
  - “So, it is important for you to deal with you risk for falling, but you also wish Otago didn’t have so many sessions”
- Look for patient-driven strengths
  - “What would make you go up to a 6 or 7?”

On a scale of 1 to 10…

- What about your confidence?
  “On a scale of 1-10 how confident you can do this new behavior?”
  “On a scale of 1-10 how confident you can take the next step?
  On a scale of 1-10, how confident are you that you can continue this new behavior?”

Source: Prantik Saha, MD, MPH. *Motivational Interviewing: Approaching Behavioral Change.* Columbia University / Children’s Hospital of New York

Resistance!

- In motivational interviewing philosophy, resistance is elicited when we try to push patients farther than they are ready to go.
- Resistance also occurs when patients have not been given sufficient opportunity to direct their actions and have simply been given instructions from their providers.

Source: Prantik Saha, MD, MPH. *Motivational Interviewing: Approaching Behavioral Change.* Columbia University / Children’s Hospital of New York
How to deal with resistance?

• Empathizing with the patient
  “It sounds like many of us have been telling you what you should do
  and we’re not listening to what you would like to do for yourself.”

• EMPOWER the patient
  “You know, it’s up to you what you would like to do—after all, it’s your
  goals for your quality of life, independence and health that count the
  most.”

Source: Prantik Saha, MD, MPH. Motivational Interviewing: Approaching
Behavioral Change. Columbia University / Children’s Hospital of New York

Application

• LIFE project in Australia
• Group Exercise in Minnesota
Questions?

tshubert@med.unc.edu
Mary_Altpeter@unc.edu