USING MOTIVATIONAL TOOLS IN PATIENT EDUCATION AND THE ROLE PHARMACISTS PLAY

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Disclosures

- None
Objectives

- Review 3 models of Diabetes management offered at the Health Education Center for Wellness at Northern Navajo Medical Center
- Important aspects of individual patient management based on individual patient needs, interpretation of data, and DM standards of care
- Learn about the benefits of patient education using motivational tools
Three models of DM Management

- Group Clinic/Educations sessions – New onset DM Class
- Individual DM management – DM walk-in Clinic
- Scheduled Cardiovascular Risk Reduction Clinic – Healthy Heart Clinic
NEW ONSET CLINIC

- Three part series offered each month
  - Class 1: The Basics
  - Class 2: Nutrition
  - Class 3: Exercise/Medications/Mental Health

- Standards of care are completed across the class sessions by collaborating with Optometry, RT, Dental and Lab
NEW ONSET CLINIC

Average A1Cs for 107 Graduates

NO1: 9.9
NO3: 8.2
Appt: 6.9
Goal: Manage cardiovascular disease risk factors (diabetes, hypertension, dyslipidemia, obesity, tobacco use, alcohol use etc.)

Benefits:

• Provide medication therapy management - to achieve definite outcomes that improve patient’s QOL

• Enable patients to assume greater responsibility for self-care through health education & motivational interviewing

• Decrease physician workload and obtain appropriate reimbursement for clinical pharmacy services

Eligibility: Unpaneled patients who complete the Pre-DM clinic or hypertension/ hyperlipidemia clinic
## HEALTHY HEART CLINIC

<table>
<thead>
<tr>
<th>Measure Name</th>
<th># Patients in Denominator</th>
<th># Patients in Numerator</th>
<th>Met</th>
<th>2015 Goal</th>
<th>IHS Current National Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression: Screening or Diagnosis 18+</td>
<td>129</td>
<td>83</td>
<td>64.3%</td>
<td>64.3%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Colorectal Cancer Screen 50-75</td>
<td>66</td>
<td>25</td>
<td>37.9%</td>
<td>35.2%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Mammogram Rates 52-64</td>
<td>28</td>
<td>16</td>
<td>57.1%</td>
<td>54.8%</td>
<td>54.2%</td>
</tr>
<tr>
<td>Pap Smear Rates 24-64</td>
<td>55</td>
<td>37</td>
<td>67.3%</td>
<td>54.6%</td>
<td>54.6%</td>
</tr>
<tr>
<td>Influenza IZ 65+</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>67.2%</td>
<td>68.1%</td>
</tr>
<tr>
<td>Pneumovax 65+</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>85.7%</td>
<td>85.7%</td>
</tr>
<tr>
<td>23+: LDL Assessed</td>
<td>128</td>
<td>122</td>
<td>95.3%</td>
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</tr>
<tr>
<td>BMI Measured 2-74</td>
<td>128</td>
<td>115</td>
<td>89.8%</td>
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</tr>
<tr>
<td>BMI: Assessed Overweight or Obese 2-74</td>
<td>115</td>
<td>108</td>
<td>93.9%</td>
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<td></td>
</tr>
<tr>
<td>Overweight Pts 6+: Exercise Education</td>
<td>108</td>
<td>74</td>
<td>68.5%</td>
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<td></td>
</tr>
<tr>
<td>18+: BP Assessed</td>
<td>129</td>
<td>110</td>
<td>85.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23+: Cholesterol Screening</td>
<td>128</td>
<td>122</td>
<td>95.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP&lt;140/90</td>
<td>128</td>
<td>113</td>
<td>88.3%</td>
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</tbody>
</table>
INDIVIDUAL DM MANAGEMENT

- Assessing individual patient needs
  - Access to food
  - Physical capabilities
  - Cultural sensitivity
- Glucometer Data Vs. A1C Data
  - Interpretation of patient collected data vs. lab data
  - Positive affirmation
- Diabetes Related Standards of care
  - Labs, eye, foot, dental, behavioral screenings, and immunizations
USE OF MOTIVATIONAL TOOLS

MOTIVATIONAL INTERVIEWING (MI)

THE SPIRIT OF MI

BRIEF ACTION PLANNING
Motivational Interviewing (MI)

- MI is an effective way of talking with people about CHANGE

Why I like using MI in my practice?

- Helps motivating patients to change their behavior
- Promotes better listening skills & empathy
- It doesn’t get in the way of other assessments
- It doesn’t take a long time
- When it is done well, it not only helps to lower patient resistance but also helps to reduce clinician anxiety

Empathy: The Human Connection to Patient Care (Cleveland Clinic)

Motivational Interviewing in Health Care by Stephen Rollnick & William R. Miller
The Spirit of MI

- **Compassion**
  - The clinician has the patient’s best interest always in mind

- **Acceptance**
  - Accepts that the ultimate choice to change is the patient’s alone

- **Partnership**
  - A partnership with the patient rather than a prescription for change

- **Evocation**
  - Acknowledges that individuals bring expertise about themselves and their lives to the conversation

Steven Cole, with contributions from Mary Cole, Connie Davis, and Damara Gutnick, Brief Action Planning (B.A.P.)
Brief Action Planning (BAP)

- BAP is grounded in the principles and practice of MI and the psychology of behavioral change
- Action Planning is a highly structured, stepped-care, self-management support technique
- Composed of a series of 3 questions and 5 skills
- BAP can be used to facilitate goal setting and action planning to build self-efficacy in chronic illness management and disease prevention
- The overall goal of BAP is to assist an individual to create an action plan for a self-management behavior that they feel confident that they can achieve
- BAP is also being used to assist patients to develop action plans for disease prevention
Brief Action Planning

Three Core Questions

- “Is there anything you would like to do for your health in the next week or two?” (what, when, where, how often, etc?)
- “On a 0-10 scale of confidence, were 0 means no confidence and 10 means a lot of confidence, about how confident are you that you will be able to carry out your plan?” (If confidence <7, initiate collaborative problem-solving)
- “Would you like to set a specific time to check in about your plan to see how things have been going?”
Brief Action Planning

Five Additional Skills

- Presentation of a Behavioral Menu
- SMART Behavioral Planning
- Elicitation of Commitment Statement
- Collaborative Problem Solving
- Follow-Up
Brief Action Planning Flow Chart

- Is there anything you would like to do for your health in the next week or two?
  - Have an idea?
  - Not sure? Behavioral Menu
  - Not at this time
  - That’s fine, if it’s okay with you, I’ll check next time.
  - With permission, when? Where? When?
  - How often/long? How much?
  - How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?

- Confidence? “Yeah, great!”
  - “A 9 is higher than a 6, that’s good! We know people are more likely to complete a plan if it’s higher than 7.”

- Problem Solving: Any ideas about what might raise your confidence?
  - Yes
  - No
  - Behavioral Menu
  - Assess improved confidence
  - Restart plan and rating as needed.

- “Would it be helpful to set up a check on how things are going with your plan?”

Checking on the Brief Action Plan

- How did it go with your plan?
  - Completion
  - Partial Completion
  - Did not carry out plan
    - Pressure that this is common occurrence

- Recognize success
- Recognize partial completion

The Spirit of Motivational Interviewing is the Foundation of Brief Action Planning: Compassion, Acceptance, Partnership, Engagement

Behavioral Menu

HEALTHY IDEAS

 Decrease Eating out  Decrease sugar sweetened beverages

 Increase Activity  Reduce TV Time

 Get enough sleep  Reduce Alcohol

 Increase amount of vegetables a day  Reduce Portions

 Reduce stress/start meditation

Taking Care of My Health or Well-Being

Today's Date: 

My health or well-being goal is:  

Is there anything you'd like to do for your health or well-being in the next week or two? If there isn't anything you'd like to do for your health or well-being right now, you might want to consider this again in the future. Fill in the following details. Some of these may not apply. Try to be as specific as possible.

<table>
<thead>
<tr>
<th>My Action Plan</th>
<th>My Answers</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you like to do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When and how often?  (What time of day will you do this? If it happens more than once/how often will it happen?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long or how much?  (minutes, servings, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When will you start?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) Review your plan 

2a) How sure or confident are you that you will be able to accomplish your plan?

Not sure at all 0 1 2 3 4 5 6 7 8 9 10 Very sure

*Note: If you chose 6 or lower, go to question 2b. If you chose 7 or higher, go to question 3.

2b) How might you change your plan to make it possible to raise your number to 7 or higher?

3) Check how you are doing

☐ I will do this myself
☐ I will check with someone else (a family member or a healthcare team member)
Who is that person? __________________________
How and when would you like to check in (i.e. in a week or a day, by phone or in person)? __________________________

Back Up Plan: __________________________

Barriers: __________________________

Adjust your plan as needed. Remember to celebrate things that went well!
The different models of diabetes management offered at the Health Education Center for Wellness at Northern Navajo Medical Center

Important aspects of individual patient management based on individual patient needs, interpretation of data, and DM standards of care

The benefits of patient education using motivational tools (MI & BAP)
“The best way to find yourself is to lose yourself in the service of others”
— Mahatma Gandhi