"JUST WHAT THE DOCTOR ORDERED" ISN'T SO SIMPLE: *UNDERSTANDING & PROMOTING PATIENT ADHERENCE*

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PART ONE: KNOW

OBJECTIVES

PART I

- Enhance your understanding of the multi-factorial barriers to patient adherence
- Learn simple strategies to identify specific patient barriers to medical care

PART II

- Develop clinical intervention skills to interact with patients in ways to promote their own motivation for behavior change

RELEVANCE

- Acute to chronic illnesses
  - Biomedical → Biopsychosocial model
- Preventable!
  - Premature morbidity & mortality from chronic disease is **preventable**
- Actual **causes** of death linked to health behaviors – alcohol, tobacco, and unhealthy nutrition and activity
- Maternal-fetal health & well-being

Biological
- Age, Gender, Genetics
- Physiologic Reactions
- Tissue Health

Psychological
- Mental Health
- Emotional Health
- Beliefs & Expectations

Sociological
- Interpersonal Relationships
- Social Support Dynamics
- Socioeconomics

GENERAL ADHERENCE STATS

- Attend scheduled appointments?
- Take medication as prescribed?
- Successful with smoking cessation at 1 year mark?
- Follow activity recommendations?

PERINATAL SIGNIFICANCE

Weight
- Pregnancy complications (PTL, gestational diabetes)
- Higher birth weight for infant
- Ongoing obesity for mother and infant

Smoking
- Fetal risks include pre-term birth, SIDS
- Maternal complications including water breaking early, problems with placenta
- 1 in 5 smoke 3 mos prior to pregnancy; 1 in 10 in last 3 mos of pregnancy

Depression
- 1 in 5 to 8 women depression in pregnancy
- Only about one-half receive adequate treatment
- Long-standing impact for maternal and fetal well-being

Medication
- Fear of effects on fetus
- Rates vary but still high, esp with chronic illnesses

FACTORS THAT AFFECT ADHERENCE

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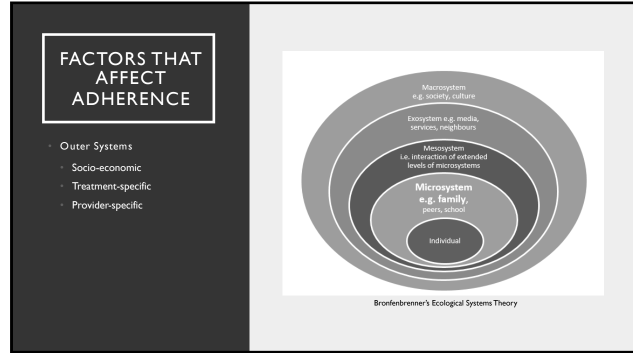
- Outer Systems
  - Socio-economic
  - Treatment-specific
  - Provider-specific



Bronfenbrenner's Ecological Systems Theory

DIAGNOSIS & TREATMENT-BASED BARRIERS

- Nature of disease – symptoms
  - Depression
  - Pain
  - Fatigue
- Lack of symptoms
- Treatment side-effects
- Treatment complexity
  - Time, duration, method

PROVIDER-BASED BARRIERS

6.1 Barriers to Provider Involvement in Behavior Change Interventions

Physician barriers

Knowledge deficit
- Behavior change principles
- Effectiveness of physician intervention
- Intervention methods
- Resources for patients—materials and referrals
- Organizational and system models for supporting behavior change and self-management

Skill deficit
- Interviewing/assessment/diagnostic skills
- Patient education skills
- Behavioral counseling skills
- Maintenance/relapse prevention skills

Beliefs and attitudes
- Belief that patients don't want to change or can't change
- Perceived ineffectiveness in helping patients follow through with treatment or change
- Lack of confidence in helping patents adhere or change
- Emphasis on final outcomes
- Disease-oriented biomedical approach
- Provider-centered, directive style
- Moralistic view of behavior problems

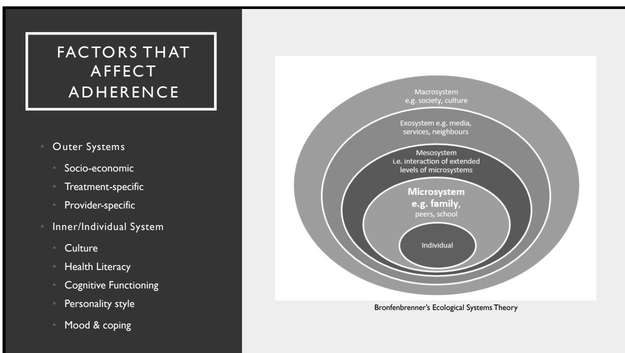
Poor personal health habits

Dearth of role models practicing preventive care

Note. From "Behavioral Medicine Strategies for Medical Patients" by M. G. Goldstein, L. Ruggiero, B. J. Guise, & D. B. Abrams, in *Clinical Psychiatry for Medical Students* (2nd ed., pp. 671–693).

FACTORS THAT AFFECT ADHERENCE

- Outer Systems
  - Socio-economic
  - Treatment-specific
  - Provider-specific
- Inner/Individual System
  - Culture
  - Health Literacy
  - Cognitive Functioning
  - Personality style
  - Mood & coping



Bronfenbrenner's Ecological Systems Theory

CULTURE

- Consider the influences of their culture on their health beliefs or behaviors, view of themselves, others
- Know your own cultural beliefs, values, biases
- Different cultures interpret disease and symptoms differently
- **What can I do?**
  - **Openly dialogue with patient, ask them, educate yourselves**

HEALTH LITERACY

"degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions"

(Razan and Parker 2000 – as cited in IOM 2004)

- Involves knowledge about the body, disease, and specific medical information
- Also affects identifying details of precipitating events, reactions, strategies to avoid risk, how they access health-related information
- Lack understanding of risk/benefit, managing complex routines

MORE THAN 80% of health information provided in a doctor's office is forgotten before patients or parents get home.

MORE THAN HALF of the recalled information is remembered incorrectly.[1,2]

According to the Institute of Medicine, patients need these skills to be knowledgeable and literate about their own health:

NAVIGATION The ability to locate a provider or prescribed ancillary services as well as filling out the required forms to get the service.

COMMUNICATION The ability to share personal health information with a provider who needs it to provide care.

MANAGING CHRONIC DISEASE The ability to act on provided health information for chronic disease management. This could include skills that require patients to understand a wide range of information visually,

NUMERACY Being able to measure and appropriately deliver a liquid medication to a child as well as comparing different health plan information. Patients and parents often need to be able to analyze relative risks and benefits if they are going to fully participate

contemporarypediatrics.com

HEALTH LITERACY

- **NOT** predicted by age or educational level
- What can I do?
  - Administer a brief assessment at initial appointment and document in chart
  - Inquire about how they best learn – Verbal? Auditory? Visual?
  - Communicate clearly with plain jargon
  - Consistently use teach-back method

REALM-SF Score Sheet

Patient ID #: ____________ Date: ________ Examiner Initials: ____

Behavior ____
Exercise ____
Menopause ____
Rectal ____
Antibiotics ____
Anemia ____
Jaundice ____

TOTAL SCORE _____

Administering the REALM-SF:

Suggested Introduction:

"Providers often use words that patients don't understand. We are looking at words providers often use with their patients in order to improve communication between health care providers and patients. Here is a list of medical words.

Starting at the top of the list, please read each word aloud to me. If you don't recognize a word, you can say 'pass' and move on to the next word."

Interviewer: Give the participant the word list. If the participant takes more than 5 seconds on a words, say "pass" and point to the next word. Hold this scoring sheet so that it is not visible to the participant.

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html#rapid

NEUROCOGNITIVE STATUS

- Issues can happen at any stage in the process
- Interplay between cognitions & emotions
- What can I do?
  - Consider contributing factors – mood concerns, learning disabilities; benefit from neurological evaluation or neuropsychological testing?

MOOD

- Depression
  - Apathy, loss of motivation, attention/concentration issues, sleep
- Anxiety
  - Mixed – can be motivating factor leading to excess utilization or means of avoidance based on fear
- What can I do?
  - Make sure you're assessing emotional well-being and identifying any mood concerns at all appts
  - If concerns arise, intervene with treatment options - self-care, therapy, medication

PERSONALITY

Difference between temperament/personality style versus clinical disorder

There is **no evidence** for a non-adherent personality

Common adherence traits: *conscientious, agreeable, and optimistic*

Importance of **BELIEFS**

PERSONALITY DISORDERS

- ✓ Distorted thinking patterns
- ✓ Problematic emotional responses
- ✓ Over- or under-regulated impulse control
- ✓ Interpersonal difficulties
- What can I do?
  - Get a sense of patient's identity and interpersonal relationships – and identify if indicative of a more clinically significant presentation
    - If so, recognize what you can and cannot control, set limits/boundaries, communicate clearly

DSM-5 personality disorders[1]

Personality disorder	Key features
Paranoid	Distrust and suspiciousness; others are regarded as having malevolent intentions
Schizoid	Persistent detachment from social relationships; restricted emotional expression
Schizotypal	Reduced capacity for interpersonal relationships; cognitive or perceptual distortions; eccentric behavior
Antisocial	Violation of the rights of others; impulsive and irresponsible behavior; lack of remorse
Borderline	Unstable interpersonal relationships; unstable identity and emotions; impulsivity
Histrionic	Excessive yet superficial emotionality; attention-seeking behavior
Narcissistic	Grandiose fantasies; need for admiration; lack of empathy
Avoidant	Social inhibition; feelings of inadequacy; fear of criticism or rejection
Dependent	Submissive and clinging behavior; excessive need for advice and reassurance
Obsessive-compulsive	Preoccupation with orderliness, perfectionism, and control
Personality change due to another medical condition	Persistent personality disturbance directly related to a physiological condition (eg, temporal lobe lesion)
Other specified personality disorder and Unspecified personality disorder	Meets general criteria for a personality disorder, but (1) has a PD that is not included in the DSM-5 classification or (2) has traits of several PDs, but not meeting criteria for any single PD

DSM-5, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed; PD, personality disorder.

COPING STYLES

- Unhelpful versus helpful coping responses

THEORIES OF HEALTH BEHAVIOR CHANGE

HEALTH BELIEF MODEL

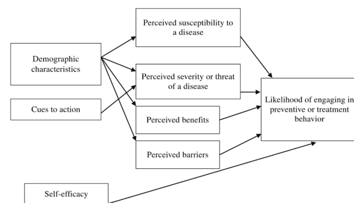


Figure 1.1 Health belief model.

Health Behavior Change & Treatment Adherence, Martin

Perceived Susceptibility	Tobacco user's perceived chances of developing smoking-related conditions (i.e., lung cancer, CVD, gum disease, infertility, etc.)
Perceived Severity	Tobacco user's beliefs regarding seriousness of various smoking-related conditions and the consequences of these conditions
Perceived Benefits	Tobacco user's belief in the efficacy of the advised action for smoking cessation in reducing various health risks
Perceived Barriers	Tobacco user's opinion of the tangible and psychological costs of the advised action for quitting smoking
Cues to Action	Strategies to activate "readiness" to quit within tobacco user
Self-Efficacy	Tobacco user's confidence in their ability to terminate use of tobacco

THEORY OF PLANNED BEHAVIOR

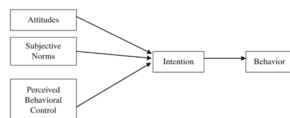


Figure 1.3 Theory of planned behavior.

Health Behavior Change & Treatment Adherence, Martin

Behavioral Intention	Perceived likelihood of continuing to smoke or of quitting smoking
Experiential Attitude (Affect)	Belief that using tobacco or engaging in cessation is associated with certain positive or negative feelings
Instrumental Attitude	Belief that using tobacco or engaging in cessation is associated with certain attributes or outcomes, and values attached to these outcomes or attributes
Subjective (Injunctive) Norm	Belief about whether most individuals (and/or important others) approve or disapprove of tobacco use or cessation, and degree of motivation to comply with these views
Descriptive Norm	Belief about whether most individuals (and/or important others) use tobacco or have quit using tobacco
Perceived Behavioral Control	Perceived likelihood of various events occurring that will act to facilitate or thwart tobacco use or cessation, and the perceived impact that such events will have in making tobacco use or cessation difficult or easy
Self-Efficacy	Perceived ability to overcome various events or conditions that may act as a barrier to tobacco cessation

RESOURCES

- *Handbook of Health Behavior Change, Third Edition* – Shumaker, Ockene, Riekert
- *Motivational Interviewing in Health Care* – Rollnick, Miller, and Butler
- *Health Behavior Change & Treatment Adherence* – Martin, Haskard-Zolnierek, DiMatteo