Patient Engagement and Evidence-Based Treatment Approaches: Core Skills

Session 3
Learning Objectives

• Describe the treatment to target goals when working with the SMI population

• Identify evidence-based nursing interventions to engage patients with SMI

• Describe the assessment and treatment planning process for RN care managers in a behavioral health setting
Minnesota Public Health Nursing Framework
Nurse Care Manager in Behavioral Health

- Screening: Case Finding
- Health Teaching
- Case Management
- Consultation
- Collaboration
- Delegated Functions
- Referral and Follow Up
- Surveillance
Screening – ‘CHODS’

Helpful acronym for screening of five prominent health conditions:

- **Cholesterol**
- **Hypertension**
- **Obesity**
- **Diabetes**
- **Smoking**
Screening

- Data collection begins
- APA metabolic monitoring guidelines

APA Metabolic Monitoring Parameters

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>Week 4</th>
<th>Week 8</th>
<th>Week 12</th>
<th>Every 3 months thereafter</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical history</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Fasting glucose/hemoglobin A1c</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Fasting lipids</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

* Personal and family history of obesity, diabetes, hypertension, and cardiovascular disease.
Screening: Treat to Target Goals

• Blood glucose guidelines
• Blood pressure guidelines
• Cholesterol guidelines
• Body mass index

“Know your numbers”
Screening: Treat to Target Goals
Blood Glucose and Hgb a1c

<table>
<thead>
<tr>
<th>A1C Now Value (%)</th>
<th>Average Blood Glucose (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.5 and above</td>
<td>298 and above</td>
</tr>
<tr>
<td>8.5 - 10.4</td>
<td>269</td>
</tr>
<tr>
<td>8.1 - 8.4</td>
<td>240</td>
</tr>
<tr>
<td>6.1 - 7.0</td>
<td>212</td>
</tr>
<tr>
<td>4.0 - 6.0</td>
<td>185</td>
</tr>
<tr>
<td></td>
<td>154</td>
</tr>
<tr>
<td></td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>68</td>
</tr>
</tbody>
</table>

Used with permission from the University of Washington AIMS Center
## Screening: Treat to Target Goals
### Blood Pressure

<table>
<thead>
<tr>
<th>Blood Pressure Category</th>
<th>Systolic mm Hg (Upper Number)</th>
<th>Diastolic mm Hg (Lower Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Normal</strong></td>
<td>Less Than 120</td>
<td>Less Than 80</td>
</tr>
<tr>
<td><strong>Elevated</strong></td>
<td>120 – 129</td>
<td>Less Than 80</td>
</tr>
<tr>
<td><strong>High Blood Pressure (Hypertension) Stage 1</strong></td>
<td>130 – 139</td>
<td>80 – 89</td>
</tr>
<tr>
<td><strong>High Blood Pressure (Hypertension) Stage 2</strong></td>
<td>140 or Higher</td>
<td>90 or Higher</td>
</tr>
<tr>
<td><strong>Hypertensive Crisis</strong> (Consult Your Doctor Immediately)</td>
<td>Higher Than 180</td>
<td>and/or Higher Than 120</td>
</tr>
</tbody>
</table>

American Heart Association

Used with permission from the University of Washington AIMS Center
Screening: Treat to Target Goals

Cholesterol

- Total Cholesterol = Less than 200
- LDL = Less than 100
- HDL = Greater than 60
- Triglycerides = Less than 150
### Screening: Treat to Target Goals

**Weight/BMI**

<table>
<thead>
<tr>
<th>HEIGHT in/cm</th>
<th>Underweight</th>
<th>Healthy</th>
<th>Overweight</th>
<th>Obese</th>
<th>Extremely obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>5'0&quot; - 152.4</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>5'1&quot; - 154.9</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>5'2&quot; - 157.4</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>5'3&quot; - 160.0</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>5'4&quot; - 162.5</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>5'5&quot; - 165.1</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>5'6&quot; - 167.6</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>5'7&quot; - 170.1</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>5'8&quot; - 172.7</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>5'9&quot; - 175.2</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>5'10&quot; - 177.8</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>5'11&quot; - 180.3</td>
<td>14</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>6'0&quot; - 182.8</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>6'1&quot; - 185.4</td>
<td>13</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>6'2&quot; - 187.9</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>6'3&quot; - 190.5</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>6'4&quot; - 193.0</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>
Screening: Case Finding

- Database usage
- Identification of at-risk population
- Registry functions
- Various technology formats
We Have a Group of Clients. *Now what?*
Planning, Initiating & Ongoing Treatment

- Consultation
- Health Teaching
- Collaboration
- Delegated Functions
- Case Management
Patient Engagement (Outreach)

• Screening process (case-finding)
• Social marketing
• Referral process
• Warm hand-off
• Peer support
• Program adaptations
• Champion
• Linkage to primary care
Treatment Planning Process

- Collaborative
- Standardized best practices
- Individualized to patient
Consultation

- Meet with other team members
- Provide health information
- Guide physical health treatment plan
- Translate medical information
Health Teaching: Tools of the Trade
Checkpoint
Motivational Interviewing

Prompt
Describe your familiarity using Motivational Interviewing.

Video
Ineffective Physician
Patient Engagement in Health Teaching
Motivational Interviewing (MI)

Essential Elements:
1. MI is a particular kind of conversation about change
2. MI is collaborative
   — Not expert-recipient
   — Patient-centered
   — Partnership
   — Honors autonomy
3. MI is evocative
   — Seeks to call forth the person’s own motivation and commitment
Patient Engagement
Motivational Interviewing (MI)

Guiding Principles (RULE)

 Resist the righting reflex
 Understand your patient’s motivations
 Listen to your patient
 Empower your patient
Patient Engagement
Motivational Interviewing (MI)

A Few Premises:

• It is a myth that patients are unmotivated
• Motivation is formed best in the context of relationship
• People usually feel ambivalent about change
Patient Engagement
Motivational Interviewing (MI)

Communication Styles (Mix & Match!)

• **Following**: suspending own “stuff,” giving full attention, predominantly listening

• **Directing**: Taking charge, communicating solutions, overseeing, usually the cornerstone of health care providers

• **Guiding**: Tutoring, assisting in patient’s self-directed learning, helping patient solve a problem
Patient Engagement
Motivational Interviewing (MI)

Core Communication Skills

• **Asking**: Intent is to develop understanding of patient’s problem (versus just getting a list of symptoms)

• **Listening**: An active process, checking to see if you understand person’s meaning correctly, encouraging patient to reveal more

• **Informing**: Conveying knowledge to a patient about condition, reason for treatment, diagnoses, recommendations, etc.
Checkpoint – Group Discussion

Prompt

• Communication Skills (asking, listening, informing)
  – What is your preference?
Patient Engagement
Motivational Interviewing (MI)

“Change Talk” (DARN)

 Desire. Listen for words like *want*, *like*, and *wish*

 Ability: Listen for words like *can* and *could*

 Reasons: Listen for specifics, which can occur with “desire” verbs

 Need: Listen for words like *need*, *have to*, *got to*, *should*, *ought*, *must*

 Look for commitment and taking steps toward behavior change.
Patient Engagement
Motivational Interviewing (MI)

VIDEO - Effective Physician

Nuggets of Wisdom

- Use open questions
- Open the door (invite patient to share)
- Use agenda setting, allow patient to decide what to work on
- Silence inner chatter
- Reflect back to patient
- Summarize (bouquet of patient’s change talk)
Health Teaching Topics

- Dietary
- Exercise/activity
- Smoking cessation
- Medication management
Behavioral Weight Loss Interventions

Most likely to be effective:
• Longer duration (24 weeks)
• Manualized
• Combined education and activity
• Both nutrition and physical exercise
• Evidence-based (proven effective by RCTs)

Less likely to be successful:
• Shorter duration
• General wellness or health promotion education-only
• Non-intensive, unstructured, or non-manualized interventions

Bartels S, et al. SAMHSA-HRSA Center for Integrated Health Solutions, 2012, Available at: https://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper

Used with permission from the University of Washington AIMS Center
Health Teaching: Dietary

- Food education
- Assess for food insecurity
- Assess for food acquisition and storage
- Healthy eating principles
Health Teaching: Exercise/Activity

- Education
- Short, frequent sessions
- Set achievable goals
- Buddy up!
Health Teaching: Smoking Cessation

- Smoking is both a behavioral and physical addiction
- 5 A’s
  - ask, advise, assess readiness, assist, arrange
- Nicotine replacement
- Medications
- Individual and group counseling
Health Teaching: Medication Management

- Important for patient’s mental health
- Educate patients on the use of medications to control mental symptoms to improve quality of life
- Empower patients to mediate serious life-limiting side effects
Collaboration:

• Commits two or more persons or organizations to achieving a common goal
  - through enhancing the capacity of one or more of them to promote and protect health
• First: Develop relationships!
“Delegated Functions”

- Care tasks an RN carries out under the authority of a health care practitioner (as allowed by law)
- Care tasks an RN entrusts to other appropriate personnel to perform
Collaboration
Delegated Functions

• Delegated Functions include:
  • Vital signs
  • Referrals
  • Follow ups
  • Motivational interviewing
  • Behavior change
  • Lifestyle
  • Wellness activities
Case Management

- Delegated Function
- Nurse facilitates the treatment plan
- Collaboration with behavioral health provider to implement the plan
- Nurse consults with/guides case manager
- It is not possible for the nurse to do all the case management, but needs case management experience.
Surveillance

- Function of population health management
- Within a defined population
  - continue to do screening (case finding)
  - monitor identified cases
Referral and Follow-up

Nurse collaborates with the behavioral health staff

- Informs the staff of the referral
- Follows up