



TRANSFORMING PRACTICE INTO BEST PRACTICE

Mirroring their presentation at last year's APA national conference, HealthChange Australia's Janette Gale and Caroline Bills, APA Musculoskeletal Physiotherapist, draw on their own organisation's approach to patient care to prompt readers to question whether they are approaching their patients in the best possible way.

In the scientific literature, as well as the general media, there is much talk of 'best practice' at conferences. Most physiotherapists would say that they use best practice clinical treatment protocols but is that enough? Patient-centred best practice also requires acting as a part of a collaborative health care team; being respectful and responsive to patient preferences, needs and values; engaging patients in collaborative decision-making; providing health literacy, self-management and behaviour change support; and considering a patient's beliefs, cognitions, and social and cultural contexts. Given all of this, how can physiotherapists operationalise patient-centred best practice without adding to already tight consultation times and still meet patient expectations of treatment?

Very few clinicians are actually taught how to integrate the various aspects of the biopsychosocial model into their clinical protocols. Generally, they are left to figure it out on their own through trial and error. The result is that physiotherapy clinical practice tends to be delivered in an idiosyncratic and inconsistent manner across the workforce. Hence clinical outcomes for patients largely depend on which clinician/s they chance across.

Fortunately, the science of behaviour change is starting to provide systematic ways for clinicians to deliver patient-centred clinical best practice. One such model is the Australian-based HealthChange® Methodology that has been developed over the last 12 years by a multi-disciplinary team of allied health clinicians with input from approximately 8000 practitioners across Australia and Canada.

The methodology allows physiotherapists to use their consultation time more effectively and efficiently. It integrates patient-centred care with the provision of clinical assessment, diagnosis and education in a way that quickly identifies and addresses common patient barriers to treatment adherence. The underlying assumption is that if patients actually do the treatment tasks and self-management activities recommended to them by physiotherapists, they will be much more likely to get better clinical outcomes.

The decision line is the critical point at which a patient has decided that it is important enough for them to take action on an issue (for example, engage in active treatment activities such as exercise), and they are ready to consider how they might do this.

The below diagram shows patients' needs when they attend therapy and the order in which clinicians need to address them.



A key implication of the patient pathway is that if the patient's needs have not been fulfilled above the decision line, it is unwise to try to engage in goal-setting around active treatment recommendations. This would be likely to cause resistance or the 'patient-practitioner game'. This is where the patient pretends that they intend to carry out their prescribed treatment activities and the practitioner pretends that they believe this, even though both know it is unlikely to happen.

In our organisation's experiences, common barriers to treatment adherence can be avoided or identified and addressed by using our methodology (the HealthChange Methodology). Above the decision line, key barriers to adherence relate to perceived importance in taking action. Below the decision line, key barriers are more likely to impact on confidence or ability to carry out prescribed tasks.

A key principle of the methodology is the RICK Principle®. This principle urges clinicians to be mindful of a patient's Readiness, Importance (motivation), Confidence (self-efficacy) and knowledge (health literacy) in relation to following treatment advice. Low levels of any of these factors may indicate the presence of barriers to taking action on clinical recommendations. The 'k' for knowledge is deliberately lower case to indicate the need to provide sufficient and targeted knowledge and understanding, rather than catch-all comprehensive education.

There are a number of common barriers that lead to poor adherence to active treatment recommendations and predict poorer clinical outcomes. Many physiotherapists will know these as 'yellow flag' psychosocial issues. They are often easy to detect intuitively and the sequence of needs for patients shown in the diagram above suggests that it is unwise to leave these barriers unaddressed when they are detected. If a patient's signals about their concerns are ignored during assessment, the patient may have already disengaged by the time the clinician is ready to talk about them.

One patient barrier that impacts heavily on perceived importance above the decision line is the belief that it is the physiotherapist's role to 'fix' the problem, not the patient's. This passive role expectation may be a result of previous physiotherapy treatment encounters. It

can also relate to perceived lack of control over condition management arising from poor health literacy.

Another possible barrier relates to the patient's confusion arising from receiving multiple explanations for the condition and what can or should be done to treat it.

Further, often clinicians will encounter maladaptive beliefs about active treatment tasks being 'not worth the effort'. Associated beliefs could involve low expectations of treatment efficacy, belief that the condition will improve anyway, belief that the condition is too serious to be dealt with by such simple tasks, or a lack of perceived self-discipline to carry out tasks effectively.

Another barrier involves having other (higher) priorities in one's personal life and not making the connection that better physical function and health will enable better functioning in other important areas of life.

There are a number of clinician responses that can avoid or address these barriers. This includes explaining your role up front in a way that includes the benefits from the patient's perspective. This acts to build rapport and engagement and addresses passive expectations.

Also, before providing education or advice, find out what the patient already knows or thinks. This shows respect for the patient's knowledge base, builds rapport, identifies knowledge gaps and misunderstandings, and saves time by addressing only the necessary issues.

It is also important to ensure that the patient knows and understands the nature of their condition or diagnosis and the consequences of poor management over time. One should mention usual progression of the condition and all treatment options.

A critical part of education is to outline the broad, evidence-based active treatment recommendations with a brief explanation of why taking action in each area might be beneficial to this particular patient. Doing this improves health literacy, addresses maladaptive beliefs about active treatment efficacy and creates accurate expectations about possible treatment outcomes.

Clinicians should help patients to understand the range of options and choices available to them within each treatment or lifestyle change category in an effort to promote choice, control and shared decision-making.

It is important to reflect and normalise the notion that it is not easy to fit additional tasks into one's life given other personal priorities. This acts to acknowledge potential challenges and opens these up for discussion and problem-solving.

The health professional can also build readiness to take action in the patient by briefly inquiring about how better physical functioning might impact positively upon other important life priorities.

A patient barrier that will impact heavily on confidence below the decision line is a lack of knowledge and understanding about acute versus chronic pain management. This is often associated with the belief that if movement or other activities cause pain then they are doing more damage. A fear of movement or particular activities can result.

Another barrier below the decision line concerns the patient not engaging in treatment activities in a graded manner (all or nothing). This involves trying to do too much, too soon, and not pacing activities. Conversely, patient procrastination is another potential issue.

It should be noted that patients may also be overwhelmed by the magnitude, difficulty or complexity of self-management tasks and the number of appointments and activities they need to do. This may be associated with the belief that everything must be tackled at once.

To address these barriers, clinicians should briefly check patient understanding of their pain and what it means. This includes providing education and discussing the meaning of pain where necessary, including how to gain more control over it.

Clinicians should also inquire about how the patient tends to do things generally in their life—are they the sort of person who tries to do too much? Or doesn't do enough?

Another tip would be to normalise the tendency for people to procrastinate and put off doing treatment tasks. Briefly inquire about whether the patient might do this, particularly when they are busy. Ensure that the patient can identify personal benefits in carrying out the required active treatment tasks. If necessary, help them to devise thinking strategies to remind them about why the activities are important and ensure that they know any minimum dose of treatment activities that are likely to have an effect. This addresses common thinking barriers responsible for inaction and gives the patient control over their behaviour.

Ideally, the clinician and patient should collaboratively prioritise the possible treatment activities (such as referral, treatment and lifestyle recommendations). It is important that clinicians balance duty of care with the patient's right to make fully-informed decisions that meet their personal needs. Consider what other priorities the patient currently has, both medically and generally. A step like this provides choice and control through collaborative decision-making, and respects the patient's individual circumstances.

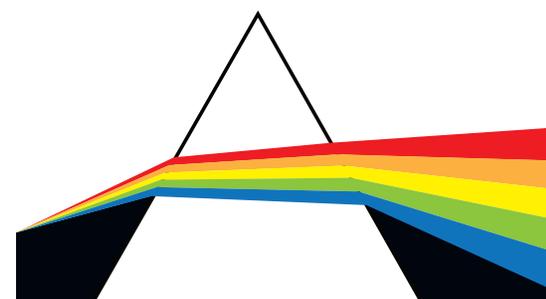
Incorporating the patient-centred responses and tasks outlined above may add some time to the subjective assessment, but will reduce the time taken for education and discussion in an initial consultation and in subsequent consultations. Clinicians can also gain time by carefully considering how much objective assessment is required in a particular consultation.

Clinicians often worry that if they change their practice to include a less-than-fully-comprehensive assessment of all possible contributing factors, then they will not be fulfilling their duty of care. The irony is that including more assessment may be at the cost of delivering patient-centred clinical care.

Physiotherapy assessment generally needs to establish a working diagnosis, exclusion of other critical clinical issues, identification of contributing physiological factors, and benchmarks to track physical progress or decline. Once these tasks have been completed,

the remaining consultation time can be used to provide passive treatment (where needed) and discuss active treatment recommendations in a patient-centred way that fulfils the patient's needs.

Using this approach also means that clinicians don't need to formally assess everyday psychosocial issues. It becomes obvious when there is a psychosocial barrier and usually these can be dealt with quickly and easily in a conversational way. Any significant clinical psychological issues will still need to be dealt with by referral to specialists.



A TAILORED APPROACH

Michael Tarquinio asks Janette and Caroline questions about the development of HealthChange's methodology, its use, and its potential impact on modern practice.

MT: What was the origin of the HealthChange Methodology 12 years ago?

JG: I found that the education I had received as a psychologist had not adequately equipped me to deal with patients with chronic health issues

and the barriers to action that I was seeing in clinical practice. So I went looking for other models to help me. I found that other health practitioners experienced the same issues and there seemed to be a gap in our training. Speaking with Dr Andrew Dawson from Deakin University School of Exercise and Nutrition Sciences at a conference a few years later, he invited me to co-develop a health coaching professional development course for clinicians, which I did. The course very quickly became all about behaviour change and health psychology within a solution-focused coaching framework.

MT: What other theoretical approaches and foundations have impacted the methodology?

JG: The methodology bridges the gap between theory and practice and enables clinicians to use the health psychology and behaviour-change evidence base in their practice without having to figure out how to do this by themselves. Just about every major behaviour change model and approach is consistent with HealthChange's methodology because it is evidence-informed. It shares principles underlying motivational interviewing, solution-focused coaching and cognitive behavioural therapy. However, over time we have developed our own unique approach to operationalising these principles to fit well with the delivery of clinical health services.

MT: What makes it different from other approaches or mechanisms?

JG: Often what is referred to as 'best practice' is just the clinical focus, that is, best practice treatment protocols. But this neglects the patient-centred part of best practice. This refers to the psychosocial aspects of the consultation interaction. However, by using the term 'psychosocial' I am not referring to psychosocial problems, but the everyday individual differences and needs of patients that require you need to treat people differently.

CB: They don't provide clinicians with an overarching decision framework to guide the consultation. A strength of our methodology is that it is flexible enough to be used in any type of consultation or context (for example, face-to-face, telephone, groups).

MT: In each of your experiences, what is the most common thing that current physiotherapists/clinicians do that has the greatest effect on poor patient adherence?

JG: They follow assessment and treatment protocols to the exclusion of using a patient-centred approach. Clinicians of all types tend to over-assess because that's what they are comfortable doing. They think that being patient-centred means having a good bedside manner and providing the best evidence-based treatment. However, they tend to treat and educate each person with the same condition in exactly the same way. This neglects their individual differences and needs as people and, therefore, doesn't address each person's barriers to following treatment recommendations.

CB: They make assumptions about what the client wants and needs. This means that they miss cues that they need to respond to, particularly during subjective assessment. They assume that being client-centred and facilitating adherence has to take a lot of time and effort.

MT: How can these issues be solved?

JG: Clinical practice needs to be restructured to build in questions, responses and tasks that provide the patient-centred part of the conversation. Not as an add-on, but integrated into normal consultation frameworks.

CB: One of the key things to do is to limit the amount of clinical assessment you do by stopping once you reach a workable diagnosis. This gives you much more time to respond to the patient's barriers and needs throughout the rest of the consult.

MT: How has the methodology been tried and tested? What are some current projects that HealthChange is involved in?

JG: Apart from being used throughout the health system for service delivery, the

HealthChange Methodology is currently being used in a number of research projects, including studies in the management of gestational weight gain, diabetic retinopathy, HIV, lung cancer, and osteoarthritis. Two of these are NHMRC funded. We are working with the physiotherapy department from the University of Melbourne on several different projects. The main one that has been underway for some time is the TELKO study. Caroline has been intimately involved in this study.

CB: This study is comparing the outcomes between two groups: those only receiving physiotherapy intervention of strengthening exercises and advice to stay active, and those who receive physiotherapy plus the addition of telephone-delivered behaviour-change support. I have been involved in the training of the clinicians delivering the telephone intervention and using our audit documents to evaluate the quality of that intervention.

JG: We are currently looking for an industry partner in the return-to-work domain [physiotherapy service provider] to embed the HealthChange Methodology, test it via a controlled trial, and report on practice change and patient outcomes. We are also interested in embedding the methodology into clinical physiotherapy training by partnering with universities to integrate the methodology with clinical teaching. We would love to be involved in a study that tests the efficacy of clinical physiotherapy practice based on the methodology, compared with traditional practice.

MT: What is next for HealthChange? How can physiotherapists and their practices get involved with HealthChange?

JG: We are trialling a physio-specific one-day workshop for the APA Gerontology group in Sydney in September. This is open to all APA members. We also intend to run this workshop format in Melbourne later in the year. Alternatively, we run our standard Core Training two-day workshops periodically in Melbourne, Sydney and Brisbane.

For more information, visit healthchange.com.