Brief Interventions for Behavior Change for Women at Risk for Heart Disease

Objectives

- To briefly review major risk factors for cardiovascular disease in women,
- To provide information on strategies for behavior change to improve health, and
- To build skills in the motivational interviewing technique to assist patients in adopting healthier behaviors

2011 Update: Guidelines for the Prevention of Cardiovascular Disease in Women

Mosca L, Benjamin EJ, Berra K, et al. Effectiveness-based guidelines for the prevention of cardiovascular disease in women-2011 update: A guideline from the American Heart Association. *Circulation*. 2011. www.circulation.org.

SOURCES:

(1) Mosca L, et al. (2004). Evidence-based guidelines for cardiovascular disease prevention in women. *Circulation*, 109, 672-693.

(2) Mosca L, et al. (2007). Evidence-based guidelines for cardiovascular disease prevention in women: 2007 update. *Circulation*, 115, 1481-501.

(3) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. *Circulation*, 123, 1243-1262.

Evidence-based guidelines for the prevention of cardiovascular disease in women developed in 2004, updated in 2007, and updated again in 2011. For the original 2004 guidelines, over 1,270 articles were screened by the panel, and 400 articles were included for evidence tables. The summary evidence used by the expert panel in 2011 can be obtained online as a Data Supplement at http://circ.ahajournals.org.

Calculate 10-Year CVD Risk using either lipids or BMI at
www.framinghamheartstudy.org/risk/gencardio.html#

SOURCE:
http://www.framinghamheartstudy.org

Cardiovascular Disease (CVD) Risk Stratification: High Risk

- Documented atherosclerotic disease, including
    - clinically manifest coronary heart disease,
    - clinically manifest peripheral arterial disease.
    - clinically manifest cerebrovascular disease,
    - abdominal aortic aneurysm, and
- Diabetes mellitus
- End-stage or chronic kidney disease
- 10-year Framingham cardiovascular disease risk ≥ 10% [new in 2011]

SOURCES:

(1) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. *Circulation*, 123, 1243-1262.

(2) National Heart Lung and Blood Institute, "What Are the Signs and Symptoms of Coronary Artery Disease?" Retrieved from http://www.nhlbi.nih.gov/health/dci/Diseases/Cad/CAD_SignsAndSymptoms.html.

The major change in the 2011 guidelines for the definition of "high risk patients" is to identify "high risk patients" as those at 10% or higher risk of a CVD event within 10 years. The previous definition specified a 20% or higher risk.

Cardiovascular Disease (CVD) Risk Stratification: At Risk

≥ 1 of the following risk factors for CVD, including (but not limited to):

- Cigarette smoking
- Hypertension: SBP ≥ 120 mm Hg, DBP ≥ 80 mm Hg or treated
- Dyslipidemia
- Family history of premature CVD in a 1st degree relative (CVD at < 55 years in a male relative, or < 65 years in a female relative)
- Obesity, especially central obesity
- Physical inactivity
- Poor diet
- Metabolic syndrome
- Advanced subclinical atherosclerosis
- Poor exercise capacity on treadmill test and/or abnormal heart rate recovery after stopping exercise
- Systemic autoimmune collagen-vascular disease (e.g. lupus, rheumatoid arthritis) [new in 2011]
- A history of pregnancy-induced hypertension, gestational diabetes, preeclampsia [new in 2011]

SOURCE:

(1) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. *Circulation*, 123, 1243-1262.

The 2011 guidelines added systemic autoimmune collagen-vascular disease (e.g., lupus, rheumatoid arthritis) and a history of pregnancy-induced hypertension, gestational diabetes, and preeclampsia to the risk classification.

CVD Risk Stratification: Ideal Cardiovascular Health

- Total cholesterol < 200 mg/dL
- BP < 120/< 80 mm Hg untreated
- Fasting blood sugar < 100 mg/dL untreated,

- Body mass index < 25 kg/m^2
- Abstinence from smoking (never or quit > 12 months)
- Physical activity at goal
- DASH-like diet

Ideal patients are rare in most clinical practices, making up less than 5% of women in most studies.
SOURCES:
(1) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. Circulation, 123, 1243-1262.

(2) Stampfer MJ, Hu FB, Manson JE, Rimm EB, Willett WC. (2000). Primary prevention of coronary heart disease in women through diet and lifestyle. New England Journal of Medicine, 343(1), 16-22.
Lloyd-Jones DM, Leip EP, Larson MG, et al. (2006). Prediction of lifetime risk for cardiovascular disease by risk factor burden at 50 years of age. *Circulation*, 113(6), 791-798.

(3) Akesson A, et al. (2007). Combined effect of low-risk dietary and lifestyle behaviors in primary prevention of myocardial infarction in women. *Archives of Internal Medicine*, 167, 2122-2127.

Using Framingham data, only 4.5% of women in a study published in 2006 were at optimal risk (3).

In a study of 24,444 postmenopausal women in Sweden after 6.2 yr follow-up, only 5% of women had all 5 measures of healthy behavior (healthy diet, moderate alcohol, physical activity, maintaining a normal weight ,and not smoking), but this was associated with a 77% lower risk of MI (4).

Cultural Competency: Considering the Diversity of Patients

- In addition to race/geographic/ethnic origin, other facets of diversity should be considered, including:
    - Age, language, culture, literacy, disability, frailty, socioeconomic status, occupational status, and religious affiliation
- The root causes of disparities include variations and lack of understanding of health beliefs, cultural values and preferences, and patients' inability to communicate symptoms in a language other than their own
- Clinicians also should be familiar with patients' socioeconomic status, which may make attaining a healthy lifestyle and using medications more difficult

SOURCE:
(1) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. *Circulation*, 123:1243-1262.

Adherence to Low Risk Lifestyle Reduces Risk of Cardiac Events

- In a population-based prospective cohort study of 24,444 postmenpausal women in Sweden, after 6.2 years of follow-up, a low risk diet characterized by a high intake of vegetables, fruit, whole grains, fish, and legumes, as well as moderate alcohol consumption, physical activity, maintaining a healthy weight, and not smoking were associated with lower risk of myocardial infarction. A combination of all healthy behaviors was predicted to prevent 77% of myocardial infarctions in the study population. In this study, only 5% of women had all healthy behaviors.
- AHA recommends women consume one or fewer alcoholic beverages a day.

SOURCES:

(1) Akesson A, et al. (2007). Combined effect of low-risk dietary and lifestyle behaviors in primary prevention of myocardial infarction in women. *Archives of Internal Medicine*, 167, 2122-2127.

(2) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. *Circulation*, 123, 1243-1262.

Talking about lifestyle change with patients can be very frustrating for both parties.

One Strategy

What is motivational interviewing?

- Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.
- It is a tool that can be integrated into any clinical setting.

SOURCE:

This is the current working definition of motivational interviewing given by Miller and Rollnick at the International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010

Teaching points:

MI is a partnership between provider and patient; they collaborate on goals, strategies, monitoring progress, creating change plans

It is the person's own motivation and commitment, which may be very different from ours, that actually drives change. Our job is explore and strengthen their motivations.

Motivational Interviewing: The Data

- Meta-analyses have shown that motivational interviewing had a significant and clinically relevant effect in approximately 3 out of 4 studies.
- 64% of brief encounters showed an effect.
- Motivational interviewing outperforms traditional advice giving in the treatment of a broad range of behavioral problems and diseases.

SOURCES:

(1) Artinian NT, Fletcher GF, Mozaffarian D, Kris-Etherton P, Van Horn L, Lichtenstein AH, Kumanyika S, Kraus WE, Fleg JL, Redeker NS, Meininger JC, Banks J, Stuart-Shor EM, Fletcher BJ, Miller TD, Hughes S, Braun LT, Kopin LA, Berra K, Hayman LL, Ewing LJ, Ades PA, Durstine JL, Houston-Miller N, Burke LE; on behalf of the American Heart Association Prevention Committee of the Council on Cardiovascular Nursing. (2010. Interventions to promote physical activity and dietary lifestyle changes for cardiovascular risk factor reduction in adults: a scientific statement from the American Heart Association. *Circulation,* 122, 406-441.

(2) Pollak KI, Alexander SC, Coffman CJ, Tulsky JA, Lyna P, Dolor RJ, James IE, Namenek Brouwer RJ, Manusov JRE, Ostbye T. (2010). Physician communication techniques and weight loss in adults: Project CHAT. *American Journal of Preventive Medicine*, 39(4), 321-328.

(3) Rubak S, Sandbæk A, Lauritzen T, & Christensen B. (2005). Motivational interviewing: A systematic review and meta-analysis. *British Journal of General Practice*, 55(513), 305-312.

(4) Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, Newby LK, Piña IL, Roger VL, Shaw LJ, Zhao D, Beckie TM, Bushnell C, D'Armiento J, Kris-Etherton PM, Fang J, Ganiats TG, Gomes AS, Gracia CR, Haan CR, Jackson EA, Judelson DR, Kelepouris E, Lavie CJ, Moore A, Nussmeier NA, Ofili E, Oparil S, Ouyang P, Pinn VW, Sherif K, Smith SC, Sopko G, Chandra-Strobos N, Urbina EM, Vaccarino V, Wenger NK. (2011). Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 Update: A Guideline From the American Heart Association. *Circulation*, 123, 1243-1262.

The following videos show 40-year-old Gina—a smoker whose best friend was recently diagnosed with lung cancer.
Gina has high blood pressure and is currently suffering from hot flashes and missed periods.
These scenarios may be familiar to you. They represent some common interactions between patients and health professionals.
First is a typical approach, followed by a behavioral/motivational interviewing approach.

Typical Approach:

Doctor: So your smoking friend has been diagnosed with lung cancer. You've been smoking for a long time, But you're not ready to quit yet? Is that—
Gina: No, oh my gosh, not with all this going on in my life, no.
Doctor: Okay, have you thought about the patch?
Gina: The patch. I used the patch 3 years ago, if you remember. My husband had a heart attack?
Doctor: So the patch didn't work. Have you thought about anything else, like hypnosis?
Gina: Oh my gosh, my girlfriend did hypnosis. She had an eating disorder – she gained 20 pounds!
Doctor: Alright, well what about prescriptions? There are medications on the market today that really help other people.
Gina: No, my other girlfriend used the meds, I don't know what she used, but she used the meds and they, um, they made her sick to her stomach, she couldn't sleep.
Doctor: Okay, well you know, if you quit smoking you WILL feel better. I mean, we'll check out the menopause, the possibility of menopause. I do want you to know that people who smoke have symptoms of menopause a lot earlier than people who don't and they also have a lot more severe symptoms, so if you wanna think about quitting—
Gina: It just..oh…I'm sorry doctor, I'm just not ready to quit smoking.
Doctor: Okay, well there are a lot of options out there, so we can really explore the ones that work for you.

Gina: I just really wanna find out what's going on with me right now.
Doctor: Okay, but the longer you smoke, the more chance you have of getting some really high risk disease.
Gina: And I'm aware of the diseases, and there's nothing that tastes better or takes away that stress and that being afraid more than smoking.
Doctor: Here, I'm looking at your chart. The nurse took your blood pressure today when you came in and it was 160 over 98. That is higher than last time. Did you know that smoking can increase your risk for high blood pressure and then the high blood pressure can increase your risk for a heart attack or a stroke? People who smoke a pack a day will have double the risk of having a heart attack than non-smokers.
Gina: Well, I think my blood pressures going up because of what's going on with me. I know my blood pressure will be fine once we get on top of, you know, all these little ailments, I know it will go back down and it'll be fine.
(Videos courtesy of The Mt. Sinai Skills and Simulation Center at Case Western Reserve University and Heart Truth-Ohio)

Behavioral Approach:
Doctor: I want you to take this ruler, and I'd like for you to tell me how ready you think you are to quit on a scale of 1-12.
Gina: Truthfully? Truthfully, a 3.
Doctor: A 3?
Gina: Um-hmm.
Doctor: Why do you say 3?
Gina: I've just never really thought about it. I thought I had more time to think about it. You know, thought, I'm only 40, I can smoke. When I'm about 50, I'll quit. Go through menopause and go on with my life.
Doctor: Well let's talk about that for a minute. What are some of the benefits of smoking?
Gina: Ah, well, the benefits. It's just become such a part of my life. It feels so good to just light up that first cigarette. I can't even imagine having a cigarette without a cup of coffee or a glass of wine. Especially with my dear Marilyn. It's just, I do enjoy smoking, and it has become part of my life.
Doctor: Alright, I understand that. So tell me this. What are some of the things you don't like about smoking?
Gina: Oh, well, you know as well as I do – it's a dirty, expensive…oh it's a terrible habit. And I know that in my heart. It's a bad example for my kids. It's expensive.
Doctor: You mentioned when you came in today that you were having some pretty severe hot flashes. You thought you were too young for menopause. Did you know that women who smoke reported nearly twice as severe hot flashes as women who did not smoke?
Gina: No, I didn't know that. And I didn't, you know, a pack a day, I thought it wouldn't hurt me.
Doctor: Women in this study typically had their first hot flashes 2-5 years earlier than women who never smoked.
Gina: No, I didn't know that.
Doctor: Okay, well, your blood pressure is 160 over 68. That's higher than last time. Did you know that smoking can increase your blood pressure?
Gina: I didn't know that.
Doctor: Yeah, high blood pressure puts you at a greater risk for a stroke or heart attack. Your risk of heart attack increases greatly with the number of cigarettes you smoke and the longer you smoke.
Gina: Even just a pack a day? It's just a pack a day.

Doctor: Yeah, people who smoke a pack of cigarettes a day have nearly twice the risk of heart attack as nonsmokers.
Gina: I didn't know that. Um, it's given me a lot to think about.
Doctor : Well, it sounds as if you have been giving a lot of thought about quitting.
Gina: Well, since Marilyn was diagnosed I can't say I haven't.
Doctor: Yeah, well you have some very serious reasons to think about quitting, and that are very important to you. And yet, you really don't want to quit because you enjoy smoking. And that's not really all that unusual. It's a strong habit that you've had for many years.
Gina: Well, do you know other people like me? That enjoy smoking like I do? That are hesitant to quit?
Doctor: Gina there are many patients like you. Smoking is a physical addiction. There's no one way to quit that works for everyone. To quit you must be ready both emotionally and mentally. You must also want to quit for yourself and not just to please friends and family. Do you think you might be ready to start a plan to quit?
Gina: Well I'm ready to start thinking about a plan to quit.
(Videos courtesy of The Mt. Sinai Skills and Simulation Center at Case Western Reserve University and Heart Truth-Ohio)

Doctors talk in pages and patients listen in sound bites. While clinicians may feel better providing more and more information, it does not necessarily motivate the patient to change.

Sample Video "Behavioral" Debrief

- How did the first video make you feel? Second video?
- What was the difference between the two?
- Is it possible that the "typical" approach turns a patient in the opposite direction, away from change?
- Are the doctor and patient wrestling or dancing? How are they working (or not working) together?
- Which interaction is more likely to result in behavior change?
- The "behavioral" video was just over 3 minutes long. Does that surprise you?

Facilitating Lifestyle and Behavior Change

- Advice from a medical provider can be made more effective and likely to be acted on when it is delivered with the ***patient's permission***, in a ***neutral tone***, and in a manner that supports ***patient autonomy and choice***.

DISCUSSION POINTS:

So, what do we know about facilitating lifestyle and behavior change?

Advice from a medical provider is important and sought after by most patients.

For some, it is enough to motivate change, usually around 5% of people.

Make the most of your professional opinion and advice, be clear, caring, and compelling.

Asking Permission/Patient Autonomy: Sample Questions

- "I know you came in today for your Pap, and I'm really concerned about your blood pressure. Would it be alright if we talked about that also?"
- "I realize that you are in the driver's seat here with your diabetes. I want to let you know that I am very concerned about _____. I believe that the new medication will help if that is something you are willing to try."
- "You are the only one who can decide what, if anything, you want to do; and as your provider, _____ is the number one thing you could do to improve your health.

DISCUSSION POINT:

These are some samples of ways to introduce or present advice. What other ideas do you have?

Facilitating Lifestyle and Behavior Change

Patients are the experts on their life, habits, desires, goals, values, and hopes. Most lifestyle change is more about engaging these motivational elements than about imparting knowledge. ***Find out what the patient knows and wants.***

DISCUSSION POINTS:

Although patients frequently lack specific knowledge about their condition, managing their health, or the importance of behavior change, it is usually not a lack of knowledge that keeps people from acting. In terms of many chronic conditions, patients may actually know a lot more than we give them credit for. This is certainly true for how it impacts their life.

Has anyone been to the doctor and had him/her tell you what you already know about your condition or your life? What did that feel like? (Gather the responses which are usually things like, I felt disrespected, he wasn't listening to me, what does she think I am, an idiot?, angry).

Assessing Patient's Knowledge: Sample Questions

- "What do you already know or have you heard about how heart disease can be prevented?"
- "What would you like to accomplish regarding your risk factors? Where would you like to be? What thoughts do you have about getting to that point?"
- "What concerns you about the possibility of developing heart disease?"
- "I've given you a lot of information here. What are your thoughts about how this applies to you?"

DISCUSSION POINT:

What ideas do you have about how to go about honoring and validating the patient's knowledge, expertise, and ability to manage their life?

Readiness Ruler

- Useful tool for assessment
- Follow up questions and discussion can elicit change talk
    - "How important is it for you to _____? On a scale from 0-10, where 0 is not at all important and 10 is extremely important where would you say you are?"
    - "Why did you pick a 4 and not a 1?"
    - "What would need to happen for you to get from a 4 to an 8?"
- Can evaluate multiple concepts

- Importance – Willingness
- Confidence – Adherence

DISCUSSION POINTS:

We saw a bit of this from the provider in the "behavioral" video.

Backwards question: Why did you pick a 4 and not a 1?
Forwards question: What would need to happen for you to get from a 4 to an 8?

Summarize:

Ask: "Did I get it all?" (Do I understand?)
Ask about the next step.
Where does that leave you now?
I wonder what you're thinking about _____ at this point.
What's the next step?
Where does _____ fit into your future?

Facilitating Lifestyle and Behavior Change

- Listen to your patient's thoughts and concerns
- Express empathy
- Reassure patient her experience is normal
- Video Example:
  - Gina: Well, do you know other people like me? That enjoy smoking like I do? That are hesitant to quit?
  - Doctor: Gina there are many patients like you. Smoking is a physical addiction. There's no one way to quit that works for everyone. To quit you must be ready both emotionally and mentally. You must also want to quit for yourself and not just to please friends and family. Do you think you might be ready to start a plan to quit?
  - Gina: Well I'm ready to start thinking about a plan to quit.

DISCUSSION POINTS:

The most important and useful tool you have in the interactions with patients is yourself. What can you do to help?

Things to remember:

Many providers are afraid that patients will go on and on if allowed and they interrupt. Although it does happen, research indicates that it is not that frequent. It is not only "safe" but a very good thing to listen to the patient. They will tell you what you need to know to be helpful.

Empathy is not sympathy or feeling sorry for the patient. It involves listening to understand the patient and conveying that understanding to the patient.

Working collaboratively supports patient activation, is empowering, and places the responsibility for change where it belongs, with the patient.

Even though we sometimes feel that patients don't have a choice about changing, the fact is they do.

Facilitating Lifestyle and Behavior Change

- Give patient the opportunity to tell *you* what you want to tell *them.*
    - Doctor: Well let's talk about that for a minute. What are some of the benefits of smoking?
    - Gina: The benefits, ah well, it's just become such a part of my life. It feels so good to just light up that first cigarette. I can't even imagine having a cigarette without a cup of coffee or a glass of wine. Especially with my dear Marilyn. It's just I do enjoy smoking, and it has become part of my life.
    - Doctor: Okay, well I understand that. So tell me this. What are some of the things you don't like about smoking.
    - Gina: Oh, you know as well as I do – it's a dirty, expensive…oh it's a terrible habit. And I know that in my heart. It's a bad example for my kids. It's expensive.

DISCUSSION POINTS:

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Talking About Change

- If a person talks about her desire, reason, ability, and need to change, she is more likely to change. If she is given the chance to say out loud what she intends to do, she is more likely to do it.
- Ask directly for a response.
    - What concerns do you have about _____?
    - What do you think will work best for you? Why?
    - Where would you like to start?
    - Is this what you are going to do?

DISCUSSION POINT:

Evidence is mounting that suggests that how a person talks about change matters. Our job is to construct or organize our time so that the patient has an opportunity to talk positively about making a change. This is what builds motivation for action.

Stages of Change: Prochaska & DiClemente

- Pre-contemplation-has not even considered changing
- Contemplation-considering change
- Preparation-has a plan and is making some effort to implement the plan but has setbacks and gets stuck
- Action-is actively making the change, has setbacks but can regroup and go forward with reinforcement
- Maintenance has minor setbacks but can regroup. Reinforcement still helps.

SOURCE:

(1) Youth Action & Policy Association NSW Inc (YAPA). Available at: http://www.yapa.org.au/youthwork/aod/stages.php.

Reinforce the "change talk"

REFLECT**:**

- "You'd like to start thinking about a plan."
- "You're feeling ready."
- "You would really like to be healthy for yourself and for others."
- Sample video:
    - Doctor : Well, it sounds as if you have been giving a lot of thought about quitting.
    - Gina: Well, since Marilyn was diagnosed I can't say I haven't.
    - Doctor: Yeah, well you have some very serious reasons to think about quitting, and they are very important to you. And yet, you really don't want to quit because you enjoy smoking. And that's not really all that unusual. It's a strong habit that you've had for many years. Do you think you might be ready to start a plan to quit?
    - Gina: Well I'm ready to start thinking about a plan to quit.

DISCUSSION POINTS:

Reflecting, summarizing, and affirming are helpful in the building of motivation and confidence. It allows the patient to see him/herself as heard, validated, and valued. Applying these skills to "change talk" also gives the patient the opportunity to elaborate on and "come to believe" in the possibility of change and the how it might happen.

Reinforce the "change talk"

SUMMARIZE**:**

- "Let me see if I got it all. You're concerned about _____ because of _____. You'd like to change that risk factor and you are planning to_____. Did I get it?"

AFFIRM**:**

- "You are the type of person who takes on challenges and you are ready to take on this one!"
- Sample Video:
    - Doctor: So, it sounds like you have a lot of reasons why you'd like to quit, you have been successful quitting in the past, and right now you're just feeling a little bit hesitant about your ability to do it. Where do you think we should go from here?
    - Patient: I don't know. I'd like some help. I just don't really know what kind of help I need.

- Doctor: Sure, well, if you'd be interested that is something I can definitely talk to you about. There are a lot of new options that can help people be way more successful at their attempt at quitting. There's different medications you can try.
- Patient: I don't like medicine.
- Doctor: Okay, there are also a lot of support groups and classes you can take, where you have other people to go through it with you and sometimes just having that support can be a big part of it and especially for people like you where smoking is such a stress reliever.
- Patient: That sounds nice, but I'm not sure if I have the time for all that.
- Doctor: Sure, it feels like something that would take up a lot of time and maybe not fit into your life. I wonder if we could talk about some options that might fit into your life.
- Patient: That would be really nice.
- Doctor: Okay, well if you're willing, then we could set up another appointment where you could come in and we could talk more about that.
- Patient: I would like that. That would be great.
- Doctor: Great.

(Video Courtesy of Dr. Lisa Merlo, University of Florida Department of Psychiatry. Funded by a grant from the Flight Attendant Medical Research Institute)

DISCUSSION POINTS:

Reflecting, summarizing, and affirming are helpful in the building of motivation and confidence. It allows the patient to see him/herself as heard, validated, and valued. Applying these skills to "change talk" also gives the patient the opportunity to elaborate on and "come to believe" in the possibility of change and the how it might happen.

There are also many "virtual" support communities online that can be helpful.

This presentation has focused on smoking, but motivational interviewing is also relevant and useful for other behavior modification objectives:

- Nutrition
- Physical Exercise
- Medication Adherence
- Weight Control
- Self-management of chronic illness
- Alcohol/Substance Abuse

Time & Money

- Brief interventions of 3 minutes can be integrated into a routine visit, or longer separate counseling sessions can be scheduled
- There may be ways to bill for these brief interventions

SOURCE;

(1) Americans in Motion-Healthy Interventions (AIM-HI) Practice Manual. Available at: http://www.aafp.org/online/en/home/clinical/publichealth/aim/resources.html.

Get Paid (Reimbursement)

There are diagnosis codes for obesity (278.00, "Obesity, unspecified"), morbid obesity (278.01) and overweight (278.02). However, payment for these diagnoses is very limited. Some insurance carriers routinely deny claims with a primary diagnosis of obesity or overweight. The most consistent way to get payment for the services you provide is to bill for the management of the numerous co-morbidities associated with overweight and obesity. If the chief purpose of the visit is to manage co-morbid conditions, the codes for the conditions should be listed first. Some private insurers will pay for medically necessary physician supervision of weight reduction programs if members have a documented history of failure to maintain a reasonable weight and BMI, or if the member has specific co-morbidities. You should check with payers before billing for this. Some private insurers consider nutritional counseling medically necessary for chronic disease states in which dietary adjustment has a therapeutic role. The counseling must be prescribed by a physician and furnished by a licensed health professional recognized under the plan. Again, consult with individual payers before providing this service.

Communicate with payers proactively to find out if they will pay for preventive and problem-oriented services provided on the same date. Medicare requires that you deduct the amount of the problem-oriented service from the cost of the preventive service provided on the same date. If an insurer won't pay for both the preventive and problem-oriented service, you may want to report only the one that is the primary focus of the visit and requires the greatest amount of your time. Another option, if the condition doesn't require immediate attention, is to complete the preventive services exam and have the patient schedule a follow-up visit to address the problem.

Medicare Preventive Services - 2011

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Cardio-vascular Disease Screening	80061 – Lipid panel; 82465 – Cholesterol, serum or whole blood, total 83718 – Lipoprotein, direct measurement; HDL cholesterol 84478 - Triglycerides	Contact local Medicare Contractor for guidance	Excludes beneficiaries with cardiovascular disease	Once every 5 years	No copayment/ coinsurance
Diabetes Screening Tests	82947 – Glucose; quantitative, blood (except reagent strip) 82950 – Glucose; post glucose dose (includes glucose) 82951- Glucose; tolerance test (gtt), 3 specimens (includes glucose	Contact local Medicare Contractor for guidance	Excludes beneficiaries with diabetes	Based on scre results, may b eligible for up two screening each year	No copayment/ coinsurance

Diabetes Self-Management Training (DSMT)	G0108 – DSMT, individual session, per 30 minutes G0109 – DSMT, group session (2 or more), per 30 minutes	No specific code Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes Physician must certify that DSMT is needed	• Up to 10 hours of initial training within a continuous 12-month period • Subsequent years: Up to 2 hours of follow-up training each year after the initial year	Copayment/ coinsurance Deductible
Medical Nutrition Therapy (MNT)	97802, 97803, 97804, G0270, G0271 Services must be provided by registered dietitian or nutrition professional	Contact local Medicare Contractor for guidance	Medicare beneficiaries diagnosed with diabetes or a renal disease	• 1st year: 3 hours of one-on-one counseling • Subsequent years: 2 hours	No copayment/ coinsurance

SOURCE:
(1) "Your Guide to Medicare's Preventive Services," Centers for Medicare & Medicaid Services, 2011. Available at: http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf.
Billing Based on Time

If you spend more than half of the face- to-face time with a patient in counseling and coordination of care activities, the level of evaluation and management service provided may be chosen based on time. Counseling is defined as discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Thus, time spent with the patient discussing the potential benefits of lifestyle changes that may lessen the risks associated with or help in the management of their diagnosed condition would be considered counseling. Patients may be seen in follow up visits by staff, incident to the clinician, for services such as recheck of blood pressure. These follow up visits may be reported with code 99211 as long as they are medically necessary.

Billing for Preventive Services

Many insurers pay for preventive medicine service visits. These can include a risk factor review; an age and gender appropriate history (personal, social, and family) and exam; and counseling and guidance to reduce risk factors. A preventive service visit provides a prime opportunity to counsel patients on nutrition and physical activity. A preventive services visit is not problem-oriented and does not involve a chief complaint. If, during the preventive visit, your patient presents a significant new complaint or a chronic condition that requires you to perform the key components of a problem-oriented visit, then you can use both a preventive visit code and a problem-oriented visit code. The problem oriented service should be clearly documented and distinct from the documentation of the preventive service, and you should append modifier 25, "significant, separately identifiable E/M service by the same physician on the same day" to the appropriate office visit code. Link the appropriate ICD-9 code to the applicable CPT code to distinguish between preventive and problem-oriented services.

Communicate with payers proactively to find out if they will pay for preventive and problem-oriented services provided on the same date. Medicare requires that you deduct the amount of the problem-oriented service from the cost of the preventive service provided on the same date. If an insurer won't pay for both the preventive and problem-oriented service, you may want to report only the one that is the primary focus of the visit and requires the greatest amount of your time. Another option, if the condition doesn't require immediate attention, is to complete the preventive services exam and have the patient schedule a follow-up visit to address the problem.

Preventive Services Covered Without Patient Cost-Sharing in Private Health Plans – 2011 Health Reform

- Cardiovascular health
    - Hypertension screening (adults 18+)
    - Lipid disorders screenings (women 45+; younger adults at high risk)
    - Aspirin (women 55-79)
- Obesity
    - Screening (all adults)
    - Counseling and behavioral interventions (obese adults)
    - Body mass index (BMI)
- Type 2 Diabetes screening (adults w/ elevated blood pressure)
- Tobacco counseling and cessation interventions (all adults)
- Intensive healthy diet counseling (adults w/high cholesterol, CVD risk factors, diet-related chronic disease)

SOURCE:
(1) Kaiser Family Foundation (2011). "Preventive Services Covered by Private Health Plans under the Affordable Care Act." Available at: http://www.kff.org/healthreform/8219.cfm.

Final Commitment

- From what you've learned today, what is at least one thing that you will change to help your women patients reduce their risk of heart disease?

The Heart Truth Professional Education Campaign Website
www.womenshealth.gov/heart-truth

Million Hearts Campaign Website
millionhearts.hhs.gov
"Get involved and share your commitment to help prevent 1 million heart attacks and strokes in the next five years."