

Improving Self-Efficacy in Heart Failure Patients Through Motivational Interviewing

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Abstract

Problem & Purpose Heart failure (HF) patients account for a large percentage of 30-day readmissions to the hospital which can produce grim consequences for both the institution as well as the patient. On the Progressive Care unit (PCU) at an academic medical center the HF readmission rate was close to 29% for fiscal year 2018. Literature supports the use of motivational interviewing (MI) for the improvement of self-efficacy and confidence in completing self-care in patients with HF. By improving self-efficacy patients can more successfully manage their HF at home, thus keeping them out of the hospital and promoting positive outcomes long-term.

Methods In July/August of 2019, 30 patients with HF on the PCU were surveyed using the Self-Care Index of Heart Failure (SCHFI) tool twice during their admission. Once toward the beginning and then again prior to discharge. This was done to evaluate the growth in their confidence level over their inpatient stay. Upon completion, nursing staff participated in hybrid format MI training including both in-person and online components. Participants were surveyed pre- and post-training to measure their MI communication skills. Following the trainings, nursing competency was assessed in MI. In November/December post-surveys were completed for 30 new HF patients on the PCU completed in the same way as the pre-surveys, with the confidence section of the SCHFI tool at two points in their admission. A paired t-test was used to test the significance of improvement.

Results Statistically significant improvement was seen in MI communication skills from pre-training (6.6/10) to post-training (8.6/10) using paired t test ($p=0.0035$). There was also a statistically significant improvement in likelihood to use effective communication skills pre-training (1.8/5) to post-training (2.4/5) ($p=0.0216$). There was statistically insignificant improvement in confidence growth in patients cared for by MI-trained nursing staff ($M=3.77$, $SD=3.65$) ($t=2.99$, $p=0.02$) than pre-MI-trained nursing staff ($M=4$, $SD=2.60$).

Conclusion Reducing readmissions by improving the confidence in HF patients will promote more positive patient outcomes overall. Reducing hospital length of stay and improving the current readmission rate of 29% on the PCU, contributes to a culture of patient safety and high-quality patient care overall.

Introduction

Heart failure (HF) is a chronic condition impacting more than 5.7 million people in the United States (US). This can equate to a 39.2-billion-dollar cost to the country annually (Creber, et al., 2016). In order to successfully manage HF in the outpatient setting, patients must commit to maintaining a healthy lifestyle including adherence to a medication regimen, or risk grim consequences. Readmissions to the hospital and ultimately a lower quality of life are two of the negative impacts of poorly managed HF (Zomahoun et al., 2017). When patients are faced with disparities and a lack of support, it can become even worse. At a local academic inpatient facility, HF remains a major source of economic threat and quality impairment. With a readmission rate among HF patients within 30 days of discharge being 26% as of February of 2019, the hospital is facing major financial consequences as well as reputation compromise. Although it is hard to quantify the cost to the hospital of a single HF readmission, the price tag on readmissions over the course of a year for this institution is near three-million dollars (CS, personal communication, February 13, 2019). Evidence supports the need for lifestyle behavior changes as key to the success of managing chronic conditions in the outpatient setting (Linden, Butterworth, & Prochaska, 2010).

Motivational interviewing (MI) is defined as collaborative dialogue between a provider and a patient with the goal to strengthen the patient's motivation and commitment to lifestyle changes (Zomahoun et al., 2017). It is engaging, focusing, evoking, and planning through a dialogue focusing on what motivates the patient to create a change in behavior. Such strategies had originally been used to aid and support patients with drug addiction beginning in 1995 (Zomahoun et al., 2017). It has since been used to help individuals stop smoking, make lifestyle changes to manage chronic conditions, and even lose weight (Zomahoun et al., 2017).

Hospital readmissions within 30-days of discharge are a problem for the institution. HF patients account for a large percentage of these readmissions. Literature supports the use of MI for the improvement of self-efficacy and confidence in self-care in patients with HF. By improving self-efficacy patients can more successfully manage their HF at home, thus keeping them out of the hospital and promoting positive outcomes long-term (Creber et al., 2015).

Literature Review

The evidence to support MI as a technique to deliver patient education to individuals living with chronic HF is the topic of this literature review. Six articles were reviewed and shared the common theme supporting MI to improve patient outcomes including confidence level, self-management, and readmissions. Zomahoun et al. (2017) assessed the effectiveness of MI on medication adherence in chronic diseases through a meta-analysis. The 16 studies included were randomized control trials (RCTs) focusing on the effectiveness of MI on medication adherence. The pooled effect size for the 16 included was 0.23 ($P=0.003$). The effect size of the synthesis proposes that there is a very small albeit positive (Zomahoun et al., 2017). In a quasi-experimental study completed in 2010 the impact of MI on chronically ill participants was explored. A health risk assessment survey was filled out by 106 participants prior to enrolling in the program and then again after 8 months. The program consisted of telephone conversations and follow-up face-to-face sessions conducted by a trained MI coach. When compared to the control group, the treatment group yielded improvements in 4 out of 6 categories related to self-care of their chronic disease. There was an improvement (0.65 points, $P=0.01$) for the intervention group in self-efficacy scores. Another improvement (4.57 points, $P=0.02$) for the intervention group was seen in patient activation assessing the patients comfort with partnering with their provider. The lifestyle change score showed a statistically significant

improvement (1.4 points, $P=0.01$). Participants of the MI exchange were less likely to report an increase in stages of change risk ($P<0.01$) and were more likely to decrease that risk ($P=0.03$) (Linden et al. 2010). In 2015, Creber, et al. conducted a randomized control trial examining the efficacy of an MI approach for the self-care of HF. The study included 67 participants randomly assigned to control or intervention groups from a single site. The intervention group encompassed a home-based nurse visit where MI was used to identify two patient-specific goals related to the self-care of HF. The intervention included an initial encounter followed-up with 3 to 4 phone calls over a 90-day period reinforcing the goals. Self-care maintenance and confidence levels were measured using a validated tool entitled Self-Care of Heart Failure Index (SCHFI). In this measure, the intervention group improved by 8.7 points as compared to the control group ($p=0.026$). There were no statistically significant results in the physical symptoms domain ($p=0.63$) which is assessed using the Heart Failure Somatic Perception Scale (HFSPS) (Creber, et al 2015). Another randomized control trial was completed in 2016. This study assessed the impact of MI on decreasing hospital readmissions. The measurement tool was the SCHFI to assess confidence levels in the patients as a foundation for the initial MI conversation. The MI nurses were trained thoroughly and included a home visit with subsequent phone calls for reinforcement. The intervention group in this study was less likely (7.1%) than the control group (30%) to be readmitted to the hospital ($p=0.003$) (Riegel et al., 2016). A final randomized control trial was completed in Iran to determine the impact of MI on self-care in HF patients with depression. Random assignment of 82 hospitalized patients into either control or intervention group was completed. The intervention consisted of four sessions of education using the MI approach. The SCHFI tool was used at baseline and again at 8 weeks post-discharge. The specific subscales of the SCHFI that showed statistically significant improvements were the

maintenance, management, and confidence in self-care behaviors for the MI group (mean = 23.61, SD= 5.87, $p=.0001$) as compared to control group (mean= 6.59, SD= 5.11) (Navidian et al., 2017). Please refer to Appendix A for a complete review of the evidence.

Whether assessing the effects of MI on HF outcomes, or other chronic conditions, the theme remains that all research examined for this literature review is supportive of the MI technique. In three of five articles (Creber, et al.; 2015, Riegel et al.; 2016, Navidian et al., 2016), the effect of MI on HF self-management specifically was investigated. Two of the five articles used the SCHFI tool as the main outcome measure (Creber, et al., 2015; Navidian et al., 2016), while the third HF article looked into readmissions (Riegel et al., 2016). The small sample sizes within the HF articles posed a limitation (Creber, et al., 2015; Riegel et al., 2016; Navidian et al., 2016), The first two articles reviewed were general however the central theme of MI remains, and concepts of self-care maintenance, symptom perception, and management can be applied globally to the chronic conditions at hand (Zomahoun et al., 2016; Linden, et al., 2010).

Theoretical Framework

The Theory of HF Self-Care is a very specific theory that was utilized to implement the MI technique to improve patient outcomes (Riegel, Dickson & Faulkner, 2016). This theory is based on three major concepts. The first concept of self-care maintenance is specific to treatment plan adherence and healthy behaviors. The next concept, symptom perception is related to recognition and assessment of symptoms. The final concept is management which is defined by the response to the HF symptoms experienced (Riegel, Dickson & Faulkner, 2016). Confidence in self-care is pivotal to the success in all of the three concepts that serve as the foundation of the Theory of HF Self-Care (Riegel et al., 2016).

According to the Theory of HF self-care, a strong level of confidence in self-management is vital to the success of both self-care management and maintenance (Riegel et al., 2016). An MI approach is supported by the literature to improve confidence in self-management among HF patients (Paradis, Cossette, Frasure-Smith, Heppell, & Guertin, 2010). MI is made up of four key principles. These key principles include the nurse: expressing empathy, introducing doubt about the behaviors needing change, explaining consequences of said behavior, being adaptable to the patient's resistance, and reinforcing the patient's self-efficacy (Paradis et al., 2010). These key principles are combined with a client-centered counseling approach to assess readiness to change and develop strategies to create those behavioral changes. Pairing MI with the Theory of HF self-care created a framework for staff to understand the impetus behind their efforts, and has allowed them to see a bigger picture for their everyday interactions utilizing the MI model (Paradis et al., 2010).

Methods

This quality improvement project took place on the 28-bed PCU in an urban academic medical center. In the months of July and August, thirty HF patients on the PCU were surveyed within 24 hours of admission and then again after day three of admission to measure their confidence in their HF self-management. The growth in their confidence was noted. In the end of August into early September the nursing staff was trained in MI. The training was facilitated by a credentialed MI trainer and consisted of two hours of online modules followed by a four hour in-person education. See Appendix B for course objectives. After competency was assessed and confirmed for the nursing staff in the months of October and November, another convenience sample of 30 patients was surveyed within 24 hours of admission and then again after day three of admission to measure their confidence growth. That second series of surveys took place in

December and January. The average LOS of HF patients on the PCU is right around 6 days. Inclusion criteria used included the patient was admitted to the Blue Cardiology team, had no plans of end-of-life care, and was alert and oriented to self, place, and time, with a diagnosis of HF. Exclusion criteria included patients on hospice, not alert and oriented to self, place, or time, and not a Blue Cardiology team patient. A paired t-test was completed to analyze the difference in self-confidence growth in hospitalized HF patients being cared for by PCU nurses pre-MI training to post-MI training.

Results

Overall, 96% of PCU nurses (n=43) participated in MI training while 15 out of 28 PCTs completed the training. See Table 1 for graph of each patient surveyed growth in confidence score. Refer to Appendix C for the survey, section C only, that was administered to patients for this initiative. Permission was granted prior to surveying the patients by Dr. Barbara Riegel, creator of the SCHFI test, to use the confidence section only. The paired t-test showed that there was a statistically insignificant difference in confidence growth ($t=2.99$, $p=0.02$) for patients that were cared for by a nursing staff trained in MI as compared to nursing staff that was not. Nursing staff was also surveyed for their attitudes toward MI and patient education pre-training and upon completion of the MI training. There was a statistically significant improvement in MI communication skills from pre-training (6.6/10) to post-training (8.6/10) ($p=0.0035$). There was a statistically significant improvement in likelihood to use effective communication skills pre-training (1.8/5) to post-training (2.4/5) ($p=0.0216$). On average, the PCU's Blue Cardiology team discharges 17.91 patients with a diagnosis of HF per month. This means that the nurses utilizing MI have potentially impacted 18 patients a month (assuming they

are all alert and oriented and not in hospice care) and could contribute to improving their confidence in the self-management of their HF.

Barriers existed that were responsible for the project not being as successful as expected. Those barriers included a short time-frame for the data collection. Additionally, lack of resources to be able to follow up with the same patient two different points in time (without using MI and then again once using MI). Some facilitators include the resource of having a single surveyor to deploy all 120 surveys (30 patients at two points in time pre- and 30 patients at two points in time post-training). Additionally, it was helpful that the MI trainer was a resource that came to the institution free of cost. The only costs that were incurred were related to paying the staff for their time spent in the training. Due to the support from the Vice President of Care Management who had a vested interest in this topic as it related to 30-day readmissions, we were able to cover the labor costs through a public health budget.

Prior to the implementation of the MI training initiative, some structures needed to improve. For example, there was previously no consistent source of truth to be able to correctly identify patients who had HF. As a result, a HF systems list was created. This was a central repository that could be filtered down by unit that had any patient that had been coded with a diagnosis-related group code of heart failure or a related diagnosis (volume overload, fluid overload, acute decompensated heart failure etc.). There were some processes that needed changing as well. These included the nursing staff's knowledge and skillset (or lack thereof at the time) of delivering HF education using MI. This was addressed through the training both online and in-person. Another thing that was changed through the MI training was the nurse's confidence in delivering HF education which was vital to implementation success. Lastly, a process measure that supported the project was a question on the Hospital Consumer Assessment

of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey. This question was “Hospital staff took my preference into account.” This is something that we predicted could be impacted by the use of MI. The baseline data for the last quarter that included no months where nursing staff had MI training was April-June 2019 where 60% of patients responding “Always” to this question. The quarter that included October through December, all of which were post-training months, the percentage of patients responding “Always” was 55.8.

Discussions

This quality improvement project provides some initial support for the use of Motivational Interviewing to improve the self-confidence in HF patients. Patients involved in this quality improvement initiative who received education by using the motivational interviewing technique yielded a greater improvement in confidence scores over the course of their admission when comparing mean values for each group. However overall long-term goal of the project was not met. The short-term goal was, which included training the staff in MI and improving their attitudes toward the technique. In 2015, Creber et al. yielded an improvement in SCHFI scores, however not statistically significant. Their intervention included a home health nurse that came in some sort of contact with the patients 3 to 4 times over a 90-day timeframe. This allowed for continuity and reinforcement. In this quality improvement project, both continuity and reinforcement were lacking and could have yielded an even more significant impact if present. Linden et al., 2010 was able to capitalize on continuity as well, by following-up with participants after 8 months. This study also included a large sample size of 230 participants. They were, however, able to see statistically significant results in 4 out of 6 categories. Future quality improvement related to MI should include a way to remain in contact with the HF patient to provide continuity as well as reinforcement.

One major strength of this quality improvement initiative was the institutional support. Providing the budget for training, as well as the trainer and materials was a huge contribution to the success. The trainer came on site for all five training sessions offered which yielded a higher participation rate from the staff. The trainer has continued working with identified champions to contribute to the sustainability of this improvement as well. Additionally, all resources for the champions are provided free of cost due to a hospital partnership with the patient engagement program (PEP) and the MI trainer.

With a small sample size as well as short timeframe, we are unable to generalize any findings from this quality improvement initiative. There could also be some variations among the nurses when utilizing MI. Although staff competency was assessed and confirmed, there is no way currently to track which patients and how often received MI technique from their care team. Levels of cognition in patients can also vary which can result in a decrease in the reliability of the data collected. In order to address bias and minimize any further limitations the surveys were administered by a single surveyor, and someone that is not currently a PCU bedside nurse.

Conclusion

In order to maintain the momentum achieved from the MI quality improvement initiative, sustainability has been considered. One way to ensure sustainability was to add MI to the competency-based orientation for new hires to the PCU. This is now a mandatory concept to cover during the 16-week orientation. Currently new hires go through a four-hour patient education one-on-one teaching session while on orientation. The MI program and related concepts, in a shortened version, are presented here for all new hires as a result of this quality improvement initiative. It is also being considered for the PCTs. We are utilizing a train the trainer so that we may keep MI and the principles of this initiative renewed for the PCU staff.

The champions are participating in a quarterly call, and facilitating monthly activities provided to them by the MI trainer/coordinator. This is to maintain the idea of MI in everyone's minds as well as daily practice. Once they are brought up to a level where they can successfully train staff, we will have the champions offer classes to bring the rest of the PCTs up-to-date with training. As a unit, we also give a brief education to any travelers, agency or float pool staff that may be delivering care on the PCU. Additionally, a longer-term goal is to have the provider teams trained in MI to maintain consistency in the delivery of care at a multidisciplinary level. Care management team including Case Managers and Social Workers have MI as part of their onboarding. The patient communication boards have been identified as a way to communicate across shifts the most important things to the patient, and as a way to reinforce patient education utilizing MI at every interaction possible.

In the future, a quality improvement project could be done including the continuity and reinforcement present in studies done by Linden et al. and Creber et al. to attempt to yield a significant impact on confidence growth of HF patients on the PCU. These findings will be disseminated throughout the institution and a recommendation will be made to make MI training a mandatory component of the onboarding process for any direct-care staff. Justification for this will be the increase in the staff's attitudes and feelings toward the MI technique and patient education as a whole as a result of the training. The use of MI technique to improve confidence in the HF patient population has the potential to reduce the hospital's 30-day HF readmission rate and thus improve quality of care, patient outcomes, and the overall financial state of the institution.

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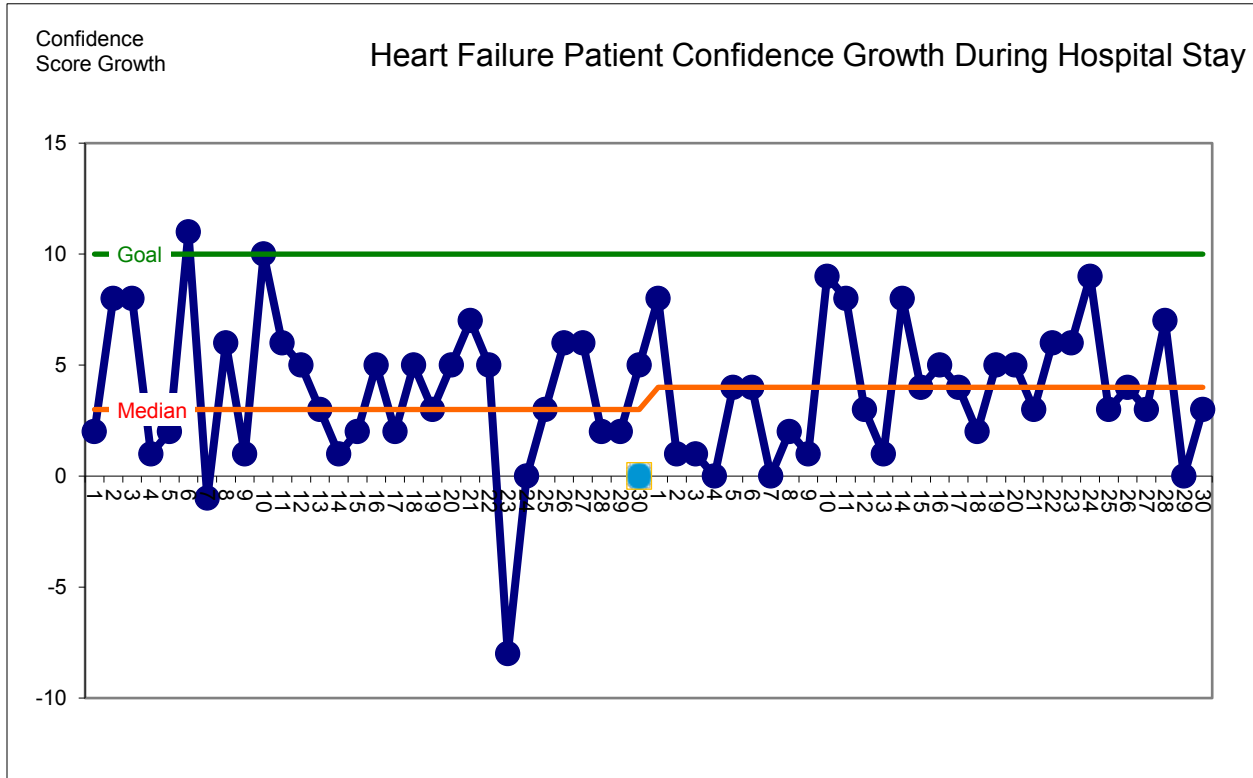
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Figure 1. Growth in Confidence Score Throughout Inpatient Hospitalization by Patient



Appendix A
Evidence Review Table

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Zomahoun, Guenette, Gr egoire, Lauzier, Lawani, Ferdynus, Hyuart, Moisan, (2016)	To assess the effectiveness of MI in enhancing medication adherence in adults with chronic conditions.	Meta-analysis	16 randomized control trials (RCTs) including 4221 participants	Self-report (14 studies) Medication Event Monitoring Systems (3 studies) Pharmacy (1 study) 1 study included all three sources.	The synthesis of RCTs concluded that MI interventions may be effective in improving medication adherence in chronically ill adults. There is a need for further research as the effect size was small. Limitation: Only addressing one component of self-management in chronic conditions. Another limitation is that the chronic conditions considered are many, and the meta-analysis is not exclusive to HF.	I B
Linden, Butterwort, Prochaska, (2010)	To assess the impact of motivational interviewing-based health coaching on chronically ill employees at a health care facility as compared to non-participants.	Quasi-experimental A large medical university in the North-West region of the United States. Health coaching delivered utilizing MI technique.	Out of 8500 employees, the selection was based on those with chronic illnesses that took the survey both times and participated in health coaching (N=106). The control group had a chronic illness and completed the survey twice but did not participate in health coaching (N=230).	HRA comprised of several different validated tools. -Self-efficacy for managing chronic illness -EQ-5D -PAM Survey taken prior to enrollment and again after 8 months	Program patients improved: Self-efficacy (p=0.01), patient activation (p=0.02), lifestyle change score (p=0.01), and perceived health status (p=0.03). Findings support the use of MI used in health coaching in improving self-efficacy as well as readiness to change in chronically ill patients. Limitation: Not exclusive to HF patients.	VI B
Creber, Patey, Lee, Kuan,	To evaluate the effectiveness of motivational	RCT Prospective, single-blinded	N=67 participants	Self-care: SCHFI tool a 22-item self-report questionnaire	This study indicated a clinically significant improvement (p=0.026) in self-care among HF patients as a	II A

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Jurgens, Riegel, (2015)	interviewing on HF self-management, symptoms, and quality of life.	Setting: University affiliated urban hospital Inclusion criteria: hospitalized with diagnosis of HF, read/speak English, >18 years old, independent in self-care, within 30 miles of University hospital, adequate health literacy, symptomatic HF Exclusion criteria: Current treatment of milrinone, heart transplant list or VAD, pregnancy, psychosis, cognitive impairment inability to consent.	n=153 were assessed for eligibility. Patients were randomly assigned to a group by 2:1 intervention to control ratio. Control Group n=30 Intervention Group n=49	that measures HF self-efficacy. Symptoms: HF Somatic Perception Scale (HFSPS) 13 questions measuring distress related to common HF symptoms. Quality of life: Kansas City Cardiomyopathy Questionnaire (KCCQ) 23-item instrument addressing 5 domains including physical limitations, symptoms, quality of life, social interference, and self-efficacy.	result of MI. A nurse-led MI intervention is supported as a result of this study. Self-care: 8.7-point increase in intervention group (p=0.026) No statistically significant difference in improvement in self-care confidence between groups (0.31) Acute physical HF symptoms: No differences between groups (0.63). Quality of life: No statistical significance between groups (p=0.36). Limitations: long duration gave participants opportunity to drop out. Not a statistically significant improvement.	II B
Riegel, Creber, Hill, Chittams, Hoke (2016)	To assess the effect of MI on decreasing hospital readmissions in heart failure patients.	Prospective, single-blinded, RCT Setting: A university-affiliated urban hospital Inclusion: Diagnosis of chronic, symptomatic HF as	100 patients enrolled with 2:1 randomization to intervention group (n=70) to control group (n=30).	Health care utilization data extracted from the medical record	Readmissions related to multimorbidity were significantly lower in the intervention group (7.1%) than the control group (30%, p=0.003). Limitation: only able to include readmissions for primary site with complete confidence.	II B

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Navidian, Mobaraki, Shakiba (2016)	To assess the effectiveness of MI on self-care behaviors in HF patients with depression.	<p>assessed by New York Heart Association functional class, able to read and speak English, > 18 years old, able to self-care, within driving distance of research office.</p> <p>Exclusion: Current treatment of mitrinone, heart transplant list or VAD, pregnancy, psychosis, cognitive impairment inability to consent.</p>	Convenience sample of 82 randomly assigned to control group (n=41) vs intervention group. (n=41)	SCHFI tool	Confidence scores improved significantly in the intervention group over the control group (p<.05). Limitations: Not US-based, specific subset of HF patients (depression).	II A

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
		of addiction or drug abuse, no participation in other rehab or educational programs.				

HF= Heart Failure, MI = Motivational Interviewing, HRA= Health Risk Assessment, EQ-5D= EuroQoL 5-dimension, PAM= Patient Activation

Measure, SCHFI= Self-Care Heart Failure Index, ED= Emergency Department, VAD= Ventricular assistive device, EF=Ejection fraction

***Rating System for Hierarchy of Evidence**

- Level of the Evidence Type of the Evidence
- I (1) Evidence from systematic review, meta-analysis of randomized controlled trails (RCTs), or practice-guidelines based on systematic review of RCTs.
- II (2) Evidence obtained from well-designed RCT
- III (3) Evidence obtained from well-designed controlled trials without randomization
- IV (4) Evidence from well-designed case-control and cohort studies
- V (5) Evidence from systematic reviews of descriptive and qualitative studies
- VI (6) Evidence from a single descriptive or qualitative study
- VII (7) Evidence from the opinion of authorities and/or reports of expert committees

Melnik, B.M. & Fineout-Overholt, E. (2014). *Evidence-based practice in nursing & healthcare: A guide to best practice* (3rd ed.). New York: Lippincott, Williams & Wilkins.

Rating Scale for Quality of Evidence

- A: High – consistent results with sufficient sample, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific literature
- B: Good – reasonably consistent results; sufficient sample, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
- C: Low/major flaw – Little evidence with inconsistent results; insufficient sample size; conclusions cannot be drawn

Appendix B Lesson Plan

Patient Engagement Training Summary



Part 1

PET Core Principles: PACE

- Partnership: Working together and in-consultation with the person
- Acceptance: Respecting the person's autonomy, resourcefulness, ability to choose
- Compassion: Showing empathy and respect
- Evocation: Listening more than telling; understanding and building on their values

Readiness to Engage- People vary, each encounter moves them toward or away from health

- Ambivalence - "Lack of engagement" is often ambivalence
 - Want to look for reasons WHY the patient might want to make a change – these always exist within the person
- If you argue for one side, an ambivalent person is likely to defend the other
 - So, if you try to convince the person to make a change, they will give you all the reasons to NOT make a change
- As a person defends the status quo, the likelihood of change decreases
- Resist the "righting reflex" – the desire to tell people the correct choice

Part 2

PET Core Skills: OARS

- OPEN questions, ask them - not short-answer, yes/no, or rhetorical questions
- AFFIRM the person - comment positively on strengths, effort, intention and what that says about who they are
- REFLECT what the person says - "active listening"
- SUMMARIZE - draw together the person's own perspectives on engagement and change

Part 3

Applying Core Principles and Skills

- Reflective Listening: A Valuable Skill
 - A reflection seeks to summarize what the person means; it makes a guess; good reflection is a statement, not a question
 - Levels of reflection
 - Repeat - Direct restatement of what the person said
 - Rephrase - Saying the same thing in slightly different words
 - Paraphrase - Making a guess about meaning; continuing the paragraph;
 - Emotion reflection - adds something that was not said directly
 - Double-sided reflection - Capture the ambivalence (.. AND ...)
- Support Engagement
 - Interact in a way that invites the person to make the arguments for change or engagement

Eliciting Engagement Talk

- The simplest way: Ask for it, in open questions to elicit desire, ability, reasons, need
 - In what ways* would it be good for you to . . . ?
 - If you did decide to . . . , how would you do it?
 - What would be the good things about . . . ?
 - Why would you want to . . . ?
- The balance: What are the good things about . . . And what are the not so good things?
- Looking forward
 - If you don't make any change, what do you think will happen?
 - Where would you like to be in ___ years? What do you hope will be different?
 - And how does ___ [smoking] ___ fit into that?
- When you hear engagement talk, don't just sit there!
 - Reflect it - Restate it back to the person
 - Ask for examples/elaboration: When was the last time; in what ways,
 - Ask for more: What else? What other reasons?
 - Summarize - "Collecting flowers into a bouquet"

Giving Advice – avoid it

The person is more likely to hear and heed your advice if you have permission to give it.

Three forms of permission:

- The patient asks for advice
- You ask permission to give advice
- You preface your advice with permission to disagree/disregard
- Offer several options, rather than suggesting only one

Closing Summary

- Complete an interaction by giving a summary:
 - Bouquet: draw together the person's desire, ability, reasons, need theme
 - Briefly acknowledge areas of reluctance, if appropriate
 - Summarize the person's commitment strength
 - If commitment is strong, elicit/negotiate a change plan

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Learn more at our website: <https://www.johnshopkinsolutions.com/solution/pet>

Adapted from: Bill Miller

Appendix C

Data Collection Tool

SELF-CARE OF HEART FAILURE INDEX*All answers are confidential.***SECTION C:**

In general, how confident are you that you can:

	Not Confident	Somewhat Confident	Very Confident	Extremely Confident
1. <u>Keep yourself free of heart failure symptoms?</u>	1	2	3	4
2. <u>Follow the treatment advice</u> you have been given?	1	2	3	4
3. <u>Evaluate the importance</u> of your symptoms?	1	2	3	4
4. <u>Recognize changes</u> in your health if they occur?	1	2	3	4
5. <u>Do something</u> that will relieve your symptoms?	1	2	3	4
6. <u>Evaluate</u> how well a remedy works?	1	2	3	4