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Co-creating health in physiotherapy:
Moving beyond adherence, education and prescription

Associate Professor Nicola Kayes

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Adherence in physiotherapy

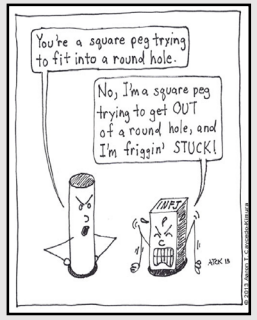
- Achieving optimal outcomes dependent on clients supplementing face to face therapy with recommended self-management strategies (e.g. Jack et al., 2010)
- But, rates of non-adherence are as high as 70% (McLean et al., 2010; Beinart et al., 2013; Peek et al., 2016)
- No matter how good physiotherapy treatments are deemed to be, they are unlikely to be effective in this context

Old news?

- Proliferation of literature since the 1990s
  - Exploring predictors of adherence
  - Developing and testing a range of adherence-promoting strategies
- Yet, the pattern remains the same….
- Why?

Some possible explanations?

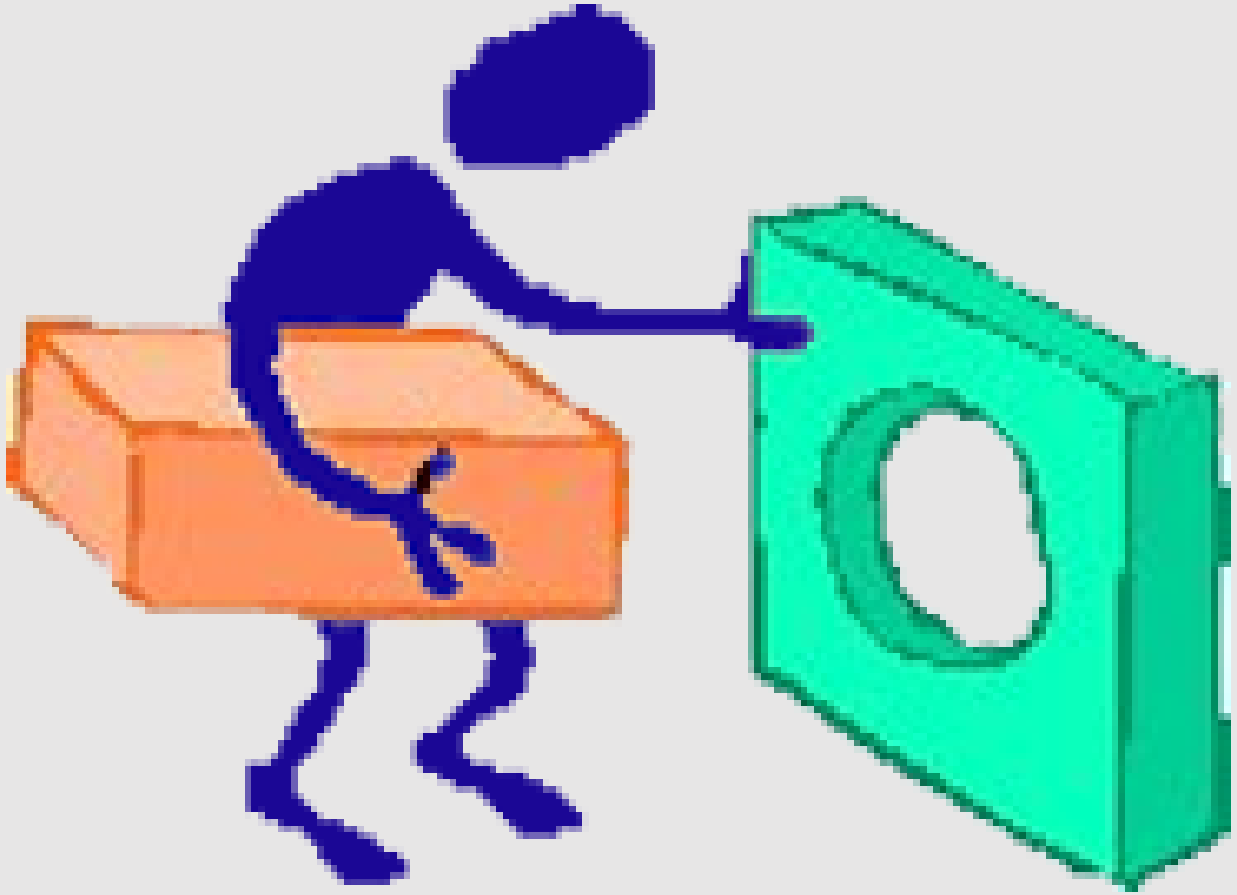
#1 Strategies most routinely used in practice are not necessarily fit for purpose



#2 Integration of alternate approaches into practice has been difficult

#3 It is possible we are looking at the problem the wrong way

#1 Strategies routinely used in practice are not necessarily fit for purpose



Adherence widely recognised to be complex and multi-dimensional…..

Marks & Allegrante, 2005	Osteoarthritis	Self-efficacy Social support Sense of progress
Jack et al., 2010	Physiotherapy outpatient clinics	Lack of positive response from therapist Low patient self-efficacy Presence of depression Poor social support Greater number of perceived barriers
Beinart et al., 2013	Chronic low back pain	Health locus of control Supervision Motivational strategies
Picorelli et al., 2014	Older adults	Health status Physical ability Cognitive ability Depression Supervision
Essery et al., 2015	Home-based physical therapy	Intention to engage in HBPT Self-motivation Self-efficacy Previous adherence to exercise-related behaviours Social support

…. yet education and prescription remain the dominant strategies

….our responsibility is to **set a programme for them** and to **educate them** on why they're doing those bits and pieces we've given to them and an idea of how often they need to be doing them so quite **clear prescription** and then from there my expectation is that they commit to that.

I think a really key thing is them buying into the concept of what they actually have to do and so **a big part of that I believe is education** so I think like **our role is really educating them** on that the fact that this is actually a long term problem…

I think from a physio perspective I think **educating the patient** in terms of the path of physiology of the condition so they understand what can be done, what their options are, and kind of the likely outcome in the end - so I think **education is kind of your number one.**

…**the education side is really important** so I remember when I was a junior physio I would've just given the exercises and said this will help you, whereas now you kind of need to make that link.

I: How do you think a patient would describe self-management?
P: **Depends how much education they've had**.

Consistent with the evidence e.g.

- Education about the benefits of exercise the most common adherence strategy used by physiotherapists in knee OA (Nicholson et al., 2016)
- 97% provide ‘verbal or written instruction for exercise’ and ‘information about condition or diagnosis’ *always* or *very often* (Forbes et al., 2017)

Looking back at the level of complexity….

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….our responsibility is to **set a programme for them** and to **educate them** on wh… doing those … we'v… need to …so quite **clear …iption** and then from there my expectation is that they commit to that.

Is education alone enough to achieve commitment?

I think a really key thing is them buyi… concept of what they actuall… …d so **a big part of that I h… …tion** so I think like **our r… …cating them** on that the … …s actually a long term problem…

Does education really achieve buy-in?

I think from a physio perspective I think **educating the patient** in t… of the path of physi… condition so t… can h… …are, …tcome in the … **education is kind of your number one.**

Does education truly account for the inherent complexity?

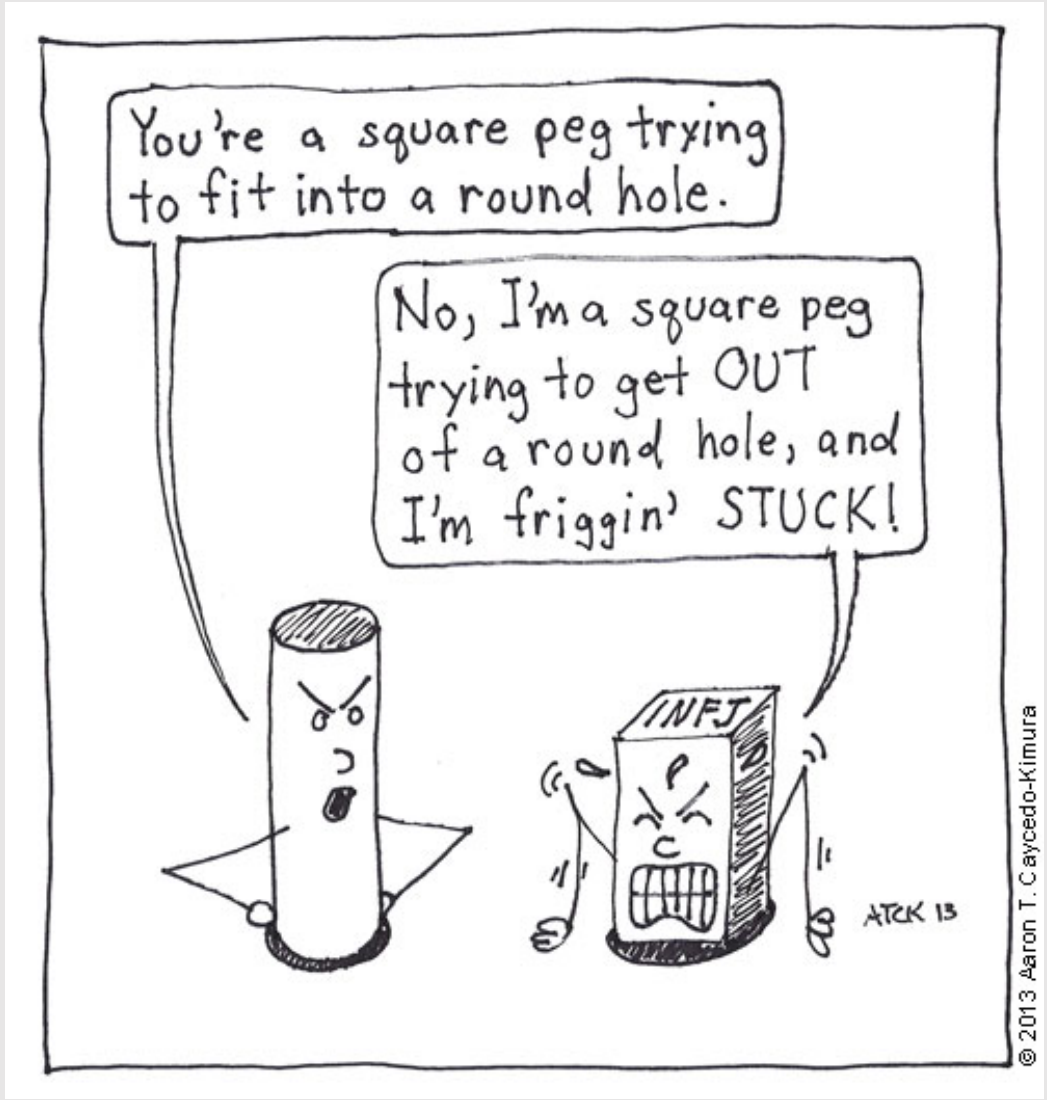
…**the education side is really important** so I remem… when I was a ju… would'… …n the …d said this will …you, whereas now you kind of need to make that link.

Have we moved far enough?

I: How do yo… …scribe self-management? …**education they've had**.

Does the practitioner hold all the relevant knowledge?

#2 Integration of alternate approaches into practice has been difficult



A combination of person-centred practice and behavioural strategies may optimise adherence (McLean et al., 2010)….

But…

Research

Physiotherapists may stigmatise or feel unprepared to treat people with low back pain and psychosocial factors that influence recovery: a systematic review

Aoife Synnott [a], Mary O'Keeffe [a], Samantha Bunzli [b], Wim Dankaerts [c], Peter O'Sullivan [b], Kieran O'Sullivan [a]

Original article

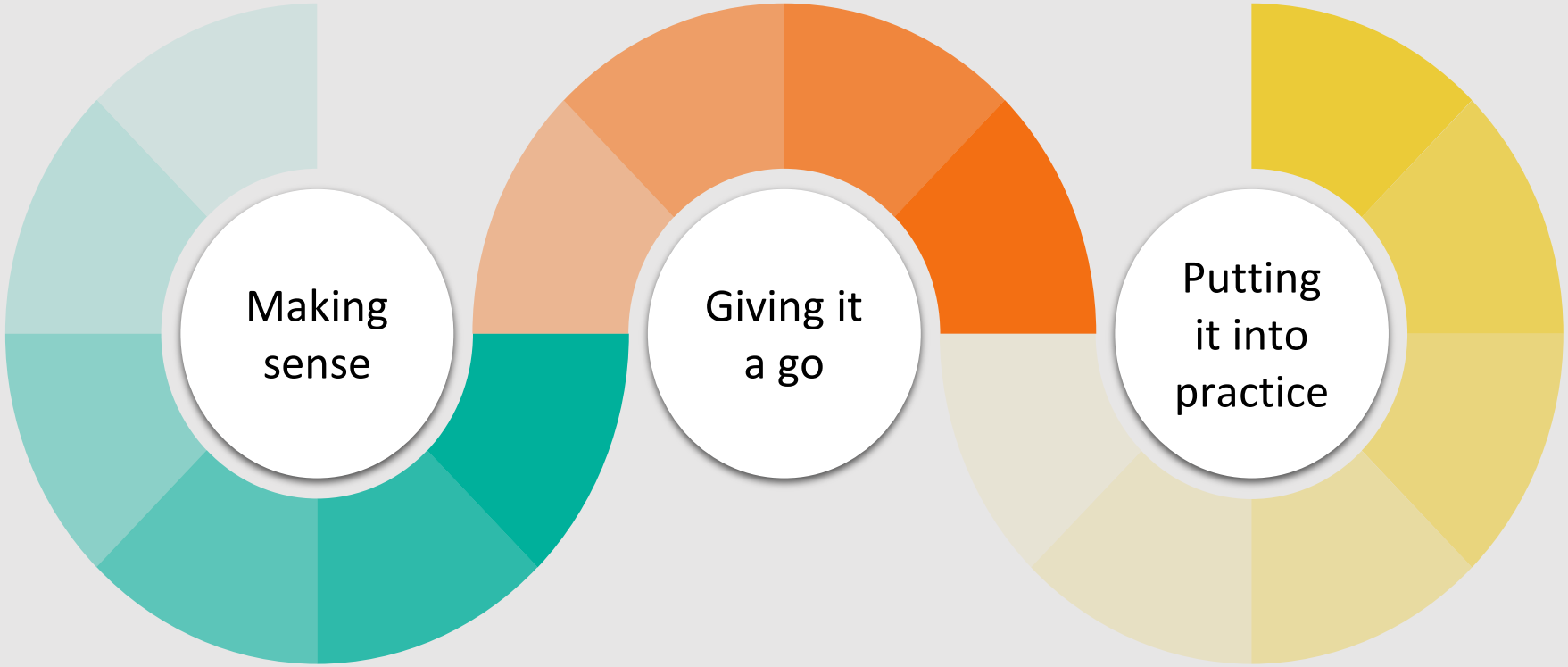
Physiotherapists' assessment of patients' psychosocial status: Are we standing on thin ice? A qualitative descriptive study

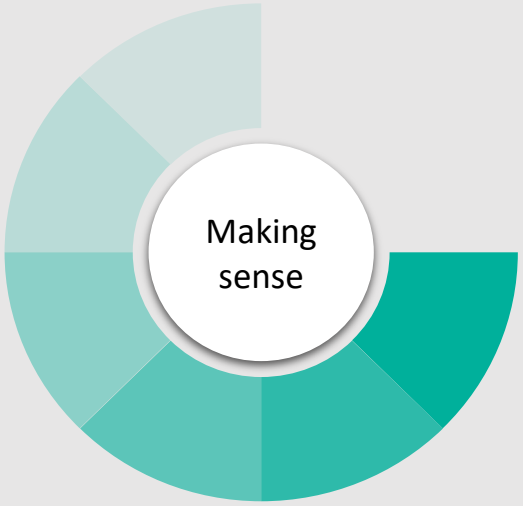
Mukul Singla*, Mark Jones [1], Ian Edwards [2], Saravana Kumar [3]

Knowledge, behaviors, attitudes and beliefs of physiotherapists towards the use of psychological interventions in physiotherapy practice: a systematic review

Christina Driver, Bridie Kean, Florin Oprescu & Geoff P. Lovell

Integrating new ways of working into practice is complex





CONDITIONS
- Perceived value/need
- Service structures
- Knowledge broker

INTER/ACTIONS
- Gathering information
- Contextualising knowledge
- Finding fit

CONSEQUENCES/ CONDITIONS
- Consolidating
- Developing coherence
- Seeing the possibility

"I think that's - I use **wishy washy** - it's probably not a very descriptive word but it just seems like it's **not so physio related** and it's not**, it feels like it doesn't go with what I do in my job**"

CONDITIONS
- Knowledge broker
- Simple/intuitive
- Perceived expectations

INTER/ACTIONS
- Looking for opportunities
- Testing the water
- Slipping it in

CONSEQUENCES/ CONDITIONS
- Developing Capability
- Recognising value
- Tailoring

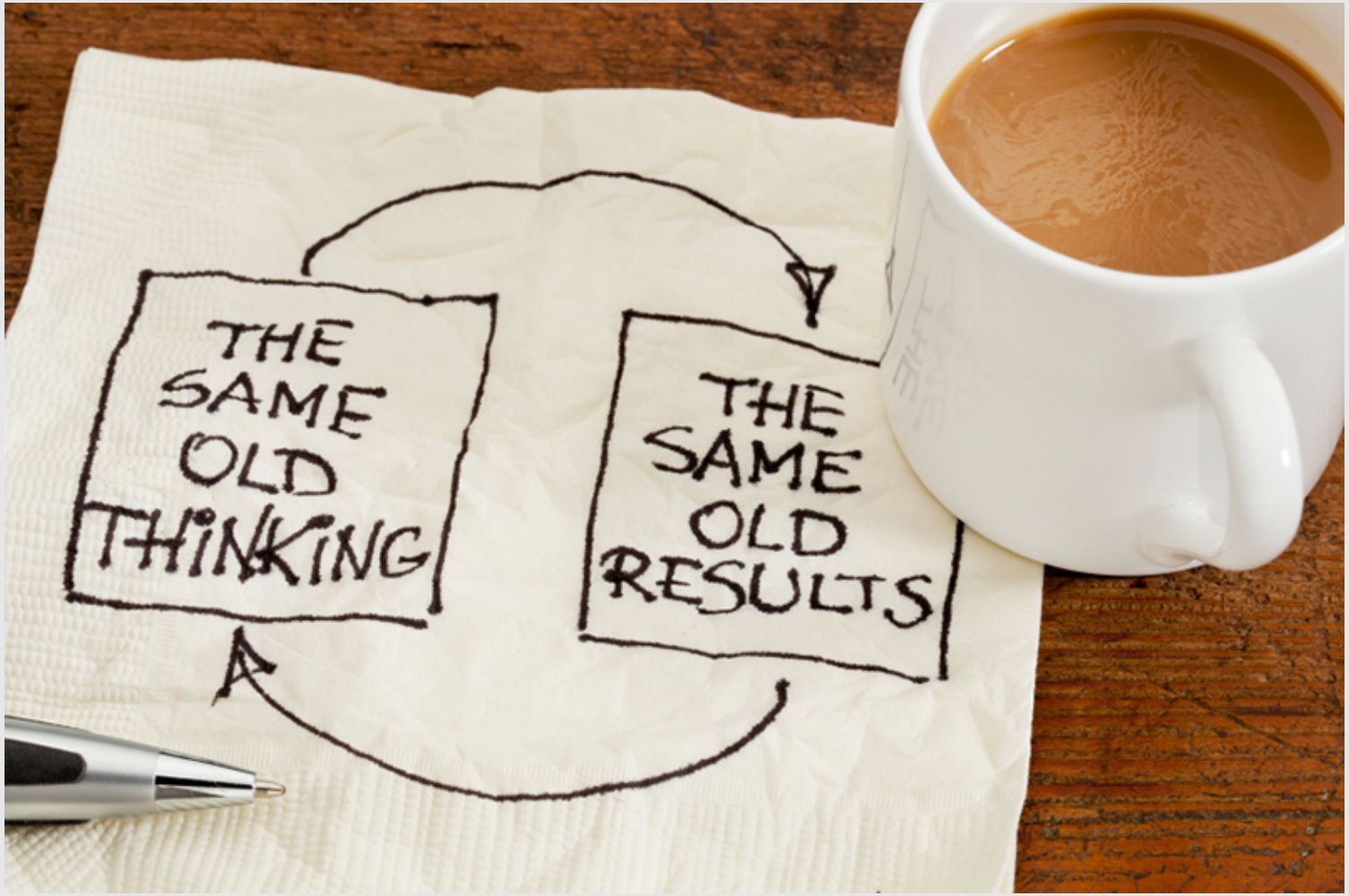
"As a physio it's hard to say that because **we are expected to get everything and kind of know what we are doing** and feel confident about what we are doing"

CONDITIONS
- Reflecting on practice
- Seeing results
- Retaining professional identity

INTER/ACTIONS
- Gaining confidence
- Experiencing success
- Embedding into practice

CONSEQUENCES/ CONDITIONS
- Feeling empowered
- Feeling good
- Making a difference

#3 It is possible we are looking at the problem the wrong way



‘Adherence’ – a borrowed concept

- Came into use as an alternative to compliance in the context of medication use
  - Compliance: The extent to which the patients behaviour matches the prescribers recommendations
  - Adherence: The extent to which the patients behaviour matches agreed recommendations from the prescriber

(Horne et al., 2005)

- In reality, adherence and compliance used interchangeably and synonymously (Bissonnette, 2008)
- … and leads to a primary focus on patient behaviour.

Engagement and outcome increasingly understood to be co-constructed

The Influence of the Therapist-Patient Relationship on Treatment Outcome in Physical Rehabilitation: A Systematic Review

Amanda M. Hall, Paulo H. Ferreira, Christopher G. Maher, Jane Latimer, Manuela L. Ferreira

Background. The working alliance, or collaborative bond, between client ar psychotherapist has been found to be related to outcome in psychotherapy.

Purpose. The purpose of this study was to investigate whether the worki alliance is related to outcome in physical rehabilitation settings.

Data Sources. A sensitive search of 6 databases identified a total of 1,600 titl

Study Selection. Prospective studies of patients undergoing physical rehabi tation were selected for this systematic review.

Data Extraction. For each included study, descriptive data regarding parti pants, interventions, and measures of alliance and outcome—as well as correlati data for alliance and outcomes—were extracted.

Data Synthesis. Thirteen studies including patients with brain injury, muscul skeletal conditions, cardiac conditions, or multiple pathologies were retrieved. Va ious outcomes were measured, including pain, disability, quality of life, depressio adherence, and satisfaction with treatment. The alliance was most commonly me sured with the Working Alliance Inventory, which was rated by both patient ar therapist during the third or fourth treatment session. The results indicate that th alliance is positively associated with: (1) treatment adherence in patients with bra injury and patients with multiple pathologies seeking physical therapy, (2) depre

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REVIEW

A conceptual review of engagement in healthcare and rehabilitation

Felicity A. S. Bright[1], Nicola M. Kayes[1], Linda Worrall[2], and Kathryn M. McPherson[1]

[1]*Person Centred Research Centre, School of Rehabilitation and Occupation Studies, AUT University, Auckland, New Zealand and* [2]*Communication Disability Centre, CCRE-Aphasia and School of Health and Rehabilitation Sciences, The University of Queensland, Brisbane, Australia*

Abstract

Purpose: This review sought to develop an understanding of how engagement in healthcare has been conceptualized in the literature in order to inform future clinical practice and research in rehabilitation. A secondary purpose was to propose a working definition of engagement. *Methods*: EBSCO and SCOPUS databases and reference lists were searched for papers that sought to understand or describe the concept of engagement in healthcare or reported the development of a measure of engagement in healthcare. We drew on a Pragmatic Utility approach to concept analysis. *Results*: Thirty-one articles met the criteria and were included in the review. Engagement appeared to be conceptualized in two inter-connected ways: as a gradual process of connection between the healthcare provider and patient; and as an internal state, which may be accompanied by observable behaviors indicating engagement. *Conclusion*: Our review suggests engagement to be multi-dimensional, comprising both a co-constructed process and a patient state. While engagement is commonly considered a patient behavior, the review findings suggest clinicians play a pivotal role in patient engagement. This review challenges some understandings of engagement and how we work with patients and highlights conceptual limitations of some measures.

Keywords

Adherence, clinical practice, compliance, engagement, healthcare, participation

History

Received 14 November 2013
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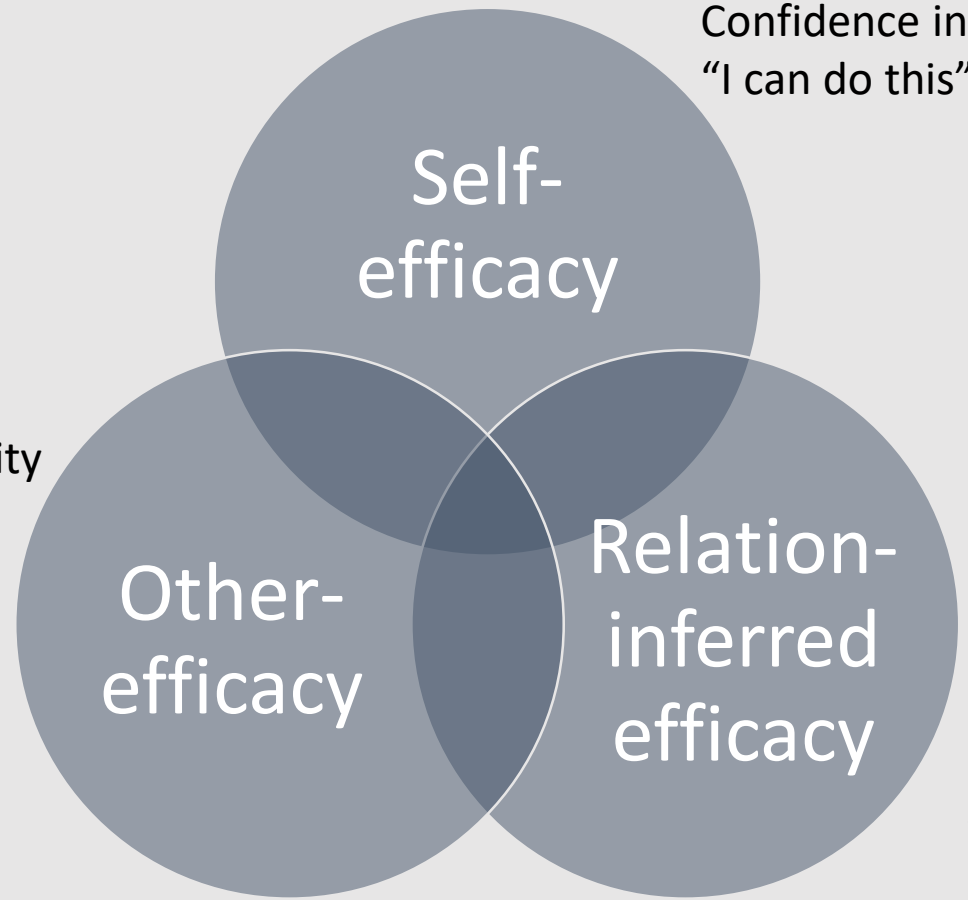
A tripartite efficacy perspective?

Confidence in ones own ability
"I can do this"



Confidence in therapists ability
"I have a great therapist"

Appraisal re: how confident the therapist is in their ability
"I think my therapist really believes in me"

Lent & Lopez (2002); Jackson et al. (2012)

"I think the therapist and their listening and their flexibility in being able to work with me… if I wasn't quite feeling there or involved, they had the ability to change it. And that I understood what was required of me in what they were saying. And caring. They have a lot of energy and positive feedback and that spurred me on. This isn't bad at all. I can do this. If they're positive in their energy and the material they give me, and it's not the same thing every day […] so I think it's, the therapists' attitude and skills that helped me through and persist."

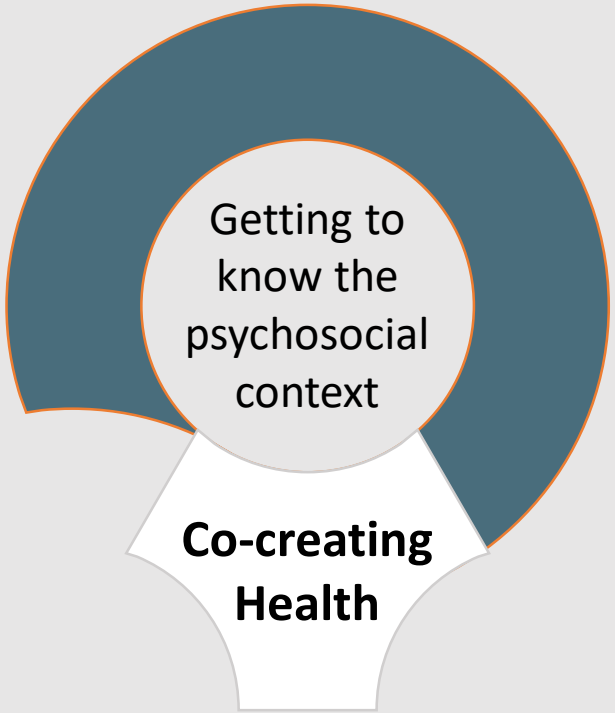
(Person w SCI)

Some questions….

- Are the strategies most routinely adopted in practice really fit for purpose?
- Is adherence a helpful concept?
- Or, does it:
  - focus our attention on patient behaviour?
  - limit our potential to critically reflect on ones own role?
- Is a more fundamental shift in practice necessary?
- What is the role of a physiotherapist in:
  - Creating the context for a motivated and engaged client?
  - Building client skill and capability to optimise outcome?

Co-creating health in physiotherapy

1. The starting point



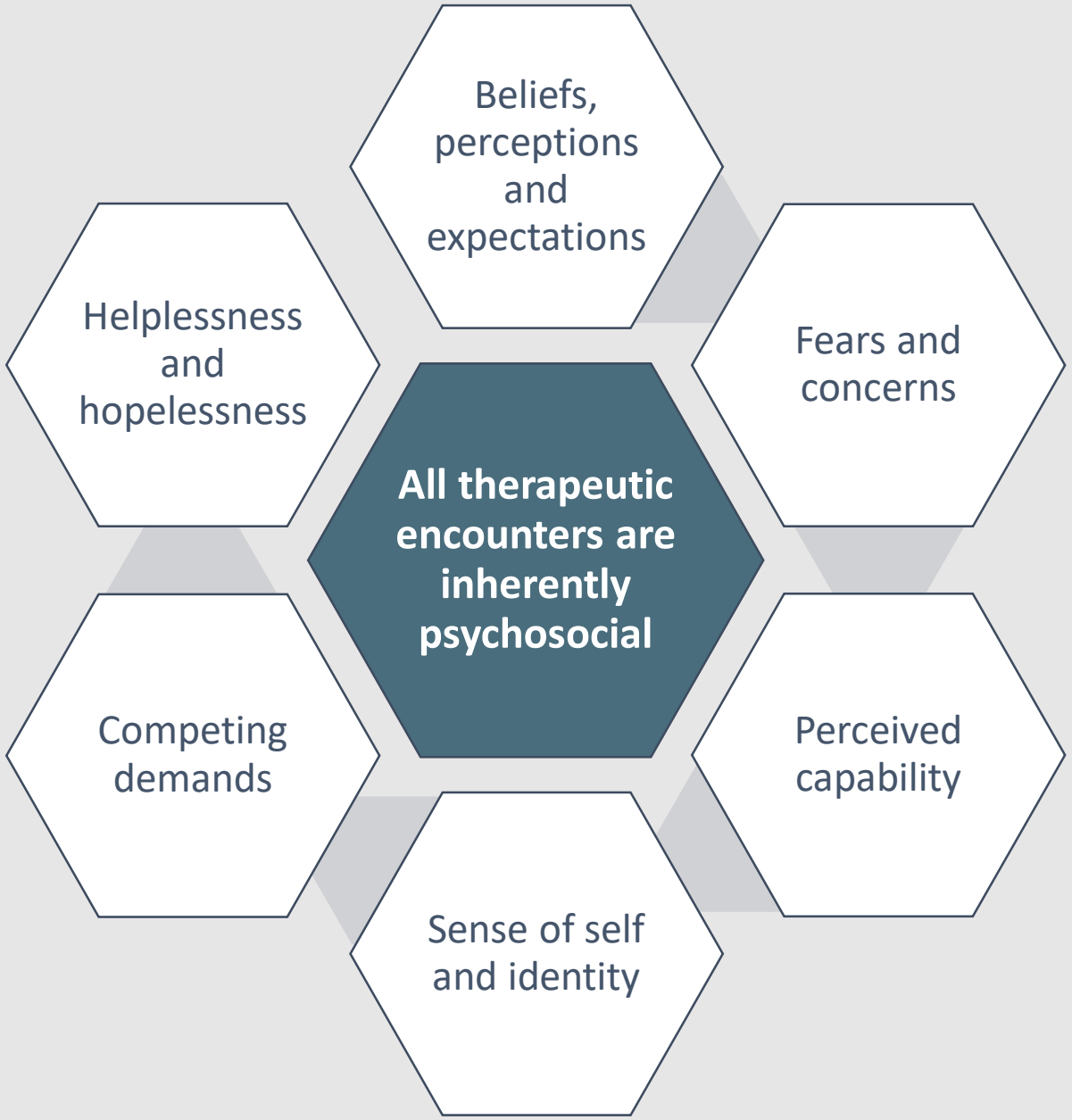
The psychosocial context

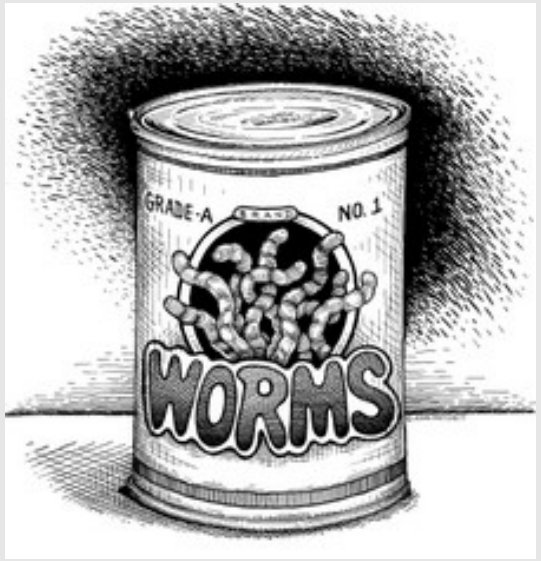
"The implant's quite heavy and I'm just a bit worried [..] you don't know that you are being realistically self- protective, or just unnecessarily cautious […] I wish I could pick up a badminton racket and just see what it feels like […] to get my confidence back." (Person w cancer)

"It's like having a tin can with holes punched in it, no matter how much water you pour into it, it is still pouring out. So even if you pour heaps more water in, it will still pour out, you will never get anywhere." (Person w MS)

"I couldn't even turn over in bed and the idea of that was devastating for me, but I didn't feel like doing anything about it. So a lot of those exercises involved sitting me on the side of the bed and just sitting up – strengthening my trunk – I hadn't visualised the need for that. I didn't understand what had happened or why I couldn't do things." (Person w stroke)

"They want you to feel your pain and embrace your pain etc., etc. I spend my whole life learning how to deal with my pain and live with it as best I can. I do not want to embrace it. It is not my friend!" (Person w chronic pain)

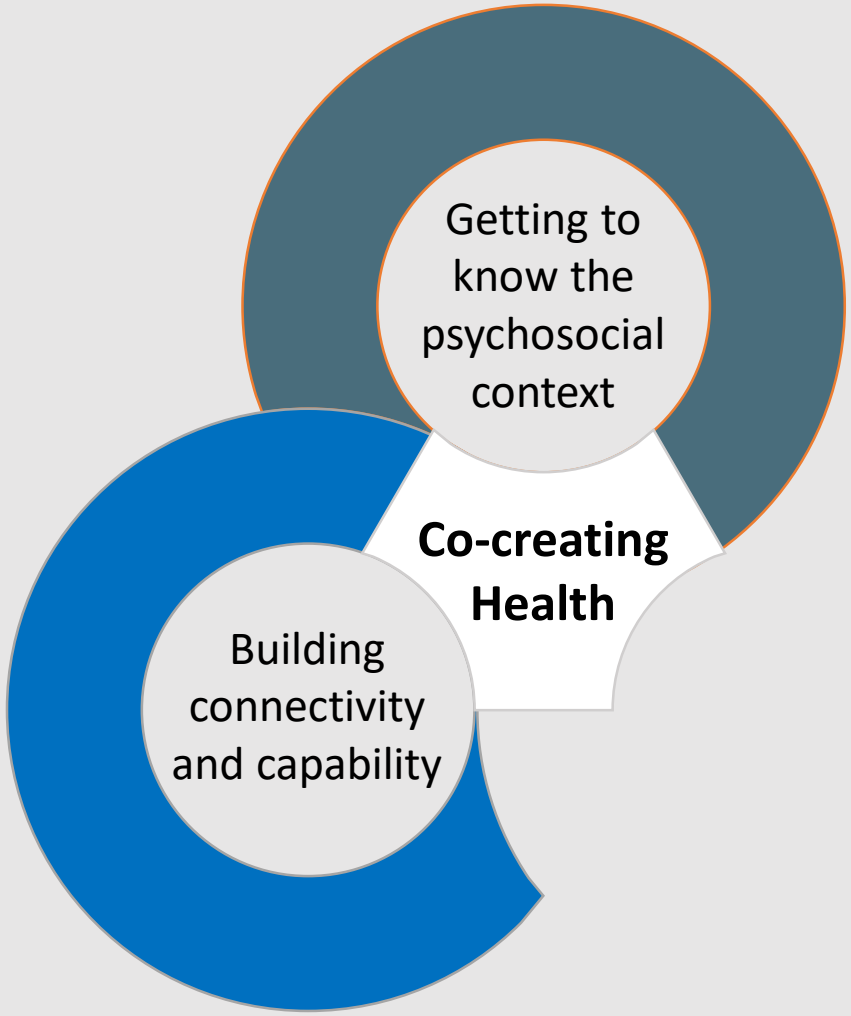

Beliefs, perceptions and expectations
Fears and concerns
Perceived capability
Sense of self and identity
Competing demands
Helplessness and hopelessness
All therapeutic encounters are inherently psychosocial



OR

?

2. Laying the foundations



‘Connectivity’ central to engagement

“It’s a relationship really and creating that trust, and the feeling valued as a person, that your point of view is important and that the person [therapist] wants to work with you to achieve what you need to do”
(Person w stroke)

What matters most in the therapeutic relationship?

"I think you've got to trust that they know what they're doing, that they care about what they are doing, that they are going to do it to the best of their ability, that they've got your best interest at heart"

"She tends to make you believe in yourself a lot more than you normally would"

3. Building the bridge

Understanding behaviour and behaviour change

- We all have good intentions – some of mine…
  - I'm going to exercise more
  - I'm going to manage my work-life balance better
- BUT often a gap between what we intend to do, and what we actually do
- Behaviour change involves at least two key processes
  - Motivational – establishing the intention to change
  - Volitional – translating intentions into action

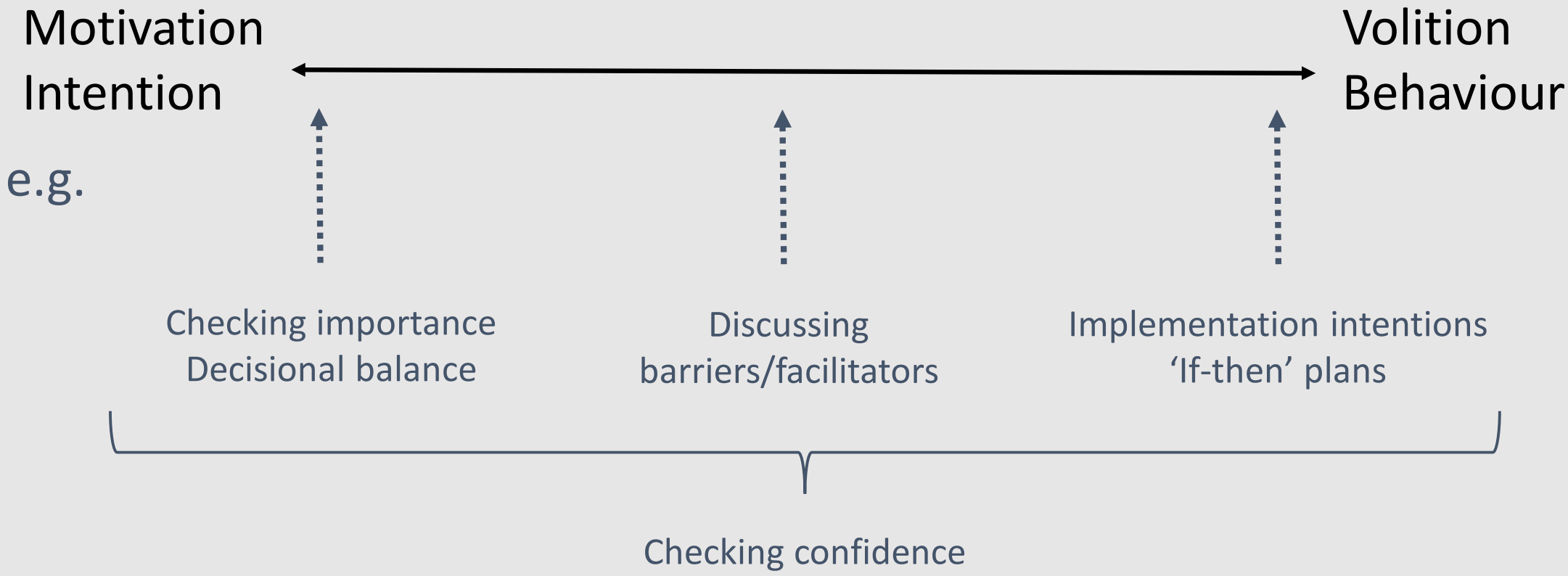
Intention-behaviour continuity

- Core assumption of many early behaviour change theories
- Hall et al. (2008) argue this assumption only holds when:
  - the behaviour in question is discrete rather than repetitive
  - the behaviour is fully under the control of the individual
  - the costs and benefits of the behaviour occur at the same point in time allowing for equal temporal weighting

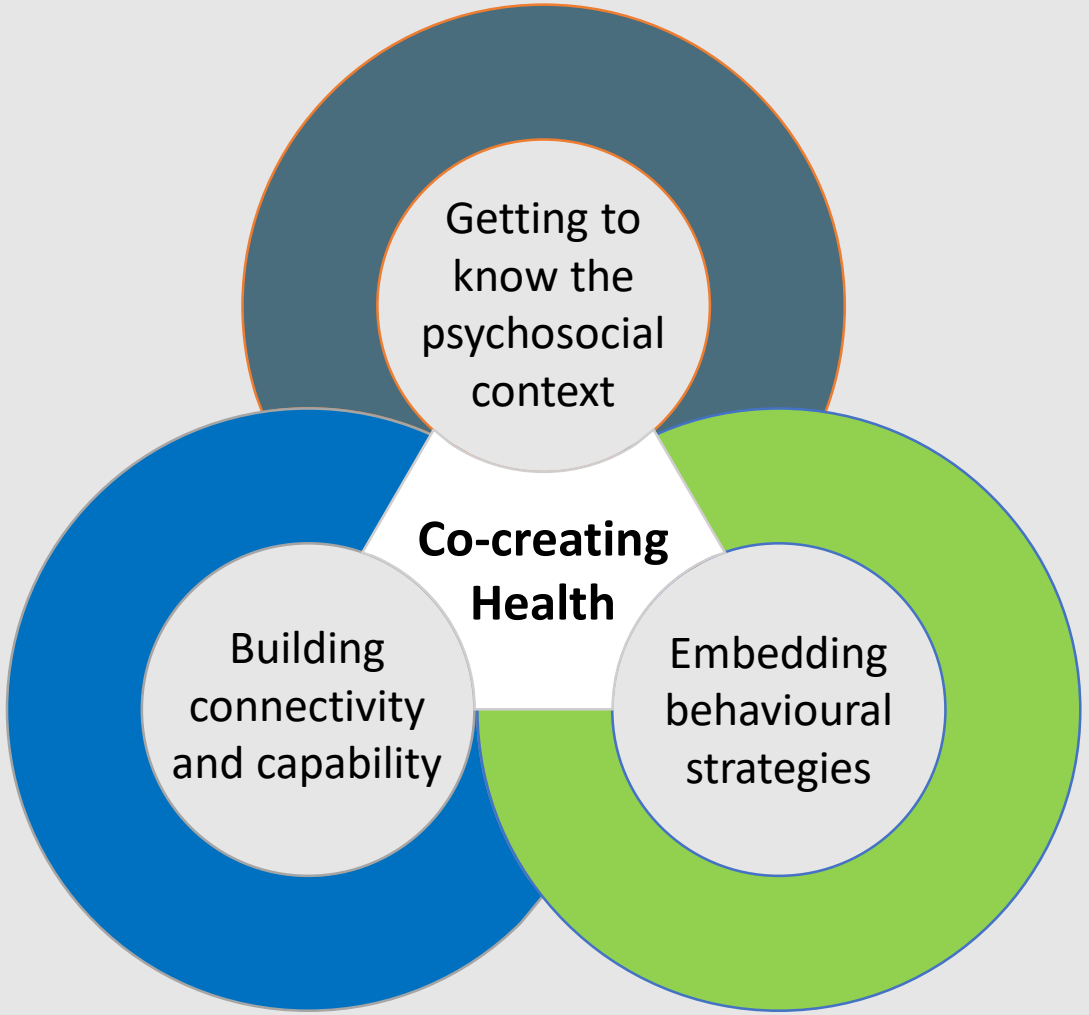
So….

- Behaviour change involves at least two key processes
  - Motivational – establishing the intention to change
  - Volitional – translating intentions into action
- Different strategies may be necessary depending on where the person is at

A tailored approach is necessary…..



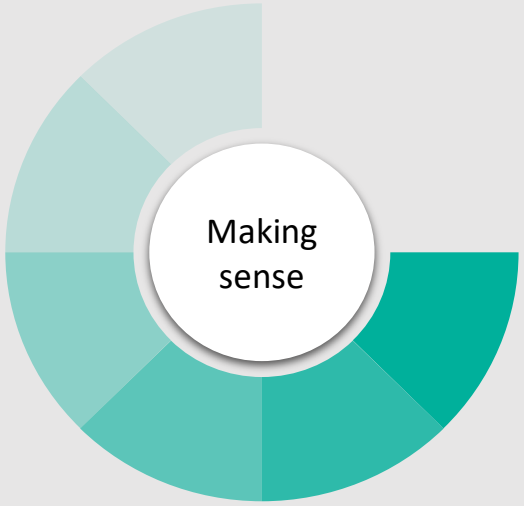
Co-creating health in physiotherapy



Embedding into practice

“I think it’s had a big impact. I can see with my patients […] I have noticed a big change and when people come back in […] they actually are getting better.”

“[…] It’s kind of exciting. It’s nice to think, the biggest thing for me is to make a difference for people, that’s the satisfaction I get from my job and that’s why we do it […] all those little things like being able to incorporate that and actually be working to something that that patient actually wants, feels like I am helping them. It feels satisfying to me.”



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BUT, getting there requires:

- recognising these ways of working as a critical component of practice
- active and explicit management
- ongoing critical reflection on practice

Some final words

- While *what we do* is important, *who we are* and *how we work* with our clients may be critical
- Relying only on disciplinary skills and technical competence is rarely sufficient
- A shift to *Co-creating health* legitimises the value of other core skills and processes
  - E.g. therapeutic relationship, engagement, behavioural strategies, self-management support
- More explicit emphasis on these core skills has the potential to optimise the impact of physiotherapy

AUT CENTRE FOR
PERSON CENTRED RESEARCH

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