Behaviour Change
Engagement and Adherence

HIN CVD Fellows – 4.12.23

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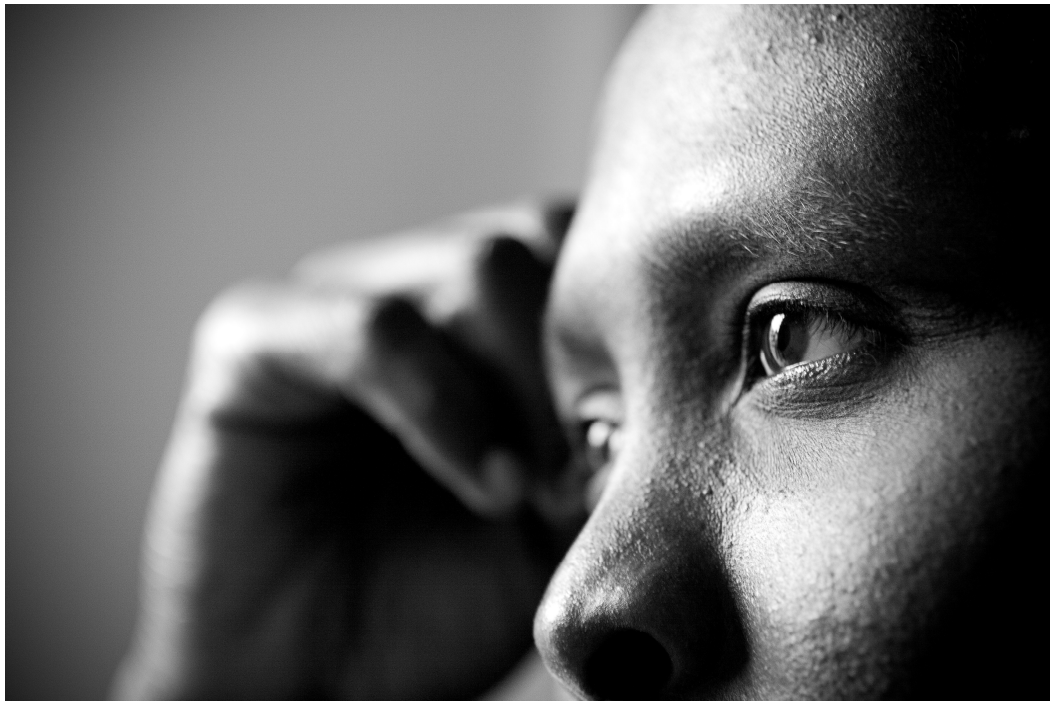
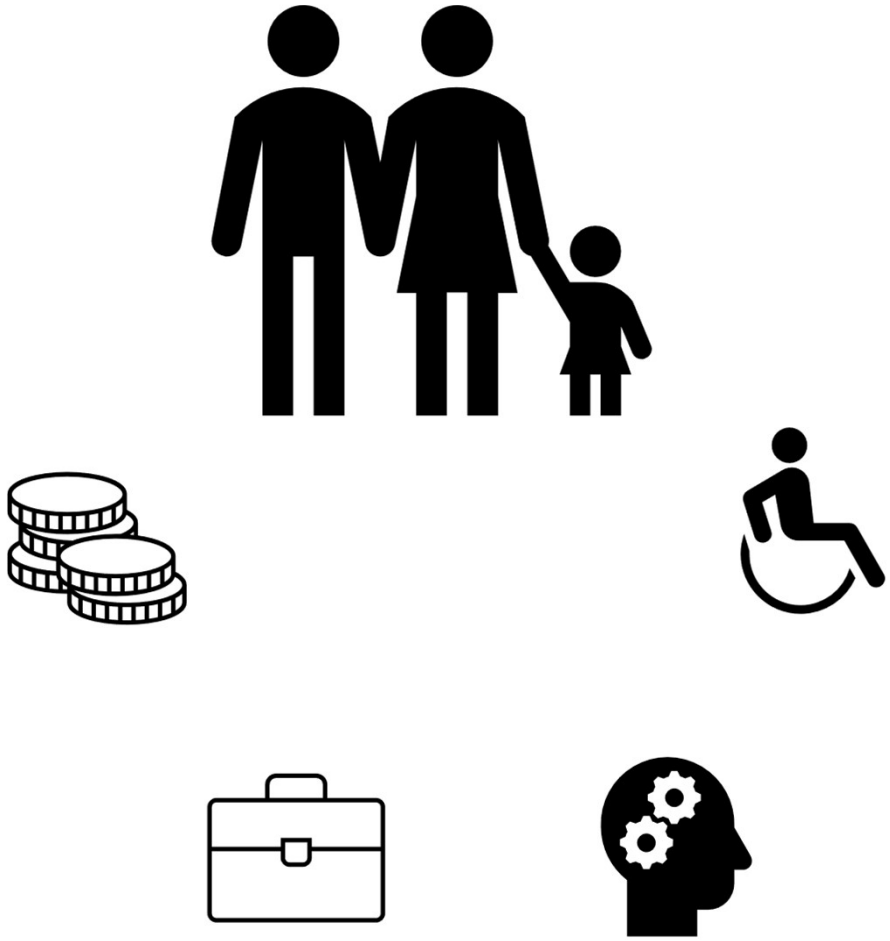
Learning outcomes

- Consider using the Illness Perception Model to improve engagement with your patients
- Harness behavioural science principles to frame your messaging to patients
- Consider using the Illness Perception Model to support medication adherence

Why we need to engage better





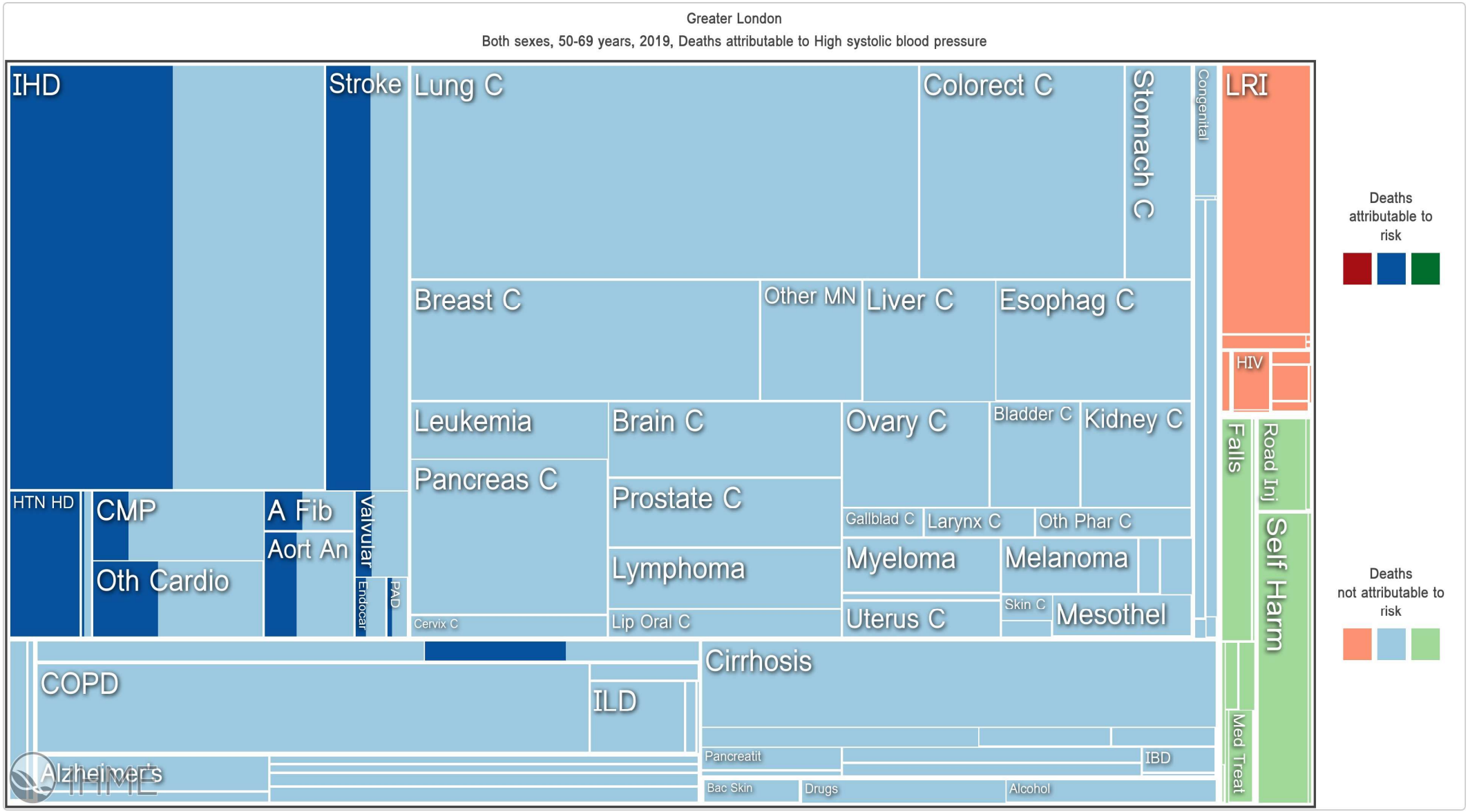
Wider determinants of health

- Environment 5%
- Healthcare 10%
- Social and economic circumstances 15%
- Genetics 30%
- Behaviours 40%

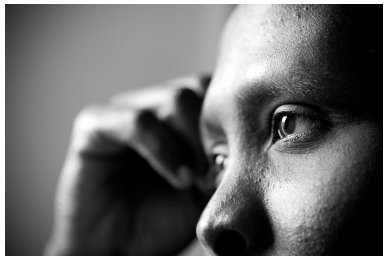
Dahlgren and Whitehead, 1991

McGinnis, Williams-Russo and Knickman, 2002

Greater London (SEL) –HSBP risk contributing to deaths 2019



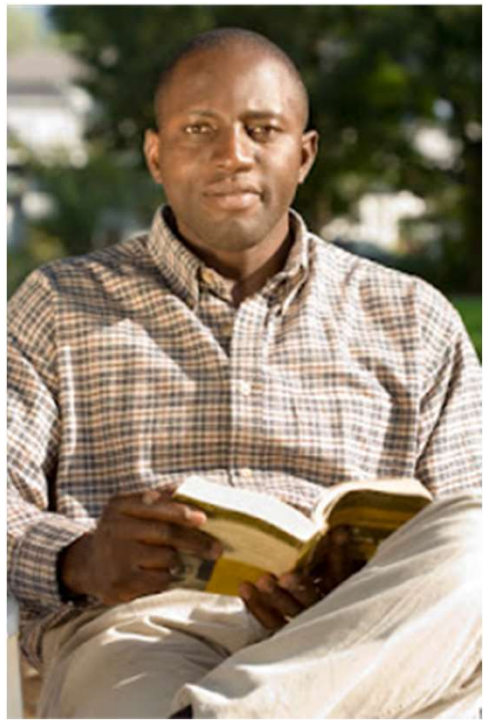
IHME, GBD, 2019



Individual patients sit IN FRONT of the data

Case Study - Engagement

Michael



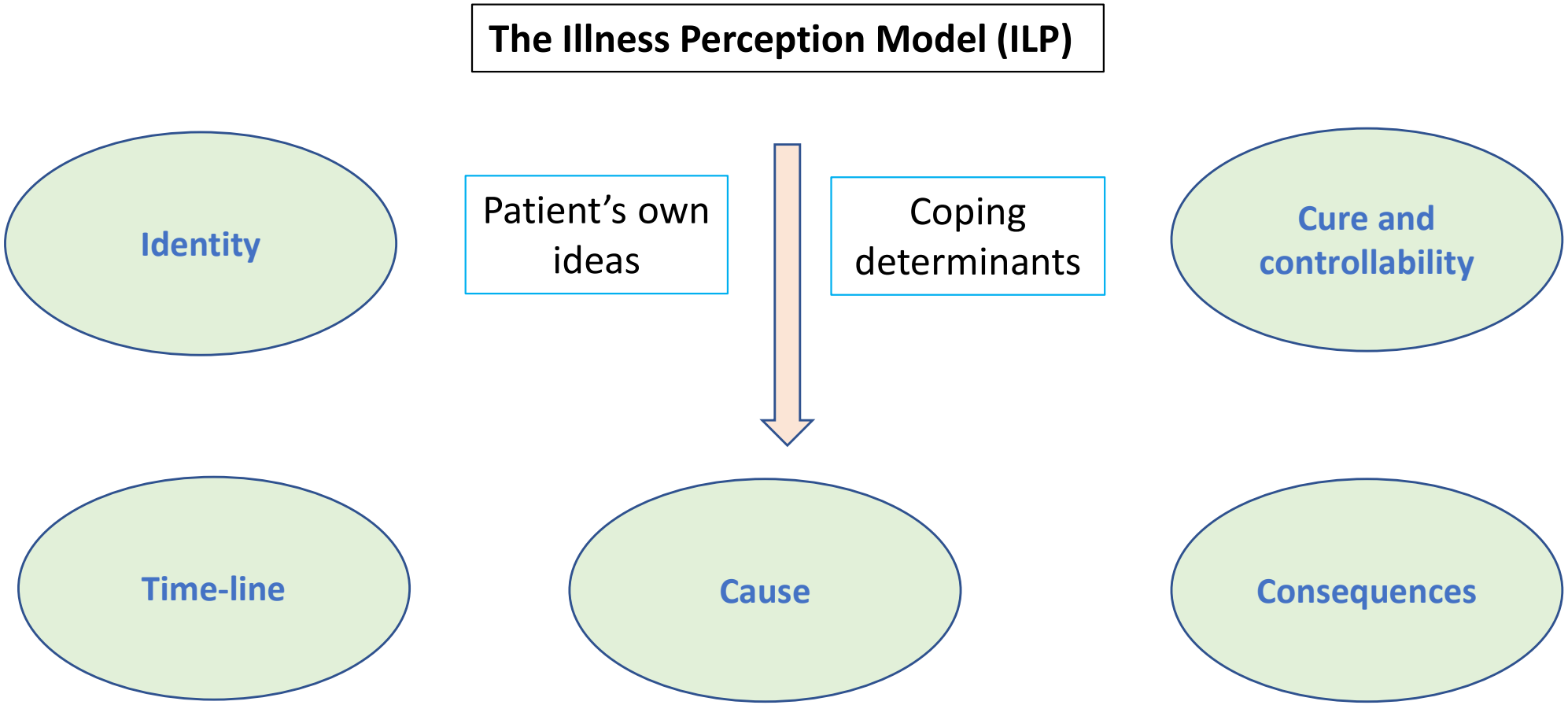
- 42, married, lives with wife and 2 children aged 9 and 7
- Works in IT – travels often
- BMI 32
- Presented with headache, high BP found.
- ABPM = 158/100
- Qrisk >10%
- Lifestyle advice given 6/12 ago
- BP machine in reception – 3 readings in last 6 weeks- BP remains > 150/95
- Stage 2 HTN with high Qrisk, NICE advise “discuss” starting BP treatment

Activity

You have been tasked with “discussing” starting BP treatment with Michael

SLIDO -What are the potential challenges you perceive arising in this discussion?

How do we perceive illness?



HCP failure to identify how people understand their disease cause and risk is a significant barrier to success

Engagement and Illness Perception

Do you ever explore all of these?

Identity	"I'm an ill person" "I'm an old person"
Cause	"Stress has caused my high BP" "Is this my fault?"
Cure and controllability	"There must be a cure I'm not being told about….their first port of call is to give me some pills" "This is a disaster, I've lost control of my body"
Time-line	"This will be short lived, my stress will settle soon" "I have a problem that affects me till I die!"
Consequences	"I'm too young to have a stroke" "I feel fine, this is nothing important for me, I'm busy"

Engagement and Message Framing

SLIDO -What option decreases DNAs?

1. 175 people **failed to attend** their appointment at the surgery last month

2. 4825 people **did attend** their appointment at the surgery last month

The power of social norms!

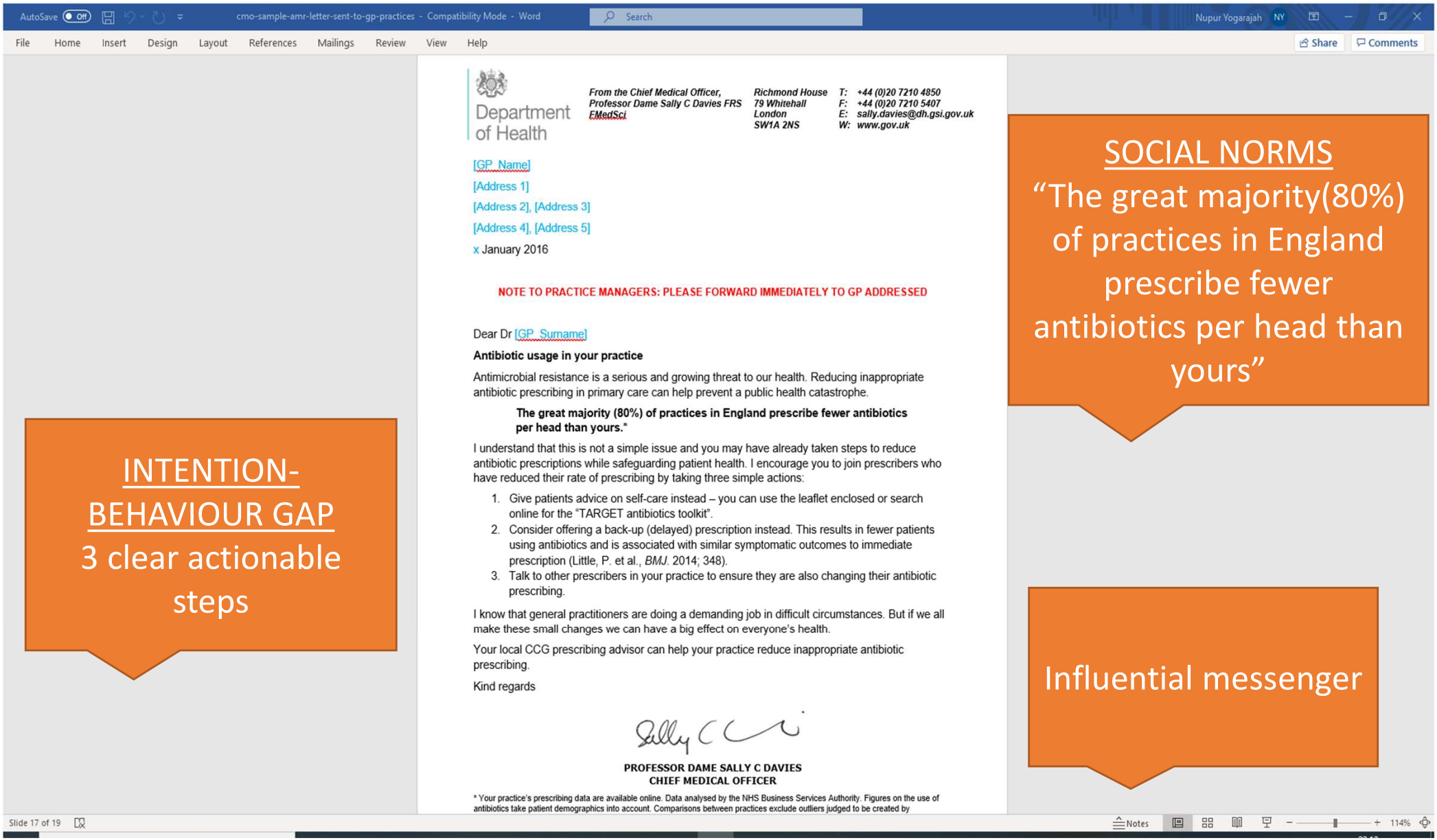
Drawing attention to frequency of unwanted behaviours – **NORMALISING**

Displaying the message to those who are attending

Advertising the merits of not attending?

Social norms are powerful……..we mostly like to “fit in” with group behaviours

Engagement and Message Framing



AutoSave Off cmo-sample-amr-letter-sent-to-gp-practices - Compatibility Mode - Word Search Nupur Yogarajah NY

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Department of Health

From the Chief Medical Officer, Professor Dame Sally C Davies FRS FMedSci

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[GP_Name]
[Address 1]
[Address 2], [Address 3]
[Address 4], [Address 5]
x January 2016

NOTE TO PRACTICE MANAGERS: PLEASE FORWARD IMMEDIATELY TO GP ADDRESSED

Dear Dr [GP_Surname]

Antibiotic usage in your practice

Antimicrobial resistance is a serious and growing threat to our health. Reducing inappropriate antibiotic prescribing in primary care can help prevent a public health catastrophe.

The great majority (80%) of practices in England prescribe fewer antibiotics per head than yours.*

I understand that this is not a simple issue and you may have already taken steps to reduce antibiotic prescriptions while safeguarding patient health. I encourage you to join prescribers who have reduced their rate of prescribing by taking three simple actions:

1. Give patients advice on self-care instead – you can use the leaflet enclosed or search online for the "TARGET antibiotics toolkit".
2. Consider offering a back-up (delayed) prescription instead. This results in fewer patients using antibiotics and is associated with similar symptomatic outcomes to immediate prescription (Little, P. et al., *BMJ*. 2014; 348).
3. Talk to other prescribers in your practice to ensure they are also changing their antibiotic prescribing.

I know that general practitioners are doing a demanding job in difficult circumstances. But if we all make these small changes we can have a big effect on everyone's health.

Your local CCG prescribing advisor can help your practice reduce inappropriate antibiotic prescribing.

Kind regards

PROFESSOR DAME SALLY C DAVIES
CHIEF MEDICAL OFFICER

* Your practice's prescribing data are available online. Data analysed by the NHS Business Services Authority. Figures on the use of antibiotics take patient demographics into account. Comparisons between practices exclude outliers judged to be created by

Slide 17 of 19 Notes 114%

INTENTION-BEHAVIOUR GAP
3 clear actionable steps

SOCIAL NORMS
"The great majority(80%) of practices in England prescribe fewer antibiotics per head than yours"

Influential messenger

Patient Comms – Message Framing

Social norms

"The majority of patients attended their diabetes review appointment this year."

Influential messenger

"Pharmacist Adeola is reminding you to book your hypertension review appointment."

Intention-behaviour gaps

"Please add the appointment to your phone/other calendar."

"We offer weekend and evening appointments."

Remember – it's always context dependent!

Pulling together illness perception and message framing…..

Did you frame your text according to behavioural science (+ your context) principles?

<u>Consider:</u>

What impact did it have on their identity?

What impact did it have on their beliefs about their own mortality?

What impact did it have on their beliefs about their ability to support their dependents?

Maybe it had no impact!

Can you dig deeper using IPM framework with those harder to engage?

-phone-calls

-build rapport

-invest the time

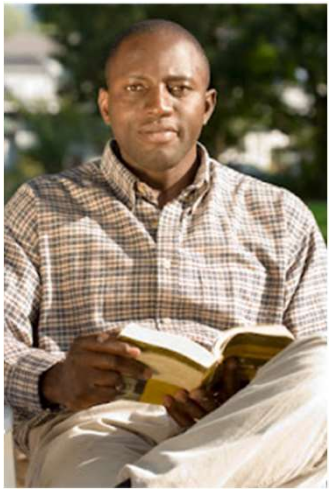
Case Study - adherence

Michael

- Initiated on Amlodipine 5mg-BP uncontrolled
- Up-titrated to 10mg Amlodipine-BP 128/74 after 1 month on new regime
- Doesn't return for 3/12 review
- After 6/12 sees GP with headache –BP 160/104
- Re-starts Amlodipine 10mg (2/12 px given)
- Doesn't request repeat medication when due
- After 3rd reminder attends annual review- BP 162/100

Intentional vs Non-intentional adherence

Is Michael forgetting to take his medication intentionally or non-intentionally?

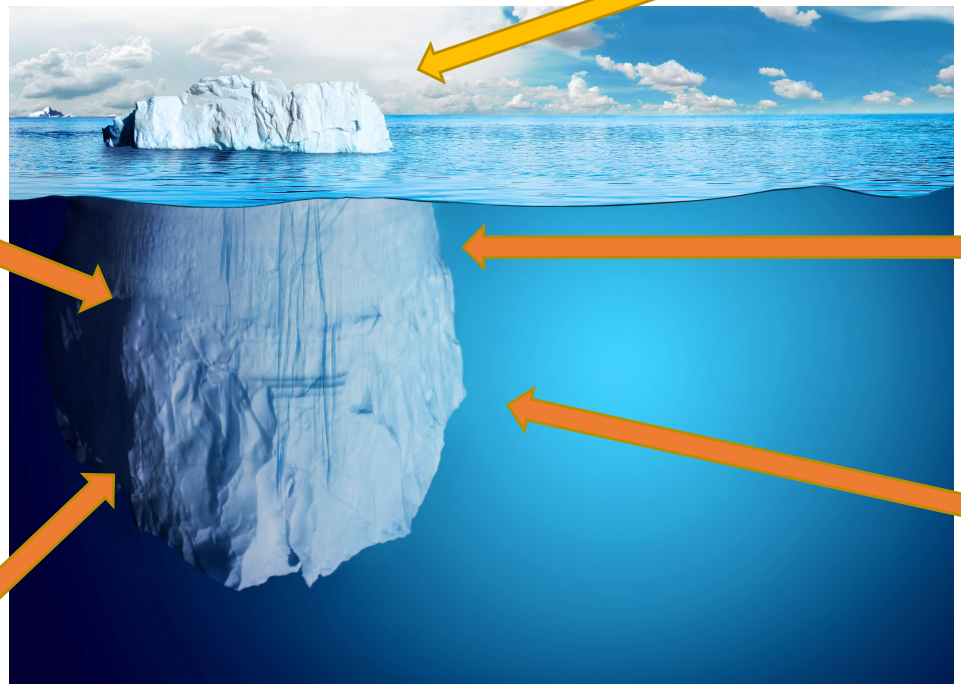


Medication adherence is a complex issue and can't be categorised simply as intentional vs non-intentional

Patients HTN beliefs and adherence – BMJ Review

Variable adherence to HTN meds

Fears about SE and addiction



Produces symptoms- headache/dizziness/ sweating

No symptoms = no treatment required

HTN is temporary and curable

BMJ Systematic Review *(Marshall, 2012)*

Encouraging adherence behaviours – tips

Acknowledge symptoms rather than deny patient experience

Headaches

Be mindful of language descriptors "your blood pressure is **normal** today"

No headache = no medication?

Engage with patients about their understanding of cause/curability/controllability

Where has it come from? Episodic/acute/chronic?

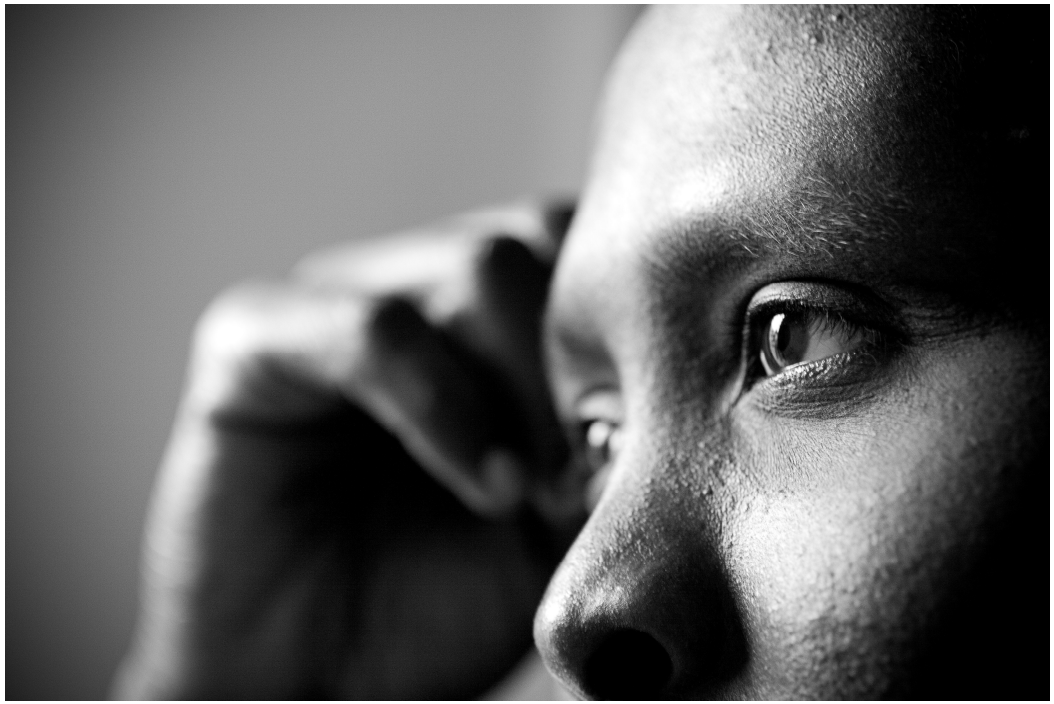
Discuss long-term risks persist even in absence of symptoms

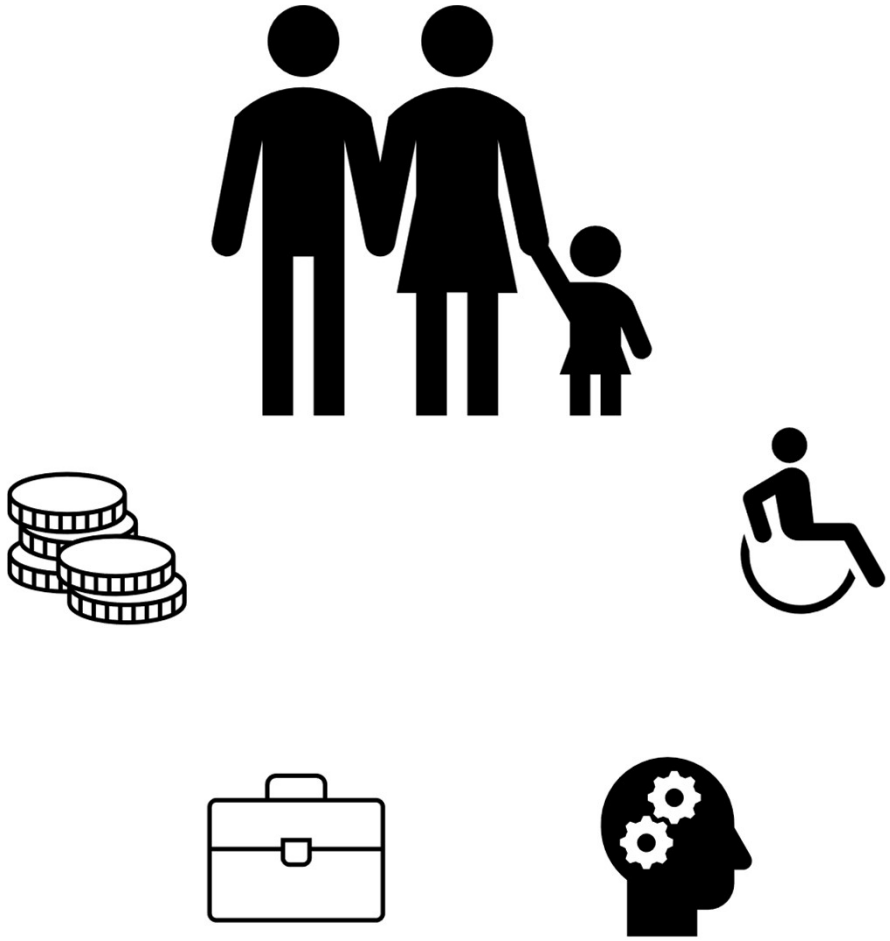
HCP understanding of consequences vs your patient's

Acknowledge differences in culture and influence on interpretation (eg Bush remedies in African-Caribbean patients) *Connell, McKevitt & Wolfe, 2005.*

Patients do not want to appear "stupid, critical or ungrateful"

Would this story have been different if we had engaged better?





Take Home Messages

Engagement

- Consider the IPM with patients harder to engage
- Harness behavioural science to frame your comms

Adherence

- Patients commonly link symptoms to their BP – what does this mean for adherence?
- Use the IPM to dig deeper and understand adherence issues

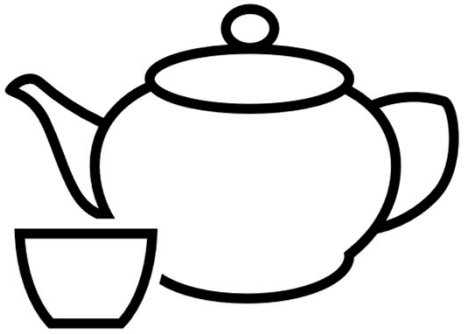
Thank you for listening!

Any:

Reflections?

Comments?

Questions?



Over to slido……