Implementing Compassionate Care Interventions in an Urban Primary Care Setting

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Purpose

- Provide evidence-based education, interventions and support
- Goal of enhancing a culturally focused and compassionate environment for both staff and patients
- Interventions will include mindfulness training, lateral violence awareness, motivational interviewing techniques and culturally appropriate care training

Background

- Construct of Compassionate Care program in an urban primary care setting
- Interventions focus on several national priorities within Patient Protection and Affordable Care Act of 2010, specifically in area of quality improvement
- ACA's first priority is identified within the category of improvement in quality and health system performance.
- This section outlines the national priorities specific to the improvement in delivery of health care services, patient health outcomes and population health (ACA, 2013).

Background

Institute of Medicine's Priority Areas for National Action:

- Transforming Health Care Quality (2014), predominant priority in the improvement of quality is to provide patient with an enhanced care experience
- Evaluation and selection of these priorities were identified according to the degree in which changes in the system can improve day to day care and quality of life for the patients (Institute of Medicine, 2014).

Priorities

Include:

- Six quality aims of safety as well as timeliness, efficiency, patient-centeredness and equity.
- Efforts may include reorganization at a micro, organizational or environmental level
- Focused on and evaluated by their ability to improve the overall patient experience.

Compassionate Care Research

- Leadership programs that explored of relationships with self, patients, families, teams and the organization
- Use of caring conversations.
- Goal was to support staff to work together to develop a culture of inquiry that would enhance delivery of compassionate care.

Compassionate Care

- Participants worked with action learning sets
- Used a range of structured tools to learn about others and to identify best caring practices
- Explored ways to implement the practices more often
- Goal for participants to be reflective and engaged versus passive actors in shaping cultural climate around compassionate relationship centered care

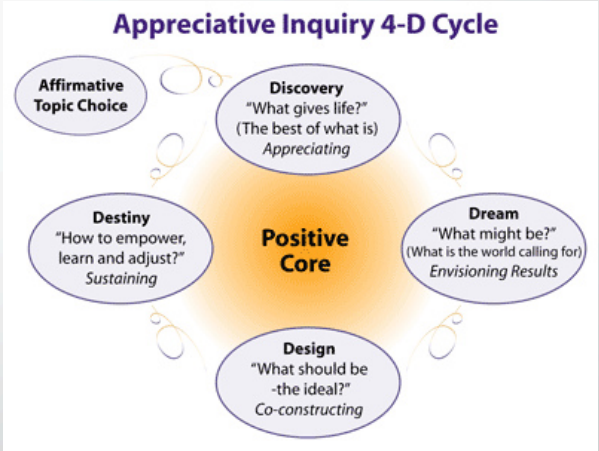
Compassionate Caring and Promoting Dignity

Model developed on "appreciative caring conversations" centered around relationships

- All parties gained 2 forms of "person and relational knowledge about who people are and what matters to them"
- Determined how people "feel about their experience"
- Enabled staff, patients and those who care for them to work together to "shape how things are done"
- Model includes staff to staff, staff to patient and includes family members

Phases of Appreciative Inquiry

- Discovery (finding what works well)
- Dream (exploring where people want to be)
- Design (developing activities to achieve the dream)
- Destiny (working to sustain these developments over time)



Questions to Support Engagement

- What matters most to you while in the clinic?
- Tell me something that will help us to care for you here
- How do you feel about your experience?
- What helps you feel upbeat and well?
- How would you like us to respond to you if you are feeling low?
- Who/what are the most important people/things for you?
- What worries/concerns do you have?
- What things have worked well for you here?

7 C's

- Collaborate
- Connect Emotionally
- Compromise
- Be Courageous
- Consider perspectives of others
- Be Curious
- Celebrate

Multidisciplinary Vision/Goals

- Increase compassion behaviors
- Increase patient satisfaction
- Increase staff satisfaction
- Promotes team cohesion
- Involvement in all levels
- Decrease compassion fatigue

Mindfulness

- **Paying attention in present moment**
- Being in the present moment without judgment
- Awareness of what is occurring in present moment
- Waking from life lived on auto pilot or habitual response
- Contrasted to mindless preoccupation with past or future plans or worries

Mindfulness Cultivation

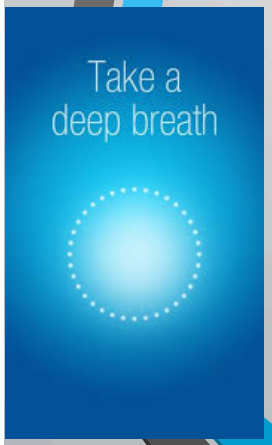
Mindfulness cultivation incorporates three components:

- Clear intention as to why it is practiced;
- Observation of one's moment to moment experience without interpretation, elaboration, or analysis;
- Attending to self with an attitude of acceptance, kindness, openness, patience, non-striving, equanimity, curiosity, and non-evaluation. (Carmody, Baer, Lykins, and Olendski, 2009)

Benefits

- Mindfulness training offers framework to support increased coping strategies
- Mindfulness offers tools to improve stress level while allowing participants to practice in own time frame and location

Mindfulness Effects



- Interrupt or down regulate individual's psychological reactivity to stress triggers, in turn mitigating physiologic response. (Rosenzweig et al., 2007)
- Altering perceptions of depression and pain. (Sephton et al. 2007; Kabat-Zinn, 2003)

Mindfulness-Based Stress Reduction (MBSR)

Meditation program created by Jon Kabat-Zinn (1979), roots in Buddhism, group-treatment modality for chronic pain, includes:

- **Body scan**
- **Sitting meditation** attention to breath and nonjudgmental observations of thoughts and distractions that flow through mind.
- **Hatha yoga** practices of stretches and postures to relax and strengthen. (Kabat-Zinn, 2009)

MBSR

- **Attitudes** (a) non-judging, (b) patience, (c) "Beginner's mind", (d) trust, (e) non-striving, (f) acceptance, (e) letting go.
- **Elements** (a) **attention,** (b) **attitude**- wisdom, spirituality, compassion, peace of mind; (c) **intention-** self-regulation, self-exploration, self-liberation. (Kabat-Zinn, 2009).

MBI Structure

- **Week 1-** review body scan protocol, PHQ-9, MAAS.
- **Week 2-** review supine yoga and practices, review mindfulness concepts.
- **Week 3-** review sitting meditation concepts and practice.
- **Week 4-** review yoga postures, sitting meditation concepts, mindfulness concepts; PHQ-9, MAAS, evaluation.

- Spend about 15-45 minutes each day being mindful.
- On days when you are able to spend just 5 or 10 minutes, it's still worth doing.
- For mindfulness, some practice is good, and more is even better!
- Aim for about 6-7 days per week whenever possible.
- Many people find it helpful to choose a certain time of day for their mindfulness practice.
- Many people find it helpful to think of ways to remind themselves to engage in their mindfulness practice.

Breathe2Relax

- Portable skill rehearsal tool for practicing diaphragmatic breathing
- Developed by Department of Defense to promote resilience, recovery and reintegration of soldiers with traumatic brain injury and PTSD.

Mindfulness and Self Care

Mindfulness practices are useful for the health care provider to provide enhanced care by both self-disciplined practice of present-centered awareness, as well as a treatment modality that could enhance patient/client well-being.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What do we want?!
Mindfulness!
When do we want it?!
NOW!
8-23-13
Dist. by King Features

What is Lateral Violence?

The literature defines LV as health care workers overtly or covertly directing their dissatisfaction inward toward:

- Those less powerful than themselves
- Themselves
- Each other
- Act of aggression

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SafetyBriefs

HIGH-ALERT **Auvi-Q post injection ticking sound.** There's something important to know about the **AUVI-Q** auto-injector (**EPINEPH**rine injection), which uses digital voice instructions to "talk" people through the injection process (**Figure 1**). The device has LED light cues that flash green during injection and red after the device has been used. Prior to injection, Auvi-Q

Part II: Disrespectful behaviors

Their impact, why they arise and persist, and how to address them

In 2013, ISMP conducted a survey on bullying, incivility, intimidation, and other forms of disrespectful behavior that have run rampant in healthcare while many remain silent or make excuses to minimize the profound devastation that disrespectful behavior leaves in its wake. These behaviors harm patients. These behaviors have been linked to adverse events, medical errors, compromises in patient safety, and even patient mortality.[2,3] Disrespect causes the recipient to experience fear, anger, shame, confusion, uncertainty, isolation, self-doubt, depression, and a whole host of

Categories of Behavior

Behavior Category	Description	Examples
Passive Disrespect	Uncooperative behaviors that are nonmalevolent	Chronic lateness, sluggish response to requests, ill prepared, non prepared, non participative in improvements
Dismissive Treatment	Behavior that makes patients or other staff feel unimportant	Condescending, patronizing, gossip, aloof, uninterested, impatient, resistant to collaboration, exclusionary and over-ruling
Non-verbal insidious behavior	Subtle unspoken behavior that may seem innocent but is disrespectful	Staring, sighing, making faces and gestures, positioning body to exclude others
Systemic Disrespect	Disruptive behaviors entrenched in culture that the element of respect is overlooked	Making patients and staff wait for services, requiring long work hours, excessive workloads

Categories of Behavior

Behavior Category	Description	Examples
Disruptive	Egregious conduct clearly evident by actions	Angry, rude, threats, pushing or throwing objects
Demeaning	Debasing behaviors that exploit weakness of another	Shaming, humiliating, spiteful, backstabbing, faultfinding, education by humiliation
Intimidating	Behaviors or threats of one to control another, abuse of power	Overbearing, arrogant, sarcasm, intentional invasion of space, patronizing or arrogant
Passive Aggressive	Negative attitudes, passive resistance towards demands for performance, pleasant comments but behave otherwise	Unreasonably critical of authority, negative comments about colleagues, refusal to do tasks, deliberate delays, failure to support a co worker

Impact on the Clinic

- Low self esteem
- Low morale
- Disconnected from other staff members
- Depression
- Excessive sick leave
- High rate of burn out
- Staff lack initiative to do their job well
- Erosion of trust
- Errors
- Diminished teamwork
- 60% of nurses who experience LV within the first 6 months will leave the unit
- COST!! $22K to $64K per nurse

Signs and Symptoms of Burnout

- Physical and emotional exhaustion
- Detachment
- Over identification or over involvement
- Sense of ineffectiveness
- Avoidance of emotionally difficult situations
- Difficulty with concentration
- Frequent illness
- Addictive behaviors

Commitment to My Team

- As your co-worker with a shared goal of providing excellent care to our patients, I commit to the following:
- I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you and every member of this staff. I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need advice or help in deciding how to communicate with you appropriately.
- I will maintain a relationship of functional trust with you and every member of this staff. My relationships with each of you will be equally respectful, regardless of job titles or levels of educational preparation.
- I will not engage in the 3 Bs
  (bickering, back biting and blaming)
  and will ask you not to as well.
  I will not complain about another team member:
  and ask you not to as well.
  If I hear you doing so, I will ask you to talk to that person.
- I will accept you as you are today, forgiving past problems and ask you to do the same with me.
- I will be committed to finding solutions to problems rather than complaining about them or blaming someone for them and ask you to do the same.
- I will affirm your contribution to quality patient care.

  I will remember that neither of us is perfect,
  And those human errors are opportunities,
  not for shame or guilt but for
  forgiveness and growth.
- Signed _____ Date_____

Other Solutions from ANA

- Protect from retribution
- Utilize employee assistance
- Interrupt violence
- Assess the nursing unit and raise awareness
- Brainstorm solutions and encourage dialogue
- Create unit specific guidelines

Summary

- Provide mandatory clinic-wide education
- Make an effort to care more about each other
- Acknowledge the part that they play
- Recognize these behaviors
- Changing the cycle of negative behavior with evidence based practices
- Professional reflection
- Cognitive rehearsal and carefronting
- Caring enough and using respect, forgiveness and courage to confront in a responsible manner

What Is Motivational Interviewing?

A particular kind of conversation about behavior changes.

- Think about a change you would like to make…
  - Exercising more?
  - Quitting smoking?
  - Managing anger?
  - Managing stress?
  - Eating healthy foods?
  - Taking better care of yourself?

Myth of Unmotivated Patient

- Way in which provider talks with patients about their health can substantially influence their personal motivation for behavior change
- MI is skillful clinical style for eliciting from patients their own good motivations for making behavior changes in the interest of their health
- "Guiding rather than directing, dancing rather than wrestling, listening at least as much as telling". (Rollnick, Miller & Butler, 2008)

Common Assumptions About the Change Process

- **There is a lack of education or knowledge**

"If she only knew what I knew, she wouldn't do this anymore".

- **Scare tactics always work.**

"If you don't stop this now, you are going to die'.

- **Now is the best time to change. There may be reasons why change needs to be delayed.**
- "He will never change".
- **Person with the problem is to blame.**

"Spirit" of Motivational Interviewing

- **Collaboration-** cooperative, collaborative partnership
  - Instead of uneven power relationship in which expert clinician directs passive patient on what to do
  - Necessary as ultimately it is only patient who can enact the change
- **Evocative-**rather than seeing patients as lacking skills,
  - seeking to evoke what they already have
  - activating own motivation and resources for change

"Spirit" of Motivational Interviewing

Honoring patient's autonomy

- Detachment from outcomes- accepting that people can and do make choices about the course of their lives
- Acknowledging person's right and freedom not to change, can sometimes make it possible.
- Explore patient's perception about their current situation and motivations for change. (Rollnick, Miller & Butler, 2008)

Motivational Interviewing (MI)

William Miller(1993)- noted Rogerian counseling skills led to positive change outcomes:

- Empathy
- Open ended questions
- Affirmations
- Reflective listening

Motivational Interviewing

- Clients who verbalized reasons for change and their own strategies for change-"CHANGE TALK" more likely to create lasting change.
- Research noted positive relationship between amount of change talk and amount of change
- **Major goal MI- facilitate process of verbalizing change talk**

Empowering

- Outcomes are better when patients take active role in setting goals
- Patients are essentially the consultants and experts on their own health
- This is a paradigm shift from the power structure of Western medicine
- Need to support hope that the change is possible AND can make a difference in their health

Open Questions

Invite person to offer own experiences and perceptions:

- "How are you feeling today?"
- "Tell me from the beginning how your pain developed?"
- "How can I help you?"
- "In what way has this interfered with your life?"
- "Tell me about a typical day when you drink."
- "Tell me about your headache."
- "How are things going in your family?"
- "What are you most worried about?"
- "What are the thinks you like and don't like about smoking?" (Rollnick, Miller & Butler, 2008)

Cultural Competence

Four Challenges for Health Care Providers:

- Identifying clinical differences among various cultural and ethnic groups
- Communication
- Ethical Practice
- Trust

Culture Basics:
Masson's Lessons Learned in Primary Care
Lesson 1

"The whole point of Primary Health Care is to get to know the patient, his or her family, his or her living situation, and the community over time-and allow yourself to be known".

Ask-How often do we <u>really see</u> the person who has come to us for care?

Culture Basics:
Masson's Lessons Learned in Primary Care
Lesson 2 & 3

- *"Getting to know a patient takes time, but in the end it saves time and prevents duplication of efforts and errors".*

- *"Names are powerful. Get them right-your patient's and yours".*

Culture Basics:
Masson's Lessons Learned in Primary Care
Lesson 4 & 5

- *"A picture (of your patient, in your patient's wallet, made by your patient) may be worth a thousand words".*
- *"Clues to diagnosis are embedded in Language. Learn your patient's language".*

Culture Basics:
Masson's Lessons Learned in Primary Care
Lesson 6 & 7

- *"Respect quirks, boundaries and defenses. Show respect, period".*
- *"Remember that you may not find the answers to health problems in a textbook, you may find them in the news, a story or a song".*

Culture Basics:
Masson's Lessons Learned in Primary Care
Lesson 8 & 9

- *"Think of your patient as a long and fascinating story. If you embrace evidence-based practice, count that story as evidence".*
- If you listen to your patient long enough, they will tell you what's wrong

"Prescribed regimens must be understandable, practical, affordable and sustainable in your patient's terms".

Culture Basics:
Masson's Lessons Learned in Primary Care
Lesson 10

"You may be the best medicine for your patient-you and the potential for healing that you evoke".

- *Use your senses to get to know your patients*
- *Discover what you can about their culture, language and beliefs.*
- *Offer what you can-your knowledge, skill, time, attention and patience.*

The Basics

- Begin by being more formal with patients born of another culture-best to use last name except young adults and children
- Do not be offended by lack of eye contact
- Do not make assumptions about beliefs in ways to maintain health, the cause of illness or the means to prevent or cure.
- Assume a style of questioning that helps to determine the patient's central beliefs
- Perform a cultural assessment which includes foods, pain beliefs, family systems

Understanding Differences

- Eye contact
- Touch
- Silence-common in Chinese and Japanese, mandatory when speaking to elders in Asian culture
- Space and Distance
- Health Care Beliefs
  - Allow the patient to be open and honest especially with treatments that conflict with modern medicine
  - Be restrained in providing bad news or too detailed explanations without evaluating the patient
  - Try to determine the value of the family on the medical decisions
  - If possible, incorporate the patient's folk medicine as long as it doesn't interfere with their medical care

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Resources

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- Kabat-Zinn, J. (1991). *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Delta Trade Paperbacks.
- Mindfulnet.org; http://www.mindfulnet.org/
- Santorelli, S., (2010). *Heal Thy Self: Lessons on Mindfulness in Medicine*. New York, NY: Harmony/Bell Tower.

Resources

Integrative Medicine for the Underserved, http://www.im4us.org/;

Mindfulness-based patient handouts:

General Introduction to Mindfulness - Describes the practice of mindfulness, its benefits, the approach to wandering thoughts, and a script for a meditation noticing thoughts, feelings, and sensations

Instructions for Mindfulness Meditation - A description of mindful practice noticing sensations

Body Scan - Script for the classic body scan technique for passive progressive relaxation

Mindfulness with Pain - A mindful practice focusing on pain sensations, acceptance and noticing or labeling the sensations without judgment

A short video of Jon Kabat-Zinn presenting at Google