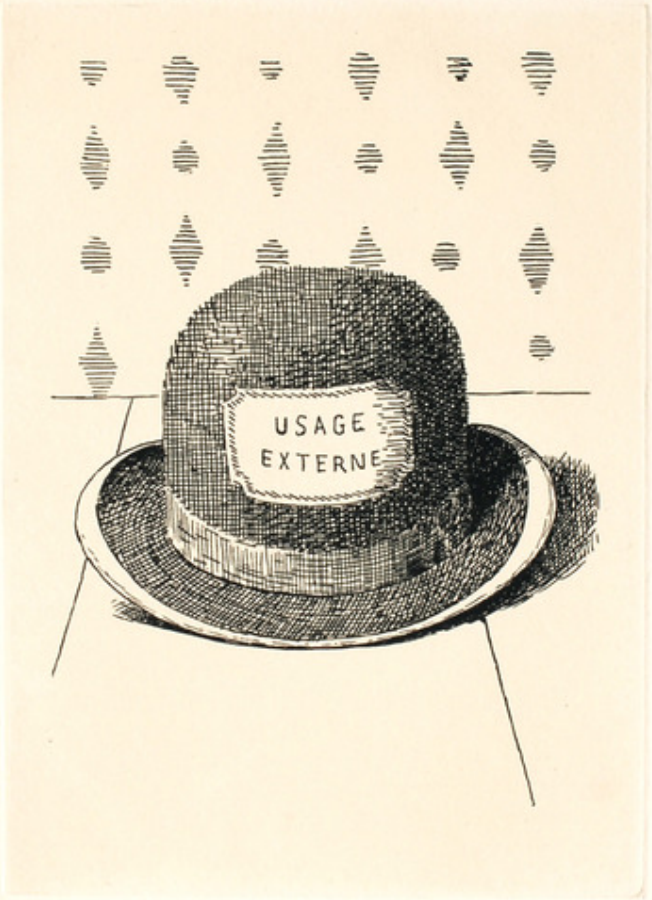
UNIVERSITÉ DE NAMUR

RESEARCH GROUP
Access to Care & Therapy Optimisation

Medication to take or not to take

a shared-decision making process

Dr Marc Tomas



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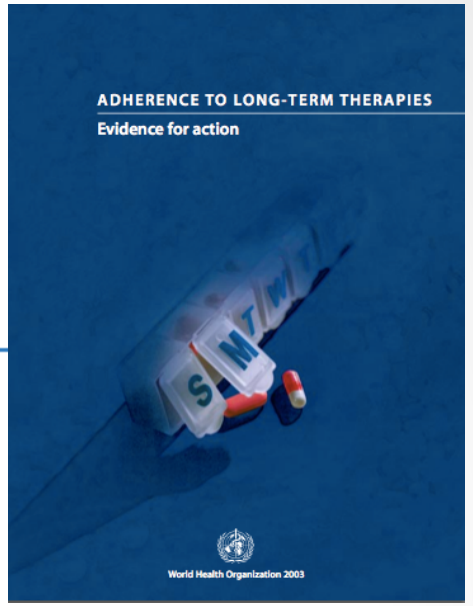
Magritte



CHAPTER IV

Lessons learned

1. Patients need to be supported, not blamed 36
2. The consequences of poor adherence to long-term therapies are poor health outcomes and increased health care costs 36
3. Improving adherence also enhances patient safety 38
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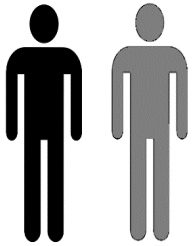
The non adherence burden in Europe/Belgium



50%

of chronic patients are non-adherent

4,5%

of healthcare budget in Europe

200.000

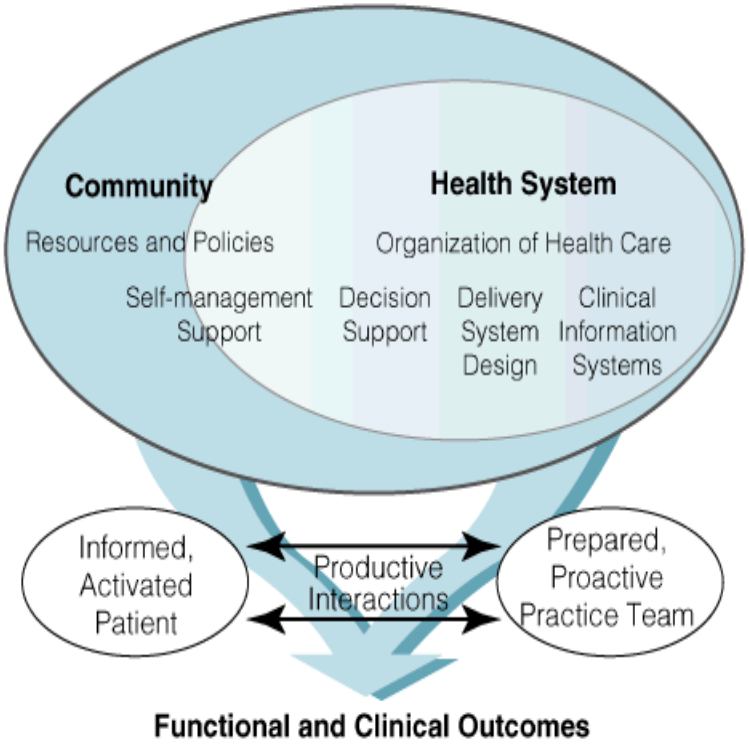
Deaths in Europe due to non-adherence

40.000

hospitalisations in Belgium due to uncorrect use of medications

World Health Organization. Adherence to long-term therapy. Switzerland, 2003.
Centre Fédéral d'Expertise des soins de Santé. Position paper (KCE): organisation des soins pour les maladies chroniques en Belgique. Health Service Research (HSR). Bruxelles: 2012.
From C. Billocq, 2016

CHRONIC CARE MODEL (WAGNER,1998)



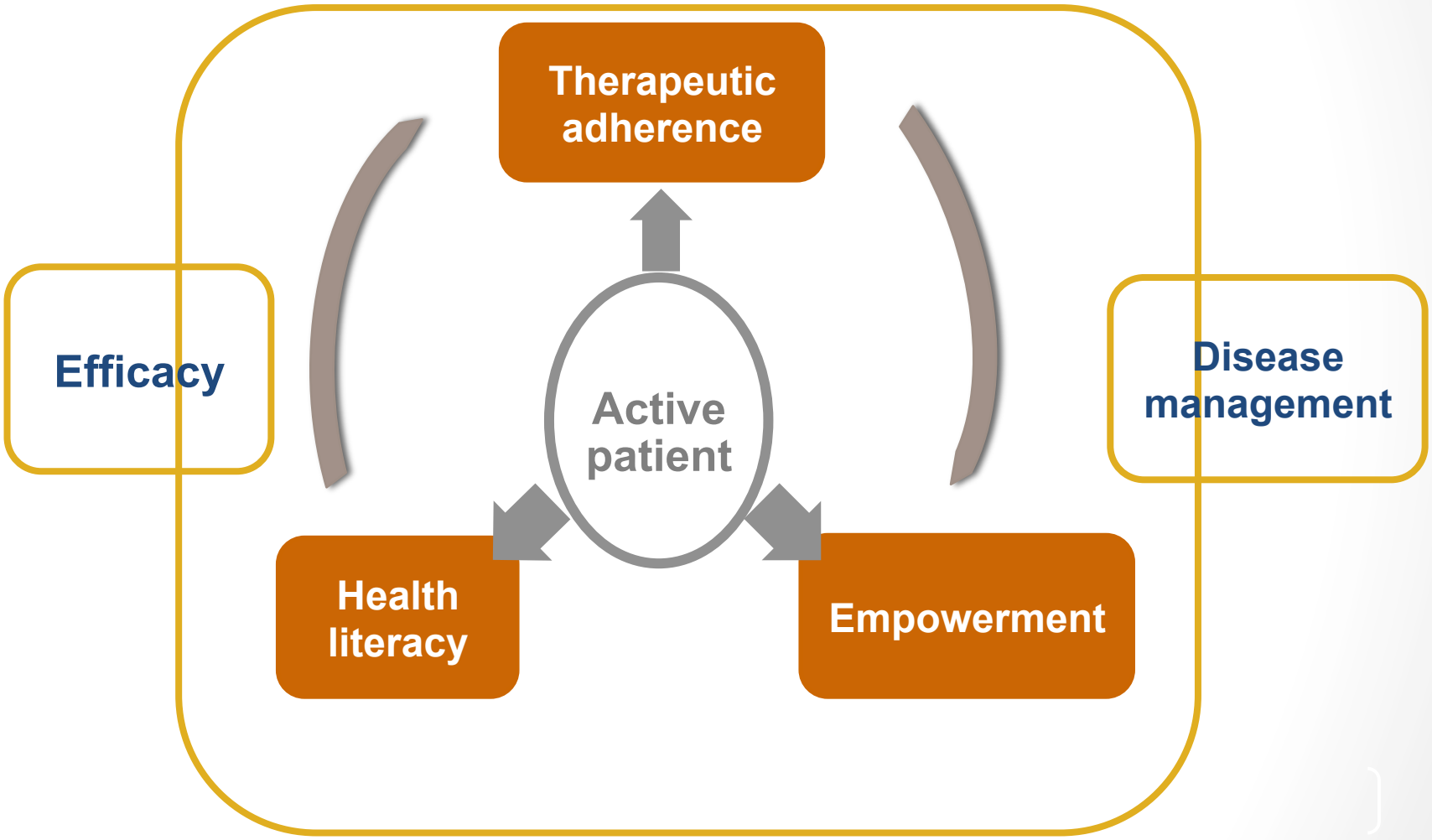
6 DOMAINS OF ACTION:

1. Organisation of Health Care
2. **Patient empowerment**
3. **Support to clinical decision**
4. Clinical Information systems
5. Use of community ressources
6. Organisation of the Health Care system

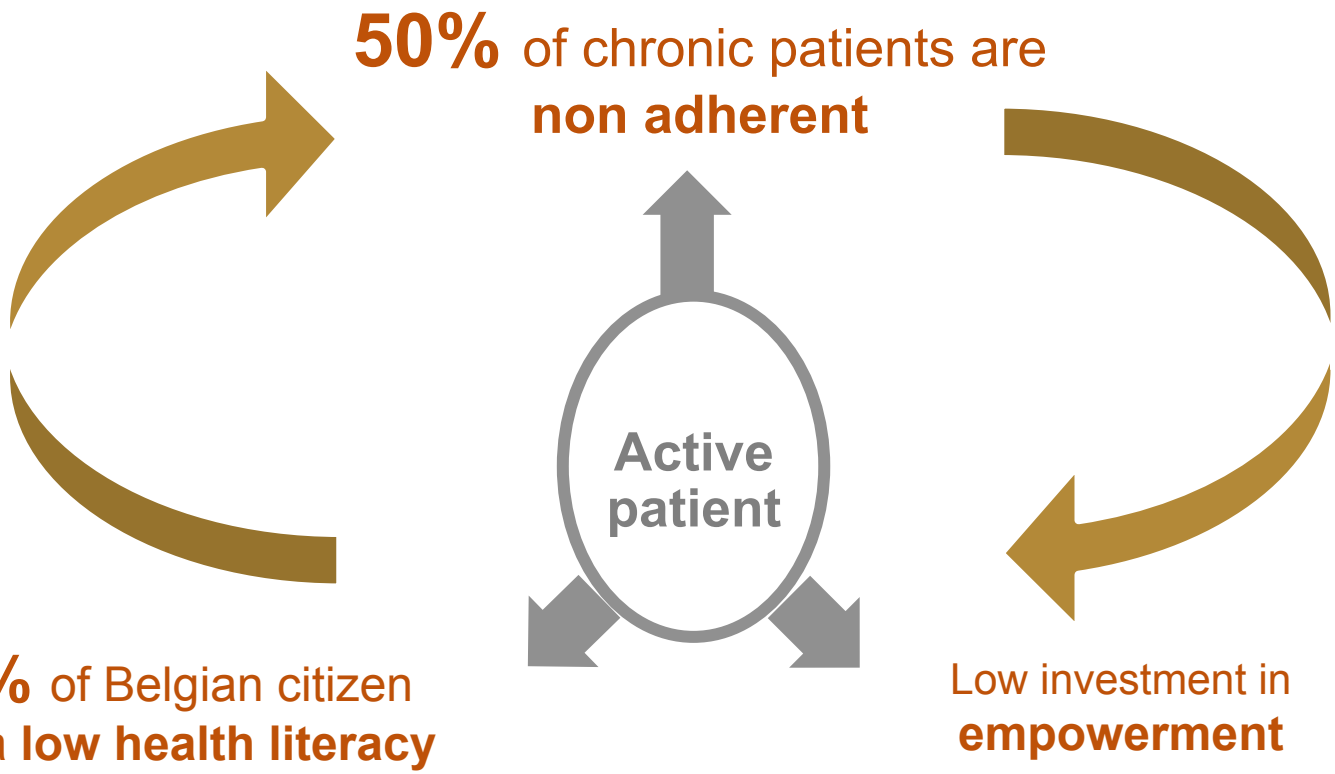
Wagner, 1998. Available at www.nicsl.com.au

Patient centricity: so desirable ?

Dealing with non-adherence: the key triad



Non-adherence : Belgian situation



World Health Organization. Adherence to long-term therapy. Switzerland, 2003.
Centre Fédéral d'Expertise des soins de Santé. Position paper (KCE): organisation des soins pour les maladies chroniques en Belgique. Health Service Research (HSR). Bruxelles: 2012.
Van den Broucke S, Renwart A. La litteratie en sante en belgique : un mediateur des inegalites sociales et des comportements de sante. Louvain-La-Neuve, 2014.

ELSEVIER

Social Science & Medicine 66 (2008) 1228–1239

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Reconsidering patient empowerment in chronic illness: A critique of models of self-efficacy and bodily control

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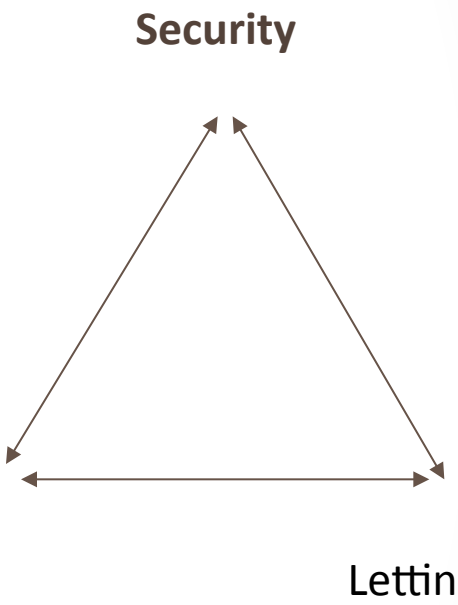
Available online 21 December 2007

Abstract

Studies that focus on patient empowerment tend to address more specifically two issues of patients' experience of illness: managing regimens and relating to health-care providers. Other aspects of illness experience, such as coming to terms with disrupted identities, tend to be overlooked. The outcome of empowerment is therefore usually referred to as achieving self-efficacy, mastery and control. We conducted an inductive exploratory study, based on individual in-depth interviews with 40 chronically ill patients in Belgium and Italy, in order to understand the process of empowerment as it may occur in patients whose experience of illness has at some point induced a feeling of powerlessness, which we conceptualised as a threat to their senses of security and identity. Our findings show that empowerment and control are not one and the same thing. We describe patient empowerment as a process of personal transformation which occurs through a double process of (i) "holding on" to previous self-representations and roles and learning to control the disease and treatment, so as to differentiate one's self from illness on the one hand, and on the other hand (ii) "letting go", by accepting to relinquish control, so as to integrate illness and illness-driven boundaries as being part of a reconciled self. Whereas the process of separating identities ("holding on") was indeed found to be linked to efforts aimed at taking control and maintaining or regaining a sense of mastery, the process of reconciling identities ("letting go") was found to be linked to a need for coherence, which included a search for meaning and the acceptance that not everything is controllable. We argue that the process of relinquishing control is as central to empowerment as is the process of gaining control. As a "successful" process of empowerment occurs when patients come to terms with their threatened security and identity, not only with their treatment, it may be facilitated by health-care providers through the use of narratives.

Keywords: Belgium; Italy; Chronic illness; Patient Education; Powerlessness; Empowerment; Self; Identity

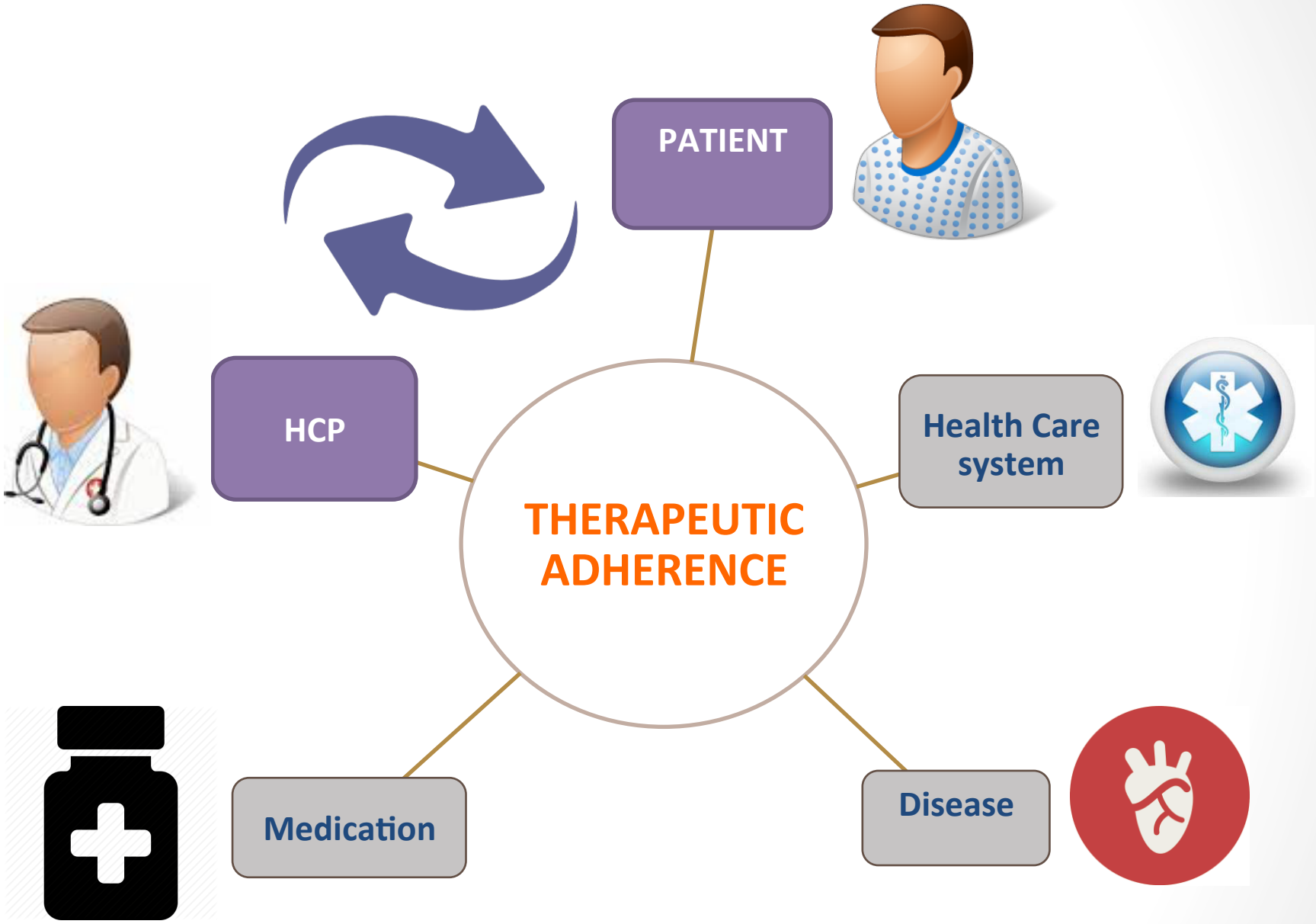
Initiating a processus of empowerment



The « healthy ill patient » (H Milz, 1992)

"One comes back out of such abysses, out of such severe sickness, and out of the sickness of strong suspicion - new-born, with
the skin cast: more sensitive, more wicked, with a finer taste for joy, with a more delicate tongue for all good things, with
a merrier disposition, with a second and more dangerous innocence in joy, more childish at the same time, and a hundred
times more refined than ever before."

Nietsche, 1886


PATIENT
HCP
Health Care system
THERAPEUTIC ADHERENCE
Medication
Disease

The KEY reasons for non-adherence

Patient related

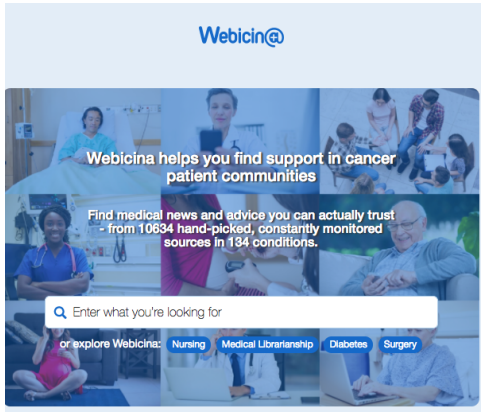
- Poor health literacy
- Health & medication beliefs
- Understanding adherence
- Trust in HCPs

HCP related

- Communication skills
- No-judgement
- Attention to adherence
- Ability to form partnership

« Healthcare cannot really advance without physicians letting their patients help themselves and be a full partner in making the decisions that affect them. »

Let Patients Help, Dave de Bronkart


Webicin@
Webicina helps you find support in cancer patient communities
Find medical news and advice you can actually trust - from 10634 hand-picked, constantly monitored sources in 134 conditions.
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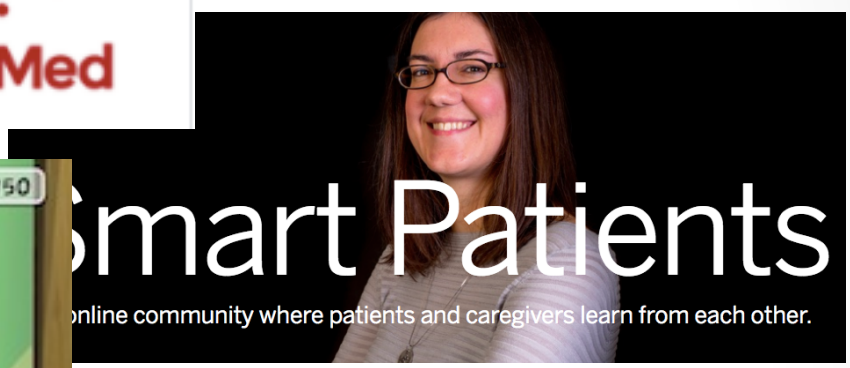
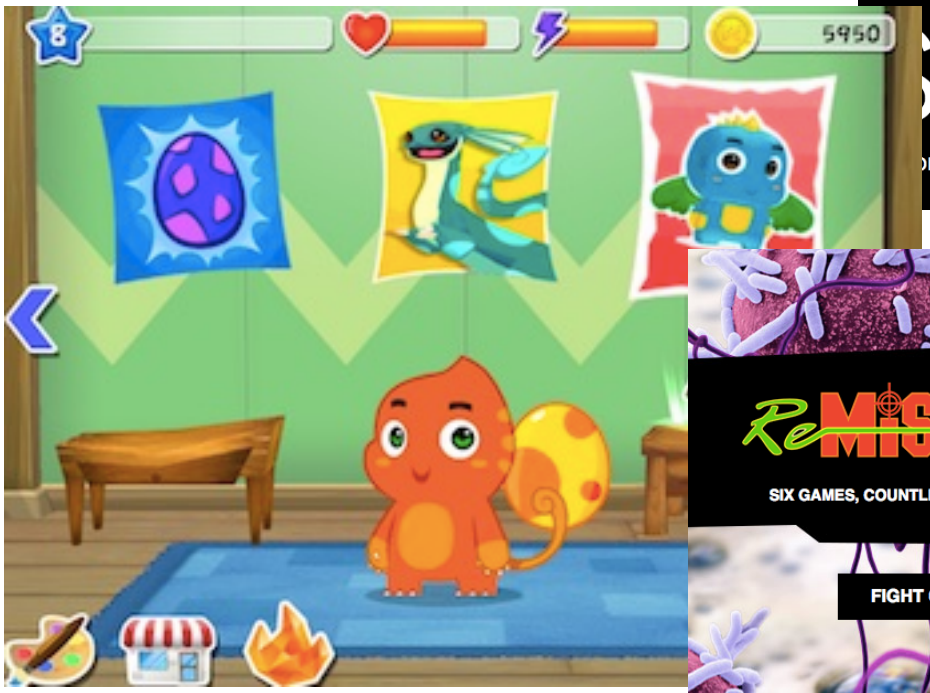

Smart Patients
online community where patients and caregivers learn from each other.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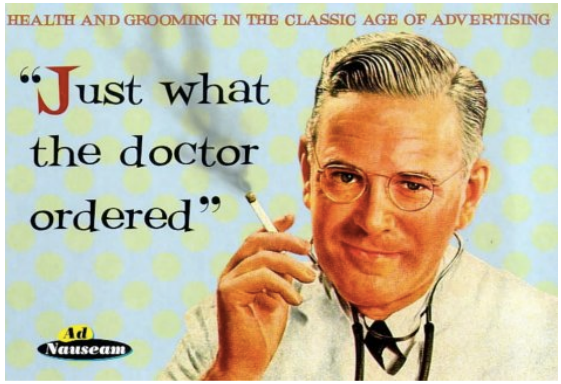
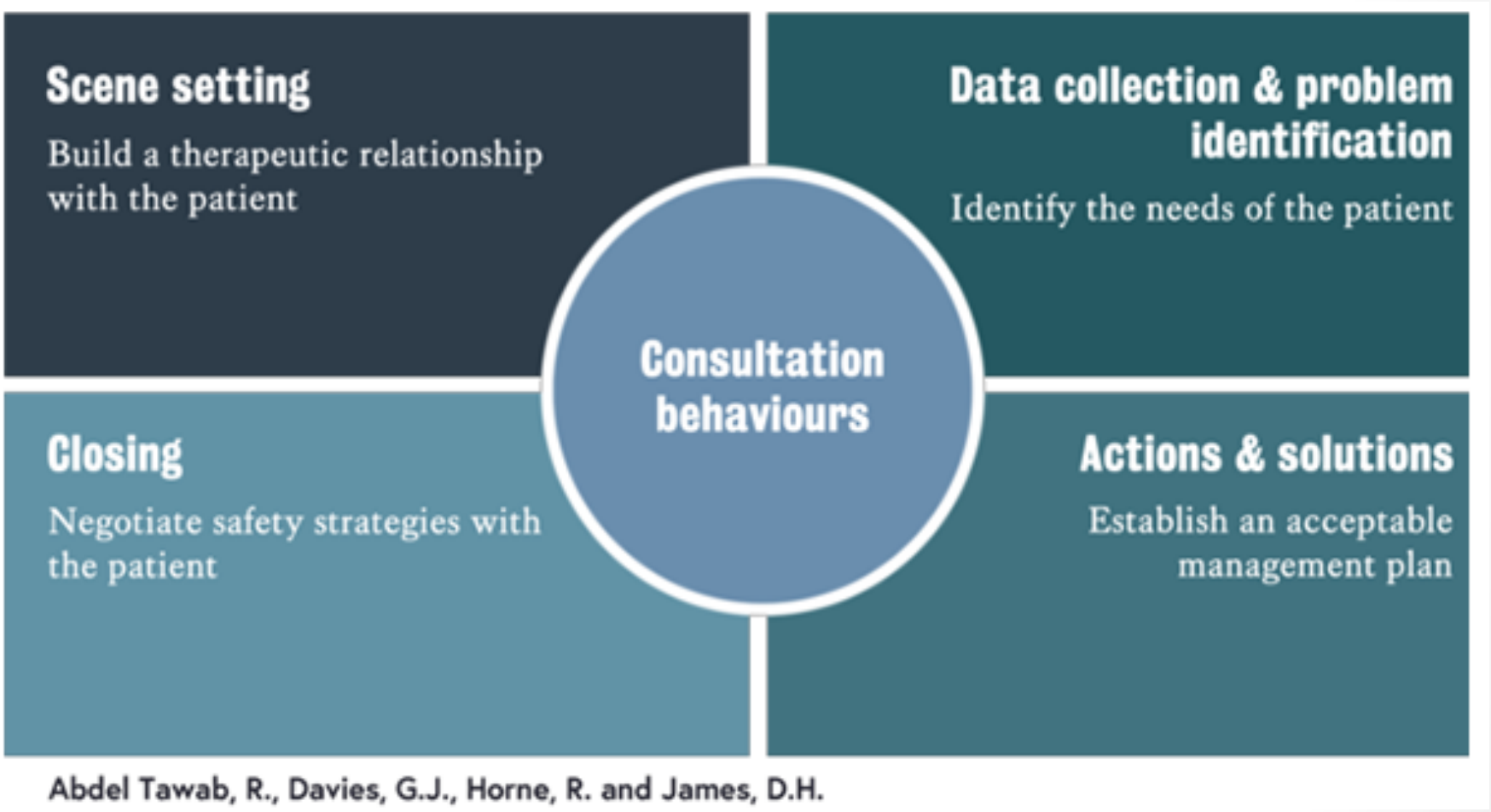
Real conversation is the future

Corporatism /paternalism → centricity → partnership



LIFE OBJECTIVE



Abdel Tawab, R., Davies, G.J., Horne, R. and James, D.H.

The Information-Motivation-Action model

(Di Matteo)

Information

Health Literacy

Motivation

Empowerment

Action

Adherence

Moving to efficient communication

- Active listening
- Chunking
- Reformulation
- Motivational Interview
- Multi-channel

Ask Me 3™

Good Questions for Your Good Health

Health Coaching in non adherence

IFWHC

'There is no smartphone app for empathy, offering emotional care or for looking a patient in the eye'

New technologies will not replace HCPs but provide medical professionals an unique opportunity to focus on patient as human being rather spending time hunting down evidence

IFWHC

THE FIVE ROLES OF A HEALTH COACH

Self-management support	Bridge between clinician and patient	Navigation of the health care system	Emotional support	Continuity
• Providing information • Teaching disease-specific skills • Promoting behavior change • Imparting problem-solving skills • Assisting with the emotional impact of chronic illness • Encouraging follow up • Encouraging participation	• Serving as the patient's liaison • Ensuring that patient understands and agrees with care plan • Providing cultural and language-concordance	• Connecting the patient with resources • Facilitating support • Empowering the patient • Ensuring the patient's voice is heard	• Showing interest • Inquiring about emotional issues • Showing compassion • Teaching coping skills	• Providing familiarity • Following up • Establishing trust • Being available

Coaching patients On Achieving Cardiovascular Health (COACH)

A Multicenter Randomized Trial in Patients With Coronary Heart Disease

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Background: Disease management programs in which drugs are prescribed by dietitians or nurses have been shown to improve the coronary risk factor profile in patients with coronary heart disease. However, those disease management programs in which drugs are not prescribed by allied health professionals have not improved coronary risk factor status. The objective of the Coaching patients On Achieving Cardiovascular Health (COACH) study was to determine whether dietitians or nurses who did not prescribe medications could coach patients with coronary heart disease to work with their physicians to achieve the target levels for their total cholesterol (TC) and other risk factors.

Methods: Multicenter randomized controlled trial in which 792 patients from 6 university teaching hospitals underwent a stratified randomization by cardiac diagnosis within each hospital: 398 were assigned to usual care plus The COACH Program and 394 to usual care alone. Patients in The COACH Program group received regular personal coaching via telephone and mailings to achieve the target levels for their particular coronary risk factors. There was one coach per hospital. The primary outcome was the change in TC (ΔTC) from baseline (in hospital) to 6 months after randomization. Secondary outcomes included measurement of a wide range of physical, nutritional, and psychological factors. The analysis was performed by intention to treat.

Results: The COACH Program achieved a significantly greater ΔTC than usual care alone: the mean ΔTC was 21 mg/dL (0.54 mmol/L) (95% confidence interval [CI], 16-25 mg/dL [0.42-0.65 mmol/L]) in The COACH Program vs 7 mg/dL (0.18 mmol/L) (95% CI, 3-11 mg/dL [0.07-0.29 mmol/L]) in the usual care group ($P<.0001$). Thus, the reduction in TC from baseline to 6 months after randomization was 14 mg/dL (0.36 mmol/L) (95% CI, 8-20 mg/dL [0.20-0.52 mmol/L]) greater in The COACH Program group than in the usual care group. Coaching produced substantial improvements in most of the other coronary risk factors and in patient quality of life.

Conclusions: Coaching, delivered as The COACH Program, is a highly effective strategy in reducing TC and many other coronary risk factors in patients with coronary heart disease. Coaching has potential effectiveness in the whole area of chronic disease management.

Arch Intern Med. 2003;163:2775-2783

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RESEARCH GROUP
Access to Care & Therapy Optimisation

Medication to take or not to take

Take away Message

Non-adherence

- Make of non-adherence a national priority
- Increase stakeholders collaborations
- Improve patient-physician partnership
- Introduce health coaches in the HC organisation