Home Health Care Nursing Application of the Transtheoretical Model of Change to Patients with Congestive Heart Failure: A Case Study

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Objectives

- Explore the six stages, three key concepts and stage appropriate interventions of the Transtheoretical Model of Change (TTM).

- Reflect on a case study where TTM was used to help an older gentleman with congestive heart failure (CHF) change his poor health behaviors.
The Problem

- WHO: cardiovascular disease causes greatest number of deaths
- CHF patients: frequent emergency rooms visits and hospitalizations
- Home care: limited ability to deal with complex heart failure symptoms
One Solution

- A specialized team of clinicians to care for patients with stage 3 and 4 CHF: Cardiac Life

- Team members: physicians, nurse practitioners, registered nurses and therapists
Cardiac Life

Complex & Chronic Home Care Clinical Delivery Model For Congestive Heart Failure

- Enhance health promotion (TTM)
- Effectively palliate symptoms
- Improve safety
- Decrease caregiver burden
- Improve well-being
- Decrease emergency room visits
- Decrease hospital readmissions
Keys to Success

• Nurse Practitioner (NP) home visits
• Weekly clinical CHF team meetings
• Physical therapists trained in *TAI CHI*
• Palliative care
• Transtheoretical Model (TTM) of Change
Why TTM?

- TTM has been effective in many areas including:
  - Smoking cessation
  - Weight reduction
  - Exercise
  - Healthy eating
Why TTM?

- TTM is a model that emphasizes change takes time.
Transtheoretical Model (TTM)

- Three core concepts
- Six stages or time points
- Ten process steps

Prochaska, Johnson & Lee, 2009
Core Concept: Decisional Balance

- Decisional Balance: potential pros and cons

- I decide:
  - If I want to think about changing.
  - Based on why or why not I think I should change.
  - If I should keep this new healthier habit.
  - If I should return to the old habit.
Core Concept: Self-efficacy

- Self-efficacy: confidence one has in one’s self

- One may say, I:
  - Can change!
  - Can’t do that.
  - Am not able to change.
Core Concept: Temptation

- Temptation: how much one can resist returning to old behaviors

- One may think, I:
  - Miss my habit.
  - Hate thinking about this (new health behavior) all the time.
  - Do not see what this (new health behavior) is doing for me.
TTM Stage: Precontemplation

- Precontemplation stage:
  - No thought or consideration of change
  - May not know now what the unhealthy behavior is
  - May choose to do nothing about it

- Nursing Actions:
  - Assess patient’s understanding of healthy behaviors
  - Provide health care education
TTM Stage: Contemplation

Contemplation stage:
- Thinking about a need for change
- Lasts up to six months

Nursing Actions:
- Assess perceived barriers
- Emphasize pros over cons
- Provide health care education
- Discuss a time in the future to take action
TTM Stage: Preparation

• Preparation stage:
  o Preparing to change
  o Usually within one month

• Nursing Actions:
  o Discuss ways to prepare for change
  o Determine what may need to be bought, altered or removed in order for change to occur
TTM Stage: Action

- **Action stage:**
  - Actively making the change
  - Last up to six months

- **Nursing Actions**
  - Offer encouragement
  - Discuss change maintenance strategies
  - Show support if there is a relapse back to the old habit
TTM Stage: Maintenance

- **Maintenance stage:**
  - Choosing to continue in the new behavior
  - Working to prevent relapse

- **Nursing Actions:**
  - Keep in touch in person or by phone
  - Offer continued encouragement
• Termination stage: complete behavior change and no temptation to return to the old behavior
Change Process Steps

- **Conscious Raising**
  - increases awareness

- **Dramatic Relief**
  - increases emotion

- **Self-reevaluation**
  - assess self-image

- **Environment reevaluation**
  - assess society image

- **Stimulus control**
  - prompts

- **Self Liberation**
  - self commitment

- **Social liberation**
  - empowerment

- **Counter conditioning**
  - alternatives

- **Contingency management**
  - reinforcements

- **Helping relationships**
  - social support
Case Study

- 76 year old man with multiple co-morbidities: CHF, chronic obstructive lung disease, diabetes

- On admission: overweight, depressed, elevated blood sugar, elevated blood pressure, 4+ pitting edema
The Problems

- The patient:
  - Not weighing self
  - Not doing daily blood sugars
  - Smoked
  - Poor diet
• High reliance on medical system to *cure*

• Transference of reliance to his wife to:
  - Cook
  - Give medications
  - Blood sugar

• Wife had multiple medical problems: increasingly difficult to care for husband
Case Study Plan

- Assess patient awareness of negative behaviors
- Consciousness—raising
- Education of need to care for self
- Patient was in the stage of contemplation
Case Study Plan

- Immediate health management issues:
  - Dietary restriction of salt
  - Self-management of daily blood sugar
  - Weighing self daily
  - Change of medications (NP)
Moments of Frustration

- For weeks, the patient would not care for self.

- Clinicians increasingly frustrated!
Case Study Plan

- Dramatic relief
- Past, present and future consequences
- Pros and cons
At 9th week of care, the patient stated:

- “I knew you were coming and so I figured I better do this...I cut down on the salt too!”

Weight and blood sugar log had been completed
Action Stage

- Patient had entered the action stage

- There were occasional lapses in self care

- At each visit, nurses
  - Offered support and encouragement
  - Discussed barriers and strategies to maintain change
Case Study Outcomes

- This paradigm case became the jumping board for a renewed sense of enthusiasm in the clinical team!
Clinical Team Outcomes

- Change in nurses and therapists:
  - Enhanced knowledge of change
  - Understanding that change takes time
  - Greater number of change strategies
  - Increased interest in motivating patients to change
  - Increased team communication
  - Increased patience with elderly patients
Cardiac Life Outcomes

Of the first 90 discharges from Cardiac Life

- 36 discharges to self care (40%)
- 23 discharges to hospice (25%)
- 15 hospitalizations for CHF symptoms (16%)
- 12 hospitalizations for other (13%)
- 4 deaths (4%)
Nursing Implications

- Consider the use of TTM as a foundational change theory
- Promote TTM in settings where patients are seen over a long period of time (i.e. home care)
- Educate nurses and nursing students on TTM
Research Needs

- Research needs:
  - Efficacy of TTM in home care
  - Effect of TTM on nursing satisfaction
  - Multi-cultural usefulness of TTM
Conclusion

- TTM appears appropriate for the home setting:
  - Emphasis that change takes time is appropriate for the older adult
  - Stages of change provide focus for the team in care planning
  - Potpourri of change strategies
  - Research of TTM in home care is warranted
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