



Starting the conversation: Patient initiation of weight-related behavioral counseling during pregnancy



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ABSTRACT

Objective: To examine the relationship between patient initiation and weight-related behavioral counseling during pregnancy.

Methods: We examined audio recordings of prenatal visits between 22 obstetricians and 120 patients for behavioral counseling using the Roter Interaction Analysis System and the 5A's behavioral counseling framework. We used multivariate regression models to examine the relationship between patient initiation and communication outcomes.

Results: Overall, 55% of prenatal visits included any behavioral counseling. Patients initiated counseling episodes 45.5% of these visits. Patients were less verbally dominated by their clinicians in prenatal visits with patient-initiated behavioral counseling episodes (difference in clinician verbal dominance ratio = 0.73, 95% CI = 0.16–1.30). Patient-initiated counseling episodes included more socioemotional communication relative to those initiated by clinicians ($p = 0.02$). The total duration of counseling was 28 s longer (95% CI 0.27–56.0 s) and clinicians were more likely to use two or more 5A's strategies (OR = 3.61, 95% CI = 1.01–12.88) when patients initiated discussions.

Conclusions: Patient initiation may lead to behavioral counseling that is longer in duration and includes more 5A's strategies, possibly mediated by socioemotional communication.

Practice implications: Participatory prenatal care communication may lead to more effective counseling that is responsive to women's concerns.

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1. Introduction

Although pregnancy is widely regarded as teachable moment for health behavior change [1–3], studies suggest that obstetric clinicians do not routinely counsel pregnant women on weight, nutrition and physical activity [4–6]. Studies suggest that the majority of women do not recall being counseled about weight gain during pregnancy [4,7], and many clinicians report not providing their pregnant patients with behavioral counseling on nutrition, physical activity and weight management [5,6,8]. Clinicians cite many reasons for not providing counseling, including limited time, the perceived inefficacy of behavioral counseling, the complexity of health behaviors, a lack of training on nutrition and physical activity, and the perceived sensitivity of discussions about weight [5,8–13].

Although patient initiation of counseling topics has received limited attention in patient-provider communication research, it is an aspect of patient participation in prenatal visits that may affect the quality of behavioral counseling that patients receive [6,14,15]. In two studies in primary care, patients initiated the majority of discussions of weight, nutrition and physical activity [16,17]. In a qualitative study, clinicians providing care to pregnant women perceived that patient initiation was a cue of patient interest in behavioral counseling, and some clinicians reported that they would only provide counseling on nutrition, physical activity, and recommended weight gain to patients who raised the topic during their prenatal visits [6]. In a primary care study with non-pregnant patients, clinicians used more of the 5A's (*Assess, Advise, Agree, Assist, and Arrange*) behavioral counseling strategies (providing more referrals and coming up with plans for follow-up) when patients initiated discussions of weight, nutrition and physical activity [9,18]. Outside of the literature on weight management, researchers have found that clinicians perceive information disclosure to be more reliable, and patient-provider relationship

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to be stronger, when patients initiate discussions, rather than the clinicians themselves [15]. Participatory prenatal visit communication – that is responsive to women's concerns about nutrition, physical activity and weight management – may strengthen therapeutic relationships between pregnant women and their providers and facilitate teachable moments for health behavior change during pregnancy [1,3]. Moreover, behavioral counseling provided in response to patient-initiated discussions of weight, nutrition and physical activity may also include more complete use of evidence-based counseling strategies [18].

The objective of this study was to examine the relationship between patient initiation of behavioral counseling episodes and communication outcomes. We hypothesized that prenatal visits in which patients initiated behavioral counseling episodes would have a more patient-centered style and that clinicians would be less verbally dominant throughout these prenatal visits. We hypothesized that patient-initiated behavioral counseling episodes would include greater use of socioemotional communication (e.g. empathy, expresses worry or concern, etc.) compared to clinician-initiated behavioral counseling episodes. Finally, we hypothesized that patients who initiated weight-related behavioral counseling episodes would receive counseling that was longer in duration, with greater use the 5A's strategies.

2. Methods

2.1. Design and participants

We conducted a cross-sectional, secondary data analysis using audio recordings, surveys and medical record reviews collected as part of a randomized control trial of a patient communication intervention. Details of the parent study are described elsewhere [19]. In brief, 23 clinicians and 130 of their patients were recruited from a single urban teaching hospital's obstetric outpatient clinic in Baltimore, MD. The majority of patients attending the participating clinic were eligible for Medicaid and the Women, Infants and Children (WIC) program. Clinicians were nurse practitioners, resident physicians, and attending physicians. At the time of recruitment, the revised IOM guidelines for gestational weight gain had been released and were intended to be the standard for behavioral counseling at the participating clinic [20].

Patients were recruited from consenting clinicians' panels, and agreed to have a single prenatal visit recorded [19]. We used 50 audio recordings of prenatal visits from the baseline cohort (June–December 2009) and 80 additional visits from the randomization cohort, in which patient participants received one of two communication skills programs (June 2010–January 2011). The first intervention was a computer-based communication activation program designed to encourage patients to engage actively in their prenatal visits. The second intervention was a facilitated review of relevant sections of *Baby Basics: Your Month by Month Guide to a Healthy Pregnancy* [21]. Clinicians were not aware of the patients' randomization assignments. Women randomized to the computer-based intervention were more verbally active, less verbally dominated by clinicians, demonstrated greater use of communication skills targeted by the intervention, and experienced visits that were more patient-centered. The interventions did not include specific discussions of nutrition, physical activity, gestational weight gain, or the 5A's [19].

For the current analysis, patients who did not have height or pre-pregnancy weight recorded ($n=3$) or were underweight ($BMI < 18.5 \text{ kg/m}^2$; $n=7$) were excluded. The final sample for the current study included 22 obstetrical clinicians and 120 of their patients. The Johns Hopkins University Institutional Review Board approved the study procedures.

2.2. RIAS-facilitated targeted transcription of behavioral counseling episodes

The Roter Interaction Analysis System (RIAS) was used to code each recorded prenatal visit. Two trained RIAS coders assigned each complete thought, expressed by the patient or clinician, to 1 of 37 mutually exclusive and exhaustive categories representing the functions of the medical dialogue. A 10% random subset of the audio recordings was double coded to establish inter-coder reliability of RIAS coding. Pearson correlation coefficients averaged 0.90 across clinician categories and 0.91 for patient categories. RIAS coders were not aware of the study hypotheses or group assignments for the parent or current studies.

RIAS lifestyle categories were used to identify and transcribe weight-related behavioral counseling in each of the recorded prenatal visits. A third coder, who was not aware of parent study group assignments, used RIAS coding logs to identify time stamps for all lifestyle statements (patient and clinician lifestyle questions, lifestyle information giving and clinician lifestyle counseling) in the recordings of each prenatal visit. The coder listened to the relevant sections of the recordings and transcribed all discussions about nutrition, physical activity and weight. The first and last RIAS lifestyle statements in a discussion were used to mark the beginning and end of each episode of behavioral counseling. The initiator of behavioral counseling was defined as the speaker who made the first weight-related lifestyle statement in the prenatal visit. The coder listened to the complete audio recording for a 25% random subset of the prenatal visits to confirm that the RIAS codes captured all relevant discussions of weight, nutrition and physical activity. No additional weight-related behavioral counseling was identified in this subset of prenatal visits.

2.3. Communication outcome measures: overview

The independent variable for this study was patient initiation of behavioral counseling episodes. The relationship between patient initiation and communication was examined using several different communication measures. First, the total patient and clinician statements, clinician verbal dominance ratio and patient-centeredness ratio were examined using all RIAS codes from the complete prenatal visit recordings (Section 2.3.1). Second, socioemotional valence was examined, using socioemotional RIAS codes within transcribed behavioral counseling episodes (Section 2.3.2). Third, the duration of counseling and clinicians' use of 5A's were examined within transcribed behavioral counseling episodes (Section 2.3.3).

2.3.1. Communication outcome measures: patient and clinician statements, clinician verbal dominance and patient-centeredness of overall prenatal visit communication

The total number of patient and clinician statements were used as an indicator of total dialogue throughout each prenatal visit. As in a number of other RIAS-based studies [22,23], clinician verbal dominance was calculated as a ratio of the total number of clinician statements relative to the total number of patient statements throughout the entire prenatal visit. Second, patient-centeredness was operationalized as a ratio of the psychosocial and socioemotional focus of the prenatal visit relative to the biomedical focus of the prenatal visit. The numerator included psychosocial and lifestyle disclosure, all patient questions and emotional statements plus the clinician's psychosocial questions, psychosocial and lifestyle information and counseling and facilitation statements. The denominator included clinician medical questions, clinician orientation statements, and both patient and clinician biomedical information.

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