W18: Implementation of pelvic floor muscle training programs in health services: challenges and strategies

Workshop Chair: Helena Frawley, Australia
12 September 2017 13:30 - 16:30

Start	End	Topic	Speakers
13:30	13:40	- Welcome to participants, introduction to panel and participants; brief background re disciplines and clinical vs research interests for later group-based discussions - Introduction to topic: Implementation: leakage of evidence-into-practice throughout the healthcare system	Helena Frawley
13:40	14:00	- Barriers and enablers to implementation of PFMT - this topic will explore examples of barriers and enablers in a health service that may impact on successful implementation	Helena Frawley
14:00	14:20	- Introduction to Capability Opportunity Motivation Behaviour (COM-B) model as it applies to PFMT - Exploration of the barriers/enablers from 1st activity as positive/negative characteristics of the individual, and how this impacts on implementation of PFMT	Doreen McClurg
14:20	14:40	- Applying the COM-B: skills and strategies for clinicians to implement PFMT - What is behaviour change and to what extent is this determined by the individual's motivation vs external influences - Exploration of goal setting and strategies to maximise self-efficacy - Examples will draw upon previous and current research trials of the panel	Sarah Dean
14:40	15:00	- Addition of the intervention function and policy categories layers of the Behaviour Change Wheel (BCW) to COM-B as it applies to PFMT intervention - Mapping of the barriers/enablers identified in the first activity to these levels	Jean Hay-Smith
15:00	15:30	Break	None
15:30	15:50	- Specific populations: neurological: older person; menopausal; migrant women - With reference to models (COM-B, BCW), consider specific populations: any barriers / enablers not previously considered - Consider patient & clinician, as well as social and organisational levels within the healthcare system	Chantale Dumoulin
15:50	16:10	- Trouble-shooting at service delivery level - Planning implementation into your clinical practice & research designs - Group discussion, case studies	All
16:10	16:25	- Conclusion: Participant action plan: modelling a behavioural contract (write, share, sign, "I will")	All
16:25	16:30	Participants complete workshop evaluations	None

Speaker Powerpoint Slides

Please note that where authorised by the speaker all PowerPoint slides presented at the workshop will be made available after the meeting via the ICS website www.ics.org/2017/programme Please do not film or photograph the slides during the workshop as this is distracting for the speakers.

Aims of Workshop

This workshop will address the barriers and enablers to implementation of pelvic floor muscle training (PFMT) in health services. While evidence for PFMT as an effective treatment for urinary incontinence and pelvic organ prolapse is strong, and international recommendations endorse this intervention as first-line treatment, availability of the service is variable and uptake and adherence is poor. The reasons are complex and relate to several levels within the health service: the treatment itself, the patient, the clinician, the social and the organisational context. This interactive workshop will explore the barriers and enablers at each level and provide strategies for participants to implement in their workplace.

Learning Objectives

1. Appreciation of the complexity and challenges of implementation of PFMT into a health service, and an understanding of why it is not always successful
2. Awareness of the importance of considering barriers and enablers to implementation of PFMT and how to find these in the workplace
3. Development of strategies to enhance implementation of PFMT in the workplace and in research designs

Learning Outcomes

On completion of the workshop the participant will:

1. be able to identify barriers and enablers to implementation of PFMT in their workplace
2. have developed several workplace-specific strategies to address these barriers and enablers

at the level of:

- the patient and the clinician
- the service and the organisation.

Target Audience

all disciplines interested in the effective implementation of PFMT in health services

Advanced/Basic

Basic

Conditions for Learning

This workshop is interactive. Each presenter (n=5) will facilitate group discussions. A maximum of 8 per group will allow for effective dialogue and problem-solving. Therefore ideally a maximum of 40 delegates may attend.

Suggested Learning before Workshop Attendance

- Barry, Michael J. and Susan Edgman-Levitan. (2012) 'Shared Decision-Making – The Pinnacle of Patient-Centered Care.' New England Medicine Journal 366(9), 780-781.
- Damschroder, L. J., D. C. Aron, et al. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation Science 4: 50 DOI: 50 10.1186/1748-5908-4-50
- Dumoulin, C., J. Hay-Smith, et al. (2015). "2014 consensus statement on improving pelvic floor muscle training adherence: International Continence Society 2011 State-of-the-Science Seminar." Neurourology and Urodynamics 34(7): 600-605.
- Lamin E, et al, (2016) Pelvic Floor Muscle Training: Underutilization in the USA, Current Urology Reports, 17(2): DOI: 10.1007/s11934-015-0572-0
- Frawley, H., P. Chiarelli, et al. (2014). Uptake of antepartum continence screening and pelvic floor muscle exercise instruction by maternity care providers: an implementation project. Neurourology and Urodynamics 33(6): 976-977.
- Greenhalgh, T. (2014). How to Read a Paper: The Basics of Evidence-based Medicine. Ch15: Getting evidence into practice,
- Grimshaw, J. M., M. P. Eccles, et al. (2012). "Knowledge translation of research findings." Implement Sci 7: 50.
- Grol, R., M. Wensing, et al., Eds. (2013). Improving patient care: the implementation of change in health care. Oxford, Wiley Blackwell.
- Michie, S., M. M. van Stralen, et al. (2011). "The behaviour change wheel: A new method for characterising and designing behaviour change interventions." Implementation Science 6(1).
- Willis CD et al. (2016). Sustaining organizational culture change in health systems ", Journal of Health Organization and Management, Vol. 30 Iss 1 pp. 2 – 30 DOI: org/10.1108/JHOM-07-2014-0117.

Suggested Reading

- Barry, Michael J. and Susan Edgman-Levitan. (2012) 'Shared Decision-Making – The Pinnacle of Patient-Centered Care.' New England Medicine Journal 366(9), 780-781.
- Damschroder, L. J., D. C. Aron, et al. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation Science 4: 50 DOI: 50 10.1186/1748-5908-4-50
- Dumoulin, C., J. Hay-Smith, et al. (2015). "2014 consensus statement on improving pelvic floor muscle training adherence: International Continence Society 2011 State-of-the-Science Seminar." Neurourology and Urodynamics 34(7): 600-605.
- Lamin E, et al (2016), Pelvic Floor Muscle Training: Underutilization in the USA, Current Urology Reports, 17(2): DOI: 10.1007/s11934-015-0572-0
- Frawley, H., P. Chiarelli, et al. (2014). Uptake of antepartum continence screening and pelvic floor muscle exercise instruction by maternity care providers: an implementation project. Neurourology and Urodynamics 33(6): 976-977.

- Greenhalgh, T. (2014). How to Read a Paper: The Basics of Evidence-based Medicine. Ch15: Getting evidence into practice,
- Grimshaw, J. M., M. P. Eccles, et al. (2012). "Knowledge translation of research findings." Implement Sci 7: 50.
- Grol, R., M. Wensing, et al., Eds. (2013). Improving patient care: the implementation of change in health care. Oxford, Wiley Blackwell.
- Michie, S., M. M. van Stralen, et al. (2011). "The behaviour change wheel: A new method for characterising and designing behaviour change interventions." Implementation Science 6(1).
- Willis CD et al. (2016). Sustaining organizational culture change in health systems ", Journal of Health Organization and Management, Vol. 30 Iss 1 pp. 2 – 30 DOI: org/10.1108/JHOM-07-2014-0117.

Other Supporting Documents, Teaching Tools, Patient Education etc

Handouts will be prepared and available to participants prior to the workshop. The handouts will cover the background theory and research which supports this topic. However as this will be an interactive workshop, the discussions and strategies developed cannot be pre-scripted, so the major value to attendees will be the participative experience and their own learning of context-specific strategies which will be of value in their own workplaces. We will provide work-sheets so that participants may keep a record of the most valuable discussion points.

Helena Frawley, Physiotherapist, Australia:

Introduction: Implementation: leakage of evidence-into-practice throughout the healthcare system

Implementation of evidence-into-practice into a healthcare system – with fidelity to the research – is challenging, and these challenges are faced by many evidence-based interventions. Health services delivery of evidence-based PFMT is not immune to these challenges. While PFMT is recommended as the first-line intervention for women with urinary incontinence (UI) or pelvic organ prolapse (POP) (Dumoulin 2016), actual practice does not reflect these good intentions in many jurisdictions (Lamin 2016, Ismail 2009, Chiarelli 1997). There is a known evidence-into-practice gap of up to 17 years (Morris 2011) for new interventions, and the incorporation of evidence into policy, in order to change a healthcare system, may be an even larger gap. Even when there is an intent to implement evidence, attrition or 'leakage' of adherence to the recommendations occurs along the pipeline of research into practice (Glasziou 2004). This attrition has been documented in many aspects of healthcare (Mickan 2011), however there are no reports of why and how this attrition occurs in the implementation of PFMT. Lack of attention to the attrition which occurs at each of the stages of change (aware, agree, adopt, adhere) is a lost opportunity for patient benefit. Findings from these other areas of healthcare will be used to inform our discussions of why and how the 'leakage' is occurring in the health system for PFMT, and why there may be unique aspects related to PFMT. Studies are emerging which consider the broader aspects which impact on implementation and uptake of PFMT in the childbearing year (Salmon 2017), however a complete synthesis of factors relevant to other populations affected by pelvic floor dysfunction is lacking. Indeed, recent research suggests local uptake of evidence is less informed by the traditional linear pipeline of 'evidence–guidelines–practice' and more by locally contextual issues such as budget, capacity and political influence (Atkins 2017).

Barriers and enablers to implementation of PFMT

- This topic will explore examples of barriers and enablers in a health service that may impact on successful implementation.

This session will involve a practical activity to be done in groups per table. Participants will brainstorm the aspects they perceive to be barriers and enablers in a health service which impact on the implementation of adoption and adherence to the evidence-based recommendations. These will include aspects which affect awareness, agreement, accessibility, adoption and adherence to the evidence-based recommendations.

Doreen McClurg, Physiotherapist, UK:

Introduction to Capability Opportunity Motivation Behaviour (COM-B) model as it applies to PFMT

- Exploration of the barriers/enablers from 1st activity as positive/negative characteristics of the individual, and how this impacts on implementation of PFMT

The use of theory is advocated by the Medical Research Council (MRC) framework for the development and evaluation of complex interventions (Campbell et al, 2000; Craig et al, 2008) and by others working in implementation research (Eccles et al, 2012; French et al, 2012) and should result in interventions that are more likely to be successfully implemented not just at clinician-patient level but also in the context of the health service structures.

There are many theories of behaviour change often with overlapping, but differently named, constructs (Michie et al, 2014). In addition, there is little guidance on how to choose an appropriate theory for a particular context (Michie et al, 2011). This diversity and complexity has been cited as a potential reason why theory is under-used in intervention design and evaluation making replication, implementation, evaluation and improvement more difficult (Eccles et al, 2012; Michie et al, 2011). Researchers working in this area argue that there is a need for a comprehensive supra-theory model of behaviour applicable across contexts.

Following on from the previous discussions on barriers and enablers, we will explore the COM-B model in which Michie et al (2014) propose that people need capability (C), opportunity (O) and motivation (M) to perform a behaviour (B). The model provides a simple starting point and can signpost to specific psychological theories of, for example, motivation if a more granular theoretical understanding of behaviour is required The model proposes that for someone to engage in a particular behaviour (B) at a given moment they must be physically and psychologically able (C) and have the social and physical opportunity (O) to do the behaviour and, in addition, want or need to do the behaviour more than any other competing behaviours at that moment. This inclusive definition of motivation (M) covers basic drives and automatic processes such as habit and impulses as well as reflective processes such as intention and choice.
The COM-B model has been developed as part of a larger system of behaviour called the behaviour change wheel (BCW) (Michie 2011, 2014) and allows developers to identify, in a systematic and transparent way, intervention functions and policy categories that could bring about change. Once intervention functions and policy categories have been selected, the final step in intervention design is to step outside the Wheel and identify specific behaviour change techniques and modes of delivery that are likely to be effective and that can be linked back to psychological theory.

<u>Sarah Dean, Psychologist, UK and Jean Hay-Smith, Physiotherapist, New Zealand:</u>

Applying the COM-B: skills and strategies for clinicians to implement PFMT

- What is behaviour change and to what extent is this determined by the individual's motivation vs external influences
- Exploration of goal setting and strategies to maximise self-efficacy
- Examples will draw upon previous and current research trials of the panel
- Addition of the intervention function and policy categories layers of the Behaviour Change Wheel (BCW) to COM-B as it applies to PFMT intervention
- Mapping of the barriers/enablers identified in the first activity to these levels

The Behaviour Change Wheel (Michie 2011) suggests nine approaches to intervention that may lead to behaviour change. Four of these approaches might be useful in implementing effective pelvic floor muscle training (PFMT). Based on a synthesis of qualitative studies of women's experiences of PFMT, Hay-Smith et al (2015) suggested that women are supported to adopt and maintain PFMT when the healthcare professional (HCP):

- Educates (e.g. provides information in a way that facilitates understanding about what to do and why)
- Trains (e.g. gives feedback to reinforce a correct contraction, prescribes a tailored and progressive exercise programme)
- Enables (e.g. nurtures positive thoughts and feelings about PFMT, and avoids imparting guilt or blame for past or current failures of exercise adherence)
- Persuades (e.g. fosters active planning to find solutions to exercise barriers).

Sarah, Jean, and Doreen, were all involved in developing a PFMT intervention for OPAL (OAPL), a large randomised trial that tests whether biofeedback intensified PFMT is better than standard PFMT in women with urinary incontinence to decrease incontinence and increase longer-term PFMT adherence. The OPAL intervention makes it clear how the HCPs educate, train, enable, and persuade women to adopt and continue with PFMT; a taxonomy of behaviour change techniques (Michie 2013) is used to explain how HCPs do this. During the workshop you will have completed an activity in which you named and practised some different behaviour change techniques.
However, our research suggests there is one intervention approach (called 'modelling') that we might not be using much, but could be very fruitful. Women often hear from others that incontinence is 'normal' after having children or as you get older, and that pelvic floor muscle exercises do not work (Hay-Smith 2015). Further, continence product companies may reinforce 'normality' and 'acceptability' in marketing messages that show idealised women managing 'light bladder leakage' with pads. Women may consciously or unconsciously be de-motivated by these messages, in the absence of positive role modelling. The workshop includes a brain-storm about what HCP's can do to turn modelling from a barrier (the negative messaging) to an enabler (positive messaging about the effectiveness of PFMT).
To complete this section of the workshop we review the complete BCW; Jean will select some examples from the first workshop activity (barriers and enablers within a health service that impact on implementation of PFMT) and map these to the BCW. The mapping will demonstrate that attrition or 'leakage' of adherence to the evidence-based PFMT recommendations occurs along the pipeline of research into practice. Further, the mapping will show that HCPs need to consider the complete 'system' (or 'society' or 'context') in which PFMT interventions are delivered if many barriers to implementation are to be addressed.

<u>Chantale Dumoulin, Physiotherapist, Canada:</u>

Specific populations: older person; menopausal; migrant women, neurological patients

- With reference to models (COM-B, BCW), consider specific populations: any barriers / enablers not previously considered
- Consider patient & clinician, as well as social and organisational levels within the healthcare system

Through a 2011 Citizen Jury study, Chantale identified the need for older women to actively participate in their conservative management of urinary incontinence. (Dumoulin, 2012) She also ran two qualitative studies to explore and identify facilitators and deterrents of conservative management involving pelvic floor muscle training in aging women with incontinence.(Martin, 2007; Elliott, 2015) These studies helped her develop a PFMT intervention for the GROUP trial, a large non-inferiority

randomised trial assessing, in women 65 and older with stress or mixed U, if group PFM training is at least as effective as individualised PFM training, one year after randomisation. During the workshop you will learn more about this exercise program favoring self management. Further, preliminary results from our latest qualitative study (post-intervention interviews presented in the main meeting; Ruella, 2017) will inform you about the activities that were more helpful to initiate behavioral change among the GROUP project participants and those that helped to facilitate long term adherence to the PFM exercises.
The workshop will expend to other specific population, neurological patients, menopausal women, migrant women with reference to the COM-B, BCW; participants will be invited to share their experience. Further, the importance of the social and organisational context, health care system in which the intervention occur will be highlighted. Support from key stake-holders and available human and financial resources will be discussed in the context of implementation of PFMT program. Drawing from presenters' and participants' experience, strategies to address these will be shared.

References:

Atkins, L., M. P. Kelly, et al. (2017). "Reversing the pipeline? Implementing public health evidence-based guidance in english local government." Implementation Science 12(63).

Campbell M., Fitzpatrick R., Haines A., Kinmonth A.L., Sandercock P., et al. 2000. Framework for design and evaluation of complex interventions to improve health. BMJ, 321, 694–696.

Chiarelli, P. and E. Campbell (1997). "Incontinence during pregnancy. Prevalence and opportunities for continence promotion." Australian and New Zealand Journal of Obstetrics and Gynaecology 37(1): 66-73.

Craig P., Dieppe P., Macintyre S., Michie S., Nazareth I. & Petticrew M. 2008. Developing and evaluating complex interventions: the new Medical Research Council guidance. BMJ, 337, 1655.

Dumoulin, C., K. F. Hunter, et al. (2016). "Conservative management for female urinary incontinence and pelvic organ prolapse review 2013: Summary of the 5th international consultation on incontinence." Neurourology and Urodynamics 35(1): 15-20.

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Eccles M.P., Grimshaw J.M., MacLennan G., Bonetti D., Glidewell L., et al. 2012. Explaining clinical behaviors using multiple theoretical models. Implement Sci, 7, 99.

Elliott V, de Bruin E, Dumoulin C. (2015). Virtual reality rehabilitation as a treatment approach for older women with mixed urinary incontinence: a feasibility study. Neurourology & Urodynamics; Neurourology & Urodynamics, March 2015; 34(3):236-43.

French S.D., Green S.E., O'Connor D.A., McKenzie J.E., Francis J.J., et al. 2012. Developing theory-informed behaviour change interventions to implement evidence into practice: a systematic approach using the Theoretical Domains Framework. Implement Sci, 7, 38.

Glasziou, P. and R. B. Haynes (2005). "The paths from research to improved health outcomes." Evidence-Based Medicine 10: 4-7.

W18:
Implementation of pelvic floor muscle training programs in health services:
challenges and strategies

- Helena Frawley
- Doreen McClurg
- Sarah Dean, UK
- Jean Hay-Smith, New Zealand
- Chantale Dumoulin, Canada

PROGRAM

Start	End	Topic	Speaker
13:30	13:40	Welcome Implementation of PFMT	Helena Frawley
13:40	14:00	Barriers & enablers to PFMT implementation	Helena Frawley
14:00	14:20	Capability Opportunity Motivation Behaviour (COM-B) model as it applies to PFMT	Doreen McClurg
14:20	15:00	Practical: mapping Behaviour Change Techniques (BCTs) to a PFMT intervention. Applying mapped intervention and policy categories to COM-B and the Behaviour Change Wheel (BCW)	Sarah Dean & Jean Hay-Smith
15:00	*15:30*	*Break*	
15:30	15:50	Specific populations	Chantale Dumoulin
15:50	16:10	Trouble-shooting; Group discussion	All
16:10	16:25	Conclusion	All
16:25	16:30	Workshop evaluations	All

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PHYSIOTHERAPY

Implementation of PFMT

Helena Frawley, *PhD, FACP*

- Assoc Prof Physiotherapy, Monash University, Melbourne, Australia
- NHMRC Health Professional Research Fellow
- Head, Centre for Allied Health Research and Education, Cabrini Institute, Melbourne

GROUP OF EIGHT AUSTRALIA

Helena Frawley

Affiliations to disclose†:

Salaried employee of:

- Monash University, Melbourne
- Cabrini Health, Melbourne

† All financial ties (over the last year) that you may have with any business organisation with respect to the subjects mentioned during your presentation

Funding for speaker to attend:

- [X] Self-funded
- [X] Institution (non-industry) funded
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Health Services Delivery

Image: from: http://www.federicaamati.com/public-health-reports/2016/7/8/who-regional-office-consultation-on-integrated-health-service-delivery

Implementation of PFMT:
leakage of evidence-into-practice throughout the healthcare system

What is implementation?

- Implementation: (Lomas 1993)
  - Active, planned, tailored
  - involves identifying & assisting in overcoming the barriers to the use of the knowledge
  - It uses the message itself, plus:
  - Organisational & behavioural tools that are sensitive to constraints & opportunities of health professionals in identified settings
- Implementation research:
  - Scientific study of methods to promote the uptake of research findings for the purpose of improving the quality of care

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Implementation on the research pathway (Campbell 2000)

Image: Phases of research as endorsed by the Medical Research Council UK for testing effects of intervention studies (Campbell 2000)

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Implementation in clinical practice

Image from: Image from: https://neurodevnet.wordpress.com/2015/05/01/research-partners-research-users-and-research-impact/

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The challenge of implementation

- Implementation of guidelines into clinical practice
  - Only 20% of guidelines are taken up by clinicians

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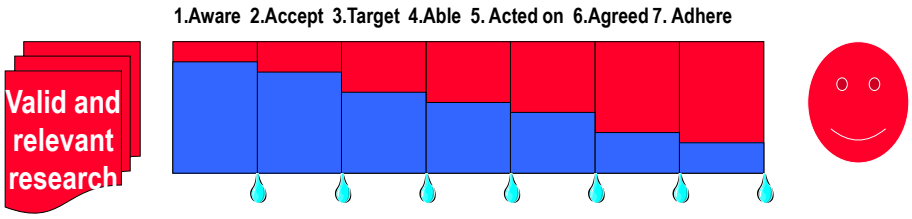
The leaky 'pipeline' of research to practice

(Glasziou & Haynes 2005)



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The 'pipeline' of research to practice

(Mickan 2011)

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Evidence–practice gap

- time lag from research into clinical practice: → 17 years (Morris 2011)
- ≤ 10% antenatal women taught PFM exercises using clinical examination, confirmed correct contraction:
  - Australia (Chiarelli 1997, Brown 1998, Dietz 2003)
  - Internationally (Mason 2001, Fine 2007, Guerrero 2007, Whitford 2007, Sangi-Haphpeykar 2008, Ege 2008, Ismail 2009)

- *How long is the evidence to policy gap??*

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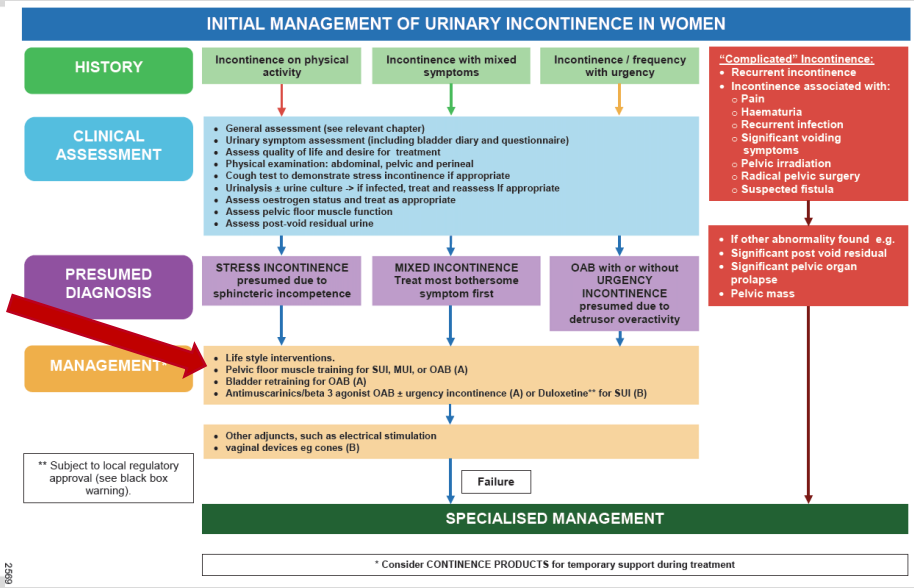
13

What to implement for UI? (ICI 2017)



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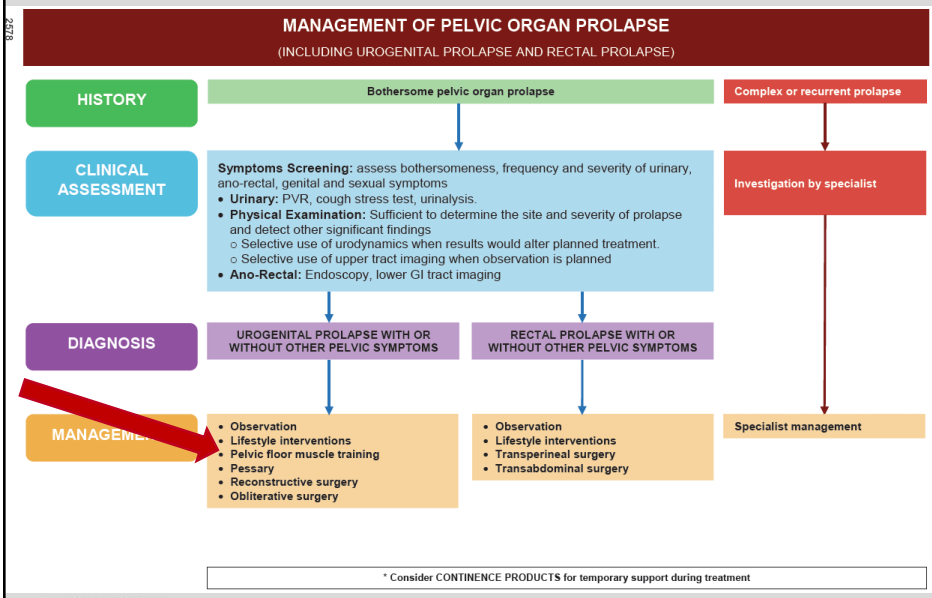
What to implement for POP? (ICI 2017)



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The good ship PFMT evidence

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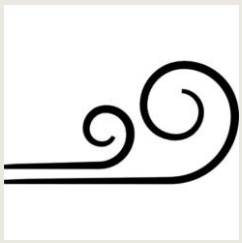
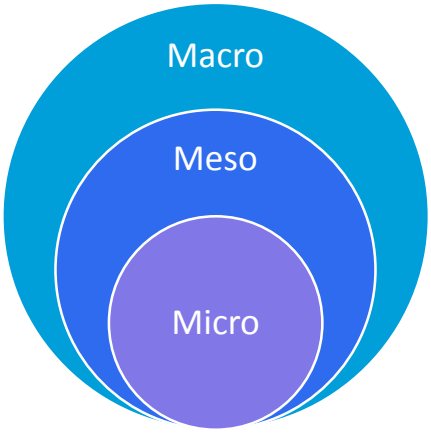
Barriers and enablers to implementation of PFMT



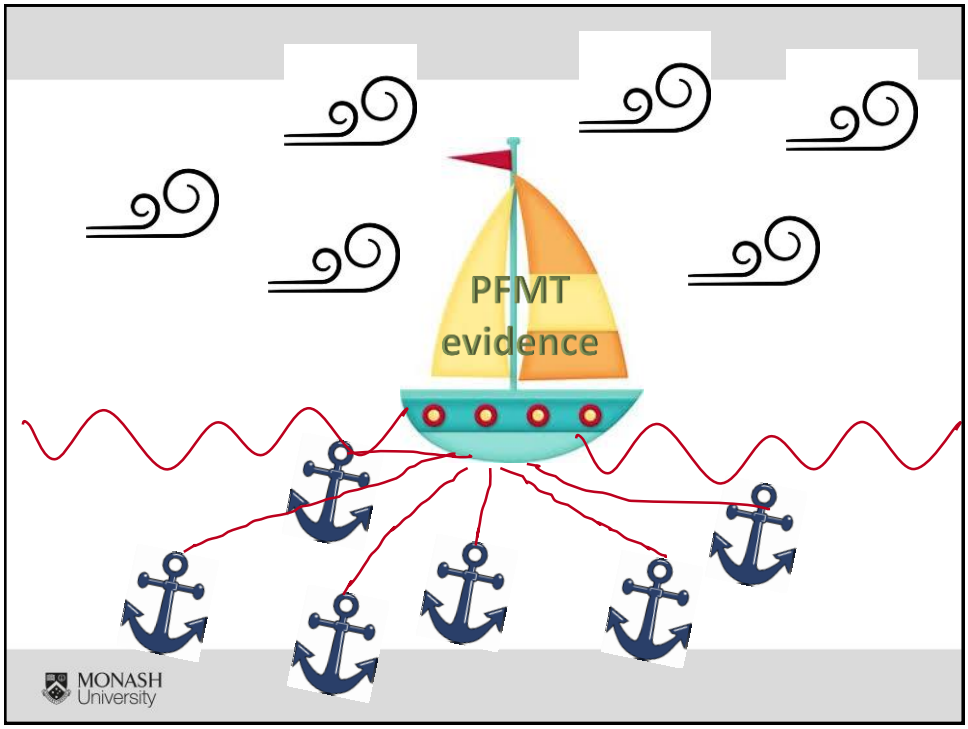
Barriers and enablers



Economic and political

Social and organisational

Individual clinician and patient


PFMT
evidence
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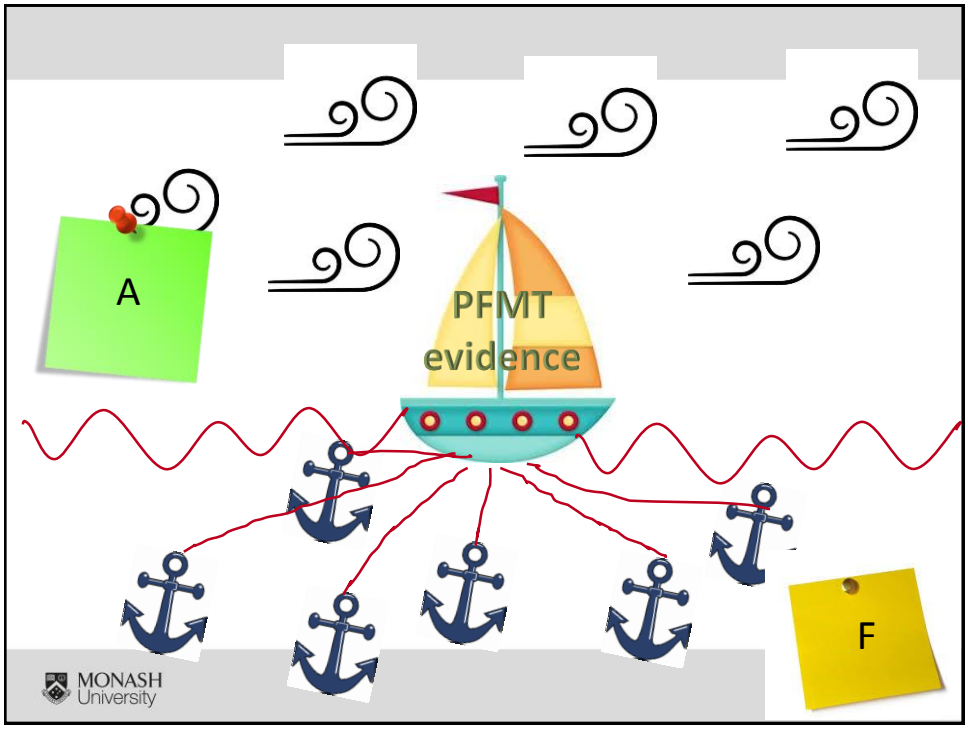
A
PFMT
evidence
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Doreen McClurg

Physiotherapist, UK

Sarah Dean
Physiotherapist &
Psychologist, UK

Jean Hay-Smith
Physiotherapist, NZ

Introduction
Practical: Mapping Behaviour Change Techniques (BCTs) to a PFMT intervention
Feedback

Applying mapped intervention and policy categories to COM-B and the Behaviour Change Wheel (BCW)

Jean Hay-Smith

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† All financial ties (over the last year) that you may have with any business organisation with respect to the subjects mentioned during your presentation

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South West Peninsula Collaboration for Leadership in Applied Health Research and Care (PenCLAHRC)

NHS National Institute for Health Research

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Sarah has undertaken paid consultancy work as part of an expert panel for the development and review of UCL's Behaviour Change Taxonomy project.

Introduction

- What is behaviour change?
- Behaviour Change Taxonomy
- How much is behaviour change determined by an individual's motivation versus external influences?

- Behaviour Change Techniques (BCTs) – as skills and strategies for clinicians to use to implement PFMT
- two examples:
  - BCTs that relate to goal setting
  - BCTs that maximise self-efficacy
  - As used in the OPAL trial

OPAL optimising pelvic floor exercises to achieve longterm benefits

https://www.opaltrial.co.uk/

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What and when do we do a behaviour change?

- Engaging in a healthy lifestyle
- Adopting advice for self-management
- Taking or doing a prescribed treatment

Behaviour Change Taxonomy

ann. behav. med.
DOI 10.1007/s12160-013-9486-6

ORIGINAL ARTICLE

The Behavior Change Technique Taxonomy (v1) of 93 Hierarchically Clustered Techniques: Building an International Consensus for the Reporting of Behavior Change Interventions

Susan Michie, DPhil, CPsychol · Michelle Richardson, PhD · Marie Johnston, PhD, CPsychol · Charles Abraham, DPhil, CPsychol · Jill Francis, PhD, CPsychol · Wendy Hardeman, PhD · Martin P. Eccles, MD · James Cane, PhD · Caroline E. Wood, PhD

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How much is behaviour change determined by an individual's motivation versus external influences?

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Behaviour Change Techniques (BCTs) – as skills and strategies for clinicians to use to implement PFMT

NHS National Institute for Health Research

Goal Setting and Action Planning

BCTs in this group are:

- Problem solving
- Goal setting (behaviour)
- Goal setting (outcome)
- Action planning
- Review behaviour goal(s)
- Review outcome goal(s)
- Behavioural Contract

Source: BCT Taxonomy (v1) Michie *et al* 2013

Behaviour Change Techniques (BCTs) – as skills and strategies for clinicians to use to implement PFMT

NHS National Institute for Health Research

Promoting self-efficacy: Rehearse and practice skills (BCT 23)

- Confidence in a correct contraction
- A pelvic floor muscle contraction is a physical (neuromotor) skill
- Women highly **value** knowing that they can perform a correct contraction – skill **mastery** – that will help them become dry (**health outcome**)
- Physical practice and mental rehearsal

Introduction to the practical activity

- Pack content
  - Fictional extract from a PFMT treatment intervention session
  - BCT slips (and some BCT briefing sheets)
  - Highlighter and marker pens, blu tac
- Mapping (coding) exercise
  - Highlight text corresponding to the BCT slip
  - Attach BCT slip nearby on flip chart paper, using blu tack
  - Use marker pen to draw line from coded text to the BCT slip
  - Repeat with remaining BCTs (there are a few red herrings)
  - Ask facilitator for help if not sure what to do
  - Let facilitator know when finished (prizes for best performances)
- Practice a BCT (optional activity)
  - Select a BCT briefing sheet and practice with a partner

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Feedback on the practical activity

- Mapping (coding) exercise
  - How many BCTs did you spot?
  - How many are approaches you use normally?
  - Did you know this is how you can label them?
  - Any 'new' BCTs?
  - Any BCTs you are not sure about?
- Prizes

Feedback on the practical activity

- Take home messages
  - You use many of these techniques and psychological approaches all the time and are good at making use of them
  - Now be more explicit in naming and labelling them, documenting what you have done
  - Now use the new ones you have learnt about today to further enhance your practice and ability to help women change their behaviour and adhere to their PFMT routine
  - You are an 'external' influence and by making explicit use of BCTs you can enhance an individual's motivation; but there are other external influences to also consider…….

Sources of behaviour

- How much is behaviour change determined by an individual's motivation versus external influences?
- Motivation one part
- External influences just as important

Michie S et al. *Impl Sci*, 2011

Influencing through interventions

- Education to increase knowledge or understanding
- Persuasion to stimulate PFMT behaviour
- Training to help patients acquire PFMT skills
- Enabling by increasing facilitators and decreasing barriers to the behaviour

Michie S et al. *Impl Sci*, 2011

Modelling

- Modelling provides examples for the person to aspire to, or imitate.
- Patients have many examples of 'negative' modelling
- Supplementary written education materials were provided which included stories from women who had succeeded in achieving continence by doing their PFM exercises.
- Positive modelling – can we do better?

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'Missing' intervention influences?

- Incentivisation - creating expectation of reward
- Coercion - creating an expectation of punishment or cost
- Restriction - using 'rules' to make it harder to do harmful behaviour or easier to do the desired behaviour
- Environmental restructuring - changing the physical or social context

Michie S et al. *Impl Sci*, 2011

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'Policy' levels of influence

- Failure to implement evidence
- Social stigma
- Power of media to shape beliefs
- Laws that govern funding of health services
- Service constraints
- Payment rules

Michie S et al. *Impl Sci*, 2011

Motivation versus external influences?

Chantale Dumoulin

Physiotherapist, Canada

WORKSHOP DISCUSSION

- Trouble-shooting at service delivery level
- Planning implementation into your clinical practice & research designs
- Case studies

CONCLUSION

- Participant action plan: modelling a behavioural contract (write, share, sign, “I will”)

Strategies: Interventions targeted at healthcare workers

- Audit and feedback
- Clinical incident reporting
- Monitoring the performance of the delivery of healthcare
- Communities of practice
- Continuous quality improvement
- **Educational** games
- **Educational** materials
-

Evaluating your efforts at implementing evidence (Lewis 2016)

- Acceptability
- Adoption
- Appropriateness
- Cost
- Feasibility
- Fidelity
- Penetration
- Sustainability

Does it change patient outcomes?

(Grimshaw 2004)

- Majority of studies observed improvements in care
- Large variations within & across interventions
- Improvements: small to moderate
- Median improvement in measures of quality of care:

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Does it change patient outcomes?

(Grimshaw 2004)

- Majority of studies observed improvements in care
- Large variations within & across interventions
- Improvements: small to moderate
- Median improvement in measures of quality of care: 10%
- Multifaceted interventions did not appear more effective than single interventions

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Thank you!

Please complete workshop evaluations