TREATING PATIENTS WITH TLC: INCORPORATING THERAPEUTIC LIFESTYLE CHANGE INTO YOUR PRACTICE

As presented at the 2003 American Academy of Physician Assistants 31st Annual Physician Assistant Conference by Sandra L. Mackey, MPAS, PA-C

Sandra L. Mackey, MPAS, PA-C, developed her strong interest in preventive medicine while serving as an Assistant Professor at The University of Texas Southwestern Medical Center Department of Physician Assistant Studies in Dallas. During that time, she established a therapeutic lifestyle change referral clinic at Healthcare Associates of Irving, a private family practice group. Currently, Ms. Mackey is Director of Staff Wellness at Texas Scottish Rite Hospital for Children, also in Dallas. She continues to use motivational interviewing skills in her work with the hospital employees.

Given the epidemic of overweight and obesity in the United States, it is not surprising that the conditions frequently associated with excess weight are also rising sharply. As Sandra L. Mackey, MPAS, PA-C, Director of Staff Wellness at Texas Scottish Rite Hospital for Children in Dallas, points out, we have numerous medications to manage and treat diagnoses such as hypertension, type 2 diabetes, cardiovascular disease, and hypercholesterolemia, but the prevalence of all of these disorders can be decreased in most cases—and can be partially or completely reversible through lifestyle changes. The Third Adult Treatment Panel of the National Cholesterol Education Program (NCEP ATP III) first coined the term “therapeutic lifestyle changes,” or TLC, as a constellation of healthy behaviors and established specific guidelines for TLC intervention in the treatment of lipid abnormalities. However, the concept of healthy lifestyle changes as recommendations to reduce vascular disease risk were also included in the sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI). The components of TLC are obvious and have been part of our cultural vernacular and common news stories for the past several decades: weight loss, smoking cessation, reduced sodium intake, limited alcohol intake, reduced saturated fat and cholesterol intake, and adequate dietary potassium, calcium, and magnesium. Of note, the recently published JNC VII retained the lifestyle recommendations established in JNC VI.

Ms. Mackey provided a “how-to” seminar for physician assistants (PAs) who are currently implementing or wish to incorporate TLC into their practices. Speaking from experience, Ms. Mackey began by discussing one of the significant challenges of using TLC in primary care: TLC intervention presents a necessity for medical providers to learn new clinical skills. Although TLC may be clearly indicated, it is not as easy to “prescribe” as a pharmaceutical intervention. Overweight and obesity in the United States reflect a cultural problem with medical consequences. Therefore, before PAs can hope to have a real impact on their patients’ medical conditions with TLC recommendations, PAs will also need to examine the influence of modern cultural norms on lifestyle behaviors and their own personal views on diet, exercise, smoking cessation, and the other components of TLC.
PAs also need to consider their patients’ daily circumstances and obligations that may present barriers to change. Ms Mackey also discussed why the medical community in general has not fully addressed patient obesity and inactivity, indicating that the reasons are multiple and varied. Lack of training in the skills necessary for effecting behavioral change is most commonly cited by providers, followed by time constraint and limited or no reimbursement for services. Incorporation of TLC counseling into the practice setting requires skill in motivational interviewing, knowledge of the stages-of-change theoretical model and medical coding, and a flexible schedule.

**Opening the Dialogue**

While some patients have the education, motivation, and organization to make necessary lifestyle changes without provider intervention, others do not. For those who do not have the tools to incorporate TLC on their own, providers can facilitate movement through the stages-of-change process as described by Prochaska and DiClemente: precontemplation, contemplation, determination, action, maintenance, relapse, and termination.4

Ms Mackey specifically described strategies to incorporate these stages of change into TLC. The first step is to identify the stage of change for the patient, and this can be achieved by asking the patient 3 questions: what they know, how they feel, and what they are willing to do about the problem in question. The patient’s answers will reveal their stage of change. Ms Mackey emphasized that this is not a time to educate the patient, to outline the reasons why they should make the change, or even to discuss the process of change. The PA’s objective is to determine the stage in which the patient resides. The PA will want to tailor the remainder of the appointment to the patient’s stage of change. Should the PA be tempted to argue for the targeted change, without first assessing the patient’s stage of change, they may find—once their monologue on the virtues of exercise is over, for example—that the patient bought a treadmill 2 weeks ago and has obtained a personal trainer. The PA has wasted precious office time convincing the patient of something they have already decided, and this has not moved the patient toward the next stage of establishing a new behavior, nor the PA-patient relationship forward.

Identifying the stage can be done by first naming the problem (eg, obesity, high cholesterol) and making a very clear, strong statement, such as “Ms Smith, I feel that your cholesterol of 236 mg/dL is a significant health risk to you.” The purpose of this statement is to define a specific problem (or constellation of problems) that result from a behavior. According to Ms Mackey, the PA should be clear, brief, and personal. It is a professional opinion and needs to be expressed in the first person (I see, I feel, I am concerned, etc). Then the PA should ask the patient to answer the questions that will reveal their current stage: What do you know about this? How do you feel about this? What are you willing to do about this?

**What Do You Know?**

Patients in the precontemplation stage can be characterized as uninterested, unaware, and unwilling to think about it. They are often surprised when the problem is stated to them. They either have no awareness of the situation or no concern over the consequences. They may be especially surprised if the problem identified is the result of routine blood work or clinical screening.

When those in the contemplation stage are asked “What do you know?” they are aware of the problem and are thinking about it. Patients in this stage are ambivalent and will argue for and against the targeted change. When the patient discusses the problem, a discrepancy between their goals (weight loss), and individual reality (no time to exercise) emerges, followed frequently by a position of defensiveness.

The patient in the stage of determination will agree about the type and severity of the problem and has most likely already taken small steps of action (eg, buying a treadmill for more exercise). Determination is often a short-lived stage, as the patient moves quickly then to action.

Patients in the action stage discuss the changes that they have made and are making. However, they may sound rather cautious, because these changes have not yet fully become a part of their lifestyle. They may have implemented an exercise routine or joined a gym, but they may also voice concern about how they will continue when the children get out of school, or when the weather changes.

Ms Mackey also explained that working with patients in the maintenance phase is a wonderful opportunity to hear the patients share what they have learned from the changes that they have made. It is
also a great opportunity to hear more about their daily lives. Often, the skills mastered to make one change in patient behavior can be tapped to bring about success in another change process.

The patient in the relapse stage will tell you, “I don’t know how this happened,” or “I know exactly how this happened.” There is a sense of shame with the relapse phase; patients in this phase will describe what changes they were making but are no longer doing.

**How Do You Feel?**

Responses to this question typically fall into 2 categories: intense (often negative) feelings or humility and gratitude. Those in precontemplation are surprised, while those in contemplation are grappling with the mismatch of what they desperately want and what they have. These feelings can be intense if the patient understands the severity of the problem. Humility and gratitude are found in those in the maintenance or termination phases. As they have succeeded in their change, they share with modesty what they have learned from the process, or how they feel about it. Those in relapse may express a great deal of remorse or guilt.

**What Are You Willing to Do?**

Contemplating patients often have confidence that they can change but are not yet willing to do it. Again, patients reveal ambivalence or a mismatch between importance and confidence. They have the confidence that they could make the change, but it has not yet become important enough for them to do so. Those in the determination phase will either ask for a plan or outline their prospective plan. Those in action or maintenance will tell you what they are doing currently, and those in precontemplation are not yet ready to answer this question.

**Interventions**

As Ms. Mackey emphasized, it is necessary to determine the stage of change before attempting an intervention, because the PA can then begin to facilitate the patient through the change process, rather than educate them on the change they are about to make. Roughly 80% of patients are going to fall into the precontemplation or contemplation stage of change. Because those in the precontemplation stage are unaware, uninterested, and/or unwilling, the most important intervention the PA can offer is information. As Ms. Mackey explained, most of us make changes in our life based on knowledge. Precontemplative patients do not need to be convinced, but rather educated, including tools for self-evaluation. Ms. Mackey recommends delivering the intervention information in any and all formats that are useful: face-to-face, as reading material to take home, or as a referral to other outside resources as needed. She also recommends setting a definite follow-up appointment in a reasonable amount of time to discuss the issue again. At the follow-up, the conversation should begin with the same 3 questions: What do you know? How do you feel? What are you willing to do about it? Patients may have moved to the determination stage as a result of the last visit. Stage-specific intervention will likely help the patient move more quickly through the stages and make the targeted changes.

When a patient is found to be in contemplation, the intervention goal is to build a rapport with the patient and help the patient work through feelings of ambivalence. This can be achieved through motivational interviewing (discussed below). Because most patients will fall into the precontemplative and/or contemplative stage in the clinical setting, learning to perform a motivational interview takes on significant importance in facilitating behavioral change.

Interventions for determined patients are to support, plan, and problem solve. These patients usually move directly into the action stage. Patients in action need constant development and reinforcement of new coping skills, cues, and rewards to move from action to maintenance. Patients in maintenance also benefit from reviewing strategies with the PA and sharing knowledge with others who need to make similar changes. Use of reflective exercises will help the patient in maintenance use the tools they developed in one change to address other issues where change is indicated.

Patients who have relapsed to old behavior patterns are often filled with guilt, remorse, and a loss of self-esteem as a result of their “failure.” Ms. Mackey was encouraging, however, as she explained that the PA can help the patient reframe this experience from a “failed attempt” to a learning experience that will better prepare the patient to try again. She suggested asking the patient where it went wrong, what could be done differently, and how the individual might take the knowledge now gained from the experience and move back toward action. Many patients will need to go through
the cycle multiple times to gather all the self-efficacy tools necessary to make the targeted change an enduring lifestyle.

**Motivational Interviewing**

Patients in the contemplation stage are ambivalent about the problem. They want the problem to be resolved, and yet they do not want to make the changes necessary. Often, they feel the change is important to them, but they are not confident they can do what is needed to make the change for a variety of reasons. Conversely, patients may express great confidence in their ability to change, but find the change to be unimportant. In short, ambivalent patients will voice the discrepancy between their goal and reality as long as the provider uses reflective conversation and resists the urge to solve the patient’s problems or offer persuasive argument for the targeted change. Ms Mackey indicated that adopting the motivational interview style may seem a bit counterintuitive initially. In motivational interviewing, she explained, the PA listens rather than talks, asks rather than tells, and leaves the issue open rather than offering a solution. Traditional medical interview training develops skills in educating, diagnosing, and problem solving. In the traditional model, the patient owns the problem and the provider owns the solution. In the motivational interview model, the patient owns both and the provider facilitates their verbal expression. Getting the patient to express ambivalence (tell both sides of the story) can be done through reflective, empathic listening. Ms Mackey offered an example: “I have 3 jobs, and I need all of them to meet my financial obligations as a single mother. Each requires that I’m sitting throughout my shift. I don’t have time to exercise.” A reflective, empathic response would be, “So, time is a real issue for you.” As the conversation progresses, the patient will arrive at her own solutions to the identified problems. If not, the PA might ask, “What do you think might help you resolve this issue?” A persuasive response would be, “Well, maybe on your day off,” or, “Maybe on your break.” At that point, the patient is obligated by her ambivalence to tell you why that will not work. The nature of ambivalence is such that patients will strongly desire to explore both sides of the discrepancy between their goals and their reality. If the PA supplies the solutions, the patient will choose to supply the obstacles to the solution.

As with any new skill, this takes practice and much patience. Patients are keenly perceptive and sensitive to judgmental responses and frustration with the process. It is important that the PA monitor his or her feelings while learning this new skill. The best predictor of success in any behavioral change is what the patient says about the change. The goal of motivational interviewing is to get the patients to argue for the change themselves. They will become most strongly aligned with their own words and feelings on change. If the PA offers all of the positive change and the patient expresses resistance, the patient leaves the interview more closely aligned to resistance than to the possibilities for change. A full discussion of motivational interviewing is beyond the scope of this article, but Ms Mackey referred to the published literature on treating addiction for an in-depth explanation of this technique, particularly the book *Motivational Interviewing* by Miller et al.5

**Barriers**

Ms Mackey also addressed some of the barriers to motivational interviewing, including time, scheduling, knowledge, skill, and reimbursement. Time is a premium in any outpatient setting, and scheduling therefore is a challenge. However, for TLC counseling to be effective, she noted, specific time must be set aside—20 to 30 minutes. She suggests asking the patient to come back for a separate appointment, rather than risk a “doorknob consultation” that may be rushed and more than the patient can really work through in one session. Making a separate appointment also validates the seriousness of the issue in the patient’s mind and gives the PA time that is not focused on other waiting appointments. Those in precontemplation or contemplation can be given information to consider in the interim until the next appointment. Follow-up appointments should not be delayed or the importance of the issue will be undermined.

Ms Mackey emphasized that knowledge and skills are certainly surmountable barriers and underscored this by noting that PAs are lifelong learners. As mentioned previously, much can be learned about counseling strategies and motivational interviewing from the literature on addiction treatment.5 As with other skills, she suggests, nothing can replace practice. It is important to remember that the PA need not be an expert in any of the behaviors to be changed (eg, an exercise
physiologist or a registered dietician). The PA's goal is to learn how to facilitate change and to identify resources for patients in those areas that require expertise beyond the PA's training.

**Documentation and Coding**

TLC can be documented and coded for reimbursement. Ms Mackey indicated that TLC should be coded as counseling and coordination of care for established patients. Many PAs do not use this code because it seems nebulous, or they are uncertain of the documentation requirements. Counseling and coordination of care is documented not by elements of history or physical examination, or even level of difficulty. Counseling and coordination of care, she explained, is coded simply by time; it is the only outpatient code documented by time. To qualify for counseling and coordination of care, more than 50% of the total time spent with the patient needs to be in counseling, and the counseling must be related to a documented medical issue or diagnosis. The requirements for documentation are: patient identification information, diagnosis (relevant to this appointment), stage of change, goals, plan, and total time spent with the patient. Ms Mackey assures that it is not necessary to write out the conversation; most of the elements for documentation can be placed on the progress note as a check-off, fill-in-the-blank, or circle item. This method is especially useful for the stage of change and plan. The evaluation-management codes corresponding to the length of the face-to-face visit time are: 15 minutes (99213), 25 minutes (99214), and 40 minutes (99215).

**Conclusion**

Ms Mackey concluded by reiterating that the number of patients PAs see for cardiovascular disease, hypertension, diabetes, osteoporosis, and osteoarthritis is enormous and growing. To successfully prescribe TLC, assess the patient's stage of change and use motivational interviewing to help the patient move through the stages of change. Time and skill are the biggest obstacles. Separate appointments for TLC counseling are necessary to appropriately discuss TLC and to underscore the importance of this intervention. The newly acquired skills of motivational interviewing require patience and practice. However, along with appropriate documentation and coding, TLC can be successfully implemented and reimbursed.

**References**