

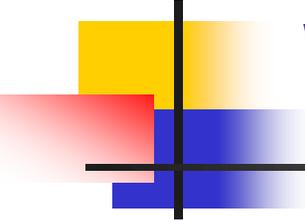
# W2: Teaching Motivational Interviewing Skills in the Primary Care Practice Setting: Engaging Physicians and Practice Staff

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Walter L. Calmbach MD MPH

Alan M. Adelman MD MS

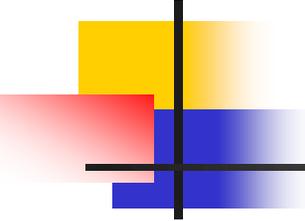
10:15-11:45 am, Monday, June 24,  
*Judiciary*



# Welcome and Introductions

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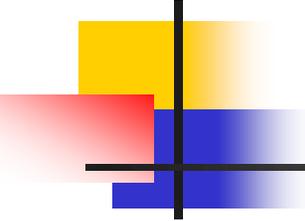
- Walter L. Calmbach MD MPH
  - Dept. of Family & Comm. Med. UT Health San Antonio
  - STARNet (South Texas Ambulatory Research Network)
  - taught Motivational Interviewing skills to MD's and staff
- Alan M. Adelman MD MS
  - Department of Family & Comm. Med, PSUCOM
  - NIH RCT for training physicians in MI
  - Experience with training medical students & residents in MI



# Purpose

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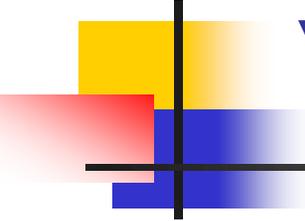
- The **purpose** of this workshop is to help participants work through the difficulties they can expect when delivering an educational intervention like Motivational Interviewing in the busy practice setting.
- We will briefly review the principles of Motivational Interviewing and what is known about educational interventions in practice.
- Participants will work in groups to specify what information will be delivered, shape the message for physicians & staff, & modify the intervention based on feedback.



# Learning Objectives

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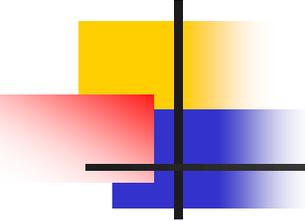
- At the completion of this workshop, participants will:
- 1) be familiar with the principles of Motivational Interviewing;
- 2) be aware of potential barriers to educational interventions in the busy primary care practice setting;
- 3) be prepared to create a practice-friendly educational intervention that can engage both physicians and practice staff.



## “Go around the room...”

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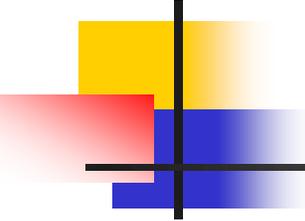
- Please tell us a little bit about yourselves, and what experience you have had using Motivational Interviewing in the practice setting...



# Background: Motivational Interviewing in Primary Care

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- Originally developed for use in addictions counseling
  - i.e., stopping a negative behavior
- Now also used in many “positive” applications
  - i.e., adopting healthy behaviors
- Goal: harness the *patient’s own motivation* for change
- while avoiding a directive or prescriptive approach that actually generates *resistance* to change
- Challenge: avoid “the righting reflex”



# What is Motivational Interviewing?

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- Motivational Interviewing is a goal-oriented patient-centered *counseling style* that enhances motivation for change by helping the patient clarify and resolve ambivalence about behavior change
  - The goal of MI is to create & amplify *discrepancy* between current behavior and broader goals
  - i.e., create *cognitive dissonance* between where the patient is and where the patient wants to be

# Why should we use MI?

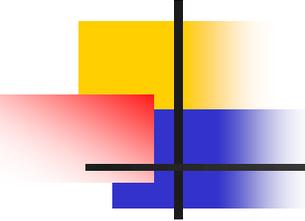


- Simply giving patients advice to change is often *unrewarding* and *ineffective*
- Motivational Interviewing is both a *set of techniques* and a *counseling style*
  - “think of yourself as an experienced guide”
- MI uses a *guiding style*
  - engage with patients
  - clarify their strengths and hopes
  - bring out their own motivations for change

# Avoid the Righting Reflex



Marilyn Herie PhD RSW:  
<https://www.slideshare.net/MarilynHerie/mi-queens-2013-pub>



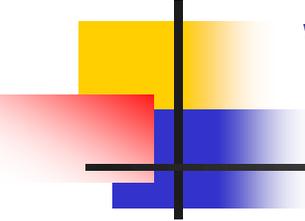
# Toward a Theory of Motivational Interviewing...

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- 2 specific active components:
  - a *relational* component
    - client-centered empathy and the interpersonal spirit of MI

and

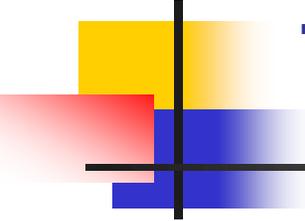
- a *technical* component
  - evoking and reinforcing change talk



# What is “the Spirit of MI”?

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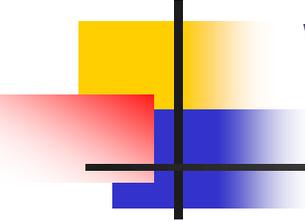
- The spirit of MI:
  - collaboration* in all areas of MI practice
  - eliciting* and *respecting* the patient’s ideas, perceptions and opinions;
  - eliciting* and *reinforcing* the patient’s autonomy and choices; and
  - accepting* the patient’s decisions
- “Without ‘the spirit of MI’ we would not be practicing MI.”



# The Spirit of Primary Care

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- put the patient first
- listen to the patient
- treat the patient as a person,  
not as a collection of diseases
- see the patient in the  
context of the whole family
- ... all very consistent with the Motivational  
Interviewing approach

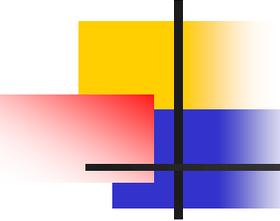


# What we did: STARNet

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- STARNet physicians asked us to come up with a way to “get through” to their overweight or obese patients
- We used an “Academic Detailing” approach to teach physicians & staff about 4 key principles of MI:
  - OARS skills (Open-ended questions, Affirmations, Reflective statements, Summaries)
  - Setting the Agenda (collaboratively with the patient)
  - Assessing Importance and Confidence
  - Eliciting (and Recognizing!) Change Talk
- 4 one-hour sessions over 4 months during usual staff mtg time
  - Brief PPT re MI, 5 min video, roleplay in pairs, debrief after roleplay, use new skills





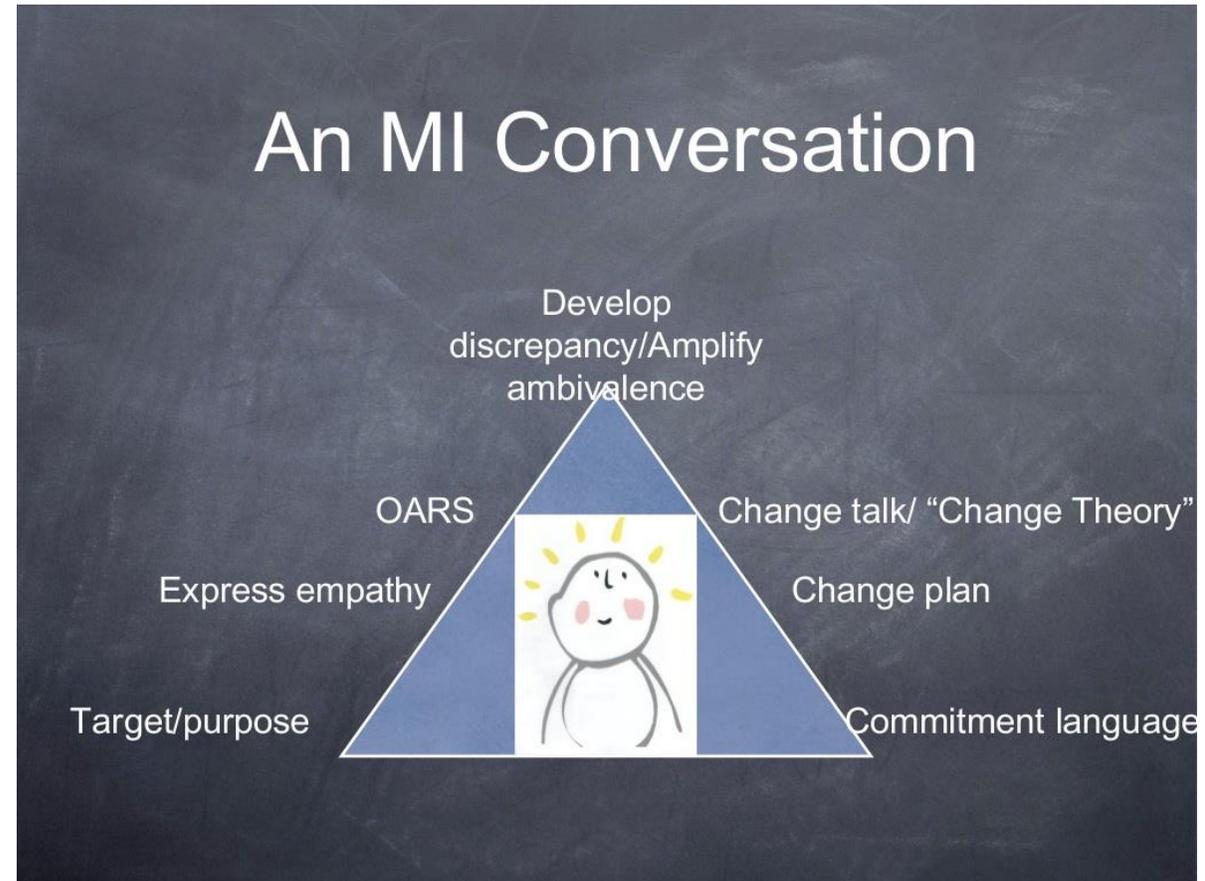
# STARNet: What we did not do

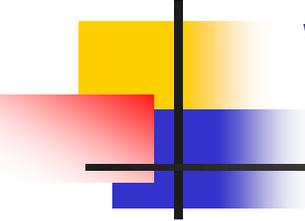
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- Many facets of Motivational Interviewing not addressed in the 4 training sessions
  - Not possible to become an MI expert in 4 sessions
    - Focus on **skills, tips, approaches**
  - Practice physicians not willing to allow unlimited access to staff time for training
  - “MI Updates” emailed to physicians and ofc mgrs
- 1. An MI Conversation
  - 2. Which MI Skills Will You Commit To Use?
  - 3. Who Was Your Favorite Teacher, and Why?
  - 4. Unsolicited Advice is the Junk Mail of Life
  - 5. Tips for Mastering the Art of Medicine \*
  - 6. Find Out Where The Patient Is, and Meet Them There
  - 7. Simple vs. Complex Reflections
  - 8. A Motivational Exercise
  - 9. Change Talk, Sustain Talk: Two Sides of the Same Coin
  - 10. An MI Causal Chain
  - 11. Affirmations: Powerful Inducements to Behavior Change
  - 12. 4 Processes of MI
  - 13. Evoking the Patient’s Own Motivation for Change
  - 14. Find the Change Talk

# Motivational Interviewing Update #1: an MI Conversation

- It is difficult to be mindful of the Motivational Interviewing approach in the crush of a busy clinic day,
- but this technique might actually be time-saving and is certainly far more satisfying for both patient and physician.
- Rather than being prescriptive, try targeting the conversation to a change the patient is already considering,
- express empathy for their situation, and listen for “change talk”...

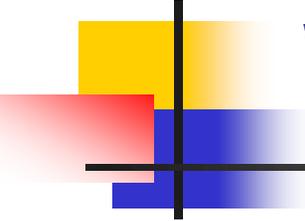




# What we did: Penn State/PSARN

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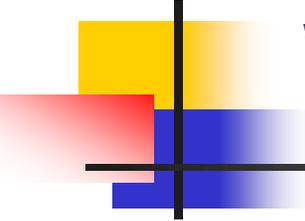
- Recruited 24 clinicians from the Penn State Ambulatory Research Network
- Randomized by office to intervention/control
- 12 Month training program



# What we did: Penn State/PSARN, cont'd

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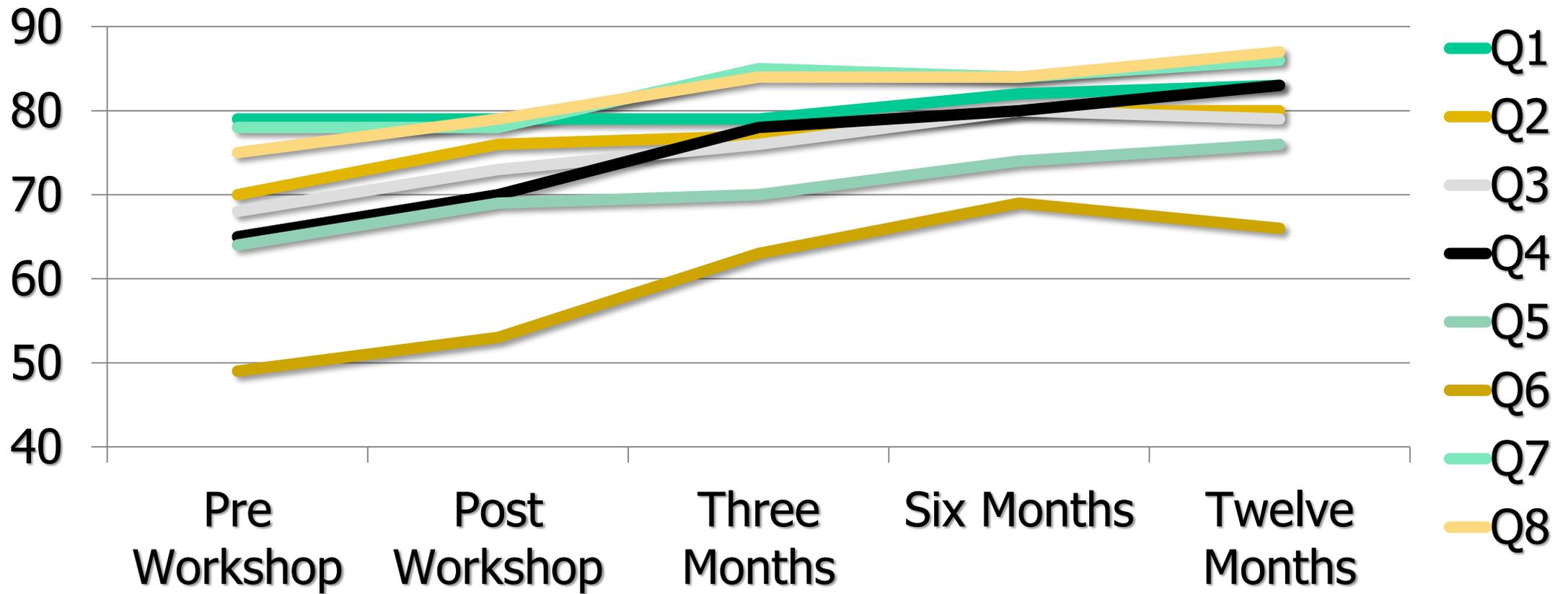
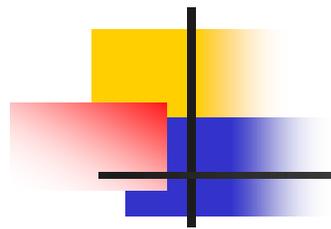
- Pre-evaluation
  - Audio-taped baseline encounters with participant-selected established patient
- Post-evaluation
  - Control – audiotaped encounters with participant-selected established patient
  - Intervention – 2 unannounced visits by standardized patients
- Tapes rated using BECCI and MITI scales

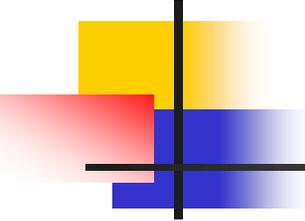


## What we did: Penn State/PSARN, cont'd

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- 3 hour workshops at baseline and 3 months
- 1 hour sessions at 1,2, 4, 5, 6, 9 and 12 months
- Submission of 2 audiotaped encounters with own patients before each training session – rated using BECCI and MITI with personalized feedback
- *Motivational Interviewing in Health Care – Helping Patients Change Behavior by Rollnick, Miller & Butler*
- *Measured Diabetes Measures – baseline, 16 months*

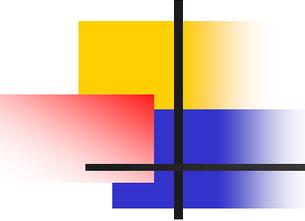




# MI approaches we did use/teach:

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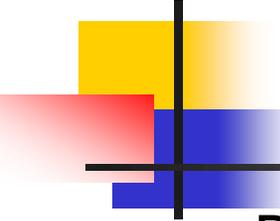
- OARS skills
  - Open-ended questions, Affirmations, Reflective statements Summaries  
Setting the Agenda  
Assessing Importance & Confidence  
Eliciting Change Talk
- DARN CAT acronym
  - Desire, Ability, Reason, Need
  - Commitment, Activation, Taking Steps
- 5-minute video illustrating key points (positive, negative)
- Roleplay in groups of 2 (patient, clinician), debrief after roleplay



# MI approaches we did not use/teach:

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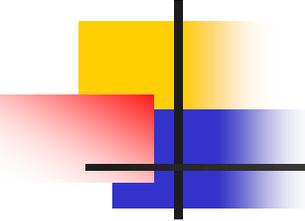
- Decisional Balance, Pro's and Con's
- FRAMES: Feedback, emphasis on personal Responsibility, Advice, a Menu of options, an Empathic counseling style, and support for Self-efficacy.
- ACE: Autonomy, Collaboration, Evocation
- Change Talk vs Sustain Talk
- Simple vs Complex Reflections
  - Repeating, rephrasing, empathic reflection, reframing, feeling reflection, amplified reflection, double-sided reflection



# MI approaches we did not use/teach:

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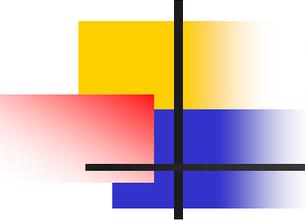
- Roleplay in groups of 3:
  - -> Speaker/Patient/Client: talks about a change they want to make but feel ambivalent
  - -> Counselor #1: listen carefully, offer no advice, then ask 5 open-ended questions:
    - Why would you want to make this change?
    - How might you go about it, in order to succeed?
    - What are the three best reasons to do it?
    - On a scale from 0 to 10, how important would you say it is to make this change?
    - And why are you at \_\_\_\_ and not zero?
  - -> Counselor #2:
    - Give a short summary/reflection of the speaker's motivations for change
    - - Desire for change, Ability to change, Reasons for change, Need for change
    - Then ask: "So what do you think you will do?" and just listen with interest
- Roleplay in groups of 3, Penn State version: Patient, Clinician, Observer



# MI approaches we did not use/teach:

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- The Four Processes of MI:
  - Engaging, Focusing, Evoking, Planning
- “Typical Day”
  - rapport-building strategy, physician assesses patient's social context and behavior in a nonjudgmental way
  - "What is a typical day like for you, from start to finish? If you don't mind, tell me about where [taking your medication, smoking, etc.] fits into your day?"
  - This gives the patient a choice of whether or not to discuss the target behavior. Using an open-ended question, the physician may learn valuable information essential to the treatment plan but may not otherwise be divulged



# Small Group Tasks

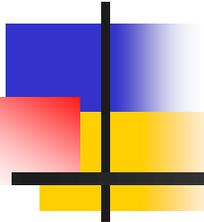
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- 1) what information will be delivered (i.e., of the many complex issues involved in the Motivational Interviewing technique, which ones are *most relevant* and *necessary* in the primary care practice setting?);
- 2) how will the relevant information be *modified* or *shaped* to engage both physicians and practice staff?; and
- 3) how can/will the initial planned educational intervention be *modified* based on experience with and feedback from participating practices?



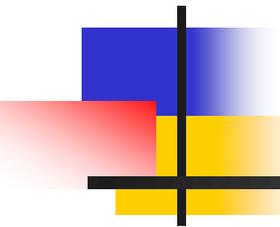
Break

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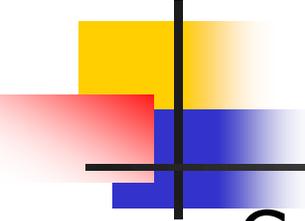
# Small Group Reports

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# Summary

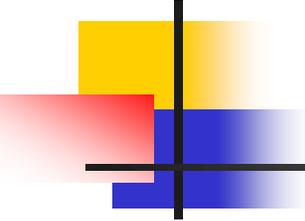
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# 1. Summary of Small Group Reports

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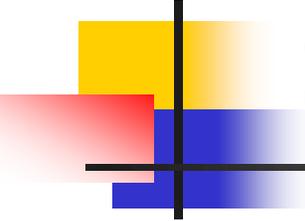
- Group #1:
  - Focus on asking questions, determine which questions were most helpful to clinicians, offer a detailed script, plan 3-person roleplay exercise
- Group #2:
  - Use the “typical day” scenario to generate patient responses, develop next steps and options, help patients get to the “next level”, plan relatively frequent small doses of MI training
- Group #3:
  - Meet with clinicians and staff at noon, provide lunch, plan 6 sessions q 2 weeks (4 re MI, 1 re wellness visits, 1 re chronic care visits), question: how do you track uptake of MI skills?



## 2. “What Worked”, Penn State, university-related practices

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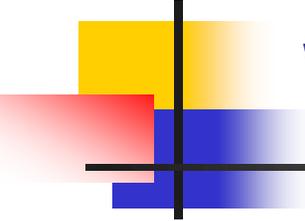
- MI skills & self-efficacy improved
- No significant changes in diabetes measures
- No long term outcomes – are skills retained?
- Some clinicians by nature are directive and others are more patient-centered
- The question remains – What ‘dose’ of MI delivered by clinicians is necessary to bring about significant change?



# 3. “What Worked”, STARNet, independent private practices

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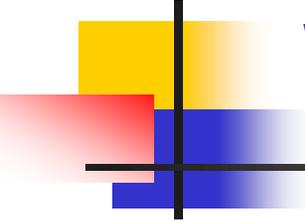
- 1) train physicians & staff *together*;
- 2) emulate the behavior you are trying to instill;
- 3) simplify language;
- 4) avoid Motivational Interviewing jargon;
- 5) solicit physician and staff input at each step;
- 6) get *them* to talk (i.e., emulate the behavior you are trying to instill);
- 7) plan for “1-hour” training sessions (ready to start 10 min. late, end 10 min. early!);
- 8) be alert to body language (e.g., MD’s fidgeting, checking email, etc.);
- 9) avoid “hot-button” words (not “role-play”, but “practice”; not “homework”, but “stories”);
- 10) sidestep physicians who block staff input;
- 11) use videos to show that using MI techniques need not lengthen the office visit;
- 12) focus on tips, skills, behaviors, “value-added” to a busy practice



# Group Discussion: Next Steps, Future Directions, Where Do We Go From Here?

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- 1. new uses for Motivational Interviewing?
- 2. feasibility of educational interventions in busy practices
- 3. is it really necessary to train MD's & staff together?
- 4. conference theme: *"How do we keep prevention on the table in face of disease management incentives?"*



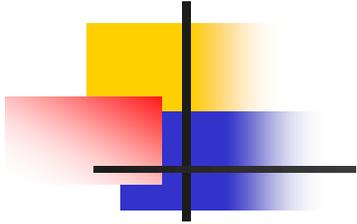
# Wrap-up and Evaluations

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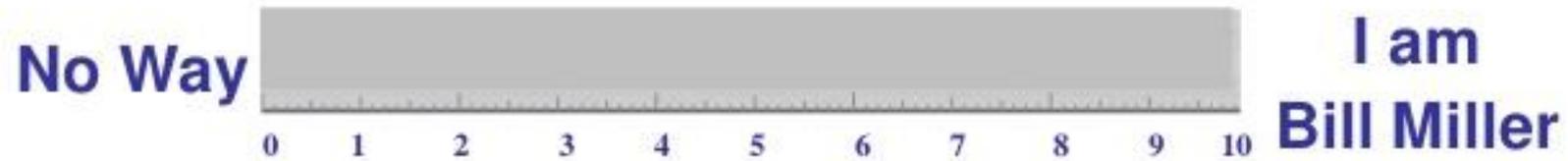
- How did we do addressing our 3 learning objectives?
  - ...be familiar with the principles of Motivational Interviewing
  - ...be aware of potential barriers to educational interventions in the busy primary care practice setting
  - ...be prepared to create a practice-friendly educational intervention that can engage both physicians and practice staff

# 10 Things that Motivational Interviewing is Not

- 1. *MI is not based on the Transtheoretical Model*
- 2. *MI is not a way of tricking people into doing what they don't want to do*
- 3. *MI is not a 'technique'*
- 4. *MI is not a Decisional Balance*
- 5. *MI does not require assessment feedback*
- 6. *MI is not a form of Cognitive-Behavior Therapy*
- 7. *MI is not just Client-Centered Counseling*
- 8. *MI is not easy*
- \* 9. *MI is not what you were already doing*
- 10. *MI is not a panacea*



# Confidence Ruler



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