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

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10:15-11:45 am, Monday, June 24, Judiciary
Welcome and Introductions

- 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
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

- 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…”

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

- 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”
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.

Mary Marden Velasquez PhD
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

Practitioner to the rescue!

Marilyn Herie PhD RSW:
https://www.slideshare.net/MarilynHerie/mi-queens-2013-pub
Toward a Theory of Motivational Interviewing...

- 2 specific active components:
  - a relational component
    - client-centered empathy and the interpersonal spirit of MI
  - a technical component
    - evoking and reinforcing change talk

What is “the Spirit of MI”?

- 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

- 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

- 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

This work was supported by grant PP120167 from the Cancer Prevention Research Institute of Texas (CPRIT).
STARNet: What we did not do

- 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”...

An MI Conversation

- Develop discrepancy/Amplify ambivalence
- Change talk/ “Change Theory”
- Change plan
- Commitment language
- OARS
- Express empathy
- Target/purpose
What we did: Penn State/PSARN

- 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

- 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

- 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:

- 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:

- 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:

- 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:

- 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

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
Small Group Reports
Summary
1. Summary of Small Group Reports

- **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

- 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

- 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?

- 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

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

No Way

I am Bill Miller

http://www.williamrmiller.net/

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