MOTIVATIONAL INTERVIEWING

PATIENT ENGAGEMENT REFRESHER

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ON A SCALE 0-10

How important is it for your patients to follow your recommendations and adhere to what you prescribe?

WHAT PERCENTAGE

of your patients do this?

LETS TAKE A CLOSER LOOK

Who has a case of a patient who has returned to your office, more than once, having not followed your recommendations?

DESCRIBE THE CASE FOR US.

WHAT HAVE YOU TRIED SO FAR?

What recommendations, prescriptions, and/or advice have you given this patient thus far.

RESIDENTS

What assumptions are you making about why this patient has not followed these specific recommendations or guidance?

WHAT DON'T YOU KNOW?

What is unknown about this patient's situation or context?

WHAT DON'T YOU KNOW?

What is unknown about this patient's situation or context?

Character vs situational attributions?

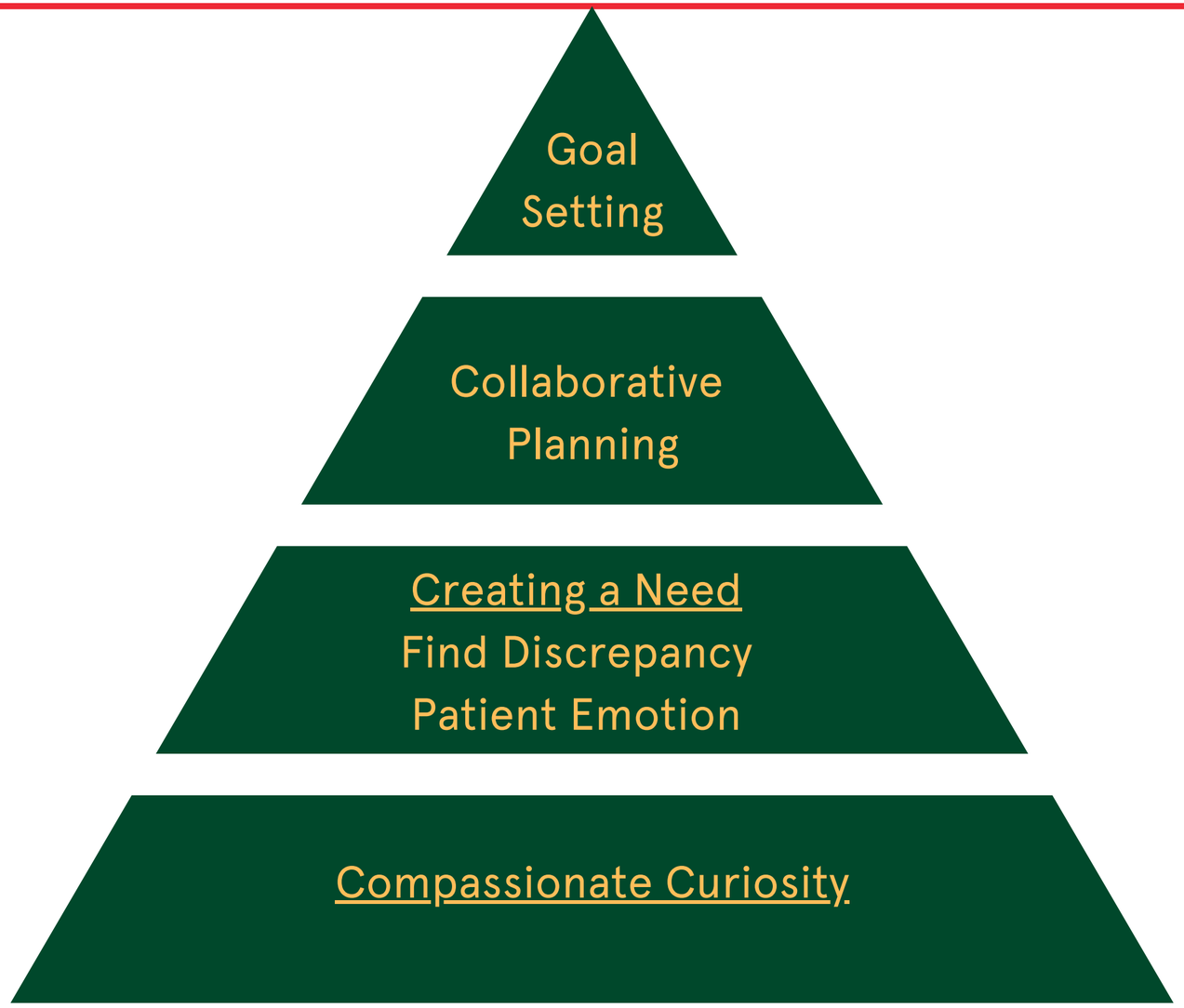
WHO IS DOING THE PROBLEM SOLVING?

How can we get the patient doing this work?

Collaborative Role Play

GOAL OF PATIENT ENGAGEMENT

Optimal Health Outcomes



GOAL OF PATIENT ENGAGEMENT

Optimal Health Outcomes

Leaves the patient falling short.

Goal Setting

Education & Advice

Goal Setting

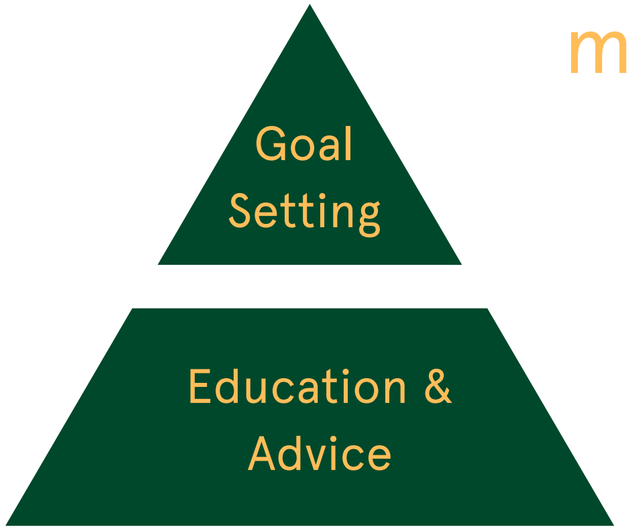
Collaborative Planning

Creating a Need
Find Discrepancy
Patient Emotion

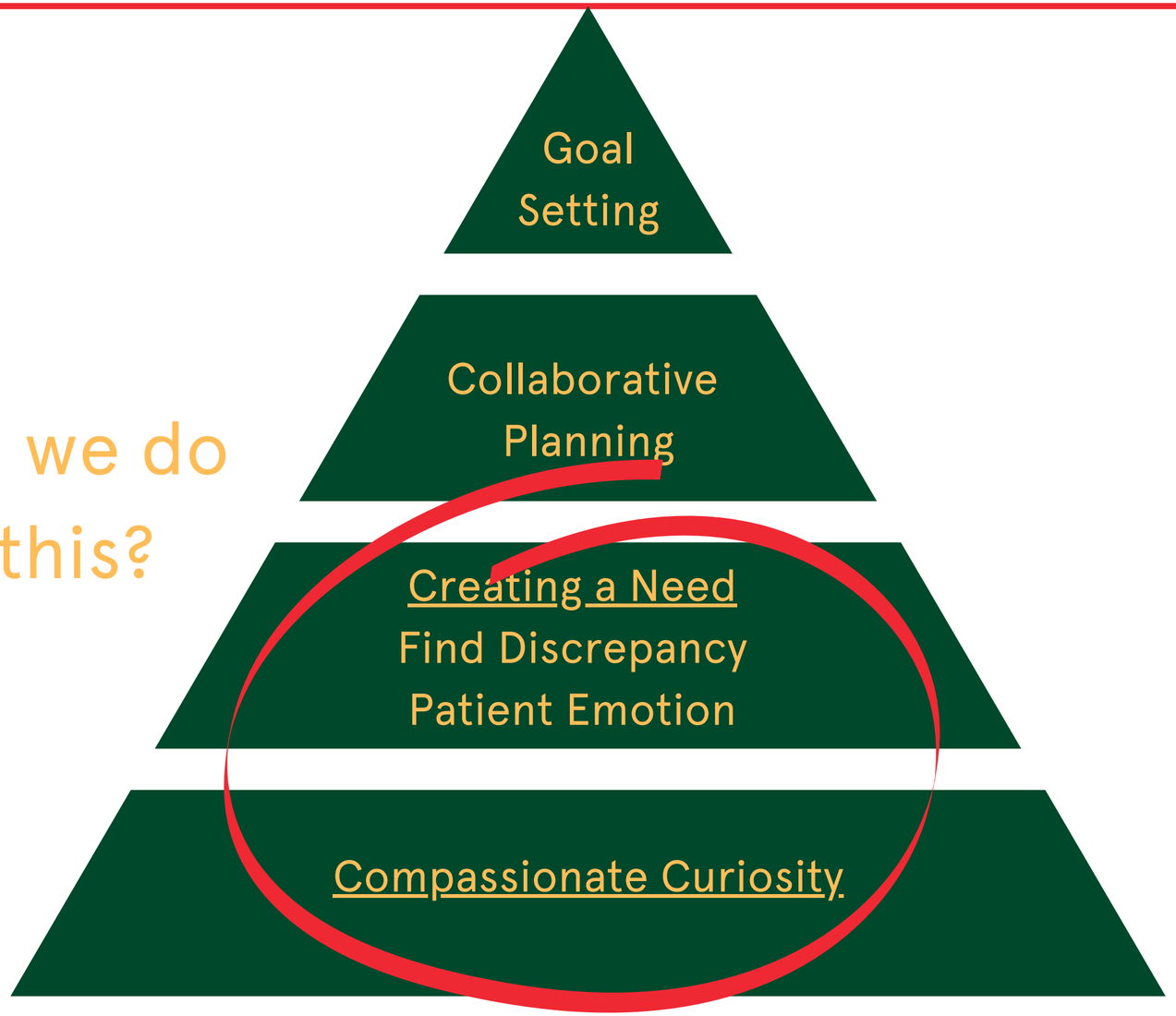
Compassionate Curiosity

GOAL OF PATIENT ENGAGEMENT

Optimal Health Outcomes



So how do we do more of this?



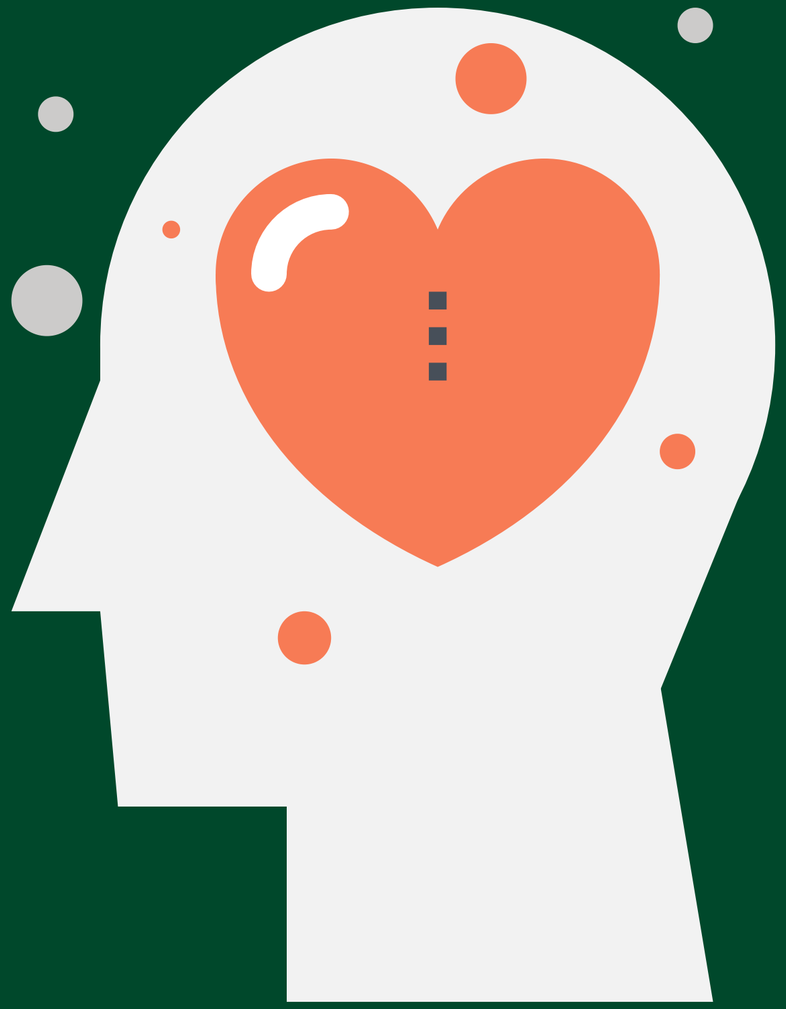
KNOWLEDGE AND BEHAVIOR

$$\frac{\text{knowledge} \times \textbf{motivation}}{\text{resistance}} = \text{change}$$

Two important contributors to motivation are **emotion** and/or **discrepancy**.

Resistance involves barriers to change.

EMOTION



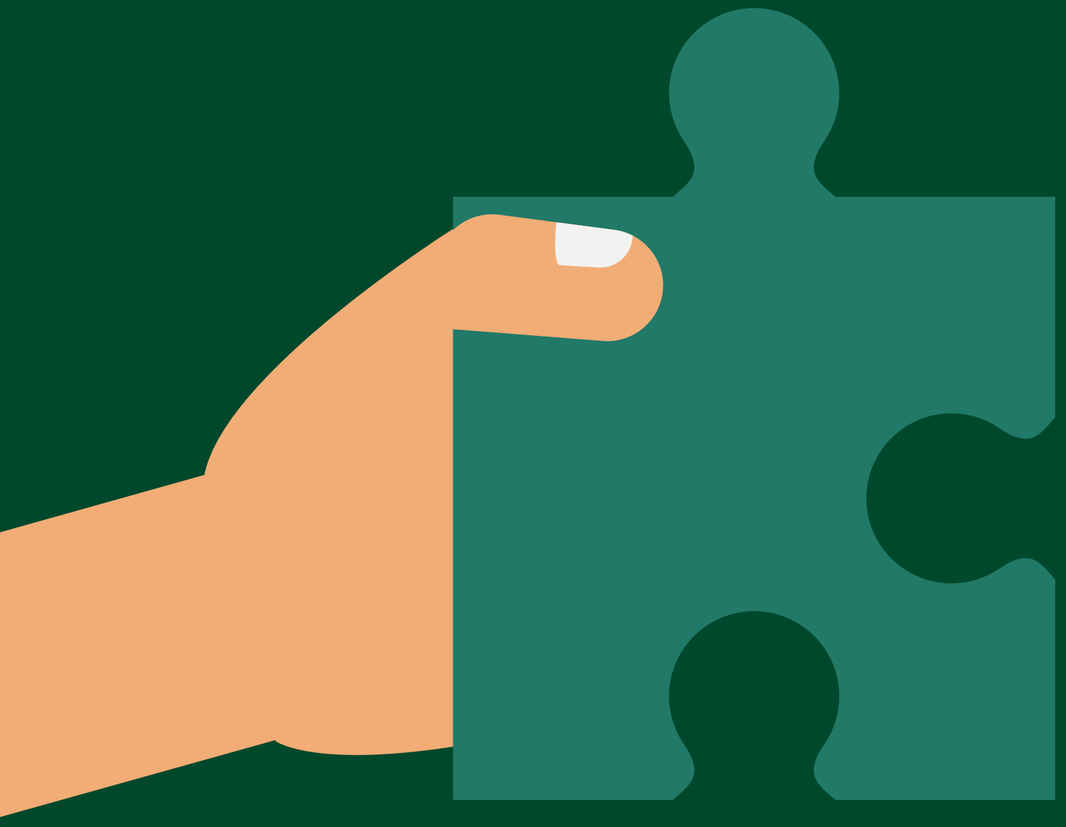
- Emotion is typically a stronger driver of change than reason is.
- What is the patient's "why?" What does the patient care about? Where does there appear to be emotion, both in verbal content and in observed affect?
- What does the patient value? (time, family, longevity, happiness/satisfaction, money, etc.)
- How is the patient's health connected to their "why?"

WHAT IS YOUR EXPERIENCE WITH MOTIVATIONAL INTERVIEWING?

DISCREPANCY

- Ambivalence is about the "buts."
- "I know I should exercise more but I just don't have the time."
- Explore both sides of the "but."
- "Sustain talk" is about the status quo whereas "Change talk is about reasons for change.
- Develop the discrepancy between what the patient says is important to him/her, and what h/she is currently doing. (Desires vs. Actions)
- Compassionately cultivate discomfort.

MI SKILLS



- OPEN ENDED QUESTIONS
- AFFIRMATIONS
- REFLECTIVE LISTENING
- SUMMARIZING
- INFORMING AND ADVISING
  (ONLY DONE WITH PATIENT REQEUST OR PERMISSION)

MI SKILLS

OPEN ENDED QUESTIONS

- Questions that cannot be answered with "yes" or "no."
- What, how, when, where, who, tell me about . . .
- "Can you . . . " "Is there . . . " "Are you . . . " "Have you. . . " are all closed stems, even if what follows asks for an open-ended response.
- Aim for an economy of words (e.g., "Can you tell me what makes it better? vs. "What makes it better?)

MI SKILLS

AFFIRMATIONS

- Statements that accentuate positive patient attributes or behavior (not the same as praise).
- Ex: "I see that you've already taken some steps to improve your health."
- Affirm examples of previous or partial adherence.
- Ex: "Quitting smoking has been important to you in order to try so many times."
- Can help build discrepancy.

MI SKILLS

REFLECTIVE LISTENING

- Statements that indicate understanding of what the patient is saying.
- Pausing after a reflective statement nonverbally invites the patient to say more.
- What comes after "Do you mean that . . " without the "Do you mean that. . . " preface.
- Other variations "So it sounds like" "So what you're saying is" "So I hear you saying."

MI SKILLS

REFLECTIVE LISTENING

- Simple reflection - paraphrase of what the patient says.
- Complex reflection - adds additional/different meaning to what the patient says; contain a guess.
- "Double sided reflections" (e.g., "On the one hand you aren't sure you'd be able to lose weight, and on the other hand you think your weight is making your knee pain worse." (important that "sustain talk" is followed by "change talk")

MI SKILLS

SUMMARIZING

- Combination of several reflections with the intent of drawing together the patient's concerns, intentions, and/or plans.
- Summary of main ideas helps identify what else needs to be learned.
- Micro Summary - paraphrase of what the patients utterance was.
- Macro Summary - 30,000 feet view of the appt to help decide where to go next.

MI SKILLS

INFORMING AND ADVISING

- Only done when there is a knowledge gap.
- First elicit what the patient already knows (often there isn't a need for patient education).
- If still a knowledge gap exists, get permission to educate: "If it's OK with you, I could share some of the reasons . . . "
- If you are educating because you feel the need to educate and not because the patient needs/requests it . . . it is likely unwarranted.

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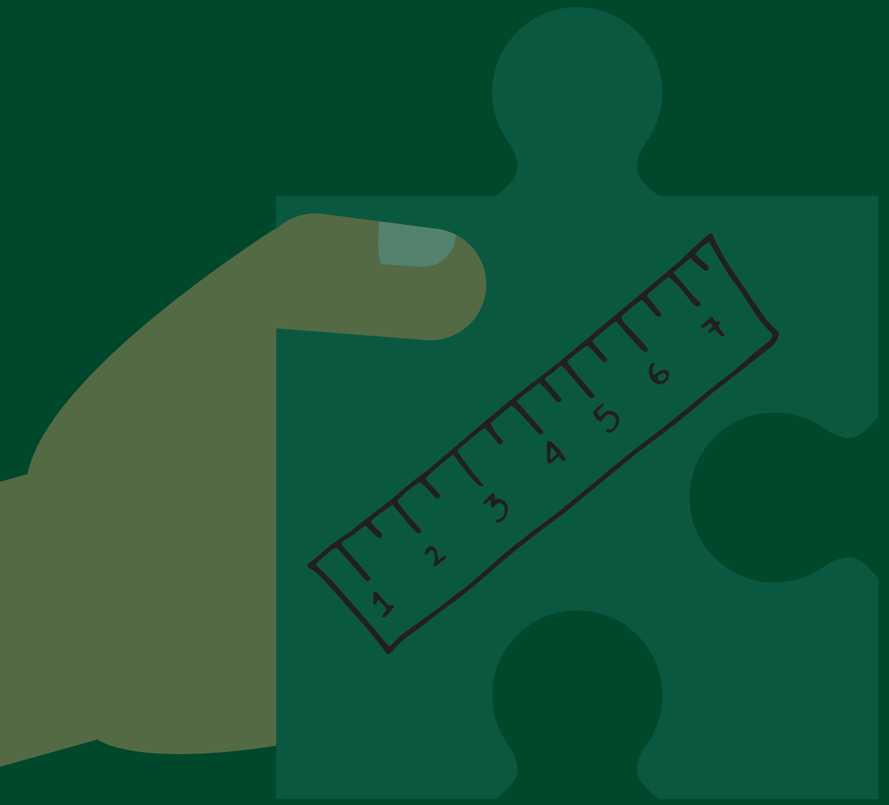
MI SKILLS

INFORMING AND ADVISING

- Good to follow "education" with open-ended inquiry about patient's reaction to the information.
- "How does hearing this affect your thoughts about . . . ?"
- Avoid educating with an open-ended suggestion. ("What would you think about using a pill box to help you remember to take your medication?")

MI SKILLS

0-10 SCALES



- Ask patients to rate importance, confidence, or readiness to change on 0 - 10 scales.
- "On a scale of 0 - 10, with 0 meaning that you aren't even considering quitting, and 10 being ready to quit right now, how ready are you to quit smoking?"
- If patient says "3" . . .
- "What makes you a 3, and not a 1 or 2?"
- "What would it take to move you to a 4 or 5?"

SUSTAIN TALK

- Why did you start smoking again?
- What barriers do you see to this plan?
- Why did you say 5 and not a higher number like 7?
    - This will elicit responses of why they should stay where they are.

CHANGE TALK

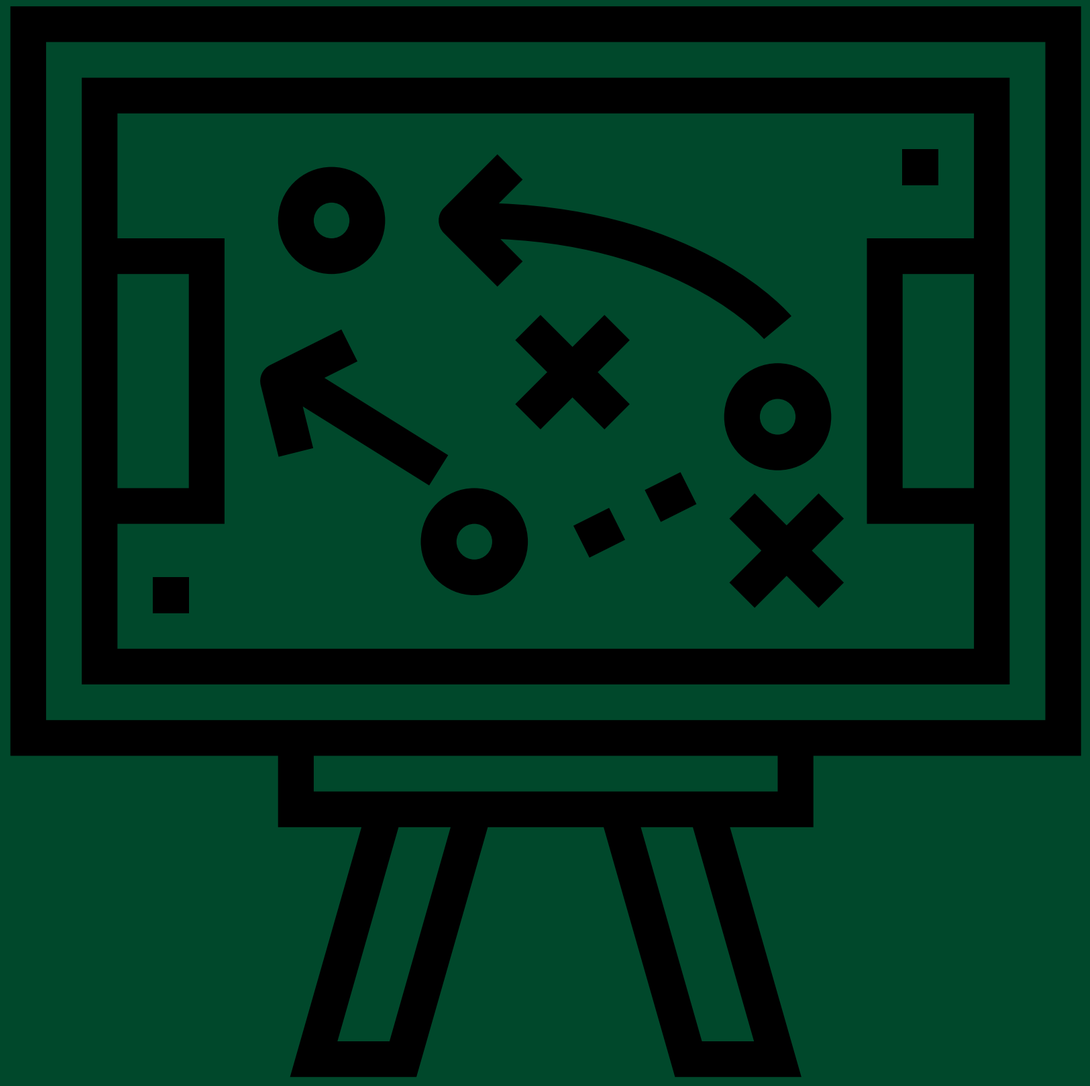
- What made you attempt to quit smoking before?
- What do you think will be better when you implement this change?
- Why did you say 5 and not something lower like a 2?
    - This will elicit responses of why they should make a change.

PROVIDER WORK

- DIAGNOSIS
- TREATMENT / MANAGEMENT OPTIONS
- APPRECIATING PATIENT AUTONOMY
- GUIDING ROLE

PATIENT WORK

- DECISIONS ABOUT TREATMENT OPTIONS
- ADHERENCE
- HEALTH BEHAVIORS
- PLANS FOR CHANGE



STRATEGIES

STRATEGIES

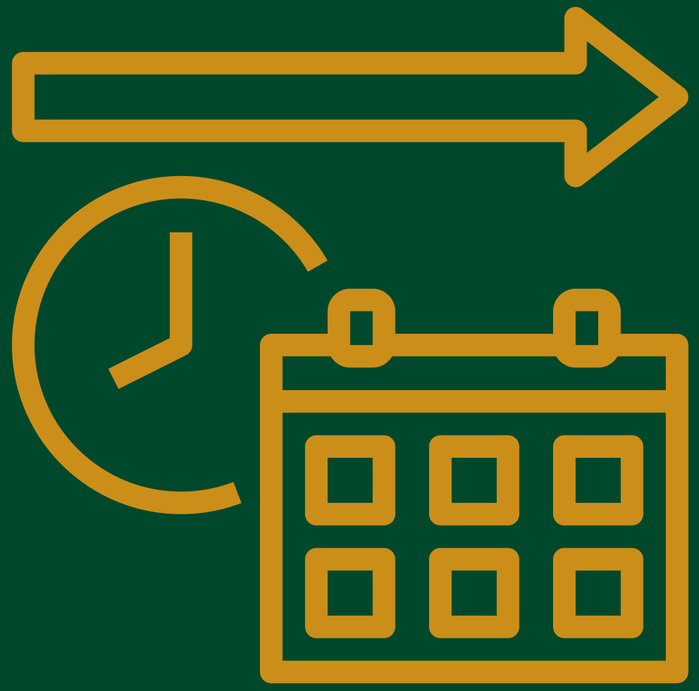
AVOID PREMATURELY MOVING TO PROBLEM SOLVING

Why does the smoker need another way to relax until there is a need to change?

To what extent does the patient perceive a reason for changing? (Prior to planning or goal setting.)

STRATEGIES

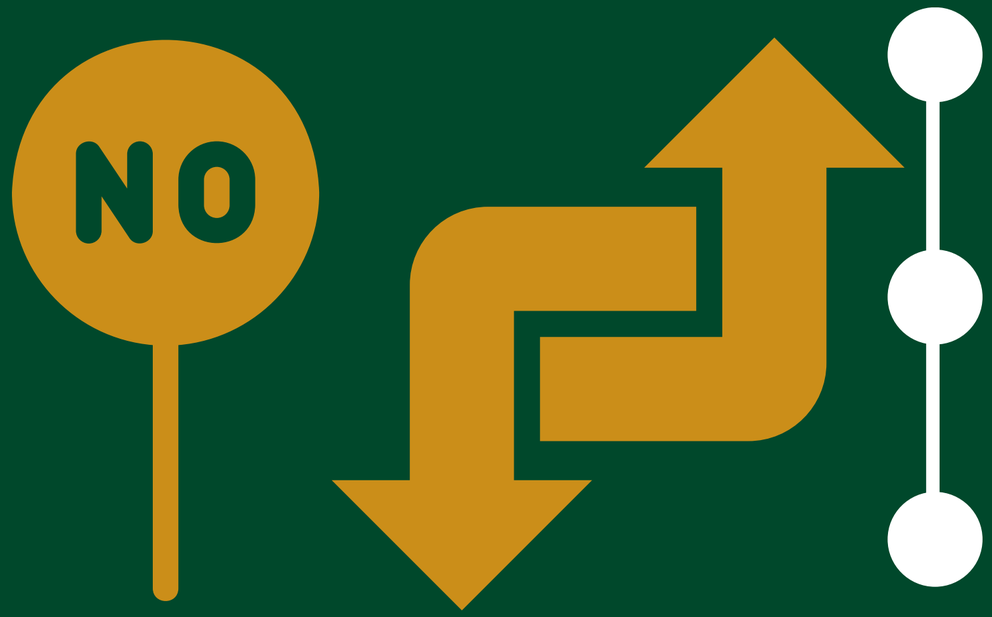
FUTURE EXPLORATION



- How does the future look with continuation of current behavior?
- "What do you see happening if you continue to smoke a pack a day?"
- "What do you see happening if you continue to not take your medication?"

STRATEGIES

THE NO CHANGE OPTION



The option many patients are choosing.

"Suppose you decide to make no change at all? What do you see happening?"

"What if you decided to just not take any of your medications, what do you suppose would happen?"

STRATEGIES

PREVIOUS/PARTIAL ADHERENCE

Look for past adherence, partial current adherence, or any combination thereof. Follow with an open ended question to elicit change talk.

"You've attempted to quit in the past, what made you decide that you wanted to quit then?"

"You choose not to drink during the week, what's made you make that choice?"

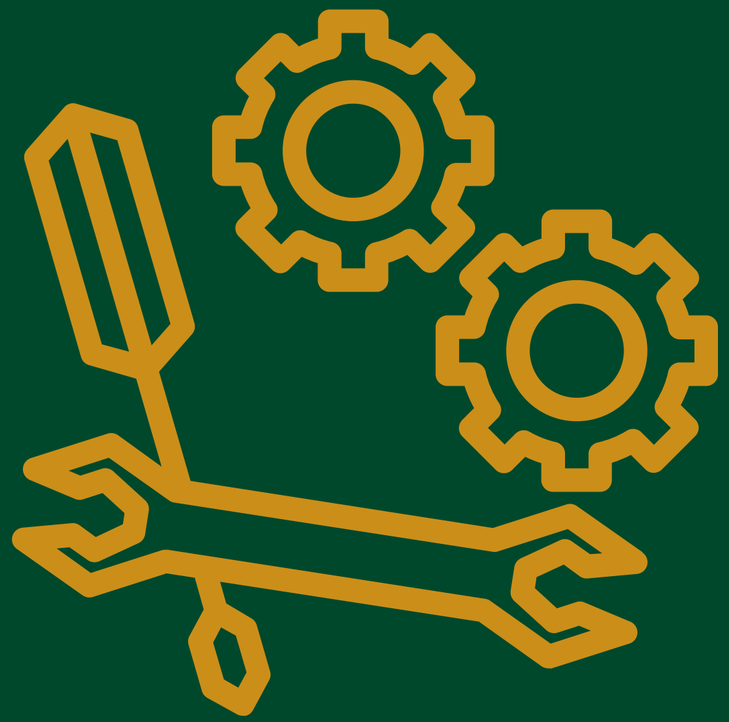
STRATEGIES

EMOTION

- Connect what the patient cares about to why they are in your office.
- "How do you think having high blood pressure could impact your ability to spend time with your grandchildren?"
- "How do you think management of your high blood pressure would be important to the success of your business?

STRATEGIES

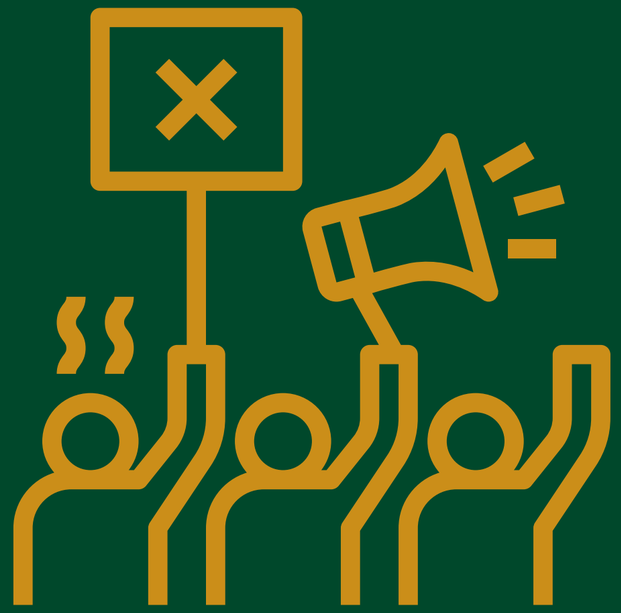
AVOID BEING THE FIXER



- Pay attention to when you begin to solve the problem for the patient.
- Does the patient perceive the need to make a change?
- What solutions can the patient come up with?

STRATEGIES

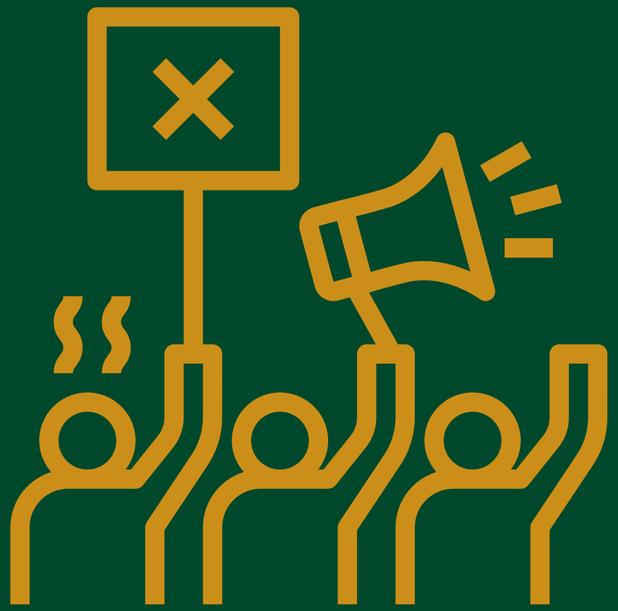
RESISTANT PATIENTS



- Highlight patient autonomy.
- "The decision is ultimately up to you."
- "What would have to happen in order for you to be ready to make a change?"

STRATEGIES

RESISTANT PATIENTS



Inquire about patient's understanding of your concerns.

"What do you suppose my concerns are as your physician?"

When change is low, assess how important they think YOU think it is: "How important do you think I believe it is for you to (quit smoking, take your medications, exercise)?"

STRATEGIES

AVOID BEING THE ADVICE-GIVER

- Remember: Advice is context dependent and breaks down in another person's context.
- Well meaning ideas that have worked for others or yourself may feel judgmental and off base for some patients.
- Allowing patients to come up with their own solutions avoids these advice giving traps.

STRATEGIES

AVOID BEING THE ADVICE-GIVER

If you think the patients solution will be ineffective, guide the patient to explore the potential impact.

"What are your thoughts about how cutting out the McDonalds drive thru once a week will impact your A1C?"

STRATEGIES

THE PLAN

When the patient is ready to make a plan, rather than providing a suggestion:

"What would change look like for you?"

"How would making this change impact your hypertension?"

MOTIVATIONAL INTERVIEWING IS NOT

CHEERLEADING

- Motivation is elicited from within the patient.
- Not just looking at positive aspects of the patients behavior.

MOTIVATIONAL INTERVIEWING IS NOT

RESCUING

- Patients are responsible for their own behavior.
- Refusing the "righting reflex."

MOTIVATIONAL INTERVIEWING IS NOT

COMFORTING

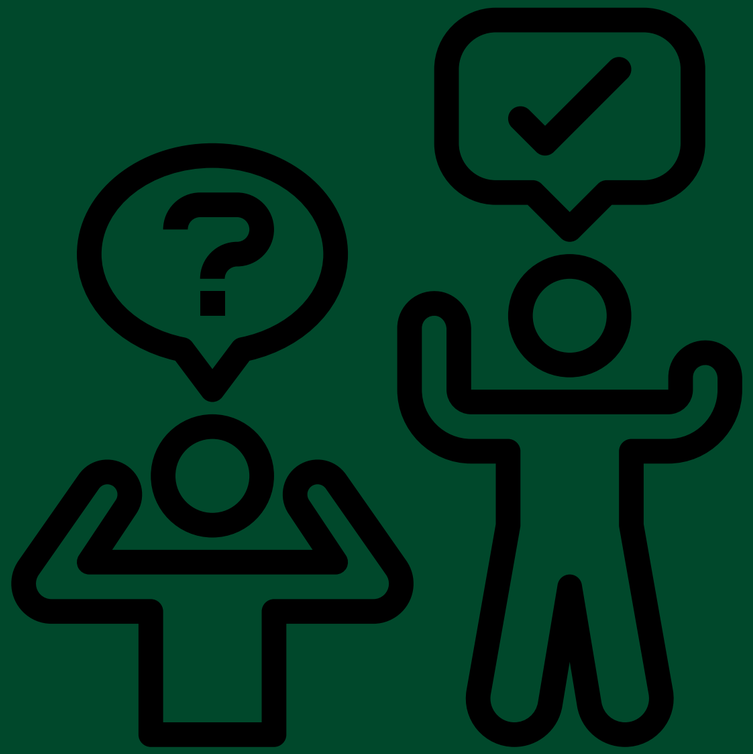
- Discrepancy is discomforting.
- Their seat should be warm.

PITFALLS

SEARCHING

- Do not just search for the place you would like to provide education or advice. If that is all you look for, that is all you will find. Stay curious.

PITFALLS



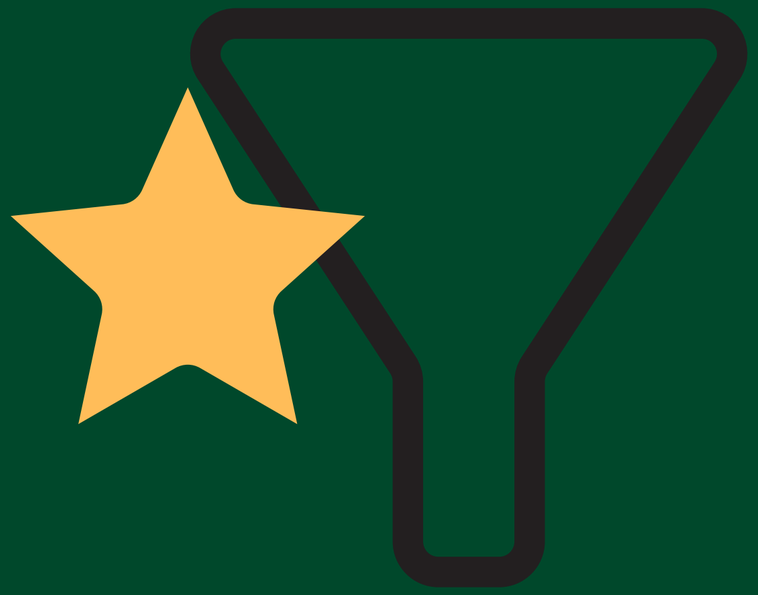
SUGGESTIONS

- Do not provide suggestions in the form of open ended questions. "How would using a pill box help you remember to take your medications?" (This is laiden with assumption)

PITFALLS

FOLLOWING

- Do not just allow the patient to lead the conversation all over the room. Your role is to guide.



VS

APPROACH

Way of thinking about and conversing with patients throughout the entire encounter.

TECHNIQUE

Something else to do that will take more time.

TIME SPENT

CURRENT APPROACH

MI APPROACH

MI ROADMAP

- Tell me more about current behavior.
- What do you like about current behavior? Summarize
- What don't you like about current behavior?
- Suppose you don't make any change. How does that look to you going forward? (How would this affect something the patient cares about?)
- Given that there are some things you don't like about current behavior and that you have some concerns about not making any change, how ready would you be to make a change? (0-10 scale)
- Why not a lower number? (skip if 7-10)
- What would change look like for you?

COLLABORATIVE PRACTICE

- Stop smoking (maybe has severe copd, threatened limb ischemia, coronary artery disease)
- Stop using alcohol (maybe has know advanced cirrhosis, history of recurring pancreatitis, or upper GI bleeding)
- Reduce or stop using sleeping pills (schedule medication, like ambien)–noting nothing else works for sleep
- Regularly use CPAP (maybe has severe copd, right chf with pedal edema)
- Add additional medications for diabetes control (too expensive, don't like meds, too many meds, prefer natural products, concern for side effects)
- Requests benzo for anxiety (says other meds don't work)
- Requests opioid for chronic pain (says other meds, therapies, adjuncts don't work)

COLLABORATIVE PRACTICE

- 38 yo man with pmh of substance use, prior MVA with several orthopedic surgeries and chronic back pain. He presented to the ED with a red swollen left knee. ED recommended admission, arthrocentesis, further work up for acute monoarticular arthritis. He signed out AMA, but was given doxycycline. He is following up in clinic as new patient. He notes slight improvement in his pain but the swelling and redness persist.
- He declines in office arthrocentesis, referral to orthopedics, referral to ED/admission. He requests continued doxycycline
- (Upon further history you learn he has elective surgery planned in 2 weeks for removal of a spinal stimulator that seems to have malfunctioned and is aggravating his chronic back pain; he is concerned that any additional therapies, procedures, or admission would jeopardize his planned same day surgery.)

COLLABORATIVE PRACTICE

- 27 yo lady here to establish pcp and discuss weight loss. She is a single mother. She had NSVG one year ago and her baby daughter is doing well. She notes pre-pregnancy her weight was 140 lbs. In the past few months her weight has gradually declined to 105 lbs. She denies hx of anorexia, bulimia, diarrhea, steatorrhea. She is very busy and under stress. She is a master's student on line in counseling. She works around 25 hours per week as a waitress. She has disrupted sleep due to her job, studying and caring for her baby. She eats breakfast only 2-3 days per week, lunch 2-3 days per week and dinner most nights. She has ok appetite but finds she is often just in too much of a hurry to eat. She was breast feeding and is weaning her daughter. She is receiving counseling by a LCPC. licensed clinical professional counselor She feels counseling is helping cope with some chronic anxiety. Her family lives several hours away. She has one close friend in the area.
- Here exam is normal except for low BMI; labs seem unremarkable for malabsorption; thyroid function is normal. She completed a 3-day food diary and average calorie counts are 1200-1300 cal per day. She does not want to try SSRI or other pharmacologic treatment.

COMMENTS/QUESTIONS