

Applying Motivational Interviewing in Primary Care: An Integrated Model

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Case Example #1: Warned about Non-adherence

- 14 year old adolescent with diabetes
- Monthly clinic visit – poor glucose reading 200
- Feeling depressed, alienated from peers
- Did not keep his dietary logs as he was advised to last visit
- Feeling embarrassed about it
- PCP “strongly advises” him to keep his logs and injection routine more faithfully

(Miller, Rollnick, & Butler, 2008)

Rationale for MI in Primary Care

- High nonadherence rates: 24.8% to 50%
(Brockmans, 2010; DiMatteo, 2004; Shin et al., 2012; Zulman, 2012)
- \$100-300 billion dollars annually (Iuga & McGuire, 2014)
- Largest MI effect sizes for weight loss, blood pressure, substance use (.38-.47) (Van Buskirk & Wetherell, 2014)
- May require as little as 1-3 contacts; once for 15-30 minutes may be effective

Rationale for MI in Primary Care

- PC is optimal point for screening for behavioral health concerns (e.g., 70% of adults 18-29 positive for self-reported unhealthy drinking) (Rose et al., 2015)
- Motivational enhancement: providing feedback in an MI-style (Dawson et al., 2014; Hasin et al., 2013; Lai et al., 2014; McDevitt-Murphy, et al. 2015)

Survey feedback, normative information, or other data provided evocatively, with autonomy support and acceptance, **to increase importance in change**

Three Primary Care MI-Delivery Approaches

(IF using MET *option 1*)
SCREENING PRIOR TO APPOINTMENT (PHQ, AUDIT...)

CO-LOCATED	WARM HAND-OFF	INTEGRATED
Referral made in PCP visit and psychologist delivers MI/MET in a session at a later date	10-15 minutes of MI/MET delivered after the PCP has completed visit	Either PCP delivers MI/MET as part of the visit, or dual interviewing with PCP and psychologist
<i>option 2:</i> Screening in PCP visit prior to referral	<i>option 2:</i> Screening in PCP visit prior to warm hand-off	<i>option 2:</i> Screening may be completed in visit

O.A.R.S. + P.A.C.E.

(**method & spirit**) = Building Blocks of MI

O pen Questions	P artnership
A ffirmations	A cceptance (Absolute Worth, Autonomy Support, Accurate Empathy, Affirmation)
R eflections	C ompassion
S ummaries	E vocation
Helping <u>the Patient</u> Make the Argument for Change	
Desire Ability Reasons Need	
Commitment Activation Taking Steps	

Miller & Rollnick, 2013

Case Example #2: Taking Medication

- 50 year old female
- A1C: 10
- Ambivalence toward taking Metformin
- Patient identified 1 year health functioning goals.
- Patient identified **discrepancy** between her long-term goals and current behavior.
- Small, realistic, behavioral, short-term steps to work toward future.

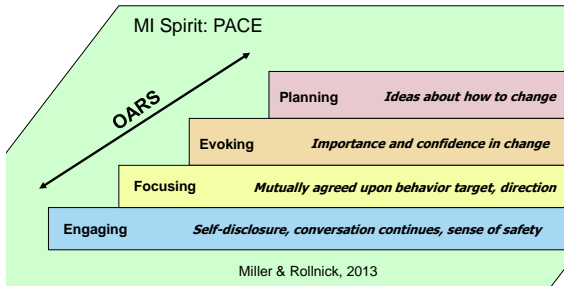
Case Example #3: Going for a Stress Test

- 40 year old male
- Reported lightheadedness while exercising
- Referred for Stress Test after in office EKG
- Avoiding test due to beliefs of minimal risk
- Rolled with patient's sustain talk/discord
- **Amplified Reflection:** Your physician is going overboard wanting to screen for heart disease.
- **Reframing:** It sounds like your physician is really focused on keeping you healthy, although the tools medicine has to do that feel invasive and over-the-top.

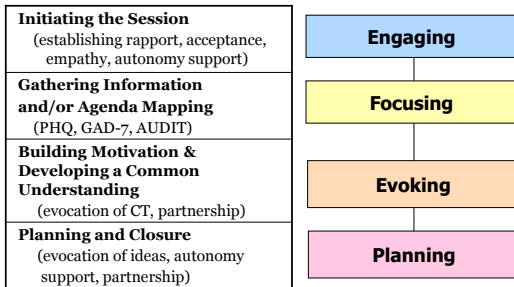
Case Example #4: Liver Transplant

- 64 year old male
- Doesn't want to be on the transplant list
- "I may as well just give up and live for however long I have."
- Expressed empathy
- Listened (avoided telling)
- Nonjudgmental

4 Processes in an MI Conversation

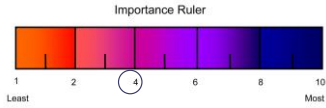


4 Processes & Brief Consultation



Brief MI in Consults: 3-Step CHANGE model (Martino et al., 2007)

- Step 1** **C**heck patient's perspective (OQs)
Hear what they said (Rs, Summaries)
Avoid confrontation and arguing
- Step 2** **N**ote change priorities and commitments
(Importance & Confidence Rulers)
- Step 3** **G**ive feedback after permission
*** (may occur between steps 1 & 2 if MET)
End with summary of plans and follow-up



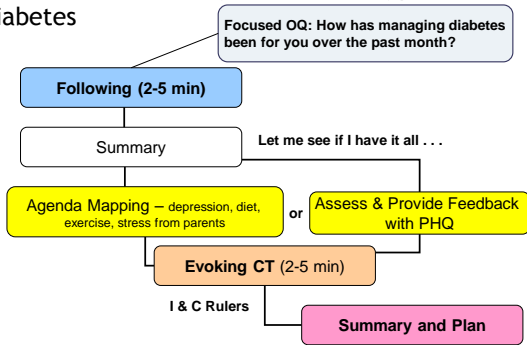
What makes you a 4 and not a lower number, say a 2?
 What makes it a little bit important to you today to change your diet?

At least 1 Reflective listening statement

What would have to happen for you to move from a _____ to a couple points higher?

At least 1 Reflective listening statement

Consult with Dan: 14 year old with Type II Diabetes



Screening, Brief Intervention, & Referral to Treatment

- Evidence-based, PC-friendly approach that can incorporate MI
- Associated with reduced drug and alcohol use (Gryczynski, 2011; Kaner et al., 2007)
- Recommended at every adolescent preventive and all appropriate urgent visits
- Depression, alcohol, substance abuse: Higher referral rates (12.4% vs. 1%) and kept appointments (25% vs. 18%) at FQHC (Dwinnells, 2015)

Components of Brief MI in SBIRT

1. **Raise the Subject (after screening)**
2. **Exchanging Information (elicit – provide - elicit)**
3. **Enhance Motivation**
4. **Plan Collaboratively**

(Adapted from Kriss Haren and Kettering Health, 2014)

#1: Raise the Subject

“Would you mind taking a few minutes to talk with me about _____?”

“You’ve answered some questions already about drinking. Would it be all right to talk more about it?”

#2: Exchanging Information

- Respectful, collaborative way of providing information
- Particularly targets increasing importance of change
- A way of developing discrepancy between goals/values and behavior
 - can use norms, guidelines, self-reported consequences

Exchanging Information Cont'd

- **Elicit:** **Ask Permission**
Clarify Needs or Prior Knowledge
Ask about Interest
Ask about Predictions

(might only use 1 or 2 of these forms of eliciting here)

“Would you be interested in learning what the survey you filled out said about _____?”

Exchanging Information Cont'd

- **Provide:** **Tips for Providing the Information**

- Give what they most want or need**
- Give information in small pieces**
- Avoid coercive tone/ “if-then” consequences**
- Use objective language**
 - “For some people....”
 - “Research shows....”

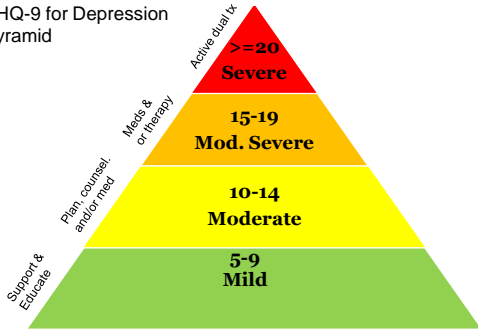
“According to the CDC . . .”



Retrieved from: <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>

“Based on our treatment guidelines, someone with your score . . .”

PHQ-9 for Depression Pyramid



Giving Advice - Not a Mainstay of MI, but if you must do it . . .

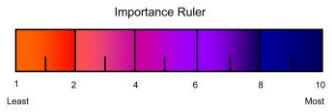
- Engage first
- Use sparingly
- Ask permission
- **Emphasize personal choice**
- Follow advice with a menu of options

#3. IE & Enhancing Motivation

- **Elicit:** Check in to explore patient's understanding, interpretation, response

“How well does that apply to you?”
 “What do you think about that?”
 “How might knowing this affect what you think about _____?”

“Hearing this, how important is it for you today to ...”



What makes you a 6 and not a lower number, say a 2?
What makes it a little bit important to you today to change your diet?

At least 1 Reflective listening statement

What would have to happen for you to move from a ____ to a couple points higher?

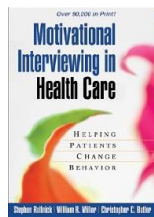
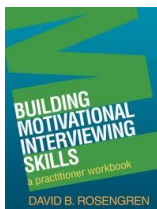
At least 1 Reflective listening statement

#4. Plan Collaboratively

- **Elicit patient's next steps or ideas about planning first**

“Is this the right time for you to make a plan?
“Where does that leave you in thinking about what you might do?”
“What ideas do you have about where to begin?”

MI Resources





Contact Information

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References Distributed Separately & Available Upon Request
