Motivational Interviewing and Risk Stratification to Improve Outcomes

CSM – 2017 Section for Health Policy and Administration. Friday, February 17. 3:00 – 5:00 PM

Presenters: David Levison, PT, MHS, Robert Scales, PhD, and Stephen Hunter, PT, DPT, OCS (Biographies listed below)

Session Objectives:

1. Describe the spirit, principles and application strategies of Motivational Interviewing
2. Understand how MI is philosophically consistent with modern physical therapy education and practice expectations
3. Appreciate the experience of a large rehabilitation agency in training PTs in MI
4. Discover the outcomes achieved when a patient classification scheme combined with risk stratification directs services provided by PTs trained in MI.

Presentation Outline with References and Bibliography

Part One - The case for improved counseling skills in physical therapy practice

I. The big expensive health problems - The high-need/high cost patient
   a. Chronic conditions

II. Prevention Opportunity

III. Patient behavior – healthy vs not so healthy
   a. Lifestyle changes
   b. The little things count too

IV. Typical provider response
   a. How’s that working?

V. Another approach – Motivational Interviewing

VI. How does MI fit with PT professional practice?
   a. Patient-Practitioner Collaborative Model
   b. Patient-centered Care
   c. Biopsychosocial Model
   d. Prevention/Wellness
   e. Code of ethics
   f. Core Values
   g. Guiding Principles of APTA Vision
      i. Quality
      ii. Value
      iii. Innovation
      iv. Consumer-centricity

VII. How does MI fit with PT academic education expectations?
Part Two: What is Motivational Interviewing?

Behavior change counseling in the medical setting has progressed from simple advice-giving, to structured brief interventions,1 to strategic patient-centered methods of communication, such as motivational interviewing.2-3 This latter approach has gained substantial empirical support as an effective option for clinicians to counsel patients that are ambivalent or not ready to change their behavior.4,5 It has been described as a teachable, collaborative, goal-oriented style of communication for eliciting and strengthening a person’s own motivation to change.2-3 The distinct style, skills, and strategies that characterize the approach differ from traditional persuasive methods by enabling patients to discover their own intrinsic motivation for change, which is supported with strategic empathic listening. Patients are given the opportunity to partner with their clinician to interpret personalized health information and identify solutions rather than being told what they must do. In the negotiation of a treatment plan, the clinician acknowledges the patient’s freedom to decide what, if anything, they will change when they leave the clinic. In a systematic review and meta-analysis of 72 randomized controlled trials, motivational interviewing outperformed traditional advice-giving in approximately 80% of the studies.4

Motivational interviewing first demonstrated its efficacy in the treatment of substance abuse and addictions,6 but the evidence-base has continued to grow with successful applications to variety of clinical populations in healthcare settings.4,7 Although grounded in psychology, the approach is not exclusive to counselors or psychologists. When effectively delivered, patients are more receptive to treatment recommendations, which make consultations less frustrating for the clinician. Improved behavioral and clinical outcomes have been observed in brief consultations.4 Therefore, it lends itself well to the clinical setting, where time is often a limiting factor.8 An investigation of motivational interviewing training methods identified significant short-term gains in competency with participation in an interactive workshop. Longer-term improvements in proficiency were observed with ongoing feedback and supervision.9-10 Experienced trainers are available in the United States and other regions of the world to provide this type of professional training to clinicians.11 In addition, there are now several medical schools that have included motivational interviewing training in their academic program.12 Students, clinicians and researchers have shown an interest in applying motivational interviewing into Physical Medicine and Rehabilitation,13-22 but the research to evaluate the effect of physical therapist delivered motivational interviewing is limited.23

The following key components of motivational interviewing have been adapted from a variety of related sources.3,8 This includes the style or mindset of the clinician, the skills and strategies that can be used in a way that is relevant to the patient’s stage of readiness to change.24 An attempt has been made to sequence these key components roughly in the order in which they may be applied during the typical phases of a medical visit.25 However, each component can be relevant throughout the motivational enhancement process when there is a focus on behavior change.

Key Components of Motivational Interviewing

- **EXPRESS APPRECIATION AND OFFER APPROPRIATE PRAISE**
POSSIBLE for the positive steps being taken, for their honesty, for their willingness
to consider change, for showing up . . .

- **BEGIN WITH A STRUCTURING STATEMENT & SET A COLLABORATIVE TONE.**
  During your introduction give a brief outline of what the patient can expect and then
  step out of the expert role to let them know they will have a say in any decisions
  about change. They are the experts on what will work for them.

- **SHARE OPTIMISM ABOUT THE POSSIBILITY OF CHANGE.**
  Instill a belief that patients are capable of changing behavior, now or in the future, and that the
  patient’s health may improve as a direct result of that change.

- **USE OPEN-ENDED QUESTIONS** to build rapport and focus the discussion.

- **SUPPRESS A WELL-INTENTIONED REFLEX TO ADVOCATE FOR CHANGE.**

- **RECOGNIZE THAT IT IS NORMAL TO HAVE MIXED FEELINGS ABOUT MAKING A CHANGE.**
  Invite patients to look at the pros and the cons of their current behavior
  as well as the pros and cons of making a change.

- **AVOID ARGUMENTS.** Arguments are hard work, counter-productive and a signal to
  use an alternative approach. Let the patient make the case for change. Provide
  opportunities for them to see the gap between the way things are now and the way
  they would like things to be.

- **LISTEN WITH EMPATHY.** Use respectful attention. Demonstrate a desire to gain
  mutual understanding by giving short summaries of what you hear the person say,
  what you think it means, and, as appropriate, what you think the person is feeling.

- **MATCH YOUR STRATEGIES WITH THE PERSON’S READINESS TO CHANGE.**
  Assess the stages of change across multiple behaviors and use appropriate
  strategies.

- **ASK EVOCATIVE QUESTIONS** to encourage talk about change.

- **RESPOND TO WHAT YOU HEAR WITH STRATEGIC REFLECTIVE STATEMENTS**
  to highlight the thoughts and feelings that reinforce the person’s own
  reasons for making a positive change.

- **PROVIDE FEEDBACK & INFORMATION WITH PERMISSION** and in a caring,
  collaborative manner. Let the patient come to their own conclusions about how
  useful it is, if at all.

- **GIVE ADVICE SPARINGLY AND WITH RESPECT FOR FREEDOM OF CHOICE.**

- **USE SUMMARIES** to clarify and to reinforce what the person is saying about making
  or maintaining a change. (“Let me make sure I’m getting this right...”)

- **ASK FOR A DECISION TO CHANGE.** “What would you like to do about
  _______?”

- **NEGOTIATE A CHANGE PLAN** only when the person expresses readiness to
  change. Continue to invite the patient to explore their own ideas and solutions.

- **PROVIDE A MENU OF OPTIONS FOR CHANGE.** Let the patient choose what they
think will work best for them.

Part Three: Disseminating Motivational Interviewing in a Health Care System

I. Teaching Motivational Interviewing (MI) at Intermountain Healthcare fits with its values
   a. Patient Engagement is one of the 6 dimensions of care at Intermountain
   b. MI promotes patient engagement

II. There is a process for implementing a new intervention
   a. Determine the process to improve
   b. Create a measurement infrastructure
   c. Track the process and the outcome

III. The need for MI at Intermountain
   a. Prior to 2006 only 40% of the care was adherent to an active approach
   b. Care matched to a classification improves outcomes that can be sustained
   c. Low back pain patients can be classified based on a treatment approach
   d. Chronic patients are resistant to improvement
   e. Intermountain tracks “failure to improve” as an outcome metric

IV. Risk for chronic low back pain can be predicted by STarTBack survey on the first PT visit
   a. Therapists can be informed of the chronic risk on the first visit to intervene with MI
   b. Chronic low back pain is associated with worse outcomes

V. The process for measurement of outcomes at Intermountain is ROMS
   a. It is part of the daily work flow
   b. It requires very little time from the therapist

VI. Motivational Interviewing can lead to a change in patient behavior

VII. Intermountain Healthcare process for training their therapists in MI
   a. Bring in an expert for training
   b. Integrate MI into patient evaluation, treatment and documentation
   c. Perform repeated training
   d. Perform peer chart review to promote compliance

VIII. Failure to Improve rates can be reduced with MI training

References


Bibliography:


Jette, Alan M. Meeting the challenge of the high-need, high-cost population. PTJ. 2016;96,11.1682-1683.

Presenter Biographies:

Dave Levison, PT, MHS, is a Clinical Associate Professor, Director of Clinical Education at the School of Physical Therapy and Rehabilitation Science, and Director of Interprofessional Education in the College of Health Professions and Biomedical Sciences at the University of Montana. He has been on faculty at the University of Montana since 1990 where he has had teaching responsibilities in a variety of areas including content related to professionalism, teaching and learning, patient–provider communication, prevention and wellness, clinical reasoning, and practice management and administration. Mr. Levison has attended the standard 2-day training workshop in Motivational Interviewing.

Robert Scales, Ph.D. is currently, the Director of Cardiac Rehabilitation and Wellness in the Division of Cardiovascular Diseases at Mayo Clinic in Arizona. He joined Mayo Clinic in 2008 as an exercise physiologist and in his administrative role he has provided leadership in the development of a cardiology-based initiative that is designed to prevent heart disease. He has his doctorate degree in education and he holds an adjunct faculty appointment as a Clinical Associate Professor in the School of Nutrition and Health Promotion at Arizona State University. His primary research interest is the application of motivational interviewing (MI) and effective provider-patient communication in the healthcare setting.

He was the Principal Investigator in the Cardiovascular Health Initiative and Lifestyle Education (CHILE) Study, the first study to investigate the impact of motivational interviewing and skills-based counseling on the behaviors of patients attending cardiac rehabilitation (CR). More recently, he was the Lead Consultant on a National Institutes for Health (NIH) funded study to investigate methods of teaching motivational interviewing in a physical therapy academic program.
Dr. Scales has counseled thousands of patients and is also an accomplished international speaker on the topic of disease prevention. Adaptations of his work using motivational interviewing with clinical populations have focused on the prevention and management of diabetes in Native American communities. He is an experienced trainer in motivational interviewing, having trained both students and clinicians from a variety of healthcare disciplines. Dr. Scales is a member of the Motivational Interviewing Network of Trainers (MINT); is a Certified Health Education Specialist (CHES); and a Fellow of the American Association of Cardiovascular and Pulmonary Rehabilitation (FAACVPR).

Stephen Hunter, PT, DPT, OCS, received his Bachelor of Arts in Physical Therapy from University of Utah in 1984, and his Clinical Doctorate in 2008. He began working for Intermountain Healthcare in 1984. Stephen completed a 2-year orthopedic residency 1995 and became board certified in orthopedic physical therapy in 1996 (renewed in 2006). Currently, Stephen continues to treat patients and is also an Administrator with Intermountain Rehabilitation Agency for 10 outpatient orthopedic physical therapy clinics in Salt Lake City, Utah. Stephen has been involved in clinical and quality improvement research since 1986. He has authored, or co-authored over 20 articles in peer reviewed journals on this topic.