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Slide 2 - Title

CAROL: Good afternoon, and welcome to the National Diabetes Education Program's webinar, *Motivational Interviewing: How and Why It Works for People With Diabetes*.

Slide 3 -Welcome & Introductions

We are delighted to have so many people registered for today's session. I've been told that over 1,600 people registered, and that we're breaking an NDEP record. Our presenters today will show how a well-designed, motivational interviewing intervention can foster patient empowerment by making the patients themselves aware of the potential for change in behavior, resulting in improved diabetes treatment and care.

We believe this webinar will allow all of us to learn more about how several motivational interviewing diabetes education programs were performed in rural and other settings, as well as the methods that were used for client counseling. By the end of the webinar, it is our hope that you will see how motivational interviewing can be integrated into daily clinical work with diabetic patients to bring about clinically relevant effects that benefit our patients.

Slide 4 – Motivational Interviewing: Perspectives on Concepts, Training, and Specific Applications

Our first speaker is Dr. Jan Kavookjian. Jan is an associate professor of health outcomes research and policy at Auburn University's Harrison School of Pharmacy. She will provide a brief overview of motivational interviewing concepts and skills, with a focus on provider-patient encounters related to diabetes self-management behavior. She will also share with us her perspectives from her 15 years of experience in training providers from across the spectrum of health professions and lay leaders.

Her presentation will end with highlights from diabetes intervention projects that include a study of pharmacists trained in motivational interviewing for use with diabetes patients coming for medication refills, and a diabetes education program implemented in a southern rural minority community. Jan?

Slide 5 – Motivational Interviewing (MI) Background

DR. JAN KAVOOKJIAN Well, I am delighted to be presenting today with my distinguished colleagues, and welcome to all of you today. We have been asked to each spend about 12 minutes giving you our perspectives on training and applications, and I have also been asked to overview

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some of the MI concepts. So I'll be spending about 4 minutes on the overview, and I regret that it's going to be so brief, because I have looked at a lot of the questions that you all have posted, and many of you are looking for information about the concepts and the rationale for MI. And unfortunately, in our brief webinar today, we won't have time to get too deep with that.

But I did put together a reference list for you. I had my PhD student Gladys gather some of the latest literature, some systematic reviews, probably from about the last 10 years, and some landmark pieces, as well as a list of books. And the book that we use most frequently is *Motivational Interviewing and Healthcare*. It's the one that I use as the textbook in the MI elective courses that I teach at the pharm D and graduate levels, and also one that I recommend when I do a training. But I would also like to point out that on that list is a book that's coming out this year from my co-presenter, Marc Steinberg. It's coming out, I think he said, in August. And so I want to draw your attention to that book, because we're very excited about that particular one as well.

So I guess just to kind of dive right into this overview that I hope to give; you know, motivational interviewing is about behavior change. And I know I'm preaching to the choir. You're here because you were looking for how to intervene to help patients decide to make changes. And in diabetes, it is so complex, and it's a very individual thing. And MI has emerged in chronic disease management, especially in diabetes, because of that complexity and individuality. And it is a patient-centered communication skillset and way of being. You've probably heard the patient-centered term outside of MI. It is an evidence-based concept in and of itself, and it's about tailoring to the patient preferences, literacy level, cultural norms, and just, you know, their individual motivators and barriers.

And I'm sure if you think about your own behavior changes, you know, we're all working on something, aren't we? And the things that motivate me are gonna be very different from the things that motivate you, even if we're working on the same target behavior. So MI is this communication skillset and way of being that brings us directly to this particular person, while taking our own preconceived notions out of the picture. It has its origins in the addictions and counseling fields. Miller and Rollnick are the originators, and, you know, there are several of us in behavior sciences and disease management across healthcare that saw that success in those difficult target behaviors and thought, "Wow," you know, "we should take a look at this for health behavior change," in relation to disease management or health promotion.

And so the evidence base for MI is expanding rapidly. As a behavior scientist, I've been in MI for about 17 years, but in the last decade in particular, we have just seen it explode worldwide. And at last count, to my knowledge, it's been translated into over 17 different languages. And if you look at the literature, not just in our resource that we've posted but elsewhere, you'll find such a diversity of populations, target behaviors, conditions, providers, settings, countries, etc. And in fact, we're seeing an important adoption of MI by professional associations at the national level for

dissemination to their healthcare provider members. For example, the American Association of Diabetes Educators, or AADE, has been immersed in MI for quite some time. I've been doing some MI things for them over time. The American Pharmacists Association, the Case Management Society of America, which is predominantly training nurse case managers, and several others that I could list. It's showing up in practice guidelines for entities like the American Diabetes Association and in health professions education accreditation standards.

Slide 6 – We Tend to Believe Whatever we Hear Ourselves Say

So the evidence base is growing rapidly, and I wish I had more time to tell you about the evidence base. I think the one premise that I hope that you'll take away from this is captured in this quote out of the MI and healthcare book that I have here at the top of the slide. "We tend to believe what we hear ourselves say." So MI is about interviewing the patient in a way that the patient ends up giving the input and making the argument for the change. And it's about interviewing the patient in a way that it is listening, this notion of internal motivation.

Slide 7 – The Motivation Conundrum

And in fact, we've been talking about internal motivation and looking at it for about a half of a century. It is certainly required for lasting change, and it is an important premise in motivational interviewing because, you know, everybody has something internal that is important to them that can be tied to that particular target behavior. But unfortunately, all the strategies that prevail in healthcare are external push or pull, and that can do more harm than good, as noted in these couple of sub-bullets on the slide.

So patients are gonna, by push or pull, they're gonna either feel violated and resist further, or they're gonna make that temporary change, and they're excited about that temporary change while they're with you. But then when they go home and they get away from that external push or pull, they're going to fail. Probability is they're going to fail and relapse and then feel even less confident about making or sustaining change because of that failure.

Slide 8 – MI Way of Being: “Spirit of MI”

So MI also includes this way of being, or it's known as the spirit of MI, and this is a really critical part. And in fact, it's a part that can be very challenging to healthcare providers, trying to use MI. So if you think about the origins of MI and psychology and counseling, the persons that are working in that realm are highly trained in communication skills. They have a background in psychology and psychosocial aspects of behavior change for patients, and they often have a 50-minute psychotherapy session, and that's not always the case with healthcare providers.

Now, if you look at the things on this slide, a lot of these things are things that people in those professions are trained to do, but healthcare providers often don't get that training in their health professions education. So for most of us, and I include myself in that "us," it requires a mindful act of will to decide you're going to set your judgments and your biases and your need for control in this interaction aside so that we can be collaborative and patient-centered and listen carefully to where the patient wants to go in this encounter.

Slide 9 – MI Communication Principles

And so we do that with these MI communication principles. The five things that you see listed on this slide have been part of the foundation of MI since the beginning. And I put expressing empathy at the very top, because I personally feel that it's one of the most important aspects of MI. Empathy in and of itself is evidence based. I was immersed in empathy before MI, and it's actually what drew me to MI initially. It is about listening to what feeling that patient is expressing and then reflecting that back to the patient in its simplest form, because we all want to be understood, and feeling understood helps us feel less alone in this encounter and in this effort at change.

Now, expressing empathy is not saying, "I'm sorry you feel that way," and it's certainly not saying, "I understand how you feel," because you probably really don't understand, and that is problematic in and of itself. Expressing empathy is saying something like, "You sound really discouraged, Mr. Smith," or, "Ms. Jones, it's clear that this seems very unfair to you." And then down at the bottom of that list, supporting self-efficacy. In all my years of training providers across professions, that's the one that I see is typically the easiest to embrace. It's about supporting what they are doing, even if they're thinking about making a change. So it might be something like, "That's great that you're thinking about quitting smoking," for example.

Slide 10 – MI Micro Skills

And then there's also what we refer to as the micro skills in our training model, and our training model pulls in this notion of we're doing this in the context of comprehensive disease management, the clinical aspects as well as the behavior change aspects. So we think it's very important to pull into this the context of talking about this in terms of what they understand about the diagnosis of diabetes and the risks that they are susceptible to if it doesn't get under control. So we pull that out into the conversation early on, and we have the patient answer that question. Or we support their autonomy by asking permission to fill in the information or advice that they need, you know, after we've elicited from them first.

Hallmarks of MI include some of the other things on the slide, like asking open-ended questions, engaging change talk, which Miller and Rollnick themselves have emphasized how important change talk is in recent time, and that is really the pivotal piece for the internal motivation. So it's

about asking questions like, "What do you see as the benefits for this particular target change?" Or, "What would be the reasons for you to engage more activity into your routine to bring your blood sugar down?" Those would be the kind of things that you might ask for that. And then of course, setting incremental goals to build self-efficacy, with the hope that building small successes can help in confidence for bigger change.

Slide 11 – MI is Intuitive, but Requires Training and Practice

So that brings me to this notion of training, because if you think about it, healthcare providers who are being trained in MI are actually facing a behavior change in terms of their practice behaviors. So our philosophy is that we use MI to train MI. We focus on incremental changes, and this is very important in training healthcare providers who, again, don't have those backgrounds that we talked about previously.

Sometimes I get invited to come do a 2-hour training, and I don't even want to call that a training. I would call it an overview that at best, we could do some awareness raising with. The evidence base says that we really need this to be at least a 2-day workshop. I've done it in less than that. I don't like to, but I know that a lot of care settings have a hard time setting everybody aside for 2 days at a time. But really, the evidence base says it needs to be at least 2 days, with more than one role-play, with MI expert feedback, and some form of follow-up training or practice opportunities or coaching, as you'll hear Marc talk about in just a moment.

And some things that we've learned as well, kinda coming from the academic side, from adult learning theory and strategies that work and don't work in helping adults, especially intelligent adults, learn skills is the critical aspects of cognitive development first, and then going into the skills application process. I worry about settings where persons are going into a brief training, and then they're being thrown into role-play. And this can be particularly problematic because they're not ready, and it can destroy their self-efficacy for that.

Slide 12 – Application: Pharmacists Diabetes Program for Medication Adherence

So I am just going to briefly tell you about this particular project that I had the great honor of consulting with for the American Pharmacists Association, and this was about medication adherence and non-adherent diabetes patients who were recruited into this project. And my involvement was training the pharmacists in MI and helping to develop these structured communication prompt pieces. These were some paper-based pieces that you could actually see an example of if you can acquire the article, which is cited there on the slide.

And so essentially, these patients came in for their refills every month for 6 months, and they talked to the pharmacist for about 5 minutes using these little prompts, and at the end of that timeframe, medication adherence had increased and satisfaction had increased.

Slide 13 – Southern Rural Minority Diabetes Education Project

And then I'm not gonna linger on this project, because in the interest of respect for my colleagues, I'm gonna move on. I just want to highlight, there are things in this project that are similar to the things that the Kentucky Group will be telling you about, and it boils down to the engagement of community health workers or layhelpers. That's a critical part of cultural tailoring and developing relationships when you're going into a particular community that might have, say, minority or rural characteristics.

So that concludes my portion. I thank you so much for your attention, and I encourage you to contact me if you want to know anything more about the things that I've covered or potential training opportunities in the future. Thank you.

CAROL: Thank you, Jan. You talked about how motivational interviewing can be a useful intervention strategy that can empower participants. Do you believe that MI outperforms traditional advice given in the treatment of behavior problems in diabetes?

DR. JAN KAVOOKJIAN: I absolutely do, and the evidence base certainly supports that. A little bit of MI, and actually MI, even portions of it, can be even timesaving, compared to traditional advice-giving as well. A little bit of MI is better than a lot of advice giving, which can be violating to patients. Thank you.

Slide 14 – Learning & Improving MI use in Your Practice

Our next speaker is Dr. Marc Steinberg. Marc is a motivational interviewing trainer with The Group4QualityCare. He will discuss the client-centered counseling techniques he used during motivational interviewing to stimulate behavior change. He will wrap up his presentation by offering information on lessons learned as a result of those interventions. Marc?

Marc Steinburg, Good morning to everybody. I'm still in morning. Some of you may be in afternoon now, but I'm glad to be able to speak with you today, and I'm looking forward to sharing some information with you. But more importantly, I want to ask you a question. Have you ever been sitting in a consultation and working with somebody, and suddenly this invisible 3-foot wide panel of concrete descends from the wall; you're on one side, and the client or patient you're working with is on the other one? Well, I suspect that may have happened at some point in time, that loss of engagement in a conversation.

In the 1990s, physical exams and visits with physicians were largely related to meeting clinical practice goals, or guidelines rather, and these proliferated in the '90s. And I got really--I've always been involved in quality care, and I had this difficulty. There were these people who wouldn't do what I would tell them to do. And I wondered, why is that? And basically, what I found was that it was not a problem that they were having. It was me. I had very little training in behavior change, and I was more than halfway through my practice when these clinical practice guidelines appeared, and I wanted to do something about it. I felt very much as though I couldn't move forward with patients and help them achieve better health.

Slide 15 – Learning how to use MI in Your Practice

MI is what ended up happening. Over a period of years, I discussed with my wife how frustrating it was not being able to reach some people. And I finally ended up serendipitously getting this invitation to a meeting to learn motivational interviewing about 15 years ago, and it just lit up my life. I basically found out that yes, there are ways to learn behavior change, and it gave me a feeling that there was some hope for working with people who had challenges, who were struggling or completely ignoring self care in diabetes. Most of my practice, and towards the last years of my practice, I did exclusively diabetes care.

The good news is, is that MI is learnable. It's easy to understand but difficult to learn, and a lot of that is because it's skills based. Imagine learning how to play the piano. You can't go and listen to your piano teacher play and then be able to play yourself. It takes time, and it takes repeated exposure to the aspects of playing a piano. The important thing about MI is it's not dependent on your educational level. MI is a style of practice. It's a way of conducting conversations, of sharing conversations with people that use many skills that we already have, as well as some that we have to learn.

Slide 16 – Listening is a challenging skill for many of us

When we use MI, listening is critical, and for me, listening is the most difficult task in the world. If I tell you about, or if you tell me about, a fishing trip you went on in Montana where I live, and you tell me what you did last weekend fishing, it immediately evokes or involves my thinking of experiences that I've had fishing, and it's very easy for me to disconnect from what you're saying and to think about my experiences. So MI really is--the most critical skill is listening, and listening carefully, because we have to differentiate among different types of utterances or statements that people make; change talk, sustain talk, signs of ambivalence.

Change talk basically is anything that sounds like you're willing or interested in change. Sustain talk is, "I'm okay where I am." We don't look at people as resistant in MI. We look at them as people who are happy with where they are, even though it may be an unhealthy place to be, and we

look also for signs of ambivalence. It can become very difficult, and this is where the training comes in, in distinguishing these different types of utterances.

For example, if I come to your office today for diabetes education, had type one diabetes for over 40 years, I could come in and say something to you like, "Gosh, you know, I really had a hard time getting off work for this appointment, and, you know, when I drove up in your parking lot, I wanted to wait about 5 or 10 minutes. I mean, I'm not even sure I want to be here. I've had a lot of trouble with this diabetes, and it's difficult." Is that change talk or sustain talk? Your answer obviously is "I showed up and I'm telling you this," so there is some change talk here. If I were going--if I were in a sustain talk mode, I might've backed out and gone somewhere else at the time of our appointment.

The other thing that's really important about listening in MI is the heart of MI is not questions. In fact, in healthcare, most people ask questions more than reflections. Reflections are simply listening to the client, the patient, and then taking what they say and repeating it back to them, along with a guess about what it meant. And that, in effect, stimulates more conversation and is really the key for evoking the patient's own ideas and plans.

So for example, I go in and see you and I say, "I really don't like checking my blood glucose at night." And you say, "Why don't you like doing that?" I can answer the question, "Well, it hurts." But on the other hand, you say, "You're having problems with that, Marc. You don't really feel that it's useful for you." "Well, no, I know it's useful," and again, I go on and expand and provide more information. The important thing about MI is that reflective listening, using reflections rather than questions, is really the key. It's the heart of MI, and it's very hard to get going without that skill, and that's the most difficult skill in MI.

Patients always offer us feedback. The invisible 3-foot concrete wall that descends between two people and sort of ends engagement or disengages one another is an example of that. Also, people nodding their heads or talking with you--that gives you feedback. People, when they argue with you--that's a very dangerous place to go because we avoid discord at all costs in MI, but it's listening to the patient to find out what you need to do next.

Slide 17 – Learning MI Takes Time

MI isn't mastered in a 2-day workshop, as Jan pointed out. It takes both practice and coaching.

Slide 18 – Coaching

The coaching part of it is a bit like a piano teacher. If I wanted to learn how to play the piano, I would play for somebody in the course of learning it. I would go to their house or to their office and play what I was supposed to practice during the week. When this came to me in motivational

interviewing, this coaching part where I was being coached, I was very fortunate. I was working with two psychologists in fact, and we were working on research projects and motivational interviewing. It helped a lot to work with them because I got a great deal of coaching from them. That was in my early MI years, and we started also doing trainings, which helped as well.

But the coaching is really important. For example, if I'm learning how to play an electronic keyboard and show up at my teacher's for a lesson, and I say, "You know, I really don't want to play in front of you today because I'm not really sure I can do it. But I'm not gonna turn on the keyboard. You can just watch my fingers. You can't hear me." And it's hard to learn in that mode. So one of the best ways, really, of learning MI is to do a training and then to be sure that you get follow-up.

Recording the interviews and receiving feedback from them is a really good way to learn. When I started doing that, I found it enormously difficult, and I felt very vulnerable. And in fact, in a number of conversations, I really got a lot of critical input and observations that I needed to make some change if I wanted to call my style of practice motivational interviewing. It was a bit disappointing, but it was presented in a way that just--"But to change that, you could do this, this, and this."

There are a lot of trainers across the world. There's a group called the Motivational Interviewing Network of Trainers, MINTs, that are part of MotivationalInterviewing.org, and they have trainer profiles there. And you can also get together with a local group. I've been meeting with a group, of those two psychologists and now a psychiatrist who's joined us, on the first Friday of each month for well over a decade. So that's another way that we end up discussing MI.

Slide 19 - Resources

Over the years, I've been very fortunate to spend a lot of time in motivational interviewing, and I've spent the past 2 years working with Bill Miller, who developed motivational interviewing, and I've written a book on motivational interviewing and diabetes care, which will be coming out in the summer, but there are a lot of other good motivational interviewing resources.

You can't learn MI from reading--that's for sure--the same way you can't learn tennis from reading or watching it on television. But *Motivational Interviewing*, the third edition, *Helping People Change* is really the tome for MI and a very worthwhile book if you're interested in this.

We're gonna move forward and hear of other people's experiences with MI, but I really appreciate having the opportunity to speak with you today.

CAROL: Thank you, Marc. You pointed out how motivational interviewing should be performed and how to use the methods of counseling to maximize our efforts. In motivational interviewing, is there a specific timeframe for follow-up to avoid the risk of counseling failure?

DR. MARC STEINBERG: There is research on learning motivational interviewing. In today's world, what I try to do in trainings, which is based on that research, is to not do so much a 2-day training all in one dose, but to do one day intensively, and then get back together in a month and go forward and to work on where people have been in the past month. Recording conversations is worthwhile. It's difficult to do because people are busy and because of the vulnerability people feel doing it. But generally speaking, in the VA study, they did a recorded conversation once a month. Most of the people that I've worked with do them every 4 to 8 weeks, and they involve basically somebody listening, like me listening to the tape, and then providing them with written feedback and asking them to make an appointment for a conversation to discuss it. It's a very positive activity. It's not negative or critical.

CAROL: Thank you.

Slide 20 – Diabetes Peer Mentoring Program and Motivational Interviewing

Our final presentation will include remarks from a team of presenters. They include Dr. Pamela Yankeelov, who is Professor and Associate Dean of Student Services at the Kent School of Social Work, University of Louisville; Dr. Joseph D'Ambrosio, Assistant Professor, University of Louisville School of Medicine; and Luana Hester, who is a diabetes peer mentor with the Kentuckiana Regional Planning and Development Agency. They will provide us with an overview of how motivational interviewing was used as part of a community health worker diabetes peer mentoring program in Kentucky. Their presentation will provide a description of their program, how motivational interviewing was used to shape the work of the peer mentors, along with examples from one peer mentor. Can we have the team from Kentucky?

Slide 21 – KIPDA Rural Diabetes Coalition

DR. PAMELA YANKEELOV: Hi, there. Thank you so much, Carol. Our peer mentoring program is part of a larger brand initiative. Now, CDC provided funding to KIPDA--KIPDA is an area agency on aging organization--and the University of Louisville, Kent School of Social Work, to, in part, develop a coalition. And our coalition's goal is to create a community for individuals living with diabetes and organizations to support one another and advocate for healthier communities.

Slide 22 – Peer Mentors

Our peer mentoring program is one of the activities of our rural coalition. Our peer mentors are typically individuals who have experiential knowledge of a stressor, such as diabetes, and have

similar characteristics to the target population. The concept of peer mentoring comes out of a community health worker model. Our peer mentors explore feelings and social support, problem solving, goal setting, and self-efficacy with their mentees.

Slide 23 – Social Cognitive Theory

Our program is based on two theories: social cognitive theory and social norms theory. Social cognitive theory suggests that a person needs to know what to do, how to do it?, knows consequences of the actions before engaging, has confidence in their ability to be able to execute the desired behavior. Social norms theory focuses on correcting misperceptions of perceived norms.

Motivational interviewing is the practice perspective that's layered over those two theories. Our mentees are actually supported by our mentors, of course, who are supported by community organizers and a clinical consultant, who is also supported by the coalition. And the initial objective is for the mentees to reach certain goals, and the ultimate objective is for the mentees to actually become part of a community of carers, specifically in our community and the coalition. And the program really has more of an egalitarian relationship between the mentor and the mentee, something a little bit different than what you would get with a health professional and a patient.

Slide 24 – Program Intake

So our peer mentoring program begins with a program intake to identify priorities of the mentee. Then the mentee and the mentor come together, and they share their story. They share their journey of what it's like taking care of their diabetes. Then there are nine subsequent sessions, alternating face-to-face and phone contact, and sessions two, four, six, and eight talk about priorities that have been identified by the mentee in regards to their health management, their self-management of their diabetes. And then we do alternating phone contacts.

There's also the last month. There's two phone check-ins in the final month, and we also aim to have some field trips if possible, and the field trips would be, again, to the community, to the coalition, to support groups, to exercise programs with the mentor.

Slide 25 – True Peer Mentor

The unique features of our peer mentoring program is that our peer mentors are persons thriving with diabetes, who live in the counties of our mentees. And as I said, social support is one of the initial sessions because we're assessing for social support within the home, outside of the home. We attempt to connect the mentees to like-minded individuals in the community. We use the existing coalition, as well as we have a public-private partnership in the sense that we have materials from pharmacies and pharmaceutical companies, ADA, as well as NDEP.

Right now, I'm gonna turn over to my colleague, Dr. Joe D'Ambrosio. He's gonna talk to you about the training.

Slide 26 – Peer Mentor Initial Training

DR. JOSEPH D'AMBROSIO: Thank you. We had a dilemma in trying to decide how to train our peer mentors, because most trainings, as you heard from Jan and Marc, are done over a 2- or 3-day period, and it really does take a long time to learn the process and really make it a part of your life. We decided to put this project together and this training together in a short period of time because our peer mentors, although they're being paid the paltry sum of 10 dollars an hour, we like to look at them as volunteers also. So I'm going to be talking about a lot of the items that Jan and Marc talked about, so maybe this will help reinforce some of the motivational interviewing process for you.

Slide 27 – Basic Motivational Interviewing Mindset for Peer Mentors

The basic motivational training that we did was a 3-hour training. We started with a pretest, and in that pretest, we asked our mentors if they would answer three simple questions, and these are questions or statements that a mentee would typically make. So if our mentors heard their mentees say, "I know you mean well, but I'm never going to get better," how would they respond? And they wrote down that answer. Our second question was, "I don't have time or support to do what you want me to do. I want to get better, but I don't know how to do it." Our mentors wrote down the answer to that. And then our third question or statement from our mentee would be, "I failed before, and I will probably fail again."

So at the end of the training, we asked those questions to our mentors again, and we really did see a change in the way they answered them, from the way they started before they heard about motivational interviewing to when they ended. We then proceeded to introduce MI with the three main tenets of the process: style, skill, and building motivation. We tried to make it less a lecture and more a conversation, modeling MI ourselves.

Slide 28 – MI Training Focus

Style was introduced by showing the *Stop It* video, which is an expert from the Bob Newhart series and is available on YouTube. If you haven't seen it, please watch it, as it shows what many of us have always wanted to do with a client, and that's yell, "Stop it!" It's the opposite of MI, but it shows what not to do. We then reinforce MI style, explaining that it's not a technique, but rather a way of being with a mentee, learning how to dance with their mentee, and introducing many of the tenets of MI, which are already embedded in what these people do every day.

Slide 29 – So what is different than what we already do?

We then focused on showing mentors that MI is a different way of being with someone we're trying to help. In the MI world, we call it “The MI Shift,” that allows a mentor to let go of the need to change the mentee, but rather support them on their journey to health. This relieves the mentor of the responsibility of having the mentee change, and instead allows them to let go and enjoy the process of change, watching their mentee grow at their own pace.

We ended this session with another YouTube video of a very bad MI session, where the therapist started to metaphorically twist their client's arm to get them to stop smoking. It was the opposite of MI and allowed us to hone in on a process that was shown that does not motivate change. If you're interested, that video is on YouTube, and it's called *How NOT to do MI: A Conversation With Sal About Managing His Asthma*.

Slide 30 – MI Style

Get REAL is an acronym that is used in MI that's a template of the style that MI requires. Jan and Marc already mentioned respect, empathy, active collaboration, and listening. Isn't this the way we really need to treat each other on a daily basis? They're pretty self-explanatory, but when you try to help someone, the helper forgets these simple instructions about being with another human being and instead tries to force change. So we gave explanations in detail.

Respect is having a deep admiration. A mentor has to believe in the mentee, [that they have] worth of their own and in their own decisions, believe in the trustworthiness of their mentee, believe that they will help themselves, and that they have what it takes to change. Empathy: the ability to share someone else's feelings. Not pity, and no need to have a similar experience. Active collaboration involves partnership. It's not something done by an expert to a passive recipient. It's not something done for a person; rather, it's something with a person. And then listening is being present, undivided attention, curiosity, delight in being okay with silence and using encouragers, such as, "Mm, I see. Okay, go on. Really? No way. What else? Tell me more."

We focused on listening for change talk, but there's not sufficient time in the first session to anchor this in. In our conversation with the mentors, we try to emulate the MI principles by listening for change talk in the mentors.

Slide 31 – Tame the “Righting” Reflex

We really tried to emphasize “Stop fixing.” This is hard because those who are helpers want to help clients get better, and it's a natural response to fix clients. So we talked quite a bit about taming the righting reflex.

Slide 32 – The Skill of MI

And then finally, we went into some skill building with the EARS, explore with open-ended questions. Ask for collaboration; how, what ways? Ask for examples. We went over the negative effects of closed-ended questions. Affirming our mentees; honoring their strengths and attributes. Marc mentioned reflection, which I agree is one of the main, main parts of MI that we all have to continually practice, simple or complex. We gave them some short ways to respond to reflection by saying to a mentee, “So you feel,” or “It sounds like you,” or “You're wondering if,” or “It seems that you,” or “You're feeling so-and-so,” and then summarizing, pulling all of the elements that a mentee has offered and collecting them in a bouquet that the mentor was able to hand back to the mentee.

Slide 33 – Building Motivation

And we ended our training. By this time, our mentors looked at us a bit confused because so much was covered in the short 3-hour session. We briefly touched on recognizing resistance as a signal to change strategies. And the resistance could be arguing, ignoring, interrupting, withdrawing, negativity, or denial. We briefly touched on developing discrepancy. We emphasized asking for permission to give advice and normalizing mentees' actions when it was appropriate. But overall, this was a bit much on the first rounds.

Slide 34 – Shift Happens!!!

And then finally, the main message to the mentors is that shift happens. Don't worry about getting MI right. Rather, focus on joining with their mentee and be themselves. The school of MI can be practiced over and over again, and as you do it over and over again, you do get better.

Slide 35 – Ongoing Mentor Support

DR. PAMELA YANKEELOV: We also did some ongoing mentor support in which we had weekly meetings with the mentees--I mean with the mentors, and the mentors would come together and they would give case presentations. They would talk about what was going on with their mentee. We would also provide support via the telephone, and if there was any additional need outside of those weekly meetings and telephone support, we would do case-by-case analysis.

Slide 36 – A Mentor's Perspective

DR. JOSEPH D'AMBROSIO: Let's hear a little bit from Luana, who's one of our mentors. Luana, how did you shift from wanting to direct change to allowing change to happen?

MS. LUANA HESTER: It's hard not to want to force people to change, but from my training in motivational interviewing, I learned that if I forced someone to change, it won't last long term. The change that motivational interviewing is trying to accomplish is long term, and it comes with the mentee finding something inside that motivates them. It's not about what I think the mentee wants. I like to ask some of these mentees what they like and what they want, what makes them happy, and accept them as they are.

DR. JOSEPH D'AMBROSIO: How did you begin to ask permission before giving advice?

MS. LUANA HESTER: One of the main things I've learned from motivational interviewing is that it's about building trust with the mentee. Part of building trusting relationships with anyone is to always ask permission before you give advice. I have found that when the opportunity arises for me to share, I say, "Is it okay if I tell you what works for me?" Or, "Is it okay for me to tell you what works for my other mentees?" This way, it is not me forcing my opinion or ideas on mentees without their permission.

I remember when I was working with my mentee who was always glued to her couch. When I brought up the subject, she--for like exercise, she'd turn away, look at a lamp beside her couch. This is a clear sign for me to back up and try another approach. I then said, "It might be a good idea for us to get up and walk around a bit." I asked her, "How about if we get up and walk up and down your hallway one time?" By the time I returned a week later, she told me she was walking around the hallway 15 times a day. That made both of us happy.

DR. JOSEPH D'AMBROSIO: That's good. What do you feel you did to encourage intrinsic motivation to arise within the mentees?

MS. LUANA HESTER: It was really more about me listening to and getting to know the mentee than me doing anything to get them to do something good for themselves. One thing that I learned in my motivational interviewing training was to listen for any words that could get the mentee to shift to a better place for them.

I worked with a mentee who was of Asian descent and eats bowls of rice that are not good for his diabetes. I learned how important the rice was to him because of his culture, and I also learned the importance of his family. His daughter is his intrinsic motivation. He was willing to modify his diet because he knows it makes him healthier. Motivational interviewing is about--I'm sorry. Motivational interviewing is really about me listening with a much deeper standpoint. One thing I want to add to this. That gentleman's blood glucose went down 30 points.

DR. JOSEPH D'AMBROSIO: That's amazing.

MS. LUANA HESTER: Yes.

DR. JOSEPH D'AMBROSIO: As a mentor, what's the best lesson you've learned from MI?

MS. LUANA HESTER: I think the most important lesson I've learned is to first develop a trusting relationship with my mentee. Slow down and don't go fast. Just relax and let the mentee be who they want to be while a trusting and deep relationship is made. I love getting to know people, and this program gives me a chance to get to know great people, while also doing something good for them and me. I couldn't ask the mentee to do things that I wasn't doing. Example, glucose testing, watching what and the amounts of foods that I ate.

DR. JOSEPH D'AMBROSIO: Well, thank you, Luana. We appreciate you sharing. Thank you for being a mentor. I know your mentees love you.

MS. LUANA HESTER: Thank you very much. I love them too.

DR. PAMELA YANKEELOV: I just wanted to conclude by saying that we have some great results from our mentoring program. Our mentees report high satisfaction with the program. They report increased perception of support. They also have increased self-efficacy on all of the diabetes-related self-management tasks. They increased in their self-reported blood glucose testing, and there's trends in the increase in their fruit and vegetable consumption. And, as Luana has told us in many of our trainings and case conferences, it's hard because we all want to be fixers. And we have these great mentors that are extraordinary in the way that they manage their diabetes, and they want to impart those experiences with their mentees, because they want to reduce the mentee's suffering. But Joe often reminds us at our training that we have to kind of wait for change. Basically, be patient. So I'm gonna go on and conclude there. Thank you.

CAROL: And thank you. You underscored the importance of the motivational interviewing setting and program designed for mentors. Are the duration of sessions and the number of participants important in mentor training?

DR. JOSEPH D'AMBROSIO: Well, the less number that you have, the lower number that you have is better, but what we found is not so much the training. It was the follow-up. So we gave them an opportunity to call us when they had questions. We met with them. We did problem deconstruction, and it was this ongoing connection that we had with the mentors that really, really helped them learn MI.

CAROL: All right. I thank you for that.

Slide 37 – Q & A

We're, at this time, ready to accept questions through the chat box. If you have questions, would you please forward them now?

ALEXIS: So hi, Carol, it's Alexis. We have a lot of questions coming in already. One group of questions is around training. So there are questions about whether people can get online training for MI, what are some cost-effective ways to get training, and, I think one of the speakers covered this: What are some ways that people can sort of support each other in a community of practice?

CAROL: All right. Do we want some of our speakers to respond to that?

DR. JAN KAVOOKJIAN: Well, this is Jan. I will just say that there are lots of opportunities for training out there. I know Marc was telling you about the MINT network, and I know his group and I do training. And there are other organizations out there that do it. It is something that works best in person. Sometimes some of the cognitive development aspects of training can be done, you know, online or, you know, via other media. But when it comes time for the actual skills development training portion, it's very important to be doing that in the presence of--at least facilitated by an MI expert who can be, you know, giving feedback for that.

CAROL: Thank you. Go ahead. I'm sorry, Marc.

DR. JOSEPH D'AMBROSIO: We just spoke with Luana, and Luana was saying that MI training online would have not worked for her. It was that meeting with her in person and that constant feedback, where she knew she could make a phone call to ask a question when she was stuck. That's what really help her.

MS. LUANA HESTER: It definitely did.

DR. MARC STEINBERG: I think, while the emphasis is on training and that is important, getting together and doing training; really, the key to learning is coaching. And getting together with a group playing piano doesn't always help your piano playing or my piano playing. And so when you think of training, it's really important to think of it as a ball of activities that needs to be on this side with a group and at other times in a smaller--so that you get one-to-one feedback on how you're doing, 'cause that really makes the difference in becoming more satisfied with using MI.

The neat thing about MI is, is that it doesn't just change the people we work with. It changes us and it makes our work a lot easier, and there's actually evidence that basically says that people don't look at an appointment list and say, "Oh, no, look who's coming in at 3:00 today. That guy's so hard to deal with." I mean, those were the only people I saw the last 3 years of my practice, and I looked forward to seeing each of them.

DR. JAN KAVOOKJIAN: I think one thing I will add to that about training, I think that the group model has evolved because it's efficient, and it is just kind of a way that it seems to be done in healthcare settings because it's an efficient way, you know, to get a number of people done. So, an important strategy, and this works on adult learning theory as well, has to do with doing some, you know, team building and rapport building at the beginning, because you're trying to develop a culture of MI if you're coming into a healthcare setting and trying to train a group.

You're trying to create this culture of MI, so there's some team building that happens in the beginning, and then engaging everybody in the feedback process contributes to the learning of everybody, even in, you know, some of the role play. So if you've done a good job of setting the comfort zone and the team building in the early part of the training, then once we get to that feedback, I mean, the role-play process in small groups, where everybody's giving each other feedback, they can learn from the process of hearing others receive feedback, the process of critically evaluating to give feedback, but also so that that person who's receiving the feedback can learn from that as well. And that is a model that has worked fairly well, at least for the initial part, as Marc said.

CAROL: Let's move on. Marc, is the MI--is the healthcare book available in an audio format? I think you had talked about a healthcare book, and someone was asking if it is available in an audio format.

DR. JAN KAVOOKJIAN: The MI and healthcare book is a Rollnick, Miller, and Butler book, and I'm not sure if it's available in audio, but I know Marc's book is coming out this year, and it's *MI and Diabetes Care*. We'll just defer to him to tell whether that will be available in audio.

CAROL: Thank you. Has MI efficacy been tested amongst communities of color?

DR. JAN KAVOOKJIAN: Definitely. The evidence base has seen it applied in a lot of minority populations, again, across conditions and particular target behaviors. But there are a couple of great studies out there in African American communities, Hispanic communities, Asian communities. Like I said, it's been translated into over 17 languages, at last count that I saw.

DR. MARC STEINBERG: Ken Resnicow at University of Michigan had done incredible work in inner-city settings with weight loss, and all the counseling took place in churches, for the most part. And the people providing the motivational interviewing, the people who were sort of developing the motivational interviewing skills, were members of the church, some of whom did not have high school educations. They hadn't completed high school, and they did a wonderful job. I think a study's reported in 2002. It's a very interesting one, and he continues in that vein of work, Ken Resnicow at the University of Michigan.

DR. PAMELA YANKEELOV: And you're saying that it can be applied in a group setting.

DR. MARC STEINBERG: There's a very good book, *Motivational Interviewing in Groups*. It's a little bit different in groups than with individuals because when we're with individuals, we're evoking their ideas, that specific individual's ideas. And when we're doing it in groups, we have to sort of control who talks, in a sense. Not control, but influence who talks and make sure that everybody has a voice in the conversation. So it's a little bit different, and it's a little bit more difficult to do in my experience.

CAROL: How do we deal with a patient who does not want to change his A1C levels, you know, as recommended by a provider; or doesn't work to change his A1C levels or any of his labs?

DR. JAN KAVOOKJIAN: That is a complicated question that will be hard to answer in a moment or two. I will just say that's a resistant person, and it's very important to just roll with the resistance, empathize with it, explore it. You know, let the patient talk about that, and it's just really hard to really answer that in 2 minutes because that is a lengthy conversation. But I would say that an initial response is to, you know, empathize and roll with it, don't get into an argument with that patient. Try to engage them in change talk, you know, open-ended ways of, you know, what they know about the benefits or how important it might be, what their long-range vision is for their health, and trying to develop some discrepancy between the attitude about the A1C and the long-range, you know, future hopes for their health.

CAROL: You know our primary care practices are quite busy places. How do we integrate MI into their programs?

DR. MARC STEINBERG: Can I go back just a moment, before we get to that question, in terms of dealing with people who are in sustain???, you know, they're in a situation of status quo and don't want to change? I think that's an important question, because we think of MI as a way of helping people resolve ambivalence about change, but in people who seem disinterested in change, we use MI to create ambivalence. So a lot of the conversation hinges around speculative questions and things of that nature, and helping them to find ambivalence. And I'm sorry to interrupt that prior question. Go ahead.

CAROL: Okay. I will repeat it again. You know many of the primary care offices are very busy places. How do we integrate motivational interviewing into their setting?

DR. JAN KAVOOKJIAN: Well, I think, you know, we've presented to you today some comprehensive models of MI, you know, all the concepts and some of the perspectives of everything you need to know. And not every encounter is gonna include everything we've highlighted today. And in fact, if you only have 2 or 3 minutes with a patient, you know, being MI

consistent in that 2 or 3 minutes means you might engage in a few of the strategies, because you're not going to have a comprehensive conversation in that brief amount of time.

But I think one thing that Luana said that I think is a key is, you know, it's about building trust. You know, building a relationship is the foundational objective here, and in primary care, you're hoping to see that patient continually over time and developing that relationship. And so, hopefully there will be time at some point to have a more lengthy conversation, you know, if needed, or even to bring in other collaborative providers to help, you know, in the comprehensive behavior change piece of that.

But I think that even just a little bit of MI, you know, active listening, being collaborative, using open-ended questions, even thought-provoking questions. I think Marc just said something about asking these thought-provoking questions; that can be very discrepancy developing to get people to just kind of think about making that change. You know, being empathic, not engaging the patient in further resistance.

CAROL: All right. Can you offer any advice on how to engage clients when working with health insurance companies, making outreach calls to try to get them to work with the nurse on their chronic conditions?

DR. JAN KAVOOKJIAN: Well, I actually had--this is Jan--I had a lot of experience with that in the past, have collaborated in the past with Case Management Society of America, and the majority of their participants were nurse case managers doing telephonic case management. And, you know, it works the same way. I mean, even though it's on the phone and unfortunately, over the phone, you lose a lot of the nonverbal aspects of the communication, like being able to have the patient see you nod and engage in direct eye contact. So it's very important to think about, you know, voice tone and those kinds of nonverbals that are so important on the phone. But, you know, the process that's done face-to-face is still, you know, what you would apply in over the phone.

I think one thing that I encountered in trainings with nurse case managers doing telephonic is that they often have a checklist. There's a protocol that they have to follow, and there's a checklist, and so they are struggling with how to be MI adherent, and yet they've got this checklist that they have to complete. So my recommendation with that has always been to tell the patient up front: "You know, I have this checklist that I'm going to have to complete as part of the protocol for this conversation, but before I get to that, I'd really like to just have a little conversation with you to see, you know, how things are going with you."

And so you engage in a few minutes of that, you know, open-ended questions and MI, and chances are you're gonna answer through that rapport building some of the questions on the checklist

anyway. And so then you steer the conversation back around to the things that you have to complete on that checklist, and then you can engage it at that point.

CAROL: Moving on, we have a question. How long would it take to be a real expert in motivational interviewing?

DR. MARC STEINBERG: You don't have to be a real expert in it. You just have to keep doing it. Over time, it takes probably--there are studies that have shown that in 6 months with follow-up, people go from .2 reflections per question to about .8 or 1 reflection per question, and that's a big change. Generally speaking, learning how to speak reflectively, where you're doing basically one question and two or three reflections takes some time, but it's very achievable for those who are interested in doing it.

DR. JOSEPH D'AMBROSIO: This is Joe. When I went through training, I went through hours of videos that I had to send in, and I was rated. But I agree with what Marc is saying. I think I learned motivational interviewing more by doing it and then having peers that can challenge me and help me learn this new way of letting go and just journeying with my clients rather than forcing them into doing what I want them to do.

CAROL: Another participant is asking, "How do you talk to a patient who's scared of the side effects of their medication?"

DR. MARC STEINBERG: Basically, ask them what they know about the medications initially. Find out what their knowledge is, and then use that as a jumping point to offering information. And there are ways in MI to offer information, asking their permission, "Would it be okay if I gave you some ideas? You have a good idea of what's going on with that medication. Would it be okay if I provided you with some other information?"

DR. JOSEPH D'AMBROSIO: And also spending a lot of time on reflecting their fears, so what they're feeling is real and not being afraid to stay with them in that fear that they have.

CAROL: All right. We have another question. Is it difficult to get MINT trainers to train folks in healthcare because they charge up to \$250 an hour? This is too expensive for most clinics. Can you help with resources for getting training that is not as expensive?

DR. MARC STEINBERG: There are a lot of us in MINT who work with organizations that are having that difficulty, and so that is definitely done regularly. That's something that you really have to reach out to specific trainers and ask where they are with that. So you have to really get the list from MotivationalInterviewing.org, and you can almost always find somebody who will do that.

CAROL: Next question. Are there situations in which you do not want to use MI?

DR. JAN KAVOOKJIAN: Well, this is Jan again. I think, you know, it's important to remember that MI is about volitional control over behavior change, and yet we still can use it in a situation like with your teenagers. You know, they don't have a choice about keeping the curfew, right? Hopefully they don't have a choice, but we still can use it in that context. Or an employer could use it with employees, even though that employee has to come to work and fulfill those responsibilities to get paid. But it really is geared for situations where one has volitional control over making that target behavior change.

One thing that I will say is it is important to remember that it works optimally--there are certainly aspects of MI being collaborative, the spirit of MI and so on, that you would use with persons who are not cognitively capable. Persons with, say, dementia or Alzheimer's, or persons with mental illness or learning disabilities who can't cognitively process, then your approach with MI would be a little bit--well, considerably different, but you still could exhibit the spirit of MI. And, you know, oftentimes, you might be talking to the caregiver in the case of dementia and Alzheimer's, and you would use MI with that caregiver, but you would be hopefully trying to also engage the patient to the degree that that's feasible.

CAROL: Thank you. Are there situations--I'm sorry, we've addressed that one. Would you please talk about MI in relation to the stages of change or as a trans-theoretical model of change? What are the connections to the two and the differences?

DR. MARC STEINBERG: They both focus on behavior change, but MI does not look at--is not the trans-theoretical model of change. We look at people either who are interested in making change and are struggling with it because they're either ambivalent or have other things going on, or there are people who really are satisfied with status quo. That used to be called resistance, and it's viewed as a state that people are in because that's where they want to be. And what we do with that group is basically try to do some of the stuff that did come from Rollnick's work and Miller's work in creating ambivalence. And so it's a little bit different than stages of change sort of counseling, where we view people at one of several levels of making change.

DR. JAN KAVOOKJIAN: This is Jan. I haven't done extensive work in the trans-theoretical model before immersing in MI. I think it's a great method for assessing where one is in terms of motivational readiness. I have kind of moved away from that, even though that was the focus of my dissertation research. I only really use that so much in research now. If I need to have a measure for how adherent someone is, I might use a staging algorithm.

But I think when you're talking to a patient and you're being patient centered, I caution against relying on spending your thought process on pegging someone into one of five, you know, stages

and putting a label on that. I think MI, as somebody said, it's more of a dance and patient centered. You're following where the patient is going, and the trans-theoretical model grew up separately from MI, although they both arose at similar times, and they're very complementary. But MI, I think, is more of the strategy for what to do next, whereas I see the trans-theoretical model being very relevant if you're trying to gauge, you know, where, where someone is.

Slide 38 - Presenter Information

ALEXIS: So at this time, we are all out of time for questions. We know there're still lots of questions in the queue, so we're taking these down, and we will send them out to the presenters and get responses back to people who posted questions. You'll also get a resource list in the follow-up e-mail to this webinar. So that resource list will probably answer a lot of the questions that you have. So at this time, I'm gonna turn it back over to Carol to wrap up. And thank you so much for joining us, and thank you to the presenters for answering all of those questions.

Slide 39 – Additional comments

CAROL: Thank you, Alexis. On behalf of the National Diabetes Education Program, I'd like to thank all of the presenters for sharing their profound knowledge about motivational interviewing.

Slide 40 – Learn More

And for our participants, we hope that the information provided can be used by each of you in some way for the benefit of patients. As Alexis indicated, unfortunately, we are unable to get to every question. However again, I will repeat that NDEP will compile all questions and share them among the co-presenters, and responses will be shared —

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