Motivational Interviewing: Helping People Improve Diabetes Self-Care

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The GROUP 4 Quality Care
Presenter Disclosure Information

In compliance with the accrediting board policies, the American Diabetes Association requires the following disclosure to the participants:

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Disclosed no conflict of interest
HAVEN’T HEALTHCARE PROVIDERS
ALREADY TAKEN GREAT STRIDES
TOWARD HELPING PEOPLE
WITH THEIR SELF-CARE

DO WE REALLY NEED NEW WAYS TO
HELPING PEOPLE WITH DIABETES
IMPROVE THEIR SELF-CARE?
A huge survey regularly asks people with diabetes, “How you are doing?”

1. National Health and Nutrition Surveys (NHANES) results in diabetes care:

2. From 1988 to 2010 those at goal in the ABC’s of diabetes care (A1c, BP & LDL levels) have been 1.7% to 18.8%, respectively.

3. This means over 22 years of NHANES Surveys 98.5% to 81.2% of people with diabetes were not reaching healthy goals.
Why Don’t People Do What We Tell Them to Do?

• Reactance – when freedoms drift away people reach out to hold onto them tightly.

• Ambivalence – our internal committee.

• It costs a lot to change. Even those at goal struggle constantly.

• Depression, substance use, mental health or cognitive issues.
EVEN WE CAN INHIBIT CHANGE

• Discord (arguing for change)

• The Righting Reflex (“installing change”)
The **RIGHTING REFLEX** is telling people what *we think* they should do.
Helpful signs tell us when we resort to the RIGHTING REFLEX:

• Working persuasively without permission.

• But as we attempt to “install change,” we are working harder than the patient.
The RIGHTING REFLEX often fails because:

– **STATUS QUO** is perceived as easier, change is hard work

– **AMBIVALENCE** is unresolved; people have concerns about success

– There are costs in making changes
Remember: IN CONVERSATIONS WITH PATIENTS THE MOST INFLUENTIAL AND PERSUASIVE VOICE IS WITHIN THE PERSON YOU’RE SEEING
MI is a style of practice:

“MI is a collaborative, goal oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.”

Listening in MI

• Change Talk: “I want to lose weight.”

• Activated Change Talk – or Commitment Language: “I’m thinking about going to a gym so that I can get some activity. That might help me lose weight.”

• Sustain Talk: “I really enjoy eating. I’m not going to try again to lose weight. I’ve never been able to keep my lost weight off.”
4 Processes: The Method of MI*

The Heart-Set and Mind-Set of MI

- Partnership
- Acceptance
- Compassion
- Evocation
Partnership

• You bring expertise to consultations *and* so do the people you see, a wonderful basis for **PARTNERSHIP**.

• People acquire expertise day by day in ways they work with their diabetes.

• One demonstration of partnership is “horizontal conversations” between 2 experts:

• You as the healthcare expert and the patient who has a *unique* personal expertise.
Acceptance

• Acceptance creates a positive environment that frees people to think about what they might or could become.

• It avoids finger-wagging, “You ought to do this” or “Don’t do it like that.”

• Acceptance has 4 aspects.
Absolute Worth

- People have dignity and deserve humane treatment.

- They shouldn’t need to prove their worth to earn our respect.
Affirmation

• This aspect of MI creates a powerful, positive patient-centered momentum.

• Rather than focusing on people’s deficits or mistakes, MI centers on strengths by affirming patients’ accomplishments, insights and capacities for change.

• We will discuss this more in MI skills.
Accurate Empathy

• Empathy is a desire to see the world from another person’s perspective.

• It’s neither sympathy nor encouragement.

• It reflects a deeper understanding of another’s plight.
Autonomy

• We don’t “give” people autonomy; they make all the decisions about what they do.

• Acknowledging this during conversations frees people to think about change, rather than arguing with you.

• Reminding people they are autonomous makes your job easier; you don’t have to attempt the impossible, “getting someone to do something.”
Compassion

• Concern about the person’s well-being.

• A desire and commitment to work for ameliorating or preventing suffering.

• “First do no harm,” an underlying purpose of good healthcare, is an example of working for people’s welfare.
Evocation

- Throughout MI conversations the theme is: “You have what you need and we will work together to find it.”

- People typically have at least a bit of ambivalence.

- MI evokes the thoughts and ideas patients have about change.

- Reflections, especially reflective listening, offer you a way to help patients as they build their plans.
MI Skills - OARS

- Open Questions
- Affirmations
- Reflections
- Summaries
OPEN QUESTIONS

• Are an important part of focusing and facilitating activated change talk.

• Closed questions (those answerable with minimal detail or a simple yes or no) are all right. *But they can clash with evocation and reflective listening.*
AFFIRMATIONS

• Affirmations are statements about self efficacy, efforts, achievements or insights.

• They often involve empathy: “A few years ago you stopped smoking in just one month. You’re capable of making difficult changes to improve your life.”

• Affirmations, an example of accurate empathy, is an understanding of the patient’s circumstances.

• It’s not about encouraging and cheerleading.
AFFIRMATION EXAMPLES

• “You see the benefit of night time blood glucose testing. It helps you avoid lows at night.”

• “You worked hard to get into the habit of regular physical activity. You enjoy long walks and you’ve lost weight since starting it.”
REFLECTIONS are the heart of evocation.

Reflective listening is an important skill for helping people change.
Reflections: Statements that evoke the patient’s ideas or perspectives

• Listen for change talk and use it in your reflections.

• Listen to what is said rather than thinking about your next question.

• What *feelings* does the person wind around the words?

• Levels of reflection:
  ▪ Simple Reflection – Rephrase or repeat
  ▪ Complex reflection – Paraphrase or add more than one idea – can amplify by adding feeling/emotion)
Forming Reflective *Statements*

- Not a question; a statement.

- A hypothesis, a guess.

- Inflect your voice downward:
  “It’s important to you to be able to lose weight without causing hypoglycemia. (complex reflection)

- *It doesn’t matter if our reflections are accurate – patients love to correct us!*
Reflective Listening and Evoking

- Reflective listening is the key skill for evoking.

- It takes time to get it down but it’s definitely learnable.

- 2 or 3 reflections for each question creates a rhythm.

- Research shows coaching facilitates learning how to do this.

Providing Information or Advice
Information and Advice: 3 Kinds of Permission

✓ The person asks you for advice or info
   “Which option is best for you?”

✓ You ask permission to give advice or info:
   “Would it be helpful for me to suggest some choices?”

✓ You qualify the advice or info to emphasize autonomy
   “I can provide you with some ideas and you could decide what would work best for you.”
Elicit – Provide – Elicit (E-P-E)

• Stick to the principle of necessary and sufficient

• Ask the patient what they already know about the topic: “What do you already know about ____________?”

• Ask permission. It’s helpful to emphasize autonomy. “Would it be helpful to you if I offered (either information or advice)? You’re the one who will decide what to do.”

• End with evoking: What do you think of what I said?”
Offering Info or Advice When Risks are Great or When Approaching Sensitive Topics

- Ask permission, “May I speak with you about something important, something that could make you quite ill?”

- Express your concerns: “It’s important for you to know that skipping some of your insulin every day causes your blood glucose levels become uncontrolled. You could develop DKA and end up in the hospital. Some people with DKA die.

- Evoke further exploration of the topic: “I am interested in what you think about this.”
BEHAVIOR CHANGE IS DIFFICULT

- Few of us have received training to competency in helping people change.

- Change is not just on the patient’s to-do list, it can be part of our to-do list also.

- MI is learnable.

- Learning new clinical skills doesn’t just help people with diabetes fare better. It makes our work easier.
How Effective is MI?

• Mixed results occur commonly with complex behavioral interventions.

• The same is also observed in research on medical treatments and drugs.

• However the variability in behavioral research is greater and more challenging to control.
The Gold Standard in Medical Research

• Double blinded randomized control trials (DBRCT) are regarded as *the standard* in medical research.

• That standard is impossible in behavioral research.

• Blinding the subjects and using a “placebo” would corrupt the research.

• Participants would distinguish the differences readily.
Intervention Content

• Many studies of MI in healthcare combine different approaches in the research, e.g., cognitive-behavioral therapy, client-centered counseling and decisional balance (stages of change) and others.

• The “combined” approaches often lack the essence of MI:
  – a non-authoritarian counseling style,
  – a clearly defined change goal that the conversation focused on
  – and differential evoking to strengthen the patient’s own motivation for change.(Miller & Rollnick 2014)
Quality Assurance of the Intervention

• In the past MI or when another behavioral intervention was purportedly used, but there was no documentation of what was actually delivered.

• Researchers and funding organizations regularly neglect this when they fund studies on using “MI techniques.”

• Even manual-based MI studies have been found to be ineffective.

• However, well validated tools have been available since 2003: the MISC and the MITI can quantify statements in the conversation and gauge the skillfulness of MI use. (Moyers & Martin, 2006; Moyers et al 2009)
Fidelity of the Intervention

• People don’t benefit from treatment they don’t receive.

• Although MI competency is measureable, it does not have a quantified amount of training that predicts clinicians’ competency.

• Publishers have no specified level of MI competency in studies they publish.

• Research has shown convincingly that learning MI is achieved by training, coaching and review.
Adequacy of Treatment

• There are no agreed upon methods for managing insufficient clinical performance in behavioral studies.

• Measured dosing and scheduling of treatment with behavioral interventions is difficult to quantify.

• This may be easier to overcome with multi-site efficacy studies. (Miller, W. R., & Rollnick, S. 2014)
From Efficacy to Effectiveness

• Efficacy trials demonstrate the success of minimizing the impact of variables on behavioral research.

• Effectiveness measures the impact of the treatment.

• Historically healthcare has had difficulties identifying the specific ingredients that produce effective results.
The Active Ingredients of MI

• Miller & Rollnick have identified 3 empirical items in MI that may be linked to successful change:
  – Accurate empathy, understanding the perspective of the patient
  – MI does not include confrontation and arguments, elements shown to increased resistance to change.
  – MI training leads to more evocation of change talk and decreased sustain talk, both of which have been shown to facilitate change (Miller & Rollnick, 2014)
THE CLINICAL EFFECTIVENESS OF MI

- MI has shown effectiveness in:
- The UK DPP (Tuomilehto, Lindstrom, et al).
- In smoking cessation (Grimshaw & Stanton, 2006).
- In medical interventions for blood pressure, cholesterol, dental caries, HIV viral load, and mortality (Lundahl et al., 2013).
- Changes in A1c have been variable with small to moderate improvements over a number of studies. (Jones et al., 2014; Channon et al, 2007).
- MI has been used effectively in adolescent with diabetes (Channon et al, 2007).
So where does that leave us?

- **Self-care is the key to improving outcomes in diabetes care.** “If they want to, people can ‘out-eat’ any diabetes treatment plan.”

- **Research on MI in diabetes care is still young.**

- **And an overwhelming majority of people with diabetes still need to improve their self-care.**

- **How will you help them?**
RESOURCES


REFERENCES For the MI Research Section


