



Motivational Interviewing

A Recipe for Patient Engagement in HIV Treatment and Care

Presenter: Deborah Cestaro-Seifer, MS, RN
16 June 2016

Motivational Interviewing

A Recipe for Patient Engagement
in HIV Treatment and Care

DEBBIE CESTARO-SEIFER MS, RN

Disclosure

The presenter does not have any financial relationships with commercial entities to disclose.

The presenter will not discuss any off-label use or investigational product during the program.

This slide set has been peer-reviewed to ensure that there are no conflicts of interest represented in the presentation.

Learning Objectives

As a result of attending this program participants will be able to:

1. Discuss the application of Motivational Interviewing (MI) to the delivery of person-centered HIV treatment and care.
2. Describe the overall spirit of Motivational Interviewing.
3. List the fundamental principles of MI.
4. Identify the core MI communication skills and their role in the MI process.
5. Define self-efficacy and explain its role in behavior change and engaging patients in HIV treatment and care.

Self-management Needs of People Living with HIV

Individuals living with HIV must learn to:

1. **Cope** with the intense, sometimes debilitating, emotions that accompany living with chronic disease and the perceived and/or actual stigma associated with the condition
2. **Change behaviors** to minimize the impact of HIV and maximize antiretroviral (ARV) treatment
3. **Manage the disruptions** their illness may cause to their work, school and family life

Stanton, Revenson, & Tennen (2007)

Potential Social-Emotional Health Issues Experienced by Individuals Who are HIV+

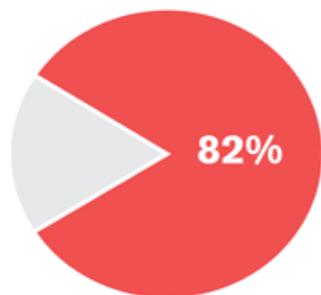
- Grief
- Insomnia
- Fatigue
- Anxiety
- Depression
- Social isolation

Drop-offs in Engagement, Prescribed Antiretroviral Therapy (ART) and Viral Suppression

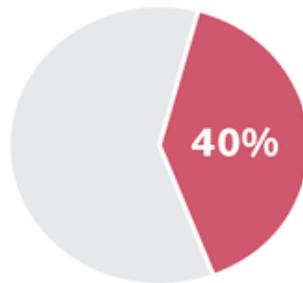
HIV Care Continuum

Testing, engagement lacking

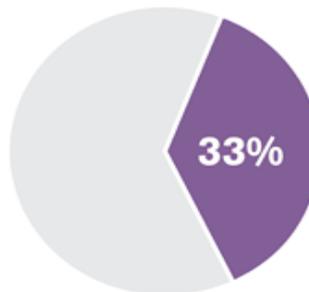
PERCENT OF ALL PEOPLE LIVING WITH HIV



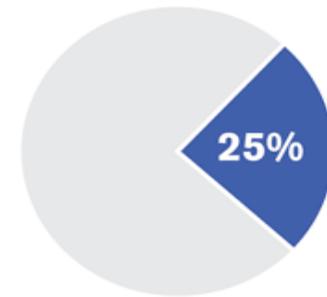
Diagnosed



Engaged in care



Prescribed ART



Virally suppressed

ART = Antiretroviral therapy

SOURCE: CDC. Vital Signs: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV – United States, 2011. MMWR. 2014, 63(47): 1113-1117

Source: CDC. Vital Signs: HIV Diagnosis Care and Treatment Among Persons Living with HIV-United States, 2011. MMWR, 2014, 63(47):1113-1117

Chi Chi Udeagu: New York City Patient Find Study

Most common reasons cited by people in the study who were out of care (more than 9 months):

“Felt well” (41%)

“Felt depressed”

Disbelief they had HIV

Udeagu, C., et al. (2012) Impact of a New York City Health Department Initiative to Expand HIV Partner Services Outside STD Clinics, *Public Health Rep.* Jan-Feb; 127(1): 107-114, PMID: PMC3234386

Patients Who Reportedly Were and Felt Engaged

Said that their providers:

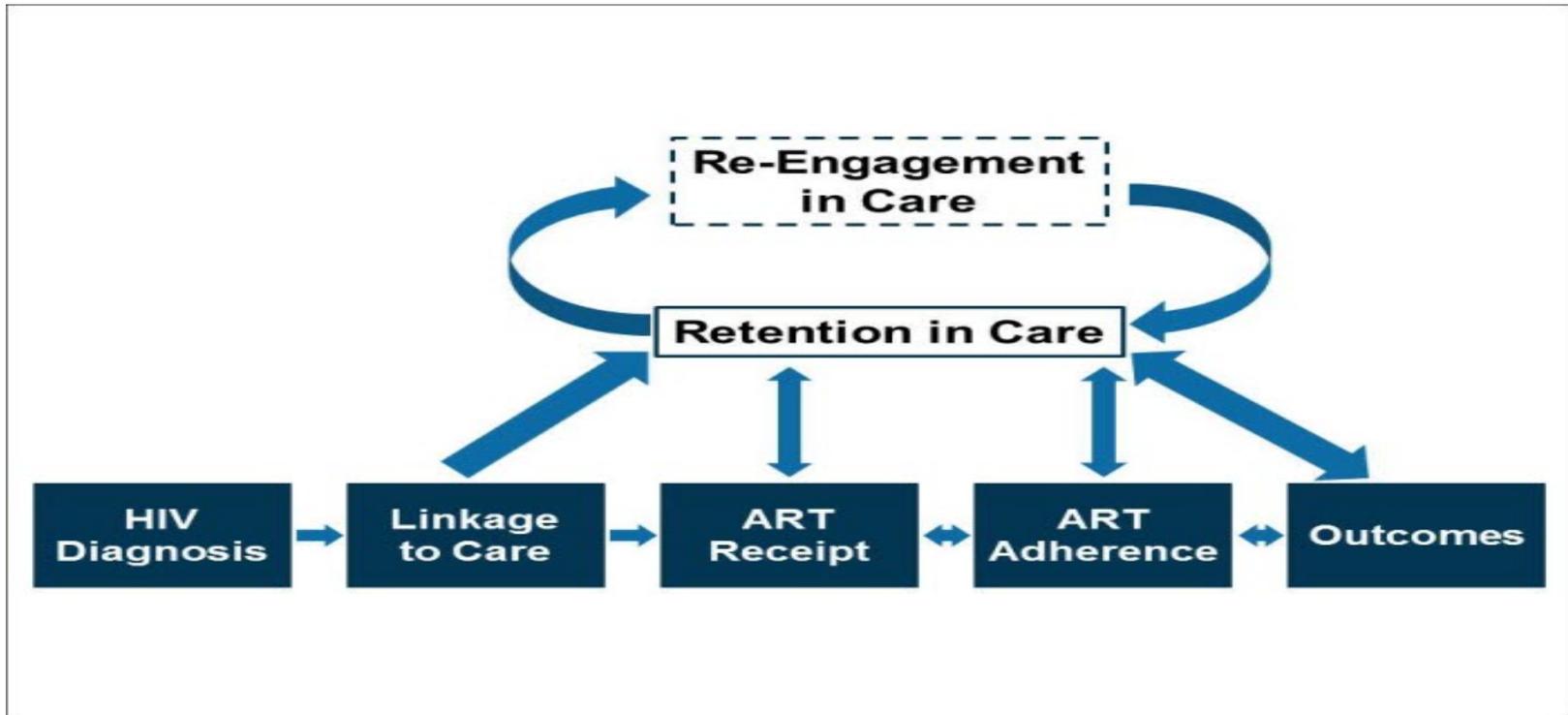
1. Treated them with dignity and respect
2. Listened carefully
3. Explained things about care and treatment in a way they could understand
4. Knew them as people

Udeagu, C., et al. (2012) Impact of a New York City Health Department Initiative to Expand HIV Partner Services Outside STD Clinics, *Public Health Rep.* Jan-Feb; 127(1): 107-114, PMID: PMC3234386

Engagement in Care

- Engagement in HIV care involves a spectrum of activities, **not a singular event or visit**
- A patient's location on the continuum of HIV care **is not static**
- Movement away from engagement in care often occurs as a **result of unmet needs**
- Full engagement and retention in care **is essential** for people living with HIV to experience optimal health outcomes

HIV Care Model: Non-linear & Dynamic

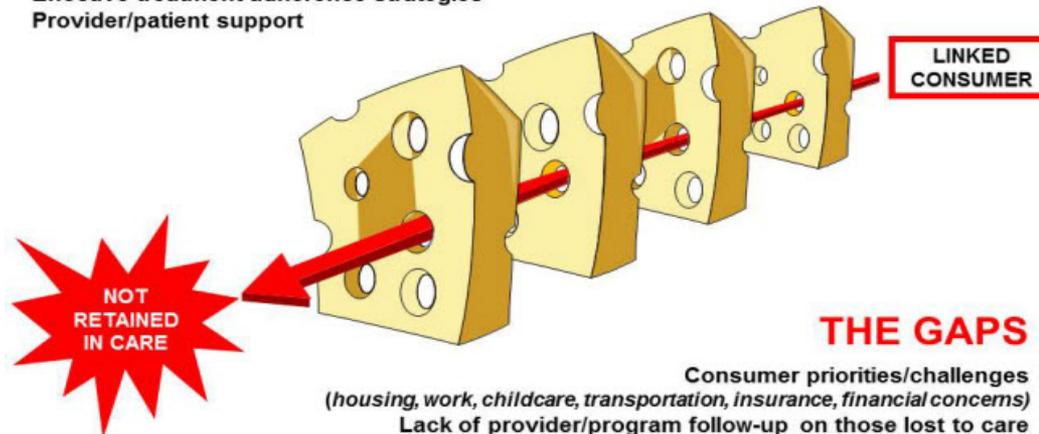


Source: <http://img.medscape.com/article/767/261/767261-fig2.jpg>

Retention in HIV Care 2012

DEFENSES

- Effective connection to ongoing supportive services
- Flexible appointment/reminder systems
- Friendly and supportive clinical environment
- Peer navigation/support
- Effective treatment adherence strategies
- Provider/patient support



THE GAPS

- Consumer priorities/challenges
(housing, work, childcare, transportation, insurance, financial concerns)
- Lack of provider/program follow-up on those lost to care
- Appointment scheduling and provider availability
- Unfriendly clinic environment or "just a bad day today"
- Lack of supportive services for mental health, substance abuse

Medscape

Downs, B. (2012) How can we improve rates of retention in HIV care?. Medscape:

Evidence for What Drives Antiretroviral Therapy Adherence and Viral Suppression

Key Finding

Contact with Providers
Improved engagement in care

Munene, E. & Ekman, B. (2015). *AIDS Care*, 27(3):378-86. E pub 2014, Oct 8.
Crawford et al (2014). *J. Int Assoc Provid AIDS Care*, May/June: 13(3): 242-9.

Activate Patient Engagement by Building Patient Partnerships

Does this Sound like a Partnership?

- “You better start taking care of yourself or else...”
- “I am pleading with you to take your medication. If you don’t you will...”
- “You have to understand....”
- “You have to make a change or you will die.”
- “What don’t you understand about this? To live with HIV you have to take medication everyday and never miss a dose!”

Is this a Partnership?

Take your medication! Every dose! Stop doing drugs! Use condoms! Exercise! **Get your labs drawn! Come to clinic!** Disclose to your sexual partners! No drugs! No smoking! **Safe sex! Did you take your meds? Did you take every dose?** You know you have to take your meds or you will get really sick and possible die!

What Happens When We Tell Someone What to Do?

- They do the opposite!
- They get tired of it!
- They tune us out!
- They don't come back for care and become **disengaged!**

“

providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions

”

INSTITUTE OF MEDICINE CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001)

Person-Centered Care

What Promotes an Engaging Partnership ?

- **Feeling welcome**
- *Feeling comfortable*
- **Feeling understood**
- *Having mutual goals*
- **Being hopeful**

Traditional Health Education

TRADITIONAL HEALTH TEACHING BEHAVIORS

- Authoritative
- Prescriptive
- Persuasive

Teach Instruct Lead

ASSUMPTION

Patient is a passive recipient of care

Techniques to Guide Patients and Create Partnerships

Direct

Teach

Instruct

Lead

Guide

Draw out

Encourage

Motivate

Follow

Listen

Understand

Go along with

Motivational Interviewing (MI)

A Chronic Disease Management Tool

a method of counseling, designed to facilitate natural change (the patient's internal motivation)

Lussier & Richard (2007)

goal is to increase internal motivation to change health behaviors by addressing ambivalence toward change

William Miller & Stephen Rollnick (2012)

premise is that **confrontational strategies are not effective**

William Miller & Stephen Rollnick (2012)

based on “Stages of Change” model

Prochaska, J. and Velicer, W. (1997b)

Prochaska, J, and DiClemente, C. (1983)

Evidence-based Practice: MI and HIV Care

Using Motivational Interviewing in HIV Field Outreach With Young African American Men Who Have Sex With Men: A Randomized Clinical Trial

Location: Portland, Oregon 2001 through 2005

Target population: recently incarcerated women who were HIV negative

Sample Size: 530 women

54% white, 18% African American, 15% multiracial/other, 6% Native American/American Indian, 6% Hispanic/Latino

Intervention: 30-45 minute individual MI sessions lasting up to 12 weeks

Three(3) Groups: HIV risk reduction; HIV & IPV risk reduction & control group

Interventionists: community health specialists trained in MI

Weir, B. W., et al.(2009). Reducing HIV and partner violence risk among women with criminal justice system involvement: A randomized controlled trial of 2 motivational interviewing-based interventions. *AIDS and Behavior*, 13, 509-522.

Evidence-based Practice: MI and HIV Care (2)

Using Motivational Interviewing in HIV Field Outreach With Young African American Men Who Have Sex With Men: A Randomized Clinical Trial

Significant Outcomes

Participants from the HIV Risk Reduction & HIV & IPV Risk Reduction interventions (combined) reported significantly fewer episodes of unprotected intercourse at 3 months post-intervention ($p < .05$) and 6 months post-intervention ($p = .05$) than control participants.

Weir, B. W., et al.(2009). Reducing HIV and partner violence risk among women with criminal justice system involvement: A randomized controlled trial of 2 motivational interviewing-based interventions. *AIDS and Behavior*, 13, 509-522.

Evidence-based Practice: MI and HIV Care (3)

Does Motivational Interviewing Counseling Time Influence HIV-Positive Persons' Self-Efficacy to Practice Safer Sex?

OBJECTIVE: The study examined the impact of motivational interviewing (MI) counseling time (SafeTalk) on self-efficacy to practice safer sex for people living with HIV/AIDS (PLWHA).

METHODS: A sample of 490 PLWHA was followed for 12 months. The researchers examined changes in safer sex self-efficacy when participants received zero, low to moderate (5-131 min) and high (132-320 min) doses of MI time.

RESULTS :

Participants with low to moderate doses of MI counseling had 0.26 higher self-efficacy scores than participants with zero MI time ($p=0.01$). Participants with high doses of MI had a 0.5 higher self-efficacy score than participants with zero amount of MI time ($p<0.0001$). Those who had 1-2 sessions on MI showed greater self efficacy than individuals who had no MI.

CONCLUSION: MI time is a key to enhancing safer sex self-efficacy among PLWHA.

Chariyeva, Z., Golin, C. E., Earp, J. A., & Suchindran, C. (2012). Does Motivational Interviewing Counseling Time Influence HIV-Positive Persons' Self-Efficacy to Practice Safer Sex? *Patient Education and Counseling*, 87(1), 101–107.

Evidence-based Practice: MI and HIV Care (4)

Using Motivational Interviewing in HIV Field Outreach With Young African American Men Who Have Sex with Men: A Randomized Clinical Trial

OBJECTIVE: To determine if Field Outreach with MI versus traditional field outreach leads to increased counseling and HIV testing and rates of return for HIV test results among young African American men who have sex with men.

METHODS: A randomized 2-group 96 young African American MSM completed a motivational interview based field outreach session and 92 young African American MSM completed a traditional field outreach session. The percentages of participants agreeing to traditional HIV counseling and testing (oral cheek swab) and returning for test results were the primary outcome measures.

RESULTS : More of the participants in the motivational interviewing intervention requested HIV counseling and testing and wanted to know their status (49% versus 20%) and returned for test results (98% versus 72%).

Outlaw, et. Al (2010). Using motivational Interviewing in HIV Field Outreach with Young African American Men Who Have Sex with Men: A Randomized Clinical Trial. *Am J Public Health, Supplement 100 (1)*.

Motivational Interviewing Pyramid

MI Pyramid



The Spirit of MI is Nonjudgmental



"If you treat people 'up' they reach up!"

"People get more out of life if they do it themselves!"

Motivational Interviewing is a Counseling Technique that Encompasses Many Skills

- ✓ Listening
- ✓ Communication
- ✓ Collaboration
- ✓ Cultural care
- ✓ Developmental care
- ✓ Patient empowerment
- ✓ Mentoring

HEALTH BEHAVIOR CHANGE

Communication and Collaboration

Behavior Change: Ambivalence

Feeling two ways about something; wanting and not wanting

“Contemplation Stage”

It's normal

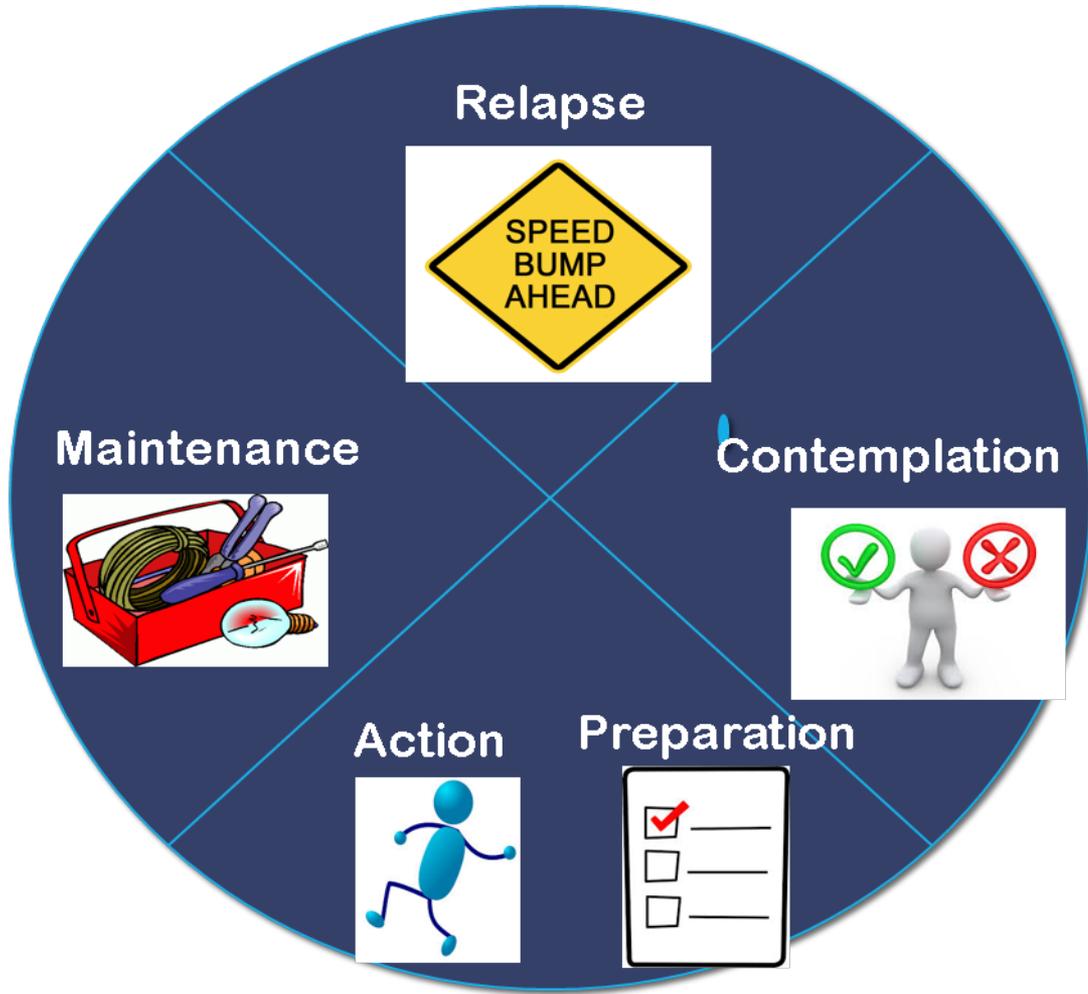
Keeps people “stuck”

The Stages of Change

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

(**Relapse**- not a stage, but a speed bump on the journey)

Is Your Patient a Shopper for Change?



Pre-contemplation

Not Shopping
Not Browsing
Not "Buying"

Application: Name That Stage

According to the "Stages of Change" model, individuals in the precontemplation stage would say which of the following?

- A. Don't even talk to me about taking meds.
- B. I am thinking about taking meds.
- C. I am getting ready to take my meds.
- D. I took my meds twice today.

Name That Stage

“I’ve been using the stuff I learned in group so I don’t get so “heated up” and “punching mad” at home and at work. I haven’t gotten angry in a while, and my girlfriend seems happier. I think I’ll keep this up.”

- A. Pre-contemplation
- B. Contemplation
- C. Preparation
- D. Action
- E. **Maintenance**
- F. Relapse

Name That Stage (2)

“I picked up my HIV meds at the pharmacy last week and filled up a 7-day pill box. I’m going to see my auntie for the holiday though and I’m afraid she might see me taking pills and I’ll have to explain ...*(shaking her head from side to side)*”

- A. Pre-contemplation
- B. Contemplation
- C. **Preparation**
- D. Action
- E. Maintenance
- F. Relapse

Name That Stage (3)

“My mother doesn’t know anything about what I do. I’ll take the medicine when I’m ready. I’m not ready yet. It’s nobody’s business but mine anyways.

- A. Pre-contemplation
- B. Contemplation**
- C. Preparation
- D. Action
- E. Maintenance
- F. Relapse

Recognizing Change Talk

Desire: “I want to...”

Ability: “I can...”

Reason: “It’s important....”

Need: “If...then....”

Commitment: “I will...”

Activation: “I am ready”

Taking steps: “I am doing it now..”

Recognizing Sustained Talk

“I’m not going to do that.”

“I don’t have that problem.”

“I’m going to do what I want.”

“I have plenty of time. Maybe down the road.”

“No way I can do it right now.”

How to Talk with Patients About How to Manage their HIV

Tip #1

Avoid beginning
with a prejudgment
that the patient is
the problem

Tip #2

Match your strategies (words) to
the patient's
readiness to change

MI Principles

- ✓ **Assume the patient is competent and capable**
- ✓ **Control and responsibility lie within the patient, not the professional**
- ✓ **Open-ended questions** allow the patient to tell the provider and staff what they know, what they are experiencing and what tools they have to address their health issues
- ✓ **Treat behavior change as a journey:** destination (goal), map (pathways), and a means of transportation (agency/provider leveraging resources)

MI Skills

Provider Actions

1. Express empathy
2. Listen
3. Ask open-ended questions
4. Avoid argumentation
5. Roll with resistance
6. Support self-efficacy

William R. Miller & Stephen Rollnick (2012)

Self-Efficacy

A person's belief that change is possible for them is an important motivator to succeeding in making a behavioral health change.

The MI approach to behavioral change is successful because it highlights that **there is no one right way to change a behavior. MI promotes individuality and creativity in devising a plan or "recipe"** that is of the patient's own making.

BELIEVE

*"They are able
who think they are able."*

Virgil



Foundation Communication Skills: Prerequisites for the Practice of MI

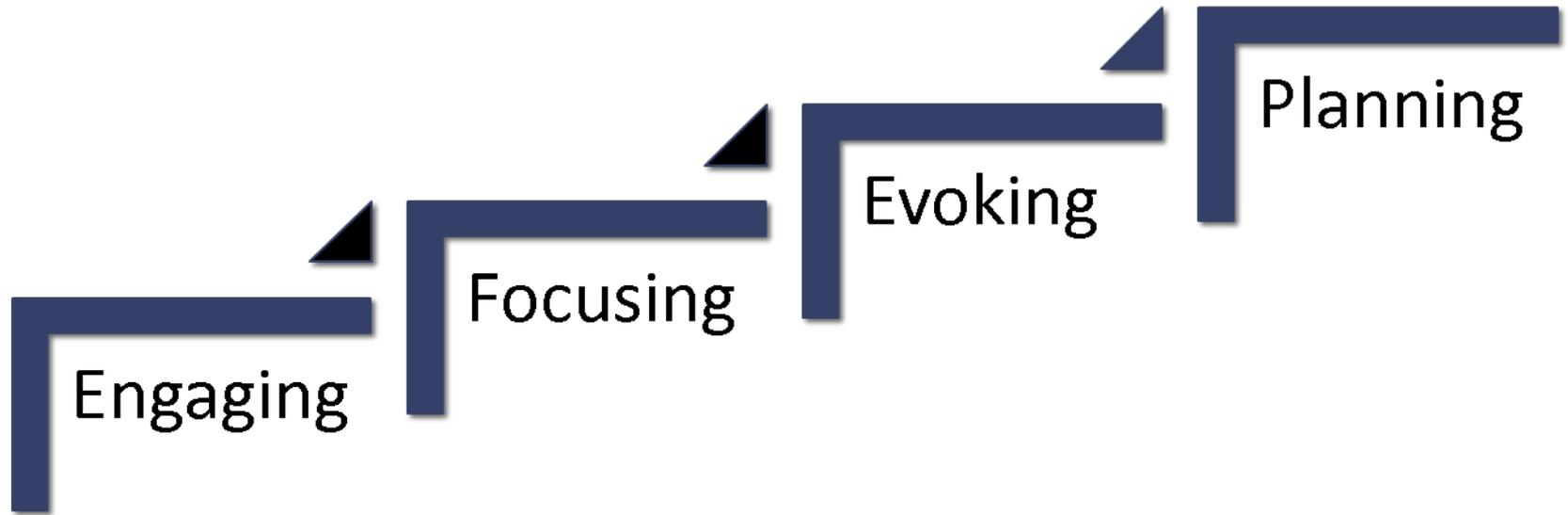
Listening

MI Definition of Listening

Focusing all of one's purpose, attention, and energy on **understanding what the SPEAKER'S message means to the SPEAKER**

Focus on **what the SPEAKER is experiencing right now** as well as hearing what the SPEAKER is NOT saying

The Four Processes of MI



Engaging

Take 2 -3 minutes at the beginning of each encounter with a patient to engage the “person”

Give the patient time to address overwhelming emotions, thoughts and/or concerns. Ask the patient about their life and take interest in what is going on with them in addition to their health concerns or challenges.

Goal: to address issues that are on the forefront of the patient’s mind and acknowledge the person.

Focusing

Focusing is not a one-time solitary event; refocusing is needed and focus may change.

It becomes MI when there is a particular identified target for change that is the topic or focus of conversation

Goal: The patient will identify a health behavior that they believe they can adopt or change.

Evoking

Ambivalence is normal

You can hear a mixture of change talk and sustained talk.

Goal: evoke change talk to move patient toward change

How to Evoke Change Talk

“What is going well for you?” What could you improve?”

“It sounds like exercise is important to you and sweating is uncomfortable. You don’t like sweat, but you like exercise.”

“If you decided to take your medications every day how would you do it?”

“How will you know when you are ‘sick enough’ to take the medication?”

Planning

Ongoing process into implementation and uses the patient's expertise.

Be sure to ask how the patient will know if the plan is working- this is the "measure" and the reason for the change.

Goal: For the patient to develop a clear health behavior goal.

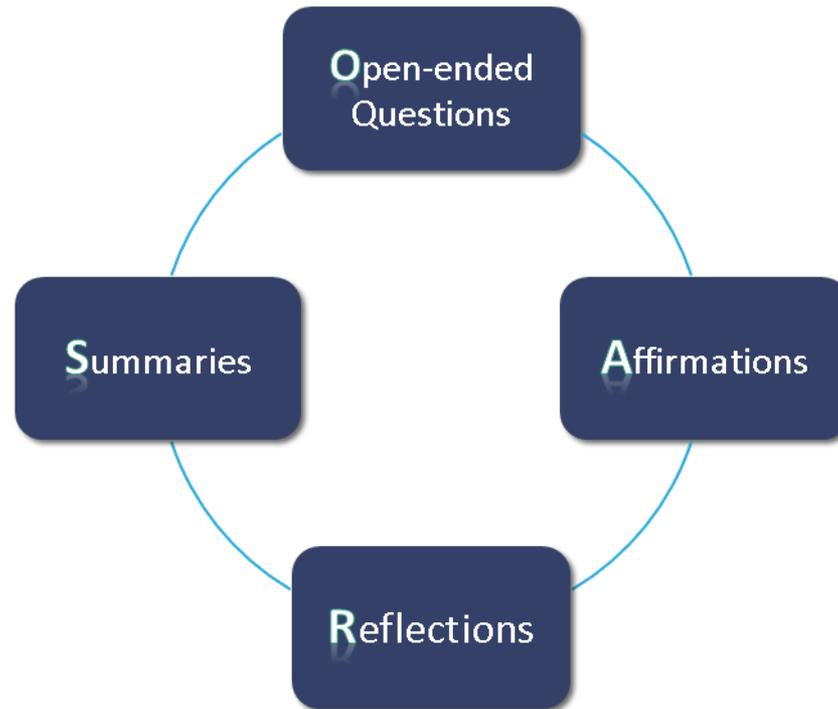
Plans have **CATs**:

C: What do you intend to do?

A: What are you ready or willing to do?

T: What have you already done?

Core MI Communication Techniques: Using Your OARS



Open-ended Versus Closed-ended

Open-ended Questions

1. How can we care for you today?
2. How are you doing?
3. How are you taking your medications?
4. What is the most important issue you want to talk about today?
5. What benefits are you hoping to get from the herbal remedy you are using?

Closed-ended Questions

1. Did you write your name on the sign in sheet?
2. Are you feeling okay?
3. Did you take all your medications?
4. Are you drinking more than 4 glasses of wine in a day?
5. Do you have any questions for me?

Affirmations

Purpose: Build feelings of self-efficacy and empowerment

Goal: To actively listen for the patient's strengths, values, aspirations and positive qualities and to reflect those to the patient in a affirming way.

Examples:

“This is hard work you are doing.”

“Your anger is understandable.”

“Disclosing your status showed a lot of courage and concern for your new partner.”

Reflections

Purpose: To state what the patient is saying using the same words or different words that “rephrase” the patient’s words.

Goal: To repeat, rephrase, and paraphrase the words of the patient in a collaborative non-judgmental manner.

Important: The rule of thumb in MI is to respond to clients with more reflective statements than questions.

Examples of reflection stems:

“It sounds like...

“You’re wondering..

“That makes me think...

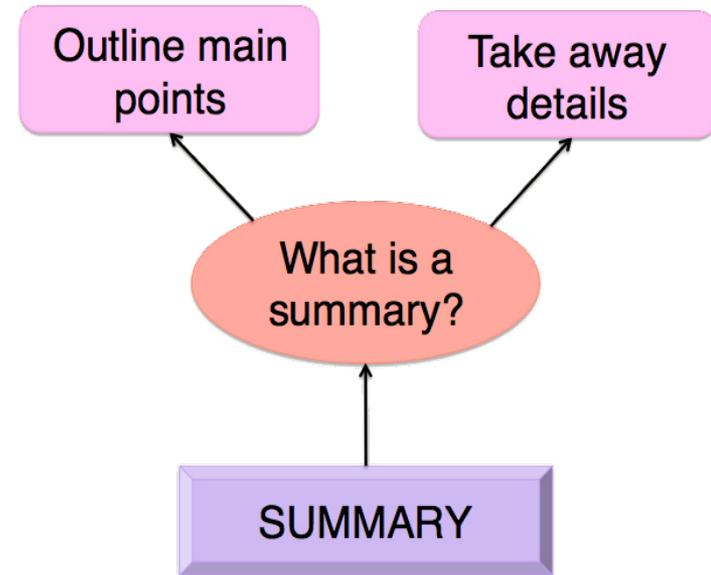
“If I understand you correctly...

Summaries

Purpose: A short and concise review of the conversation between patient and the healthcare professional.

Summaries may help to encourage a call to action or an “aha” moment, encourage a patient to look at his/her strengths, look at both sides of ambivalence, and/or prepares the patient to move on.

Goal: Pull together the information discussed in the conversation in a strategic way and use the information that will encourage the patient the most.



Resistance and Motivational Interviewing

Motivational Interviewing is very effective when working with patients who are resistant to change.

“MI is like dancing rather than wrestling.”

Rollnick et al., 2008

Case Conference

Edward is a 28-year old black male who is bisexual and HIV-positive since 2011. His mode of HIV transmission was intravenous drug use. The patient spent 9 months in prison in 2012 for drug possession and has been attending NA since his release from prison. This visit, Edward has a viral load of **1700 copies/mL** after having two previous visits being undetectable. You and the medical provider are concerned. **The provider asks Edward, “What thoughts are you having about your higher viral load?”**

Edward: “ I may have forgotten some doses of my meds ...there’s a lot going on...it’s all my fault. You know I met a guy...he’s great. He doesn’t know I’m positive though... What do you think I should do?”

OARS Application

Possible responses to the patient's question are listed below.

Choose the best response using an **open-ended question**:

1. Are you having protected sex with this new guy?
2. How could telling your partner about your status improve your health?
3. Is this new guy HIV-positive too?
4. **What changes in your life have happened since you met this man?**

OARS Application (2)

Choose the response that is a helpful **affirmation** :

1. Honesty is always the best policy.
2. Telling the truth is the harder choice, but you can do it.
3. **This is hard work you are doing right now; weighing important choices.**
4. It's good you are mindful of your legal responsibility to your partners.

OARS Application (3)

Choose the response that is a **reflection**:

1. What are you afraid of?
2. I think you need to tell him about your status, don't you?
3. Some people disclose and some people don't. It's really up to you.
4. **You are wanting to make good choices, but worry about the outcome, if you do choose to disclose.**

OARS Application (4)

Edward goes on to talk with his provider about how he has been not taking his meds regularly because he did not want his new friend to ask him why he was taking medication. Edward is still going to his NA meetings. He did disclose his past drug history with his new friend, which the new friend accepted and genuinely expressed his support and happiness for Edward that he has been able to stay “clean.”

On a scale of 1-10 with 1 being “not important at all” and 10 being “very important”, Edward says that **disclosing his HIV-status is a 7.**

On a scale of 1-10 with 1 being “not at all confident” and 10 being “extremely confident”, Edward reports being a **4 in his level of confidence to successfully disclose his status** to his new friend.

OARS/Summary

Choose the response that is a good summary:

Version #1

Let's just wrap up this visit with a quick summary of what we have discussed today. You are afraid to disclose your status to your friend because you think he will leave. You don't plan on telling him your status because **your level of confidence is low**. You know that you may be putting your health at risk by not taking your medication regularly, but you **want to withhold this important information about your HIV at all costs** even, if it **means becoming sick and losing everything** you have worked so hard to **“get right”** in your life. Do you have anything more to add?

OARS/Summary (cont)

Choose the response that is a good summary:

Version #2

Let's stop and summarize what we've just talked about. You are **not sure** that you want to disclose to your new friend that you are HIV-positive because you fear he may become disinterested in you. **You did share with him** your past history of heroin use and **were pleasantly surprised** that he was supportive and recognized **your great strength to stop using drugs**. You are **worried about your higher viral load** and **recognize** that keeping your status a secret requires you to miss doses of your medication and **you are not happy about that**. **I am wondering what you make of all these things?**

Ten Things MI is NOT!

1. A way of tricking people to do what you want them to do
2. Psychotherapy
3. Magic
4. Confrontational
5. Argumentative
6. Persuasion
7. Selling
8. A Panacea

Ten Things MI is

1. A conversation about change
2. Respectful
3. Collaborative
4. Honors autonomy and self-determination
5. Patient Centered
6. Goal Oriented
7. Empowering
8. Cooperative
9. Effective
10. Engages patients in care

MI: Am I Doing This Right?

MI **MOTIVATIONAL INTERVIEWING**
an evidence-based treatment



Encouraging Motivation to Change
Am I Doing this Right?

Motivational interviewing encourages you to help people in a variety of service settings discover their interest in considering and making a change in their lives (e.g., to manage symptoms of mental illness, substance abuse, other chronic illnesses such as diabetes and heart disease).

REMINDE ME
Use the back of this card to build self-awareness about your attitudes, thoughts, and communication style as you conduct your work. Keep your attention centered on the people you serve. Encourage their motivation to change.

CENTER FOR EVIDENCE-BASED PRACTICES | Build Trust
Improve Outcomes
Promote Recovery

www.centerforebp.case.edu

 **CASE WESTERN RESERVE UNIVERSITY** EST. 1826

Encouraging Motivation to Change
Am I Doing this Right?

1. ✓ **Do I listen more than I talk?**
X Or am I talking more than I listen?
2. ✓ **Do I keep myself sensitive and open to this person's issues, whatever they may be?**
X Or am I talking about what I think the problem is?
3. ✓ **Do I invite this person to talk about and explore his/her own ideas for change?**
X Or am I jumping to conclusions and possible solutions?
4. ✓ **Do I encourage this person to talk about his/her reasons for *not* changing?**
X Or am I forcing him/her to talk only about change?
5. ✓ **Do I ask permission to give my feedback?**
X Or am I presuming that my ideas are what he/she really needs to hear?
6. ✓ **Do I reassure this person that ambivalence to change is normal?**
X Or am I telling him/her to take action and push ahead for a solution?
7. ✓ **Do I help this person identify successes and challenges from his/her past *and* relate them to present change efforts?**
X Or am I encouraging him/her to ignore or get stuck on old stories?
8. ✓ **Do I seek to understand this person?**
X Or am I spending a lot of time trying to convince him/her to understand me and my ideas?
9. ✓ **Do I summarize for this person what I am hearing?**
X Or am I just summarizing what I think?
10. ✓ **Do I value this person's opinion more than my own?**
X Or am I giving more value to my viewpoint?
11. ✓ **Do I remind myself that this person is capable of making his/her own choices?**
X Or am I assuming that he/she is not capable of making good choices?

www.centerforebp.case.edu

SPEAKER CONTACT INFORMATION

DEBBIE CESTARO-SEIFER, MS, RN
