

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Motivational Interviewing:

A Recipe for Patient Engagement in HIV Treatment and Care

16 June 2016

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh and I'd like to welcome you to the Motivational Interviewing, A Recipe for Patient Engagement in HIV Treatment and Care Webinar. This webinar is brought to you by the Partnerships for Care HIV Training, Technical Assistance, and Collaboration Center or HIV TAC. The Partnerships for Care project is a three year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project or to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, two, to build sustainable partnerships between health centers and their state health department and three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance, and Collaboration Center or HIV TAC.

Our speaker today is Debbie Cestaro-Seifer. Debbie is a project coordinator for the Florida Caribbean Telehealth Education Training Center and a faculty member with the Florida Caribbean AIDS Education and Training Center. Having more than 35 years of mental health and chronic disease management experience, Ms. Cestaro-Seifer has provided care and treatment to individuals living in the rural mountain communities of Tennessee, North Carolina, and Virginia. Additionally, she has served as Assistant Professor of Nursing at the University of the Virgin Islands since September, 2007 through July 2012. Please join me in welcoming Ms. Cestaro-Seifer.

DEBBIE CESTARO-SEIFER: Thank you so much, Steve. I appreciate that. And I see that we have 62 people on this call today so I thank you for inviting us in to have a discussion about motivational interviewing, a recipe for patient engagement in HIV treatment and care. I have developed several learning objectives for this program. They're very measurable so that to for those of you that are educators and for those of you that are case managers and working with your patients, just a reminder in ensuring that all learning objectives and all kinds of goals we that we set for our patients to be clear have action verbs that can be measured. So today we're going to hopefully have at the end of this session, your ability to be able to discuss the application of motivational interviewing, the delivery of person-centered HIV treatment and care, to be able to describe the overall spirit of motivational interviewing, to list the fundamental



principles of motivational interviewing, to identify the core motivational interviewing communication skills and their role in the MI process and then, finally, to define self-efficacy and explain its role in behavior change and engaging patients in HIV treatment and care.

Self-management in living with HIV for our individuals is very challenging. And I'm sure many of you on this call are very familiar with those challenges. Our patients have to learn to cope with the intense, sometimes very debilitating, emotions that accompany living with HIV and other chronic diseases. There are changes in behaviors that they have to make to minimize the impact that HIV has on their lives and to maximize the treatment that they are engaged in taking. And that would be their antiretroviral therapy.

And then, lastly, somehow they have to learn how to manage these disruptions that their illness causes in their work, their school, their family life, their social life. So there's a lot. This is a lot to handle for many patients who have never been sick before, who don't know what this is all about. It is a learning curve.

There are potential social emotional health issues that are experienced by persons who are living with HIV. These include grief, insomnia, fatigue, anxiety, depression, and often social isolation. So one of the very big potential outcomes of chronic disease of any kind and especially in HIV treatment and care is the unplugged person, the person that's exhausted, the person that just doesn't have the energy to do all the things that are necessary to stay engaged in care so that their journey in life is the healthiest one, one of quality.

The HIV care continuum, as many of you are familiar, we are lacking in areas such as testing, finding all the individuals who are positive in our communities, and then engaging folks in care. We're linking them into care, maybe not as fast as we would like and I think we're going to see that change, but the engagement of care, keeping them in care, keeping them motivated and preventing them from becoming unplugged.

There was a wonderful study that was done in New York City. This group of folks that work for the New York City Health Department, they used surveillance data over the years, 2008 to 2010 to identify individuals with HIV who are out of care in New York City because they wanted to give them the option, these individuals they could find, to get back into care. When they found these individuals, to determine, gosh, why did you get out of care? And they found a lot of folks, this was a well done study. And they found a lot of people. They found almost 600 some folks. The individual said, I didn't come back because I felt well. 41% said they felt well. And this we understand because initially when one is identified early with HIV, there is a sense of feeling well. There is not a sense of feeling poorly unless they have other co-morbidities.

Another group of individuals who were found and out of care for more than nine months said they felt depressed. Well, what do we do when we're depressed? We don't do anything. We certainly don't go into a clinic. We certainly don't make phone calls to check on when our next appointment is. And, lastly, there was a group that said they didn't believe they had HIV. And that's probably related to the fact that they felt well, that this disbelief that how could I have something like HIV if I feel so good and I have all my energy? So these are conflicting issues for our patients.



This group of researchers also went back to the folks that they had seen that were engaged in care, the group that stayed in care. And they said, what did we do right? Why did you stay in care? And this group said that their providers treated them with dignity and respect, that they felt listened to, and, lastly, they felt that things were explained about their care and treatment in a way they could understand. These are all very important things that we're hearing from patients who are engaged in care. And there's one more.

They felt known as people. So they didn't feel like they were their disease they felt that they were known as a person first. This is very important as we learn to engage our patients in care. Engagement in care, as many of us know, is not a singular event. It's not based on a single visit, in fact. It's not static. It's constantly changing. And when it changes, there is often a situation where there is an unmet need. And oftentimes our patients, for different reasons-- maybe cultural, maybe social, maybe psychological-- they are not comfortable in sharing what those unmet needs, but if you do the groundwork and we find our individuals out of care, there's often some need that went untapped that we as providers did not know about. So full engagement and retention and care is essential for people living with HIV so that they can experience optimal health outcomes.

So I want to share this model with you, the non-linear and more dynamic model that I've given the reference here for. It's that out of care re-engagement that is so very important for us to understand what happens. And if unmet needs are a part of this, how do we determine those in enough time so that we prevent a nine month delay in the patients receiving the care and treatment that helps them have a long journey and hopefully improve quality of life and living with HIV.

This is a model showing retention in HIV care in 2012 and it's called the Swiss cheese model. The defenses are different things that we can do to prevent the loss of patients out of care. This includes peer navigators, individuals, outreach workers, people that are on the ground to identify patients who are out of care and finding out what those unmet needs are. And let me not forget the case managers and the nursing staff as well as providers who work hard to stay in contact with their patients.

The gaps or the hole in the Swiss cheese model are patients' unmet needs, consumer priorities and challenges in life that are, just like anyone, there are certain issues in our lives to take precedence and so we put care in the back burner. There may be a lack of provider follow-up. There could be appointment scheduling issues, new jobs, things that take us away from perhaps caring about our health for putting it not at the top of the list.

There is very strong evidence, and this came out in 2015, just last year and it was published last year that I want to share with you. And the key finding on the question, what evidence, what drives antiretroviral therapy adherence and viral suppression, the key finding was contact with providers. Improved engagement in care. That's a key finding and very, very important to us. It gives us that the reason for making sure our patients stay in care. And that extra work we put into partnering with our patients to determine if they are at risk for being lost to care or coming out of care or making care and treatment a not priority in their life. So partnering is important.

So I hear a lot of things in all the clinics that I work in and I hear a lot of patients say, and a lot of providers say to our patients, you better start taking care of yourself or else. Now, I'm wondering if that really sounds like a partnership. We get frustrated as providers. We don't exactly know what to say. Sometimes we say, I'm pleading with you to take your medicine if you don't, you will-- something bad will happen, right? We tell our patients, you have to understand this but knowing that our patients really don't have to understand anything if they choose not to. This creates a lot of frustration for providers and myself included. We don't understand what the patients and the people we care for don't understand about how important it is to stay in care and to take their medication.

This doesn't look like a partnership at all. Here we have a provider or someone on the care team, anyone, basically shouting out to the client, to the patient, this is what you need to do. I don't see the patient really talking. I don't see the opportunity to find out what their unmet needs are.

So what happens when we tell someone what to do? Well, they don't listen. They get tired of it. They get used to us sort of telling them what to do and they tune us out. They don't come back from care and, hence, many of our patients become disengaged. This is a visual of a partnership, one that has to be grown from the very beginning initial meeting through appointment after appointment.

Person-centered care is about partnerships and the Institute of Medicine has developed, I think, a very strong and respectful definition of person-centered care. You may know this is patient-centered care, but I like to bring out the fact that our patients are people first so I call it person-centered care. And that definition is providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensures that patient's values guide all clinical decisions because if the patient isn't the partner and if it's not their agenda that is helping us together formulate goals that are measurable, then we don't really have a partnership. We really don't have person-centered care.

So what promotes an engaging partnership? Well, this visual is of three plants that are growing at their own pace, each one an individual with little sprouts of new knowledge, of more engagement in care, perhaps better management even, or better harm reduction. These kinds of things our patients, we water, we create partnerships, and try to support our patients in their development as an individual and as someone living with HIV. So we want our patients to feel welcome, comfortable, understood and hopeful about their life and living with HIV. And to have that, we have to have mutual goals.

Traditionally, health education was more about authority, prescription, and a very persuasive type of manner. We would give our patients a prescription, a list, a discharge summary, a list of things that they had to do once they left their appointment or left the hospital. We taught, we instructed, and we lead it, which left very little for the patient to actually do. And if we think back to some of our individual, what they remember when given a lot of information at one time, most people only remember 10% of what they hear. That's just what they auditorily hear.

So if we're teaching, instructing, and leading and the patient is only remembering 10%, then we do have a problem. Our assumption is probably wrong that the patient is a passive recipient of

care. Perhaps someone that is like filling up a bucket, an empty bucket of water. And we we're thinking in our head, we're giving them all this powerfully good information, but is it user friendly? Is it coming in a way that the patient can absorb it? And is it something they can remember? And is it culturally relevant and socially and emotionally relevant to them?

So in my mind, motivational interviewing, which is why we're here today, is better at helping us to draw out, encourage, and motivate patients as opposed to doing the old education way. Drawing out, encouraging and motivating our patients. Let's look at that and see what that looks like.

Motivational interviewing is a chronic disease management tool. It is a method of counseling designed to facilitate natural change, the patient's internal motivation. The goal is to increase internal motivation to change health behaviors. And this whole motivational interviewing was started by doctors William Miller and Stephen Rollnick. They have been doing this a very long time and they had started with using this technique of counseling with individuals who had substance use disorders. And they found it very relevant to assisting patients to be heard and to be more open to making small changes in the management of their disease which is substance use disorders.

We found that the premise for this program for this type of counseling is that confrontational strategies are really not effective. Patients run from them, they disconnect from those kinds of strategies, and we're more likely to get a more engaged partnership with a patient when we don't use confrontational strategies. Motivational interviewing is based on the stages of change model. And here I'm just rocking and rolling with this because motivational interviewing is really about dancing with our patients. It's about not wrestling them down to say you must do this. It's not forcing information, basically, down their throats. It's sometimes even asking their permission to give them important information that may help them decide how to manage their disease.

There is evidence-based practice on motivational interviewing in HIV care. Although there's not a lot of good randomized study, there are a few out there and some of them are about risk behaviors-- using condoms. And then I did find one that was related to outreach and working with individuals to become tested who might not necessarily come in routinely for HIV testing.

Here's one that was done in Portland, Oregon in 2001 to 2005. It was a randomized clinical trial. It was all about women, women specifically who were incarcerated at one time, recently incarcerated. And it was the hope that these individuals who had a strong history of substance use disorders and some who had very high risk for HIV, that they would receive a 30 to 45 minute individual MI session and then that would be followed by several other sessions lasting up to 12 weeks. The sample size was about 530 on this and the interventionists were community health specialists who were trained in how to deliver MI. And the focus here was on risk reduction. Could we have individuals use less substances and use condoms more when they were engaging in sexual activities?

And the story here, the outcome was very positive in that we did see a result of this 12 week program, the individuals that were in the HIV risk reduction group did, indeed, use condoms more. And the individuals in the HIV and intravenous drug use random sample also were more

likely to use better risk reduction strategies in working and living in their new found environment upon being discharged or moving into their communities after, again, being in prison for up to a year or longer.

So another group that was done which was about the HIV field outreach with young African American men who have sex with men, it was a randomized clinical trial. And there were significant outcomes with this. We saw that participants in this study reported significantly fewer episodes of unprotected intercourse at three months post-intervention. And they, again, received some really nice motivational interviewing counseling. And this was maintained-- I love that word sustained. Anything that we can do as an intervention that can be sustained for longer than a few months is really good news. And in this study there was sustainability six months post-intervention. Those individuals who received MI did a better job of using condoms when they were having sexual relations.

Here's another study that was done. This study examined the impact of motivational interviewing counseling in a study that was done previously called Safe Talk. And it was looking at self-efficacy to practice safer sex for people living with HIV/AIDS, a really good strong sample, 490 folks. And there were a number of different, what we call, doses of MI, time, motivational interviewing, that was given to these individuals, different dosages, low to moderate and high doses. And the results were extremely beneficial showing that participants with low to moderate doses of MI counseling had a 0.26 higher self-efficacy scores, meaning that they felt more able, better prepared to utilize safe sex practices. Patients with a high dose of motivational interviewing and at 0.5 higher self-efficacy score meaning that they really did feel that they could utilize a safe sex practices in their day to day life.

So the conclusion was at the end of the study that MI time as a key to enhancing safer sex practices among people living with HIV. So exciting things showing the use of HIV.

This is the field outreach, HIV field outreach study, I alluded to earlier. And in this study it was randomized, there were two groups. A very acorous population, young African American men reporting MSM. They completed a motivational interviewing-based field outreach session. And 92 did a traditional field outreach session which meant no motivational interviewing. The results, more of the participants in them motivational interviewing intervention requested HIV counseling and testing, wanted to know their status, and get this, they returned for their test results. So this is powerful information and I'm excited to share this with you.

MI does definitely has a place in the workings of developing partnerships with our patients. It gives patient self-efficacy and helps them learn how to take better care of themselves. And it seems like it's sustainable which is really good news.

So the MI pyramid is-- the bottom of the pyramid, the foundation, is about the spirit of motivational interviewing. Then we have the principles and the strategies. What do you do? What does it look like? What are the interventions? We're going to talk about this today.

The spirit of motivational interviewing is nonjudgmental. It is treating people up, treating people in a way even if we know that their past history is that they go out of care on a frequent basis or



perhaps they have very high risk behaviors, it's treating them up. Treating them in a nonjudgmental way, in a way that we expect more, that we hope for more from them. When I use this technique, I feel that patients rise to the occasion. It's a way of treating them with respect even if they've had a hard time taking good care of themselves in the past. It doesn't mean that that's going to continue. So I try to make every encounter with a patient or a person living with HIV as one as, here we go, here's another day, here's another opportunity for us to work together and develop and give for you the opportunity to develop new skills.

OK, so motivational interviewing is a counseling technique. We know that. And it encompasses many skills. And I love this little comic. It's about listening. It's about communication, collaboration, cultural care, developmental care, patient empowerment, and mentoring.

So we're talking about MI and health behavior change. And all the techniques are about communicating well and collaborating with our patients. So let's think about behavior change. What's involved? Have you yourself ever felt ambivalent about a potential health change that you think you may want to take on? I'm sure you have.

And what is ambivalence? Well, ambivalence, as I share it with the patients, is feeling two ways about something-- wanting it and not wanting it at the same time. It's that contemplation stage where we're trying to decide if there's enough momentum to go forward and actually tried to make a change, either reducing or taking away something that is not good for us or adding something on that can be healthy for us. Ambivalence is very normal and unfortunately ambivalence is the part that gets us stuck not being able to decide, but it is a normal part of the process in making any kind of change.

The stages of change are pre-contemplation, contemplation, preparation, action, and maintenance. Relapse is really not a stage, but I call it the speed bump on the journey. And we do have to know about it and we do want to have conversations with our patients about relapse.

So this is what I call the change wheel and I've created it so that you can see how this process all goes. And it's a process where these different changes are constantly moving. It's a moving wheel. If you notice here, my little pointer is going, pre-contemplation isn't even on my wheel of change. And I specifically left it out because these individuals are not shopping, they're not browsing, they're not buying any new behaviors today. It's like going into a store and saying, I'm not interested in buying anything, I'm just waiting here for a friend so please don't get me involved, don't show me the sale rack, I'm not buying.

Contemplation is more that stage where individuals are in ambivalence. They have some reasons to make the change and they have some good reasons not to make the change. Preparation is that part of the wheel where that change level that is preparing, the patient or person is preparing to make a change, maybe even doing some things-- cleaning my house out, perhaps it getting some new ideas about what they're going to do differently so that when they actually implement their plan, they're ready to act.

And that takes us to action. That's where a patient or person is really actively looking at the recipe of change that they've created with their provider or their health care team member and

they're actually doing the work. There is an action, there's behavior that's changing. Maintenance is keeping it up, sustaining it. And, again, not part of the actual five stages of change, but that relapse, the times where we get out of sync and we're not sustaining the new change that we've made. In fact, if anything we're falling back, perhaps, to an old behavior.

So let's apply this information about change and see if we can name at that stage. According to the stages of change model, individuals in pre-contemplation stage would say which of the following? And you can see all the answers here and we're going to pull this out to you and let you decide what you think might be the real answer to this. Would a person in pre-contemplation stage say, don't even talk to me about taking meds, I am thinking about taking meds, I'm getting ready to take my meds, or D, I took my minutes twice yesterday. Hopefully everybody's on the same page with me and the patient in pre-contemplation is saying, don't even talk to me about taking meds, I'm not doing it, I'm not shopping. They are not changing their behavior. They don't have a good reason to do it or they simply aren't doing it today.

Here's another scenario. 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. What is this person saying to us? Are they in a pre-contemplator, a contemplator, or preparer? Are they in action mode? Are they maintaining something that they started or are they in relapse? Hopefully everybody's had a chance to think about this one. And here we go. I hope that you thought maintenance was the one. This person had a reason to make a change, actually probably went to some sort of intervention program for anger management is what we're probably guessing here, and this person has a reason because his girlfriend seems happier.

So he's saying to us, I think I'll keep this up, which to me means I'm going to maintain this. However, is this person out of the woods? Do we just say, hey, that's great, high five, you're in, glad you've got this. No we don't. We want to have maybe even a little role playing session on relapse. And I've got a lot of great things that I've done in this actual scenario that I've done for relapse prevention. And I've had fun with it with the patients. Again, partnering with them, thinking of some outrageous things that could make them pretty angry and what they would do. Sometimes when we role play it, the patient or the person gets a better idea of what could happen around the corner so that they feel more prepared, they have a plan B.

Here's another scenario. This patient says, I picked up my HIV meds at the pharmacy last week and I filled up a seven day pill box. I'm going to see my auntie for the holiday though and I'm afraid she might see me taking my pills and I'll have to explain. This individual shaking the head from side to side. So this is not looking good to the provider. Where is this patient on the stages of change? Are they in pre-contemplation, contemplation, preparation, action, maintenance or relapse? I say this person is in preparation. They filled up the seven day pill box. They're really ready to go. They just haven't started taking medication, but, oh, we've got a new situation that's gotten in a problem, that's going to present a problem for the recipe that they originally created to start taking the meds. Now we've got a wrench in that because they're going for a holiday and there's an issue with auntie who, obviously, they have not disclosed to. So in this situation, it's going to take a new conversation about how further this individual may have to prepare. Or is the date of starting medicines the right date? Again, wonderful opportunities to work with your

patient to discuss what they think might be best and for them to hear from you about what other people have tried who may be in a similar situation.

Here's another one. Patient says, my mother doesn't know anything about what I do. I'll take the medicine when I'm good and ready. I'm not ready yet. It's nobody's business but mine anyways. Where is this patient on the wheel of change? This person is in contemplation and the reason they're in contemplation is these words, I'm not ready yet. That tells us that there is a point that they may be ready. And so the question I might pose to this individual would be, what would it look like, what would need to happen for you to be ready? Having a discussion about something in the future is an opportunity for us is to talk to the patient to find out what is going on for them, what would the impetus for starting medication be and using that information to have a lively discussion as opposed to not talking about it.

So motivational interviewing has really-- gives us great opportunities to partner with our patients in conversation about even what ifs. If a patient is not ready, well what if? And if you were ready, what would that look like?

So when we want to recognize change talk, I tell folks that we want to listen for desire, ability, a reason, a need, commitment, activation, and taking steps. And these are the things that you might be hearing from the patient that you want to document. You want to register this in your head, you want to make note of it in your chart when you're writing down what happened at the meeting.

We also want to recognize sustained talk. That's talk that we are listening for that tells us the patient's not shopping or they're not ready to move to another level of change. Things like, 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 could do that right now. These are things that maintain the status quo for the patient and we've got to be listening for this because that tells us where the patient is.

So my two tips on how to talk to a patient about how to manage their HIV using motivational interviewing, the spirit of and the change theory is avoid beginning with a pre-judgement that the patient has a problem or that they can't do, that they can't make any changes. And two, to match our strategies, what we say and what we ask the patient. We want to match that with the patients' readiness to make a change because if we're too far ahead of the patient, we're going to have a disconnect. And disconnects, unfortunately, can relate-- end up with the patient disconnecting from care altogether.

So MIT principles, what are they? Assume the patient is competent and capable even if their history tells us something different. Control and responsibility lie within the patient, not within the professional. Open-ended questions allow the patient to tell the provider and staff what they know, what they're experiencing, and what tools they have to address their health issues.

Treat behavior change as a journey. Don't get too far ahead of the patient. Try to walk with them on this journey so that we are not pushing them along, so that it's a walk. Sometimes we speed along with them but at their pace.

MI provider skills-- we want to be empathic, we want to understand that the patient's experience of living with HIV has certain repercussions in their life and we want to help them problem solve to minimize those. We don't want to be overly sympathetic doing and enabling for our patients because we're going to be going in the quicksand with them and we're not then helpful.

We want to express empathy. We want to listen more than we talk. And we want to ask those open-ended questions, avoiding argumentation at all costs if we can. WE want to roll with resistance. That comes directly from doctors Miller and Rollnik. And we want to support the patient's self-efficacy. What can they do right now? What skills do they have that will help them develop and fine tune new skills for the future?

Self-efficacy is a person's belief that they can make a change and that it's possible. And Virgil said, they are able who think they are able. There's no one right way to change behavior. MI promotes individuality and creativity in designing a plan-- I call it a recipe because at some point in time everybody that I've ever met knows what a recipe is.

I like to develop act ways, analogies that help patients better understand what I'm talking about when I talk about a health care plan. The foundation of MI is communication skills and listening, lots of good listening. We have to be very good listeners when we use MI. The definition of listening for motivational interviewing is focusing all of our energy, purpose, attention, and energy on understanding what the speaker's message means to the speaker, focusing on what the speaker is experiencing right now, and hearing what they may be thinking but not saying. And a lot of nonverbal communication comes with that. The four important processes of motivational interviewing are engagement, focusing, evoking, and planning. And we do all of these in every motivational interaction we have with the patient, including our phone calls.

Engaging is taking two to three minutes at the beginning of every encounter, whether it's on the phone and in person to engage the person, giving the patient time or the person time to address overwhelming emotions, thoughts, or concerns that may have nothing to do with the actual appointment-- asking the individual about their life and taking an interest in what's going on with them. This is just basic good customer service. It can be done at the front desk. It can be done anywhere in the health arena. The goal is to address issues that are on the forefront of the patient's mind and acknowledging the person as a person first and not their disease.

Focusing on is not a one-time solitary event. Refocusing is needed and sometimes focus changes based on where the patient is. It becomes motivational interviewing when there is a particular identify target for change that you're having a conversation with the patient about. The goal is at the pace will identify a health care behavior that they believe they may be able to adopt now or sometime in the future based on their knowledge at the time.

Evoking, that's the ambivalence piece. It's when we hear a mixture of change talk and sustain talk. The goal here is to evoke more change talk. How do we evoke change talk? We ask open-ended questions. What's going well for you right now? What could you improve? If you decided to take your medications every day, how would you do it? So we're not saying, do it, we're saying if you decided that, what would it look like? And then letting the patients know what we just heard them say.



The planning piece is an ongoing process and it helps us with the implementation and it uses the patient's expertise. Be sure that we ask at this phase how the patient will know what the plan is working, what the measure they're going to use to measure that success. The goal here is for the patient to develop a clear health behavior goal. And we call that CATs, identifying what do you intend to do, what are you ready or willing to do, and what have you already done.

So communication is about four very important tools, communication tools-- not only used in MI. They're used in all kinds of therapeutic conversations. They start with open-ended questions, affirmations, reflections and summaries, hence, the acronym OARs. Is

For open-ended questions, let's just take a peek. Well, close-ended questions are answers that only can be yes or no. So if I ask the patient, are you feeling OK, the only answer is a yes or no or maybe shrugging the shoulders. Did you take your medicines? Again, yes, no. But an open-ended question that you can't just answer yes or no, how can we care for you today? Well, you can't say yes or no to that. How are you doing? You can't say yes or no to that. These encourage patient conversation, more than one word answers. These are wonderful tools, open-ended questions.

Affirmations, the purpose is to build feelings of self-efficacy and empowerment. The goal is to listen for the patient's strengths and values even when they've had a hard time of it and they haven't maybe gotten it right yet with managing their illness. We want to affirm who they are. They have strengths. Maybe they're not traditional strengths, but they've got them. And we can apply those and they can apply them in developing a plan of action to bring on a new health behavior. Examples might be, this is hard work you're doing, your anger is very understandable, disclosing your status showed a lot of courage.

Reflections are a way of stating what the patient is saying. It's a way of reflecting back to the patient, like in a mirror, what they just said. Most people when they're talking, they don't listen to themselves. So a stem in a sentence of a reflection might be, it sounds like, you're wondering if. These are not questions. They're simply statements. The importance is the rule in MI is to respond to clients with more reflective statements than questions. We want to basically build on what they have said. And so if we're asking too many questions, we don't have MI right.

Summaries, the purpose is a short and concise review of the conversation that we've just had with our person our patient and we are trying to summarize to help to encourage a very, very maybe slight call to action that may have come up during the conversation, sort of those aha moments. We're accenting on the positive here, the things that the patient's said that show evidence that there's an opportunity or room to think about change, pulling it all together and putting this information on a plate and sort of handing it to the patient and saying, what do you think of all this?

Motivational interviewing is a way of dancing with patients. And I love this visual. It reminds me to just go with the flow. Here's a case conference. Let's take a patient that I've created and let's see if we can work through developing a relationship with this patient and also communicating using some of the MIT tools that we've discussed in this presentation.

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 nine months in prison in 2012 for drug possession and has been attending Narcs Anonymous since his release from prison. This visit, Edward has a viral load of 1,700 copies per mL after having two previous visits being undetectable. You and the medical provider are concerned. The provider asked Edward, what thoughts are you having about your higher viral load? Edwards says, I may have forgotten some doses of my meds. Ugh, there's a lot going on. It's 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?

OK, so we're having a good conversation with this patient and he's asking us for our advice. So if we're going to apply OARS or MI, the possible responses to the patient's questions are listed below. We're going to choose which open-ended question might be very good to use in this case scenario. One, are you having unprotected sex with this new guy? Two, how could telling your partner about your status improve your health? Three, is this new guy HIV positive too? Or four, what changes in your life have happened since you met this man?

And notice I did not put a scenario where the provider says, this is what you should do, because that goes against the entire spirit of motivational interviewing because it's really not our choice to make. We want to hear what the patient has thought of. What has this person thought of as possibilities in perhaps sharing his status with this new individual in his life. So if we were to use motivational interviewing and a good open-ended question, my choice would be, what changes in your life have happened since you've met this man because I don't want to be too far ahead of this individual in talking about this opportunity to disclose. I want to find out where his ambivalence is. So by going back a little step, he's going to fill in the blanks for us and then I can reflect on what this individual or Edward is telling us.

Here's another application question. Which one of these is an affirmation that would be good to use in this scenario with Edward? One, honesty is always the best policy. Two, telling the truth is the harder choice, but you can do it. Three, this is hard work you're doing right now, weighing important choices. Or four, it's good you are mindful of your legal responsibility to tell your partners.

This is my choice, this is hard work you're doing right now weighing important choices. And notice how I said that. I'm saying, you are doing some very good work here. You're weighing important choices that you have. I'm building the patient up with an affirmation. I'm not telling him what to do, but I am building those strengths that he has to continue our conversation. I'm not asking more questions right now. I'm affirming who is and the work he is doing.

All right, now let's look at if we decided to use a reflection in this conversation with Edward. Would we say, in a reflection mode, what are you afraid of? Two, I think you need to tell me about your status, don't you? Three, some people disclose and some people don't, it's really up to you. Or four, you are wanting to make good choices but worry about the outcome if you choose to disclose here.

So which one would you choose? Which is a really good reflection? One is a question, so we already know that one is out. I say that four is a really good reflection. You're wanting to make

good choices but worry about the outcome if you choose to disclose. Again, putting that decision back to the patient but reflecting on what we heard. He's trying to make good choices maybe for him, maybe for the partner, maybe for both of them, but he's worrying about the outcome because if he wasn't worried about the outcome, he would have already done that already. So I'm reflecting back on what this person has said and I'm not giving him what my judgment is.

So as we continue to apply the OARS, Edward goes on to talk with this provider about how he's been not taking his meds regularly because he didn't want his new friend asked him why he was taking the medication. Edward is still going to his Narcs Anonymous meetings. He did disclose his past history with his new friend which is 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 to 10, with 1 being not important at all and 10 being very important, Edwards says that disclosing his HIV status is a seven. So that's pretty high on the scale. It's important to Edward. On a scale of 1 to 10, with 1 being not at all confident and 10 big extremely confident, Edward would reports to me that being a four in his level of confidence to successfully disclose his status to his new friend is-- so he's got a four which is not as high as I would like for him to have if he's going to make that disclosure. There's obviously something that-- a tool perhaps or maybe the fear of what the outcome could be-- but there's something more to discuss here with Edward.

So let's choose the response here that a good summary might be because I only have a short amount of time with this patient. Maybe we're not going to get to disclosure today or maybe we're going to have a follow up session tomorrow or on the phone. So I've got to summarize it or maybe I'm summarizing because I want Edward to hear what is going on with what I've been hearing. I'm trying to reflect back some of the things we've talked about to help put things in perspective and take a break.

So in this version one, let's wrap up this visit with a quick summary of what we've discussed today. You're 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've worked so hard to get right in your life. Do you have anything more to add? What do you think about this one?

I'm not so keen on it, actually. I find that by telling the patient that his confidence is low, it's not building on what he had. He had a confidence of four. I'm sort of curious what got him to four. So having that conversation would be really important. I'm trying to build this patient up in accentuate the positive, not bring the things to light that are going to be disenfranchising or perhaps make the patient feel even lower in terms of self-efficacy.

Another point, the patient in the summary wanting to withhold that's important information, I may not have gotten this right. This is a judgment and that means becoming sick and losing everything. Hard to get it right. Again, judgmental. I'm doing MI and I'm trying to keep a non-

judgment spirit of MI thing going here. And I don't want to go backwards and suddenly be judgmental to a patient what we've done such good work today.

So I like this one better, version two. Let's stop and summarize what we've just talked about. You're 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 you 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 the keeping your status the secret requires you to miss doses of your medication. And you're not happy about that. I'm wondering, what do you make of all these things?

So in this summary we're using that information to really open up the conversation again but to take a break and summarize, where did we begin and where did we come from, where did we come from and where are we going.

So MI is not a lot of things. It's not magic, it's not psychotherapy, it's not confrontational, it's not argumentative. And it's not selling or persuading and it's certainly not a panacea, it doesn't do everything, but it does do a lot. MI is a conversation about change. It's respectful, it's collaborative. It honors autonomy and self-determination, that self-efficacy we've been talking about. MI is patient-centered, goal-oriented, empowering, cooperative, effective, and I say in my experience it engages patients in HIV care.

Here's a wonderful tool. I hope you'll look it up. It is a free resource you can download from the internet. Am I doing it right? You can put it in your pocket too and when you're finished working with the patient, you can say, hmm did I get it right? What could I have done better? I love tools like that.

I'm sorry I had to speed up the end there. I know I've run out of time. Thank you so much. I look forward to new opportunities to share and talk to you about MI. I'm looking for any questions and I'm looking for organizers to help me sort of put a final goodbye to this.

STEVE LUCKABAUGH: All right we have a few moments here. We can take some questions. If anyone has any questions, please enter them into the Questions pane on the go to webinar toolbar. If you would like to speak a question and you have audio-enabled, you can raise your hand. I can unmute you. Right now I'm not seeing any questions.

DEBBIE CESTARO-SEIFER: I see 70 people on the program today. So thank you all. Please know that we are so thrilled that you signed up and came on board and I hope that this has been helpful to you. And I will stay on to take any questions or lingering questions.

STEVE LUCKABAUGH: OK, We have a couple comments, a few “thank yous.” And Edward Kayando says “one of the best presentations we have ever had.” Thank you.

DEBBIE CESTARO-SEIFER: Thank you so much.

STEVE LUCKABAUGH: Karen Hart says, “where can you find the card?”



DEBBIE CESTARO-SEIFER: That card is online and when you download the handout for this slide presentation or you review it again, because I know we're going to post this for you, it is a website that you can easily go to and it is on the slide.

STEVE LUCKABAUGH: OK, and you can grab that handout and the slides right now if you go to your go to webinar toolbar. There is a little box at the bottom that says "handouts." Click the plus sign next to it and you should see it. We have a "very informative. Thank you, great presentation." Lots of "thank yous" so that's good.

DEBBIE CESTARO-SEIFER: Well, thank you. I hope this gets people excited. It's another tool to put in our tool bag, Steve. It's a wonderful opportunity to maybe shake it up a little bit, do something a little different.

STEVE LUCKABAUGH: OK, (another comment) "this was a very good training. I felt that it was very informative. I will definitely use this for my encounters with my clients."

DEBBIE CESTARO SEIFER: Wonderful.

STEVE LUCKABAUGH: That's one and someone said I may have missed the acronym, OARS, O-A-R-S. Do you mind spelling it out, please? DEBBIE CESTARO-SEIFER: O-A-R-S. O is open-ended questions. A is affirmation. R is reflections and S is summaries. Great question.

STEVE LUCKABAUGH: OK, thanks. OK. Anyone have any further questions before we wrap it up? OK. Not seeing any, just lots more thanks.

DEBBIE CESTARO-SEIFER: OK, well we thank you for the "thank yous" and I believe there is some information or can be how to reach me. If you would like more information or have some tough patient situations, sometimes just talking about it with someone about or maybe you could try something different. And I'm all about motivational interviewing so it's a tool that I think we have to practice to get better at. I'm still practicing. So I'd love to hear from you.

STEVE LUCKABAUGH: OK so I'd like to thank everyone for participating in today's webinar. And we hope that you're able to find the information provided useful as you continue your P4C project. Today's webinar was recorded in audio and video versions of the entire webinar as well as the slides from today's webinar will be available on the P4C website within the next few weeks. Copies of our prior P4C webinars are currently available on the website on the P4C Resource Materials page at P4CHIVTAC.com. You will need to log in to access the materials. If you need login credentials, send an email to p4chivtac@mayatech.com. Thank you again for participating in today's webinar. And thank you, Ms. Cestaro-Seifer for that excellent presentation. If M have any additional questions for the P4C project or for Cestaro-Seifer, please email us at p4chivetac@mayatech.com. Take care, everybody and we'll see you next time. Thank you.