Some information is not consistent with the approved product labeling for the Sanofi U.S. product(s) being discussed; this information may relate to the indication or use, dosage and administration, patient population, combination use, or other potential unapproved uses. No conclusion regarding safety and efficacy can be made for such uses.

The Motivational Interviewing Toolbox: A Sensible Approach for HCPs to Improve Non-Adherence and Patient Engagement

Medical Affairs, Sanofi US

Learning Objectives

- Describe medication non-adherence and why it is a public health problem
- Discuss factors affecting medication adherence in patients with diabetes
- Introduce and provide examples of Medication Possession Ratio (MPR) and Proportion of Days Covered (PDC)
- Identify common barriers preventing effective communication and patient engagement
- Define Motivational Interviewing and review guiding principles
- Refine counseling methods to roll with resistance, express empathy, and avoid argumentation

"Across diseases, adherence is the single most important modifiable factor that compromises treatment outcome."[1]

1. World Health Organization. Adherence to Long-term Therapies: Evidence for Action. Geneva, Switzerland: World Health Organization, 2003.

Medication Non-Adherence: America's Other Drug Problem

- National Community Pharmacists Association survey[1]
  - 49% patients forget to take prescribed medications
  - 31% did not fill prescriptions
  - 29% discontinued medication before supply ran out
  - 24% took dose lower than recommended
- United States pharmacy data[2]
  - New prescriptions are less likely to be filled when:
    - Cost > $50
    - Copayments ≥ $45-50

[1]National Council on Patient Information and Education. Enhancing prescription medicine Adherence: a national action plan. August 2002. Available at http://www.talkaboutrx.org/med_compliance_publications.jsp. Accessed May 12, 2011.
[2]Shrank WH, et al. *Ann Intern Med.* 2010;153:633-640.

Prescription Medicine Adherence
Lack of a Standard Definition[1]

- **Compliance:** the extent to which patient's behavior coincide with the HCP's medical or health advice
- **Adherence:** the extent to which a person's behavior in taking medication corresponds with agreed upon recommendations through collaboration
  - **Primary Nonadherence:** not initially filling the prescription
  - **Secondary Nonadherence:** failure to follow the instructions or to refill the prescription

1. Adapted from National Council on Patient Information and Education. Enhancing Prescription Medicine Adherence: A National Action Plan. August 2007.

Prescription Medicine Adherence
Lack of a Standard Definition[1]

- **Persistence**
  - The ability of a person to continue taking medications for the intended course of therapy
  - Medication persistence is "the length of time from initiation to discontinuation of therapy and is measured in units of time."[2]
    - Persistency
    - Continuous adherence
    - Discontinuation rates

1. Adapted from National Council on Patient Information and Education. Enhancing Prescription Medicine Adherence: A National Action Plan. August 2007.
2. Cramer JA, et al. Value Health. 2008 Jan-Feb;11(1):44-7

Measures of Adherence and Persistence

Medication Possession Ratio (MPR)

- Usually defined as the sum of days supply of medication divided by the number of days between the first fill and the last fill plus the days supply on the last fill
- Days supply on last fill days not always included
- Generally an MPR of 0 indicates no fills and 1 indicates perfect compliance
- Early refills could lead to MPR >1
- $\geq$ 0.8 generally indicates good compliance

Goodman et al. *International Journal for Quality in Health Care*. 2012;24(3):293-300.10.1093/intqhc/mzs017.

Proportion of Days Covered Model

Proportion of Days Covered (PDC)

- **Patient is considered persistent if enough medicine has been dispensed to cover a proportion of days during the specified interval**
- **Interval can vary – 3 months, 6 months, 1 year**
- **Similar to fixed time as a function of the MPR**
- **If the interval is one year**
  - **MPR of 80% would be 292 days covered**

Goodman et al. *International Journal for Quality in Health Care*. 2012;24(3):293-300.10.1093/intqhc/mzs017.

Measures of Adherence at 6 Months

Proportion of days covered (PDC)

- The number of unique days with therapy in the 180 days after the index date divided by 180 (4 x 30 day refills, but late)
- PDC = $\frac{\text{Number of days with therapy}}{180} = \frac{100}{180}$ (x100) = 56%

Medication Possession Ratio (MPR)

- The sum of the days supplied from all prescriptions within 180 days after the index date divided by 180 (4 x 30 day refills)
- Truncated at 100%
- MPR = $\frac{\text{Days Supplied}}{180} = \frac{120}{180}$ (x100) = 66%

✓ **Typical PDC and MPR goals are ≥ 80%**

Goodman et al. *International Journal for Quality in Health Care*. 2012;24(3):293-300.10.1093/intqhc/mzs017.

Comparison of Different Persistency Methodologies

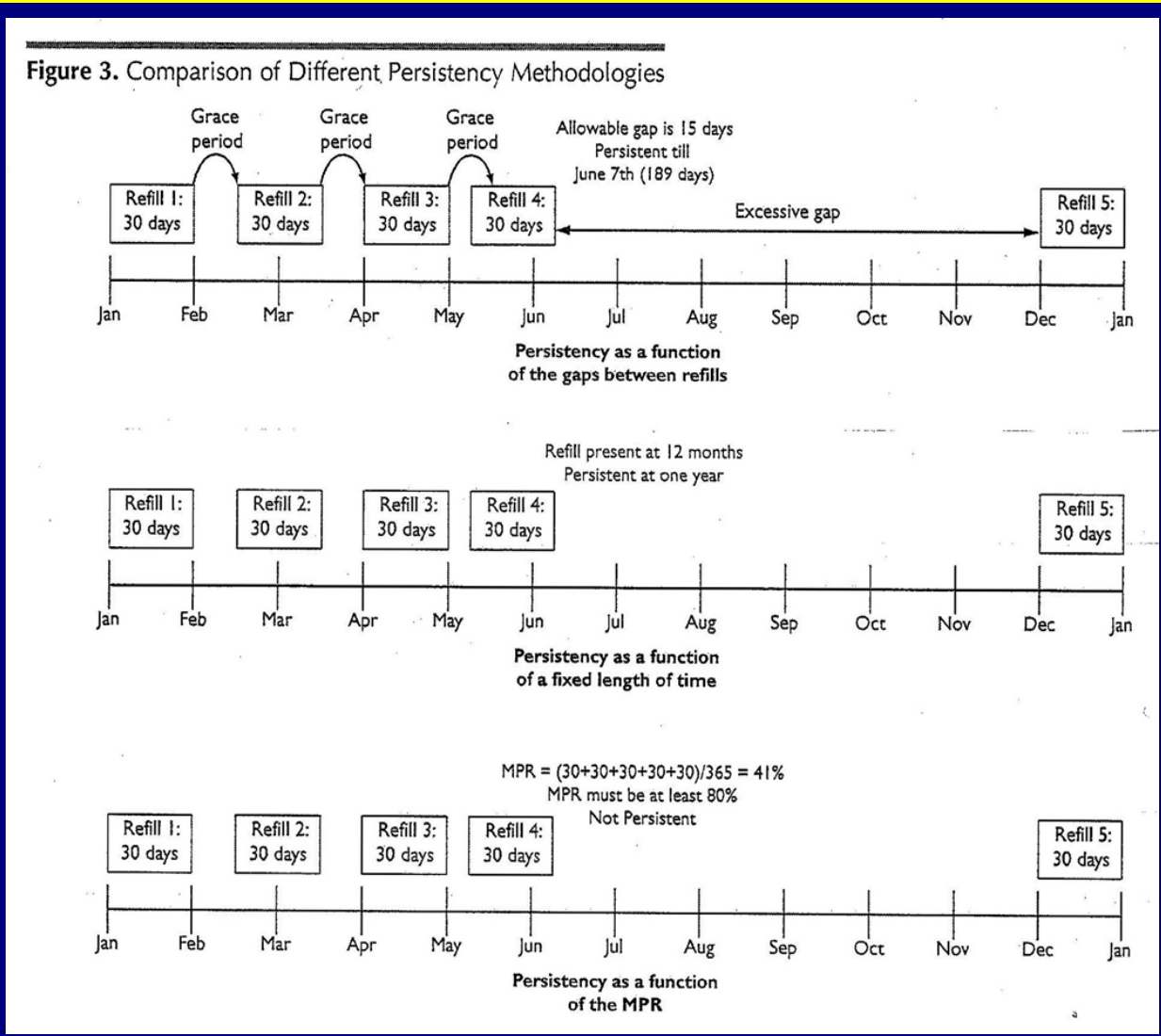


Figure 3. Comparison of Different Persistency Methodologies

Caetano PA, et al. *Clinical Therapeutics.* 2006;28:1411-1424.

Adherence Challenges

Examples of Medication Non-Adherence

- Failing to initially fill a prescription
- Failing to refill a prescription as directed
- Omitting a dose or doses
- Taking more or less of a medication than prescribed
- Taking a dose at the wrong time or changing the regimen
- Taking a medication prescribed for someone else
- Taking outdated medications
- Taking damaged medications
- Simple forgetfulness
- Hoarding old medications to take later

Poor Adherence Exists Across Therapeutic Categories

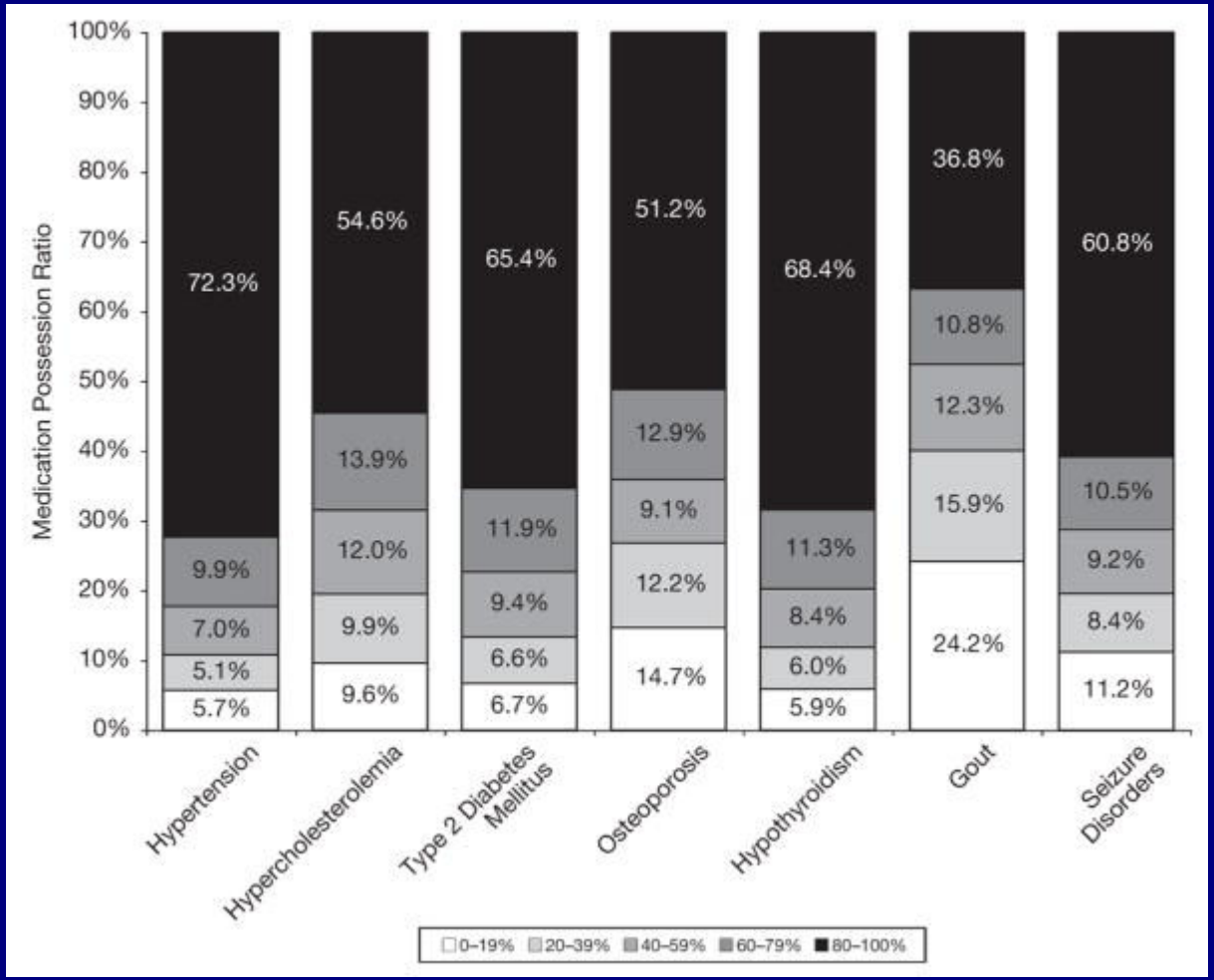
- **National Quality Forum endorsed proportion of days covered (PDC) as adherence quality indicator**
- **Retrospective analysis of pharmacy claims for 167,907 patients new to a chronic medication class**

Drug class	12-month adherence
Prostaglandin analogs (glaucoma)	37%
Statins	61%
Bisphosphonates	60%
Oral antidiabetics	72%
Angiotensin II receptor blockers	66%
Overactive bladder medications	35%

Yeaw J, et al. *J Manag Care Pharm.* 2009;15:728-740.

Poor Adherence Exists Across Chronic Conditions

- Adherence over first year of new treatment
- 696,317 patients with chronic condition
- MarketScan Research 2001 - 2004 databases
- Overall, lower adherence in patients <60 yo



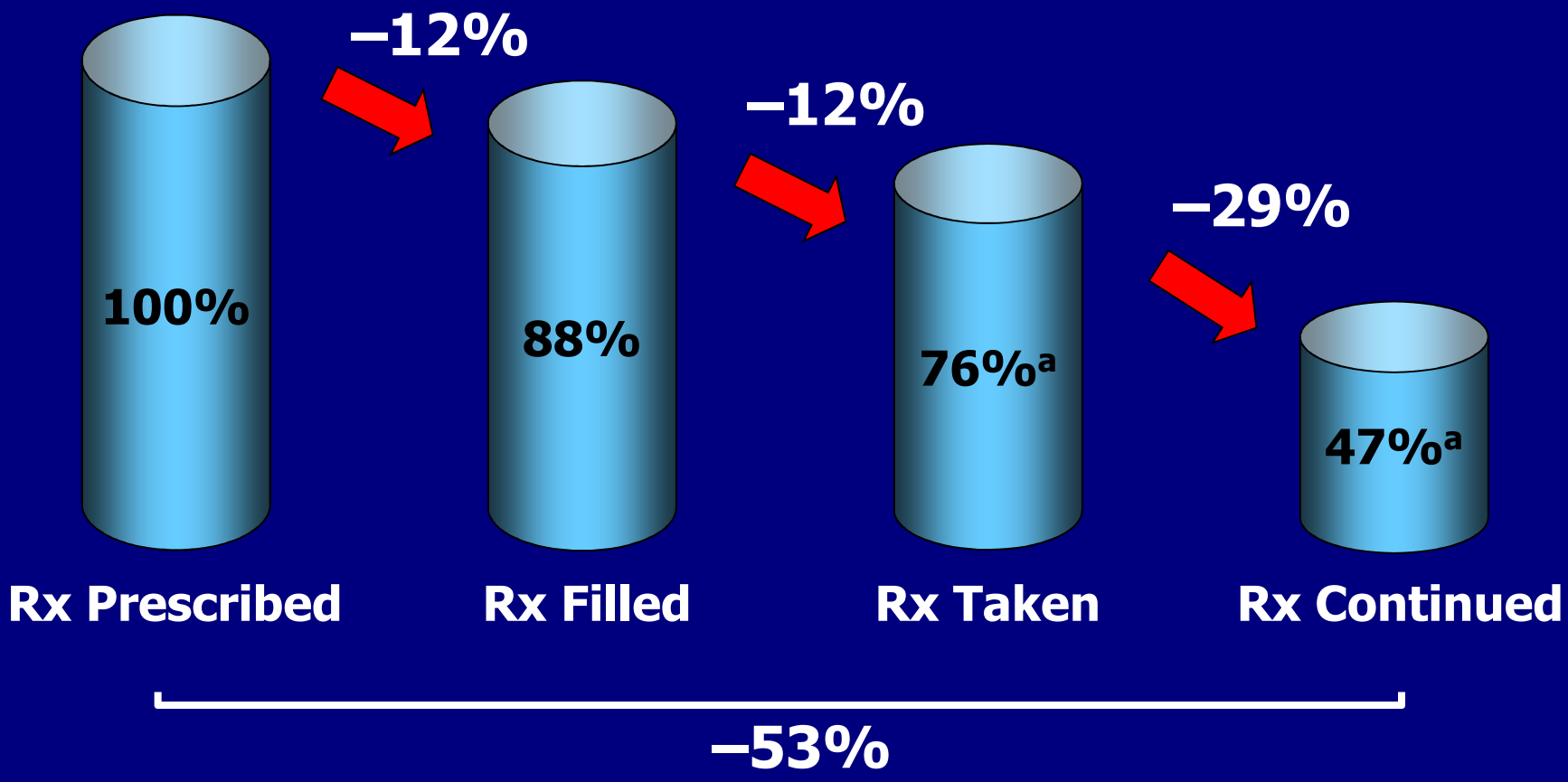
Briesacher BA, et al. *Pharmacotherapy*. 2008;28:437-443.

Medication Non-Adherence: A Central Public Health Problem

- Adherence occurs in about 50% of patients with chronic conditions[1]
- More than 10% of all hospital admissions and 23% of all nursing home admissions are due to patients failing to take medications correctly[1]
- The average length of stay in hospitals due to medication noncompliance is 4.2 days[1]
- Poor medication adherence costs ~ $177 billion annually in total direct / indirect health care costs
  - Non-adherence results in about $47 billion annually for drug-related hospitalizations

1. Heart Disease and Stroke Statistics — 2007 Update, American Heart Association
2. National Council on Patient Information and Education. Enhancing prescription medicine Adherence: a national action plan. August 2002. Available at http://www.talkaboutrx.org/med_compliance_publications.jsp. Accessed May 12, 2011.

US Patients Do Not Take Medications as Prescribed

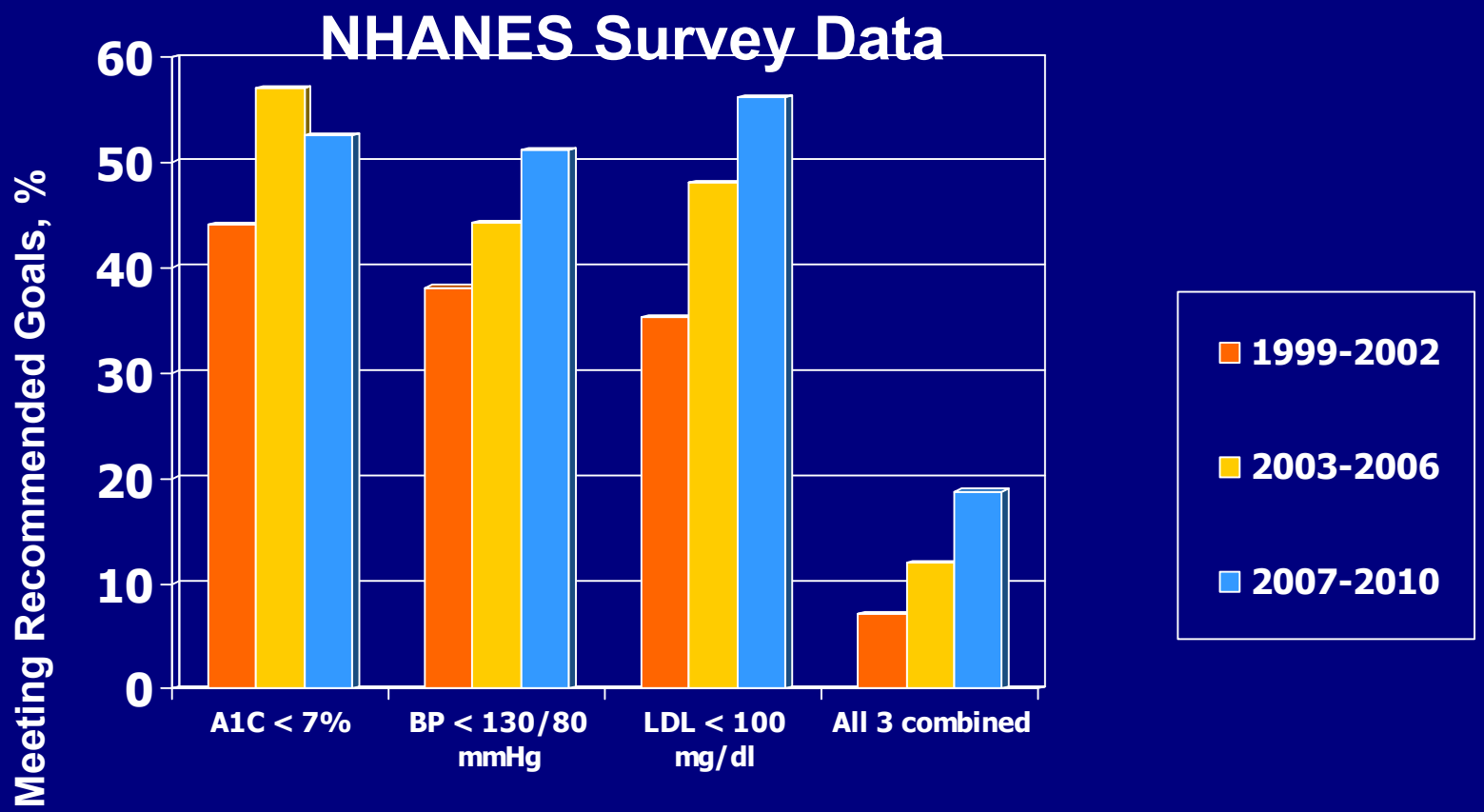


[a]22% of US patients take less medication than is prescribed.

AHA. Statistics you need to know. http://www.americanheart.org/print_presenter.jhtml?identifier=107. Accessed January 21, 2010.

Provided for your medical information and general background.

Many Diabetes Patients Do Not Achieve Recommended Goals

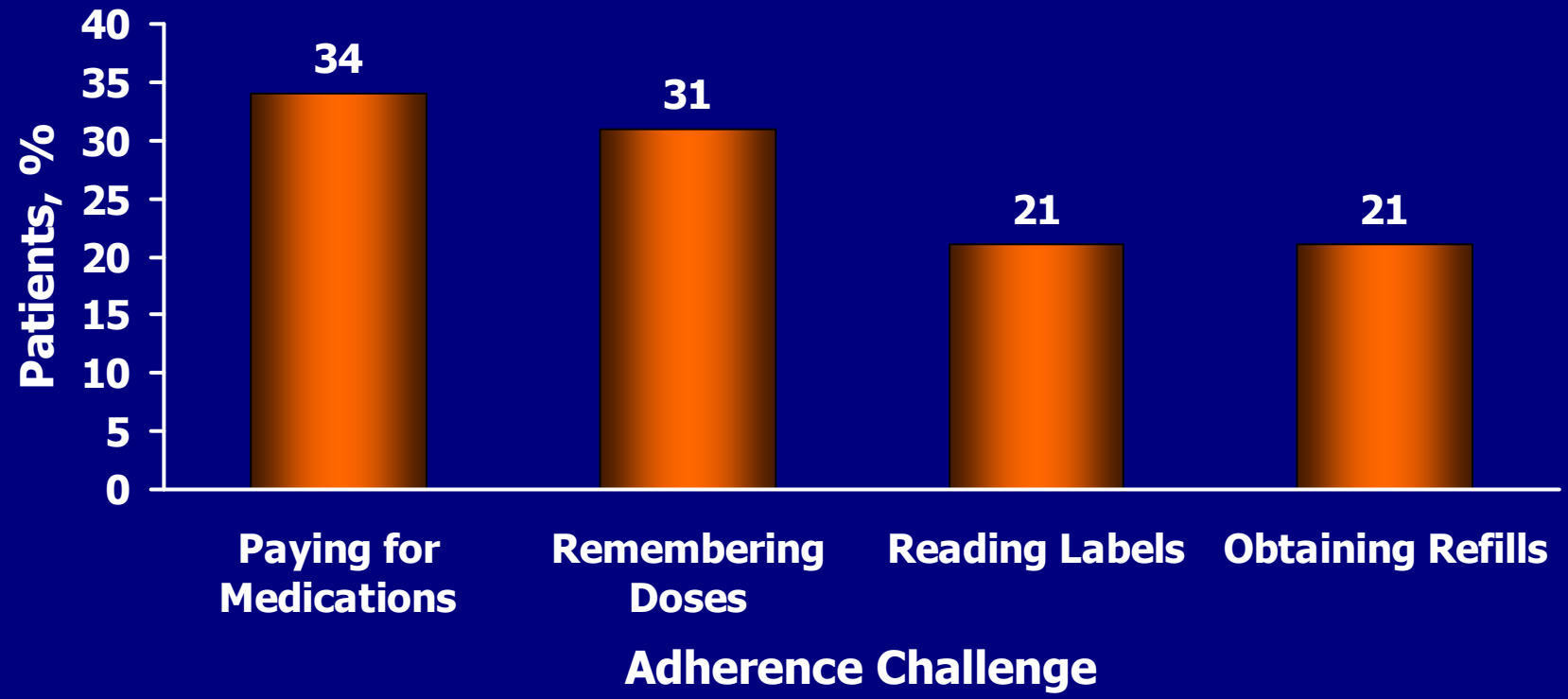


BP = Blood Pressure; LDL = low-density lipoprotein cholesterol; NHANES = National Health and Nutrition Examination Survey

Stark et al. *Diabetes Care* published ahead of print February 15, 2013,doi:10.2337/dc12-2258

The Most Common Medication Adherence Challenges in Adults With A1C ≥9.0%

- Higher A1C was associated with taking >2 doses/d and with difficulty reading prescription label



N=77 patients with T2DM.

Odegard PS et al. *Diabetes Educ.* 2008;34:692-697.

"Drugs don't work if people don't take them."

C. Everett Koop, US Surgeon General 1985

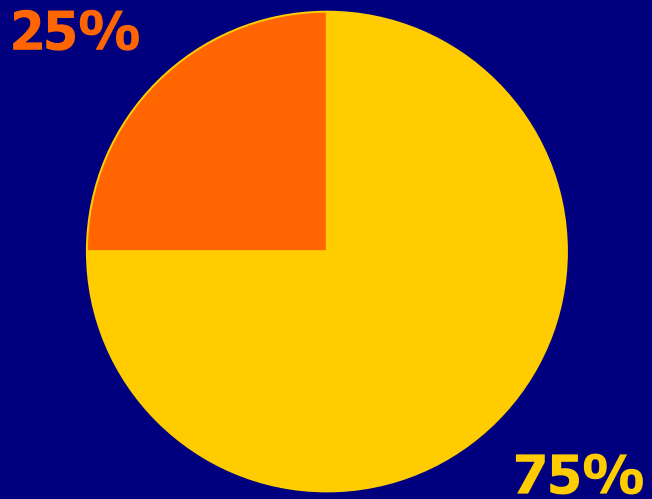
Why Should We Care About Medication Adherence?

The Full Cost of Poor Health

Personal Health Costs

- Medical Care
- Pharmacy

$3,376 PEPY



Productivity Costs

Absenteeism

- Short-, Long-Term Disability

Presenteeism

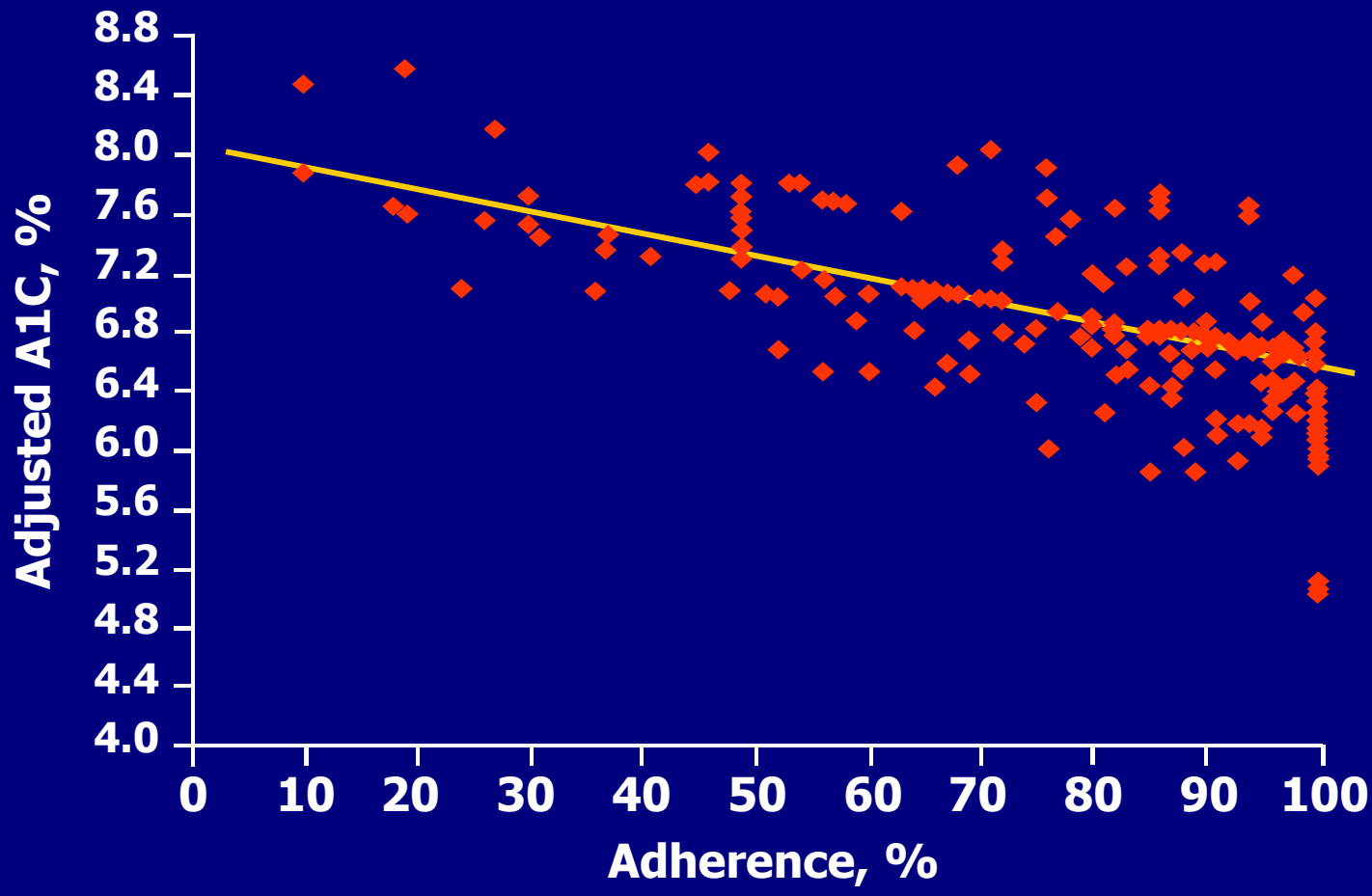
- Overtime
- Turnover
- Temporary Staffing
- Administrative Costs
- Replacement Training
- Office Travel for Care
- Customer Dissatisfaction
- Variable Product Quality

$10,128 PEPY

PEPY: Per Employee Per Year

Adapted from the Foundation for Managed Care Pharmacy presentation, from the 2008 Mercer Annual Benefits Survey

Adherence and A1C Are Inversely Related[a]



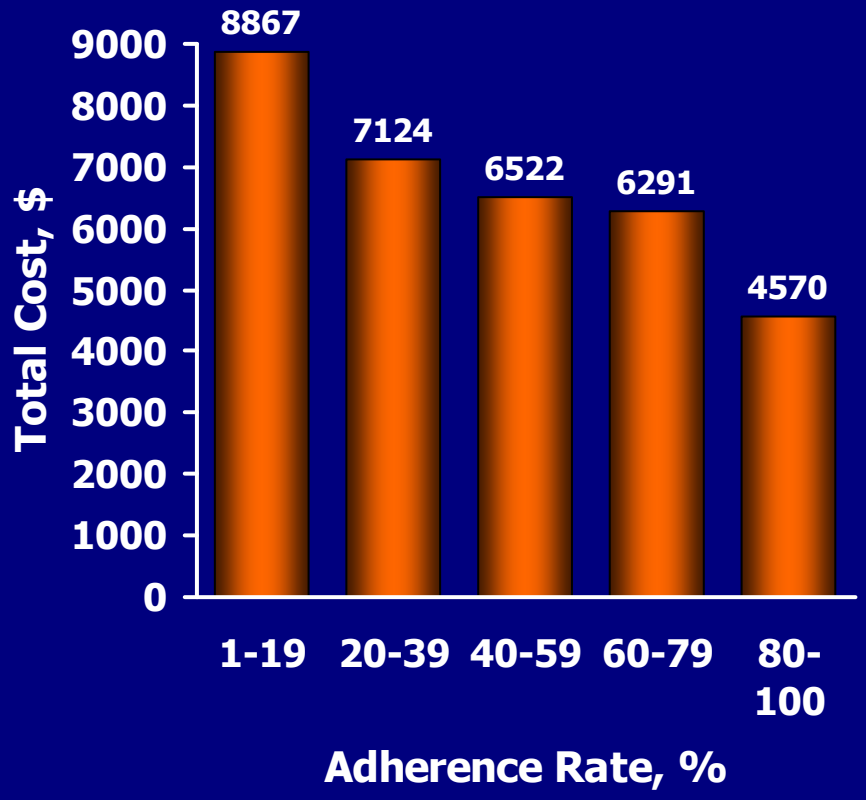
OAD = oral antidiabetic drug.

[a]Each 10% increase in OAD adherence resulted in a 0.1% reduction in A1C (*P*=0.0004).

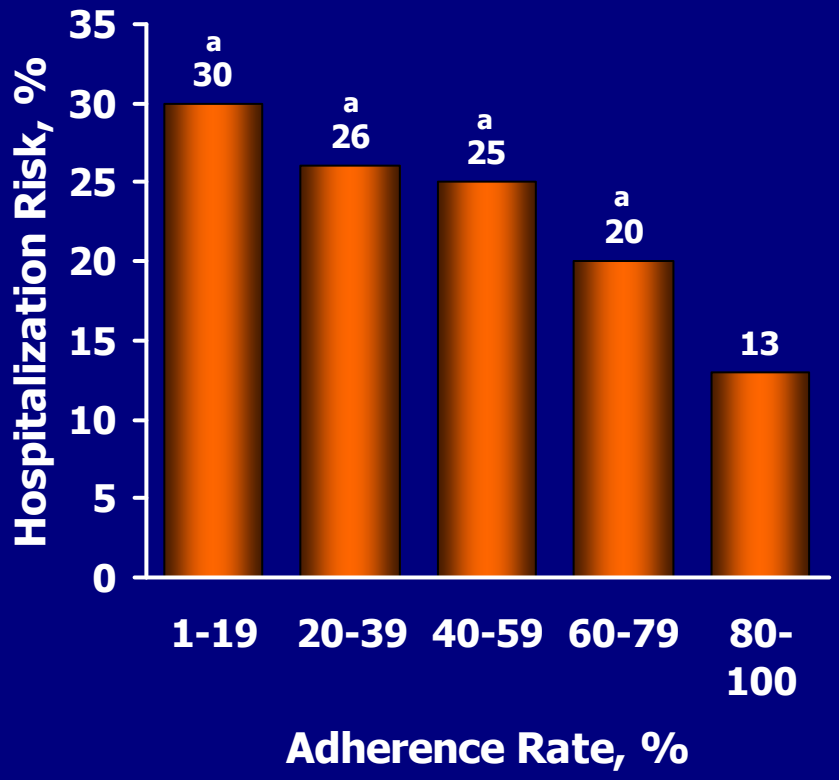
Rozenfeld Y et al. *Am J Manag Care.* 2008;14:71-75.

Impact of Medication Adherence on Health Care Costs and Hospitalization Risk in Diabetes

Total Diabetes-Related Health Care Costs



Hospitalization Risk



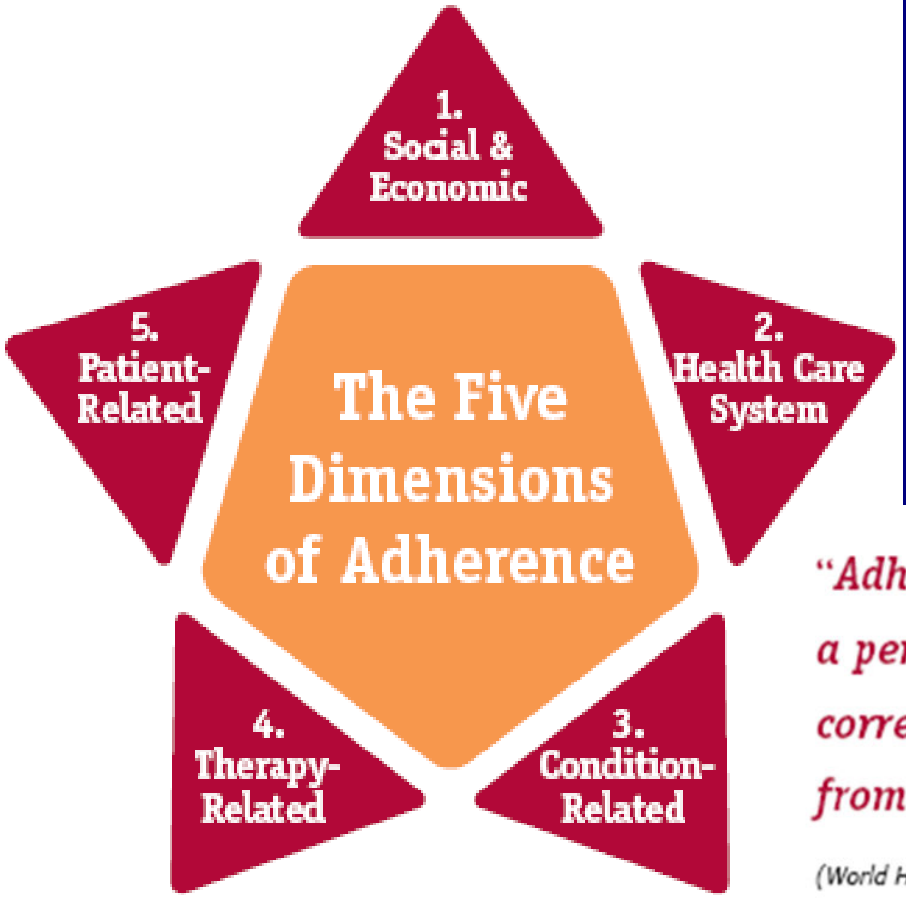
N=182, 259, 419, 599, and 1801 in the 1%-19%, 20%-39%, 40%-59%, 60%-79%, and 80%-100% adherence groups, respectively.

[a] *P*<0.05 vs 80%-100%.

Sokol MC et al. *Med Care.* 2005;43:521-530.

Factors Impacting Medication Adherence

Adherence is Affected by Multiple Factors



"Adherence is the extent to which a person's behavior [in] taking medication... corresponds with agreed recommendations from a health care provider"

(World Health Organization, 2003)

Patient-Related Factors Affecting Adherence: Psychological/Behavioral Factors

- Knowledge about the disease
- Perceived risk/susceptibility to disease
- Understanding reasons for medication
- Expectations or attitudes toward treatment
- Perceived benefit of treatment
- Confidence in ability to follow treatment regimen
- Motivation
- Fear of AEs
- Fear of dependence
- Feeling stigmatized by disease
- Frustration with HCPs
- Psychosocial stress, anxiety, anger, depression
- Alcohol or substance abuse

Adult Meducation™: Improving Medication Adherence in Older Adults. American Society on Aging and American Society of Consultant Pharmacists. http://www.adultmeducation.com. Accessed April 4, 2011.

Behavior is an Important Component to Diabetes Adherence

- **Optimizing outcomes for patients with diabetes cannot be achieved through infrequent encounters with HCPs**
- **Nearly every intervention designed to improve metabolic control in diabetes or reduce risk of acute or chronic complications impacts patient self-management behaviors**
- **Diabetes self-management (self-care) behaviors**
  - **SMBG**
  - **Monitoring food intake**
  - **Matching insulin requirements to food intake**
  - **Administering doses**
  - **Monitoring physical activity**
  - **Screening for complications (e.g., foot care, eye exams, etc.)**

Nuovo J, et al. *Curr Diabetes Rev.* 2007;3:226-228.; Whittemore R. *Nurs Clin N Am.* 2006;41:641-654.
Clark M. *Prim Care Diabetes*. 2008;2:113-130.; Glasgow RE, et al. *Diabetes Care.* 1999;22:832-843.
Russell-Minda E, et al. *J Diabetes Sci Technol.* 2009;3:1460-1471.

Burden of Treatment

- Diabetes impacts many aspects of a patient's life
- Often is accompanied by other comorbid conditions which increases overall burden of treatment
- Increased burden of treatment may lead to increased challenges with adherence to treatment strategies.

Burden of Treatment

- **Another group of researchers divided burden of treatment this way:**

Domain	Definition
Access	**Patient's efforts or difficulty obtaining treatment in a timely, convenient or affordable manner**
Administration	**Burdens in correctly delivering or taking a treatment**
Effects	**Unwanted or unintended symptoms or consequences of the prescribed treatment**
Monitoring	**Trouble complying with the monitoring required for effective or safe use of the medication and following its ongoing effects**

Bohlen, et. al. *Diabetes Care*. 2012. 35: 47-49.

Linking Adherence Problems to Solutions

Linking Adherence Problems to Solutions

- **Social & Economic**
  - **Educating HCP on health literacy and cultural competence**
  - **Utilizing health literacy evaluation tools**
  - **Connecting patients with community resources for assistance with care/supplies/medications**
- **Health Care System**
  - **Ensuring quality communication with patients**
  - **Interprofessional teams / care coordination (ACO)**
  - **Patient-centered medical home (PCMH)**
- **Condition related:**
  - **Continuing, persistent education with patients**
  - **Consistent care within a care team the patient trusts**

Linking Adherence Problems to Solutions

- **Therapy related**
  - **Medication Therapy Management (MTM): Full assessment of drug therapy and potential drug related problems, including patient's understanding of the regimen and willingness to comply, then working to resolve those drug-related problems**
- **Patient-related**
  - **Identify sensory problems patient may have impacting ability to adhere to therapy and provide appropriate resource to resolve problem**
    - **Examples: switching to liquid formulations, alternative easier-to-swallow medications, easy-off caps, larger print on Rx label**

Other Strategies to Improve Adherence

- **Motivational Interviewing (MI)**
  - **MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change**
- **Medication reminder devices**
  - **Pill boxes, alarms**
- **Mobile device technology**
  - **MedsLog, Medsy, Dosecast, MediRemind**
  - **Check out app store and current websites for reviews**

Behavior Is An Important Component to Diabetes Adherence

Learning and adopting new, complex pattern of behavior normally requires modifying many smaller behaviors that comprise overall complex behavior

Peyrot M and Rubin RR. *Diabetes Care*. 2007;30:2433-2440.
Edwards et al. *Diabetes Spectrum*. 1999;12:157-160.
Behavior Change Theories and Models. http://www.csupomona.edu/~jvgrizzell/best_practices/bctheory.html. Accessed May 12, 2011.

Why Do We Need to Involve Patients?

- Managing illness requires change (behavior modification)
- Behavioral mechanisms are important factors for non-adherence
- According to WHO, "an understanding of basic behavioral principles and change is relevant to adherence…for all chronic medical conditions, and more helpful than a disease-specific approach to the issue."
- Patients need to be supported, not blamed. Patient-tailored interventions are required

World Health Organization. *Adherence to Long-term Therapies: Evidence for Action*. Geneva, Switzerland: World Health Organization, 2003.

Adherence Is A Complex Behavioral Process

- **Adherence is strongly influenced by:**
  - **Environment in which people live**
  - **How healthcare providers practice**
  - **How healthcare systems deliver care**
- **Adherence is related to people's:**
  - **Knowledge and beliefs about their illness**
  - **Motivation to manage illness**
  - **Confidence in their ability to engage in illness-management behaviors**
  - **Expectations regarding treatment outcomes and consequences of poor adherence**

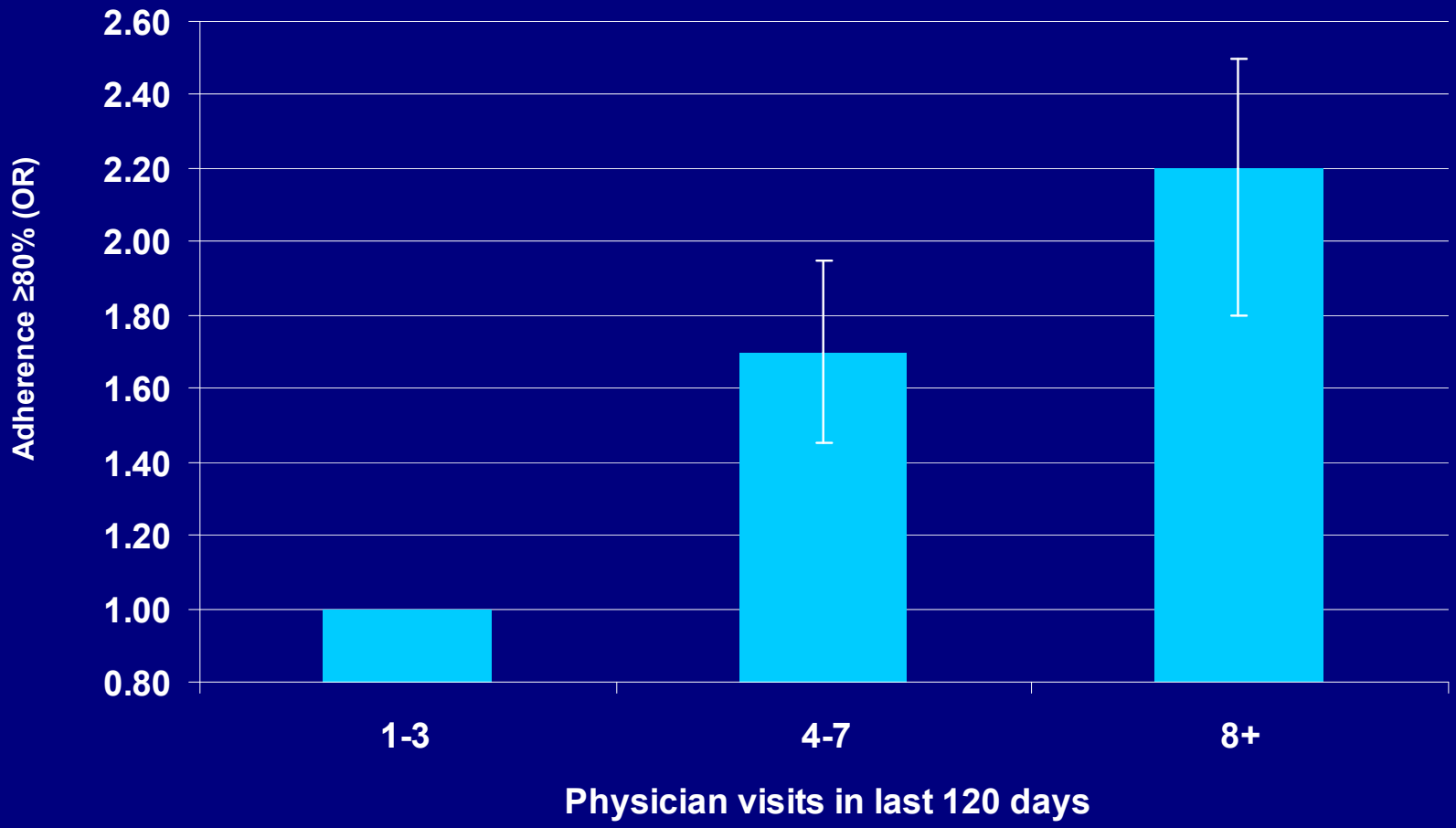
Adult Meducation™: Improving Medication Adherence in Older Adults. American Society on Aging and American Society of Consultant Pharmacists. http://www.adultmeducation.com. Accessed April 4, 2011.

Adherence Improvement Rates for Different Interventions

Type of Intervention	% Adherence Improvement
Theory-based interventions	5% - 43%
Disease-based interventions	4% - 46%
Dosage simplification	4% - 24%
Reminders	1% - 41%
Discharge interventions	7% - 43%
One-time intervention (no follow-up)	11% - 36%
Self-care initiatives	12% - 17%

Krueger KP, et al. *Adv Ther.* 2005;22:313-356.

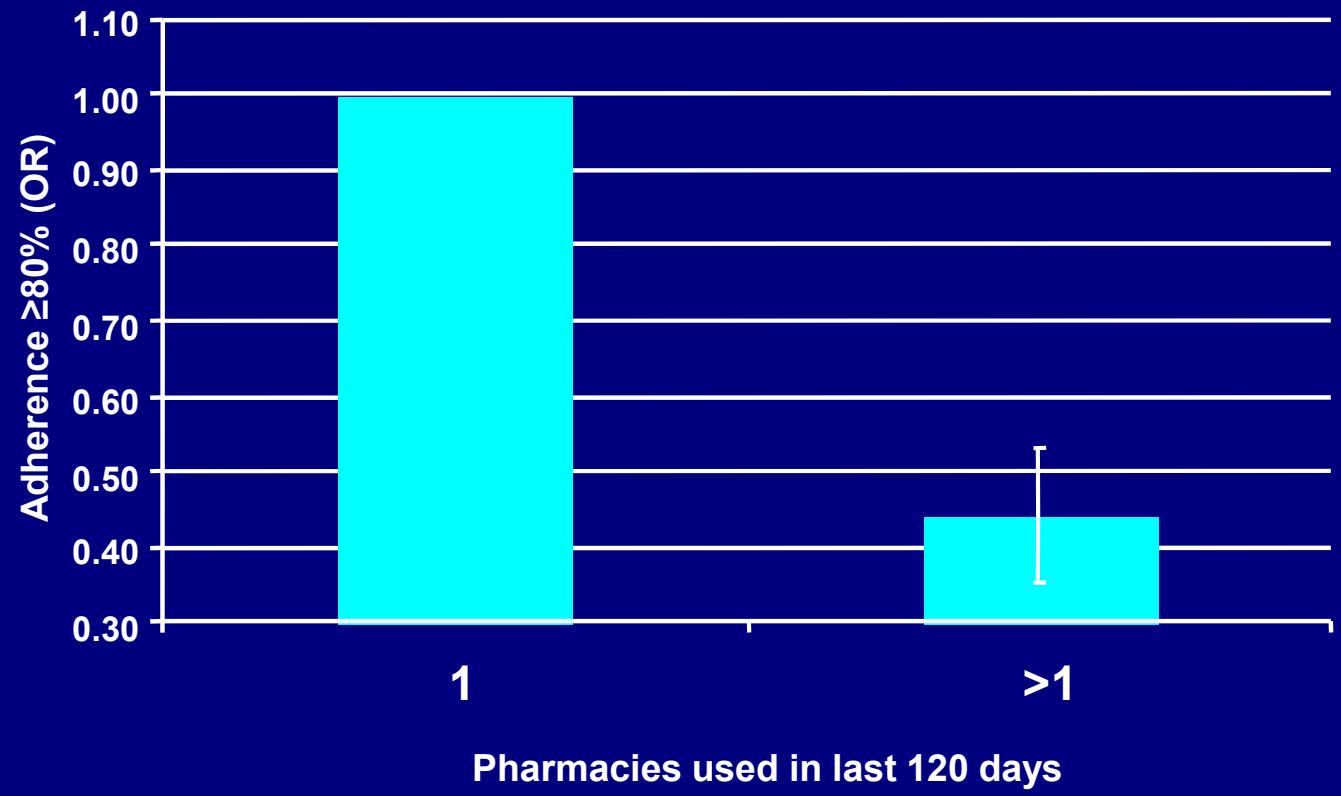
More Frequent Provider Visits Improves Adherence



Retrospective study of elderly (aged 65 to 99 years) members of the New Jersey Medicaid and Medicare populations (N=8643).

Monane M et al. *Am J Hypertens.* 1997;10:697-704.

Using Multiple Pharmacies Negatively Affects Adherence



Retrospective study of elderly (aged 65 to 99 years) members of the New Jersey Medicaid and Medicare populations (N=8643).

Monane M et al. *Am J Hypertens.* 1997;10:697-704.

Key Considerations for Adherence

- **Involving patients in the decision-making process and setting relevant goals are important to improving adherence**
- **Adherence with short-term therapy is poor unless patient is properly educated about how medication works, how long to take it, and what to expect**
- **Patients manage their own illness, not us**
- **New ways of thinking and more comprehensive patient-centric approaches are needed**

Krueger KP, et al. *Adv Ther*. 2005;22:313-356.

Key Considerations for Adherence: Long-Term Therapy

- Benefits of therapy must be clear
- Barriers must be discussed and strategies for overcoming them determined
- Regimens need to be tailored to patient's daily routines
- Follow-up care should be provided
- Adherence and good/improving performance should be commended

Krueger KP, et al. *Adv Ther.* 2005;22:313-356.

Discussion Questions

- What do you think are the top three barriers to adherence to diabetes medications?
- Do the barriers differ as the disease progresses?
  - At the time of diagnosis of diabetes?
  - At the time when injectables are prescribed?
  - At the time when multiple injections are prescribed?
- What initiatives does your organization offer to improve adherence?
- What initiatives are most effective in improving adherence?

Eliciting Change in Patient's Behavior: Introduction to Motivational Interviewing

Two Different Models of Care

BIOMEDICAL[1]

- Practitioner centered
- Information giving
- "Save" the patient
- Dictate behavior (directive)
- Compliance
- Authoritarian (parent to child)
- Motivate the patient
- Persuade, manipulate
- Resistance is bad
- Argue
- Respect expected

PSYCHOSOCIAL[1]

- Patient centered
- Information exchange
- Patient "saves" self
- Negotiate behavior
- Adherence
- Servant
- Assess motivation
- Understand, accept
- Resistance is information
- Confront
- Respect earned

"A disturbing pattern seems evident in health care, with the balance of communication shifting toward directing rather than following and guiding."[2]

[1]Berger BA. *Case Manager*. 2004;15:46-50.
[2]Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, p. 17.

How We Talk to Our Patients: Does This Sound Familiar?

- "I tell them and tell them what to do, but they won't do it"
- "It's my job just to give them the facts, and that's all I can do"
- "I'm not a counselor; I diagnose and manage medical conditions"
- "Some of my patients are in complete denial"

Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, p. vii.

Resistance and Change: Opposite Sides of the Same Coin

"Faced with the choice between changing … and proving that there is no need to do so, almost everyone gets busy on the proof."[1]

- John Galbraith

"There is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes makes change possible."[2]

- Stephen Rollnick, William Miller, & Christopher Butler

"There is very little evidence…that people will change if you just make them feel bad (scared, ashamed, humiliated) enough. To the contrary, it is the supportive, compassionate, empathic practitioner who is most effective in inspiring behavior change." [2]

- Stephen Rollnick, William Miller, & Christopher Butler

[1]Galbraith JK. *Economics, Peace and Laughter*. New York, NY: New American Library, 1971, p. 50.

[2]Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, pp. 7 and 98.

Engaging Patients

- Warm greeting; Introduce yourself
- Eye contact; sit at their level
- No medical jargon; use simple terms
- Speak slowing
- Assess understanding with open-ended questions
- Limit content; emphasize key points
- Repetition; repeat key points
- Write down instructions; distribute written materials
- Use graphics or visual aids

http://www.ahrq.gov/qual/literacy/healthliteracttoolkit.pdf

What is Motivational Interviewing?

What is Motivational Interviewing?

- **"Motivational interviewing is a guided, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence."[1] – Stephen Rollnick & William R. Miller**
- **MI helps activate patient's own motivation for change and adherence[2]**
- **MI is concerned with assessing a patient's motivation for change, NOT motivating the patient[1]**

[1]Rollnick S and Miller WR. Motivational interviewing. Available at http://motivationalinterview.net/clinical/whatismi.html. Accessed 5/12/2011.
[2]Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, pp. 5 and 6.
[3]Wagner C and Conners W. Motivational interviewing. The Philosophy Behind Motivational Interviewing. Available at http://motivationalinterview.net/clinical/whatismi.html. Accessed 5/12/2011.

Updated Definition of MI

"MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change."

Miller WR, Rollnick S. Ten things motivational interviewing is not. Behav Cogn Psychother 2009;37:120-40.

New Definition of MI

- **MI is a collaborative, person-centered form of information exchange to facilitate constructive patient sense-making about health.**
  - **Berger and Villaume, 2012**

"Spirit" of Motivational Interviewing

- **Collaborative**
  - **Cooperative partnership between patient and clinician, not directive, with joint decision-making process**
- **Evocative**
  - **Evoke patient's reasons for change by connecting health behavior change with their values/concerns**
- **Honoring Patient Autonomy**
  - **Inform, advise, and warn but ultimately it is the patient who decides what to do**

Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, pp. 6 and 7.

OARS

O: Ask open questions

A: Affirm (comment positively on intent, effort, strengths)

R: Reflect (active listening)

S: Summarize the patient's perspectives on change

Sim MG, et al. *Aust Fam Physician*. 2009;38:986-989.

Guiding Principles of Motivational Interviewing: R U L E

R: Resist the Righting Reflex

- Suppress "fixing" the problem by having patient "voice" arguments for change

U: Understand Your Patient's Motivations

- Evoke patient's perception of their situation and motivation for change

L: Listen to Your Patients

E: Empower Your Patients

- Help patients explore how they can make a difference in their own health

Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, pp. 7-10.

Additional Interaction Practices

- 5As[1]
  - Ask, Advise, Assess, Assist, Arrange
- 5Cs[1]
  - Construct the problem
  - Collaborate on goal setting
  - Collaborate on problem solving
  - Contract for change
  - Continue support

[1]Peyrot M and Rubin RR. *Diabetes Care.* 2007;30:2433-2440.

General Principles of Motivational Interviewing: R E A D S

R: Roll with resistance
- to understand patient's reluctance to change

E: Express empathy
- to accurately understand patient's issues; ask permission

A: Avoid argumentation
- to avoid defensive responses

D: Develop discrepancy
- to clarify patient's own goals

S: Support self-efficacy
- to enhance patient's confidence that change is possible

Adult Meducation™: Improving Medication Adherence in Older Adults. American Society on Aging and American Society of Consultant Pharmacists. http://www.adultmeducation.com. Accessed April 4, 2011.

Roll with Resistance & Avoid Argumentation

- Don't fight resistance but "roll" with it[1]
- Explore ambivalence or resistance rather than explain it[1]
- Arguing benefits to patients will force them to defend their position (resistance to change) and may reduce probability of behavior change occuring[2]
- Rather than arguing for change, assist patient in voicing arguments for change[2]

[1]Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008, p. 8.
[2]Wagner C and Conners W. Motivational interviewing. Motivational Interviewing Principles. Available at http://www.motivationalinterview.net/clinical/principles.html. Accessed 5/12/2011.

Example of Roll with Resistance

- **Patient:** "I just don't like to take medicine every day. It's not good for you. I don't want to become dependent."
- **HCP:** "You worry that taking medicine every day might actually be harmful and that you might even become dependent on it."
- **Patient:** "Right. I don't want that."
- **HCP:** "I don't want that either. Would it be OK if I gave you some information that might address your concerns, and you can let me know what you think?"

Example of Avoid Argumentation

- **Patient:** "You're not my doctor! I don't have time to wait for some pharmacist to tell me about this medicine."
- **Pharmacist:** "Mrs. Rogers, I see you're in a hurry, so I will only cover three important things you need to know about taking the medicine. Would that be OK?"

Express Empathy

- When patients feel that they are understood, they may be more willing to share their experiences
- Sharing their experience allows providers to assess motivation and support needs in order to facilitate behavior change
- Importantly, when patients perceive empathy, they may be more open to "gentle challenges" for behavior change
- Patients may be more comfortable examining ambivalence about change and less likely to defend ideas like their denial of problems
- An accurate understanding of the patient's experience can facilitate change

Wagner C and Conners W. Motivational interviewing. Motivational Interviewing Principles. Available at http://www.motivationalinterview.net/clinical/principles.html. Accessed May 12, 2011.

Example of Express Empathy

- **Patient:** "Everyone makes it sound so easy — just take the medicine, quit smoking, change your diet, and exercise more!"
- **HCP:** "You sound frustrated. You have been asked to make a lot of changes to control your diabetes and people don't seem to appreciate how overwhelming and difficult all of it can be."
- **Patient**: "Exactly! This is impossible."
- **HCP**: "Would it be OK if I provide some information on those topics and you can decide what you want to work on first?"
- **Patient**: "That sounds reasonable."

Develop Discrepancy

- "Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be."[1]
- "Pros" and "cons" of making change need to be explored with patient[2]
  - Balance needs to be tipped to "pro" side for change to occur
- "When patients perceive that their current behaviors are not leading toward some important future goal, they become more motivated to make important life changes."[3]

1 Miller WR, et al. *Motivational Enhancement Therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1994, p. 8.

[2]Krueger KP, et al. *Adv Ther*. 2005;22:313-356.

[3]Wagner C and Conners W. Motivational interviewing. Motivational Interviewing Principles. Available at http://www.motivationalinterview.net/clinical/principles.html. Accessed 5/12/2011.

Example of Develop Discrepancy

- **Pharmacist:** "Mr. Brown, you haven't filled your blood pressure medicine in several weeks. What are your thoughts on how this might affect your goal we discussed during our last time about reducing your risk of heart attack and stroke?"

Importance and Confidence "Rulers"

- On a scale from 0 to 10, how important is it for you to…
  - And why are you at _____ and not zero?
  - The answer is "change talk"
- On a scale from 0 to 10, how confident are you that you could…
  - And why are you at _____ and not zero?
  - The answer is "ability talk"

Welch G, et al. *Diabetes Spectrum.* 2006;19:5-11.

Support Self-Efficacy

- Patient's belief that change is possible is important motivator to succeeding in making change
- Providers should support patients' sense of "self-efficacy" to keep them motivated
- In MI, there is no "right way" to change and when change does not work, patients can choose and carry out new actions to change
- In group classes or shared medical visits, having other people who have changed a variety of behaviors during their lifetime gives provider enormous power to show that people can change

Wagner C and Conners W. Motivational interviewing. Motivational Interviewing Principles. Available at http://www.motivationalinterview.net/clinical/principles.html. Accessed May 12, 2011.

Example of Support Self-Efficacy

- **Pharmacist:** "Mr. Simmons, it's great that you take your diabetes medicine every day as you planned. Keep it up! What things do you do to stay on track?"
- **HCP**: "I really believe you're on your way to better health since you are taking your statin daily to lower cholesterol and decrease risk of heart attack and stroke."

Motivational Interviewing

Part 2

OL Name
OL / NOLD
Medical Affairs, Sanofi US

Learning Objectives

- Define Motivational Interviewing and review guiding principles
- Provide strategies to elicit change in patient's behavior
- Learn 10 motivational interviewing tips to improve patient counseling
- Discuss the patient centered approach to motivational interviewing
- Assist the patient in making sense of their disease, care plan, and HC encounters
- Identify the patient's core concern and line of reasoning during MI counseling session

New Definition of MI

- **MI is a collaborative, person-centered form of information exchange to facilitate constructive patient sense-making about health.**
  - **Berger and Villaume, 2012**

MI Summary

- **MI is…**
  - Guided
  - Patient centric
  - Patient assesses understanding
  - Empathetic /understanding
  - Patient makes the decision
  - Tool box of options
  - Exploring resistance
  - Flexible
  - Building relationships/caring
  - Information exchange
  - Identifying barriers
  - LISTENING
  - Asking permission
- **MI is not…**
  - Directive
  - Provider centric
  - Provider claims understanding
  - Saying "I understand"
  - Provider makes the decision
  - A technique
  - Judgmental or Argumentative
  - Formal
  - Being offended or offensive
  - Information giving
  - Telling patient what to do
  - Dictating instructions
  - Assuming lack of knowledge

Ten Motivational Interviewing Tips

1. **Always keep the spirit of MI (caring) in the forefront of everything you do for the patient**
2. **Resistance and ambivalence are relational; When you experience them, you need to change how you are talking to the patient and EXPLORE**
3. **Change talk on the part of the patient means the conversation is in the right direction. Resistance is the signal that you have veered off course**
4. **Unless a current "problem" behavior is in conflict with something that the patient values more highly, there is no basis for motivational interviewing**

Miller WR and Rollnick S. *Motivational Interviewing, Second Edition: Preparing People for Change*. New York, NY: Guilford Press, 2002.

Ten Motivational Interviewing Tips

5. **Your patients are your teachers, offering you an opportunity to refine your reflective listening skills. Every patient TEACHES YOU what is important to them if you pay attention**

6. **You can tell you are on the right track when your communication enhances commitment/change talk**

7. **Learn to notice your own emotional and behavioral responses (e.g., anxiety) to patient's ambivalence and use it as a cue to respond differently. Realize the patient is providing valuable information that is disconcerting to YOU**

Miller WR and Rollnick S. *Motivational Interviewing, Second Edition: Preparing People for Change*. New York, NY: Guilford Press, 2002.

Ten Motivational Interviewing Tips

8. **Arguing against patient resistance forces the patient to defend "bad" behavior. Ambivalence occurs BECAUSE the patient weighs the good and the bad equally. Don't force the patient to defend the bad...EXPLORE!**
9. **LISTEN, LISTEN, LISTEN and reflect back what you understand**
10. **Reflecting your understanding does NOT mean agreement, it means that you understand and are not judgmental**

Miller WR and Rollnick S. *Motivational Interviewing, Second Edition: Preparing People for Change*. New York, NY: Guilford Press, 2002.

Explaining the Synergy of MI

- **IF the patient attributes the provision of information to such things as:**
  - **"The HCP is just going through the steps."**
  - **"The HCP is giving me the standard lecture."**
  - **"The HCP is running his/her own agenda."**
  - **"The HCP is putting me down."**
  - **"The HCP is blaming me."**
- **The patient will feel warranted to dismiss any information you have provided!!**

Explaining the Synergy of MI

- **IF the patient attributes the provision of information to all of the following:**
  - **"The HCP really cares about me."**
  - **"The HCP really understands and respects my issues and concerns."**
  - **"The HCP has provided information that directly addresses my issues and concerns."**
- ***The patient will feel the impulse to consider the information and possibly to draw a new conclusion***

Key Motivational Interviewing Takeaways

- **Motivational interviewing is concerned with assessing patient motivation for change, NOT motivating the patient[1]**
- **The patient's own reasons for change, and not the provider's, are most likely to trigger behavior change[1]**
- **Create a climate that is safe to change and safe to learn[2]**
- **Assist patient in making argument for change by exploring their ambivalence[1]**

[1]Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008.
[2]Newman CF. *Cogn Behav Pract*. 1994;1:47-69.

Key Motivational Interviewing Tips

- Look for opportunities to reflect your understanding
- Identify motivational issues
- Assess patient's understanding of illness and treatment
- Ask permission to give advice/information
- Explore decisional balance pros and cons
- When faced with ambivalence or resistance, EXPLORE – don't explain
- Respect patient autonomy

Rollnick S, et al. *Motivational Interviewing in Health Care. Helping Patients Change Behavior*. New York, NY: Guilford Press, 2008.

MI Evidence From 100+ Studies

- Works for clients regardless of problem severity, age, or gender
- Effective for a wide variety of problems
- Possibly more effective for ethnic minority patients
- Is equally learnable by practitioners of diverse professions
- Reported results are durable up to 1 year in RCTs

J of Clin Psychology 2009;65(11):1232-1245.

Evidence Supporting MI Efficacy

- Chen SM, et al. *Effects of motivational interviewing intervention on self-management, psychological and glycemic outcomes in type 2 diabetes: A randomized controlled trial.* Int J Nurs Stud. 2012 Jun;49(6):637-44.
- Berger BA, et al. *Evaluation of software-based telephone counseling to enhance medication persistency among patients with multiple sclerosis.* J Am Pharm Assoc 2005;45:1-7.
- Golin C, et al. *A 2-arm randomized, controlled trial of a motivational interviewing-based intervention to improve adherence to antiretorviral therapy (ART) among patients failing or initiating ART.* Acquir Immune Defic Syndr 2006:42; 42-51.
- Soria R. et al. *A randomized controlled trial of motivational interviewing for smoking cessation.* Br J Gen Pract 2006;56:768-74.
- Anshel MH, Kang M. *Effectiveness of motivational interviewing on changes in fitness, blood lipids, and exercise adherence of police officers: an outcome-based action study.* JCHC 2009;14:48-62.
- Brodie DA, et al. *Motivational interviewing to change quality of life for people with chronic heart failure: a randomized controlled trial.* Int J Nurs Stud 2008;45:489-500.

The following video vignettes (MET-11-06-02RML3) are for demonstrative purposes only. This is not an actual video of a real patient and HCP interview but a mock case illustration.

[redacted]

Provided for your medical information and general background.

[redacted]

Provided for your medical information and general background.

Ways to "Wrestle" With Patients

- Offer premature solutions
- Lecture and provide instructions
- Ask mainly closed-ended questions
- Persuade with logic
- Offer unsolicited advice
- Make a suggestion without asking permission

Motivational interviewing in health care: helping patients change behavior. New York, NY: The Guilford Press; 2008.

MI Strategy

"Motivational interviewing is like dancing rather than wrestling."

Motivational interviewing in health care: helping patients change behavior. New York, NY: The Guilford Press; 2008.

The Spirit of MI
Collaborative

- Partnership
- Active, collaborative conversation
- Joint decision-making process
- Shared power and control
- Dancing rather than wrestling

Motivational interviewing in health care: helping patients change behavior. New York, NY: The Guilford Press; 2008.

The Spirit of MI
Evocative

- Activating patient motivation for change
- Mobilizing patient resources
- Eliciting personal goals and values
- Connecting change with what matters to *patient*
- Encouraging patient to do most of the talking

Motivational interviewing in health care: helping patients change behavior. New York, NY: The Guilford Press; 2008.

The Spirit of MI
Honoring Patient Autonomy

- Detachment from outcomes
- Acceptance of patient choices
- Respect for the patient's perspective
- Acknowledgement of personal control

Motivational interviewing in health care: helping patients change behavior. New York, NY: The Guilford Press; 2008.

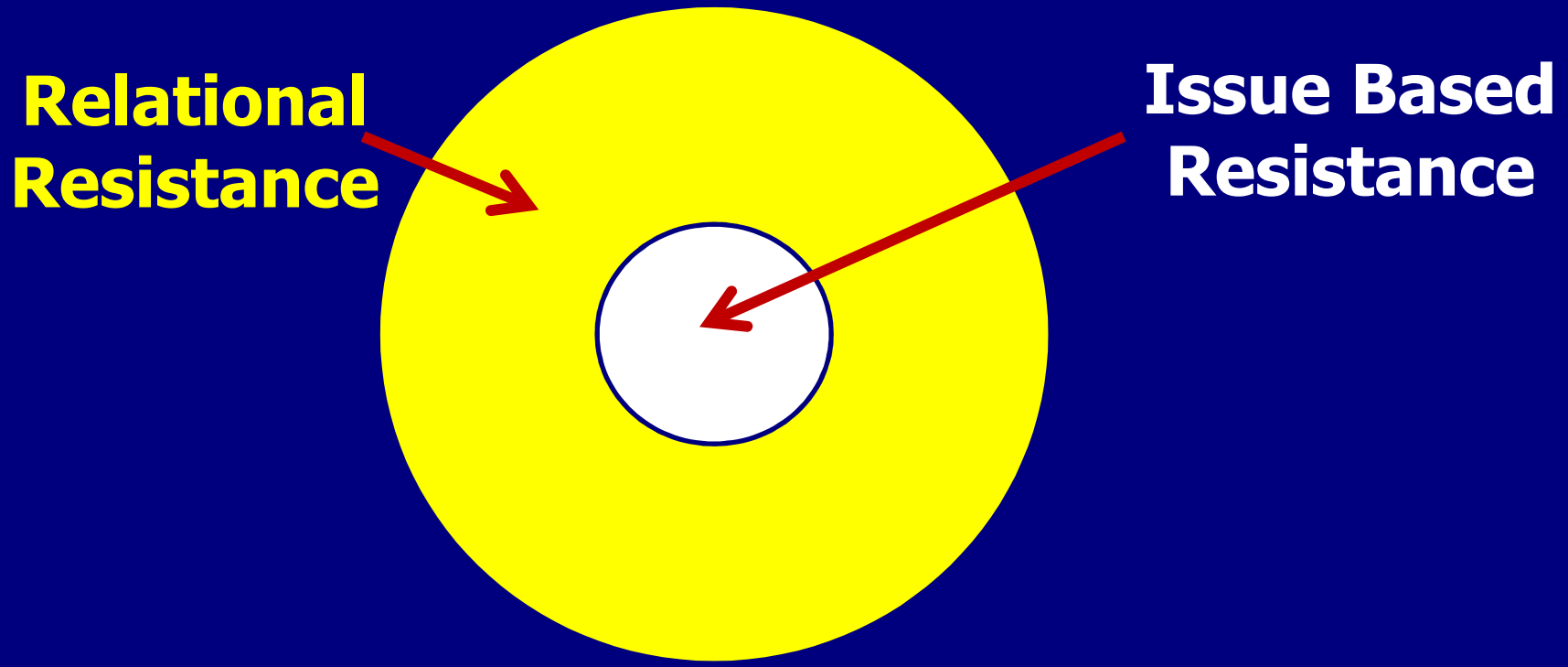
Overview: How Does MI Work?

- Human beings are sense makers
- MI focuses on facilitating patient sense making
- Patients are making sense of two things simultaneously
  - What's going on with my health or disease?
    - "I don't know why I need this medicine, I feel fine."
  - What's going on with this HCP?
    - "I don't like how he/she is talking to me."

Resistance Can Develop in Two Ways

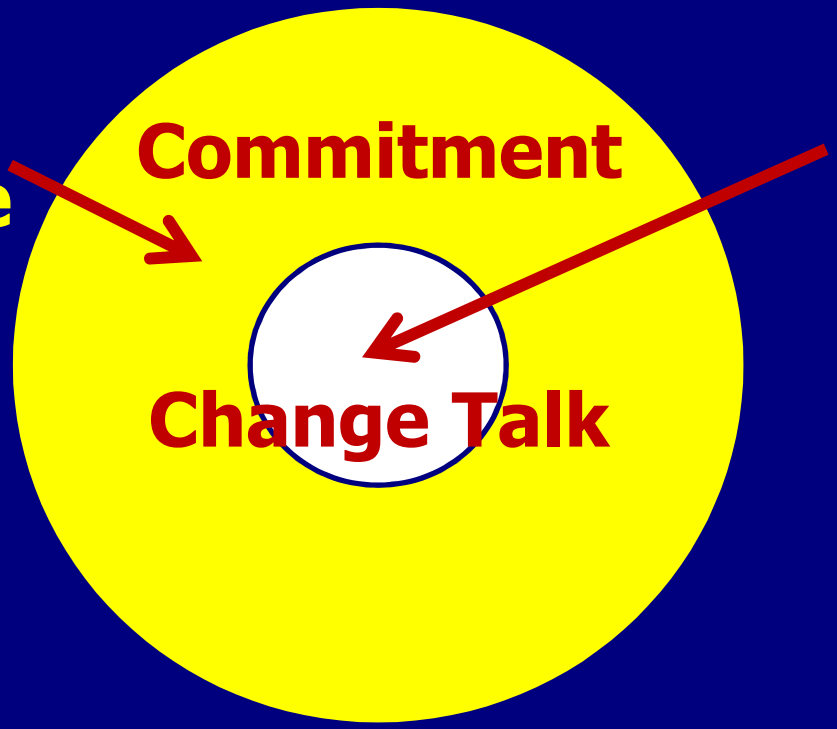
- **Issue Resistance**
  - Patient's sense making or reasoning about an issue
  - Involves all the concerns, worries, and doubts that lead patients to make decisions, e.g. ambivalence
  - Patients adjust practical reasoning as they make sense of changing circumstances or health status
- **Relational Resistance**
  - "I don't like how I am being treated; therefore I will resist doing what I think the HCP wants me to do."
  - Avoid face loss
  - MI reflects the patient's questions and concerns without judgment

Two Forms of Resistance



What MI Does: 2 Steps

Relational Resistance



Issue Based Resistance

Info #1
Info #2
Info #3
Info #4

Three Predictors of Motivation For Change

- **Importance**
  - "I need to take my medication to control my diabetes. I don't want to have all of those complications."
- **Confidence**
  - "I can manage what I need to do."
- **Rapport**
  - Essential to addressing importance and confidence
  - Allows the patient to hear your expertise as an extension of caring

MI Steps to Address Knowledge Deficits

- Develop rapport
- Reflect back your understanding of the patient's sense making
- Ask permission to provide information to address the patient's sense making
- Provide new information
- Ask the patient what he/she thinks of this new information
- Summarize and discuss next steps

Building Rapport

- Every day talk makes a lot implicit assumptions
- Others talk and we nod or say, "Right", "Yes", "Uh huh", "I understand", "Got it"
- Our training also teaches us how to talk to or at patients, rather than with patients. We are taught that we are the expert so often our talk is directed outward, rather than as an exchange of expertise and sense making
- MI changes both of these dynamics
  - We have to learn to become more explicit in responding to patients
  - We have to learn to exchange information to influence sense making

Building Rapport Examples

- **Patient: That's what the medicine's for. I shouldn't have to change my eating habits and lose weight if I take the medicine.**
- **HCP: That's not true; (or)**
- **HCP: Doctor said you have to lose 15 pounds.**

- **Patient: That's what the medicine's for. I shouldn't have to change my eating habits and lose weight if I take the medicine.**
- **HCP: You have done a great job of taking the medicine. At this point, you're frustrated and wondering why in the world would you need to do more?**

Core Concern and Line of Reasoning

Step 1: Acknowledge the patient's Core Concern

- What does the pt see as the problem or primary concern?
- Listen and reflect back in the form of a question
  - "So you're wondering…"

Step 2. Identify the patient's Line of Reasoning

- How does the patient make sense of their disease or therapy?
- Is their Line of Reasoning faulty?
- Avoid the 'Righting Reflex' or trying to fix the problem

Step 3. Target information directly to the patient's core concern

- Ask permission to provide information
- Encourage the patient to give you feedback
  - "May I provide some information on this topic and you can let me know what you think?"

Core Concern and Line of Reasoning

- **Core concern and line of reasoning must be addressed or you will not move forward with eliciting behavior change**
- **Respect and compassion are essential**
- **Patients will not change behavior if they fear they are losing face**
- **MI does not cause 'face loss'**
  - "You need to take your medication… We have been over this before. If you don't listen, you could go blind."
  - "Do you think your doctor would give you something that does not work? Why would the medication work for everyone else except you?"

Core Concern and Line of Reasoning

- Patients should have a good understanding of their disease and risks before recommending treatment options
- If the patient does not make sense of the risks or consequences of the unhealthy behavior (smoking, obesity), what is their motivation for change?
- Summarize on occasion to reflect and gather feedback
  - "This is what I have heard…"
  - "Here is where we are now…"

Core Concern and Line of Reasoning

- **After identifying and reflecting your understanding of the core concern and line of reasoning, ask permission to give information**
- **Present a menu of options and ask what the patient would like to work on first**
  - "Diabetes is controlled by medications, healthy eating, and physical activity. Which option would you like to work on (or discuss) first?"
  - "Treatment for high cholesterol involves statin medications, decreasing fat intake, and increasing exercise. Which option would you like to discuss first?"

Core Concern and Line of Reasoning

Pt: My diabetes is not that bad. My last A1C was 9% and my doctor told me the goal is < 7%. I am not that far off. Do I really need the new medication?

HCP: So you're wondering since your A1C is 9% which seems close to the goal, if you really need to take the new medication?

Pt: Right.

HCP: That is a great question. Would you mind if I gave you some information to address your concern, and you let me know what you think?

Pt: Sure.

Core Concern and Line of Reasoning

Pt: I just don't like taking medications every day… it's probably not good for you. I may become dependent on the meds.

HCP: You worry that taking medicine every day might actually be harmful and that you will become dependent on it.

Pt: Right. I am trying to avoid that.

HCP: I don't want that either. What concerns you most about taking the medication?

Pt: If I take the medication daily it could stop working.

HCP: Would you mind if I gave you some information to address your concern, and you let me know what you think?

Pt: Sure.

Dealing with Resistance

- Avoid correcting or persuading the patient
  - Forces the patient to defend the behavior you are trying to change
  - Creates relational resistance between HCP and patient
  - Safe, caring, non-judgmental relationship is paramount
- Resist trying to 'save' the patient… they must save themselves
- Behavior change must be voluntary
- Empathize and explore resistance

Empathy statements

- "You seem…"
- "In other words…"
- "You feel____ because____"
- "It seems to you…"
- "You seem to be saying…"
- "I gather that…"
- "You sound frustrated/concerned/worried…"
- AVOID "I understand"
  - The patient decides whether you understand

Express Empathy

- **Pt: Everyone makes it sound so easy… just take the medicine twice daily, quit smoking, change your diet, and exercise more!**
- **HCP: You sound overwhelmed and frustrated. You have been asked to make a lot of changes to control your diabetes and people don't seem to appreciate how overwhelming and challenging the task.**
- **Pt: That is right.**
- **HCP: May I tell you what concerns me?**

Exploring Resistance

- When faced with resistance or ambivalence, **explore** the patient's core concern
- Patients develop an internal decisional balance about the change (pros/cons, benefits/risks)
- Negotiate rather than dictate behavior change
- **Create dissonance** between where they are now and where they want to be regarding health

Developing Discrepancy

- **Anxiety or discomfort develops when patient's goals and desires do NOT match up with their behavior**
  - **Identify discrepancies in what patients say vs. do**
- **Take a "Look Over the Fence"**
  - **"If you woke up tomorrow smoke free, what would you like about that?"**
  - **"If you returned to clinic in 3 months with normal glucose values and your diabetes was under control, what would that feel like?"**
  - **"What would have to change to consider taking your medications to control your blood pressure?"**
  - **"If you had a stroke, how would that affect your life?"**

Self Efficacy

- Praise the patient for small changes; Tie that behavior change to a positive outcome
  - "That sounds like a great start to better control your DM"
  - "Tell me more about the changes you have made?"
- Ruler: On a scale of 1-10 how important is this change for you? Why ____, and not a 1?
  - Builds confidence; elicits change talk
- Ramp up their response: What would have to happen in your life to answer 9 or 10?

The Envelope

- Elicits change talk
- "If I were to hand you an envelope, what would the message have to say for you to:
  - Consider quitting smoking
  - Take your medicine every day
  - Start insulin injections every evening with dinner
  - Start the new medication to control your diabetes
  - Start exercising 3 times per week

Questions to Address

- What does the patient know and understand about the illness and its treatment?
- What is the patient's understanding of what can happen if the disease (or behavior) is not changed?
- What are the patient's goals for therapy
- What options are available to the patient?
- What does the patient want to work on first?

Summary

- Non-adherence to medications is a global issue that increases morbidity, mortality, and cost
- Patient behavior is an important component of adherence
- MI is a communication method that is guided and patient-centered, to elicit behavior change by helping patients explore and resolve ambivalence
- MI is concerned with assessing a patient's motivation for change, NOT motivating the patient
- The spirit of MI is collaborative, evocative, and honoring patient's autonomy
- Acknowledge (do not explain) the patient's core concern
- Create dissonance between the patient's goals and behaviors
- Respond with empathy and involve patient in the decision

Discussion Questions

- What are the patient characteristics that predict success or failure with diabetes medication adherence?
- How do you approach medication adherence?
  - Patient interviewing
  - Pharmacy claims or refill histories
  - Phone follow-up post new prescription or discharge
  - Individual vs Group visit
- What are the most effective tactics?
- What resources would improve diabetes adherence with your patients?

Suggested Readings

- Berger BA, Villaume WA, *Motivational Interviewing for Health Care Professionals: A Sensible Approach.* Washington, DC: American Pharmacists Association, 2013
- Miller WR and Rollnick S, *Motivational Interviewing, Second Edition: Preparing People for Change*. New York, NY: Guilford Press, 2002
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- Berger BA, *Communication Skills for Pharmacists: Building Relationships, Improving Patient Care*. 3rd edition. Washington, DC: American Pharmacists Association, 2009
- Rollnick S, Mason P, Butler C. *Health Behavior Change: A Guide for Practitioners*. London: Churchill Livingstone, 1999