Enhancing Motivation to Change: Motivational Interviewing in Primary Care

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Welcome and Introduction
Good afternoon and good morning and welcome to the atom Alliance Quality Innovation Network event entitled Enhancing Motivation to Change Motivational Interviewing in Primary Care.

I will be your moderator today.

The agenda includes opening remarks, a few housekeeping items, presentations, Q&A, and closing remarks.

atom Alliance is a five-year five-state initiative for powerful change in healthcare quality. We welcome participants from Alabama, Indiana, Kentucky, Mississippi and Tennessee, as well as other states that may be participating. Thank you for taking the time to join us. We appreciate all you do to improve quality and achieve better outcomes in health and healthcare.

Here are the objectives, you will learn how to describe motivational interviewing as a conceptual model, identify why the use of highly confrontational interventions are less likely to evoke behavior change, and earn basic concepts and techniques.

WebEx Chat, Q&A and Poll Instructions
Before we begin I would to run through a few housekeeping items, all the phone lines are on Mute however we encourage your participation throughout using the chat box. We will monitor the chat box for questions. We will respond to you there would be a link to download the slides from this presentation that will be posted in the chat box. Feel free to address the chat question now to test that.

You may also use the Q&A function to direct questions to certain individuals privately. During the presentation, we ask you please engage by participating in a few polling questions. Be sure to hit the submit button in the bottom right corner so we can capture your answer.

Polling Question
Here is the first question. Which screening tools are you currently using to assess behavioral health and or substance abuse?

If you do not know the name of the tool, please check other. Don't forget to hit the submit button.

I will give you a few moments to complete the poll.

**Introduction of Speakers**

Doctor Bailey is the Director of Integrated Services at Cherokee Health Systems. She provides leadership oversight and guidance on clinical services and is involved in consultation and training in integrated care. Doctor Hovis is a board-certified internal physician at Cherokee Health. She also provides clinical supervision and teaching for nurse practitioners.

I will go ahead and turn it over to Doctor Bailey and Doctor Hovis.

**Introduction and Background**

Thank you very much we're excited to be here with you today, to talk about what we see as a fundamentally important component of screening for an effectively treating behavioral health and substance use concerns and primary care and that is motivational interviewing. We want to start by talking about who we are giving you some context about our background, and then we will dive right into the topic, motivational interviewing.

We are employed by Cherokee health systems which is a large federally qualified health center, in Tennessee. The mission is consistent with the screening and treatment that we're talking about today. We think of the screening and treatment of behavioral health concerns is not just something to do it is really about the mission. We see that as a key part of improving the quality of the life of the patient and communities that we serve and we are blending behavioral health care with our primary care services.

The roots are in community mental health. We began in the early 70s as a community mental health organization, and first began incorporating primary care into our mental health clinics in 1979. We have several years of experience integrating behavioral health into primary care and really working to provide the best of both worlds to our patients by merging the mission of federally qualified health centers and community mental health centers.
The service area continues to expand, it expanded quite a bit. We have about 23 brick and mortar clinics throughout Tennessee, that now range from the mountaintop town of Clearfield, Tennessee in eastern Tennessee all the way to Memphis.

The corporate profile. We serve almost 74,000 patients last year and have a very diverse multidisciplinary staff, that includes a lot of psychologists, as well as primary care providers, medical specialists, psychiatrists, and community health workers.

As an organization, we focus on blending behavioral health into primary care, we have a saying that we do that by going where the grass is around us. We rely on our patients to show us where the unmet needs are, and that we work to address those needs.

We do a lot of training of healthcare providers, and do a lot of work via telehealth.

**Motivational Interviewing**
We will go into motivational interviewing.

**Poor Treatment Engagement**
First, patient engagement, poor treatment engagement is the behavior that has the most impact on outcomes and costs. The most underutilized resource is the patient. Patients to open our passive participants so it's on us to provide and will make them and empower them to actively engage. As a provider, a few things are more challenging than caring for a patient who struggles to engage in our recommended treatment and behavior change. Rather than giving these patients, who must either in the once as a component of the disease process and target that for treatment. Enhancing motivation and engaging them is a shared responsibility. It's really a partnership between patients and providers.

When I was first trained, we do not talk about this at all. We just were trained for action. We're trying to tell the patient what they need to do and implement a plan for them so when I came to Cherokee Health this was a new idea, that I knew to enhance the motivation of a patient and I could do that with my style of interaction.
Why don't patients change? As we think about why they don't change it helpful to think about why all of us struggle to change, change is hard. Think for a moment about a significant change -- [ No Audio ]

We apologize for the interruption. Sorry for the interruption. We should continue momentarily.

Welcome back. We were talking about why patients don't change. We have to think about why change matters.

We were talking about why patients struggle with change and it's because change is hard. If you think for a moment about a change you thought about but you have not started. You can think of a lot of reasons this change might be important, but you also know the challenges and the barriers costs that afforded the action in the past. So, we need to understand and validate the patient and help them reconcile the cost versus benefits. We must recognize that our treatment plan may be inconsistent with the patient's values, I have a lot of patients who don't value improving their A1c. They don't care about that. With those patients, my goal is to determine what do they value and how can I organize a treatment plan around that. A patient with significant diabetes and neuropathy may not care about improving his A1c, but instead values limiting the progression of his neuropathy so he can play baseball with his grandchildren.

**Stages of Change**

One thing that is important as we're intervening with patients is making sure that the intervention plan is not just matched to the patient level of severity of illness, but also to the readiness to change. We recognize that often when patients are seeing us, the complaint have nothing to do with the depression or the substance misuse that we identify through scrutiny. Often, the depression or substance use as an incidental finding that they do not plan to discuss during their visit. The way we have those conversations with patients are so important in determining the receptiveness and response to those conversations.

Many of you may be familiar with research done in the early 80s with Prochaska and DiClemente, that changed the way alcohol and drug treatment was provided. Before this time, treatment was very confrontational, and this made us really think more about the patient as an expert in their care plan and as an agent for change. Patients present with varying levels of motivation to change, ranging from
precontemplation, a patient that says I don't have a problem to contemplation that I have a problem, but I'm not sure I will change. This is a place where we see many of our patients, they recognize the depression is a problem with a substance use. It is a problem, but they are not at a place where they will change. Healthcare providers we are better equipped and comfortable intervening with patients that are in the preparation, action, or maintenance phase. This patient is more motivated, take action. They just need this skill and resource to be able to do that. We want to provide a common real-world example to help us illustrate the importance of the way we talk with patients about the goals.

A change you want to make in your life — I thought about getting back into running before I had children. I used to run most mornings. Now that I have two young children, it's been a goal that keeps getting put off. Running is a great goal you need the exercise and need that to be part of your life. Let's do it. I know that it's good for my health but I have two children. It's unrealistic.

What we need to do is make a plan to make this happen. You need to see that the running will impact your health and will improve your life over all regardless of your busy schedule.

I want to make a plan, but it is complicated.

We will stop there, but this is a good illustration of I think what happens with patients. We have a value. Something I said I wanted to do, about running, when I was pushed on that and him and I changed. When I was not ready and did not acknowledge, or allow me to discuss the obstacles. Instead of me talking about why I want to do something that I said was important to me, I started defending the status quo and say why I could not. Often, we can feel physical action with patients that yes, every great idea we have, that's [Indiscernible]

Ready for Action?

Are we ready for action? Providers are always in the action phase, are the patients? We are ready to go. We identify the problems, and we are ready to offer the evidence-based solutions. But if we're not careful, we will not offer intervention match to our own readiness without considering the patient and their motivation, values and level of engagement. In Cherokee Clinic, screening for depression and substance abuse are a routine part of care, as we believe there's really no health without mental health. Many times, the patient comments the present with a
complaint, such as back pain, and the fact that they are drinking 18 beers a day is an incidental finding because of our screening. If I refer every patient who drinks 18 beers a day and needs detox to alcohol and drugs, what would happen? Overwhelmingly, they don't go. They don't go because they are not ready. They often do not view the alcohol consumption as problematic. So why would they want treatment to stop? I began to understand that the best evidence-based treatment is the treatment that is a match, not only to the disparity of their symptoms, but also to the readiness to change.

Common pitfalls

It's not intuitive, is it? When I see a patient with poorly managed diabetes, drinking 18 beers a day, I feel compelled to give them a lecture or place a referral. In fact, that's what I was trained to do. I'm ready for action. The patient presents with alcohol dependence—they need detox. I was not trained to use both a symptom severity and their motivation to develop a patient-centered stage matched treatment plan. It sucks and it's frustrating. The provider recommends a treatment or offers the referral that the patient sees as a necessary, so the patient doesn't go. At a follow-up visit, nothing has changed, and both the provider and the patient feel defeated.

When the Plan Doesn't Work

It doesn't work, what happens is we create resistance, and defensiveness. Meaning our patients change when they are not ready and create resistance. It's just ineffective. Commonly patients will say yes, but, I'm sure we have all experienced this during a patient visit. No matter what great idea we have, the patient says yes. But, now when I hear “yes, but” from a patient, I immediately visualize a stop sign in my head. I want to recognize that their resistance is the queue. I push for action further and if they are comfortable with it, then I need to push no further. In fact, the motivational interviewing data indicated that if I push patients on demand, engage in a treatment that's not matched to the level of motivation, I make them less likely to change than if I did nothing at all.

One of the most important lessons is that change is incremental baby steps. I've learned that I cannot give up on my patients when they are not ready to change. Their lack of readiness is not a flaw within my patient. It is normal. It's an expected part of the disease process. Change starts small. Often, they are talking about the
possibility of changing and it's synergistic. So, if I have more than a longitudinal approach, I can help my patients engage in success of the desired health behavior.

Change Your Thinking

Changing our thinking about changing our patients. We must change the way we think about changing them. As providers, we tend to tell them what to do. We must understand what they value. They are really our guide. They are the most important resource that we need to utilize. So, our job is to guide the conversation with patients so they provide the argument for change. They come up with the idea themselves, and they can describe the potential benefit. We empower the patient to be the captain of their own treatment team. We normalize their experience of ambivalence and we give them responsibility for their health. More than anything, motivational interviewing is a “style” of interaction with our patients. At Cherokee, we think of motivational interviewing as a foundation on which any other interventions are built.

Polling Question

Let's stop for a second for the second polling question. If you will go ahead and give us a rating of how comfortable you feel using motivational interviewing to address a positive depression or substance misuse screening with a patient.

What is MI?

Motivational interviewing is a collaborative patient-centered way to have a conversation with our patients. That enhances motivation and strengthens their commitment to change.

One thing that really changes is, instead of us as healthcare providers always wearing the expert hat, then we must really develop a partnership with our patients and see our patients of having expertise in themselves and recognize that rather than motivation change being something we can impose on our patient, we have to enlist and confront them. I know that sometimes, as we talk with primary care providers about this, they think I don't want to do therapy with my patients. I don't have time. So, you had this type of thoughts. Initially it for like a burden that I was going to add something to my 15-minute visit with a patient that will require more time and more thought. But, as I became more familiar with interviewing and comfortable, I realize I'm not really adding a burden to the visit I'm just changing the way that I am interacting with the patient. Instead of talking about their
depression, assessing and offering the treatment that is available I'm asking them to talk about their depression what do they know about that and what they see as benefit to treatment, and getting a feel for where they are in the motivation to change. It's just a different approach.

Polling Results
To think about the poll, we have a range of comfort level with many of you saying that you are somewhat comfortable, some neutral, somewhat uncomfortable, so we have a lot of experts in the crowd. That's great.

Efficacy of MI
A quick look at motivational interviewing efficacy. We are now at the point with motivational interviewing that we can say there really is a plethora of data to support its efficacy. To me, one of the best things about the data associated is this is really data that came from consensus. It's not ivory tower data or from universities. This is data from places where you and I work, emergency rooms, clinics, hospitals, what it shows is that it works, there are significant effect sizes, significantly better than no treatment and it increases engagement and attention to change and that is what we're focusing on as much as anything in screening for depression and substance misuse. We have an opportunity to engage patients who are not currently getting treatment for these life altering problem. Engaging them in treatment with the intention to change is important.

Is like to see the statistic at the end of motivational interviewing took over 100 fewer minutes of treatment so hopefully in the long term this reduces the amount of time we have to spent on these topics.

MI in a Nutshell
In a nutshell, the goal of motivational interviewing is to avoid creating resistance. In the real-world example, we used a few moments ago, we tried to help me into running, immediately. She started to talk with me and she created resistance and I became defensive. So, the goal of motivational interviewing is to avoid that. We want to avoid creating resistance and instead, we want to guide the conversation so the patient elicits their own self-motivating statement as to why this change is important to them.

One way we do that is we work to create a discrepancy between their current behavior and the patient's goals and values. Often when we talk with a patient
about what is important to them. We recognize being able to play baseball with my son is important, being a good parent. Maybe their current behavior is not consistent with those goals. We want to help them recognize that. We might say, drinking keeps me from being able to go to my grandson’s baseball game. So, we might reflect back that it sounds like it's difficult for you to think about stopping drinking, but we really recognize that you want to play an active role in your grandson’s life and this is getting in the way. We want to help patients to see that discrepancy.

When we hear patients engaging in change, I should change, I could change, the benefits of change... Really, we want to stop and listen. I had a primary care provider tell me the other day they have found that that's a good point to do documentation when patients start to talk about the possibility of change. The data on motivational interviewing suggests if we let them talk, it can make a big difference. They are making the argument to change for themselves. When we hear that, pause, and let them talk at lunch -- if you routinely do that with your practice, listen and reflect. We want to restate what the patient has said. The patients that are just really difficult to contain during an appointment and they want to tell you a lot of stories or a lot of things, motivational interviewing can be a good style to contain them. A lot of times the function is that they want you to understand. The way to understand how difficult this problem is. So, when we can [ lost audio], then they no longer feel like they have to spent all that time telling us about it. I hear you saying you have given full for treatment, but your life is so busy right now, you wonder if you could take that on. The potential benefits of getting treatment would be X, Y, and Z. Really listening and showing the patient that we listen by giving that back to them.

The Dos and Don'ts of MI

DO

The do's and don'ts of motivational interviewing. One of the most important things we want to do is to express empathy. One thing that always amazes me in working with patients, especially around alcohol and drug problems, is how willing they are to accept feedback when we say things with genuine empathy and concern and in the right tone of voice. We want to listen and reflect back what the patient has said, and show them that we really care. We want to develop discrepancies between values and current behaviors. We want to avoid argumentation. I remember when I heard my first lecture on motivational interviewing, I thought to myself, maybe
that is why that patient walked out on me last week. Arguing is something we naturally want to do, because we feel like we have the points and we need to get through to the patient. We really want to avoid that. It will create more resistance with them and they are arguing against change. That's not what you want to do. We want to roll the resistance to the plan of care. We want to recognize in a moment where they are. What the level of motivation is and roll with that. We want to support their self-efficacy to change.

A great example of a patient that motivational interviewing was essential is a patient will call him John, he's a patient who presented to a Cherokee clinic one winter day. He was wearing a big brown trench coat that had the big square pockets, and he had two beers in each of the two front pockets. Right about the time that we had implemented expert screening, it did not take much formal screening to recognize this is a problem. As you can assess, just based on his presentation bringing beers to the appointment, John was not motivated. That's not why he was there. He certainly was not interested in talking about going to detox or stopping drinking. The approach we talked with John is really part of the beauty of using motivational interviewing and primary care and making that incremental baby steps to changes. Every time he visited for a nurse visit or sick visit, we talked about it. We talked about his values. We talked about the consequences of his consumption. We talked about how, perhaps he could live a life more consistent with his values if he cut back or decrease. A turning point for John was, one time he got a girlfriend, who did not like his drinking. It was causing problems. Suddenly, John had a very important value to him that in this relationship. Working with him gradually over time, he cut back on his drinking, and is now doing much better.

DON'T

We have a list of things that you want to avoid. We want to avoid thinking that we know what the patient should do or what they want to do, we want to avoid the mistake that their health is the primary motivating factor for them it is not the Navy at the doctor for a cup of their problem but their health may not be the primary factor it may be something about their lifestyle or another call they want to accomplish, if the patient doesn't decide to change themselves we think we failed want to avoid that also we have to have healthy boundaries and realized we have not failed this is an expected part of the disease process, we can stop there, and say
I see this is where we are askew discussing this or is it okay if we discussing this over time.

This is really a key place for everyone to see the patient as the expert. They are going to tell us what they value, and what they are ready to do, we don't want to make assumptions that what we value is what they value. Very often patients don't value health and wellness promotion the way we have, as healthcare providers. We are not sure what to do with the patient, where the best places we can go to say what is important to you. Then, we could organize a plan around that value, around the patient's value rather than the providers value. It will get a lot further.

**Specific MI Tools**

In terms of specific tools, one of the first things we can help patients to do is list the pros and cons for and against behavior change. We talked about one reason. Sometimes patients will go on and on and tell us lots of stories during visits. It's because they want us to understand. Sometimes they want us to understand how complex their life is and how difficult change is. I had a patient who was explaining how difficult it was for them to check their blood sugar every day. Sometimes when we can say that, I know this is really hard for you, checking your blood sugar and keeping this log. We show that we get it and can help them talk about the pros and cons. We can help them to reconcile that ambivalence and move closer towards readiness to make change.

We want to know how confident they are in the delivery to make change. We also want to help them to identify strategies that have worked in the past. This is consistent with the idea of the patient at the expert. Often, research shows that patients have had success in managing their condition even before they come to treatment. Helping them to identify what did you do in the past that was helpful. It's a good example of this is with substance use folks. I frequently see people who maybe went to detox and then they get out of treatment and they relapse five days later. Which they will conceptualize many times for themselves as a failure. What we can do is recognize the illness of success in this and say five days; you do not use for five days. What did you do differently for those five days? Helped you to identify the solutions that they have already used.

**Make a Plan**
Finally, if the patient is motivated, we want them to make a plan. We want to consider the options. I find especially in the rush of a busy primary care clinic, getting the patient a menu of options can be really helpful. And then letting the patient pick from those. In managing depression for example, we can talk about some ways that the patient might decrease time in bed during the day. We can talk about this handout that can help with strategies to improve your sleep and which one of those things seems like the best fit. So, in a very fast way, be able to move to a place of action if the patient is motivated.

**MI Pocket Cards**

I want to bring your attention to an excellent resource that is being developed by the atom Alliance, which are some motivational interviewing pockets of cards. Most of the content that we are using today are on this tip card. Which is a great way to keep this talk of mine, and the resource as we go through the day seeing patients.

**Confidence Rulers**

One of the most efficient motivational strategies I have used is the use of rulers. It is a quick way to assess where a patient is. As providers, we are excellent at addressing knowledge deficits. We often struggle to determine if a patient lack of progress is related to a knowledge or in motivational deficit, so intervention can be more appropriately targeted. I ask on a scale of one to ten, how motivated are you to make a change? And the matter what number they say, I always respond with why not less, why not lower, this is a fast, easy way to have a patient engage and change talk or tell me the reason they are considering this change, then I ask on a scale of 1 to 10 with 10 being the most how confident are you that you can make this change if you want to. These questions together helping to clarify if the patient has the knowledge or motivation and sometimes both. In general, I don't push the patient to pursue an action goal, unless they are motivation around a six or seven with 10 being the most.

**Change Talk**

I like the strategy you're talking about of using the ruler, I find that's one of the fastest ways to get a patient to engage in change talk when we ask on a scale of 1 to 10 with 10 being the most how motivated are you, anytime you respond to say why not lower they will give you the reason that they are motivated, that's exactly what we want, we want to use this tool for conversation, to ask the patient to make
the argument for change, another strategy I like is this question on the slide, if hypothetically you decided you wanted to cut back on your drinking what could be the potential benefits? Without pushing the patient to make change we are eliciting the reasons they might be motivated, I never cease to be amazed with the patient's response to that because it's often articulating a value I would never have come up with. So, recognizing the importance of change talk and the patient value, and we want to listen here and allowing the patient to engage in change talk. Even if we don't set any action goals is an intervention, sometimes that's hard to sit with when we are used to prescribing a medication. But, the most appropriate intervention is the one match to the readiness to change with the patient is not ready, we don't want to take that and this is a great intervention.

**Stage Matched Interventions**

Anticontemplation and Precontemplation

Let's look a little bit at stage match interventions. We've talked about the need to match interventions not only to the patient severity of illness, but also to the motivation to change. Let's break that down and think about what type of intervention we offer. Anti-contemplation, this is a newer stage that has been add to this area of research in the last few years. We can all appreciate this one. The idea, I resent your assertion that I have a problem. When we have a patient, who is presenting in the state- do not push. We want to convey readiness to help. So, it may sound something like- I respect you don't want to talk about this today. I want to partner with you to improve all aspects of your health. Can we talk another time? Really, the message we want to give is respect and they don't want to talk about it now. We're not going to agree to never talk about this important aspect of their health.

For a patient who is more in the precontemplation stage, thinking it's not a problem. We still don't want to push. This is a time when I might ask permission. One of the best ways to reduce a patient's defensiveness and level of resistance, is to ask their permission to give it. I might say would it be okay with you if I share why I am concerned about your depression? And then we might frame in the context of concern, I am concerned that your depression is impacting your quality of life. So, in this situation we just want to build awareness and insight without pushing the patient to do anything differently. One of the best strategies is asking permission.
Contemplation and Preparation

For a patient was contemplated, they recognize the problem, they're just not sure they want to change. We don't want to push too hard, but we want to encourage the patient to talk about the potential benefits of changing. This is a time when we might use that hypothetically you decide you want to make changes to the treatment of your depression what could be the benefit of changing. We don't want to push to an action step often with patients that we do once to pull from motivation and to see if we can get the patient to make an argument for change.

The preparation phase— this is a patient that recognizes the problem and the need to change, and they want to make change soon. These are the patients that I think we all feel equipped to help because of the patients that need strategies and skills. At this point we can start problem-solving barriers and identifying small action steps. This is the place where we can get a menu of options or talk with the patient about what they have done that is helpful.

Action and Maintenance

Finally, in the action or maintenance stage, these places are reinforcing progress and continued to problem solve barriers and to refine the action plan.

Case Studies

We want to spend a few minutes talking through some cases before we move into some discussion and Q&A.

Clyde

The first patient is Clyde. He a 66-year-old male was last seen six months ago, he presents today for routine follow-up care for his diabetes and hypertension, is PHQ2 to is prescreened with elevated so the PHQ9 was administered and that was moderately elevated with a score of 11. His wife died three months ago after a life full battle with cancer. In many clinics, it brings the screening results to you so how would you begin a conversation with this patient about the screening results and discuss possible treatment options.

The first thing I want to do is ask the patient permission, so I might ask would it be okay if we talk about your depression screening results.

I think asking permission is an excellent way to start. We know that that will make Mr. Myers much less likely to become defensive or resistant, to talk with you, if he
agrees to talk with you, which most patient give you permission to do. What would you say next?

Your depression screening was moderately elevated, which indicates you are feeling down, having trouble sleeping, little energy and the symptoms are impacting your functioning. Your wife recently passed and I am so sorry for your loss. Then I will work to understand more about the onset, duration, intensity of the symptoms. I might use a motivational ruler, and he was a six or seven or more on the motivational ruler, I would talk with him about medication, or a behavioral health consult.

That's a great way to start the conversation with this patient.

**John Doe**

Let's look at another patient. John Doe, a 31-year-old male, here for an ER follow-up to discuss recent aggressive behavior, the PHQ2 was positive and his PHQ9 score was minimally elevated with a score of 4 how would you begin the conversation?

The patient is presenting complaints of recent ER visits and discussion of recent aggressive behavior, it appears related to his depression screening. I might start having share his own concerns about his aggressive behavior. Then, after listening, I may ask permission to offer some education I find the patients frequently don't recognize that irritability is often a prominent symptom of depression. Linking his presenting complaint to depression screening might enhances motivation for treatment. His pH score is low, but if his symptoms are causing impairment, I would like will use a motivational ruler and discuss the treatment options.

This is a great example of the intent of why we are embedding the screening in primary care. We recognize that only that most people who get behavioral health treatment for depression get in primary care, but also, so many patients who don't get any treatment at all that are seen in primary care. We have the opportunity to identify these patients especially these patients with relatively mild symptoms, intervening more quickly and hopefully shift the trajectory of this illness, these mental health problems are so connected to the physical problems. The medical physical problems that we want to address otherwise so we can get to the bottom of the problem.
I remember the patient was altogether last week, the patient that we were initially targeting diabetes, she seemed so apathetic and she wasn't doing anything with that we had asked her to do. When we started to talk, she was vegetative depressed. We recognize we were never going to help her improve the management of her diabetes until we were able to help her treat her depression.

On the surface, she just appeared to have an attitude problem. But when we dove deeper we saw she was really depressed.

I think sometimes what might seem like a knowledge deficit, is really depression. Digging deeper and finding and making sure we are now merging all the complexity.

**Johnny**

Johnny Woods is a 26-year-old male who was been seem for the same day sick visit, his quick screen was positive and his AUDIT score was high. 35 out of 40. How would you intervene?

I started by asking his permission to discuss his screening results, then I might say something like the results indicate that their alcohol consumption is causing problems in your life. Are you concerned about your drinking? I would use his response to that to gauge his recognition of the consequences of his actions, and maybe consider using a motivational ruler if his level of motivation remains unclear. I might ask a question that would get the patient to engage in change talk like his hypothetically you decide to cut back or stop using alcohol what might be the potential benefit? If he was motivated at this point, I might offer him a menu of options. Like relapse prevention plans, getting some trigger handouts, or potentially a referral and let him choose what he was comfortable with. I recognize I'm not going to be able to effectively manage any of his chronic conditions if we don't partner over time to address his alcohol consumption.

One thing I recognize in caring for patients like this is because if the patient is not ready for a referral today doesn't mean they never will be. Sometimes I see part of our role in primary care is working to build that motivation, in a more appropriate level of care. Sometimes, we have to see them and care for them for a while.

**Polling Question**
Will have one last polling question and then we will open the lines for discussion. Are you familiar with referral resources for behavioral health and substance abuse that are available in your area?

Please feel free to type in any questions or discussion points.

We have about half and half. Many of you are familiar and others aren't.

**Discussion**
We will open it up for any questions. Any discussion? Do we have any questions? There are no questions. Please feel free to type any in.

I am wondering if you have any referral resources that you can share?

One of the best places for resources, nationally, is SAMSHA. SAMHSA has a fine treatment, I think it's actually SAMHSA@findtreatment.gov. They have a great database of treatment that you can look by ZIP Code, to find treatment resources and they also do a good job of breaking it down by payer source. You can look at the patient payer source and then determine what that might be eligible for.

Another great strategy since we are dealing with a Medicare population, looking at a number on the back of the insurance card that they can call and get a list of providers in their network. Then helping them to select the one that is best suited for them.

What about preventive care? Like a mammogram, colonoscopy or even an ammonia shot how can it be used in those cases?

I like the way you're thinking, this is a concept that is much broader than addressing screening, the first thing we must do is roll a patient's resistance. Once they tell us that they don't want to do something they start telling us why they cannot or won't we want to not push, then one of the best places we can go is to figure out what do they value and what is important to them. How can you align that with the care plan or the goals you have for them? Especially with mammograms we see a lot of times that is associated with trauma history or depression. So, asking the patient to talk to you about why they do not want that preventive care is important.

That may be along the lines of the next question, of what recommendations do you have to handle those patients who are resistant to treatment?
I think one of the main things is you must roll with this. Don't push, sometimes patients are resistant to show the resistance in words and sometimes they show it in behavior. What they are really telling us when they don't follow through with the referral is I am not ready. That lets you know that you have a lot of work to do and take it slowly. The primary care is a longitudinal relationship. We want to make that slow systematic process in the story of John, the guy with the two beers in each pocket, it probably took me six, eight years to get him to the point where he had a value that really made him want to stop drinking. But that's okay. Sometimes when we push too far, for patients to do what we want to do, they don't come back.

I agree, we must show respect for the patient. I think patients appreciate what we say. I respect your point of view and you don't want to get this test done at this time. You are not the only one, especially if you know why you can validate some of those feelings, but also asking questions about is it okay. We continue to talk about this over time. Is it okay about offering you education? Just because we are being patient centered doesn't mean we don't want to educate. Some patients may not realize what they are smoking or what the alcohol use is doing in their lives. We still want to give education, but we need to give it with an error of respect and patience and permission. Is it okay if I provide you some education about potential harm? Maybe you can even move past that we start to discuss benefits of making the change.

The permission is important and it brings down the resistance because they are allowing you to begin that behavior change conversation.

**Closing**

We have answered all questions. Thank you again and thank you to all the participants for joining our call today, especially with some of the technical difficulties we had, the atom Alliance staff is here to help! Please feel free to contact us if you have any questions about what you just heard or if you need technical assistance. Please take a few minutes to complete our survey. Your feedback is valuable and will help us to shape future learning events.

This call was recorded, the recording and transcript will be posted on the atomalliance.org website. You can also check our past presentations under the on-demand section. We would love to see you, so please feel free to like us or connect with us on our various social media platforms. Thank you for your participation have a great afternoon everyone.