



## Short communication

# Effect of teaching motivational interviewing via communication coaching on clinician and patient satisfaction in primary care and pediatric obesity-focused offices



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## ABSTRACT

**Objective:** Studies indicate needed improvement in clinician communication and patient satisfaction. Motivational interviewing (MI) helps promote patient behavior change and improves satisfaction. In this pilot study, we tested a coaching intervention to teach MI to all clinic staff to improve clinician and patient satisfaction.

**Methods:** We included four clinics ( $n = 29$  staff members). In the intervention clinics (one primary care and one pediatric obesity-focused), we trained all clinic staff in MI through meetings as a group seven times, directly observing clinicians in practice 4–10 times, and providing real-time feedback on MI techniques. In all clinics, we assessed patient satisfaction via anonymous surveys and also assessed clinician burnout and self-rated MI skills.

**Results:** Clinicians in the intervention clinics reported improvements in burnout scores, self-rated MI skills, and perceived cohesion whereas clinicians in the control clinic reported worse scores. Patient satisfaction improved in the intervention clinics more than in the control clinics.

**Conclusion:** This is the first study to find some benefit of training an entire clinic staff in MI via a coaching model.

**Practice implications:** It might help to train staff in MI to improve clinician satisfaction, team cohesion, perceived skills, and patient satisfaction.

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## 1. Introduction

Motivational interviewing (MI) has 30 years of evidence showing its positive effect on patient health and satisfaction [1]. MI has only recently been introduced into health care encounters and has much less evidence of its efficacy. Some studies suggest its promise however [2,3]. It is suggested that

when clinicians use MI and their patients make more changes, clinicians will find their career more satisfying and feel less burnout. This has not been studied yet, though. MI includes understanding patients' perspectives, recognizing and accepting desire for change, facilitating collaborative solutions, motivation via "change talk," affirming autonomy, and mobilizing commitment to action.

Despite the promise of MI, teaching physicians MI using in-person trainings or online modules is challenging: curricula lack standardization, teaching is difficult to disseminate, and few include real-world feedback [3–9]. Our previous online interventions included audio recording and coding of encounters, and were

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costly and time consuming. The long-term effect of these online interventions is unknown.

A promising adult-learning strategy for teaching interpersonal skills is *communication coaching*: the shadowing of participants and giving immediate feedback. This pilot's aim was to test an MI communication coaching model in primary care and pediatric obesity-focused clinics. We hypothesized that in the intervention clinics (1) patients would report greater provider satisfaction and (2) clinicians would report less burnout and greater mastery of MI skills.

## 2. Methods

### 2.1. Recruitment

This protocol was approved by the Duke University School of Medicine IRB. Two primary care and two pediatric obesity-focused clinics participated in the study. The primary care clinics were randomized to control or intervention; the pediatric clinics were assigned, given the proximity of one of the clinics to the MI preceptors. Clinicians in all four clinics gave written consent and completed baseline and post-intervention surveys.

### 2.2. Intervention

Coaches trained intervention staff using a comprehensive approach. (1) Coaches provided a one-hour overview of MI to the group and repeated group coaching sessions monthly. (2) Coaches shadowed staff and clinicians in actual encounters, and provided feedback on up to 10 encounters. Using MI techniques, coaches affirmed and labeled effective behaviors and had clinicians and staff problem-solve on how to handle the harder parts of the encounters. Coaches provided feedback to clinicians on opportunities to use MI techniques. (3) Coaches provided written and timely feedback on each observed encounter, including "MI Spirit" (collaboration, acceptance, evocation, and compassion), the OARS (open-ended questions, affirmations, reflections, and summaries), and the four processes (engaging, focusing, evoking, planning). Staff and clinicians in the control group provided standard care.

### 2.3. Baseline measures

We assessed clinician and staff age, gender, race, ethnicity, years since medical/physician assistant/nursing school (for clinicians only), and prior MI training (including behavioral change counseling and MI techniques training).

We assessed patient satisfaction in all clinics two days pre- and eight days post-intervention. We used the Session Rating Scale (SRS) to anonymously rate patient satisfaction in the primary care clinics [10]. This scale has 4 items on a 10 cm visual analog scale with a possible score of 40; a score of at least 36 indicates adequate satisfaction. In the pediatric clinics, we learned from our work in the primary care clinic and changed our patient survey to assess patient-perceived clinician empathy via anonymous surveys with a summed 10-item scale ( $\alpha = 0.95$ ; e.g., "Thinking about your visit

with your doctor, how was your doctor at fully understanding your concerns?") (1 = Not at all good to 5 = Extremely good)) [11].

We assessed clinician satisfaction in the pediatric clinics pre and post-intervention using the Maslach Burnout Inventory,  $r = 0.82$  [12] that has three subscales: emotional exhaustion, depersonalization, and personal accomplishment. We also assessed how much clinicians felt they were working together as a team, "How cohesive do you feel the entire clinic staff is," (1 = Not at all cohesive, 5 = Extremely cohesive) and "How much do you feel entire clinic staff has a common goal?" (1 = Does not have a common goal, 5 = Totally has a common goal). We assessed clinician and staff uptake of MI methods using the 12-item Motivational Interviewing Assessment: Supervisory Tools for Enhancing Performance [13].

We assessed four barriers to discussing behavior change [14], and assessed confidence in using 6 MI techniques. Finally, we assessed clinicians' perceptions: have they changed clinical practice as a result of coaching, was coaching worth their time, and would they recommend coaching to a colleague.

### 2.4. Analyses

We used SAS (Version 9.2: SAS Institute, Cary, NC) to examine differences in outcomes. We used multilevel mixed models (GLM) to include treatment arm, time and baseline covariate for each primary and secondary outcome.

## 3. Results

Table 1 shows demographic characteristics of the 29 clinicians included in the study.

### 3.1. Patient satisfaction

In the primary care clinics, we collected 264 anonymous patient satisfaction surveys over 18 days, including 2 days prior to the intervention. We found increases in satisfaction among patients surveyed post-intervention compared to pre-intervention in the intervention arm but not in the control arm. Patients in the control clinic started with high satisfaction scores that did not change over time ( $M = 37.4$ ,  $SD = 4.4$ , vs.  $M = 37.4$ ,  $SD = 6.0$ ). In the intervention clinic, patients' ratings were lower pre-intervention ( $M = 36.5$ ,  $SD = 5.9$ ), and improved post-intervention to exceed the 36 score threshold ( $M = 37.8$ ,  $SD = 2.8$ ).

In the pediatric clinics, we surveyed 114 patients over 10 days, including 2 days prior to the intervention starting. Patients in both the control and intervention clinics showed slight increases in perceived empathy from pre- to post-intervention: (control:  $M = 46.3$ ,  $SD = 4.4$ , vs.  $M = 47.7$ ,  $SD = 3.5$ ; intervention:  $M = 44.2$ ,  $SD = 5.3$ , vs.  $M = 45.9$ ,  $SD = 6.5$ ).

### 3.2. Physician satisfaction, team cohesiveness, and self-rated skills

We found differences in pre- and post-intervention burnout scores for all three subscales, clinician self-rated MI skills, and

**Table 1**  
Clinician characteristics.

Characteristic	Overall (N=29) M (SD)/%	Intervention (N=14) M (SD)/%	Control (N=15) M (SD)/%
Age (M, SD) <sup>a</sup>	43 (11.3)	44 (9.0)	41 (13.5)
White/Asian race (%)	97	93	100
Female (%)	90	93	87
Specialty pediatrics (%)	48	50	47
Prior MITI training (%) <sup>b</sup>	74	64	85

<sup>a</sup> Three clinicians did not report age (intervention:  $n = 1$  and control:  $n = 2$ ).

<sup>b</sup> Two clinicians in control arm did not report prior MITI training.

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