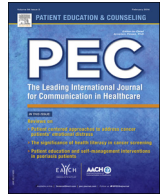




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Short communication

A research coding method to evaluate a smoking cessation model for training residents—A preliminary report

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ABSTRACT

Objective: Develop a reliable coding method of a cigarette cessation model used to train residents – a preliminary report.

Methods: Two trained (30 h) undergraduates coded videotaped interviews from 161 resident-simulated patient (SP) interactions. To establish reliability, coders coded 33 (20%) of 161 study set tapes for the BHTM. Cohen's Kappa and percent of agreement were used to measure coders' reliability in unitizing and coding residents' skills for eliciting 5 variables: Educating, Informing, and Motivating (3 items); Commitment and Goals (3 items); Negotiate Plan (7 items); Patient-Centered Skills (9 items); Emotional Skills (6 items).

Results: 50 items were dichotomized a priori from analysis of the training model and were reduced to 28 during training. Kappa ranged from 0.73 to 0.87 for the 5 variables and 28 individual items. The overall kappa was 0.84, and percent of agreement was 93%. Percent of agreement by item ranged from 82 to 100%.

Conclusions: A highly reliable coding method, weighted (by no. of items) to highlight the key elements of the teaching, is recommended for investigators wishing to better focus on the partnership, emotions, and planning.

Practice implications: This is a unique way to integrate patient-centered skills into motivational interviewing.

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1. Introduction

Although declining from 20.9% in 2005, the Center for Disease Control and Prevention reported that, in 2015, 15.1% of adults over 18 years of age currently smoked cigarettes. Smoking is the leading cause of preventable disease and death in the U.S., accounting for >480,000 deaths yearly, one of every five deaths, and >16 million Americans live with a smoking related disease [1]. Efforts to train clinicians to encourage patients to stop smoking have had variable results, several studies disappointing [2].

We are conducting a 5-year trial testing the training of residents in many facets of behavioral health, one of which is smoking cessation [3]. For this, we needed a measure to evaluate the success of residents' learning a method that integrates patient-centered and motivational interviewing principles [4,5]. The method, summarized in Table 1, provided greater emphasis on patient-

centered skills and on planning than most motivational interviewing approaches [4–pp. 147–151].

This paper reports our development of a coding procedure to evaluate this teaching method. We reviewed a number of existing measures of motivational interviewing, reviewed in Discussion, but we sought higher reliabilities and a method undergraduates could code. We also wanted to identify specific key behaviors, the presence or absence of which could be used in providing feedback to learners. These issues led us to dichotomize specific behaviors to be coded as present or absent. To avoid the loss of information that can attend yes/no responses, we weighted the key variables with greater numbers of items.

2. Methods

2.1. Design, setting, and participants

The research team videotaped residents once interviewing standardized patients (SP) in a modern simulation center. Residents (n=161) were primarily international graduates (n=89/161, 55%) and male (n=93, 58%). The ethnicity was Asian

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Table 1
Smoking Cessation Model, Abbreviated (From Laminated Card Provided to Residents).**INFORM AND MOTIVATE TO QUIT SMOKING****Education**

1. **ASK** – “What’s Your Understanding”
 - a. Is there a problem with smoking
 - b. What is the problem
2. **TELL** –
 - “There are Bad Outcomes”
 - a. Cancer, COPD, CVD, premature death/disability
 - b. Non-medical (cost, ostracism)
 - “You need to quit”
 - c. Need to quit completely
 - d. Help available (you, medications, groups)
 - e. Treatment works
 - “You can do it”
 - f. Capacity to change
 - g. Past failures don’t mean anything
3. **ASK** – “Please summarize what you’ve heard”

Commitment

1. **ASK** – “Are you committed to treatment”
2. **TELL** – “You need to be active, I can’t do by myself”
3. **ASK** – “Please summarize your commitment”

Goals

1. Obtain *long-term goals* → achieve via Plan (next)

Negotiate Plan

1. *Determine* present smoking behaviors in detail
2. *Negotiate*
 - a. Changes in specific behaviors
 - b. Bupropion, nicotine replacement, varenicline
 - c. Group work
 - d. Exercise &/or relaxation program
 - e. Follow-up visit with you
3. Have *patient summarize* treatment plan
4. *Praise* patient for commitment

ASK for EMOTIONS and use NURS at each

COPD = chronic obstructive pulmonary disease; CVD = cardiovascular disease; NURS = Naming the emotion; Understanding the emotion; Respecting the emotion; Supporting the emotion.

(n = 71, 44%), Caucasian (n = 57, 35%), Black (n = 5, 3%), Hispanic/Latino (n = 1, < 1%), and another race or ethnicity (n = 27, 17%). At the time of data collection, resident’s training level ranged from 0 to 3 years. There were 12 SPs: 8 female, 4 male; 11 Caucasian, 1 black. SPs ranged in age from 38 to 58 years. The present report is part of a larger study comprising three interviews [3]; only the smoking cessation interview is reported here. Training of SPs initially included 20 h, with approximately 6.5 additional hours of training/year to ensure fidelity. Scenarios, instructions, and scripts provided to SPs are available from the authors. The university Institutional Review Board approved this project.

2.2. Procedure

We constructed a scenario that SPs portrayed in a 15 min interaction to test 161 residents’ skills with a Smoking Cessation Model (Table 1). Each interview occurred in a modern simulation center and was allotted 15 min. The authors trained two undergraduate students, independent of the study, to rate resident-SP interactions. Over two months, the authors met two times per week with coders for a total of 30 h. Pilot videotapes were used to train coders. Videotapes were reviewed in person, and coding agreements were reached by discussing discrepancies in coders’ identification of the content and ratings until there was

clarity on definitions. Once trained, coders required approximately 30 min per, on average, 12 min videotapes (range 6–15 min). Coders first reviewed the tape in its entirety and then a second time to ensure quality ratings.

2.3. Instrumentation

We structured our coding procedure to reflect the Smoking Cessation Model in Table 1 [4–pp. 147–151]. It is derived from a rich literature in patient-centered interviewing and motivational interviewing [4,6]. The authors identified as many ways as possible that we might dichotomously depict the skills in the model. After several iterations and removal of confusing and redundant items, we identified 50 yes/no items. During rater training, we excluded 22 additional items, retaining the 28 items where coders consistently agreed with each other and with our conceptual and operational definitions; see Table 2 for the coding sheet.

We created five variables, and the 28 variable items were assigned in proportion to their importance in the basic Smoking Cessation Model (Table 1). The 5 coding variables were: 1) Educating, Informing, and Motivating (3 items); 2) Commitment and Goals (3 items); 3) Negotiate Plan (7 items); 4) Non-Emotion Patient-Centered Skills (9 items); and 5) Patient-Centered Emotional Skills (6 items). The first three variables contain items that

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