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Introducing the Health Coach Method of Motivational Interviewing to Medical Assistants to Improve the Patient Care Approach

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This is to certify that the doctoral study by

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Abstract

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MSN, Walden University, 2014

BSN, University of Phoenix, 2010

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The emerging health care culture of accountability for patient outcomes compounds problems for already overwhelmed clinicians struggling to fit everything entailed in complicated office visits into 15-minute appointments. Unprocessed frustrations tempt clinicians to use ineffective and outdated methods for trying to get their patients to comply or adhere to their care plans, undermining effective health care management. The intention of this project was to evaluate whether educating medical assistants in the health coaching method of motivational interviewing can improve the patient care approach while simultaneously assisting clinicians struggling with insufficient time. Several individual scheduling conflicts limited the target population into two primary care medical assistants and two auxiliary primary care office staff who voluntarily chose to learn the new approach. Guided by the adult learning theory, an educational lecture project was designed to capture the spirit of motivational interviewing through basic descriptions and strategies that will assist learners to focus on person-centered conversation skills, helping to balance both the needs of the patient and clinician. Following the education, participants filled out an anonymous post-lecture evaluation questionnaire to provide immediate feedback about learner understanding. Responses indicated the project met its stated objectives, and results showed the versatility of the motivational interviewing method which can be learned and effectively applied by health care workers from a wide range of professional backgrounds. Motivational interviewing is an innovative approach that utilizes therapeutic communication to promote behavior changes that lead to improved health of our communities and country.

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Dedication

I would like to dedicate this project to my parents Herbert and Sandra Souza and grandparents Augustino J. Lavezzari and Agnes Souza. As always, motivation to achieve my milestones are driven by your unconditional love, encouragement and unwavering support.

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Section 1: Overview of the Evidence-Based Project

Introduction

Discouraging statistics and the high cost of health care associated with chronic conditions show traditional methods are failing to meet the idea of patient-centered care. At a time when one in five people will die of lifestyle-related disease, and when diabetes and obesity are at an all-time high, society desperately needs lifestyle guidance to find its way back to health (Haskins, 2015). Health care professionals need to reassess their approach to patients to ensure patients understand important health information, make informed decisions, and participate in self-care management. However, this need for reassessment poses challenges to already overwhelmed clinicians struggling to fit everything encompassed in today's complicated office visits into 15-minute appointments. My intention in this paper is to describe the doctorate in nursing practice scholarly project I developed to evaluate whether educating medical assistants (MAs) in the health coaching method of motivational interviewing (MI) can improve patient care while simultaneously assisting clinicians struggling with insufficient time.

Problem Statement

In the emerging health care culture of accountability for patient outcomes, clinicians are more tempted to use ineffective methods of behavior change such as reciting educational information, using scare tactics, or even antagonizing the patient; this unprocessed provider frustration is a hidden threat to good health care (Burg & Oyama, 2015). Evidence shows that authoritarian, confrontational, forceful, or guilt-inducing

attitudes not only limit progress, but also correlate with an increase in patient resistance and negative behavioral and clinical outcomes (Linden, Butterworth, & Prochaska 2010).

There is no question that self-care management strategies can be frustrating for clinicians to implement; the problem is that they must be aware of how attitudes limit approaches to clinical practice and undermine effective health care management (Delamater, 2006). Yet, some clinicians continue to use fear-based messages when advising patients about chronic disease self-management or prevention, especially when faced with patients believed to be unmotivated or non-adherent (Kandula & Wynia, 2015). In such situations, using fear as a tool is appealing because instinctively fear can be a powerful motivator creating an emotional reaction to potential threats of disease, disability, or death, which are thought to motivate behavior changes (Kandula & Wynia, 2015). Research has demonstrated otherwise. Fear-based appeals have been extensively tested, and empirical findings in several meta-analyses clearly show that threatening communication methods are ineffective and do not elicit behavior changes (Ruiter, Kessels, Peters & Kok, 2014).

A recent meta-analysis by Peters, Ruiter, and Kok (2013) found that threatening patients with bad outcomes fails to persuade behavior changes, but instead has significantly negative effects including defensive and health-defeating behaviors. That is, fear-based appeals do not translate into health promoting messages regarding how make the healthy behavior changes possible. One study cited within Peters et al.'s meta-analysis evaluated internet interventions. In this study, Webb, Joseph, Yardley, and Michie (2010) found that one of the five most powerful behavior change methods was

general communication skills training. Counterproductive responses may be avoided simply by changing the communication approach.

Health care professionals must abandon outdated concepts of trying to get their patients to comply or adhere; instead patient care approaches must shift to patient responsibility for self-management, and to a new patient-provider collaborative relationship (Delamater, 2006). In this DNP project, I sought to evaluate whether educating MAs in the health coach method of MI can improve the patient care approach while simultaneously assisting clinicians struggling with insufficient time.

Purpose Statement and Project Objectives

Health coaches assist patients in acquiring knowledge, skills, and attitudes to become active participants in their care so that they can reach their self-identified health goals (Bennett, Coleman, Parry, Bodenheimer, & Chen, 2010). The MI method is focused on patient centered care, and is specifically designed to address and resolve ambivalence to change. This innovative strategy helps patients establish and attain lifestyle-related behaviors to reduce health risks, improve self-care management of chronic diseases, and increase quality of life (Linden, Butterworth, & Prochaska 2010).

MI is designed to change the direction of a conversation in order to stimulate the patient's desire to change and give them the confidence to do so (Stewart & Fox, 2011). Nearly every clinician has been in the position where patients present with chronic diseases directly associated with their lifestyle habits and choices. In addition, patients sometimes express beliefs and feelings that they are powerless to improve their conditions (Stewart & Fox, 2011). Often, healthy changes patients should make are

obvious to healthcare clinicians; what is not so obvious is where these patients are on their journey toward healthy changes or why they are so reluctant to make them. This moment when patients are at the crossroads of feelings of ambivalence and frustration presents the perfect opportunity to use MI, (Stewart & Fox, 2011).

MI can be adapted into a brief form that any busy health care professional can implement (Abramowitz & Franses, n.d.). In the healthcare field alone there are incredible application opportunities for using brief MI lectures. Introductory MI lectures have been developed for schools of medicine, residency faculties, nurse practitioner schools, group medical practices, university health centers, and community health centers (Abramowitz & Franses, n.d.). Although any professional can apply the MI method to practice, I designed this project with scheduling considerations to direct patient care staff. Thus, the goal was to provide the primary care office MAs with an educational lecture design that can be implemented in the least amount of time in order to avoid disrupting the primary care practice.

MAs are considered essential staff in most primary care practices who carry out a variety of medically-based job responsibilities. The most important job responsibility is to keep patients flowing smoothly through the office by ensuring that providers have the most accurate information needed for each assessment. Considering that the MAs are one of the first points of contact for patients, their approach to patients can be expanded upon. Thus education on the health coaching style of MI can help MAs broaden their roles in preventive care. Through better utilization of MAs, there can be an increase in practice workflow efficiency because clinicians can focus on tasks that require their level of

expertise (Bodenheimer, Willard-Grace, & Ghorob, 2014). Education on MI can help establish self-management support to patients with chronic conditions, assist them with lifestyle changes and medication adherence, and encourage them to be active participants in their care. Studies of programs using MAs as health coaches have shown positive trends for hemoglobin A1C levels, blood pressure, cholesterol levels, BMI, and smoking cessation rates (Bodenheimer, Willard-Grace, & Ghorob, 2014). At my project site for lecture implementation there is one MA assigned to each physician, with supportive administration staff. Since there are no nurses or mid-level providers at this site, I chose MAs as the target group. I designed the educational lecture to capture the spirit of MI through basic descriptions and strategies that will assist the MAs in their conversational approach to patient-centered care.

Objective 1

My first objective was to collaborate with a certified health coach to develop a brief form MI lecture designed to introduce primary care MAs to the basics of MI conversation approaches. When designing the MI lecture materials I used the O.A.R.S. acronym which offers four simple reminders: ask open-ended questions, provide affirmation to the patient, use reflective listening, and summarize the discussion for the patient. In the lecture, I summarized O.A.R.S. to explain how (a) broader questions allow patients to respond with more freedom; (b) affirmations express empathy during difficult stages and praise for goals accomplished by patients (c) reflective listening allows patients to express their own thoughts instead of telling them what to do, and facilitates collaboration to arrive at a compromise for changes; and (d) summarizing recaptures

relevant elements of what the patient has said and allows the patient to correct any misunderstandings in the conversation (Stewart & Fox, 2011).

Every decision that a patient makes throughout the day has an influence on her or his health. However, we must also consider that experience, skill level, motivation, culture, confidence, habits, function, cognition, support systems, and access to care are all key factors that can affect self-care management (Riegel, Jaarsma, & Stromberg, 2012). Thus the O.A.R.S. acronym is a simple reminder that can be used as a prompt to help MAs evaluate and improve upon their approach to patients' health promotion and self-care behaviors.

Objective 2

My second objective was to implement the educational MI lecture to the primary care office MAs, clarifying to the learners that the educational materials are a basic explanation and only a starting point. The main point of the lecture was to stress to the staff that the MI approach relies heavily on a partnership between health care professionals and patients, and works to avoid the outdated authoritarian approach of just telling someone what to do. Emphasis was placed on the need for continuing maintenance of the method and continuing education outside the facility to become truly proficient in MI. Continued maintenance of this conversation approach is important in helping to empower patients to find their own solutions and motivation for healthy behavior changes.

Objective 3

My last and most important objective was to gauge whether the lecture content was effectively retained by the learners. I chose the interactive lecture design with consideration to scheduling and time constraints of the busy primary care office. The design included sample MI questions and statements. Thus, my goal was that, upon completion of the lecture, participants would be able to (a) discuss the importance of the assessment approach and communication style in regards to patient assessments, (b) identify how MI-based approach styles can be an important strategy in assisting patients to establish and attain lifestyle-related behaviors that reduce health risks, (c) improve self-care management of chronic diseases and increase quality of life (Linden, Butterworth & Prochaska 2010), and informally verbalize how they would apply the newly learned materials into their workflow.

Project Significance and Relevance to Practice

Although effective communication between a clinician and patient is empirically linked to positive outcomes of care (ACPM, 2011), many clinicians fail to fully explore whether barriers to self-management can be modified (Dellasega, Gabbay, Durdock & Martinez-King, 2010). Non-adherence rates for chronic illness regimens and for lifestyle changes are 50% (Delamater, 2006); there is simply not enough time spent in behavior modifications, lifestyle modifications, or overall health strategies. Frustrations regarding time constraints or lack of communication skills often result in healthcare staff falling back on antiquated strategies of scare tactics, advice-giving, badgering, and other highly-imposing approaches still believed to elicit behavior changes (Dellasega, Gabbay,

Durdock, & Martinez-King, 2010). MI goes beyond therapeutic communication skills used just to obtain required information. Instead, it includes a desire to understand, not correct, the patient's ideas and perspectives, and results in a collaborative and nonjudgmental approach to care (Berger & Villaume, 2016). The heart of MI is empathy, achieved through continuous listening and reflection which provides patients the opportunity to take the lead in identifying their feelings.

Constantly correcting and passing judgment on how patients make sense of their illnesses or treatments is far from a patient-centered care approach. A brief yet far more effective intervention approach to behavior change is one that includes patient empowerment, education, and psychosocial understanding (Dellasega, Gabbay, Durdock, & Martinez-King, 2010). The best known models for brief intervention use in the primary care settings are MI-based interventions which are appropriate for a wide variety of health-related problems that benefit from behavior changes (Burg & Oyama, 2015).

MI is an evidence-based conversational approach that addresses patient ambivalence to change (CEBP, 2016). With consideration to time management, the approach takes the pressure off staff; if a patient is not in the contemplation stage, you can move on without wasting time and energy. Even very brief (5-minute) sessions have positive results, particularly when patients are highly resistant to change (Stewart & Fox, 2011); staff can easily identify a readiness to change in the patient during any office visit. The critical principle with MI is that the motivation for behavior or lifestyle changes must emanate from the patient rather than the health care worker. Lifestyle and behavior changes prompted by the method have a broad range of application benefits for weight

loss, smoking cessation, increasing physical activity, and improved self-management of a chronic disease such as decreasing edema or improving glucometer/A1C numbers. Helping patients become more self-reliant and take more responsibility for their health care is an important component of primary care prevention, and is necessary for promoting self-care behaviors.

The most important job responsibility of MAs at my field site is to keep patients flowing smoothly through the office in a timely manner, ensuring that the providers have the most accurate information needed for each assessment prior to entering the exam room. The MAs are the first point of contact for the patients, and their approach sets not only the tone of the appointment, but also the opportunity to explore a patient's readiness to change unhealthy lifestyles or behaviors. Thus, education on the health coaching style of MI helps MAs broaden their roles in preventive care by already addressing whether or not a patient is in the contemplation stage, saving the clinician precious exam time. Better utilization of MAs increases workflow efficiency, provides individualized patient-centered care, and allows clinicians to focus on tasks that require their level of expertise.

Project Statement

In this project, I introduced the health coach method of MI to MAs to improve the patient care approach at my project site.

Evidence-Based Significance of Project

The Healthy People 2020 initiative is a national effort that was created to improve the nation's overall health and to provide focus to high-priority health issues. Its leading health indicators were selected on the basis of their ability to motivate action, the

availability of data to measure progress, and their importance as public health issues (CDC, 2013). With leading health indicators being highly dependent on behavioral change, the use of MI can only enhance success in reaching health promotion goals. Healthy People helps shape the focus for practice based on statistical data, but practitioners also need a method for accomplishing those goals that is based on scientific research such as MI (Dart, 2011). Although effective in a wide range of areas, MI fits very well into the basics of nursing practice, which include the use of therapeutic communication and the nursing process.

The MI purpose is to encourage patient involvement in constructing more individualized treatment approaches while providing a more holistic approach to mind, body, and lifestyle modifications (Thorpe, 2012). The goal is to implement this educational tool using the most current research available. The change in practice approach allows the patient, with clinician support, to set small achievable goals. Over time, meeting small achievable goals has a cumulative effect, increasing motivation and empowering the patient to change poor lifestyle choices and behaviors into healthy ones. MI is an innovative approach that utilizes therapeutic communication to promote behavior changes that lead to improved health of our communities and country (Dart, 2011).

Definition of Terms

Ambivalence: A natural state of uncertainty and conflicting feelings that is experienced throughout most change processes (CEBP, 2016).

Brief motivational interviewing: A interviewing method that was originally developed for use in a single session (around 40 minutes) in primary care settings, and was designed with a set of quick, concrete techniques meant to manifest the spirit and practice of motivational interviewing in brief contact settings (Wagner & Conners, 2001).

Clinicians: Licensed health care professionals that have direct contact and responsibility for diagnosing and/or treating patients. Some examples include: physicians, nurses, nurse practitioners, physician assistants, and speech-language pathologists.

Health professional or healthcare provider: An individual operating within any branch of health care who provides preventive, curative, promotional, or rehabilitative health care services in a systematic way to people, families, or communities.

Medical assistant (MA): Certified allied health care workers that perform a multitude of direct patient care tasks and procedures in clinical settings such as: measuring vital signs, administering medications/injections, recording pertinent health information, preparation of medical instruments/supplies, and collection/preparation of specimens for testing.

Motivational Interviewing (MI): A collaborative approach between members of the health care team and patient. The conversation style is designed to elicit and strengthen motivation for change from the patients, helping them to explore and resolve ambivalence to change.

Self-care management: In health care most descriptions are similar, and frame self-care as a deliberate and self-initiated form of care. For patients with chronic conditions, it means those who make many day-to-day decisions to self-manage their

disease/illness. Self-management education is complementary to traditional primary care education, and is needed in order to better support patients in having the best possible quality of life. Self-care is purposeful, learned, and continuous.

Assumptions

When designing this lecture, I made the following assumptions: (a) the participants will give their best effort to learn and understand the materials provided to them during the lecture; (b) lecture materials will be based upon the most current and valid data available; (c) participants have experience in direct patient care; (d) participants voluntarily agree to learn the lecture materials to improve upon their approach to patient care; and (e) participants will acknowledge that the lecture materials are a basic start to understanding MI, and that continuing maintenance of the method and further education outside the facility would be needed to become truly proficient in MI approach.

Limitations

This project had a few limitations. First, there was a lack of staff variety. The site I chose for lecture implementation has one MA assigned to each physician, with supportive administration staff. Since there are no nurses or mid-level providers at this site, I chose MAs as the target group. Second, there was the small number of participants with a constantly changing full time and part time staff ratio. Third, time constraints of the primary care office work schedule restricted the scheduling of the lecture to an early morning office meeting timeslot. This was the only available time allowing all staff to meet prior to patient visits, which is usually set aside for the monthly morning meetings.

Fourth, variations of participants' work experiences, recall, and level of communication skills in regards to application of lecture materials posed additional limiting factors to the success of this project. The fifth limitation was unpredictability in the learner's professional choices to implement the method, and to pursue proficiency in MI with further education.

Section 2: Review of Scholarly and Conceptual Framework

Review of Scholarly Evidence

Sufficient evidence exist indicating lifestyle behaviors as key factors to chronic illness prevention and management (Linden, Butterworth, & Prochaska 2010). In fact, self-management support has become the central focus in the Institute of Medicine's *Crossing the Quality Chasm* report, the patient-centered medical home models, and in continuing education programs of numerous professional organizations (Schaefer, Miller, Goldstein, & Simmons, 2009). According to data from the Agency for Healthcare Research and Quality website (2016), self-management strategies improve patients' health-related behaviors and result in improved clinical outcomes. The California HealthCare Foundation found a significant association between improved information given by the physician, and more participatory decision making, enhanced self-efficacy, healthier behaviors, and better outcomes in patients with diabetes (AHRQ, 2016).

Additionally, evidence from controlled clinical trials has indicated that programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes and reducing costs for patients with a variety of chronic conditions (AHRQ, 2016). I their systematic review from of randomized controlled trials, Knight, McGowan, Dickens, and Bundy (2006) found that compared to standard approaches, MI had promising effects on lifestyle changes and health outcomes. The systematic techniques the authors used in this review included identifying articles through an electronic database search for articles specifying the use of MI in physical health care settings between 1966 and April 2004. Their search yielded 51 relevant

abstracts, and data was extracted from eight significant studies in the fields of diabetes, asthma, hypertension, hyperlipidemia, and heart disease. Four of eight studies were RCTs, one was a non-random controlled trial, and three were pilot studies. The central objectives of the studies were to compare the effectiveness of MI against or in addition to routine services, and to obtain data on the impact of MI on patient outcomes. Interestingly, two of the RCTs found that MI was an effective intervention for improving care for patients in terms of helping patients to adopt healthier lifestyles compared with existing services, and a majority of the studies found positive results for effects of MI on psychological, physiological, and lifestyle change outcomes (Knight, McGowan, Dickens, & Bundy, 2006).

I reviewed four meta-analyses of MI research include. The first of these was Burke, Arkowitz, and Menchola's (2003) study of 30 controlled clinical trials of individually delivered MI directed at a wide range of problem behaviors such as drinking, drug use, risky sexual behaviors, diet, and exercise. Specifically, the researchers reviewed 30 controlled clinical trials involving the adaptation of motivational interviewing (AMI) including: 15 studies for alcohol problems, two for smoking cessation, five for drug addiction, two for HIV-risk behaviors, four for diet and exercise problems, and one each for treatment adherence and eating disorders (Burke, Arkowitz, & Menchola, 2003). Substance abuse clinics and hospitals were the most common settings for the clinical trials, though some studies were conducted in general medical practices and on college campuses.

Sample sizes of the studies ranged from 22 to 952, with a mean of 206 participants, and two different design types were used comparing AMI control groups in 26 studies with AMIs with other active treatments in 9 studies; 5 of these studies used both design types (Burke, Arkowitz, & Menchola, 2003). The primary goal of Burke et al.'s review was to explore the efficacy of AMIs in comparison to control groups and other active treatments. Another broad goal of the review was to examine the clinical impact of AMI interventions using four different sources of information: percentage improved data, within-treatment effect sizes, pre–posttreatment drinking frequency estimates, and social impact measures. The researchers found that 51% of 346 people receiving AMI treatments exhibited noticeable improvement or abstinence on substance use measures taken anywhere from 4 weeks to 4 years posttreatment (Burke, Arkowitz, & Menchola, 2003). The study showed that stand-alone AMI interventions resulted in a 54% improvement; there was also a 43% improvement when AMIs were used as preludes to further clinical services. Overall, the percentage of people who improved following AMI treatments (51%) was significantly greater than the percentage who improved (37%) with either no treatment or treatment as usual, $X2(1, N = 616) = 10.95$, $p < .01$ (Burke, Arkowitz, & Menchola, 2003).

Thus, the administration of AMIs in addition to or in place of traditional treatments appears to improve success rates from about one third to one half overall, while doubling abstinence rates from roughly 1-in-5 to 2-in-5 (Burke, Arkowitz, & Menchola, 2003). Therefore, the average effect size was large (0.82), with study participants reducing their drinking by 56% from roughly 36 to 16 standard drinks per

week as a result of AMI treatment (Burke, Arkowitz, & Menchola, 2003). In terms of reasonable efficacy, AMIs remained equal to other active treatments, and superior to no-treatment or placebo controls for alcohol, drugs, and diet and exercise problems (Burke, Arkowitz, & Menchola, 2003).

The second meta-analysis by Hettema, Steele, and Miller (2005) included 72 studies spanning a range of target problems. The researchers observed that effect sizes of MI were larger with ethnic minority populations, and when the practice of MI was not manual-guided. Ethnic composition was specified in 37 studies, 43% of participants were from U.S. minority groups (Hettema, Steele, & Miller, 2005). One unexpected result of the meta-analysis was that Hettema et al. found larger effects of MI with samples primarily or exclusively comprised of people from ethnic minority groups. Although they admitted to having no theoretical explanation for the finding, they informally suggested that the client-centered, supportive, and non-confrontational style of MI resembles the normative communication style of many ethnic populations and was representative of a culturally congruent intervention (Hettema, Steele, & Miller, 2005). Another unexpected outcome was found in participants who were randomly assigned to receive manual-guided MI. For these participants, no significant benefit of MI was found. The findings were a result of following exactly what the manual instructions state to do, and pressing forward to complete the change plan even if the participant resisted--in itself a violation of good MI practice (Hettema, Steele, & Miller, 2005).

Vasilaki, Hosier, and Cox (2006) completed the third meta-analysis, which included 15 studies that specifically targeted MIs' ability to reduce problem drinking.

The total of 18 randomized controlled trials included two different groups: 9 comparing brief MI with no treatment, and 9 comparing brief MI with another treatment. In the 15 brief intervention trials, a total of 2767 participants were included: 996 were classified as dependent drinkers, and 1771 were categorized as heavy or abusive drinkers (Vasilaki, Hosier, & Cox, 2006). The meta-analytic review revealed that brief MI is an effective strategy for reducing alcohol consumption, was more efficient than no treatment in reducing alcohol consumption among non-dependent drinkers in the short term, and was more efficient than a combined set of diverse comparison treatments (Vasilaki, Hosier, & Cox, 2006). The conclusion was that MI is effective with both treatment-seeking and non-treatment-seeking samples, and is an effective treatment for heavy or abusive drinkers, and for low-dependent drinkers who willingly seek help (Vasilaki, Hosier, & Cox, 2006).

The fourth meta-analysis, conducted by Lundahl, Tollefson, Kunz, Brownell, & Burke (2009), included 119 studies that used methods that could isolate the unique contribution of MI relative to either a control group or a comparison group across multiple problems. The meta-analytic results strongly indicated that MI does exert small yet significant positive effects across a wide range of problem domains, is more effective in some situations compared to others, and does not work in all cases (Lundahl et al., 2009). However, a full 75% of the participants gained some improvement from MI; about 50% gained a small but meaningful effect, and 25% gained a moderate or strong level (Lundahl et al., 2009). The meta-analytic summary combined results of the researchers' meta-analysis and those from previously published meta-analyses, and indicated a

relatively low risk in implementing MI because it works across a wide range of problem behaviors and types and is unlikely to harm participants (Lundahl et al., 2009). In comparison to other active and specific treatments, MI was equally effective and shorter in length, providing a small yet significant advantage for a varied assortment of clients regardless of symptom severity, age, and gender, and possibly an even stronger advantage for minority clients (Lundahl et al., 2009). The meta-analytic summary also showed that MI has a clear and articulate theoretical framework complemented by specific techniques that can readily be learned (Lundahl et al., 2009).

In regards to time, three of those studies showed that MI averaged nearly 100 minutes less face-to-face time with clients compared to usual treatment programs. The lower time commitment makes MI more cost efficient, which may be a significant consideration when services or staff are limited (Lundahl & Burke, 2009). Lundahl et al. (2009) also tested whether the degree and professional level of the practitioner affected client outcomes. They found that training levels do not significantly influence MI outcomes, but rather that the versatility of MI can be learned and effectively applied by health care workers from a wide range of professional backgrounds (Lundahl & Burke, 2009). MI advocates have spent a considerable amount of time and effort in evaluating how people can optimally learn it by developing training materials, maintaining a listserv or Web presence, hosting regular conferences, and evaluating training outcomes (Lundahl & Burke, 2009).

MI in a workshop format is equally learnable by those of diverse professions, producing noticeable results in improving knowledge, attitudes, and confidence in

trainees. However, as the meta-analyses point out, workshops rarely facilitate the necessary maintenance of MI skills acquired over time with additional training strategies, such as coaching and supervision, to which only 4 of the 27 studies to date have included (Lundahl & Burke, 2009). Although, a 2-day interactive workshop followed by ongoing supervision and coaching would have been ideal, I could not accommodate such a format in this project because of time constraints, scheduling, and consideration to the least amount of workplace disruption.

MI is the gold standard for health coaching, and is backed by findings of over 200 clinical trials and multiple meta-analyses (HSI, 2015). One systematic review and meta-analysis of randomized controlled trials design used MI as the intervention (Rubak, Sandbaek, Lauritzen, & Christensen, 2005). Rubak, Sandbaek, Lauritzen, and Christensen's (2005) used a systematic literature search in 16 databases which led them to 72 randomized controlled trials displaying significant effects with a 95% confidence interval. The effects of MI were demonstrated in 53 out of the 72 randomized controlled trials, and none of the publications showed MI to be harmful or to have any kind of adverse effects, indicating that MI has a significant and clinically relevant effect in approximately three out of four studies (Rubak et al., 2005).

The method is practical for use across the care continuum, and the patient-centered design is particularly effective with patients described as "resistant" or "difficult to engage" (HSI, 2015). MI to promote self-care behaviors in primary care patients promotes well-being, emphasizes a person's physical, mental, and social resources, and enhances protective factors and conditions that foster health. Instead of the traditional

view of prevention as only avoiding or minimizing illness and risk factors, well-being also focuses on disease resistance, resilience, and self-management (U.S. Department of Health and Human Services, 2015). In their review and meta-analysis, Rubak et al. concluded that in a scientific setting, MI outperformed traditional advice giving in the treatment of a broad range of behavioral problems and diseases. The biggest challenge is getting health care professionals to adopt MI's collaborative spirit versus the prescriptive, expert-centered techniques traditionally used in medical settings (Resnicow et al., 2002).

Furthermore, consultants and trainers at the Center for Evidence-Based Practices have accumulated decades of combined experience utilizing MI in a variety of direct-practice settings (CEBP, 2016). According to Resnicow et al. (2002), evidence shows that direct patient care professionals may be able to use some of the basic MI skills and strategies with just a few hours of training. Technical skills are important, but aren't necessary to achieve the spirit of MI's strategies of asking open-ended questions, agenda setting and basic reflective listening (Resnicow et al., 2002). Often delivered via a one-time clinical workshop, studies find those who participated in MI training show modest changes in practice behavior (Miller & Mount, 2001).

The importance of the MI method is recognized and widely used in both medical and pharmacy education (Lupu, Stewart, & O'Neil, 2012). Another research study example followed first-year pharmacy students after one MI lecture to assess and measure MI skills, knowledge, confidence, and attitudes. The study findings showed that all students demonstrated improvement in skills, knowledge, and confidence which continued to improve over time as they practiced and accumulated experience (Lupu,

Stewart, & O'Neil, 2012). The practice session and the practicum examination assessments which showed significant overall improvement in scores for all students ($p \leq 0.01$) were completed by 143 consenting students, with a practice-laboratory session mean score of 30.4 and a practicum examination mean score of 42.7 (Lupu, Stewart, & O'Neil, 2012). The primary objective of the study was to evaluate and compare the impact of learning and assessment methods on student attainment of MI skills (Lupu, Stewart, & O'Neil, 2012). Additional benefits are to use the study results to improve curricular development pertaining to communication and MI skills. Integrating MI into medical curriculums has successfully enhanced student knowledge and confidence in patient counseling, and has helped learners to use the method more consistently in patient encounters (Lupu, Stewart, & O'Neil, 2012).

Further contributing to the growing literature examining strategies for disseminating MI into the health care setting are pilot studies. One example of a pilot study by Bean, Biskobing, Francis, and Wickham (2012), found that although more intensive training may be needed to develop MI competence , results suggest that brief, targeted MI training was feasible, well received, and it led to improved MI-consistent attitudes. 5 endocrinology fellows and 9 providers participated in this study using a pretest/posttest design to evaluate a brief MI training, only one participant had no prior MI training. Objective assessment of MI were conducted using the participants' audiotaped patient encounters. For adherence before and after the training the encounters were coded using the Motivational Interviewing Treatment Integrity (MITI) V. 3.0. This is a validated rating system for determining MI reliability that includes global scores and

behavior counts (Bean, Biskobing, Francis, & Wickham, 2012). Global dimensions rate the MI spirit on a 5-point Likert-style scale that includes global scores and behavior counts and paired ttests examined changes in objective and subjective assessments (Bean, Biskobing, Francis, & Wickham, 2012). Results found significant improvements in reflection-to-question ratios (P5.047) with no significant differences in competence by type of patient encounter (Bean, Biskobing, Francis, & Wickham, 2012).

Lastly, a systematic literature review was conducted from December 2010 to May 2011 by analyzing data collected from searches in seven different databases of: PubMed; Cohrane Central; Trip; PubMed Clinical Queries; Cinhal; Medline and Health Information Resources. The results of the systematic literature review concluded that training in MI appears to have positive influences on communication skills of the learners leading to an improved ability to guide patients on health behavior changes (Bala, 2011).

Mastering the MI method does require a higher degree of training, practice, and supervision not practical in most health care settings (Resnicow et al., 2002). Although MI skills can be difficult to acquire, there is growing evidence that the spirit of MI is more important than the technical skills. The pilot study by Schoo, Lawn, Rudnik, and Litt (2015) found health professionals conveyed greater confidence in their ability to support self-management of chronic conditions by incorporating MI skills into training. The study involved 36 Australian occupational therapy and physiotherapy students who were taught the principles of MI. The learners were asked to conduct a motivational interview, transcribe it, self-rate it using the MITI tool and reflect on the experience. MI skills were measured using the MITI sub-scores, and the assignments and focus group

discussion were analyzed to explore their experiences using the MITI tool, and self-reflection to improve their understanding of MI principles (Schoo, Lawn, Rudnik, & Litt, 2015). All 36 participants submitted their written interview transcripts and descriptions of their use of the MITI tool. Although all participants were encouraged to report their MITI scores, twenty-two (n = 22, 15 female, 13 PT) specifically reported all of their results (Schoo, Lawn, Rudnik, & Litt, 2015).

A convenient sample of eleven assignments were submitted electronically to provide text for content analysis (Schoo, Lawn, Rudnik, & Litt, 2015). The study results found MI challenging and that learners tended to over-state their MI skills and strategies as being competent or higher than scores expected from beginners. However, the MITI tool was identified as being useful for promoting self-reflection and MI skills. The strength of this pilot study was its inter-professional approach to teaching MI to students from different disciplines, and preparing them for reflective practice (Schoo, Lawn, Rudnik, & Litt, 2015). The results demonstrate how MI skills can be developed for health professionals by reflecting on self-assessment and what methods are more effective in helping them to acquire this complex skill. Considering the ever growing importance to be increasingly resourceful and creative in teaching learners to become competent practitioners, results from this study and others like it are important in designing transformative learning experiences for health care professionals.

Essentially, the attitudes held by the health professional are important since behavioral changes in patients need to be elicited rather than imposed (Schoo, Lawn, Rudnik & Litt, 2015). The Soderlund, Madson, Rubak, and Nilsen (2011) systematic

review of MI training for general health care practitioners study was obtained from several databases. The study included MI training that had to be provided specifically for general health care practitioners for use in daily face-to-face counselling and outcomes had to be linked to the MI training (Soderlund, Madson, Rubak, & Nilsen, 2011). The results of ten studies with a median length of nine hour training frequently addressed training elements were basic MI skills, the MI spirit and rolling with resistance (Soderlund, Madson, Rubak, & Nilsen, 2011). The study's results interpreted with caution second to inconsistent study quality that varied considerably with five studies found to have training outcomes at a single point in time resulting in low internal validity (Soderlund, Madson, Rubak, & Nilsen, 2011). However, the study of the randomly assigned practitioners to the MI training found generally positive outcomes overall and a significant effect on many aspects of the participants' daily practice (Soderlund, Madson, Rubak, & Nilsen, 2011). The largely favorable outcomes suggest that MI can be used to improve client communication and counselling concerning lifestyle-related issues in health care (Soderlund, Madson, Rubak, & Nilsen, 2011).Therefore, this opportunity to educate MA's on the basic principles of MI would have a positive influence on the learners approach and communication skills.

Theoretical Framework

Most adults enter into a learning experience to create change; in health care this can mean changes in skills, behavior, knowledge-level, attitudes or beliefs (Olff, 2012). Therefore, selecting an appropriate theory or model is essential to designing an efficient and successful educational project for adult learners. For this project example, primary

care medical assistants are the target population. Thus, the Adult Learning Theory was chosen to address the specific needs of adult learners and also that the theory mirrors the projects actual subject matter of motivational interviewing.

Utilized in the nursing process by learners and teachers, Knowles' theory can be applied to concepts of learning and self-direction (Cosejo, 2012). The Adult Learning Theory was made popular by Malcolm Knowles and arose from the practice of pedagogy to address the specific needs in the education of adults as opposed to the education of children. The term andragogy then became synonymous with adult education and has been used extensively in the design of organizational training programs, especially in domains such as management development (Cosejo, 2012).

Within the theory are the Knowles' 5 Assumptions of Adult Learners describing how education changes as a person matures. The motivation to learn becomes internal changing into a self-directed human being with a reservoir of experience that becomes an increasing resource for learning; maturity fosters a readiness to learn and time perspective changes to immediacy of application and problem centeredness (Pappas, 2013). The Knowles 4 principles of Andragogy also apply to this project in that adults differ from children in their need to be involved in the planning and evaluation of their instruction, experience (including mistakes, and adult learning is problem-centered rather than content-oriented (Pappas, 2013).

Knowles' 5 Assumptions and 4 principles of Andragogy directly parallel the patient approach technique of motivational interviewing. Both the theory and the technique support self-management through diagnose/formulate learning needs, identify

patient resources for learning, indicate and implement appropriate learning strategies and learning outcome evaluation. The learning strategies of both the theory and chosen technique address the unique characteristics of adult learners (Pappas, 2013). Although MA's are certified through formal training; prior knowledge, experience skill, belief systems, generational and cultural differences will vary. This causes varied results in how each learner organizes, interprets and implements the educational materials.

The framework is fundamental to the project design, assisting in a deeper understanding of the adult learners' motivations, needs, and reasons to participate in the learning environment. In this way we can avoid the mistake of incorporating content so basic that learners already know it, so difficult that they find it impossible to understand, or irrelevant to their professional needs (Palis & Quiros, 2014).

Section 3: Methodology

Approach

Population

I identified the health prevention problem and chose target population by analyzing the new Healthy People 2020 topic of health-related quality of life and well-being (HRQOL). HRQOL is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life (U.S. Department of Health and Human Services, 2015).

Through the generosity of Bill Matulich, Ph.D., I was granted written permission to use his *Introduction to Motivation Interviewing* PowerPoint materials. Dr. Matulich is a clinical psychologist and member of the Motivational Interviewing Network of Trainers; he teaches MI workshops for health care professionals of all kinds including psychologists, physicians, social workers, nurses, case managers, research staff, and many others. The learning materials were applicable to any direct patient care staff members willing to participate. The project is not only feasible, but easily replicated through an introductory power point that defines MI and summarizes the spirit of MI using the core skills of the O.A.R.S. and P.A.C.E. acronyms.

In order to explore their perspectives, I interviewed MAs who willing to participate in the project using an already printed questionnaire and a face-to-face, standardized, open-ended interview style. I provided an explanation of MI and emphasized that its rationale was to identify a readiness to change in patients and

promote self-care. I interviewed the willing clinical staff my primary care office project site on their opinions of traditional versus the new conversation approaches to patients. Using a free to the public online-learning style questionnaire, all interviewees were asked the same questions which allowed for faster interviews that were more easily analyzed when designing the educational style of the lecture. For any project to be effective consideration should be given to adult learning principles and learning styles (Olff, 2012).

One commonly used assessment approach described in literature is based on the senses involved in processing information. Therefore, assessing the learner's preferred learning styles can foster engagement and enhance learning (Olff, 2012). When considering the challenges of individual learning styles, I drew on many online assessment tools to design this project to fit the needs of the targeted learners. For this project, I designed a questionnaire that contained questions directed at participants' opinions of both the MI method and their approach to learning the material. Results of the short questionnaire helped direct the content design of the project. Because individual learning styles influence the way information is understood and how problems are solved by the learners, it was important that I consider these opinions.

I designed an interactive lecture strategy with consideration to office scheduling and time constraints. The design allowed for enough time at the end of the lecture for learners to demonstrate whether the new content was effectively retained, and for me to gauge their confidence in its application to practice.

The target population included primary care MAs and auxiliary office staff who were chosen to learn the new approach in order to ensure patients understand important health information, make informed decisions, and participate in self-care management. The 1-hour lecture materials touch on the basics of the MI method to help participants increase their knowledge of MI using the O.A.R.S. and P.A.C.E. acronyms, and allowed participants to practice role-playing. Materials included handouts in PowerPoint format to assist them in learning the steps of the acronym to focus on person-centered conversation skills in order to help balance the needs of both the patient and clinician.

The lecture design was informal and interactive, including sample MI questions and statements. Role-playing with samples of quick case study's make learners apply material to a realistic situations, and it promotes critical and creative thinking (University of Oregon, 2014). An anonymous post-lecture questionnaire (see Appendix A) followed the lecture and helped the learners' rate the lecture materials while still fresh in their minds. These provided me immediate feedback about learner understanding (see University of Oregon, 2014).

Summary

The project lecture is one way of inspiring MAs to further develop their personal and professional growth. In general, people want to succeed and they want to continue learning and growing (Quast, 2012). Thus, helping patients to make good choices and sustain healthy behaviors requires a collaborative relationship between health care clinicians, patients, and their families. Learning how to incorporate self-management support principles into practice not only broadens the MAs roles in preventive care, it

also supports patients in building the skills and confidence they need to lead healthier lives (AHRQ, 2016).

Section 4: Findings and Recommendations

Introduction

From the review of literature and experiences in both professional and practicum primary care settings, I found that frustrations stemming from time constraints or lack of communication skills often result in healthcare staff falling back on antiquated strategies of scare tactics, advice-giving, badgering, and other highly imposing approaches still believed to elicit behavior changes (see Dellasega, Gabbay, Durdock, & Martinez-King, 2010). Counterproductive responses may be avoided simply by changing the communication approach. Health care professionals must abandon outdated concepts of trying to get their patients to comply or adhere; instead patient care approaches must shift to patient responsibility for self-management and new patient-provider collaborative relationships (Delamater, 2006). My goal for this DNP project was to evaluate whether educating MAs in the health coach method of MI could improve the patient care approach while simultaneously assisting clinicians struggling with insufficient time. The purpose of this section of the paper is to discuss the projects findings and recommendations.

Data Collection

The most practical approach to collecting data from the small target sample was to including a short rating questionnaire at the end of the PowerPoint materials. However, the small amount of volunteers resulted in minimal, low-level data analysis. Participants were not asked to provide their names on the surveys and thus were anonymous. Finished forms were then placed by participants into a manila envelope which was collected upon

completion. In order to provide ethical protection for the participants prior to the lecture, I provided them a letter of consent and a letter of cooperation from the research partner approving opt-in data collection in instances such as this when the researcher has dual roles. The letters informed participants that the lecture and post-lecture questionnaire were voluntary and anonymous. No incentives were offered to the participants. After 5 years, I will destroy both hardcopy and electronically stored data by deleting and shredding materials. I obtained IRB approval from Walden University prior to the start of the project with the approval number for this study being 10-03-16-0390736.

Data Analysis

Data analysis for the project was minimal due to the limitations of the DNP project. Analysis included review of the post-lecture rating questionnaire from participants. The questionnaire asked participants to evaluate whether the objectives of the educational lecture were met by rating the lecture content, presentation, understanding of materials, potential to apply the approach into daily work, and whether participants would continue to learn more about MI outside of the lecture. The questionnaire also included two free text questions on the materials presentation, and a free text question allowing participants the opportunity to include qualitative data in the form of comments or suggestions as to how the material could help them in their daily work. I conducted both data collection and review to meet my project goal of whether educating MAs in the health coaching method of MI can improve patient care while simultaneously assisting clinicians struggling with insufficient time.

Project Evaluation

In this paper, I explore the completion of a DNP project I designed to evaluate whether educating MAs in the health coaching method of MI can improve patient care while simultaneously assisting clinicians struggling with insufficient time. The project design was guided by the adult learning theory I chose to address the specific needs of adult learners. I selected this theory because it is directly applicable to the subject matter of MI. The educational lecture was completed by using the most current research available, and I aimed to capture the spirit of MI through basic descriptions and strategies to help learners focus on person-centered conversation skills that help to balance the needs of both the patient and clinician. Using MI's holistic change in practice approach allows the patient, with clinician support, to set small achievable goals. Over time, meeting small achievable goals has a cumulative effect, increasing motivation and empowering the patient to change poor lifestyle choices and behaviors into healthy ones.

Because of several individual scheduling conflicts, four out of the original nine intended participants were able to participate in the project. Upon completion of the project, I reviewed the post-lecture questionnaires. The questionnaire responses indicated the project met its stated objectives and also showed that participants perceived the new information as helpful. The free text section provided additional positive qualitative data in regards to how the materials were presented. Information from the questionnaires would be helpful in guiding future educational projects. Findings from the data are shown in Table 1.

Table 1.

Results of Anonymous Post-Lecture Rating Questionnaire

	Poor	Fair	OK	Good	Excellent
How would you rate the values of the ideas, concepts and lecture content?	0%	0%	0%	0%	100% 4
How would you rate the presentation of the materials?	0%	0%	0%	0%	100% 4
How would you rate Motivational Interviewing as a patient centered care conversation approach style for eliciting behavior change by helping patients to explore and resolve resistance to change?	0%	0%	0%	0%	100% 4
How would you rate your understanding of the lecture materials?	0%	0%	0%	25% 1	75% 3
How would you rate the potential ease of transitioning the learned materials into your daily work?	0%	0%	0%	50% 2	50% 2
How would you rate the potential positive effects of the approach on your patients?	0%	0%	0%	50% 2	50% 2
How would you rate potentially continuing to use this approach in your daily work?	0%	0%	0%	50% 2	50% 2
Would you continue to learn more about Motivational Interviewing outside of this lecture?	Yes	75% 3	No	25% 1	

Unanticipated Findings

Participants responded positively in the free text question areas with comments like “very similar to counseling interactions,” and “simply applying this method would be a benefit to all.” Two participants noted the approach is not only helpful to patients, but

also “towards each other” in the workplace and “all aspects of life.” In both free text answers and during informal conversation throughout the lecture, it was most surprising to hear participants state that the approach should be applied to all aspects of life and how we treat each other both in and out of the professional arena. Another unanticipated finding was when management verbally expressed how the method would be helpful when approaching staff in making workflow changes. Initially the project was designed to educate, then survey the degree of retained information and learn if the approach would be helpful to the professionals’ patient care approach. The results showed that the variety of participant training levels did not significantly influence learning outcomes. Instead, results showed the versatility of the MI method which can be learned and effectively applied by health care workers from a wide range of professional backgrounds (Lundahl & Burke, 2009).

MI in a workshop format is equally learnable by those of diverse professions and produces noticeable results in improving knowledge, attitudes, and confidence in trainees. However, Lundahl et al. (2009) have pointed out, workshops rarely facilitate the necessary maintenance of MI skills acquired over time with additional training strategies such as coaching and supervision.

Implications of Results

Throughout the questionnaire, participant answers showed a strong agreement in learning the materials and how MI could positively affect the patient care approach. All participants marked they that would learn more about the approach after the project lecture, while only one participant answered “no” to the question about becoming more

proficient in the approach. The project results mirror evidence in the meta-analysis by Lundahl et al. (2009) and strongly indicate that MI does exert small yet significant positive effects across a wide range of problem domains, is more effective in some situations compared to others, and does not work in all cases (Lundahl, Tollefson, Kunz, Brownell, & Burke, 2009). The same meta-analysis showed a full 75% of the participants gained some improvement from MI, about 50% gained a small but meaningful effect, and 25% gained a moderate or strong level (Lundahl, Tollefson, Kunz, Brownell, & Burke, 2009).

Recommendations

In the future, it would be beneficial to lecture to a larger audience with a wider professional variety. Including those from mid-level and higher professional levels would help with follow through and continuity within an organization. Utilization of self-management support principles in primary care has the potential to have a positive effect on the health care and health outcomes of people with chronic conditions, as well the potential to improve clinician and patient satisfaction (AHRQ, 2016). The lecture and accompanying materials are easily replicable and may be beneficial to any workplace's peer education activities.

Although, commitment to the MI method cannot be taught or guaranteed, it can be inspired and supported. Exposure to new practice changes should be a progressive and positive experience that can be introduced in small training usages to promote workplace development. Management should continue to support and encourage the continuing education needs of the employees, thereby establishing groundwork for lifelong learning

of the healthcare professionals within the organization. MI is an innovative approach that utilizes therapeutic communication to promote behavior changes that lead to improved health of our communities and country (Dart, 2011).

Section 5: Dissemination Plan

As a scholarly prepared practitioner, it is important that I share new knowledge and findings with the broader community of health care professionals, adding to the knowledge base in order to benefit both providers and patients. Dissemination allows for a wider policy and health service audience in order to facilitate research uptake in decision-making processes and practice (see Wilson, Petticrew, Calnan, & Nazareth, 2010). I will disseminate this project through a peer education workplace presentation. The organization where I work is comprised of mid-level practitioners and physicians interested in learning more about the MI approach. I have discussed the lecture materials in PowerPoint format with the providers' team leader and with administration in other states via a conference call. One strength of this plan is that my professional peers are very interested in the approach and are encouraging the promotion of such peer education throughout our organization, which, through conference calls, reaches a larger number and variety of peers. I would also consider the idea of ongoing supervision for the four project attendees in order to see if the MI techniques are taking hold.

Dissemination is viewed as a key element in the knowledge translation continuum (Wilson, Petticrew, Calnan, & Nazareth, 2010). Therefore, dissemination could also be accomplished through a brief article publication in one of the many available nursing journals. Nursing journals would reach a wider professional audience who may be interested in learning a more holistic patient care approach. Given the current emphasis placed on improving knowledge application about effects of interventions into routine

practice, a number of theoretically-informed frameworks are available to help guide dissemination development and activity (Wilson, Petticrew, Calnan, & Nazareth, 2010).

Analysis of Self

The DNP project is a very intense and complex process that requires devising a project idea that encompasses a positive impact on the quality of health care, advances the nursing profession's knowledge base, and promotes positive social changes. The entire process was a humbling learning opportunity, as I have never previously developed any such project, especially one at the scholarly level. I chose the project topic through exposure to different direct patient care approaches that I experienced both through personal and professional work practices. By having the experience of both sides, being a healthcare provider and occasionally on the receiving end as a patient, conversation and approach became very personal. Thus, the DNP project not only encouraged my scholarly thought processes, but also reinforced my feelings that compelled me to choose this topic.

The project curriculum and format design is systematic in reaching specific objectives and securing needed approvals within specific timeframes. Therefore, without a previous project experience to compare this to, the entire process was challenging and I learned a great deal of patience. However, the DNP program and project are methodically designed to help transform us into scholar-practitioners, fostering commitment to positive social changes. Only by taking the time to follow the project guidelines and instruction of very committed faculty, could I have produced a final project of such quality.

Summary

AACN's Essentials defines the DNP-prepared nurse's role as learning to read and review research and evidence based practice to solve problems in practice (AACN, 2006). The DNP curriculum and project completion meets the AACN's essentials of Doctoral Education for Advanced Nursing Practice and has prepared me with the advanced knowledge and experience to positively impact health care and add to the nursing profession's knowledge base.

Regardless of what form the final DNP product takes, it is the foundation for future scholarly practice, and using evidence to improve practice or patient outcomes is the theme that links any form of scholarly experience (AACN, 2006). The challenge of completing the DNP educational and project requirements have fostered new skills and honed advanced knowledge that will help me be more successful in future roles as an educator. The DNP process has better prepared me as both a scholar-practitioner and future nurse educator to properly and skillfully give back to my profession. I believe projects at this level are empowering to the nursing professional, providing academic advancements which enhance personal and professional development.

References

Abramowitz, S., & Franses, K. (n.d.). Motivational interviewing for MDs and health practitioners: Training and consultation in health behavior change counseling for providers who treat patients with chronic diseases and addictions. Retrieved from www.miformds.com/Home.html

Agency for Healthcare Research and Quality. (2016, February). Self-management support: Why is self-management support important? Retrieved from www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/sms_why.html

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from http://www.aacn.nche.edu/dnp/Essentials.pdf

American College of Preventative Medicine. (2011). *Medication adherence time tool: Improving health outcomes*. Retrieved from www.acpm.org/?MedAdherTT_ClinRef

Bala, S. (2011). *The effect of motivational interviewing training on students' counseling skills and confidence*. A systematic literature review (master's thesis). Retrieved from https://dspace.mah.se/handle/2043/13380

Bean, M. K., Biskobing, D., Francis, G. L., & Wickham, E. (2012). Motivational interviewing in health care: Results of a brief training in endocrinology. *Journal of Graduate Medical Education*, *4*(3), 357–361. http://doi.org/10.4300/JGME-D-11-00166.1

Bennett, H. D., Coleman, E. A., Parry, C., Bodenheimer, T., & Chen, E. H. (2010). Health coaching for patients with chronic illness. *Family Practice Management, 17*(5), 24-29. Retrieved from www.aafp.org/fpm/2010/0900 /p24.html

Berger, B. A. & Villaume, W. A. (2016). A new conceptualization and approach to learning and teaching motivational interviewing. *Inovations in Pharmacy 7*(1), Article 3. Retreived from http://pubs.lib.umn.edu/innovations/vol7/iss1/3

Bodenheimer T., Willard-Grace R., Ghorob A. (2014). Expanding the roles of medical assistants: Who does what in primary care? *Journal of the American Medical Association Internal Medicine*, *174*(7)*,* 1025-1026. doi:10.1001/jamainternmed .2014

Burg, M. A. & Oyama, O. (2015). *The behavioral health specialist in primary care: Skills for integrated practice*. Retrieved from books.google.com/books?id=QO-YCgAAQBAJ&pg=PA250&lpg=PA250&dq#v=onepage&q&f=false

Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71*(5), 843–861. Accession Number: edsgcl.108911224

Centers for Disease Control and Prevention. (2013). Healthy People. Retrieved from www.cdc.gov/nchs/healthy_people.htm

Center for Evidence-Based Practices. (2016). Motivational interviewing. Retrieved from www.centerforebp.case.edu/practices/mi

Cosejo, D. (2012, August). Nursing education: An application of andragogy of learning.

Retrieved from rnspeak.com/fundamentals-of-nursing/nursing-education-an-application-of-andragogy-of-learning/

Dart, M. A. (2011). *Motivational interviewing in nursing practice: Empowering the patient*. Sudbury, Mass: Jones and Bartlett Publishers.

Delamater, A.M. (2006). Improving patient adherence. *Clinical Diabetes*, *24*(2), 71-77. Retrieved from clinical.diabetesjournals.org/content/24/2/71.full

Dellasega, C., Gabbay, R., Durdock, K., & Martinez-King, N. (2010). Motivational interviewing (MI) to change type 2DM self care behaviors: A nursing intervention. *Journal of Diabetes Nursing*, 14, 112–118. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4015115/

Haskins, S. (2015, February 4). What's a health coach? Retrieved from health.usnews.com/health-news/blogs/eat-run/2015/02/04/whats-a-health-coach

Health Sciences Institute. (2015). Motivational Interviewing and Health Coaching Case Studies. Retrieved from www.healthsciences.org/Motivational-Interviewing-Health-Coaching-Case-Studies

Hettema, J., Steele, J., & Miller, W. (2005). Motivational interviewing. *Annual Review of Clinical Psychology 1*, 91–111. Accession Number: DARE-12005006262

Kandula, N. & Wynia, M. (2015, May 29). Fear-based medicine*:* Using scare tactics in the clinical encounter [blog post]. Retrieved from thehealthcareblog.com/blog /2015/05/29/fear-based-medicine-using-scare-tactics-in-the-clinical-encounter/

Knight, K. M., McGowan, L., Dickens, C., & Bundy, C. (2006). A systematic review of

motivational interviewing in physical health care settings. *British Journal of Health Psychology*, *11*(2), 319-332. doi:10.1348/135910705X52516

Levensky, E. R., Forcehimes, A., O'Donohue, W. T., & Beitz, K. (2007). Motivational interviewing: *An evidence-based approach to counseling helps patients follow treatment recommendations*. *The American Journal of Nursing*, *107*(10), 50–59. Retrieved from www.nursingcenter.com/cearticle?tid=745019

Linden, A., Butterworth, S. W. & Prochaska, J. O. (2010). Motivational interviewing-based health coaching as a chronic care intervention. *Journal of Evaluation in Clinical Practice*, *16*(1), 166-174. doi:10.1111/j.1365-2753.2009.01300.x

Lundahl, B., Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing*:* A practice-friendly review of four meta-analyses. *Journal of Clinical Psychology*, *65*, 1232–1245.

Lundahl, B. W., Tollefson, D., Kunz, C., Brownell, C., & Burke, B. (2010). Meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*(2), 137-160. Retrieved from https://www .ncbi.nlm.nih.gov/pubmedhealth/PMH0029397/

Lupu, A. M., Stewart, A. L., & O'Neil, C. (2012). Comparison of active-learning strategies for motivational interviewing skills, knowledge, and confidence in first-year pharmacy students. *American Journal of Pharmaceutical Education*, 76(2), 28. doi.org/10.5688/ajpe76228

Matulich, B. (2013). Introduction to motivation interviewing [PowerPoint presentation]. Retrieved from www.youtube.com/watch?v=s3MCJZ7OGRk&feature=youtu.be

Miller, W.R. & Mount, K.A. (2001). A small study of training in motivational interviewing: Does one workshop change clinician and client behavior? *Behavioural and Cognitive Psychotherapy*, 29, 457-471. doi:10.1017 /S1352465801004064.

Olff, J. (2012). Adult learning theory and patient education. Retrieved from surroundhealth.net/Topics/Education-and-Learning-approaches/Adult-learning-principles/Articles/Adult-Learning-Theory-and-Patient-Education-1.aspx

Palis, A. G., & Quiros, P. A. (2014). Adult learning principles and presentation pearls. *Middle East African Journal of Ophthalmology*, *21*, 114–122. doi.org/10.4103 /0974-9233.129748

Pappas, C. (2013). The adult learning theory – andragogy – of Malcolm Knowles. Retrieved from elearningindustry.com/the-adult-learning-theory-andragogy-of-malcolm-knowles

Peters, G.-J. Y., Ruiter, R. A. C., & Kok, G. (2013). Threatening communication: a critical re-analysis and a revised meta-analytic test of fear appeal theory. *Health Psychology Review*, *7*(Suppl 1), S8–S31. http://doi.org/10.1080/17437199.2012 .703527

Quast, L. (2012). 5 Tips for Motivating Employees. Retrieved from www.forbes.com/sites/lisaquast/2012/01/10/5-tips-for-motivating-employees/#385acbf2e3da Research Methodology (2015). Interviews. Retrieved from research- methodology.net/research-methods/qualitative-research/interviews/

Resnicow K, DiIorio C, Soet J, Ernst D, Borrelli B, Hecht J: Motivational interviewing in

health promotion: sounds like something changing. *Health Psychology* 21:444–451, 2002

Riegel, B., Jaarsma, T., & Stromberg, A. (2012). Advances in Nursing Science: *A Middle-Range Theory of Self-Care of Chronic Illness.* Retrieved from journals.lww.com/advancesinnursingscience/Fulltext/2012/07000/A_Middle_Range_Theory_of_Self_Care_of_

Rubak, S., Sandbaek, A., Lauritzen, T. & Christensen, B. (2005). Motivational interviewing: a systematic review and meta-analysis. *The British Journal of General Practice*, 55, 305–312.

Ruiter, R. A., Kessels, L. T., Peters, G. J. Y., & Kok, G. (2014). Sixty years of fear appeal research: Current state of the evidence. *International Journal of Psychology* (Impact Factor: 1.23). 04/2014; 49(2):63-70. DOI: 10.1002/ijop.12042 Source: PubMed

Schaefer J, Miller D, Goldstein M, Simmons L. Partnering in Self-Management Support: A Toolkit for Clinicians. Cambridge, MA: Institute for Healthcare Improvement; 2009. Available at: www.IHI.org

Schoo, A. M., Lawn, S., Rudnik, E. & Litt, J. C. (2015). Teaching health science students foundation motivational interviewing skills: use of motivational interviewing treatment integrity and self-reflection to approach transformative learning. *BioMedCentral Medical Education,* 15, 228. http://doi.org/10.1186/s12909-015-0512-1

Soderlund L.L., Madson M.B., Rubak S., Nilsen P. (2011). A systematic review of

motivational interviewing training for general health care practitioners. Patient Education and Counseling, 84 (1), pp. 16-26. Retrieved from http://www.pec-journal.com/article/S0738-3991(10)00387-3/fulltext

Stewart, E.E. & Fox, C. (2011). Encouraging Patients to Change Unhealthy Behaviors With Motivational Interviewing. Retrieved from www.aafp.org/fpm/2011/0500/p21.html

Thorpe, G. (2012). Doctors benefits to hiring health coaches. Retrieved from www.examiner.com/article/doctors-benefits-to-hiring-health-coaches

U.S. Department of Health and Human Services (2015). Health-Related Quality of Life & Well-Being. Retrieved from www.healthypeople.gov/2020/topics-objectives/topic/health-related-quality-of-life-well-being

University of Oregon (2014). Ways to Assess Student Learning During Class. Retrieved from tep.uoregon.edu/pdf/assessment/Ways_to_Assess_Student_Learning_ During_Class.pdf

Vasilaki, E., Hosier, S., & Cox, W. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: A meta-analytic review. Alcohol and Alcoholism, 41, 328–335.

Wagner, C. & Conners, W. (2001). What is MI? Reprinted with permission from Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, 325-334. Retrieved from www.motivationalinterview.net/clinical/whatismi.html

Webb T.L., Joseph J., Yardley L., & Michie S. Using the internet to promote health

behavior change: A systematic review and meta-analysis of the impact of theoretical basis, use of behavior change techniques, and mode of delivery on efficacy. *Journal of Medical Internet Research*. 2010;12(1):e4. doi:10.2196/jmir.1376.

Wilson, P. M., Petticrew, M., Calnan, M. W., & Nazareth, I. (2010). Disseminating research findings: what should researchers do? A systematic scoping review of conceptual frameworks. *Implementation Science : IS*, *5*, 91. Retrieved from http://doi.org/10.1186/1748-5908-5-91

Appendix A: Anonymous Lecture Evaluation

Anonymous Lecture Evaluation

Please circle the appropriate answer.

1. How would you rate the values of the ideas, concepts and lecture content?
   Poor Fair OK Good Excellent

2. How would you rate the presentation of the materials?
   Poor Fair OK Good Excellent

3. How would you rate Motivational Interviewing as a patient centered care conversation approach style for eliciting behavior change by helping patients to explore and resolve resistance to change?
   Poor Fair OK Good Excellent

4. How would you rate your understanding of the lecture materials?
   Poor Fair OK Good Excellent

5. How would you rate the potential ease of transitioning the learned materials into your daily work?
   Poor Fair OK Good Excellent

6. How would you rate the potential positive effects of the approach on your patients?
   Poor Fair OK Good Excellent

7. How would you rate potentially continuing to use this approach in your daily work?
   Poor Fair OK Good Excellent

8. Would you continue to learn more about Motivational Interviewing outside of this lecture?
   Yes No

9. What did you like most about the learning materials?

10. What did you like least about the learning materials?

Do you have any other comments or suggestions regarding the lecture materials or how they can possibly help you in your daily work?