USING THE CONTEXTUAL INTERVIEW TO PROMOTE THE DELIVERY OF COMPASSIONATE CARE

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MEET DRS. BEACHY &BAUMAN

- Licensed Psychologists by trade
- BHCs for over a decade (underserved)
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- Speakers and trainers
- Will challenge traditional thinking!
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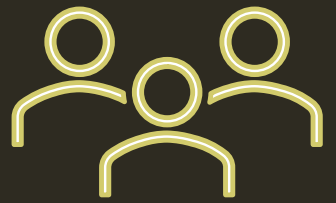
WEBINAR DESCRIPTION

Person-centered care is gaining traction across the health care landscape. Most see this as a welcomed change and positive movement for both patients and clinicians (and others working in health care.) For this paradigm shift to be fully realized, health care professionals must provide contextual and compassionate care to patients traditionally marginalized, discriminated against, or simply more vulnerable to health difficulties. In this webinar, presenters will provide a framework to support providers in delivering contextual and compassionate care to their patients.



LEARNING OBJECTIVES

By the end of this presentation, you will be able to:

- Describe the person-centered framework used to deliver contextual and compassionate care to their patients.
- Identify strategies (MI approach & Contextual interview) to have engaging conversations with patients about sexual health. (CI)
- Detail ways to reduce stigma when screening for STIs, HIV, and monkeypox. (being person centered & use of MI)

JOHN

John is a 21 y/o white male college student who was raised in a conservative, rural hometown. His family holds traditional Christian values; however, John has never quite held the same beliefs. Additionally, John has felt attracted to both men and women for as long as he could remember. He has not disclosed to any family or friends this attraction and had girlfriends throughout high school. He largely started seeking out male connections online and about a year decided to meet up in person w/one of his connections. This friend introduced him to some other male friends who had same-sex attraction. He has been having largely unprotected anal and oral sex w/multiple male friends (and friends of friends) regularly over the past year. He estimates he's had about 15 sexual partners. John doesn't disclose any of this information to his family nor does he tell his family doctor. He noticed he had some sores and lesions around his anus. Coincidentally he was going to have an appointment w/his family doctor before leaving again for college. He is deciding whether he should say anything…if he does, he's also deciding if he will reveal how many partners he's had and that he's been w/men.

What needs to be in place for John to tell us his story/circumstance?

CURRENT REALITIES[1]

"Primary care does not exist within a vacuum. Rather, it is a reflection of societal norms and values. Many primary care settings today are structured in a way that prevents the team from understanding and addressing the context in which a patient lives. An approach to care limited in this way perpetuates disadvantage and health inequity."

- *Has this been your experience?*
- *Thoughts?*

Call for:

- *Medical care to be done in a way that, "…embrace [s] both patient- and person-centeredness in order to promote health equity."*

PATIENT & PERSON-CENTERED APPROACH[2]

"Primary care is not limited to diagnosing and treating illness…it includes the full lifespan, individuals' long-term goals, and opportunities for health promotion, preventive care, and relief of suffering of both mind and body."[1]

Goal of patient centered care: functional life

Person-centered: meaningful life

Just like primary care doesn't happen in vacuums – neither does patient behavior!

If you can't imagine why this person is acting the way they are (i.e., non adherent, not being forthcoming, etc.), you may not have enough information

There's a function to every behavior; Understand the soil

So how can we do that?

"Compassionate care addresses the patient's innate need for connection and relationships and is based on attentive listening and a desire to understand the patient's context and perspective"[3]

SOUNDS GREAT, NOW HOW DO WE DO THIS?

SPIRIT OF MOTIVATIONAL INTERVIEWING[4-5]

Replace CONFRONTATION with COLLABORATION

Replace EDUCATION with EVOCATION (draw out patients' goals & values)

Replace AUTHORITY with AUTONOMY

Additionally:

Absolute Worth vs. Judgment

Accurate Empathy vs. Sympathy/Identification

Autonomy Support vs. Coercion/Control

Affirmation vs. Searching for what's wrong/fixing it

Does NOT necessarily mean that you approve of the person's actions

CONTEXTUAL INTERVIEW [6-8]

LOVE, WORK, PLAY & HEALTH BEHAVIORS

*TAKE PERSON CENTERED & MI APPROACH

*START W/LIFE CONTEXT VS SXS/PROBLEM FOCUS

Love

- Living Situation
- Relationship status
- Family
- Friends
- Spiritual, community life?

Work/School

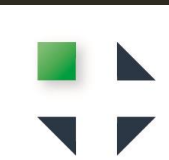
- Work/school situation/Income?

Play

- Fun/Hobbies

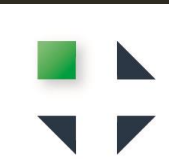
Health Behaviors

- Substance use (caffeine, nicotine, alcohol, MJ, substances)
  - "What do substances help with?"
- Sex, diet, exercise, sleep



CORE SKILLS OF MOTIVATIONAL INTERVIEWING (OARS-I)[4-5]

Open ended questions	Allow patient to reflect & elaborate
Affirmations	Recognize, support, and encourage strengths and efforts
Reflective Listening	Selectively making a guess or clarifying meaning
Summarizing	Pull together information that the patient has offered
Information and Advising	Offering with *permission*



"RULE":4 GUIDING PRINCIPLES[9]

Resist	Understand & explore	Listen	Empower
Resist the righting reflex	Understand & explore patients' concerns, values, motivations, perceptions	Listen – although we are knowledgeable, "when it comes to behavior change…the answers most likely lie within the patient…" (p.9)	Empower – "helping pts explore how they can make a difference in their own health" (p.10) outcomes are better w/active patient engagement

"CHANGE TALK" VS. "SUSTAIN TALK"[9]

When an individual feels ambivalent, there are two kinds of "talk" that emerge:

Change talk: statements for why they should make a change

Sustain talk: Statements around remaining the same and not changing; represents an impasse or a movement away from attempting to change

- Example: "I need to do something about my lack of exercise (***change talk***), but I've tried just about everything and it never lasts (***sustain talk***)." → too far out in front of patient

USING "LOVE-WORK-PLAY"

Love-Work-Play framework w/MI approach

Scan/listen for risk factors, stigma, ACEs/SDoH, pt ambivalence, other contextual/cultural variables

Resiliency detector, Pt's Values & Ideas on solution

Let their context guide the SMART Goals

OTHER TIPS?

Be curious (MI)

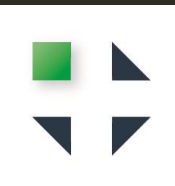
Open ended, reflective statements, empathy (MI)

Specific, measurable, achievable, realistic, & Time oriented (SMART) Goals (CBT)

Adjusting both patient and provider's expectations (CBT)

There is no try but only do (ACT)

Define why this is important to the patient (values anchoring [ACT & MI])…



WHAT COULD THIS LOOK LIKE FOR JOHN?

What behaviors need to be present to allow John to tell us what we need to hear to support him – as a patient and a person?

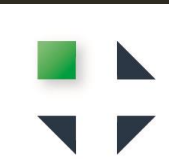
SUMMARY

Current system & education of healthcare providers doesn't always support taking a contextual, compassionate and patient or person-centered approach

- A person's context plays a huge part in the current behavior (past & present)
- Goal of patient-centered care is a **functional life** & goal of person-centered care is a **meaningful life**

Sounds great – how do we do this?

- Take **person-centered** approach – up to the patient
- Contextual interview
  - Utilize framework of **"Love – Work – Play"** to elicit info about patients' contexts
  - Mine **contextual/risk factors** and **resiliency & values**
    - Anchor **SMART** (specific, measurable, achievable, realistic, time oriented) goals with patients' values
- **MI skills** - open ended questions, affirmations, reflective listening, summaries and asking for permission before advice giving, "RULE," recognize change/sustain talk



QUESTIONS

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