

Adventures in Training Primary Care Physicians in Solution-Focused Methods

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Agenda

- Description of training program
- Approach and skill sets
- Solution-focused training
- Evaluation findings
- Conclusions



Behavioral Health Training Program in Family Medicine

- *Strengthening the Behavioral Science Training Skills of Family Medicine Faculty**
- Objective: Train Family Medicine faculty to effectively integrate behavioral health skills into practice and precepting
- Foci: health behavior change, mental health, substance abuse

*HRSA D55HP20649 (2010-2016; Werner)



Participants

- **Fellows:** Faculty preceptors at CWRU-affiliated Family Medicine residencies; 3-5/cohort
- **Instructors:** Family physician, psychiatrist, social worker, project manager, guest lecturers
- **Hours/month/fellow:** 16 (10% protected effort)
- **Fellowship term:** 10 months (January-October)



Approach

- Focus first on developing clinical behavioral skills in faculty physicians (fellows)
- Fellows integrate skills into routine practice of medicine
 - Develop expertise in the methods
- Fellows model skills & impart them to residents through precepting and residency seminars



Training Modalities

- Seminar-based learning
- Video with critique
- Simulation Center sessions
- Observations of patient encounters & coaching
- Fellows' training presentations at residencies



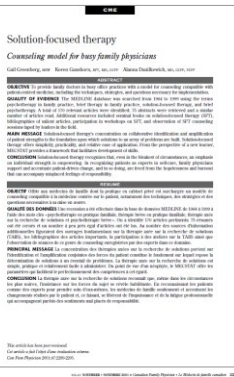
Weekly Learning Seminars

- Skills-based
- Didactics & discussion
- Adult learning principles
- Case-based
- Role/real plays
- Video-recorded skills practice
- Prep work: ~30-60 minutes/week
- Cross-critique
- Duration: 2.5 hours each



Topics & Skill Sets

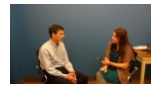
- Patient-centered methods / relationship building & empathy (2 weeks)
- Agenda setting (1 week)
- Precepting methods (1 week)
- Solution-focused methods (8 weeks)
- Motivational Interviewing (8 weeks)
- Behavioral methods & skills (3-4 weeks)
- Mindfulness for clinicians (1 week)
- Other topics as requested: substance abuse, depression, anxiety



Solution-Focused Methods

MECSTAT

- Miracle question
- Exception questions
- (Differences questions)
- Coping questions
- Scaling questions
- Time out
- Accolades
- Tasks



Greenberg G, et al. Solution focused therapy: Counseling model for busy family physicians. *Canadian Family Physician*, 2001; 47: 2289-2295.
 Giordano ME, et al. On becoming a solution-focused physician: The MED-STAT acronym. *Fam Syst Health*, 1997; 15: 361-373.



Solution-Focused Methods

Week:

1. Introduction, Key assumptions, Goal identification
2. Exceptions, Differences, Tasks
3. Miracle question
4. Skills practice (role plays, real plays)
5. Coping, Scaling
6. Accolades, Time outs
7. Simulation Center
8. Clinic observations & coaching



Fellows' Self-Rated Levels of Confidence Using Skills Consistent with Solution-Focused Methods, Pre-Post

Self-Rated Level of Confidence (1-4)	Means Pre, Post	Sig. (2 tailed)	Effect Size	Paired Differences					
				Mean	Std Dev.	SE Mean	t	df	95% CI
Acknowledging that the patient is the expert on his or her own life.	3.00, 3.90	0.0414*	1.156	0.99	1.197	0.378	2.38	9	(0.0436, 1.7564)
Eliciting a patient's goals and desired outcomes.	2.80, 3.50	0.0498*	1.012	0.700	0.977	0.309	2.26	9	(0.0007, 1.3993)
Helping patients find solutions that have worked in the past.	2.95, 3.70	0.0150*	1.265	0.250	0.790	0.250	3.00	9	(0.1845, 1.3155)
Exploring how patients cope with problems and illnesses.	2.55, 3.80	0.0007**	1.896	1.250	0.790	0.250	5.00	9	(0.6845, 1.8155)

*p<0.05, **p<0.01 *Cohen's d effect size - small: 0.2, medium: 0.5, large: 0.8 and higher



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Eliciting patients' strengths and resources.	2.75, 3.70	0.0056**	1.231	0.950	0.832	0.263	3.61	9	(0.3551, 1.5449)
Scaling levels of importance and confidence for behavior change.	2.72, 3.55	0.0282*	1.195	0.833	0.935	0.312	2.67	9	(0.1143, 1.5524)
Co-developing tasks and action plans with patients.	2.95, 3.50	0.0174*	0.899	0.550	0.598	0.189	2.91	9	(0.1218, 0.9782)
Precepting residents in effective behavior change interventions.	2.15, 3.50	0.0012**	1.906	1.35	0.914	0.289	-4.67	9	(0.6959, 2.0041)

*p<0.05, **p<0.01 †Cohen's d effect size - small: 0.2, medium: 0.5, large: 0.8 and higher



SFB what??

- *SFBT I had never heard of! (Y2)*
- *I am still trying to think about that and how to work that in. (Y2)*
- *SFBT, that is a brand new thing. (Y2)*
- *I didn't know anything about solution-focused brief therapy, hardly, so the didactic part was really helpful for me (Y3)*



Learning basic SFBT was manageable...

- *I think that one thing I liked the best was knowing how much communicating with patients is a major part of the success of what I do. That having people that made it their field of study to do that was wonderful and I would recommend it for that reason*
- *Another benefit is the intangible support one feels when having a colleague who is an expert in an area with you.*
- *I got a handle on SFBT in the time available*
- *The opportunity to role-play ad nauseum was helpful*



...and changed practice

- *I feel much more confident now that I can help my patients as they struggle with obesity, diabetes, smoking, panic attacks, depression, family difficulties, and many other common issues that they bring to me. (Y1)*
- *I feel like patients are more likely to make changes or think about making changes with these techniques than with some of the ones I was using in the past (Y4)*
- *...being able to ask my patients a kind of a different sort of question to help them figure out what the solutions to the problems might be (Y4)*
- *It's a different question now- while before I was asking four times 'Why did you start smoking again?', (now it's) more like concentrating on the positive, versus negative (Y5)*



...by promoting partnership with patients

- *I feel more comfortable (asking the patient) "How did you do this before?", and they say "Oh yeah I was watching my diet..", when they can find the solutions and something clicks, like you can kind of see it. It just takes a lot of pressure off of yourself when they can do that and it is satisfying. (Y3)*
- *I think we're seeing more success with patients, to help them with their health or losing weight or smoking (Y5)*
- *Well I think the patients get tired of being given advice. I think they like to talk about what's important to them. And all of our smokers have been told they should quit smoking before. (Y5)*



Precepting in the "time crunch"...

- *And I think that sometimes when we try to do too much we actually pull the resident away from spending the time with their patient, they get behind in their schedule they start to resent precepting.*
- *The SFBT skills feel pretty comfortable at this point, but figuring out how to get it in a teachable way kind of on the fly is a completely other thing.*
- *It is really an art to be able to have a teaching moment in this limited amount of time...What pearl do you choose to say without knowing all the learner needs?*



... results in modest goals..

- *I think sometimes we have too lofty a goal. You know the precepting of residents happens in little snippets over three years. So if I can offer one little bit of learning today..., I feel like I have gotten something accomplished (Y1)*
- *If I give the resident one bit of feedback that is going to help them shape their behavior in a way that is going to make them more effective or make patients like them more, I think it is a win (Y1).*



...and SFBT integrates successfully

- *...(It's)most effect is with the students, because they're all the time with me, so they observe me and then they're like 'Wow. You know that was interesting!' (Y5)*
- *So I've definitely been changing my precepting, but I want to change it even more and add that SFBT piece to our curriculum (Y5)*



We saw pragmatic combinations...

- *I now use a variety of techniques that draw from motivational interviewing, solution-focused therapy, narrative medicine, and cognitive-behavioral approaches to work with my patients.*
- *I think the Solution-Focused Brief Therapy and Motivational Interviewing you can use across every patient.*



... most often of SFBT and MI

- *I had heard so much about MI so I think I might have wanted to learn about it first. And in fact when patients aren't even ready for the SFBT you have to take the step back and go through to MI. (Y2)*
- *MI and SFBT: When we see a patient, we don't have a theme you know set up for us. We have to sort of decide on the fly what's gonna be the right thing to use with this patient (Y5)*
- *It's usually I mean two, three questions from the SFBT, then a couple of more from MI and that's it! (Y5)*



...and more satisfied physicians

- *I've changed my practice a little bit, but I think the thing that I've liked about the technique, especially the SFBT, is it really takes the pressure off of you as a physician. So I feel more kind of happy to see patients because it's not about me. They're the ones that had the solution, so I don't feel as upset if they don't follow my advice, 'cause I just try to use that SFBT. So I think as a provider, it's actually given me better satisfaction seeing patients by using that technique.*
- *For the resident it just shows them in that interaction that they can feel like a helper and a healer and not like they're the voice of all of the different practice guidelines that we have to adhere to*



Conclusions

- SFBT was new to all 24 fellows
- Learning basic SFBT was manageable in 8 sessions (~20 hours)
- Skills were successfully integrated into practice and precepting
- SFBT promoted partnerships with patients; consistent with current emphasis on patient-centered care (PCMH)
- SFBT skills were readily used in combination with MI and other skill sets



Conclusions

- Fellows used SFBT for health behavior change, mental health problems, and substance use disorders
- Reported that SFBT resulted in greater satisfaction with clinical care
 - Focusing on uncovering the patient's solutions and recognizing that the patient is the expert on their own life reduces pressure
- Confidence using skills consistent with solution-focused methods significantly increased from pre to post

Questions?