# Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan


## Episode 15: MI in Health Care, with Dr. Damara Gutnick, MD

**Glenn Hinds:**

Hello, everybody. And welcome back to Talking To Change: A Motivational Interviewing Podcast. My name is Glenn Hinds. And I'm joined as always with my good friend, Sebastian Kaplan. Hi, Seb.

**Sebastian Kaplan:**

Hi, Glenn. How's it going?

**Glenn Hinds:**

It's going the very best, man. Good to talk to you, good to see you.

**Sebastian Kaplan:**

Right. Yeah, you too.

**Glenn Hinds:**

Yeah. A very exciting conversation today because we're, again, taking a slight detour from our normal conversations or... not a detour, let me rephrase that, a new direction in the sense that we've got the opportunity to spend some time with a physician, Dr. Damara Gutnick, and we're going to explore what's Motivational Interviewing and the relationship with Motivational Interviewing in the medical world. But before we move on to that, perhaps you want to just remind people how they can contact us using the social media, Seb.

**Sebastian Kaplan:**

Absolutely. Facebook, the Facebook page is Talking to Change. And on Twitter, you can tweet at us, I guess that's how it's called, @ChangeTalking. And then emails, with any sort of ideas, questions, suggestions for future episodes, can go to podcast@glennhinds.com.

**Glenn Hinds:**

Great stuff. Thanks, Seb.

**Sebastian Kaplan:**

Sure.

**Glenn Hinds:**

So as I say, we're very fortunate to be today joined by Dr. Damara Gutnick, M.D., who is the medical director of Montefiore Hudson Valley Collaborative, where she is responsible

for guidance systems and practice transformation efforts to support the transition to value-based payment across the Hudson Valley as part of the New York State's Delivery System Redesign Incentive Payment program. She is an associate professor in the Department of Epidemiology & Population Health, family medicine and psychiatry and behavioral health at Albert Einstein School of Medicine and director of quality and research at the non-profit Center for Collaboration, Motivation, and Innovation.

**Glenn Hinds:**

An internist by training, Dr. Gutnick spent 18 years caring for patients at Bellevue Hospital, New York City's largest public hospital and working for New York City Health and Hospitals Corporation, where she was committed to providing culturally competent quality care to diverse inner city patient population and spearheaded behavioral health integration and self-management support initiatives. As a trainer of Motivational Interviewing and a member of the Motivational Interviewing Network of Trainers, Dr. Gutnick is passionate about encouraging clinicians to incorporate the spirit of Motivational Interviewing into their discussions with patients and dedicated to integrating Motivational Interviewing based best practices into healthcare delivery systems to improve patient engagement in their care.

**Glenn Hinds:**

She has presented MI-based workshops at national and international forums, including the Institute of Healthcare Improvement, American College of Physicians, the Society of General Internal Medicine, the American Psychiatric Association, and the MINT Forum. Dr. Gutnick is also part of the team who developed Brief Action Planning, a self-management support technique that involves using structure step-by-step process to help individuals set goals and make concrete action plans. You're very welcome, Damara. It is fantastic that you're able to join us here on a Saturday. How you doing?

**Damara Gutnick:**

I'm doing well. Thank you so much for the opportunity.

**Glenn Hinds:**

Yeah, yeah. It's exciting for us as I said because in particular, the opportunity to have a chat with someone as a physician and really to begin a conversation, I suppose, exploring with you what got a doctor involved with Motivational Interviewing? And I suppose even more interesting, once you got interested, what kept you interested? So, the relationship between MI and being a doctor.

**Damara Gutnick:**

Oh, I'm looking forward to sharing.

**Sebastian Kaplan:**

What got you started? Yeah, what's your-

**Damara Gutnick:**

What got me started?

**Sebastian Kaplan:**

Yeah.

**Damara Gutnick:**

All right. Well, so I was actually first introduced to Motivational Interviewing when I was a resident. And I actually trained at Montefiore's in their primary care program. And I had the opportunity to participate as part of my program in a substance use treatment training program at Hanley Hazelden in New York. And there was one lecture, I think it was one hour and very light touch, and they talked about Motivational Interviewing. And that was in the 1990s. And it was really solely focused on substance use. And truthfully, well, I remember that lecture and I thought the concept of Motivational Interviewing was cool. At that time, I really didn't see the relevance of Motivational Interviewing to my own clinical practice in primary care. And so, it was one of those things like, "Oh, all right, that's interesting. And all right, but I don't have patients that are severe users of substance use. I'm not in a substance use treatment program, so that's not applicable to me."

**Damara Gutnick:**

And truthfully, as a new doctor at that time, I was also very green and I still believed that because I was a doctor and I'd gone through medical school and had all this new expertise in my head that my patients would listen to me when I told them things to do. And I think it's funny because now when I train the medical students, some of them really embrace Motivational Interviewing immediately and others were like I was where, "Well, I'm a doctor and they're going to listen to me because I tell them what to do." So I think in a way, healthcare provider needs to be challenged by non-adherence and the reality of the fact that just because you're a physician doesn't mean that your patients are going to adhere to what you're suggesting. They'll often say, "Yes, of course. Yes, doctor, yes, doctor, yes, doctor, and they're not taking the medication."

**Damara Gutnick:**

So, I think you have to find the right time to introduce your audience to this. And it's oftentimes easier to train a doctor who's been in practice for a while because they're looking for a solution than a medical student who's right out of school or still in school. So that was many years ago. And then in the early 2000s, MI crossed my path again. And this time I listened, and I embraced it. And the story behind that was I've always been very interested in psychiatry and behavioral health. And there was a new program at the hospital I was working at Bellevue, which is the largest inner-city public hospital in New York. And I was working in the outpatient clinic, it was a very, very busy clinic. Lots of patients with lots of comorbidities and behavioral health issues were a big deal there.

**Damara Gutnick:**

And we didn't have the access into psychiatry. There was just not enough psychiatrists. And so, the idea was to really integrate behavioral health treatment, especially for depression into the medical clinic. And I was selected as the physician champion to bring

this new model of care into the clinic hospital system. And I was invited to participate in a New York state learning collaborative at that time. And they introduced Ed Wagner's chronic disease model and collaborative care. And are you familiar with collaborative care at all? Should I go into some?

**Glenn Hinds:**

Yeah, yeah, do. Yeah, I'm not.

**Damara Gutnick:**

Okay. So, the idea with collaborative care is that you have a team of people taking care of the patient. And so, if you have a patient with depression, you'd have a care manager that would be the right-hand person for the doctor. You've trained your doctor to feel comfortable treating depression and then the care manager is able to see the patient in between the visits to follow up and see how they're doing. And the idea is to use algorithms to help manage the depression. You start treatment, you adjust the doses, you're using evidence-based models and tools such as the PHQ-9, the Patient Health Questionnaire to actually assess the severity of depression and to guide treatment. And the chronic care model has multiple parts to it. The key thing is that there's self-management support. So the idea is how do you empower the patient to take some control of their disease management for depression, as well as how to use clinical decision-making and shared decision-making and the full care team as well as clinical information systems and decision support that could be built in.

**Damara Gutnick:**

So, you're thinking about the delivery system design, you're thinking of really the key element where MI fell in was the self-management support. And so, at this New York State learning collaborative, there were multiple teams from multiple clinics and hospitals all across the state and they presented this model to us. And the consultant on that model for the self-management component was Dr. Steven Cole. And he at that point was formally at Stony Brook and he was a behavioral health consultant as he's a psychiatrist. And he first introduced during that workshop the tool that he developed called Ultra-Brief Personal Action Plan at that point, and then also the spirit of Motivational Interviewing, which was built into the tool.

**Damara Gutnick:**

That was my first exposure. And it was a series of collaborative. So, we met every couple of months back with the same teams and you'd share what you'd learned. And over time, I developed a relationship with Dr. Cole, and I was like, "This is cool stuff." And he said, "Oh, this is just the beginning." And he said, "There's much more. There's Motivational Interviewing. You should learn Motivational Interviewing, Damara." So, I was like, "Okay." And then I went to Albuquerque, New Mexico, and I had a chance to be trained by Terri Moyer and Bill Miller and I came back, and I was like, "This is just amazing." Dr. Cole and I continued to work together, and I can talk more about that later, about the history of Brief Action Planning. But going to that workshop in New Mexico and learning from Bill and

Terri, this was amazing. I just came back, and I felt like I have a new toolkit in my back pocket.

**Damara Gutnick:**

And I think it's very important to say that at that time I was at Bellevue for quite a while taking care of really sick patients, and it was exhausting. It was exhausting because you'd see them every month or every three months and they'd come back, and their blood pressure still was not controlled and their diabetes was still poorly controlled and they were still smoking. And it was frustrating because you were trying to put your heart and soul into your work, or I was, and I was not seeing the results. And I'd look at my panel of patients and I'd say, "This is going to be exhausting. It's going to be an exhausting day." And then when I learned Motivational Interviewing and I said, "Now, I have to look for all the patients who smoke and I could use this tool. And I have to look for the patients who drink."

**Damara Gutnick:**

And I was excited because it was working in patients that needed behavior change. I was like, "This is great." But the point is it's not applicable to all of my panel of patients. And then my colleague Connie Davis said to me, "Damara, do you have patients with hypertension that are poorly controlled?" And I was like, "Yeah." And she said, "Do you have patients with diabetes that are poorly controlled?" And I said, "Yes." She goes, "You could apply this everywhere for every patient." I said, "Really?" It hadn't even crossed my mind. I was only looking for the patients that it would work on, like the patients with substance use, the patients with smoking and it was working well. But I didn't even think about the impact I could really have on my panel.

**Damara Gutnick:**

And when I realized that, then it opened up the flood gates and it brought a lot of joy back to my work because before I was wrestling with these patients around their chronic disease management and encouraging them to take a bigger responsibility on their care and it was frustrating. And we were butting heads, constantly we were wrestling. And when I learned these skills, the entire dynamic changed, and I enjoyed my work again. I had these relationships, these meaningful relationships with patients again.

**Sebastian Kaplan:**

Wow. So that's a few interesting things jump out at me there. One is this idea that where you are professionally, perhaps even personally, but certainly what you emphasize is where you are at professionally made a huge difference in your, I guess, openness or how much MI resonated with you, that as a medical student, perhaps you're going in excited to learn all the answers for people's problems and maybe an approach like MI doesn't quite fit with that stage of professional development, but a bit later as you've been working at a busy place like Bellevue and doing your best, but realizing that all the knowledge that you have just isn't enough. And now, you're more open to another strategy that doesn't discount your knowledge, but it approaches patients in a whole other way that unlocked things for you.

**Damara Gutnick:**

Mm-hmm (affirmative). I think I was always open to communication skills training and I was always willing to learn and apply, but I didn't see the applicability. And the first exposure it was such a light touch. And at that point, Motivational Interviewing was only being used in substance use. So, I was like, "Well, I'm not a substance use provider and I'm only dealing with primary care." So, there was this line that I didn't think I could pass, or I didn't see the opportunity. And I think healthcare training has changed a lot in the last 10 years, too. And now in medical school, I think they talk about behavior change a lot differently. So, I think medical students now are beginning to become more open to it because you're using OSCEs and standardized clinical exams to actually demonstrate that how challenging it could be working with a patient around behavior change earlier on. So even though they might not experience it because they're not responsible ultimately for a patient over time and seeing them back multiple times, in the OSCE situation, they could be challenged with that.

**Glenn Hinds:**

So, again, picking up on what Seb was saying there, it sounds like that your enthusiasm at the beginning was to be helpful. And when you discovered that what you thought was going to be helpful wasn't helping people, Motivational Interviewing seem to offer you a support. And because it was a light touch, you weren't been forced into it. And over a period of time, it began to filter more and more into your practice. And as has been the case so often with the people we've spoken to, everybody describes the idea that when MI came into their life, it offered them a response to a need that they had at the time, which was about how do you help me help people. And it sounds like when you discovered Motivational Interviewing, the process that has continued for years is that you've discovered that not only does it help in some situations, but the width and the depth of the opportunity has just expanded as your awareness and skilfulness has developed in the use of Motivational Interviewing.

**Damara Gutnick:**

Yes. And it's interesting because the time that I was trained and the time that is today in healthcare it's very, very different from the doctor's perspective. So, what I mean is that when I decided to go to medical school, the reason I decided is I actually was working as a pharmaceutical sales rep and I was visiting doctors in their practices. And I saw Norman Rockwell pictures. I saw the doctor being brought a ham by the patient as a thank you. And I saw the one-hour conversations and the rapport that was so important and that relationship, that built between the patient. It was beautiful. And then when I went to medical school, it was right by the time that the EMR came into place. And now, you had this computer that got in the way of your communicating with the patient. It was like the third person in the room that you had to look at more than the patient.

**Damara Gutnick:**

And doctors initially were not being trained on how to incorporate the computer into your interaction. So, it didn't take away from the patient. Now, we're doing shared charting and there's different processes that you could put in place to not let the computer take you

over. But what would often happen is you'd see people typing into the computer and talking to the patient over their shoulders or even while looking at the computer. So, you lose all that rapport. And then at the same time, length of the visit was getting shorter and shorter and shorter. So, there's a lot of evidence out there that shows in the last 20 years, physician burnout has been a tremendous big problem. 54% of primary care doctors are burnt out and ready to leave their profession.

**Damara Gutnick:**

And it's crazy because what we love about being a doctor is that relationship and the computer and the time constraints took away the opportunity to build the rapport. And so, what MI did for me is it let me really... I always felt I had to fix everything in those 10 minutes. And now, I don't have to have the responsibility to fix. I could be with the patient, meet them where they're at, put the responsibility back on the patient, and I could focus on the relationship. That was exciting and it brought back to the roots of why I went to healthcare in the first place.

**Damara Gutnick:**

And just to give you an example, when I started to apply MI, it was the same time that we started to get report cards in the clinic. And a lot of doctors don't like this because you're judged against your peers. And they say, "How well is the blood pressure of your panel of patients? How well-controlled is the diabetes?" And initially, we were not well-controlled because what we were doing was not so effective because we only had 5 minutes with the patient or 10 minutes with the patient. But when I learned MI, all of a sudden, my panel was in the green across the board for not every patient, but many patients.

**Damara Gutnick:**

And my patients said things like, "Dr. Gutnick, I don't know why, but it feels different now when we talk together. And I feel ready to make a change and to do something when I leave your office." And when I first heard that and I heard it repeated times from when I first heard that, it just reached me inside. I was like, "This is why I went to medicine. And this was what was taken away from me before that ability to be effective. And now, I have a skill set that I can be effective again and I can do it effectively in a short amount of time."

**Sebastian Kaplan:**

Damara, I'm glad you are touching on this issue of burnout. And actually, part of your initial story, one of the things that struck me was you made a comment about after you learned MI, after you went to Albuquerque and you did your training and brought that back with you to your clinic in Bellevue, you noticed the joy in your work returning and that caught my attention when you said it. And then it ties nicely to you bringing up the problem of burnout in amongst physicians. And it's something that some of my colleagues here at Wake Forest are thinking about too as one of the many things that perhaps we can do about the problem of burnout is changing the conversation in the office as opposed to the other things that could help with burnout, the things that happen outside the office. I'm not aware of any research on this, but I'm just wondering on your thoughts either anecdotally and within your practice, or perhaps if there is some research evidence out there around

either MI or just empathy and burnout, anything that you could offer that would be interesting to hear.

**Damara Gutnick:**

So, I don't know the research for empathy and burnout, but I know there is research. But I do know that Institute of Healthcare Improvement is doing a lot of work around burnout. And they just released last year a Framework for Improving Joy in Work. And it's really an amazing framework. But one of the things they talk about is a sense of purpose in the work that you're doing. So, if you feel that your work is meaningful, then you're less likely to be burnt out. And I've actually done some research around this too. And so when I'm effective and when I use MI, I definitely feel that connection to the patients and I feel like I'm being effective again. I feel better about my work, whereas when I'm just a paper pusher. And what's unfortunate in the last 15, 20 years is that doctors have become the most expensive clerical staff ever. There's actually a burnout metric called the pyjama time metric. Have you heard about this?

**Sebastian Kaplan:**

Mm-mm (negative), no.

**Damara Gutnick:**

It's the number of hours of clicking time that a physician does on Saturday nights and Friday nights? Like when you go home, it should be date night, but your date night is with Epic, which is the medical record. It's unusual now as a doctor to not go home and have two or three hours' worth of work documenting everything because the electronic medical record was designed to collect information for billing. At least this is how it is in the states and not designed as a tool to help us move care forward. And they're changing that now. I think there's a future for this. But at this point, physicians are burnt out because they're paperwork pushers, and they're using scribes now to try to alleviate that.

**Damara Gutnick:**

I've gotten the joy from connecting with the patients again, but I still feel frustrated by the paperwork and by the documentation. And that documentation is what used to make me not want to come to work. And when I learned Motivational Interviewing, it gave the balance to that. So even though I didn't like that part of my job, I felt so good when the patients would say, "I cut down on the smoking. I can't believe it, Dr. Gutnick, but I actually did it." Those little successes that the patients were having, I felt like were personal successes. And before that, I didn't feel it as frequently as when I learned MI.

**Glenn Hinds:**

There's so much about relationship in what you're describing there, not just the joy of the relationship that you as a helper or a physician have in offering an individual support, but also the relationship you have within the organization and the purpose that someone seems to have suggested that your role is to make billable decisions. And that's not why you became a doctor.

**Damara Gutnick:**

No, it's not even making the billable decisions, it's the documentation that could support the billing.

**Glenn Hinds:**

Right, right, right. So, there's a breakdown in the relationship between you and the employment agency or a part of that employment agency. And that in itself is potentially having a knock-on effect on doctor's experience of them fulfilling their purpose and ultimately their own burnout. And I imagine there's a lot of people listening to this across the world who can identify with that because I know that here in the UK and in Ireland, that's the sort of thing that I would often hear in my trainings about, "This isn't why I became a helper to record what it was I did for someone potentially to never read again." And it sounds like that's what's happening in the states. That there's efforts now have been made to marry those two needs, which is things have to be paid for and we have to justify what it is we've done to get paid for. But while we're doing what we're doing, we want to be helpful to the patients that we're working for. Yeah.

**Damara Gutnick:**

Mm-hmm (affirmative). Getting back to the burnout, I think that this might be a good place to talk about the What Matters to You. So, What Matters... because in the IHI framework for Joy in Work, there's four steps for leaders. And the first step is to ask your staff, "What matters to you," and identify those pebbles in the shoes, that low-hanging fruit that you could actually do something about. And just to give some background about the What Matters to You movement, I first heard about it at the Institute of Healthcare Improvement probably about seven years ago. Then Maureen Bisagno, who was the president of IHI at the time, challenged an audience of about 5,000 clinicians and healthcare executives to shift healthcare from What's The Matter? to What Matters To You?

**Damara Gutnick:**

And when you ask, "What's the matter," that's like eliciting a chief complaint, which is what doctors do all the time. It's like, "What's the matter?" "Oh, my chest hurts, or oh, I'm short of breath, or my toenail is turning white." That's how we usually start our interview. And if instead you say, "What matters to you," you oftentimes uncover social determinants of health needs that providers feel uncomfortable with, like healthcare providers. So, I might uncover that housing is an issue and the patient who I've diagnosed with breast cancer is concerned that if she goes in for surgery, she'll be evicted from our home. And that's like opening a Pandora's box for a healthcare provider because we may not have the skills to address the homelessness or the homeless concerns.

**Damara Gutnick:**

In my role now, I'm lucky because it's all about thinking about the whole patient, and that includes thinking about the social service organization that could help that person with the homelessness or help that person with the food insecurity and how physicians can link to these social supports to take care of the whole person as a whole. So, in New York State, there's a lot of work going on now about addressing social determinants. So I know

I'm going around in a circle here, but when you ask, "What matters to you," and you're able to ask, listen, and then do what matters, you could actually develop that rapport again because you're meeting them where they're at, you're meeting them around what's important to them.

**Damara Gutnick:**

And as I mentioned, some healthcare providers are concerned about opening that Pandora's box because they feel that if they ask what matters and they learn about these social issues that they can't do anything about, then what? And that's where Motivational Interviewing fits in. Because if somebody says, "Well, I'm concerned about my homelessness," and you don't have an answer for that, but you say, "That must be really hard. Wow, you're going through a lot of stress. I can understand why your diabetes is not your top priority right now," that's therapeutics. Reflecting and meeting people where they're at is doing what matters. So, I use the burnout to get into this because the idea is to ask clinicians also, "What matters to you," and get to those low-hanging fruit and actually address them. But it's very therapeutic for patients also.

**Sebastian Kaplan:**

So, you are hinting that there's perhaps some concern on the part of your physician colleagues to ask a question like, "What matters to you," because of this Pandora's box. And perhaps the patient will say that what matters to them is something that the physician can't directly help or treat or change. And therefore, physicians might think, "Well, why should I ask that?" However, it also seems like you're saying that maybe the physician can't go out and find an apartment for the person, but just by that opportunity to connect and to empathize with where they are in their situation socially as well as medically, that that is an opportunity for healing at least at some level.

**Damara Gutnick:**

Yes, definitely. Yeah.

**Sebastian Kaplan:**

And that's where the benefit comes in to ask that question and to unearth those things.

**Damara Gutnick:**

Yeah, it definitely because what happens often is that these issues get in the way of adherence with medical care plans. So, I could give people prescriptions for antibiotics... not antibiotic, for diabetes medications, or blood pressure, and then the person doesn't take it because they don't have the money to pay for the copy. But if I don't ask what matters and understand that, then I'm giving them a care plan that they're not going to be able to effectively address. And then I get frustrated because they're not listening to me. But now, I understand that I need to adjust what I do to meet the person where they're at.

**Damara Gutnick:**

Here's another example, a patient with heart failure. Basically, with heart failure, he keeps getting admitted to the hospital on Saturday. Every Saturday or every other Saturday, he

ends up in the hospital. And when they asked, "What matters to you," the gentleman said, "Having a dinner with my Romeo group." "What does Romeo group stand for?" "Retired old men eating out." "What do they like to eat." "A high salt meal?" So, he would go out with his buddies and have his French fries and ketchup and salt and end up in the hospital with heart failure the next morning.

**Damara Gutnick:**

As a physician, do I tell him, "Don't go out with your buddies, don't eat your favorite food," or do I maybe adjust what I do and say, "I know that going out with your buddies is really important to you and you end up in the hospital every time you do it. Why don't we think about how we can work together to avoid you being in the hospital."? And maybe that means my doing is changing the care plan. And maybe I'll say, "Take an extra dose of the Lasix, the water pill, before you go out to dinner with your buddies and keep that person out of the hospital." So, it's like thinking outside of the box about what's important to the person and it's evocative. What matters to you question is steeped in Motivational Interviewing spirit. It's evocative, it's pulling out what's important to the person.

**Glenn Hinds:**

So that real endeavour to understand what was emanating from that was just the individual's desire to be caring towards the individual. And it sounds like that's the bet that taken that risk of asking What Matters To You is that, "Okay, you may not be able to solve the social problem, but the individual will feel understood by you." That in itself is therapeutic, that in itself is very helpful. And then as a consequence, you as a practitioner will feel more fulfilled in your work because you're witnessing somebody who's coming towards entering into a relationship, feeling helped by you, and then beginning to make some changes in their own life. And that by doing it in a different way, a new outcome has arisen, not necessarily as you would have expected, but one that actually work.

**Damara Gutnick:**

Yeah, that's the key, doing something that actually works. And Motivational Interviewing takes a long time to learn. And this is the challenge. Healthcare provider can go to a training and get the concept, but actually to be able to apply it to practice and be effective in it, reflective listening is hard. It's a hard skill to learn. Coaching really helps, but a lot of doctors don't have time for coaching or don't understand how to get it. But What Matters to You and Brief Action Planning, for example, are structured ways to meet the patients where they're at. There's the Motivational Interviewing, the spirit is in the question. So that's easier for people to try as a first step.

**Sebastian Kaplan:**

The notion of time is something that we wanted to touch base with you about. You've mentioned it a couple of times already and I guess I like to just ask maybe even a broader question, which time will be embedded in it obviously. And that is so how does it work to do Motivational Interviewing in the midst of a seven to nine minute primary care visit with all the other things that you have to do in a busy practice? How does that work for you?

**Damara Gutnick:**

That's a great question. And that's something that I really struggled with at the beginning because I said, "I have seven to nine minutes, I can't do this." And what I've learned is I could do a little, I could sprinkle it in. I could find an opportunity to give a patient an affirmation. And so, when I do MI, maybe it makes sense for me to talk about my first experience on how I learned it myself and how I applied it to practice. I would apply one skill at a time. I'd say, "Okay, this is a difficult patient, I know him. I'm going to develop the affirmation before he comes in. And I'm going to find a time in my seven to nine minutes to use that affirmation and to really watch what happens." And I use the affirmation on an angry patient. I see the impact immediately; I saw the rapport gets strong.

**Damara Gutnick:**

And I remember the first case. It was a gentleman who was screaming in the waiting room at the entire staff. And he always did that. It was like a pattern. We all expected it. And he came into me and I was very busy, had multiple patients waiting and he's nasty. And I said, "You are a gentleman who will stop at nothing to make sure you get the best care that you can get." And he said, "Exactly, Dr. Gutnick. Everybody here falls through the cracks. There's so many places I could fall through the cracks and I'm going to be on top of my healthcare. And I'm going to make sure I get what I need." And the interaction was different going forward from then on. It was like we were a team.

**Damara Gutnick:**

So it's that one skill that sprinkled in that had a tremendous impact, that one reflection of emotion in a patient who's about to cry or a patient that I saw, like the anger building up and I named it, naming that emotion and seeing the impact. So, it was like, "I didn't have time to do it all, but I could sprinkle it in." And the sprinkling it in is really effective in healthcare. We learn open-ended questions. That's what we use all the time in healthcare. The affirmations were very effective for me and reflections really effective.

**Glenn Hinds:**

Mm-hmm (affirmative). And I could imagine that the immediate consequence of that is that given the fact that you have seven to nine minutes and that the likelihood is you're going to offer advice that my willingness to take your advice has shifted now that you've made that reflection or that you've sprinkled an affirmation and that has made me feel connected to you. And that the fact that now I feel more connected to you, I imagine opens me up more to the advice that you're going to offer me, rather than it just been a machine or a distant reflection or a distant piece of advice.

**Damara Gutnick:**

Yeah, definitely. And you brought up two things, you brought up giving advice. Because as a physician, you need to give a lot of information and advice. But you can give it with an MI adherent way, and so using ask-tell-ask where you're asking permission before you give the information advice. It felt so awkward at the beginning to ask permission for a patient, he's coming to see me because he wants information from me. But I need it part of the way I practiced. It didn't take extra time. And the rapport built so beautifully, asking

and just telling a little bit, just to fill the gap, what do you already understand about your diabetes and why it's important to get it under control? And then having the patients say, "Well, I know a lot. My grandmother had diabetes and she lost a toe and I don't want that to happen to me." The change talk just started to flow, but when I got the persons talking about what they knew rather than just jumping in and giving them information advice.

**Damara Gutnick:**

And then finally, using teach back at the end. So that last ask, like somebody in your family asked you what we talked about today, what would you tell them back? I want to make sure that I was clear, not testing the patient, but making sure that I did a good job explaining it in a way that they could repeat it back. So, ask-tell-ask is such a valuable skill in healthcare. And I'd love to share a story about that if that's okay.

**Glenn Hinds:**

Please do, yeah.

**Damara Gutnick:**

So, I taught a group of nurses Motivational Interviewing a few years back at Jacobi Hospital. And then I would go and see the nurses in practice. So now, it's like two weeks after the training and I said to this one nurse who is doing a hypertension treat-to-target program, so the idea is that she'll see the patient back quite frequently on a weekly basis until the blood pressure gets controlled, and I said, "Well, did you go to my training?" And she said, “Dr. Gutnick, that was the best training ever. It was so much fun. I learned so much. It was great, great, great." I said, "Okay, did you apply anything that you learned to your work?" And she said, "Oh, no." I said, "No?" She goes, "No, there's no time. I just I can't do it."

**Damara Gutnick:**

I said, "Well, what's your next patient?" And she said, "It's a gentleman with high blood pressure. It's a new patient to the clinic. He's not adherent. His blood pressure is very high." I said, "So what are you going to do during that visit?" And she said, "Well, I have to educate him about the medications and the importance to take that. I have to tell them about the risk factors associated with high blood pressure and his risk for stroke and heart attack. I have to really talk to him about adherence because I don't think he's taking the medications that he really should be and needs to. I have to talk to him about diet and how he has to stay away from salt."

**Damara Gutnick:**

And she had this laundry list of things that she had to educate him, information advice she had to give him. And I said, "Well, if you were going to apply one MI skill, what would that be?" She goes, "I don't have the time." I said, "One skill, just next patient, one patient." She said, "All right, ask-tell-ask." And I said, "Okay, let's see what happens." The patient comes in and she asked one question. She said, "Mr. Jones, tell me a little bit about what you understand about why it's important to get your high blood pressure under control."

**Damara Gutnick:**

And this is what the patient said, "Well, I know a lot about high blood pressure. My grandmother and my mother both had strokes. I can't afford to have a stroke because I'm the sole earner for the family. The problem is I work in construction and I work on the top floor of a building and there's no bathroom up there. And the doctor gave me this medication that I'd like to take, but it makes me pee. So, I can't take it when I go to work. And the other thing is my wife, she's an amazing cook and she makes a mean kielbasa and I don't want to insult her because I know she uses a lot of salt, but I have to eat it when she makes it.

**Damara Gutnick:**

So, the nurse was just shocked because what she thought was a disengaged patient who is not adherent actually was the most adherent patient and knew everything, she needed to teach him about already. But he didn't have the tools and the care plan that worked for him. So, the nurse's role changed and she needed to advocate to change the medication and to help him have this conversation with his wife about the salt intake. So, it changed the whole dynamic. The nurse was shocked. And she said, "Wow, I just saved a ton of time and I'm effective. Whereas before, I would just check off the box that I gave all the information I did my job, but the patient knew it already. And we still were not dealing with the issue."

**Sebastian Kaplan:**

Yeah. It almost sounds like embedded in the statement, "I don't have time," is an assumption that the patients don't know what I know, or the patients don't know what they need to know. And the reason why I don't have time to do all that MI stuff is because I need to take all this time to tell them what I know.

**Damara Gutnick:**

Exactly.

**Sebastian Kaplan:**

And by changing that assumption and going to an elicit-provide-elicit, ask-tell-ask kind of model, you uncover all that they know and actually you're able to do a much more focused piece of information giving that is a lot more efficient and actually saves time.

**Damara Gutnick:**

And it's more fun because you're building that rapport, you're effective, and that gives you the sense of purpose and makes your work meaningful again, and that brings joy back in work. Yes. And that kind of story is the story that I hear all the time. And for me, that happened all the time. I was like, "Oh my gosh." Because who is the expert on the patient? It's the patient. The patient has the answers. And trust me, somebody who smokes, they know the reasons not to smoke. Here's another great story. I had a patient when I first learned MI and about acceptance and not pushing. So, this was a patient who was about 40 something years old. And she had had a stroke. Her blood pressure was high, and she was a heavy smoker.

**Damara Gutnick:**

And I said to her, "It's nice to meet you…" We went through her whole medical history and I said, "I know you smoke. And cigarettes are really a big risk factor for stroke. The smart thing to do would be to give up smoking." And she said, "Dr. Gutnick, I get that. I understand that. But I have such a stressful life. I'm a single mom and the cigarettes are my only vice and I need them." And so, I said, "Okay, I hear you. And it sounds like you have a good understanding about this, and this is your decision. And I'll even write a note in my chart not to discuss this again with you any further because this is really important to you and you need this vice."

**Damara Gutnick:**

She thanked me. I wrote it in the chart, and she came back a couple of months later and I did not discuss the smoking. And I went through the entire history and physical and at the end I said, "Is there anything else that you'd like to discuss today?" And she said, "Yes, I'd like to stop smoking. I need your help." I was like, "Wait, wait, wait, I know you love your cigarettes. I intentionally didn't go there." And she said, "That's just it, Dr. Gutnick, I couldn't use you as the excuse." She said, "I know the reasons I have to quit. I have young kids. I'm responsible for them. They need a mom and I've already had a stroke and I'm only 45 years old. I need to stop the cigarettes. I know that that's something I have to do right now." And she said, "But because you didn't push me, I knew I had to push myself." And that kind of thing happens all the time when you stop pushing.

**Glenn Hinds:**

Wow, yeah, yeah. So, it sounds like in some ways when you get out of the client's way, the helping changed... that she began to help herself. And as a consequence of her beginning to help herself, you find yourself feeling more helpful because that's what you want. You wanted her to help stop smoking. However, she decided to stop smoking was less important than the fact that she stopped smoking. But you heard her, you did something different, and as a consequence, she could do something different with you.

**Damara Gutnick:**

Mm-hmm (affirmative). And I don't know if you've seen my Mr. Smith's Smoking Evolution video.

**Glenn Hinds:**

No.

**Sebastian Kaplan:**

Yeah, it’s great.

**Damara Gutnick:**

Yeah, it's online. And it's a true story. So, the words that came out of this guy's mouth are exactly. He was one of my favorite patients and we used to bicker and banter, and he was a heavy smoker and had lots of reasons not to smoke. I had lots of reasons why he

shouldn't smoke because of his health condition. And he'd come into my room at some point and he'd put up his hands and he'd say, "Just not today, just don't discuss the smoking." And for years, I had to discuss it. I had to say, "Well, I wouldn't be a good doctor if I wasn't discussing it. I had to check off my box that I did my work that I told him," but he knew it all. And then I learned Motivational Interviewing. He was one of the first patients that had success with. And I was shocked. I was like, "Wow, this is super powerful. This guy I've been working with for many years and not getting anywhere. And now, he's willing to make a plan." I couldn't believe it.

**Sebastian Kaplan:**

Let's put a link to that video on the episode notes. It's quite creative and really delivers the message well. And so, Damara, I don't know if you've heard this comment or this anecdote, I guess, that gets shared around MI circles. But again, it's along the lines of this time issue, but often physicians saying, "I don't have time not to do Motivational Interviewing."

**Damara Gutnick:**

Yeah. I think that was one of the first people that said that because I was like, "I've been working with this guy through smoking for so many years. And yeah, it takes time to do the MI, but look it works. Whereas the other stuff I wasn't doing, wasn't working,"

**Sebastian Kaplan:**

And also, in listening to you describe all of these encounters that you've had, well, the way you describe your use of MI is a sprinkling that you do... Sometimes you'll do one thing, or you'll really emphasize an affirmation, for instance, or maybe a reflection or ask-tell-ask. And I would imagine though that we could highlight different points throughout each of these encounters where there's you could recognize the four processes in there.

**Damara Gutnick:**

Exactly, yeah.

**Sebastian Kaplan:**

You could see there's... Oh, there she is. She's engaging. She's definitely engaging with the patient. There's no other agenda other than an engagement part of the process. And then I'm sure there's a place where you do some focusing, where you talk about, "Wow, there's the diabetes and you're smoking and this-

**Damara Gutnick:**

It’s a chief complaint. ( ? 44.05)

**Sebastian Kaplan:**

... more when your back or something, which is most important to you." And Change Talking really emphasize that a lot throughout our discussion so far. And that's probably something that you're certainly listening for if not explicitly evoking. And planning is

something that you've mentioned quite a bit as well, whether it's through ask-tell-ask, or whatever. So, while sprinkling is definitely something that your intention is to do and maybe you'll highlight thing over others, but it does sound like the pieces in MI are there. They just may not be laid out in the same way or at the same pacing that it would with a substance abuse counselor or a sex therapist.

**Damara Gutnick:**

Yeah, you don't have the time in healthcare to do that reflection back and forth, back and forth, back and forth. The most valuable MI tool, the overall is change talk for a healthcare provider. When I learned change talk, I was like, "This is awesome." And the reason why is in Healthcare we learned in medical school the Prochaska model of change... And I love the analogy. I think it's Bill that talks about the MI Hill. So, the Prochaska model of change is imagine you're far away from the hill and you don't even know you… you're on a road far away, and then that's precontemplation. And then you have the contemplation, which is going up the hill. And then once you make the decision to actually make a change, you're on the way down the hill and you're starting to prepare and then you have action, which is on the other side of the hill.

**Damara Gutnick:**

So, in healthcare, you learn those skills, that Prochaska model, and you learn that at different points you could pull out different tools to help the person move forward. But you first have to figure out where they're at. And that takes some time. And each time you see them, they're in a different place since you have to actually figure out where they're at first. When I learned change talk, I was like, "Wow," because in a moment I could tell if the person's ready for change, and if the change talk's getting stronger, and if I'm ready to go to the planning stage because I need to check the box and do my goal setting, or you know what? This person's not ready for change. I've got to respect his autonomy and save my time for another patient where I have the time to do the planning.

**Damara Gutnick:**

So from a time management perspective, change talk lets me know where I should go forward because it's a worthwhile use of time versus going forward with everybody and whether or not if somebody is in ambivalence and it's going back and forth, I don't have the time to do the reflection back and forth. I don't have that in healthcare. But I could say, "Wow, it sounds like you're not ready to make a change. How about we talk about this the next time?" And then I save that time, those two minutes that I could give to the next patient who's ready for change, and then I can go on and do the planning. So, it helps me because I'm not trying to do planning when people are not ready.

**Glenn Hinds:**

Right. And from the stories you were telling, it sounds like that when you respected people's right not to change, it made a lot easier for them to decide to change for themselves so that when you didn't force someone towards being different, there are people who come back and have already started doing it differently because it wasn't something you were telling them to do. And again, I think it from a practitioner or a

trainee's perspective that there's an awful lot of theory that we've talked about today and people will have recognized a lot it from their own trainings, the idea of change talk and the openness strategies and whatever else is.

**Glenn Hinds:**

But it sounds like they have been able to connect what it is that you were doing to the theory of Motivational Interviewing and made it a lot easier for you then to maintain it, that you recognized what change talk sounds like and you developed your ear for the sound of change talk that then helped you then to decide what to do differently. And it sounds like that's the effort that you as a practitioner had to make, that you had to learn to recognize what an affirmation was, and then that they offered to practice a depth of potential reflective listening and to recognize change talk. So, there's an effort on your part to make your life easier.

**Damara Gutnick:**

Yes.

**Glenn Hinds:**

Right.

**Damara Gutnick:**

And I think about it when I first learned it, I had a parrot on my shoulder. And the first time I came back to practice after learning MI with Bill was, I was shocked at how frequently the change talk was coming from me. So that was my first realization like, "Shut up, Damara," zip my mouth and not to do it. So, my first challenge was not to tell people what to do. And that was really hard. But then I became aware of it, and then instead of filling the empty space with my words, I would try to evoke it from the individual. And the first time I was effective, I was jumping for joy inside. I was like, "Wow, this really works. Look at this." And so, it was a barometer of my effectiveness, the change talk.

**Sebastian Kaplan:**

Mm-hmm (affirmative). And so what would you say if you had to pick two or three strategies or questions or evocative statements that you feel like are typically effective at evoking change talk, what are some that come to mind for you?

**Damara Gutnick:**

It really depends on the individual. I love complex. I love the complex negative reflections.

**Sebastian Kaplan:**

The amplified?

**Damara Gutnick:**

Yeah, amplified negative reflections. I love those because they get the change talk really quick. They don't work for everybody and you have to be really careful. And I'll always

note in my notes if it flunks it, like if the patient is really concrete and they take you literally, I'll never use an amplified negative reflection again. And I write it, "Don't use it with this patient." But I find that when those work and that you can't do them often, you have to be that strategic, wow, the change talk comes like this? I'm not good at metaphors. I have like two or three that I keep in my back pocket. And I'm always in awe when I meet a clinician that they roll off their tongue. But I find them effective, but it's not natural for me.

**Damara Gutnick:**

I think in healthcare, reflecting the emotion is very, very effective also because you're getting at what's not said. And that's a skill set that the clinicians feel more comfortable with because you learn it in medical school too. The harder ones to teach and for people to feel comfortable with are obviously taking that educated guess and being risky, taking that risk of what you think is meant, but not being said.

**Glenn Hinds:**

But it sounds like there's a step forward, step sideways which is a bit of a dance going on here that you're... again, back to the effort that you're making that it's easier for you to continue when you have some success, a bit like our patients, a bit like our clients. When they see some success for their effort, they're more willing to take a next step. It's where things don't work that the difficulties start to arise.

**Glenn Hinds:**

And so it sounds like that joy that arose in you when you offer that affirmation or when you use your first reflective listening and it landed so perfectly that you went, "Yes. Did anybody else see that?" the success of the practitioners is equally as important as the success for the patient in their own development. And so it sounds like in some ways that the recommendation is for people who have started the journey of learning Motivational Interviewing. It's take one piece at a time and take the successes, and build on them and recognize not all of them are going to work, but that's not in itself a reflection on you as a practitioner in the big picture and keep going.

**Damara Gutnick:**

Yeah. And I think developing the capacity to be insightful and to see the impact of what you're doing. Take the time to really pay attention to how effective you are with your strategic use of MI like, "All right, I'm only going to do one reflection this entire visit, but I'm going to focus on what happens when I use it." And I think that's where the key is to see how effective you can be. I was watching a video of MI the other day and I think sometimes it goes on too long. At some point, like if you're not moving and conversations is going back and forth, you have to know when to gracefully exit and say, "All right, it's not worth it right now."

**Damara Gutnick:**

And I think that other providers that have more time probably don't have to make that decision as early as a medical provider does. I can't go back and forth three or four times. It has to be quicker for it to be fit into medical practice. But I think medical practitioners

work closely with other people who would spend more time and can have that back and forth. And so, knowing when to refer, when it can't be you anymore is really key.

**Sebastian Kaplan:**

Mm-hmm (affirmative). Yeah, there's such a clear intentionality about what you're describing, the I'm going to do one reflection. I'm going to pay really close attention to what happens and how it lands and how the patient responds. And I just love hearing this because I can imagine for physicians that are learning MI, go to a workshop or maybe their clinic manager says, "You should learn MI, or you read an article about it," it must feel like, "I have to learn a whole new language almost." And while learning MI could take a long time and of course it can be a tricky thing to learn, you can start with these really small steps or sprinkles as you said. And it could just be as simple as at the start anyway as, "I'm just going to do one reflection and really pay attention to what happens." That's part of a path forward of learning and using MI.

**Damara Gutnick:**

Right. And it's like any behavior change when you have success, then it builds your self-efficacy and your confidence to do more. And I find that these skills are usually successful, and that one reflection is oftentimes even a litmus test on whether or not that particular patient would be a patient that would be responding to MI too. You have to be good at it. Just a simple reflection's not going to help. But if you get good with your targeted single reflections, you can see, "This is a person that is thoughtful and insightful and can go back and forth with the banter and move."

**Glenn Hinds:**

And I think one of the things that perhaps it's important for people to appreciate as well is given that the fact that we are learning things, that one of the skills that I think has been talked about without it being named is the ability to be compassionate. And it sounds like one of the things that you're describing as well as a learner, that one of the things that you were able to do was to be compassionate with yourself when it didn't work and to be compassionate with yourself when you weren't sure what to do next and were able to keep going, recognizing, "I am learning something new here and that it didn't land."

**Glenn Hinds:**

And the reason why that arose in me was the fact that I might notice practitioners who, as you were describing there, who they appreciate that during a conversation “this isn't going anywhere. This isn't going to work right now.” And it's really important that they can hold that space with compassion for themselves and ultimately for the patient as well as they can go, "This is not the time and that's okay, both for me and for them," and to hold that space and then hope that they come back and that the opportunity arises again because I think there's potential that when it doesn't work, that we can beat ourselves up. And that in itself contributes to the practitioner burnout that I should be helping everyone all of the time in these ways.

**Glenn Hinds:**

And what you're helping us to understand today is that, "Sometimes the best way for me to help you today is not to try and make you be different, but just to accept you for who you are, and we'll maybe see you again in the future. And maybe that's the time you'll talk about it, but that's not going to change how I treat you. I don't need you to change for me to want to be with you." Lovely. Lovely.

**Sebastian Kaplan:**

Well, I think maybe this learning MI is a useful place to touch on a bit as we start winding down whether it's... Well, you talked briefly about the experience of a medical students or maybe a PA student, so there's the standpoint of an early trainee, but then also the busy practitioner that attends a workshop and is now faced with a choice really, "Do I incorporate some of this in my work or not?" What thoughts do you have about the learning of MI either as an early learner and trainee or as an experienced practitioner learning to expand their practice?

**Damara Gutnick:**

I think like I've been hinting at is start small. Don't try to do it all at first. There's so many different skills and so many different parts of it. What I recommend first is start to think about whether or not you're doing the change talk or whether or not you're letting the silence be there and eliciting change talk. Most practitioners I think when they first learn this, the first thing they notice is that they're telling people what to do all the time. So that's the first insight that you can glean. So, then the first goal would be shut up. And then how could you try one thing to elicit it and/or if you hear it on its own, then try planning after you hear it, but don't jump to the planning before the person's ready.

**Damara Gutnick:**

So, as I'm talking now, I think it could be almost a stepwise thing for primary care doctors. So first of all, don't do bad, don't give the change talk and be aware of that. And two is don't go onto planning unless the person's ready, so accepting autonomy. And then practice one skill at a time and really pay attention to the impact that it has and build your awareness of the impact and build your interest in getting good at it. And then you practice that one skill, which might be an affirmation at first, or it might be some sort of reflection, or I think in general we're pretty good at open-ended questions. But just build the awareness of the impact that you're having when you're using the scale, which will build your readiness to learn more and practice more.

**Glenn Hinds:**

Yeah. As you're describing what you're saying there, I'm writing down words almost like an MI map that's it's like, "These are the places you're going to visit in your relationship to Motivational Interviewing. Not everybody's going to start in the same place and not everybody's going to follow the same direction. But ultimately, when you get to know MI, you'll know all of these places, where would you like to start, and enjoy the journey, enjoy what you discover. There's lots of interesting things that you're going to find out, and yeah, send us a postcard.

**Sebastian Kaplan:**

Well, Damara, this has been wonderful. And I can imagine physicians and other traditional healthcare medical providers would find this really quite interesting and helpful. One of the things that we ask our guests towards the end of an episode is to find out what do you have on your horizon? What sort of project or thing that's either MI related or perhaps not MI related that you're excited about looking forward to?

**Damara Gutnick:**

So, I'm so glad you asked that because what I do in my current job is I'm doing healthcare transformation in New York State. And basically, I'm working with multiple health system providers from hospitals to primary care, behavioral health, substance use, and also community-based organizations like how they could deal with housing or even the public library. And thinking about whole person health, healthcare happens within healthcare institutions, but social determinants issues happen elsewhere and how do we link all these organizations together into an integrated delivery system and make change happen.

**Damara Gutnick:**

And what I've done in this role is I've done a lot of training of healthcare providers in MI in all these different places that they work at. And even yesterday, I did a training for librarians. Librarians have a lot of opportunities to use MI skills and they were like, "This is amazing." And they immediately saw the applicability to it. I worked yesterday also in the training there were caseworkers that only dealt with housing. And they saw opportunities to use What Matters to You even more broadly to understand the other needs of the person so they could link them to primary care or behavioral health services that may be getting in the way of them getting their housing.

**Damara Gutnick:**

So, I think the goal in the future is to think of whole person health and to realize that healthcare is not just within a medical setting, it happens everywhere, or there's opportunities for it to happen everywhere. And what I was going to get at is I'm working with all these different organizations about making changes and applying best practices in healthcare. And recognizing that on the front lines of the staff, any change feels uncomfortable also from the staff perspective.

**Damara Gutnick:**

So I've learned change management, which is it's very aligned with Motivational Interviewing, but it's applied to systems, managing the people side of change within an organization when you want to make a change in a system, and you're going to do a new screen test, or you're going... It feels uncomfortable for the staff because it's another thing to do. So how do you think about systems change and managing the people side of change on the ground when you're making changes in healthcare systems or policies? And when I learned Prosci, which is actually the change management program that I learned, I was like, "This is just like MI for organizations." So, I think there's lots of

applications for MI much more broadly. And in other sectors, they don't call it MI, but they kept the concepts there too, there's a lot of similarities.

**Glenn Hinds:**

Mm-hmm (affirmative). So, it's almost like treating the organization as an individual and relating to them at that level, understanding why this organization behaves the way it does.

**Damara Gutnick:**

Yeah, or the individuals as a workforce. Like I might have a great idea to implement at the top, but when it doesn't feel like a great idea for the staff. And if we don't take that into consideration when we're designing and implementing, you're going to have a burnt-out staff and you're going to have a lot of resistance from the staff. So, I love that the application of MI can be applied to system science, too.

**Glenn Hinds:**

Exciting stuff, exciting stuff. And it sounds like the energy of it is what's driving you forward, Damara. And it sounds like it's what gets you up in the morning and keep doing what you're doing. And we really appreciate you giving us your time today and your enthusiasm and your excitement and your commitment and dedication to what it is you do is definitely infectious. And I have no doubt that there are a lot of people who are listening to this episode will be curious to find out more. Well, we ask all our guests, if people haven't listened to you talk today, wanted to find out more about anything, or you in particular, would you be happy for them to contact you? And if they were, how would you prefer them to contact you?

**Damara Gutnick:**

Yeah, sure. I think I'm on Twitter. So, my Twitter handle is @Dr, D-R, Damara, D-A-M-A-R-A-1, and people can always write to me directly through Twitter also, there's that capacity to send a text. That's probably the best way. And if you're interested in some of the things that I'm doing, then my work website which is Montefiore, M-O-N-T-E-F-I-O-R-E-M-H-V-C Montefiore Hudson Valley Collaborative .org and I can send it to you. And we have a whole What Matters to You page over there, is a good way to see the things that we've been doing, or people could write to me directly, too.

**Sebastian Kaplan:**

And how would they do that?

**Damara Gutnick:**

Through my email. It's dgutnick@montefiore.org.

**Sebastian Kaplan:**

Okay, yeah. And we'll include all of that in the notes, but yeah-

**Damara Gutnick:**

One other really amazing thing that I wanted to share is the National Health Service has a team called the Horizons team. And it's led by this amazing woman, her name is Dr Helen Bevan. And she is an expert in systems change and building change agency within organizations. And if you follow her on Twitter, @helenbevan, you will get a curated list of materials that are just so robust on how to help change happen within institutions. So this is once again taking what we do in Motivational Interviewing on the individual patient level and thinking much more broadly about systems redesign and developing change agency that can help make change happen more broadly, just valuable resources. And the Horizons team is now doing a School for Change for the next few Thursdays at ten o'clock in the morning. But they'll be recorded, and you could find the School for Change up online and it's really robust and wonderful.

**Glenn Hinds:**

Fantastic. Thank you very much. So, again, Damara, thank you very much. We are just going to close now and perhaps as we close, Seb, would you just like to remind people how they can contact us on the social media?

**Sebastian Kaplan:**

Absolutely. Facebook is Talking to Change, Twitter is @ChangeTalking, and the email is podcast@glennhinds.com. And of course, we always welcome ratings and feedback on any of the platforms, whether it's iTunes, or Spotify, or Stitcher, or any of the others that you all are listening to us.

**Glenn Hinds:**

Fantastic. So, again, just to be grateful to you, Damara, for your time and your willingness to share with us your expertise and your enthusiasm, on behalf of myself and Seb, thank you very much. Seb, as always, good to talk to you my friend. And to everybody, thanks for listening. Thanks.

**Sebastian Kaplan:**

Great. You too, Glenn.

**Damara Gutnick:**

Thank you.

**Sebastian Kaplan:**

And Damara, thanks so much.

**Damara Gutnick:**

My pleasure. Bye.