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**From:** Wayne, Kathleen A (HSS)  
**Sent:** Friday, July 11, 2014 3:42 PM  
**To:** HSS DPA WIC Coordinators; Welch, Scooter (HSS Sponsored); O'Gara, Kathy (HSS Sponsored); Bennis, Don  
**Cc:** HSS DPA WIC Juneau; HSS DPA WIC Anchorage; Olejasz, Aimee M (HSS); 'Danielle Rybicki' ([afdr@uaa.alaska.edu](mailto:afdr@uaa.alaska.edu))  
**Subject:** WIC Update July 11

Hi Everyone,

Attached is an article on motivational interviewing with some great examples of client dialogue on page 683. Also, I will be on vacation from July 14 to August 5. Please contact Becky Carrillo in my absence, her contact information is: [Rebecca.Carrillo@alaska.gov](mailto:Rebecca.Carrillo@alaska.gov) or (907)465-8636.

Take care,  
Kathleen

1. **RD Quarter Teleconference**--Upcoming quarterly meeting: Our next quarterly meeting will take place on September 4, 2014 at 8:15 AM. We'll have a more detailed explanation and discussion of the changes that will take place for the Final Food Rule, including the policies. You're encouraged to have your CPAs and RDs attend this meeting as well.
2. **Fall Coordinator's Conference:** The Coordinator's conference will take place September 16, 17, 18 at the Frontier Building in Anchorage. Is there any interest in having a social event- like a picnic- on one of the evenings? If you think you might like to attend a mixer for an hour or two- please let me know- [Jennifer.johnson@alaska.gov](mailto:Jennifer.johnson@alaska.gov).
3. **SNAP ED Needs Assessment Report**—The Supplement Nutrition Assistance and Obesity Prevention Education Program (SNAP ED) commissioned UAF's Center for Alaska Native Health Research to conduct a needs assessment study to help guide future program services. The report is located on our SNAP ED website
4. **WIC Vendor/FMNP Update:**
  - a. **Reminder:** Gina Heffern moved to a different position in June. The Vendor Management contacts are Sandy Harbanuk, [Sandra.harbanuk@alaska.gov](mailto:Sandra.harbanuk@alaska.gov), or Erin Khmelev, [erin.khmelev@alaska.gov](mailto:erin.khmelev@alaska.gov), or 907/465-3100 to reach either.
  - b. **Food List / Participant ID booklets:** We have approximately 6,000 booklets on hand. Please contact Sandy or Erin if you need more.

- c. **FMNP Coupons:** We have approximately 4,500 FMNP coupons left to distribute. If any LA expects to use more than we initially sent, please let us know. To date, FMNP redemptions include \$1,895 in FMNP coupons, and \$34.00 in FVV's.
  - d. **WIC Farmer's Market Program** ---For participating clinics, you will soon be receiving a box containing a book or two for your waiting rooms and several magnets for your participants. The books will promote eating fresh vegetables to children and the magnets will be a reminder for your participants to use their FMNP coupons before October 31<sup>st</sup>. Once you receive the magnets please distribute one per household as we have a limited stock. If you have any questions please contact Erin Khmelev or Sandy Harbanuk.
5. **UHT Policy:** SPIRIT Tips attached are the items from the Quarterly Teleconference that didn't get reviewed. Please take a minute to review these with your staff members. They are the items that the Help Desk see come to them on a regular basis. Thanks.

In order for the Vendor Unit to help rural stores project how much milk (and types) they need to order, we are doing a quick survey to estimate the types of milk you plan to prescribe once stores with fresh milk exemptions will no longer be able to provide all UHT as a substitution. If you are a Local Agency that monitors rural vendors with milk exemptions, please fill out the survey below and email to Sandy Harbanuk [Sandra.harbanuk@alaska.gov](mailto:Sandra.harbanuk@alaska.gov) by July 18<sup>th</sup>. Thanks for your time and assistance.

**Milk Exemption Survey**

**What milk types do you plan to prescribe on client FIs used at rural vendors with milk exemptions? Please see the attached policy that provides the guidance that no more than one half of milk in a food package can be made up of UHT milk. Possibilities of milk types are: UHT (no more than ½ of the package), dry milk and evaporated.**

- |  |     |    |
|--|-----|----|
| Do you plan to provide packages with ½ UHT?                    | Yes | No |
| Do you plan to prescribe packages with evaporated milk?        | Yes | No |
| Do you plan to prescribe packages with dry milk?               | Yes | No |
| Do you plan to prescribe packages with a combination of milks? | Yes | No |
- If yes, please describe proportions and types (i.e. ½ UHT, ¼ dry, ¼ evaporated)

**Will your plan vary from city to city?**  
If yes, please describe:

**Clinic Name**

6.



**SPIRIT Tips and Reminders:**

- Users receive an error message when clicking “Update Kept” on the “Appointments for Today” list. Unfortunately, this is a “bug” with the SPIRIT software. It may be helpful to check the “Appointments for Today” screen (Participant List/Activities) to confirm that the appointment was marked as kept and retained by SPIRIT.

**SPIRIT Help Desk Info:**

- **\*\*VERY IMPORTANT\*\* Please pass along to you staff asap.**
  - If you require help desk assistance on Monday, July 14th please e-mail Terry ([terry.hoskinson@alaska.gov](mailto:terry.hoskinson@alaska.gov)) & Chris ([christopher.renfro@alaska.gov](mailto:christopher.renfro@alaska.gov)), we will get back with you as quickly as possible. If your request is urgent and you require immediate assistance call Terry at 907-465-6398. We sincerely apologize for the inconvenience this may cause and we ask your patience
  - **Normal Help Desk operations will resume on Tuesday, July 15<sup>th</sup>**. Remember to send all questions, issues and errors to the WIC SPIRIT Helpdesk at [wicpsirithelpdesk@alaska.gov](mailto:wicpsirithelpdesk@alaska.gov) or phone them at 907-334-4900.

Nice To Know:



CA WIC newsletter for the Friday update

**More Cell Phones, Fewer Words?**

According to [Environmental Health Trust](#), "excessive cell phone usage can work to hinder the communicative rhythm and bonding experience that new mothers and infants work to establish, especially within the first six months." That's because "[eye gaze between baby and mother](#) is one of the most important prelinguistic skills to occur before verbal communication develops." This has implications for moms who scan their phones while breastfeeding. So instead of texting, how about reading to our babies? The recently-updated [AAP position paper](#) recommends promoting literacy as a part of a medical practice. And whether you have a baby or not, be sure to [practice safe tech](#).

Meeting called to order 8:18am by Dana Kent

- I. **Infant FI Usage – Dana Kent:** FVV and social marketing data has been collected, details below. LAs please continue to encourage FVV usage, especially at Farmers' Markets where available.
  - May – July there were 3,160 FVVs redeemed
  - FMNP \$500 redeemed in June
  - FVV Ad campaign on Facebook reached 8,241 people and had 13,052 impressions
  - Using WIC at farmers' markets campaign was viewed by 3,974 people and Liked by 135
  
- II. **Quarterly Reporting – Dana Kent:** Quarterly report format is changing, beginning October 2014.
  - A. New report sections include: Vendor monitoring, Logic model progress, BFPC, Travel, and Video teleconferencing.
  - B. Nutrition themes are specified at each quarter and information requested will be dependent on theme. LAs will need to use SPIRIT utility site to collect data.
  - C. Third Quarter - survey results will be due in Excel.
  - D. Fourth Quarter report will have a program evaluation, as well as a wichealth.org data request – please contact Jennifer Johnson if you have any questions. Additionally, logic model progress, activities and outcomes will be visited.
  
- III. **Federal State Technical Assistance Review (STAR) and income verification – Dana Kent:** USDA will be conducting STAR focusing on certifications. Income policy is being updated (attached). New income guidelines have been posted to site. Proof of income or adjunctive eligibility must be provided and documented. For questions please contact Dana Kent.
  
- IV. **Training on Final Food rule – Jennifer Johnson & Elaine Nisonger:** PowerPoint presentation attached, training items below. Next food rule training in September, CPAs asked to attend.
  - Technical definitions
  - Terminology changes
  - Items removed/added
  - Implementation dates
  
- V. **SPIRIT Items – Terry Hoskinson:** New SPIRIT items have been added to recent updates and are attached.

**\*Next Quarterly Policy Teleconference is scheduled for Sept. Details will be provided closer to date\***

Meeting adjourned 9:31am

## **SPIRIT TIPS**

⇒ Seeing some duplicate client issues recently; please remember to do a **STATEWIDE** search by DOB for any applicant.

Because a mistake may have been made on the DOB entry into AKWIC or SPIRIT, an additional statewide search on other criteria is a good practice.

If in doubt about whether an applicant may have been on WIC in Alaska before, please call the WIC SPIRIT Help Desk and ask them to research the applicant.

⇒ The “Clinic Roster by Certification Status” report has been edited to include the Authorized Representative’s name.

⇒ Review of Breastfeeding terms in SPIRIT-

Fully Breastfeeding = Infant receives no formula

Mostly Breastfeeding = Infant breastfeeds more than receives formula

Some Breastfeeding = Infant receives more formula than breastmilk and **greater than ½ the amount of formula than a non-breastfeeding infant receives.** (The woman could be breastfeeding as little as once a day).

Non-Breastfeeding = Infant receives only formula.

How does SPIRIT count some breastfeeding women?

Some-breastfeeding women who are more than 6 months postpartum are automatically counted by SPIRIT during the End-of-Month process (as long as the women are linked to the Infants). There is no correlation between these participants being counted and the letter that automatically prints for them when benefits are issued to their linked infants.

⇒ **Reset Local Reference Data each day.** Logging off/on SPIRIT does not reset the data. You must right click the “W” in your task bar, and click on “Reset Local Reference Data.” The suggested procedure is to do this at the start of each day.

### **Also remember to:**

- Only have one staff person in a participant’s folder (record) at the same time.
- Only have one household member's folder open at a time.
- Change breastfeeding status or amounts through the Mom’s record (Infants Born from This Pregnancy).

Clear On-Site lists after running batch

⇒ If you want to change a food prescription for an MOV client, remember to first check whether the order has been printed by AIRSA (Benefit History/ highlight benefit/Show Details/ Status: "Paid" means it's been printed, "Issued" means it has not yet been printed).

If the order has been printed ("Paid"), it is too late to void the benefit. You can change the food prescription but it will not take effect until the next MOV benefit (check) printing.

If it still shows as "Issued", you can follow the "VCR" process.

Go to "Benefit Management", Void the appropriate checks, Change the food prescription, and Replace the benefits. That way the new prescription will be picked up by SPIRIT and sent on to AIRSA.

## Does Motivational Interviewing Align with International Scope of Practice, Professional Competency Standards, and Best Practice Guidelines in Dietetics Practice?

**F**ACILITATING CHANGE IN CLIENT behavior is a key challenge for registered dietitian nutritionists (RDNs). RDN frustration occurs when clients do not adhere to the behavior change plans developed during consultations.<sup>1</sup> The client may return for future appointments having made minimal or no lifestyle changes, or showing a decline in diet and physical activity behaviors. Despite many

clients having the knowledge, skills, and need to make nutritious dietary choices and to participate in regular physical activity, many still struggle to maintain behavior change in the long term.<sup>2</sup> Clients may be ambivalent when it comes to the need to make behavior changes.<sup>3</sup> Ambivalence is a state of mixed feelings resulting in an inability to choose between two courses of action.<sup>3</sup> When confronted with feelings of ambivalence in clients, an RDN may take the role of arguing for change, hoping to convince a client of the benefits of changing behavior. In response, a client may feel judged and criticized, and may rationalize his or her current behavior by providing arguments to maintain the status quo, stop engaging with the RDN, or may silently resolve not to change.<sup>4</sup>

RDNs have traditionally been trained to facilitate behavior change through giving advice, taking primary responsibility for setting the agenda and direction of consultations.<sup>5</sup> An advice-giving consultation predominantly draws on an informing communication style, where the RDN is regarded as the expert in the client's health and persuades the client to change, whilst the client listens to the advice.<sup>3</sup> There is some evidence that this communication style may be effective when the client prefers this style of consultation or if the client is unaware of the appropriate treatment.<sup>6,7</sup> However, an informing style may be met with resistance if it involves conveying information that the client is already aware of or has previously tried to act on or disagrees with, and if the informer fails to enquire about the client's opinions and concerns, negotiate treatment options, or consider readiness to change.<sup>4,6</sup>

The field of dietetics has become increasingly interested in identifying effective counseling theories,<sup>8</sup> particularly for situations when giving advice is

ineffective.<sup>9,10</sup> There is evidence that an RDN's communication skills can influence client outcome<sup>11</sup> and satisfaction.<sup>10</sup> Hancock and colleagues<sup>7</sup> found that the majority of clients reported feeling valued by the RDN when they believed that they had been listened to on the basis of the RDN paraphrasing and using reflective statements. Rapport, empathy, delivery of effective and reliable information, and providing a nonjudgmental environment were valued by clients, who report that these factors create an environment where they would be more likely to talk openly.<sup>7</sup> In a 2011 survey of Australian RDNs,<sup>12</sup> 47% reported that they lacked adequate counseling skills for behavior change to provide effective obesity treatment, with 59% of respondents indicating interest in developing these skills through continuing professional development programs.

Motivational interviewing (MI)<sup>13,14</sup> is a directive, client-centered counseling style that aims to facilitate behavior change by creating a neutral, nonjudgmental environment where clients are comfortable to explore ambivalence to behavior change.<sup>3,15</sup> MI supports a guiding communication style and aims to strengthen a client's commitment to behavior change by developing a collaborative partnership between the health care provider and his or her client, evoking intrinsic motivation, providing compassion, and showing acceptance (Figure 1).<sup>15</sup> MI advocates a range of communication skills and clinical strategies that facilitate the discussion of ambivalence, enable the health care provider to elicit and selectively reinforce client change talk to enhance motivation, and respond to any resistance encountered in a way that intends to reduce it.<sup>3,15</sup>

Studies have shown MI to be effective for weight loss and reducing systolic blood pressure, total blood

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cholesterol levels, and blood alcohol concentrations.<sup>13,14</sup> While research into the effectiveness of MI for diet and physical activity behavior change has been conducted using psychologists,<sup>16</sup> counselors,<sup>17</sup> and nurses,<sup>18</sup> few studies have employed RDNs. As a result, the efficacy and cost-effectiveness of MI in dietetics practice has not yet been established.<sup>19</sup> In one study of RDNs, Bowen and colleagues<sup>20</sup> reported a significant reduction in the percent energy from fat consumed by women receiving a 1-year counseling intervention from an MI-trained RDN compared with a standard care group (-1.3% vs +1.4%;  $P < 0.001$ ).<sup>20</sup> However, this study did not use validated techniques to assess the competency of RDNs providing the MI counseling.<sup>20</sup> Brug and colleagues<sup>11</sup> found a significantly lower saturated fat score in a group that received MI counseling by an RDN, compared with a group counseled by an RDN not trained in MI ( $\beta = .23$ ;  $P < 0.01$ ). They did assess MI fidelity, and found that despite the MI-trained RDNs not attaining MI competency, they were more empathetic, reflected more frequently, and were more likely to allow their clients to speak for the majority of the consultation.<sup>11</sup>

A challenge of incorporating MI into dietetics practice is ensuring that scope of practice and professional standards are maintained within an effective and client-preferred counseling approach.<sup>9</sup> Achieving proficiency relies to some extent on whether or not the values and beliefs of the professional group align with the MI counseling framework.<sup>21</sup> To our knowledge, no articles have examined how MI aligns with the current scope of practice or competency standards of the dietetics profession. Therefore, our aims were to examine how MI fits within international dietetics scope of practice, competency standards, and evidenced-based guidelines and provide recommendations for applying MI in dietetics practice and research.

## DESCRIPTION OF THE COMPETENCY REVIEW

### How MI Aligns with Dietetics Scope of Practice and Competency Standards

American,<sup>22,23</sup> Canadian,<sup>24</sup> European,<sup>25</sup> and Australian<sup>26,27</sup> dietetics scope of

practice statements and competency standards were examined for MI themes using the definition and synonyms of core MI principles. Two of the four concepts—partnership and compassion—were consistent with all reviewed scope of practice statements and competency standards (Figure 1). All sources stated the importance of providing client-centered, collaborative consultations that meet the needs and values of clients. Acceptance was emphasized in the Canadian<sup>24</sup> and European<sup>25</sup> competency standards, with statements such as “protects a client’s right to autonomy,” “respect for individual differences,” and “uses active listening techniques.” American<sup>22,23</sup> and Australian<sup>26,27</sup> standards do not explicitly state acceptance, although autonomy (a component of acceptance) is reflected under the MI construct of partnership based on statements such as “confers with,” “negotiates,” and “involves customers in decision making.”

No statements documented the importance of evoking intrinsic motivation from clients.<sup>23-25,27</sup> Intrinsic motivation is an autonomous form of motivation where the behavior is engaged in willingly due to the inherent satisfaction it holds for the individual.<sup>3</sup> Rather than imposing his or her views on a client, an RDN encouraging intrinsic motivation would discuss behavior change in relation to a client’s values.<sup>3,15</sup> Although the competency standards do not refer to intrinsic motivation, this does not suggest that its evocation is outside the scope of the dietetics profession; rather, that it is not considered a minimum competency for graduates of dietetics programs internationally.

Current dietetics standards, taken collectively, emphasize the importance of practitioners seeking new learning opportunities, engaging in professional development and self-review, and integrating research findings into dietetics practice.<sup>22-27</sup> Behavior change counseling has been recognized by RDNs and professional bodies as a major professional development need in recognition that additional skills may help clients achieve behavior change.<sup>12</sup>

### How MI Aligns with Evidence-Based Weight Management Guidelines

The definition and description of MI clinical strategies were reviewed

against the American,<sup>28,29</sup> Canadian,<sup>30</sup> European,<sup>31,32</sup> and Australian<sup>12,33,34</sup> weight management guidelines to determine their congruence with MI (Figure 2). The MI strategies of goal setting and developing a change plan were evident in all guidelines reviewed<sup>12,28-34</sup> and would be considered congruent with MI if the goals and strategies are developed by the client with an RDN’s support. Asking questions consistent with the MI strategy of importance and confidence rulers were recommended in the Australian guidelines.<sup>33</sup> Although no guideline specifically outlined the use of these rulers, the activity aligns with each guideline’s evidenced-based recommendation for assessing readiness to change. Decisional balances were directly mentioned by the Canadian guidelines only.<sup>30</sup> American,<sup>28,29</sup> European,<sup>31,32</sup> and Australian<sup>12,33,34</sup> guidelines stated the importance of eliciting willingness and reasons for change, but did not mention eliciting reasons for not making a change. Considering the advantages and disadvantages of change is important in resolving ambivalence in MI.<sup>3,15</sup>

Evidence-based recommendations for self-monitoring activities and barrier identification<sup>12,28-34</sup> are compatible with the action phase of MI. Best-practice clinical strategies may not be MI-adherent if carried out before a client is ready<sup>35</sup> (eg, if an RDN promotes goal setting and change plan development when his or her client is ambivalent or before he or she has expressed a commitment to change). If an RDN chooses to motivate clients using reward systems (such as prizes or gift certificates)<sup>28,36</sup> or coaches clients using motivational techniques of persuasion, coercion, or social pressure, then consultations would not be consistent with MI because these strategies promote external motivation through fear of failure, guilt, or external pressure.<sup>3</sup>

Four categories of nutrition interventions are internationally recognized by the *International Dietetics & Nutrition Terminology Reference Manual*<sup>36</sup>: food and/or nutrient delivery, nutrition education, nutrition counseling, and coordination of nutrition care. Nutrition counseling may be conducted in an MI style if it aims to collaboratively establish priorities, goals, and change plans that facilitate

Communication	US dietetics standards <sup>23</sup>	Canadian dietetics standards <sup>24</sup>	European dietetics standards <sup>25</sup>	Australian dietetics standards <sup>27</sup>
<b>Guiding communication</b>	5.5 Guides patient/clients ... in the application of knowledge and skills. 5.3 Selects appropriate information and most effective method or format when communicating information and conducting nutrition education and counseling.	3.1(s) Creates a client-centered environment conducive to achieving client outcomes. Standard 1 (s) ... it is important to assess not only the level of participation by the client, but the manner in which the dietitian supports or encourages this participation.	3.1 (s) Creates an environment conducive to effective counseling. Allows the client ... to contribute and to clarify concerns or issues and to identify the barriers to compliance and willingness to change. 3.1(s) Can adapt communication methods to meet the needs of the client. 1.8 (s) Uses effective verbal communication skills.	1.8 Demonstrates or employs effective communication and counseling strategies as they apply to nutrition and dietetic practice. 2.3.1 Uses appropriate verbal and nonverbal communication. 4.5.1 Considers an environment conducive to effective counseling.
<b>Core constructs</b>				
<b>Acceptance:</b> honoring a client's absolute worth as a human being, respecting their right to autonomy, seeking accurate empathy (an interest in understanding their perspective) and providing affirmations to communicate that the client's strengths and efforts are noticed. <sup>15</sup>	Absolute worth, affirmation and accurate empathy not stated. Autonomy was not explicitly stated, although loosely referred to under Partnership.	Affirmation and accurate empathy not stated. Accurate worth and autonomy referred to in the following standards: Standard 3 (s) ... to look at the appropriateness of the service, the client's understanding of the action or service plan, and the client's agreement to the action or service plan. 5.5 Protects a client's right to autonomy, respect, confidentiality, dignity, and access to information.	3.2 Implement the Dietetic process, including screening, assessment, identifying needs, formulating goals, planning, implementing interventions and evaluating outcomes, in order to enable client choice. 4.1 ...Apply client-centered practice, particularly, respect for individual differences and their influence on dietary and lifestyle habits and knowledge of client's expectations. 1.8 (s) Uses active listening techniques. May include: encouraging, clarifying, restating, paraphrasing, reflecting, summarizing, validating.	Autonomy was not explicitly stated, although loosely referred to under Partnership. Empathy, affirmation, and absolute worth were not explicitly referred to, although may be associated with the following standards: 2.3.2 Listens and provides feedback that encourages participation and engagement. 2.3.3 Communicates in a way that respects customs of other cultures, using socially and culturally appropriate strategies.
<b>Partnership:</b> An active collaboration between the dietitian and client that respects	3.4 Confers with patient/client, caregivers, interdisciplinary team, and other health care professionals.	Standard 1 (s) One desired outcome of this standard is the establishment of a partnership between the	1.8(s) Facilitates two-way communications. 1.8(s) Applies principles of collaboration and negotiation in	4.4 Prepares plan for achieving management goals in collaboration with client or carer and other members of <i>(continued on next page)</i>

**Figure 1.** Examples of how core motivational interviewing (MI) constructs align with international dietetics professional competency standards.

Communication	US dietetics standards <sup>23</sup>	Canadian dietetics standards <sup>24</sup>	European dietetics standards <sup>25</sup>	Australian dietetics standards <sup>27</sup>
the patient's values, perspectives, and experiences. <sup>15</sup>	3.5 Determines patient/client-centered plan, goals, and expected outcomes. 3.3D Collaborates with customers to set priorities, establish goals, and create customer-centered action plans to achieve desirable outcomes. 3.3E Involves customers in decision making.	client and dietitian. Here it is important to assess not only the level of participation by the client, but the manner in which the dietitian supports or encourages this participation. 1.1 and 3.2 Collaborates with the client and/or appropriate others. 2.6 Creates an environment that assists individuals to acquire new knowledge and skills.	teamwork. 3.1(s) Negotiates client-orientated goals and strategies. 4.1 Establish and maintain a relationship with the client, which is the foundation of practice. Apply client-centered practice, particularly, respect for individual differences and their influence on dietary and lifestyle habits and knowledge of client's expectations. 4.1(s) Collaborates with clients/care-givers in determining realistic nutrition goals and managing nutrition care. 4.2 Build partnerships and offer consultation and advice.	health care team. 4.4.1 Determines realistic goals for nutritional management in collaboration with client and other members of health care team. 4.5.3 Negotiates client-orientated goals and strategies. 4.5.2 Assists client to clarify issues, identify barriers to resolution of the problem, and identify appropriate goals and strategies.
<b>Compassion:</b> To actively promote others' welfare and to give priority to the needs of others. <sup>15</sup>	1.10D Documents and communicates patient/client perceptions, values, and motivation related to presenting problems. 3.1B Utilizes the needs, expectations, and desired outcomes of the customer in program/service development.	5.5 Protects a client's right to autonomy, respect, confidentiality, dignity, and access to information. 1.2 Manages available resources effectively and efficiently in meeting the needs of the client.	3.1 Meet the needs of clients in complex situations related to health, social situations and the environment. 4.1 ... respect for individual differences and their influence on dietary and lifestyle habits and knowledge of client's expectations. 4.3 (s) Respects individuals and their rights (...). 4.3 (s) Serves the best interest of the individual and their needs.	2.3.3 Communicates in a way that respects the customs of other cultures, using socially and culturally appropriate strategies. 2.2.3 Develops engaging nutrition education material using a mode that meets the need of the target group.
<b>Evocation:</b> To elicit the values and perceptions of the patient to evoke intrinsic motivation. <sup>15</sup>	Not specified.	Not specified.	Not specified.	Not specified.

Figure 1. (continued) Examples of how core motivational interviewing (MI) constructs align with international dietetics professional competency standards.

MI clinical strategies	US guidelines <sup>28,29</sup>	Canadian guidelines <sup>30</sup>	European guidelines <sup>31,32</sup>	Australian guidelines <sup>12,33,34</sup>
<p><b>Agenda setting:</b> A collaborative strategy that gives the client choice and control in what is discussed during the consultation and behavior changes that are prioritized.<sup>1,3</sup> The dietitian aims to guide the conversation so as to ensure that it does not veer off relevant discussion.<sup>1,3,15</sup></p>	<ul style="list-style-type: none"> <li>• Allow for program modifications based on patient responses and preferences.<sup>28</sup></li> <li>• The decision to lose weight must be made jointly between the clinician and patient.<sup>28</sup></li> <li>• Patient involvement and investment is crucial to success.<sup>28</sup></li> <li>• The patient may choose not to lose weight but rather to prevent further weight gain as a goal.<sup>28</sup></li> </ul>	<ul style="list-style-type: none"> <li>• White agenda setting was not specifically outlined, MI was recommended as a counseling style for discussing behavior change with clients.<sup>30</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Good communication is essential, supported by evidence-based information, to allow people to reach informed decisions about their care.<sup>32</sup></li> <li>• Make the choice of any intervention through negotiation with the person.<sup>32</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Advice, treatment, and care should take into account individual needs and preferences.<sup>33</sup></li> <li>• People should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals.<sup>33</sup></li> </ul>
<p><b>Decisional balance:</b> Client discusses and records the pros and cons of changing and pros and cons of not changing their behavior.<sup>1,3,15</sup></p>	<ul style="list-style-type: none"> <li>• Reasons and motivation for weight loss must be evaluated. What is the patient's current attitude about making a lifelong commitment to behavior change?<sup>28</sup></li> <li>• Reasons for not making a change not mentioned.</li> </ul>	<ul style="list-style-type: none"> <li>• Decisional balance refers to the pros and cons of performing the healthy behavior. Scales exist that provide numerical scores for pros, cons, and the difference, but clinically a list is obtained and discussed. Pros are low in pre-action stages and increase in action stages, whereas the cons of the healthy behavior are higher in pre-action than in action stages.<sup>30</sup></li> <li>• The health care professional should ask the person to list the reasons why he or she wants to change and the reasons why change is likely to</li> </ul>	<ul style="list-style-type: none"> <li>• Assess willingness and motivation to change.<sup>32</sup></li> <li>• Reasons for not making a change not mentioned.</li> </ul>	<ul style="list-style-type: none"> <li>• To target interventions appropriately, healthcare professionals need to consider a person's willingness to undertake the behavioral change required for effective weight management.<sup>33</sup></li> <li>• A discussion of the benefits and difficulties of making lifestyle changes, and whether the person is interested in looking at ways to improve health.<sup>33</sup></li> <li>• When assessing motivation to weight and lifestyle issues, record the client's reason and motivation for making lifestyle changes.<sup>34</sup> Help the client identify personal or external beneficial changes that have occurred due to the interventions implemented. This allows reinforcement of</li> </ul>

(Continued on next page)

**Figure 2.** Examples of how motivational interviewing (MI) clinical strategies align with dietetics evidenced-based weight management recommendations.

MI clinical strategies	US guidelines <sup>28,29</sup>	Canadian guidelines <sup>30</sup>	European guidelines <sup>31,32</sup>	Australian guidelines <sup>12,33,34</sup>
<p><b>Importance and confidence scales/rulers:</b> The client is asked to identify both their importance and confidence in achieving a 'desired behavior' on a scale of 1 to 10. The client is asked to explain "why you chose number X and not a lower number" to elicit change talk. Then the client is asked "what do you think it would take to increase your number to a X in the future" to identify factors that may increase behavior change success.<sup>1,3,15</sup></p>	<ul style="list-style-type: none"> <li>• Assessment of patient motivation is a prerequisite for weight loss therapy.<sup>28</sup></li> <li>• The health care practitioner needs to heighten a patient's motivation for weight loss and prepare the patient for treatment.<sup>28</sup></li> <li>• Assess the readiness of the patient to implement the plan and then take appropriate steps to motivate the patient for treatment.<sup>28</sup></li> </ul>	<p>be hard. A frank and open discussion about the disadvantages of change can lead to a realistic plan and to a commitment to change.<sup>30</sup></p> <ul style="list-style-type: none"> <li>• We suggest that health care professionals assess readiness and barriers to change before an individual implements a healthy lifestyle plan for weight control or management.<sup>35</sup></li> <li>• A person should be asked to judge his or her current level of confidence in performing the specific behavior in question.<sup>35</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Should assess the patient expectations and motivation for change.<sup>31</sup></li> <li>• Assess readiness to make changes and confidence in making changes.<sup>32</sup></li> </ul>	<p>changes.<sup>34</sup> Reasons for not making a change not mentioned.</p>
<p><b>Goal setting:</b> When the client is ready to enter into the action stage of change, the client is responsible for setting the goals of the nutrition intervention and determining</p>	<ul style="list-style-type: none"> <li>• Clinician and patient devise goals and treatment strategy for weight loss and risk factor control.<sup>28</sup></li> <li>• The decision to lose weight must be made jointly between the clinician and patient.<sup>28</sup></li> </ul>	<ul style="list-style-type: none"> <li>• The medical practitioner will be involved in goal setting (small achievable goals for weight, activity and health status).<sup>30</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Obesity treatment should focus on realistic goals and lifelong management.<sup>31</sup></li> <li>• Use multicomponent interventions such as dietary assessment and targeted advice,</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage people to make goals for behavioral change.<sup>33</sup></li> <li>• Goal setting is an important part of the management of overweight and obesity.<sup>34</sup></li> <li>• If assessment shows the client is ready to change, work in partnership with client to set short</li> </ul>

(continued on next page)

**Figure 2.** (continued) Examples of how motivational interviewing (MI) clinical strategies align with dietetics evidenced-based weight management recommendations.

MI clinical strategies	US guidelines <sup>28,29</sup>	Canadian guidelines <sup>30</sup>	European guidelines <sup>31,32</sup>	Australian guidelines <sup>1,2,33,34</sup>
<p>strategies for change, whilst the dietitian facilitates discussion.<sup>1,3,15</sup></p>	<ul style="list-style-type: none"> <li>• Goal setting is recognized as an important component of weight management interventions.<sup>29</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Approaches to problem solving include identifying weight-related problems, generating or brainstorming possible solutions and choosing one, planning and implementing the healthier alternative, and evaluating the outcome of possible changes in behavior.<sup>28</sup></li> </ul>	<p>family involvement and goal setting.<sup>32</sup></p>	<p>and long-term goals for weight management.<sup>34</sup></p>
<p><b>Developing a change plan:</b> Once the client has set their goals, the change plan summarizes the client's plan of action. Brainstorming potential approaches may help to elicit the client's ideas and provide the client with a 'menu of strategies' to choose from.<sup>1,3,15</sup></p>	<ul style="list-style-type: none"> <li>• Approaches to problem solving include identifying weight-related problems, generating or brainstorming possible solutions and choosing one, planning and implementing the healthier alternative, and evaluating the outcome of possible changes in behavior.<sup>28</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Devise goals and lifestyle modification program for weight loss and reduction of risk factors.<sup>30</sup></li> <li>• We suggest that the optimal dietary plan for achieving healthy body weight and dietary counseling for adults, adolescents and children be developed with a qualified and experienced health professional (preferably a registered dietitian) together with the individual and family to meet their needs.<sup>30</sup></li> <li>• A menu of change options listing alternatives, including diet, activity, behavior modification and social supports, is recommended.<sup>30</sup></li> </ul>	<ul style="list-style-type: none"> <li>• When choosing treatment, take into account — the person's preference, social circumstances, degree of overweight or obesity, and any previous treatments.<sup>32</sup></li> <li>• Tailor the weight management program to the person's preferences, initial fitness, health status and lifestyle.<sup>32</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Discussing strategies and developing goals that people would like to work on, rather than imposing 'solutions' on them. Weight loss programs should be developed at all health visits after weight loss goals have been agreed to.<sup>33</sup></li> <li>• Identify lifestyle changes the person would like to start with. Encourage small changes initially to increase confidence and chance of successful change.<sup>33</sup></li> <li>• An underlying principle is that care is centered on the needs of the affected individual, that it is culturally appropriate, nondirective and nonjudgmental, and that it enables people to participate in informed decision-making at all stages.<sup>33</sup></li> <li>• Client-centered diet management involves the client in the choice of method of achieving an energy deficit and may enhance initial and long-term adherence. Different methods may be chosen as therapy progresses and the client is ready to change different aspects of the food intake.<sup>34</sup></li> </ul>

**Figure 2.** (continued) Examples of how motivational interviewing (MI) clinical strategies align with dietetics evidenced-based weight management recommendations.

MI principles	Explanation	Examples of how to incorporate into dietetics practice
Roll with resistance	To avoid arguments and confrontation during the consultation, as if the patient is ambivalent about behavior change and the health professional takes the role of arguing for change, the patient may become defensive of their behavior and provide arguments not to change. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• Use reflective statements to show the client that they have been heard.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ "Losing weight has been something that you have struggled since you were a teenager and you feel angry that other people don't understand how difficult it is for you."</li> </ul> </li> <li>• Emphasize personal choice and autonomy.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ There are many different strategies that might be helpful to help you control your weight. If you like we could discuss some of these strategies together; however it is up to you to decide which strategy you think might work best for you."</li> </ul> </li> <li>• Shift the focus.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ "I can hear that drinking alcohol is not something you want to talk about now. Is there something else you would like to talk about with the time we have today?"</li> </ul> </li> </ul>
Express empathy	To accept the client's perspective without judging or criticizing. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• Use complex and simple reflective statements.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ "That must have been very difficult for you." (simple reflection)</li> <li>◦ "On one hand you want to exercise more often because you feel it will improve your health and on the other hand you feel that there is no time due to your work and family commitments" (complex reflection).</li> </ul> </li> </ul>
Develop discrepancy between actual and desired behavior	This will enable the client to identify ways in which their current behavior is inconsistent with their own values. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• Ask the client to identify discrepancies between where they are and where they want to be.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ (D<sup>a</sup>) "In 5 years from now, how would you like to be living?"</li> <li>◦ (C<sup>b</sup>) "I would like to be fit so I can play with my grandchildren and have good health so my husband and I can go traveling and enjoy our retirement."</li> <li>◦ (D) "Is there anything you could be doing now, so you can achieve these goals?"</li> <li>◦ (C) "I need to start exercising more often and cutting back on eating treats. I have high cholesterol levels and, if I don't reduce them I am concerned that I may get heart disease which may prevent us from traveling."</li> </ul> </li> </ul>
Support self-efficacy	The patient shoulders the responsibility for making a change. The health professional aims to convey hope and confidence that change is possible during all consultations. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• Client confidence can be enhanced by exploring and drawing on client strengths and past successes with both behavior change and other difficult times in their life and the strategies they used to overcome the adversity.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ (D) "Can you tell me about another difficult time in your life, not related to food, when you overcame the situation and were successful?"</li> </ul> </li> </ul>

(continued on next page)

**Figure 3.** Examples of how motivational interviewing (MI) principles and communication skills can be upheld in dietetics consultations.<sup>1,3,15</sup> <sup>a</sup>D=dietitian. <sup>b</sup>C=client.

MI principles	Explanation	Examples of how to incorporate into dietetics practice
Avoiding the expert role	The client is the expert in their own health, while the health professional aims to facilitate discussion on behavior change. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>◦ (C) "A few years ago, I was aiming for a promotion at work, which meant that I needed to work quite a bit of overtime. My husband and parents helped out with babysitting and cleaning for a few months to allow me to work more, and I eventually got the promotion."</li> <li>◦ (D) "So you found that having support from your family really helped..."</li> </ul>
Communication skills		<ul style="list-style-type: none"> <li>• By explaining to the client that they are the expert in their own life.<sup>1,3,15</sup> For example:               <ul style="list-style-type: none"> <li>◦ "I understand that you are interested in my thoughts; however, I am interested in your ideas as well because you may have a better idea of what could work for you."</li> <li>• Providing a 'menu of possible strategies' for the patient to reflect on after the client had explored their own ideas.<sup>1,3,15</sup> For example:                   <ul style="list-style-type: none"> <li>◦ "Perhaps we can come up with a list of strategies together, starting with your ideas, then I can give you suggestions of what has worked for others in a similar situation?"</li> </ul> </li> </ul> </li> </ul>
Open-ended questions	Gives the client unrestricted opportunity to describe any thoughts or feelings they may be experiencing. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• "Could you tell me about how you have been going over the last couple of months since I saw you last?"</li> <li>• "What are some of the concerns you have about your health if you weren't to make a change?"</li> <li>• "How would your life be different if you were to lose 10 kg and reach your goal weight?"</li> </ul>
Affirming	Communicating that the client's strengths and efforts are noticed. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• "That strategy could work for you."</li> <li>• "You're a strong person who has overcome a great deal of adversity in the past."</li> </ul>
Reflections	A response that includes the content and meaning that has been implicitly or explicitly stated by the client. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• "You are quite frustrated at how your family has responded" (simple reflection).</li> <li>• "Weight control is something that is important in your life and you understand that diet and physical activity need to be a part of a balanced lifestyle" (complex reflection).</li> </ul>
Summaries	Let's the client know that they have been heard and understood. <sup>1,3,15</sup>	<ul style="list-style-type: none"> <li>• "On one hand you want to lose weight and on the other hand you feel that is will be really hard to achieve" (doubled-sided reflection).</li> <li>• "Your weight is an issue that you have struggled with for a long time and you have tried to lose weight many times but haven't been able to maintain it in the long term. However, this time around you're feeling more optimistic. You have already taken proactive steps to prepare for making the change, such as checking out your local gym."</li> </ul>

**Figure 3. (continued)** Examples of how motivational interviewing (MI) principles and communication skills can be upheld in dietetics consultations.<sup>1,3,15</sup> aD=dietitian. bC=client.

client responsibility for improving health outcomes. Although nutrition education can be carried out in the spirit of MI, nutrition education would not be compliant if carried out in an instructing expert-recipient manner, if the client is not yet ready to change, or if the client's permission to receive education has not been sought before the act of informing.<sup>1</sup> RDNs may find it challenging to accept the change in role from expert to facilitator, especially if the RDN and/or client are more familiar with traditional advice-giving models. Figure 3 provides examples of the ways RDNs can incorporate MI-consistent communication into consultations.

**IMPLICATIONS FOR DIETETICS RESEARCH**

Even though the efficacy and cost-effectiveness of MI in dietetics practice has not been established,<sup>19</sup> evidence from MI interventions in other health professions warrants research examining the incorporation of MI into dietetics consultations. Researchers aiming to determine the effectiveness of MI interventions should evaluate it against an attention control.<sup>21</sup> In the absence of an attention control, it is impossible to determine whether the intervention effect is due to MI or the amount of dietetics-related contact per se.<sup>21</sup> One of the challenges in MI research is that intervention studies require a highly-documented protocol, yet the constructs of MI support a flexible consultation directed by client needs. Adhering to the research protocol could initiate client resistance due to feeling pressured to move to the next stage before they are ready; whereas conversely, adhering to MI may introduce heterogeneity into the intervention content.

MI is not a set of clinical techniques or a protocol that is applied to clients; rather, it is the spirit of the entire conversation.<sup>35</sup> It requires comprehensive training and evaluation,<sup>35,37</sup> which can be expensive and time-consuming. There is evidence that extensive MI training may be required to achieve proficiency<sup>35,37</sup> based on evidence that immediate improvements following initial MI training are not usually maintained.<sup>38</sup> Basic training may leave health care professionals feeling overly confident in their MI skill

level, or that they were already practicing according to MI principles.<sup>39</sup> The timing and intensity of training required to achieve competency in all aspects of MI remains unknown.<sup>21</sup> To ensure intervention fidelity, it is crucial that researchers evaluate and report the competence of RDNs delivering the intervention using validated fidelity tools such as the Motivational Interviewing Treatment Integrity scale (MITI)<sup>40,41</sup> or the Motivational Interviewing Screening Code (MISC).<sup>42</sup>

**IMPLICATIONS FOR DIETETICS PRACTICE**

The scope of practice statements, competency standards, and evidenced-based guidelines we evaluated predominately aligned with MI. Although this does not necessarily mean RDNs are practicing according to these principles, it is encouraging that training in MI is compatible with international dietetics practice standards. However, considering that 2 to 3 days of training has been found to be insufficient in achieving competency,<sup>11,16,17,39</sup> pure MI may not be achievable for RDNs not already skilled in advanced counseling or unwilling to engage in extensive and continual training.<sup>21</sup>

Training in MI increases the skill set of RDNs by providing effective, evidence-based communication skills and clinical strategies to guide behavior change discussions.<sup>3</sup> MI allows RDNs to distinguish between preparatory and commitment stages of change (Figure 4) and to tailor discussions to either strengthen a client's commitment or commence developing a change plan. There is no evidence to indicate that MI is harmful, even if not carried out at a high proficiency level. It is

highly recommended that RDNs demonstrate and document competence in the area of MI, nutrition education, and counseling in general before using the MI method. Introductory MI training may still foster a more collaborative, client-centered consultation compared with giving advice.<sup>6</sup> RDNs interested in learning more about MI should:

- Familiarize themselves with MI principles, communication language, and clinical strategies through books,<sup>1,3,15</sup> journal articles,<sup>6,35,43,44</sup> and information published by the Motivational Interviewing Network of Trainers,<sup>45</sup> an international organization of MI trainers.
- Participate in MI workshops with qualified trainers advertised through the Motivational Interviewing Network of Trainers<sup>45</sup> or national dietetics association websites. These courses often involve case scenarios, hands-on training, and feedback on counseling skills.
- Practice MI with appropriate clients. After obtaining client and employer consent, record consultations, and replay to identify areas of improvement, or seek feedback from colleagues for objective feedback.
- Be involved in researching the efficacy and cost-effectiveness of MI as an intervention in dietetics.
- Repeat the above-mentioned steps. As the authors of the counseling style state: learning MI is "a process, not a curriculum."<sup>3</sup> It may take years to become proficient so it should be viewed as a long-term investment in quality counseling.

↓	Desire	"I <u>want</u> to reduce the amount of take-away (take-out) food I eat each week."
	Need	"I <u>need</u> to start making some changes."
	Reason	"I <u>have to</u> start changing my diet so I <u>don't end up with major health complications</u> later in life."
	Ability	"I <u>feel confident</u> that I can do this now."
↓	Commitment	"I <u>am going to</u> cut down the number of times I eat take-away food to once per week."

**Figure 4.** Examples of how clients may verbally demonstrate the five motivational interviewing categories of change talk during a consultation.

## CONCLUSIONS

MI was not designed as a blanket counseling strategy for all clients.<sup>35</sup> Although many clients may prefer a nonprescriptive guiding approach (such as MI), some clients will prefer a more direct, advice-giving consultation,<sup>6,7</sup> particularly when ambivalence to change is low and few barriers are identified. RDNs need to be alert, flexible, and responsive to behavior change evidence and client needs to ensure that effective counseling methods are being employed.<sup>8,22-27</sup> MI is one counseling style in the array of counseling models applicable to RDNs that requires further research.

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## AUTHOR INFORMATION

### STATEMENT OF POTENTIAL CONFLICT OF INTEREST

No potential conflict of interest was reported by the authors.

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<b>Policy Title</b>	<b>MILK SUBSTITUTIONS</b>	<b>Item</b>	<b>MILK SUBSTITUTIONS</b>
<b>Policy Number</b>	SFP 7.0	<b>Effective Date</b>	3/4/14

## Purpose

To summarize, allowed substitutions of dry and evaporated milk, for fluid milk in WIC food packages.

## Authority

**Federal Regulations:** Part II, Department of Agriculture, Food and Nutrition Services, 7CFR

- Part 246- Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages
  - Interim Rule 246.7 (c)(1)(i-iii)
    - Dated December 6, 2007 and implemented October 1, 2009

## Policy

### Milk Substitutions

Federal regulations permit the substitution of dry and evaporated forms of milk for fresh fluid milks in WIC food packages. Printed on warrants containing substitute milk(s), such as dry or evaporated, is the appropriate amount of the substitute milk to purchase in place of fresh milk. UHT milk is substituted quart for quart (1 quart fresh fluid milk = 1 quart UHT milk).

### Food Instrument (FI)/Mailed FI:

UHT is an allowable substitution in place of fresh fluid milk for the following reasons:

- Homelessness
- No available refrigeration
- Unsafe water for preparation of evaporated milk and dry milk, in a rural area with a WIC vendor (and fresh milk is not available)
- No available water for preparation of evaporated and dry milk in a rural area with a WIC vendor (and fresh milk is not available)
- Inability of caregiver/client to properly prepare evaporated milk and dry milk

UHT may be prescribed for up to one-half of the milk under the following circumstances:

- In rural areas where WIC vendors have milk exemptions
- If expiration dates are an issue within the region, UHT may be substituted for up to half of the fresh, fluid milk allowed for the month

Milk types prescribed in these food prescriptions is dependent upon the vendor’s availability of products. Clinics should prescribe a combination of milk types that will meet the client’s nutrition need, which the store can provide and is economical.

Suggested milk combinations are below and can be replicated in SPIRIT. Other combinations are acceptable as long as no more than half the milk in a food prescription is comprised of UHT.

Examples	UHT Milk	Evaporate Milk	Dry Milk
Child/PP Package-16 quart	8 Qt.	10 Cans	
	8 Qt.	6Can	3 Qt.
	1 Qt.	16 Cans	3 Qt.
	5 Qt.	10 Cans	3 Qt.
	8 Qt.		8 Qt.
Pregnant- 22 quart	11 Qt.	10 Cans	3 Qt.
	10 Qt.	16 Cans	
	11 Qt.	5 Cans	8 Qt.
Exclusive BF- 24 qt	12Qt.	16 Cans	
	12 Qt.	5 Cans	8 Qt.

**MOV**

A state staff must approve a complete UHT substitution for all the milk in an MOV package, taking into consideration the high costs of the UHT milk and shipping costs weighed against the client’s need.

Possible reasons to ship UHT via the MOV system are:

- Homelessness
- No available refrigeration
- Unsafe water for preparation of evaporated milk and dry milk
- No available water for preparation of evaporated milk and dry milk
- Inability of caregiver/client to properly prepare evaporated milk and dry milk

Before prescribing a full benefit of UHT milk in a MOV food package, a state staff must approve the issuance.

Accommodate client UHT milk preference by allowing half of the milk be UHT and the rest from either dry, evaporated or a combination of all three types.

The following policies further detail substitution of dry or evaporated milk in place of fluid milk.

**Milk Substitute Table**

<b>Fresh Fluid and UHT</b>	<b>Dry Milk</b>	<b>Evaporated in No. of Cans</b>	<b>Evaporated Milk in Ounces</b>
1 quart	1 quart fluid by label	1	12
4 quarts	4 quarts fluid by label	5	60
12 quarts	12 quarts fluid by label	16	192