

SPECIAL REPORT

Motivational Interviewing: An Emerging Trend in Medical Management

An Action Guide to Eliciting Powerful Behavior Change



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Letter From the Editor



A Place of Opportunity

Seeking out new strategies and techniques to improve patient care is the tall task of all healthcare leaders. No less formidable is the ability to display the worth of a department, individual measure or organizational initiative with measurable outcomes.

The right initiative can help foster both of these pursuits. As this special report goes into detail to

show, motivational interviewing (MI) can not only strengthen a patient's disease management—thereby normalizing resource utilization and hemming in costs—but its outcomes can be tracked and measured, leaving care enhanced and work processes validated—and celebrated.

MI, which began in the substance abuse and addictions field, is gaining significant traction across the healthcare continuum, from case management departments and nursing to wellness programs and health coaching. We believe patient advocates can greatly benefit from its use. As the Case Management Society of America says, “Motivational interviewing has been shown to improve treatment adherence and outcomes, promote health behavior change, improve patient satisfaction with care and increase retention rates.”

In the pages ahead, we explore the tenets of this exciting paradigm, we hear from some of the leaders in the field, and we delve into some in-depth assays of real, working programs across a variety of settings.

I invite you along for the ride to a destination that MI holds in its studied sights—a place of improved adherence, strong satisfaction and, overall, increased outcomes for both patients and providers.

Best Practices,

Richard Scott
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Four CE credits are available to the following professionals: nurses, certified case managers, social workers, disability management specialists, psychologists, licensed mental health counselors/certified counselors, licensed marriage and family therapists, and substance abuse counselors.

Defining Motivational Interviewing



MI Expands Across the Continuum

What Is MI?

Eliciting patient behavior change is a paramount challenge for today's professional involved in medical management. Yet its importance could not come at a more crucial time. Chronic diseases are sweeping the nation, resulting in suboptimal outcomes and an overutilization of healthcare resources, which in turn drives up costs and taxes the healthcare system as a whole.

Nearly one out of two adults is living with a chronic illness, according to the Centers for Disease Control. Such chronic conditions include high blood pressure, heart disease and diabetes, all of which are growing concerns in light of the rising obesity rates. Roughly 8 percent of the population, or more than 23 million children and adults, have diabetes, according to the American Diabetes Association. And incidence rates rise in older age groups. Twenty-three percent of those over 60 have diabetes, which makes the chance of dual or comorbid conditions yet greater. Inauspiciously, the CDC predicts that one in three 5-year-olds will become diabetic.

Then there is obesity. As a contributor to a host of harmful conditions, obesity may be the scourge of the 21st century. One in three U.S. adults is obese. The same can be said for every one in five youth.

These chronic conditions merely scratch the surface of the challenges facing the medical community. Other factors contributing to over- or underutilization of resources include medication adherence, patient understanding (health literacy), poor diet, lack of exercise and unhealthy habits.

In this foreboding tableau, it is no coincidence that so much recent national thought has centered around the twin items of prevention and wellness. While our medical system spends much of its resources and energy on treating illness rather than cultivating health, the wellness movement continues to make inroads into the national theater. Do you know somebody who walks around with a pedometer every day in an effort to track the 10,000 steps it will take to receive a financial break from his insurance plan? It is this emerging movement in action.

All of these movements focus on behavior change. Whether the motive is to reduce costs or to limit the damaging effects of an illness or activity, the emergent school of thought teaches us that the most galvanizing apparatus to achieve the desired result lies within the individual or the patient. This is where a breed of interventional techniques comes in. And in this branch of patient-centered techniques is the highly effective, rapidly proliferating, behavior-boosting counseling approach known as motivational interviewing.

Defining Motivational Interviewing

The concept of motivational interviewing (MI) has been around for nearly 30 years. Dr. William Miller of the University of New Mexico introduced the clinical method in an article published in *Behavioural Psychotherapy* in 1983. The article and the new approach were based on work with substance abuse patients, and the method served as a departure from the traditional styles of intervention, which were often aggressive and confrontational. (Throughout this guide you will find multiple defining features of MI. There is the first one. It is nonconfrontational.)

These practitioners are witnessing a flurry of positive results that are not only instilling behavior change within patients but are making patients the owners of such change.

In 1991, Miller, in collaboration with a clinical psychologist by the name of Stephen Rollnick, expanded on the concept of MI, which had since made waves in the addictions community, and examined its effectiveness from a measured clinical perspective. They found that it was not only a popular but a successful approach.

Defining Motivational Interviewing

Since that time MI has expanded across diverse populations and disciplines to become a recognized element in achieving behavior change in general healthcare settings. From physicians and nurses to patient advocates, case managers and disease managers, a variety of groups and professions have invested their resources into understanding and implementing the approach. And as we'll see later, these practitioners are witnessing a flurry of positive results that are not only instilling behavior change within patients but are making patients the owners of such change.

So what exactly is MI? From the literature and the language of expert users, the definitions and descriptions all flutter around the central theme of positive behavior change. Often figurative, descriptions include:

- A meeting of experts.
- A dance with patients.
- A way of breaking down barriers.
- An approach shaped by an understanding of what triggers change.
- An approach that is well-validated and suited for case management encounters.
- The practice of disentangling competing and often obscure motives.
- A way of being with a client, not just a set of techniques.

Yet the most concise definition derives from pioneers Miller and Rollnick: "Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence." This notion of ambivalence plays a major role in MI—from its inaugural development to the practices and procedures that define it. Below we explore some of the central features behind the philosophy of MI.

Major Elements

Though MI had its beginnings in the addictions and substance abuse arena, it is rapidly expanding into other health paradigms, including disease management, nursing, patient advocacy and case management. The technique applies where change is sought after because its philosophy carries across disciplines and, of course, obstacles. The MI philosophy is broken down into a group of ideas and implications

1. Client resistance is a product of the environment, not an intrinsic behavior. The client or patient who expresses resistance to change is seen as acting in that way in response to the intervention itself. Resistance is not innate. The patient's initial response to negative attitudes and resistance from the provider will endure throughout the provider-patient relationship.

2. The patient and provider relationship should be cooperative and congenial. The MI approach places a strong emphasis on positive reinforcement and it operates under the assumption that behaviors will change in the presence of collaborative relationships, as opposed to relationships that are hierarchical or coercive. Practitioners must apply strong doses of empathy and support.

3. MI centers around overcoming ambivalence. Habits, fears and a lack of knowledge create ambivalent feelings toward change within a patient. MI seeks to overcome this ambivalence and to steer the patient toward a cooperative, goal-and-action-oriented path toward durable success. However, action may come slow. The patient and provider must resolve ambivalence before action steps can be taken.

4. The practitioner keeps options open. Instead of forcing a specific route or path that a client must take, the provider should focus on educating the patient on all of the options available to pursue. This leaves the power of choice—and its galvanizing effects—in the hands of the patient.

5. Responsibility rests on the patient. MI practitioners are like facilitators. They provide patients with information, choices, options, empathy and education. While it is their goal to instill positive changes within the client, the practitioner further liberates the patient by placing the onus of responsibility on him or her.

6. Self-efficacy is paramount. Instilling and supporting long-term behavior change hinges on the patient's ownership of the change. This ownership lends itself to a greater chance of effecting the primary goals—that is, not resisting change.

(Source: Motivational Interviewing Network of Trainers; motivationalinterview.org)

MI Enters Medical Management



Chronic Illness Meets Its Match

Professionals involved in medical management and direct patient care are often tasked with caring for patients with chronic conditions. This is an essential part of the job, and the impact of chronic disease cannot be overstated. More than 145 million Americans live with a chronic condition, and that number is expected to rise by at least 1 percent annually in the coming years. By 2030, the number will surpass the 170 million mark. Furthermore, nearly half of all individuals living with a chronic disease have multiple conditions.

The obvious consequence of chronic disease is increased health care utilization. In fact, a chronic condition is defined by continual interactions with the healthcare system, according to Improving Chronic Illness Care, an initiative of the Robert Wood Johnson Foundation that has led to exciting breakthroughs in chronic care delivery throughout the past 10 years. Most significant of these advancements is the Chronic Care Model (CCM), which the MacColl Institute for Healthcare Innovation, with support from RWJF, created as a best-practice paradigm to achieve better care for patients with chronic conditions.

CCM promotes the use of established medical guidelines, vibrant care coordination...and strong patient self-management.

At its core, CCM promotes the use of established medical guidelines, vibrant care coordination, active follow-up care and strong patient self-management. The CCM centers around six fundamental areas directed to providing quality chronic disease management:

- 1. Self management support.** This calls for health-care practitioners to emphasize the patient's own role in managing conditions and to use strategies to foster effective self-management.
- 2. Decision support.** For medical decisions, healthcare practitioners should adhere to evidence-based guidelines. Moreover, patients should be made aware of such guidelines in an effort to encourage participation.
- 3. Delivery system design.** The CCM urges a proactive rather than a reactive healthcare structure. This element promotes well-defined roles and built-in follow-up care and directly calls for case management services for complex patients.
- 4. Clinical information systems.** Robust data will help practitioners facilitate efficient and effective care. Key elements include reminders, data grouping, monitoring and information-sharing with patients.
- 5. Health system.** The most comprehensive of the elements, the health system promotes a culture shift toward continuous improvement backed by strong leadership. One net result is the coordination of care across settings and providers.
- 6. The community.** The CCM urges the use of community resources to help bridge care outside of facilities.

(Source: Improving Chronic Illness Care)

A Tool to Counteract Chronic Disease

Since its inception, the CCM has served as a highly influential paradigm. The National Committee for Quality Assurance and the Joint Commission developed accreditation and certification programs based on it, and it has served as a foundation for chronic care models for diverse organizations, including the American Academy of Family Physicians and the American College of Physicians. Further, a number of states, including California, Indiana, New York and Pennsylvania, have adopted initiatives based on the CCM.

The important of the CCM in the scope of this guide is its direct call for the use of case management services and the proposed techniques to achieve robust self-management, which include motivational interviewing: "Providers may use motivational

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interviewing with patients who are ambivalent about making changes that could help them manage their chronic illnesses, or who feel overwhelmed about how to control their disease,” reads a glossary to the CCM on the RWJF website. One paper on instilling self-management via the CCM model puts it more bluntly. “Use techniques from motivational interviewing (express empathy, develop discrepancy, avoid argumentation, roll with resistance, support self-efficacy),” it states.

The CCM is not the only model to emerge recently that promotes motivational interviewing. The Guided Care Model, originating from Dr. Chad Boulton at Johns Hopkins University, has shown phenomenal results in the coordination of care for high-risk patient with multiple chronic conditions. And it too promotes motivational interviewing.

At the heart of the model is the Guided Care nurse, who acts as the central post of the healthcare team. In preparation for this role, the Guided Care nurse must learn “special skills” to not only handle a caseload of 50-60 at-risk patients but to serve as the key facilitator of change among the care team. All Guided Care nurses are trained in the art of motivational interviewing. “The nurse uses motivational interviewing techniques to help the patient overcome obstacles,” writes Boulton and two co-authors in a 2008 issue of *The Permanente Journal*.

As health reform continues to usher in the wellness-based paradigm, initiatives like Guided Care and the Chronic Care Model are ready to proliferate—and motivational interviewing will continue to gain traction. See the articles below for further insight into these growing trends.

Trending Toward Wellness: Health Reform Elevates New Paradigms

By Rebecca Perez, RN, BSN, CCM

Healthcare reform has been signed into law, and it appears that 95 percent of the American population will now have access to healthcare benefits. However, how exactly these newly covered individuals will be managed remains unclear. It would be safe to assume that many of the uninsured have significant health issues that include chronic illness and poor lifestyle choices.

Improved or healthier lifestyle choices and access to preventive and wellness programs and activities will certainly improve the overall health of any population. Exactly who needs these services and how much they will cost is yet to be determined, but it is also understood that a reduction in the burden of illness and services related to illness will significantly reduce the overall cost of healthcare.

In the coming years, healthcare professionals will be encountering individuals who need healthcare services but have never before had the opportunity to access them. They likely will have habits that are not healthy and will be faced with new information about health that they may find confusing or even frightening.

Individuals new to healthcare coverage are not the only ones that often need guidance to improved health. Often those who have had access to care and services have never been taught how to access or how to take care of themselves so that their burden of illness is reduced.

Healthcare professionals can make an impact in the lives of individuals and nudge them to improved health and quality of life. Numerous skills can be acquired to better educate individuals, but the most important things to embrace before embarking on work with others are knowledge of self and demonstration of respect for others. Without these, no skill or ability will be effective enough, nor will the healthcare professional be sincere enough to impact others with education and support to move toward behavior change.

A Special Skill for Lifestyle Change

Knowing one’s self means recognizing biases so that they may be put aside while dealing with someone else. Showing respect is often taken to the extreme as healthcare professionals may believe they need to be

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completely culturally competent before working with an individual. Cultural competence is a fine goal, but it may not be completely realistic. What is most important is to react naturally and make every effort to show respect.

In order to help individuals make the decision to change lifestyle choices, or to begin to motivate them to change, special skills like motivational interviewing may be acquired to provide healthcare information, assist in goal-setting, provide clear feedback about success, and assist in removing barriers to that success. In any healthcare setting, assessments are conducted, and they are also important when working with an individual who may be interested in making lifestyle changes or other changes to improve health and wellness. In motivational interviewing, part of what is needed is an assessment to determine the health literacy level, or knowledge of an individual's health status, and their motivation to change. Even someone who is highly motivated to change may not succeed in their decision to make changes because they do not have a good understanding of their current condition.

There are many approaches to teaching and learning, but MI is a skill that is very popular and demonstrates a client-centered approach. MI incorporates five counseling techniques that help individuals address ambivalence or insecurities surrounding health choices and behaviors. The techniques are:

- Expressing empathy.
- Developing discrepancy.
- Avoiding argumentation.
- Rolling with resistance.
- And supporting self-efficacy.

MI assists the individual to examine his wants, fears, expectations, hopes and inconsistencies, and then how these impact or influence the problems identified.

Motivational interviewing, when used as a tool to impart new health information and skills, is

In the coming years, healthcare professionals will be encountering individuals who need healthcare services but have never before had the opportunity to access them.

successful when rapport has been established with the individual. Rapport develops as the healthcare professional demonstrates a sincere and empathic demeanor. Use of open-ended questions allows the individual to explore his/her experiences as well as the presence of ambivalence.

The healthcare professional validates the individual's information by repeating what was said by way of open-ended statements, and additional questions to determine resistance. An informational exchange between the individual and the healthcare professional results in an offer to share new information. If or when permission is granted, the new information is shared and the process of communication starts over again.

Reflective listening and eliciting, and providing information will eventually result in the beginning of change talk. Throughout encounters with the individual, it is important to affirm statements made by the individual, brainstorm with them on strategies, prioritize and develop a plan to move change talk to behavior change. The plan is supported, the individual's initiative is supported, and once implemented, the MI process continues.

Rebecca Perez, RN, BSN, CCM, is a registered nurse case manager and owner of Carative Health Solutions. She is chair of the Integrated Case Management Program for the Case Management Society of America, which addresses physical and behavioral health issues. (becky@carativehealthsolutions.com)

Evidence-Based Health Coaching: A Foundation of Case Management Practice

By Blake T. Andersen, PhD

Most chronic diseases, chronic disease-related complications and avoidable healthcare costs stem from lifestyle choices or gaps in treatment adherence or disease self-care. And many healthcare professionals and lay persons are using health coaching to support healthy behavior. Yet, while health coaching is a popular and appealing approach, it remains poorly defined. Further, popular life coaching-based health coaching training programs and approaches—while often incorporating psychological terms and concepts—do not generally reflect the body of research or the consensus of experts in health-related behavior change from the fields of health psychology and behavioral medicine.¹ Most popular approaches have been adapted to healthcare from business or personal coaching settings.

At a time when the pressure on case managers to deliver measurable results has never been higher, the case for evidence-based health coaching practice has never been clearer. At a minimum, purchasers expect that the case managers who often advocate for evidence-based medical care are themselves using validated, rather than intuitive, case management approaches. Moreover, since behavior change is often the goal of case management, optimal case management outcomes require the systematic and routine application of the best practices of the behavioral sciences. These approaches also ensure that “whole person” or “patient-centered” are not just aspirations but deliverables.

MI Reduces the Risk of “Patient Resistance”

While motivational interviewing is not the only evidence-based approach for facilitating health-related behavior change, it is an approach that is well-validated and suited for case management encounters—particularly for patients who are often described as “challenging,” “complex” or “resistant.”² Most case managers understand that self-care gaps or unhealthy habits are typically not due to a lack of knowledge, but insufficient motivation or ambivalence about change. And while information or advice may

be helpful, if overused or unsolicited they may evoke resistance and *reduce* the likelihood of change—particularly among patients who have usually been “educated,” “instructed” and “reminded” many times before. MI is particularly effective for reducing the risk of patient resistance by building the patient’s internal motivation and own reasons for change.

MI Builds Patient Self-Efficacy

Self-efficacy refers to the degree in which a person feels successful or effective in managing their health or their life. Case management patients may often feel overwhelmed, hopeless or helpless—and consequently experience lower self-efficacy. As a self-efficacy-based approach, MI is ideal for instilling hope, confidence and action. MI empowers the patient, unlike well-intentioned but overly directive helping approaches that may reinforce patient passivity or dependence on case management. MI is also well-aligned with tenets of the Chronic Care Model (CCM)³ that encourages patients to play a more active role and be more competent managers of their health—as well as newer enablement-focused models of care for the disabled and elderly.

As a self-efficacy-based approach, MI is ideal for instilling hope, confidence and action.

MI Can Be Applied and Adapted for Case Management Encounters

Since 2004, HealthSciences Institute has trained thousands of clinicians and case managers in MI and other behavioral science-based approaches through the Chronic Care Professional (CCP) learning and certification program.⁴ CCP includes the largest online motivational interviewing skill-building video library and tools to prepare clinicians in the practical application of MI in health and case management settings. In

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partnership with our university and behavioral science advisors, HealthSciences Institute has developed a brief five-step MI and behavioral science-based model for working with patients on health related change—and interventions for evidence-based health management, healthcare communications, health literacy, cultural competence, adherence support, self-care management, and integrated medical and behavioral care. Peer-reviewed studies have found that programs staffed by CCP nurses achieve improved patient and cost outcomes for patients with chronic diseases such as diabetes.⁵

In summary, health coaching is a promising but poorly defined practice. MI is an evidence-based approach to health coaching that has proven highly effective for addressing the behavioral factors such as treatment adherence, disease self-care and lifestyle

factors that case managers must impact to achieve patient and cost outcomes. MI is also particularly well-suited for use in the care and management of patients with complex health issues, or for those who may be “resistant” to traditional patient education or advice-giving approaches. As a self-efficacy-based approach, MI can be highly effective for activating and instilling hope in case management patients who are feeling hopeless or overwhelmed. MI represents a new approach, like others from the fields of health psychology and behavioral medicine, that supports the value of case management for patients and purchasers.

Dr. Blake Andersen, president and CEO of HealthSciences Institute, brings over 20 years of clinical and organization consulting experience in chronic care and health-related behavior change. He completed a Ph.D. in psychology, post-doctoral training in behavioral medicine, and served as faculty at the USF College of Medicine. (andersen@healthsciences.org)

1 Infocus: Health Coaching. Chicago, IL. 2009. HealthSciences Institute website. Available at: www.healthsciences.org/Infocus/index.html. Accessed June 9, 2010.

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5 Wilhide, C., et al. Impact of behavioral adherence on clinical improvement and functional status in a diabetes disease management program. *Disease Management.* 2008;11:169-175.

Case Study #1

3

Purely Dynamic: Enhanced Case Management

Over the past five to 10 years motivational interviewing has become a strategic intervention in case management, disease management and wellness and prevention programs. It also has been the subject of numerous clinical trials, mainly used to improve the health of those with chronic conditions.

As healthcare practitioners and care coordinators know, diabetes is a costly disease. It greatly impacts quality of life, carries the potential of severe complications, and taxes the healthcare system billions of dollars in the cost of what is often unnecessary utilization. Yet the most egregious aspect is not the cost. It is, simply put, that the healthcare system is not set up to adequately manage patients with chronic disease.

This approach is meant to bolster a patient's aptitude for self-management, which in turn can reduce the overwhelmingly preventable costs and complications related to poor diabetes management.

Researchers at the Penn State Institute for Diabetes and Obesity are working in a dynamic manner to change that—literally. An ongoing study that is supported by the National Institutes of Health is investigating the impact of nursing case management and motivational interviewing on a population of high-risk diabetic patients. The study is called DYNAMIC, a loose acronym for Diabetes Nurse Case Management and Motivational Interviewing for Change. The program, which incorporates what its researchers call “enhanced case management,” may well redefine the treatment of chronic disease as it is approached from the primary care environment.

In this model, a nurse case manager supplements the primary care physician in providing education and support to the diabetic patient. Continuing to see their primary care physician, patients also meet individually with the nurse case manager on a regular basis. At the beginning of the study, visits were scheduled for baseline, two weeks, six weeks, three months, six months, 12 months and so on. During these visits, the nurse case manager focuses on monitoring the condition, emphasizing and reinforcing behavior change goals, and conducting a clinical assessment to gauge progress.

“Nurse case managers were chosen to deliver the intervention because of the ongoing need for assessment of goal attainment, and because of their ability to work with patients to reduce ambivalence to behavior change, collaborate with PCPs, and reinforce diabetes education,” write the study authors. “The nurse case managers are integrated into the primary care setting and have a continuous relationship with study participants including both direct clinical interventions and collaboration with their PCP, endocrinologist, diabetes educator, and dietitian.”

One of the crucial parts of the program is that nurse case managers are trained in MI. This approach is meant to bolster a patient's aptitude for self-management, which in turn can reduce the overwhelmingly preventable costs and complications related to poor diabetes management like amputations and blindness. In this context, MI is meant to aid in the engagement of patients in their disease and their prevention strategies. “Specifically, MI stresses the importance of understanding each patient's unique perspective and priorities when developing a treatment plan. Consistent with the patient-centered approach, MI uses reflective listening, therapeutic communication, and rapport-building skills to empower the patient to make behavior changes,” write the authors.

Defining 5 Core Aspects of DYNAMIC

The enhanced nursing case management intervention approaches the delivery of care using the Chronic Care Model (see Section 2) as a framework. In its effort to

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foster behavior change, the initiative centers around five core aspects:

- 1. Education, counseling and MI.** Case managers teach patients about fundamental diabetes care needs like glucose monitoring and the threat of potential complications. Counseling springs from the MI approach. “MI is used to facilitate resolution of the ambivalence that often prevents patients from engaging in the self care necessary to manage a complex, chronic disease. In addition, the principles of autonomy, support, and collaboration, essential to MI, are used to assist the patient in selecting appropriate, concrete behavioral goals, in developing plans for reaching those goals, and in evaluating the progress and adequacy of those plans,” write the authors.
- 2. Patient outcomes.** An electronic information system gives case managers the latest information on their patients. This allows for concise and targeted care, with an eye on the patient’s progress.
- 3. Process measures.** Using evidence-based guidelines

for testing and exams gives case managers the advantage of adhering to national recommendations.

- 4. Interventions based on guidelines.** Again, evidence-based guidelines help case managers navigate with the primary care physician the recommended approach to overall care and the timing of proper interventions.
- 5. Follow-up care.** Case managers meet with patients individually at defined intervals. They are available via email and telephone between the in-person visits.

Using MI to effect change, the nurse case manager’s interventions will follow a workflow pattern similar to that portrayed in Figure 1.

(Source: Motivational Interviewing in Health Care: Helping Patients Change Behavior; Health Behavior Change: A Guide for Practitioners; special thanks to Penn State Hershey.)

To impart a firsthand perspective of the DYNAMIC approach, nurse case manager Kendra Durdock, RN, BSN, CDE, a practitioner at the Penn State program, shares some valuable lessons she has gleaned from working with this chronically ill population.

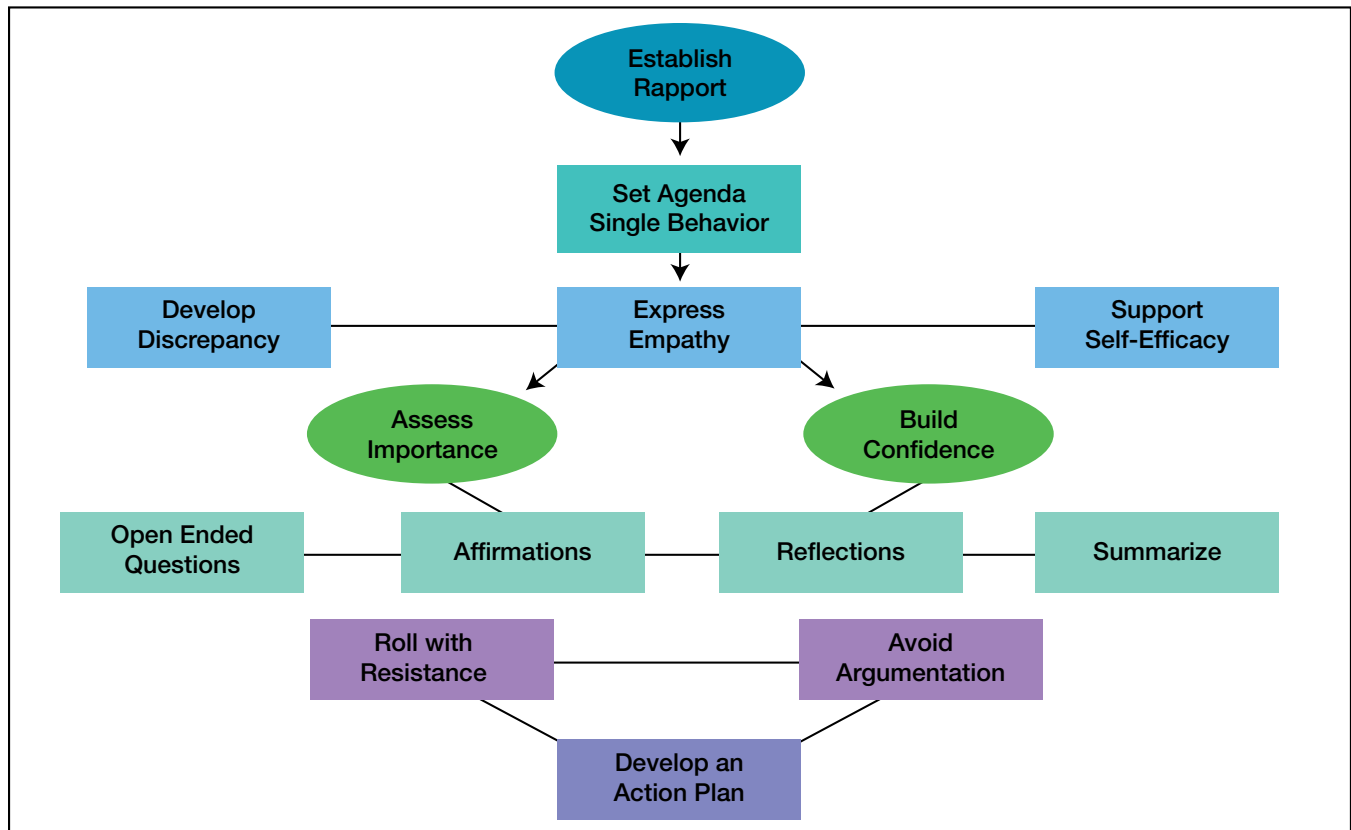


Figure 1: MI Workflow (Compliments of Penn State Hershey)

Top 5 Tips for Case Managers Working with Chronic Disease

By Kendra Durdock, RN, BSN, CDE

Knowledge does not equal motivation.

As case managers, an important role is to ensure patients have information about their disease and ways to self-manage it. Giving them information however, is not always enough to ensure they follow their treatment plan and make the necessary lifestyle changes which may be involved in managing their chronic illness. There is still the issue of motivation. Once they have all of the information they need, they then need our help to find what will motivate them to make/continue their self-management efforts. Motivational interviewing is one behavior change strategy which may provide the skills to help case managers motivate resistant-to-change patients.

Nonadherence to one's treatment plan does not mean the patient does not care.

Patients living with a chronic disease face many barriers to their self management efforts. Patients may be ambivalent about making a lifestyle change or have other things on their "to do" list that take priority. It is a case manager's role to help the patient identify their barriers to managing their chronic disease by asking open-ended questions and reflecting back the answers so the patient can process them. It is our role to use motivational interviewing skills to help them wrestle with their ambivalence and find the motivation for making self-care efforts.

One way to assist them in this process is to help them make a list of pros and cons of making a change, or not making a change/staying the same. We must teach patients problem-solving skills so that they may be able to remove the barriers to self care and identify their support systems. Sometimes the self-management activities a patient must adapt when living with a chronic disease are overwhelming. It is the case manager's role to assist the patient in setting measurable and achievable goals so that they may feel like they are a success at their self-management efforts.

It is the patient's agenda, not the case manager's.

When beginning a discussion about a patient's chronic disease, allow them to voice their concerns before doing any routine assessment or follow up. This allows the visit to be more patient-centered. What we as case managers are most concerned about as far as the patient's health may not be what the same as what they are most concerned about. If the patient is not sure what they would like to discuss, it is always appropriate to give them a menu of options or topics for discussion (the patient with diabetes may be given the option to discuss diet, monitoring, exercise, etc., whereas the patient with COPD may be given the option to discuss use of home oxygen, avoiding smoking, exercise, etc.). Since much of living with a chronic disease relies on the patient's self-management, it is important to be sure the patient has buy-in to the treatment plan. The best way to achieve this is to allow them to direct the visit and be a collaborative partner in the development of their care plan.

Match the MI technique or skill to the patient's stage of change.

Patients living with chronic disease are at different transtheoretical stages of change when they are attempting to implement treatment plans. It is important to be able to assess or recognize what stage of change the patient is going through in order to tailor the intervention to that stage. If a patient is approached about making a change in their diet when they are not ready to, they may become resistant and argumentative toward the case manager. Motivational interviewing teaches us how to assess the patient's importance of making a change, their confidence in their ability to change and finally their readiness to change by using a ruler or a scale of one to 10. Each number corresponds to a stage of change. A patient may be in precontemplation, contemplation, planning, action or maintenance stage of change. Tailoring the motivational interviewing techniques to the patient's stage of change helps to alleviate any resistance the patient may feel toward making a change and will ensure better adherence to the treatment plan when they are ready to adapt it.

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It is not the case manager's responsibility to make the patient change or adhere to the treatment plan.

Motivational interviewing is about having a collaborative relationship with the patient. The case manager's role is to facilitate behavior changes related to a patient's self-care efforts in managing their chronic disease. In the end, it is the patient's responsibility to follow their treatment plan. By taking this approach, it takes the pressure off the case manager to "make" the patient change and puts them in a more coaching kind of role, thus preventing burnout. A case manager is then free to elicit change talk in the discussions about

the patient's chronic disease. Change talk involves discussing the desire, ability, reasons and need to change specific nonhealth-promoting behaviors. Case managers may best support a patient living with a chronic disease in their self-management efforts by providing nonjudgmental feedback, assisting the patient in resolving their ambivalence to improve self-care behaviors and affirming any efforts the patient is already making in managing their chronic disease.

Kendra Durdock, RN, BSN, CDE, is a clinical case manager focusing on chronic disease at Penn State Milton S. Hershey Medical Center. Durdock underwent motivational interviewing training as a diabetes nurse case manager in the DYNAMIC study. (kdurdock@hmc.psu.edu)

'What Nursing Is Really All About'

While the DYNAMIC study is in the midst of a five-year trial, initial results show that the approach of enhancing case management with motivational interviewing is achieving its primary goal—that is, connecting patients with desired behavior change. Focus groups reveal that, in a nutshell, patients like the revamped approach to care. In an article published in the *Journal of Diabetes Nursing* in March 2010, preliminary research on the DYNAMIC impact reveals five areas where the enhanced care model is improving, strengthening and literally redefining care. The five-point list is supplemented by key quotations from the authors.

1. Creating accountability. The MI-infused case management approach, which veers away from traditional authoritarian-esque interactions, jibes with the patient's desire for routine check-ins that are at once respectful and empowering.

Key Quotes:

"As part of accountability, the participants examined their situations and decided which, if any, self-care behaviours they were willing to address. Since goal-setting occurred with the individual's permission and at his or her initiative, the feedback and accountability process became a discussion rather than a disagreement or dictate."

"'Coming along side' is a key MI concept, which conveys the role of the healthcare professional as an

ally and advocate, rather than a superior or paternalistic supervisor."

2. Delivering the right care, not the prescribed care. Participants of the focus group highlighted the nurse case manager's ability to analyze the situation and address the areas that most required care—as opposed to any formulaic, one-size-fits-all approach.

Key Quote:

"Focus group participants reflected on the way in which the study nurses were able to go beyond allocating supplies and understand what their true priorities and needs were. In this way, they received not what the nurses believed they needed or what the standard treatment plan suggested was appropriate, but what they truly valued."

3. Fostering a holistic approach. According to the preliminary results, the enhanced nurse case managers proved adept at broaching more than the physical battles of the patient. Emotional interventions helped improve the first steps in care.

Key Quote:

"Nurses were able to listen to the feelings and emotions people had about their diabetes before reviewing lab results or listening to heart sounds. This ability to 'sit with' people as they grieved the loss of 'normalcy' led to beginning acceptance of diabetes. The use of MI allowed individuals to feel supported and understood in a difficult circumstance."

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4. **Highly effective communication.** As opposed to “checklist” communication, DYNAMIC nurse case managers used their communication skills to augment the patient’s self-management and alter their behavior.

Key Quote:

“The nurses used MI in a way that provided the opportunity for the people with diabetes to take the lead in identifying their feelings about changing their self-care behavior. Many of these techniques go beyond the standards of therapeutic communication and reflect the core techniques of MI.”

5. **Positive, positive, positive.** The role of the enhanced nurse case managers centered on empowering patients to find motivation for change. Focusing on the positive consequences

of change—and the most effective ways of getting there—helped improve patients’ willingness to find their inner spark.

Key Quote:

“[Patients] described an element of hope they felt when interacting with the nurse, particularly when engaging in goal setting. People with diabetes, rather than nurses or physicians, identify the goals they wish to achieve in relation to their condition. The nurse then helped the person develop an action plan to meet and maintain their goals.”

Patients weren’t the only ones to realize positive benefits from the DYNAMIC approach. Participating nurses have reported improved relationships with doctors as well as with patients. One nurse pinpointed the collaborative, holistic, empowering, patient-centered approach, calling it “what nursing is really all about.”

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Introducing Motivational Interviewing in a Care Coordination Department

By Marcia Colone, Ph.D.

This article examines the mandate for healthcare organizations to adopt alternative methods to influence patients' motivation to change. Improved clinical outcomes and using technology to its fullest can only come if healthcare practitioners use new methods to increase intrinsic motivation and shed traditional methods which rely on advice-giving and persuasion. Case managers, whose focus is on advancing the care plan and ensuring patient participation, are in a prime position to adopt alternative communication methods. Motivational interviewing, which is patient-centered and utilizes patients' internal resources, is a promising method for case managers to ensure real behavior change.

Healthcare and Behavior Change: Finding the Right Method

In a perfect healthcare world, patients enter the portal of a hospital system expecting to be restored to health through a combination of procedures, treatments, medications and hope. Practitioners make assessments, provide recommendations and enter into insightful conversations with the patient to ensure that the information transfer is accurate and the patient is fully committed to the regimen program post-discharge. Patients leave this experience with a sense of excitement that their health is restored and their lifestyle is intact. From a patient's perspective, it doesn't get better than this.

Enter present day healthcare, where patients appear to be less healthy than previous generations. Health-threatening behaviors are now the leading cause of premature illness and death in the developed world (Goldstein et al. 2004). Chronic illness, which is growing exponentially, is strongly linked to health behaviors and lifestyle choices. Many people seeking healthcare are looking for medical cures while maintaining their lifestyle choices. The search for a "magic pill" is never ceasing. Their expectation is that the physician, other practitioners and the healthcare system itself are fully vested with the responsibility of curing them. Patients believe in the perfect healthcare world scenario de-

scribed earlier and, for many, appear to reject the notion of self-responsibility and self-management.

In the 21st century, hospitals have entered the business of long-term condition management, which requires health behavior change. Powerful technologies, in the form of cutting-edge procedures coupled with new, powerful medications, have taken medicine to its highest level in the modern world but are not universally successful for all patients and need to be utilized effectively. Take, for example, increasing hospital recidivism rates caused by exacerbations in chronic health conditions. Technologies alone have proved not to be sufficient to improve clinical outcomes without the addition of health behavior change. The question that continues to plague healthcare is how best to effect such change. If that magic bullet could be found, it would forever link world-class technology with lasting change.

In the 21st century, hospitals have entered the business of long-term condition management, which requires health behavior change

Without question, healthcare systems are directive in nature and are characterized by practitioners giving advice and making recommendations. Well-intentioned healthcare practitioners focus on the twin engines of information exchange and persuasion, which can often lead to patient resistance. Resistance is often interpreted as the patient being unmotivated and not participating fully in their care regimen. As practitioners, we often fail to understand that resistance represents the patient's ambivalence toward making the necessary health behavior change. Patients see both sides of the coin as a method of delaying change. Patients see the

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benefits of making the change (leading to improved health status) and not making the change (enjoying the lifestyle). Ambivalence toward change is a signal that the patient needs support to work through their motivations and use their intrinsic resources to change.

Changing Direction

The way in which you converse with patients about their healthcare can substantially influence their motivation for behavior change (Rollnick et al. 2008). Case managers are routinely engaged in conversations with patients about behavior change. Acknowledged as experts in communicating and coordinating care and discharge plans, they witness the same patients rehospitalized due to noncompliance with the treatment regimen. Given that their conversational methods are similar to their colleagues' advice-giving and persuasion, case managers fall into the same trap of believing that some patients who do not make changes are unmotivated and resistive.

The way in which you converse with patients about their healthcare can substantially influence their motivation for behavior change.

The concept that talking to patients differently can lead to behavior change sparked an idea among case managers at UCLA Health System to find an alternative approach with patients. Frustrated with their familiar strategies, they wanted to change direction and were ready to learn a new way of communicating, listening and empowering patients. They were ready for a primer in motivational interviewing.

As part of their staff development program, the case managers agreed to create a six month course to develop skills in motivational interviewing. Understanding that skill development takes time and practice, the case managers set realistic expectations to meet weekly for one-hour sessions utilizing both didactic and experiential approaches. The group agreed to purchase the book, "Motivational Interviewing in Health Care" (Rollnick et

al. 2008) to learn the concepts of guiding principles and new communication styles. This information requires extensive discussion and review as the concepts are complex and interwoven.

The second phase of the program will be to practice the new language patterns and learn the way in which questions should be framed. Learning to ask open-ended questions focuses the patient on her motivations and helps the patient find her own arguments for change. A question that is closed-ended—"Do you always count your carbohydrates daily?"—may elicit resistance and ambivalence. Asking an open-ended question—"Tell me a little bit more about how you count your carbohydrates daily."—can provide more insight into patients' motivations and allows them to answer more honestly. If your time is limited with patients, which is often the case with case managers, asking them why they would want to make a change and how they might do it will likely yield less resistance and empower them to address their motivation to change (Rollnick et al. 2008).

The experiential and practice phase of this experiment will mean the difference between actually changing the way in which the case managers converse with patients or reverting to familiar conversations. It will take time, rehearsal, and observations of self and their colleagues to enter a comfort level where new language is actually used. As the case manager begins to feel the nuances of a different conversational method, she will recognize that conversations with patients are easier and less conflict-ridden.

Conclusion

Healthcare reform will cause significant shifts in hospitals to create more value, better clinical outcomes and improved population management which requires health behavior change. Reimbursement will depend on these shifts. Motivational interviewing offers promise as a powerful method to influence behavior changes. The clinician style is a determinant of behavior change and motivational interviewing provides the framework to approach such change. It provides an opportunity to empower patients to make changes and empowers practitioners to be more effective. Who better than case managers to begin this shift into a bold, new era?

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Q&A: Implementing MI Into Your Department

The Case Management Society of America sponsors a groundbreaking training paradigm in the Motivational Interviewing Training Institute at Auburn University (AU MITI). CMSA calls MI “a proven, patient-centered counseling method for addressing patient ambivalence and resistance to change.”

Dr. Jan Kavookjian is an associate professor at the Harrison School of Pharmacy at Auburn University and a co-founder of AU MITI. Here, Dr. Kavookjian explores the behind-the-scenes processes of implementing an MI program or initiative into a case management or related department.

Case In Point: In your AU MITI program, you have trained a large number of case managers. Can you talk about the relationship between MI and case management? Why is there a good fit here?

Jan Kavookjian: We’ve held 12 on-site and two off-site Institutes thus far and I’ve learned a lot in response to this question. There are several reasons why MI is a good fit with case management. First, we know that case management typically 1) involves comprehensive disease management that includes health behavior changes in addition to treatment adherence; and 2) includes intervention with patients who are high-risk and/or poorly controlled in their illnesses/conditions.

MI is a strategy set that helps address the ambivalence or resistance that a patient likely has had for awhile about making changes—these are the mindsets that got them into high risk/uncontrolled status. We really can’t generalize from one patient to another about what the barriers are—one thing we know from an established body of research is that adherence with treatment

regimens and health behaviors varies significantly from one patient to another.

Motivations vary as well. This is why a patient-centered approach is so important to helping patients decide for themselves to change and for that change to last. Motivational interviewing is patient-centered and involves a “dance” with the provider interviewing while the patient leads the movement across the floor via the responses he or she gives. When MI is done well, the interviewing elicits responses from the patient that help him or her 1) get to their own internal motivation and 2) make the argument for change.

MI is a strategy that helps address the ambivalence or resistance that a patient likely has had for awhile about making changes.

MI training that we’ve done with case managers has significantly improved not only their case retention rates, but also their patient outcomes. It’s exciting and rewarding to see that kind of impact on patients who need it most.

CIP: What are the top ways for case managers (or departments) to begin an MI implementation?

JK: This is a challenging question. We often have “lone wolf” case managers come through our training who will be going back to an atmosphere where an MI culture is not the prevalent way of being, and they ask this question in looking for solutions about how to

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approach management for bringing it on board more fully, and for how to develop a core mass of colleagues who will also embrace MI and reinforce through their interactions the skills they got in the training.

We also have organizations which have plunged into the training and 1) consistently send all of their new hires through and 2) have MI working groups which continue to practice skills development in a structured way when back at the workplace. We have also had a couple of health plans bring us onsite to train 50-80 case managers all at once, with self-administered continuous skills development reinforcements later.

For development of an MI culture at a case management site, regardless of which of the above applies, my first recommendation is to use MI to help your colleagues decide to make changes. Sometimes that involves simply starting a conversation using an open-ended question like, “Hey, what do you know/what have you heard about motivational interviewing as an evidence-based way of talking with patients that helps achieve better outcomes?”

The next response is to ask permission to fill in the blanks: “May I share with you some of the things I’ve learned from the literature?” There are lists out there that include many of the published MI studies. (See Chapter 8 for an extensive list of published studies. See Chapter 9 for additional resources.)

Going into that conversation with management and/or colleagues with an eight-page list of well-conducted studies in hand is helpful in referring to the evidence and not just your opinion. My second recommendation is to get good training and get as many trained as you can in order to develop a culture of MI in your case management workplace. Even if you can get at least one other person to come with you to help reinforce skills development in the work setting after the training, this is helpful.

Regardless, getting good training is important. Be sure it is an evidence-based training that is based on adult-learning theory. One important thing we have learned is that training health care providers (HCPs) in MI is very different than training mental health professionals. Most HCPs don’t have training in psychosocial and behavioral issues that contribute to or pose barriers to health behavior change. Most HCPs haven’t been trained to respond empathically, and

Positive outcomes have included weight loss, dietary changes, engagement in physical activity, medication adherence, smoking cessation, adherence with return appointments, and many other positive benefits.

most have been highly rewarded for communicating in a clinical interrogation mode. For most, this mode feels successful because it feels efficient and it feels like something is being accomplished when the patient agrees to follow our advice.

Unfortunately, that agreement is often short-lived because this type of interviewing produces short-term external motivation. Awareness-raising about the problems this type of communication produces in patients is a key foundational piece to helping HCPs decide to change their way of talking with patients.

Our training is an intensive two-and-a-half days of progressively complex exercises—these are structured around comprehensive disease management cases, with co-morbid conditions and clinical indicators. The trainees are guided through exercises intended to first develop the cognitive aspects of MI before we expect them to apply the skills in role playing.

We then use an active feedback process to reinforce the learning of all in the small groups we use for the skills development applications. I really worry about training that lasts less than a day and puts people into role-playing too early, before they are ready. This sets them up for failure and can reduce self-efficacy and the likelihood of using MI in their future practice lives.

CIP: What types of outcomes do successful MI initiatives bring about?

JK: Many of those studies [mentioned above] have been applied in diverse patient populations and settings. Some are structured lab/clinic studies; others are

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unstructured and in the natural setting. Target populations included diversity in race, age (including seniors and adolescents), gender, socioeconomic status, urban vs. rural, etc.

Regardless, when the studies are well conducted, including well-conducted MI training and a measure of intervention fidelity for the MI intervention, positive outcomes have included weight loss, dietary changes, engagement in physical activity, medication adherence, smoking cessation, adherence with return appointments, and many other positive benefits.

Case managers indicated that the process of telephonic encounters was more efficient, more rewarding... and they felt better equipped to handle unusual cases.

I collected data among our trainees about the impact of their MI training after our fifth training session and found remarkable outcomes that included not only patient outcomes, but also HCP outcomes. For patients, these included improvements in clinical outcomes and two distinct cases of patents each losing about 100 pounds after their HCP started using MI in the intervention process. The case managers indicated that the process of telephonic encounters was more efficient and more rewarding in that they felt they were making better connections with patients and really seeing/hearing patients make changes, and they felt better equipped to handle unusual cases (e.g., resistant patients). In addition, improved case retention rates were rewarded by management.

CIP: What do you find most rewarding about MI?

JK: There isn't really one single most rewarding aspect of MI. I have a passion for MI as I have seen

it work in the lives of people and relationships in my personal and professional lives. Personally, in the 10 years I've been training HCPs and students in MI, I have learned a lot myself about how to be a better friend, parent and daughter.

I have family members, like we all do, who have chronic disease that requires health behavior changes to manage. Using the old ways of telling them what they should do meant they tuned me out. Using MI, with respect for autonomy and attempts to respond with understanding, has helped them not only make changes, but also has improved the relationships substantially. In my professional life, I use it with patients in my student care teams, with my graduate students in their decision-making about dissertation progress, and with the pharmacy students I mentor through academic recovery in helping them make decisions about how to develop study habits and work on health behaviors that might be detracting from their success (e.g., drinking, lack of sleep).

Seeing outcomes from these encounters is highly rewarding in and of itself, but even in the face of no change, the preservation of the relationship that is at the foundation of MI goes a long way toward building connections and trust. When that formerly resistant student comes back to me, asking advice because I was the one person in his/her life who didn't use a shaming/blaming approach, I feel great reward in that first step toward change.

I also really enjoy training HCPs in MI—the moments of “aha” are exciting, when they 1) realize that previous ways of being with patients haven't been effective and may have done more harm than good and 2) when they begin to succeed at developing MI skills. I hope many patient lives are impacted through the training their HCPs have gotten with me.

Jan Kavookjian, MBA, PhD, is an associate professor at the Harrison School of Pharmacy, Auburn University in Alabama, and co-founder of the Auburn University Motivational Interviewing Training Institute, an intensive training program. (kavooja@auburn.edu)

Case Study: MI in Action

By Rebecca Perez, RN, BSN, CCM

Lou is a 46-year-old construction worker recently admitted to the hospital in respiratory distress. His respiratory status quickly deteriorated in the ED, resulting in the need to intubate, sedate and transfer to the ICU. He was diagnosed with bilateral pneumonia, type 2 diabetes, obstructive sleep apnea, congestive heart failure and obesity.

Lou is 5'9" and weighed 315 lbs. on admission. He had been working very sporadically in the last year due to the current economic downturn seen in the construction industry. Lou is married with two sons, both of whom have been diagnosed with atrial septal defect. Lou's wife, Millie, does not work outside the home, but instead volunteers time at the boys' school. Lou's sporadic employment has resulted in reduced income, leaving the family financially vulnerable.

The case manager assigned to Lou by his benefit plan met with he and Millie after transfer to the medical unit. While his CHF was resolving and the pneumonia was responding well to antibiotics, Lou still required oxygen. It was obvious to the case manager that both Lou and his wife were frightened. The case manager asked Lou to recount the events leading up to this recent event by using open-ended questions. The case manager was able to ascertain that Lou did not regularly visit a primary care physician and did not have a good understanding of what his illnesses were or how they could impact his life.

During his admission, Lou was diagnosed with type 2 diabetes and was found to have chronic lung disease, asthma and congestive heart failure, all a result of obstructive sleep apnea. He expresses significant dismay at the diagnoses, appears overwhelmed, and is unsure what the future holds. He has a wife and young children to support, but how will he be able to work with such significant health issues?

Lou is allowed to express his fears and concerns. He questions what his options might be: should he apply for social security disability, never returning to work? Or could he even begin to get healthy enough to return to work? The case manager asks Lou if he would like to

learn more about his health conditions; he agrees but would like Millie included in the conversations.

Information on treatment for diabetes and CHF were discussed, and for treating OSA were requested by Lou. He asked what else he would need to do to get healthy and was encouraged that weight loss would likely be one of the most important changes he could make in restoring his health. At first he seems overwhelmed by the medication regimen, the need to check blood sugars, wearing oxygen, and using a C-PAP at night, not to mention completely changing his eating habits. Lou is asked if he is ready and able to make these changes. He states that he realizes he experienced a life-threatening health event and does not want to risk dying or leaving his family; he wants to make the necessary changes. Lou is congratulated on his decision, and is reassured that the case manager would support him through the process, facilitate communication with his providers, provide any education or information, and assist with coordination of care and services. Though overwhelmed, he seems motivated to make changes.

By allowing him the opportunity to explore his current state and options, he made his decision to move toward health.

Lou was discharged from the hospital with a completely new routine that included diet modifications, multiple medications, and instructions for reduced activity. Even with all of this change, he requested more information about diabetic and heart healthy diets. He did report having some difficulty getting enough money together for prescription co-pays, so the case manager researched resources to assist. Coupons were located that would cover the co-pay of his insulin to reduce some of the financial burden. Lou is motivated to make

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changes so that he can return to work; all of his activities are supported by the case manager. He made the choice to pursue a healthier lifestyle rather than accept the status quo and apply for permanent disability.

Ten weeks after discharge, Lou has lost 30 lbs., no longer uses oxygen, blood sugars are within normal limits, he denies any shortness of breath or chest pain; blood pressure is also within normal limits. He returns to see his primary care physician and is released to return to work—something his PCP did not anticipate. Lou's decision to make the necessary changes to his life and lifestyle resulted in the goal of a full return to work. Lou continues to follow a diabetic/heart-healthy

diet as he wants to continue to lose weight. He has been so adherent with diet and insulin, he will likely be able to manage his diabetes without insulin. Lou returned to work in construction where he remains today and continues to work on living a healthier life.

Lou made significant changes to his life in order to regain his health. By allowing him the opportunity to explore his current state and options, he made his decision to move toward health. Others may not be able to make changes as easily, but by using MI with other relationship-based techniques like the Readiness Ruler and health literacy assessment, support can be provided to assist in the movement toward change.

Motivational Interviewing Toolbox



The Hammer, the Nails and the Know-How

Now that we have a basic understanding of motivational interviewing and can see how it positively affects patient self-management and ameliorates chronic disease, the focus shifts to the core elements, the defining principles, the veritable structure of MI and its practical application.

As a full-scale behavioral-change paradigm, MI is defined by an overarching philosophy and is comprised of practical, intervention-ready elements that can be compared to a toolbox of sorts. First we look at the overriding principles that define MI.

As a full-scale behavioral-change paradigm, MI is defined by an overarching philosophy and is comprised of practical, intervention-ready elements.

MI Spirit

The spirit of MI can be considered separate from the particular techniques used to achieve behavior change in a client. The spirit is all-encompassing. It infuses the entire interaction that a healthcare practitioner will experience with the patient. It provides a theoretical framework out of which specific tactics derive.

Founders Rollnick and Miller describe the spirit of MI as a “subtle balance of directive and client-centered components, shaped by a guiding philosophy and understanding of what triggers change.”

For patient advocates and related professionals tasked with eliciting behavior change, while they may practice distinct techniques based upon their professional discipline, individual patient and particular situation, they will all adhere to the tenets of the MI spirit. These tenets are described here:

1. The practitioner is a guide, but the client controls change. Contrary to other approaches that rely on coercive or confrontational techniques, MI seeks out the positive values and goals that a patient possesses in his heart or mind—and it draws on these intrinsic desires to elicit behavior change. Thus, the patient is the author of his behavior and his health; the healthcare practitioner is a motivating idea that spurs action.

2. The patient must confront ambivalence—and remedy it—on her own. Everyone experiences ambivalence in daily decisions at some point. Should I do this or that? What are the benefits? What are the drawbacks? The problem for patients that patient advocates and related professionals see is that the decisions in question can have a significant impact on their health. For instance, a patient may be grappling with a decision about medication. “Should I take my medication for hypertension? I really don’t like the side effects, even though I know I need it to stay healthy.”

This conflict between opposing courses of action is a prime example of ambivalence. The responsibility of the healthcare practitioner is not to tell the patient what the ambivalence is, but to create a discussion, or an exploratory space, in which the patient can vocalize both sides. This coming to terms allows the practitioner to lead the patient toward a rational, and desired, resolution.

3. Ambivalence will not resolve effectively through persuasion. MI is not about telling the patient what to do, and the same can be said about resolving ambivalence. The most effective way to resolve ambivalence is, as stated above, to create an open ground that maximizes the patient’s deeply held desires and inclinations. Working from the patient’s inner motivation is the surest way to create lasting change. Persuasive techniques, on the other hand, have been shown to increase resistance and decrease the chance of change.

- 4. The style of MI centers around calm, genial interactions.** The approachable counselor is a hallmark of the MI style. The counselor does not confront and in no way gives off the impression of being “against” the patient. Instead, the counselor embarks on a collaborative effort with the patient to achieve the desired goals.
- 5. Ambivalence is the chief obstacle.** The healthcare practitioner engaged in MI has the primary task of steering the patient through the hindering morass of ambivalence. The tenets of MI state that ambivalence is the main roadblock to achieving behavior change. The practitioner facilitates a way around that roadblock.
- 6. The springboard to behavior change varies with each interaction.** MI is a fluid process, and every patient will respond in his or her own way to an intervention—and thus to what will make the moment of change imminent. This calls for an adaptable practitioner who can read the signs of her patient and understand if the patient is on the cusp of change or, conversely, displaying signs of resistance. Where there is resistance, the practitioner sees that as a notion to alter the current motivational strategies and embark on a revised plan.
- 7. It’s all about collaboration.** MI quashes the old formula of top-down counseling. Instead, both parties are on equal ground. There is a collaboration or a partnership aimed toward achieving end results, and at all times the practitioner respects the patient’s choices.

Change Talk

One of the most important aspects of the MI approach is the practitioner’s skill in listening, namely centered around the ability to understand a patient’s verbal cues about his or her behavior. In the course of a conversation, a patient may signal a resistance to change, an ambivalent disposition, or, in the best-case scenarios, a willingness to change. This verbal communication, signaling a desire, ability or need to alter a behavior is known as “change talk.”

The key for practitioners is to understand when change talk is occurring and to know how to capitalize on it by reinforcing the patient’s stated desires or needs. The

One of the most important aspects of the MI approach is the practitioner’s skill in listening.

thought is that a patient’s verbalization of behavior change is more powerful in the effort to effect lasting changes than a situation where the practitioner tells or describes to a patient what that change should be.

In this sense, change talk is a polar opposite of resistance talk. Where resistance talk is confrontational or rife with denial, change talk is positive and intentional. To illustrate what change talk is and how it can be applied in a practical setting, we look at an excerpt from the article “Influencing Patient Adherence to Treatment Guidelines” by Dr. Susan Butterworth.

Eliciting Change Talk

Objective: To evoke from the patient his/her personal reasons, desire, ability, and need for change. This “change talk” predicts increased commitment to lifestyle change, which in turn is correlated to good clinical outcome.

Example: “What makes it so important to you to start an exercise program?” “What benefits would come from losing weight?” “Why do you want to quit smoking?”

Follow-up: “You know that exercise will help you manage your stress, lost some weight, and lower your cholesterol levels. Plus, when you did it before, you had more energy and slept better. You also want to be a good role model for the kids and be able to play sports with them.”

[Source: “Influencing Patient Adherence to Treatment Guidelines.” *Journal of Managed Care Pharmacy.*]

Change talk is a core area of MI, and it is something that practitioners can learn and improve upon. Examples of questions that can elicit change talk include:

- Why do you feel that you need to change?
- What would you like to be different in your life or current situation?
- What are the consequences of not changing?

Motivational Interviewing Toolbox

- What would the benefits be of making a change?
- What would your future be like if you decided to make a change? How would it impact your life one year from now? Three years from now?
- Who is affected by your behavior?
- Who will your behavior change impact?

5 Guiding Principles

In adhering to the MI spirit and promoting change talk, healthcare practitioners utilizing this unique behavior-change style can find further enlightenment from what Gabbay and Durdock (two of the main players behind the DYNAMIC study; see chapter 3) refer to as the acronym READS. This five-point collection of guiding principles stands for:

- Rolling with Resistance
- Expressing Empathy
- Avoid Argumentation
- Develop Discrepancy
- Support Self-Efficacy

[Source: “The Use of MI to Improve Elderly Diabetic Patient’s Adherence to Treatment Recommendations.” *Handbook of Type 2 Diabetes.*]

Rolling with Resistance

Hewing to the collaborative theme of MI, this principle invokes a patient-centered approach in which a practitioner does not present a combative tone of attitude when presented with patient resistance but “rolls” with the resistance and seeks to find an avenue—through revised verbal efforts—down which patient and provider can travel to change.

A practitioner does not challenge a patient’s resistance but instead flows with the resistance, moving toward a closer inspection of the patient’s perspective or mindset. The focus remains on the patient’s view of the problem, and the practitioner can insert suggestions and offer new perspectives on how the two together may overcome the obstacle in the way to change.

Expressing Empathy

This principle calls for the practitioner to enter the patient’s world. What are the patient’s concerns? Why is change difficult? What outcomes does the patient want to see? What obstacles are in the way? What is the patient’s background?

In essence, the practitioner’s ability to understand the patient’s experience, and to communicate that understanding, will help the patient achieve the desired change. The key here is not just understanding a patient’s unique situation but reinforcing with the patient your complete understanding. When patients feel that they are understood—all their challenges, desires and fears—they will be more open to input from the practitioner on advice and wellness.

Avoid Argumentation

Conflicts and disagreement in a patient-provider relationship have no place in the MI landscape. Instead, MI promotes an open discussion and a constant search for the best avenue toward resolving the patient’s ambivalence. Coercion fails to engage the patient and is not the best route in the pursuit of lasting change. Conflicts, or discordant views, simply make the patient more resistant to any proscribed change.

A practitioner does not challenge a patient’s resistance but instead flows with the resistance.

Develop Discrepancy

In accordance with other tenets of MI, this principle can help patients come to an understanding of where they are and where they want to be. One of the finer specialties of the MI practitioner, developing discrepancy involves creating a stark picture for the patient that pits their current behavior against their present values and future goals.

This is a subtle technique that makes the patient more aware of the future results of their decision-making. For example, the practitioner may run through a list of positive and negative consequences of a decision to, say, continue to smoke or begin a cessation program. Part of the power in this approach lies in the patient’s verbalizing the positive outcomes as weighed against the current course of behavior.

Motivational Interviewing Toolbox

Support Self-Efficacy

This principle invokes the empowering notion of positive feedback. The healthcare practitioner can further promote self-efficacy by recognizing and lauding it when it occurs. With positive feedback on self-efficacy victories, the patient will gain a better belief that the current change in question is attainable. The practitioner should also promote goals that the patient can achieve, thus reinforcing the patient's ability to change and the concordant sense of accomplishment in doing so. The practitioner can refer to past accomplishments or provide examples of other patients who have become owners of their own change.

*Reflective listening serves
as a kind of sounding board
for the patient.*

MI Microskills

All of the guiding principles carry through the typical interaction of a healthcare practitioner utilizing MI. They are all focused on helping to resolve ambivalence and foment the uprising of change talk. Taking the guiding principles a step further—and crystallizing their broad approaches into actionable techniques—comes a set of tools known as the acronym OARS, which stands for:

- Open-ended questions
- Affirmations
- Reflective listening
- Summarizing

These tools, developed by Miller and Rollnick, are what the team of Gabbay and Durdock refer to as “MI Microskills.” Analyzed below, they will help practitioners achieve their behavior-change pursuits with their patients.

Open-ended Questions

By asking open-ended questions, practitioners elicit a more thoughtful response from the patient and deepen the level of understanding between the

two parties. Essentially, open-ended questions, successfully crafted by the practitioner, do not allow the patient to answer in simple terms with a “yes” or “no.” Open-ended questions force the patient to elaborate on a given thought, topic or feeling.

Action example without open-ended questions:

Practitioner: Are you adhering to your treatment plan?

Patient: No.

Action example with open-ended questions:

Practitioner: What are you doing to adhere to your treatment plan?

Patient: Well, I'm exercising most days, but there are times when I'm too exhausted from work and family obligations to fully exercise like you recommend.

As the example above shows, open-ended questions create a fertile ground for information-giving and openness.

Affirmations

Reaffirming a patient's strides toward positive behavior change can go a long way toward maintaining the salutary efforts. For example, if the patient in the example above is making a concerted effort, this microskill calls for the practitioner to recognize the effort and applaud it. Affirming the patient's behavior will help instill self-efficacy.

Action example with affirmation:

Practitioner: I know it can be difficult to follow this treatment plan, especially in light of your busy schedule, but you are doing an excellent job of working an exercise routine into your day-to-day activities. This treatment plan is really important for your health, and you are making some really positive changes.

Reflective Listening

Perhaps the most important element of the MI skillset, reflective listening can deepen levels of understanding and enhance trust between practitioner and patient. It can guide the interaction toward the eventual end goal of harnessing momentum toward a positive change. This skill involves listening closely to a patient and responding to the patient's dialogue with an assessment or encapsulation of what concerns, desires or thoughts the patient has. Essentially, reflective listening is a short statement that shows the patient that what she said has been understood.

Motivational Interviewing Toolbox

Action example with reflective listening:

Patient: I know how important exercise is for my health, but some days I simply don't have time to do it. I'm worried about my health but I don't know what to do to make things work.

Practitioner: I understand. That's not an unusual problem. You are trying to work exercise into your life but you don't always have time for it. There are some creative ways to make exercise easier to attain.

Reflective listening serves as a kind of sounding board for the patient, who can respond to the practitioner's assessment and confirm it or revise an aspect of the understanding. As always, this skill focuses on change talk. In the example above, the practitioner seizes on the patient's stated desire to more fully incorporate exercise into her life. Corralling this sentiment into actionable progression will help instill change.

Summarizing

Summarizing is a more robust form of reflective listening, and it shares many of the same principles. It just does so on a more expansive scale. With a summary, the practitioner reiterates the recent progress (or related concerns, actions, roadblocks, etc.) gleaned from the interaction. Before summarizing, the practitioner should announce that a summary is coming and invite the patient to interject any feedback, including differences in perspective.

Action example with summarizing:

Practitioner: This is a good time to pause so that we can look at a summary of what we've discussed so far. From what I understand, you have been successful in making exercise a larger part of your daily life, but you are still trying to find ways to include exercise more fully into your routine. In addition, you understand the importance of the treatment plan and wish to adhere to it. Is there anything else to add at this point?

Motivational Interviewing in Nursing



All About Empowering: Patients, Health and Healthcare

Motivational interviewing is gaining traction across a variety of settings, evidenced by the growing body of literature surrounding its testing, training and practical use. In 2010, the first comprehensive examination of MI and nursing was published by Jones and Bartlett. The book, *Motivational Interviewing in Nursing Practice: Empowering the Patient*, was penned by healthcare veteran Michelle A. Dart, MSN, PNP, CDE, who first became acquainted with MI as a diabetes educator.

Here, we check in with Dart to find out about the latest trends in MI and why the topic of her book is essential.

Case In Point: Can you tell us about your background?

Michelle Dart: I began my nursing career in 1995 when I graduated with a bachelor's degree in nursing. My first nursing position was as a charge nurse in a small hospital on a unit for pediatrics, adult medical-surgical and elderly waiting for placement in a nursing home. After I had about two years of experience, I moved to Syracuse to further my education. I attended Upstate Medical University while working in a variety of settings, including psychiatric, pediatrics and geriatrics. I graduated with a master's degree of science in nursing and received my pediatric nurse practitioner certificate in 2001.

After graduate school, I worked with children with diabetes and became a certified diabetes educator. For a short time I worked from home providing diabetes management to people all over the country. As part of this program, we were trained in motivational interviewing. This technique worked very well, even over the phone where you don't get to use your sight to "read" the patient. I had to be more in tune with tone of voice and the message they were trying to convey. I really believed in motivational interviewing and the benefit to the patient I could see when using it. I find that I even communicate in this manner with friends and family at times.

Currently, I work in pediatrics and enjoy using this technique with children and parents. I have also

started my own publishing business with a goal of writing books for children that will promote self-management, encouragement and education. I will also be offering services to write and publish any educational materials that a person or group may need developed. I guess you could say that motivational interviewing will be a part of my professional life well into the future.

Motivational interviewing is bringing us back to therapeutic communication and moving us closer to successful health promotion and disease management.

CIP: How do MI and nursing fit together?

MD: Motivational interviewing and nursing are a perfect fit, actually. In my book, I discussed the similarities of therapeutic communication and MI. As nurses, we are taught to listen to the patient, both verbal and nonverbal communication. We are taught to be respectful in our communication and show that we are listening through simple things like eye contact, body language and repeating what the patient is saying to ensure understanding. Motivational interviewing is based on respect in communication. As nurses, our goal is to help improve a patient's health or at least help them to live with their ailments. Because of time constraints and I'm sure a number of other reasons, nurses have been put in a position where they had to focus on accomplishing tasks and telling patients what needs to be accomplished. Motivational interviewing is bringing us back to therapeutic communication and moving us closer to successful health promotion and disease management, by promoting behavior change and empowering our patients.

Motivational Interviewing in Nursing

CIP: In your book, *Motivational Interviewing in Nursing Practice*, you relate MI to a host of different settings. What are the universal elements of MI that make it a good approach across the board?

MD: Motivational interviewing is based on simple communication tactics that can be used in any conversation. Being respectful, asking questions instead of telling, really listening to verbal and nonverbal communication and accepting that people can make decisions for their own healthcare are important factors of motivational interviewing. In fact, we want to encourage patients to take responsibility for their care and our role is to help them to find ways to make their healthcare regimen work within their lifestyle.

As the nursing profession evolves, I see this as being the basis of our interactions with our colleagues, patients and their families.

CIP: What types of outcomes can practitioners achieve using MI?

MD: We hope that more patients will participate in their care and find outcomes they are happy with. By asking appropriate questions, we can help the patient to explore their personal barriers, their goals and ways to improve their current situation. As patients feel more actively involved in their healthcare, they take more pride in what they can do for themselves and utilize the healthcare provider as a sort of sounding board and someone who can educate them so that they are making informed decisions.

CIP: What was the genesis of your book?

MD: The whole reason this book came about was that Jones and Bartlett contacted me to see if I was interested in writing a book. I have always wanted to write a book, but had never really explored it. So, I knew I would love the opportunity to write a book. I thought about a few different ideas for a book and quickly thought about motivational interviewing because I was utilizing it in the nursing position I held at that time. I had a great book about motivational interviewing in healthcare in general. There were not any books available that spoke directly to nurses and how it can be utilized in most every practice. My manuscript proposal was submitted and accepted quickly. The whole idea of learning more about the topic was exciting to me and I was hoping I could help nurses in a variety of roles to find ways to make it fit into their daily practice.

CIP: Where do you see the future of MI and nursing going?

MD: I believe that the use of motivational interviewing is going to change the nursing role only minimally. I see this raising our own consciousness to evaluate our own behaviors. That increased self-awareness will help us to be available to the patient in a way that fosters improved healthcare and behavior change as needed. As we learn and master motivational interviewing skills, we will be able to see how effective it is in a very positive way. At the same time, many nurses already utilize these skills and may not even be fully aware of it. As the nursing profession evolves, I see this as being the basis of our interactions with our colleagues, patients and their families. We are moving toward empowering our patients and helping them to make some healthcare decisions that they can and will follow through with and feel comfortable with.

Michelle A. Dart, MSN, PNP, CDE, is the author of *Motivational Interviewing in Nursing Practice: Empowering the Patient*. A certified diabetes educator, she first learned motivational interviewing during training for a position focused on the self-management of diabetes. (marpnp@aol.com)

Case Study #3



The Power of MI in Disease Management

The benefits of MI are well documented in clinical trials, but what about standard, everyday settings where companies and practitioners interface with individuals in a health coaching framework? Which MI skills are tried and true? Which effect change? And who is reaping the benefits from such an intervention?

One company recently implemented MI into its workforce's training. And it tracked the results. The move, it turned out, has been a robust boost to patient adherence, satisfaction rates, and overall strength of practical interventions.

Practical Implications

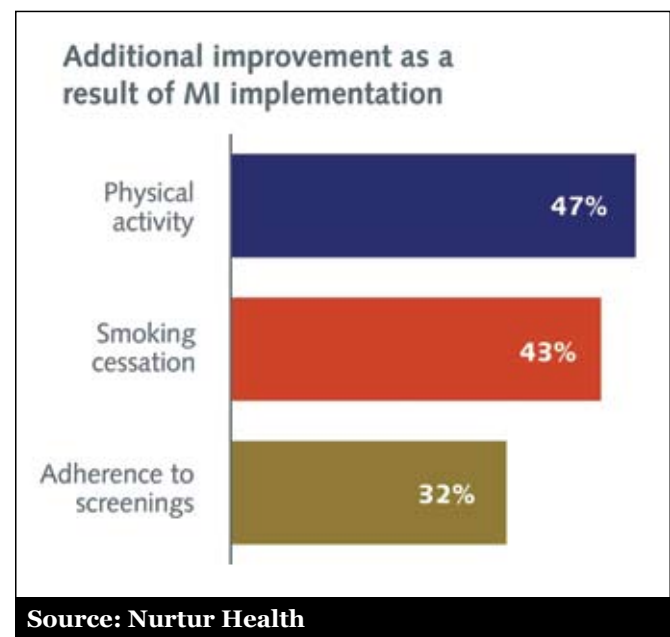
When Nurtur Health, a large health and wellness company based in Farmington, Conn., wanted to raise the bar on its disease management programs, it chose to incorporate motivational interviewing into the daily activities of its health coaches. In 2007, health coaches began to receive training from a commissioned professional from the Motivational Interviewing Network of Trainers (MINT). This onsite training was supplemented with performance feedback by the company's own MI specialists throughout 2008. Training and skills were enhanced further through relevant literature and other ongoing educational opportunities like conferences and webinars, or what education coordinator Dana Oliver calls "MI refreshers" for her team.

"They're all trained in MI," says Oliver. "It's a model [of intervention] to help people make behavior changes and improve their long-term health."

A Closer Look

In its day-to-day operations, Nurtur provides health management and work-life programs for a number of different populations, including employers, health plans, unions and the public sector. Its telephonic-based approach combines intensive motivational techniques with educational resources and tools to encourage healthy behavior, improve productivity, and ultimately reduce healthcare costs. To these ends, Nurtur has found an exceptional match in MI.

The health coaches within the organization who utilize MI are involved in handling patients with a variety of illnesses, including respiratory disease, diabetes and heart disease. Targeting the efficacy of MI among its participants, or clients, Nurtur conducted an analysis of disease management interventions among its diabetic client population. Comparing a group of diabetic program participants who had received coaching prior to MI training (2004-2008) with patients who received coaching after the implementation of MI, Nurtur witnessed some drastic benefits in the latter group.



As the chart shows, physical activity increased by 47 percent, smoking cessation improved by 43 percent, and adherence to screenings improved 32 percent. As part of a poster presentation that Nurtur unveiled at a 2009 DMAA: The Care Continuum conference, its research team concluded: "MI demonstrates a positive impact on health behavior changes, which typically leads to improved clinical measures as a result of better lifestyle choices."

Case Study #3

Strong Provider Satisfaction

As part of the company's analysis, it examined the efficacy of MI from the purview of the health coach to see how the provider deemed the new intervention method. Using anecdotal data and information, Nurtur discovered a high confidence rate on MI's efficacy in effecting change. The research also revealed which specific skills and tools health coaches found most useful.

Roughly nine out of 10 health coaches, covering respiratory disease, diabetes and heart disease, reported MI to be an effective method of conducting the daily toil—that is, instilling salutary behavior change (Figure 1).

The top MI tools from this research are 1) expressing empathy, 2) supporting self-efficacy, and 3) rolling with resistance (Figure 2). And health coaches listed the top skills in the effort to instill positive change as 1) open-ended questions, 2) reflections and reframing, and 3) affirmations (Figure 3).

"This is really part of our culture here," says Oliver. "I really believe in this program. Our coaches believe in it. And it truly helps our members."

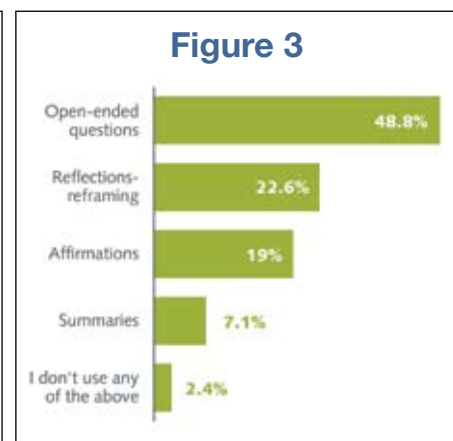
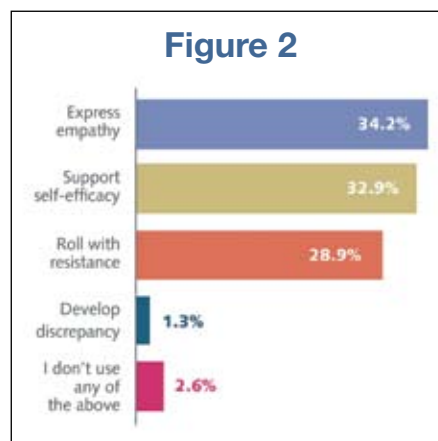
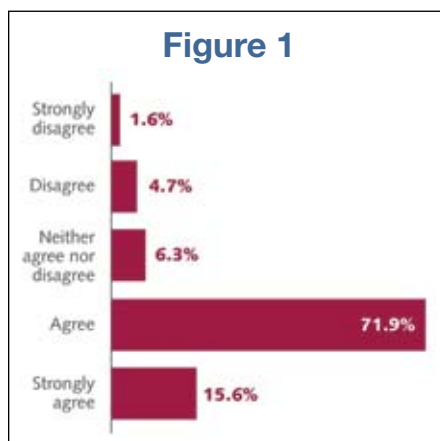
One of the most important ways that the health coaches continue to enhance their MI skillset is through regular meetings, or coaching sessions. These sessions, sort of enhanced reviews, take the following form, according to Oliver:

- Each health coach meets individually with an education coordinator on a scheduled basis.
- Sessions begin with a brief conversation of how the coach feels he/she is doing regarding his/her calls and the use of MI skills.
- The focus area that was established from the previous review session is discussed.
- The health coach and the education coordinator will review a few of the health coach's phone calls.
- The health coach is asked to provide feedback regarding their perceived MI strengths as well as areas for further development.
- The education coordinator provides additional feedback.
- The health coach determines his/her action plan/focus area going forward with guidance from the education coordinator.

"When we first started, some of our coaches were a little hesitant to do these coaching sessions," says Oliver, "and now people look forward to them. We've had coaches request additional ones."

The consistent feedback and improvement measures are vital to the quest of mastering MI. "There's always room to improve," Oliver says.

In the end, it comes down to most important question: Did you make a difference in the person's life, and do you think the participant is going to do anything differently to improve his or her wellness?



Source: Nurtur Health

Supporting MI Skill Development: Five Tips to Consider

By Ali Hall, JD

You've had some MI training, you're back at work and things are going pretty well with your MI skills. What are some ways to continue learning to support your MI skill development?

Luckily, the client we're working with is always the best barometer of whether what we're doing is effective, if what we're doing is MI adherent—or if it isn't. Bill Miller, who described MI, is fond of saying that practicing MI is *unlike* practicing piano on a silent keyboard. The client always provides us feedback, whether the keys we've touched were effective at rolling with resistance, whether we were effective at communicating MI spirit, whether we were effective at eliciting and strengthening client change talk.

Let's consider some client feedback that can give us some guidance in our MI skill development:

1. **“Yeah, but...”** If we hear our client saying “yeah, but...” it may be a signal that we might be giving advice without permission and/or providing solutions for the client that don't fit. It's a signal that there might be some things about the status quo that are important for the client, that they may need more confidence to change, that perhaps our ideas for them are not helpful, and possibly that we haven't really listened to their ideas first.

Something to try: Elicit-Provide-Elicit. First, ask the client for their own insights, ideas and solutions around the target behavior. Then, ask permission to offer some information. If the client gives permission, you might say, “In addition to the options you are considering, some people find that x, y and z are useful.” Then, ask the client what they make of the options they've generated as well as the ones you may have suggested or what steps they may consider taking as a result of the discussion.

2. **Reflections fall flat.** If our reflections seem not to move the conversation forward effectively, perhaps we are overrelying on simple reflections rather than trying out complex ones.

Something to try: Practice “complexifying” our reflections. Pause for a moment with a client, think, “What does this person really mean? What is underneath the words?” Let's say the client says, “I really want to

get my finances in order, I'm tired of relying on others.” Begin the reflection in our minds, “You mean that your independence is important to you.” Then, we strike the prefatory words and the reflection becomes, “Your independence is important to you.” Or consider a reflection that contains a metaphor, such as, “You really want to be in the driver's seat around your finances.”

One of the principle benefits of MI is that it really is a “learning to learn” model. We can continue to grow and learn in our practice when our eyes and ears are attuned to development opportunities.

3. **Client on the defensive when we ask questions?** Maybe we want to consider whether the tone or context of our question expresses judgment. If we ask, “Why haven't you followed through yet?” then we've asked the kind of question that takes us down the judger path, which in turn encourages the client to take a status quo position, defending and justifying themselves.

Something to try: Follow the learner path. Ask instead a strength-focused, change-creating question, such as, “What are your plans for following through?” or “In what ways are you able to...?”

4. **Nothing seems to change.** The next time we see the client, things seem to be about the same. Are we mining effectively for change talk?

Something to try: Perhaps we can ask a key question or two at the end of each session, such as, “What steps will you take to learn more about your options between now and the next time we meet?” or “When do you see yourself getting started on your plan to exercise more?” or “What first steps will you take this week?”

Case Study #3

5. One Minute MI Check-Up. Integrating new skills can take conscious, intentional effort, as well as awareness of efforts made.

Something to try: Take a moment near the end of the work day to ask and respond to a quick self-inventory. What MI skill did I use well today? What MI moment did I miss? What skill will I make sure I use tomorrow?

Certainly, it's great to continue learning MI in formal workshop settings, yet this isn't always an easy option in our busy work lives. One of the principle benefits of MI is

that it really is a "learning to learn" model. We can continue to grow and learn in our practice when our eyes and ears are attuned to development opportunities. And every client interaction provides a wealth of information, valuable feedback to support and encourage our effectiveness.

Ali Hall, JD, is a member of the Motivational Interviewing Network of Trainers and an independent consultant and trainer. She has designed and facilitated more than 200 MI workshops and is a training associate for the Center for Strength-Based Strategies as well as the Behavioral Healthcare Institute of the University of North Carolina School of Social Work. (mi.consult.ahall@gmail.com)

Published Research



Expanding the Mind

Dozens of clinical studies assessing the benefits of MI as an intervention method have passed through the medical landscape over the last decade-plus. The following list contains reviews, meta-analyses or other rigorous research design intervention studies using MI. These studies address certain behaviors and/or disease targets, including behavior targets, medication adherence, eating habits and physical activity in adult and adolescent populations.

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Resources & Glossary



Resources & Glossary

As we learned from Dana Oliver in Chapter 7, MI and accordant techniques can be improved endlessly. The following list of educational resources provides a launching point for your continued learning.

Books

A Toolkit of Motivational Skills: Encouraging and Supporting Change in Individuals

By Catherine Fuller and Philip Taylor

Published by Wiley

Building Motivational Interviewing Skills:

A Practitioner Workbook

By David B. Rosengren, PhD

Published by The Guilford Press

Motivational Interviewing, Second Edition:

Preparing People for Change

By William Miller, PhD, Stephen Rollnick, PhD

Published by Guilford Press

Motivational Interviewing in Health Care: Helping Patients Change Behavior

By Stephen Rollnick, PhD, William Miller, PhD, and

Christopher C. Butler, MD

Published by The Guilford Press

Motivational Interviewing in Nursing Practice:

Empowering the Patient

By Michelle Dart, MSN, PNP, CDE

Published by Jones & Bartlett

Resolving Patient Ambivalence: A Five Session

Motivational Interviewing Intervention

By Ann E. Fields, MSE, CADC III

Published by Hollfield Associates

Websites

The Motivational Interviewing Page. A comprehensive landing page for all things motivational interviewing, the site includes much original information and articles from MI pioneers Miller and Rollnick.

www.motivationalinterview.org

Stephen Rollnick's page. The MI pioneer's home page includes a discussion area as well as information on workshops.

www.stephenrollnick.com

Auburn University Motivational Training Institute. Housed on the Case Management Society of America site, this portal contains information on the groundbreaking AU MITI program, along with a look at its founding members.

www.cmsa.org/aumiti

Motivational Interviewing Network of Trainers (MINT). Housed on the Motivational Interviewing Page, this is a space for the MINT trainers.

www.motivationalinterview.org/mint/index.html

Institute for Motivation and Change. Educational and training services for MI via Gary Rose, PhD, and Ellen Glovsky, PhD, RD, LDN.

www.miinstitute.com

Training

Auburn University Motivational Training Institute

www.cmsa.org/aumiti

Bill Matulich Training. MI training with workshops and podcasts.

www.motivationalinterviewingonline.com

Cathy Cole Training. Providing training services for groups. Based in North Carolina.

www.cathycolettraining.com

Van Horn Consulting. Motivational interviewing training and consultation.

www.vanhornconsulting.com

Carolina Yahne Training. Motivational interviewing training and consultation.

www.motivationalinterviewtraining.com

Jonathan Fader Training. Innovative training for healthcare professionals.

www.jonathanfader.com

MI Training Today. Training via Katie Slack, MSW.

www.mitrainingtoday.com

Educational Resources

Unlocking Motivational Interviewing: How Eliciting Behavior Change Can Enhance Health and Cut Costs

Case In Point Webinar

www.dorlandhealth.com/Case-In-Point-Magazine/webinar-motivational-interviewing.html

MI Glossary

Evidence-based. Includes practices that are shown to be successful through research methodologies. Models that have shown the greatest levels of effectiveness have the ability to replicate successful outcomes with different populations, over time, through research. This is the status of MI. [See Miller & Rose (2009)]

Client-centered. Refers to a fundamental collaborative approach to the client-provider relationship. Client-centered specifically refers to Carl Rogers (1946) reflective listening which is a central skill for the MI practitioner. The counselor follows the client's thoughts, feelings and perceptions and responds with reflective statements. Reflective statements include degrees of complexity, meaning and possible feeling within client statements.

Person-centered. A transition of the term "client-centered." It is advocated for use by those who believe it is less clinical, less role-defining, more equalizing and more personable than the term client-centered. It serves to broaden MI's relevance beyond the clinical setting.

MI Spirit. The spirit of MI encompasses collaboration in all areas of MI practice: eliciting and respecting the client's ideas, perceptions and opinions; eliciting and reinforcing the client's autonomy and choices; and acceptance of the client's decisions. In the absence of MI spirit, one would not be practicing MI.

Ambivalence. Refers to the client's experience of conflicting thoughts and feelings about a particular behavior or change—both advantages and disadvantages. The MI counselor listens for and evokes the

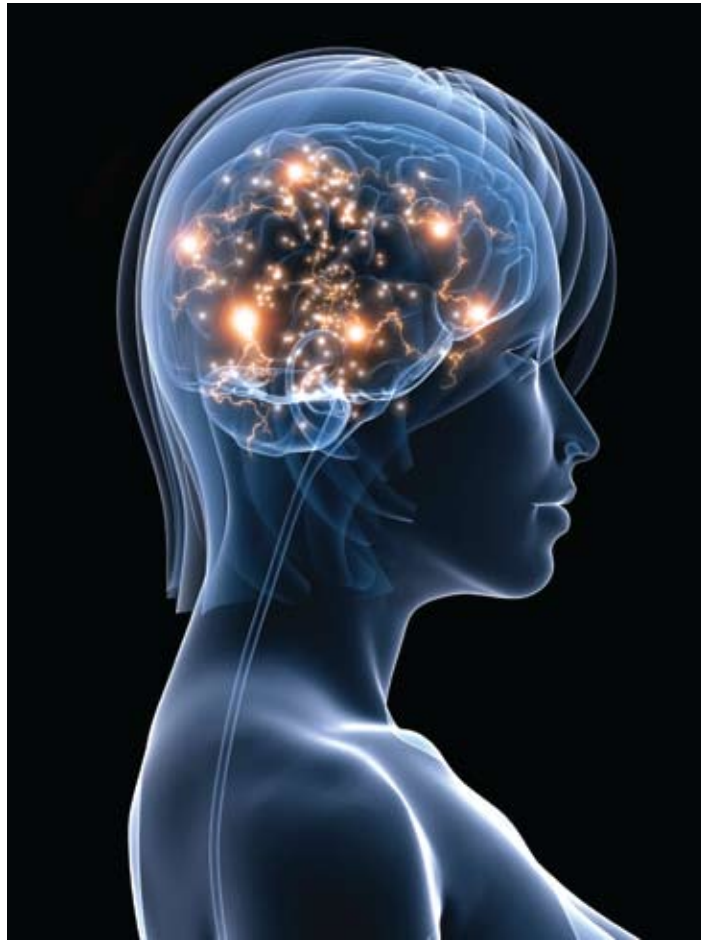
client's reasons for concern and arguments for change (change talk), while also accepting and reflecting perceived disadvantages of change (sustain talk). The counselor reflects both sides, sometimes in the form of a double-sided reflection. The recognition of ambivalence may add clarity where the client has not been ready to move forward or reach a decision. The MI counselor listens for and evokes the client's own arguments for change and assists the client to keep moving in the direction of change.

Directive. MI is both client-centered (meaning it follows the client's thoughts, feelings and perceptions) and directive. Directive refers to the use of specific strategies and interventions that may facilitate the client's movement towards exploration, change-talk, problem recognition (resolving ambivalence) or the decision to change. The practitioner guides the discussion toward the possibility of change.

Guiding. The founders of MI define guiding as "a refined form of the naturally-occurring communication style of guiding when helping someone to solve a problem. Guiding involves a flexible blend of informing, asking and listening..." "MI uses reflective listening in guiding the person to resolve ambivalence about behavior change." (Miller & Rollnick, 2009)

MINT (Inc.). Motivational Interviewing Network of Trainers. MINT members have met prerequisite requirements and completed an MI sponsored Training New Trainers (TNT) course. Members share their knowledge and materials as a professional group. They improve and revitalize their skills by attending MINT forums and advanced MI training.

Glossary content provided by Ali Hall, JD.



The staff at Dorland Health hopes that this Special Report, *Motivational Interviewing: An Emerging Trend in Medical Management*, facilitates your path toward enhanced patient outcomes, the decreased utilization of unnecessary resources, and the transparent outcomes of dedicated programs around the country.

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Name: _____ Date: _____

POST-TEST: (Please circle the correct answer.)

1. Dr. William Miller of the University of New Mexico introduced the clinical method of MI in an article published in *Behavioral Psychotherapy* in 1983.
 a. True b. False
2. In 1991, Miller, in collaboration with clinical psychologist Stephen Rollnick, expanded on the concept of MI, which had since made waves in the addictions community, and examined its effectiveness from a measured clinical perspective.
 a. True b. False
3. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.
 a. True b. False
4. At its core, the chronic care model promotes the use of established medical guidelines, care coordination, follow-up care and patient self-management
 a. True b. False
5. Motivational interviewing, when used to impart new health information and skills, is successful when rapport has been established with the individual.
 a. True b. False
6. Knowledge equals motivation.
 a. True b. False
7. Case management departments, whose focus is on advancing the care plan and ensuring patient participation, are in a prime position to adopt alternative communication methods such as motivational interviewing.
 a. True b. False
8. The spirit of motivational interviewing is described by Dr. Rollnick as a "subtle balance of directive and client-centered components, shaped by a guiding philosophy and understanding of what triggers change."
 a. True b. False
9. The patient is the author of his behavior and his health; the healthcare practitioner is a motivating idea that spurs action.
 a. True b. False
10. The responsibility of the healthcare practitioner is not to tell the patient what the ambivalence is but to create a discussion, or an exploratory space, in which the patient can vocalize both sides.
 a. True b. False
11. A professional using motivational interviewing concepts embarks on a collaborative effort with the patient to achieve their desired goals.
 a. True b. False
12. One of the most important aspects of the MI approach is the practitioner's skill in listening, namely centered around the ability to understand a patient's verbal cues about his or her behavior.
 a. True b. False
13. To overcome resistance and move toward positive changes, practitioners should not challenge a patient's resistance but instead flow with the resistance, moving toward a closer inspection of the patient's perspective or mindset.
 a. True b. False
14. Empathy is the practitioner's ability to understand the patient's experience, and to communicate that understanding, which in turn can help the patient achieve the desired change.
 a. True b. False
15. The goal of motivational interviewing is to help people make behavior changes and to improve their long-term health.
 a. True b. False

PROGRAM EVALUATION

Motivational Interviewing: An Emerging Trend in Medical Management

Your evaluation will help us improve our continuing education programs and provide insight into your educational needs. If you have questions about the post-test content or additional program evaluation comments, please email Editor in Chief Anne Llewellyn at allewellyn@accessintel.com.

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Using a scale of 1 to 5, with 1 being poor and 5 being excellent, please rate the following:

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- | | | | | | |
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| a. Define motivational interviewing. | 1 | 2 | 3 | 4 | 5 |
| b. Describe how motivational interviewing can be used to prevent/manage chronic diseases. | 1 | 2 | 3 | 4 | 5 |
| c. Provide case examples that explain how to incorporate motivational interviewing into practice. | 1 | 2 | 3 | 4 | 5 |
| d. Identify best practices that demonstrate the nuances of MI in changing patient behavior. | 1 | 2 | 3 | 4 | 5 |

2. Value of topics 1 2 3 4 5

3. Relevance to your practice 1 2 3 4 5

4. Quality of information 1 2 3 4 5

Share one piece of information that you learned as you read the special report: _____

What advances has your organization made in implementing MI into the workflow of case managers, disease managers and other professionals who work with patients/families? _____


Have you incorporated motivational interviewing into your practice? Yes ____ No ____.


If yes, what changes do you feel have occurred with your practice as a result of using this technique? _____


What other topics would you like to see covered in our Special Reports? _____

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