Using Motivational Interviewing in Care Coordination

What Is Motivational Interviewing?

Motivational Interviewing (MI) is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring a person's own reasons for change within an atmosphere of acceptance and compassion.

(Miller and Rollnick 2012)

Simply put, it is a collaborative conversation style for strengthening a person's own motivation and commitment to change.

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THE ROLE OF THE CARE COORDINATOR

Before discussing Motivational Interviewing (MI) skills, let's examine your role as a care coordinator and identify reasons you may want to try MI.

As a care coordinator, one of your goals is to increase parental engagement in their health care and the health care of their children. This includes helping parents:

- Determine whether they or their children are in need of care.
- Become increasingly receptive to referrals.
- Follow through with referrals for evaluation.
- Participate in evaluations.
- Adhere to recommended treatment and/or follow-up evaluations.

Engaging Parents Is Not Always Easy

Unfortunately, many factors interfere with parent engagement in the healthcare system for themselves and their children. These include:

- Difficulty identifying their own symptoms and/or problems.
- Lack of parental awareness of the presence of childhood difficulties and/or the consequences of them.
- Parental stress:
  - Difficulty identifying and committing to priorities.
  - Juggling multiple demands between family, work, healthcare, education.
- Parental illness: symptoms of physical or mental illnesses can limit the ability to identify the need for assistance and the ability to engage.
- Limited understanding of the availability of services or interventions and their effectiveness.

The Righting Reflex

Righting reflex is the belief that we must convince or persuade others to do the right thing by asking good questions, making strong or logical arguments, providing critical information, or provoking strong emotions. When presented with proper arguments and information, the hope is that patients will see the need and make a change.

When using the Righting Reflex, the goals of healthcare providers are well-intentioned: to help the patient takes steps towards better health.However, consider that many patients are ambivalent about changing and/or engaging with the healthcare system. That means:

- Patients see reasons to change and reasons not to change.
- Patients want to engage and do not want to engage with the healthcare system, simultaneously.

When patients are ambivalent, they have reasons both for and against change and are "stuck." As patients move towards change, the disadvantages of the change become clear and the status quo appears more appealing

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and less problematic. As patients move back towards the status quo, the disadvantages of the status quo become clear and change appears more appealing and beneficial. Patients then remain ambivalent, talking themselves into and out of change.

Despite positive intentions, with the Righting Reflex the results are almost never positive.

Why?

An ambivalent person has arguments both for and against change.

The practitioner's use of the Righting Reflex gives voice to the change side of ambivalence:

> "You should change! You should not miss your appointments!"

This may make patients feel: angry, agitated, discounted, defensive, unheard, afraid, overwhelmed, ashamed, trapped, disengaged, avoidant, uncomfortable, and resistant.

The patient, then, gives voice to the status quo/non-change side of ambivalence:

> "I can't change! I'm too overwhelmed to go to all of these appointments!"

This is labeled as resistance and denial.

But it is a natural reaction to the Righting Reflex.

In the end, efforts to increase patient change and engagement often have the opposite effect. When faced with the Righting Reflex, patients are less likely to change. In fact, they talk themselves out of change by voicing the non-change side of ambivalence.

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TIME FOR MOTIVATIONAL INTERVIEWING

We can communicate in a way to improve parental engagement in their health care and their children's health care, without the Righting Reflex.

MI is a Change of Roles

You don't need to exercise the Righting Reflex:
Your role is to listen and understand.

You don't have to make change happen:
You can't.

You don't have to come up with the answers:
You probably don't have the best ones.

You're not wrestling:
You're dancing.

Motivational Interviewing Spirit

The MI spirit is the set of heart and mind with which one enters into the practice of MI. Importantly, the MI spirit is a developmental process. It is not expected that a practitioner will have mastered the components of the spirit before engaging in MI practice. Rather, it is expected that with practice, the components of the spirit will become more natural and automatic.

The four components of the MI spirit are:

Partnership: MI is not done "to" or "on" a person; it is done "for" and "with" a person.

Acceptance: Acceptance does not mean approval. MI practitioners accept the difficulty of change and a person's right and capacity for self-direction.

Compassion: MI practitioners actively promote a patient's welfare.

Evocation: MI is a strengths-based approach and not one that probes for deficits that need improvement. Patients have what they need, together we will find it.

Core Skills

In addition to the MI Spirit, there are several core skills easily recalled with the acronym **OARS**: **O**pen questions, **A**ffirmations, **R**eflections (Reflective Listening), and **S**ummarizing. These core skills are essential for proficient practice. Additionally, the skills of Informing and Advising will also be discussed.

- Open Questions
- Affirmations
- Reflections
- Summarizing

> These skills alone do not constitute MI, but they are essential ingredients. What characterizes MI is the way the skills are used strategically to help people move in the direction of change.

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Open Questions

What are they?

Open questions leave broad latitude for responding and invite elaboration. In contrast, closed questions have short answers, including yes/no; ask for specific information; are multiple choice; and limit a person's options for answering.

Why should I try open questions?

Open questions encourage a person to talk. This results in:

- Patients feeling heard.
- Increased understanding by healthcare professionals of patients' perspectives.
- Increased opportunities for patients to talk themselves into change.

Notice the difference between open and closed questions:

Closed: "Have you been in pain?"
Open: "How has your pain been in the past two weeks?"

Closed: "Do you have any concerns about your child?"
Open: "What concerns do you have about your child?"

Closed: "Do you know why it's important to bring your child to a well-check-up?"
Open: "What have you heard about the reasons for well-child check-ups?"

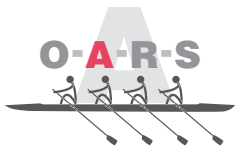
Closed: "Are your symptoms affecting your ability to work?"
Open: "How have your symptoms affected your work?"

Guidelines for Questions:

- Ask fewer questions.
- Don't "rapid fire" questions. One is usually enough.
- Ask more open than closed questions.

Affirmations

What are they?



Affirmations are statements that accentuate the positive, recognize and acknowledge inherent worth, and support and encourage. Affirmations are not praise. Praise implies a "one up" role and often starts with "I." Affirmations often start with or center around the word "you."

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How do I affirm?

- **Genuinely:** You cannot honestly affirm what you do not know and appreciate.
- **Sparingly:** Like salt in a recipe.

> Why should I use affirmations? To strengthen your relationship with patients and highlight their abilities and qualities that can facilitate change.

There are at least four types of affirmations.

1. Comment on intentions and actions.
   - "Thank you for talking with me today!"
   - "You want to make a well-informed decision."
2. Reframe negative patient statements into "glass half full" reflections.
   - "You've had trouble keeping up with your medical appointments before and now you are taking steps to have a new one scheduled. How about that!"
3. Comment on personal attributes.
   - "You have a lot on your plate and nothing can get in your way."
   - "You're persistent!"
   - "You really care about your children."
4. Reflect a broad prizing of the person.
   - "It was great talking to you."
   - "You're amazing!"

Reflections

Before discussing reflections, it is important to understand the role listening plays.

The following behaviors are examples of roadblocks to good listening. Although there may be a time and a place to use them, these behaviors do not constitute good listening:

- Ordering, directing, commanding
- Warning, threatening
- Giving advice, solutions
- Persuading with logic, lecturing
- Judging, disagreeing, blaming
- Approving, agreeing, praising
- Reassuring, sympathizing
- Questioning, probing
- Withdrawing, humoring

> It is impossible to form good reflections without really listening.

These are considered roadblocks because they block or change the patient's direction. Roadblocks often result in a premature focus on change, led by the

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therapist or helper, not the patient. Roadblocks also often communicate a "one up" role and result in the patient feeling belittled and unheard.

Good listening, in contrast, is more than being silent and paying attention. Good listening is an active process that includes attempting to understand the meaning of what is being said and clarifying with the speaker for accuracy. One way to practice good listening and to exhibit to a patient that you are listening is through the use of reflections.

What are reflections?

Reflections are:

- Statements, not questions, that make a guess about the patient's meaning.
- A way to throw statements back into the ring for further consideration, follow-up, and elaboration.

There are two levels of reflections that vary in their level of complexity:

Simple Reflections

- Repetition: Choose a portion of the patient's statement and repeat it.
- Rephrase: Repeat the patient's statement, substituting synonyms for important words.

Complex Reflections

- Paraphrase: Infer the meaning behind what was said and extend what was actually stated.
- Reflection of feeling or metaphor: Describe feelings behind the statement or use creative language to describe the statement.

How do I form reflections?

- Think of a question.
- Cut the question words.
- Form a statement and inflect your voice down.

Below are examples of simple and complex reflections for specific patient statements:

"I'm just not sure what to do."

Repetition:	"You're not sure."
Rephrase:	"You're a bit confused."
Paraphrase:	"You're stuck because there doesn't seem to be a right answer."
Reflection of Feeling/Metaphor:	"You're overwhelmed and want to make the right decision."

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> ***"I just have too much going on right now."***

Repetition:	"You have too much going on."
Rephrase:	"It's a busy time for you."
Paraphrase:	"It's difficult to juggle all of your obligations and you're wondering how you can fit in one more appointment."
Reflection of Feeling/Metaphor:	"It's like you're being pulled in 10 different directions."

> ***"My son hasn't started talking yet, like his cousins have. I don't know if that's a problem or not."***

Repetition:	"You're not sure if that's a problem."
Rephrase:	"You're uncertain whether you should be worried."
Paraphrase:	"You're noticing he's a bit behind his cousins and part of you wonders whether you need to have that checked out."
Reflection of Feeling/Metaphor:	"It's confusing. You don't want to overreact and you also don't want to miss a potential problem."

Using reflective listening or forming reflections sounds easy to most people, initially. However, once healthcare professionals make an effort to start using reflective listening, many are surprised at how difficult it is. You are not alone if this happens to you! It is common to be discouraged, but with practice, forming reflections will become much easier and more natural.

Many healthcare professionals wonder why they might try using reflective listening. This is done for several reasons:

First, reflective listening rarely evokes defensiveness.

Second, reflective listening encourages continued exploration of a topic.

Third, reflective listening invites the opportunity to ponder and respond.

Fourth, with questions, the healthcare professional decides the direction; in contrast, with reflections, the patients, after hearing their own statements repeated back, can decide the direction of the conversation.

Finally, reflections communicate the effort to understand.

Summaries

What is the purpose of a summary?

- Collect material that has been offered:
  "So far, you've mentioned that you'd like to find a doctor who takes time with patients, whose office is near the bus stop, and who has late evening hours."

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- Link something just said, with something discussed previously: "You've thought of a few reasons why you might take your baby in for his vaccines. That fits with what you said earlier when you were talking about how important it is to you that your children stay healthy."
- Pull together what has happened and transition to a new task: "Before I ask you the questions I mentioned earlier, let me summarize what you've told me so far to see if I've missed anything important. You have been in less pain lately, think your medication is working, and are not sure whether you need to see the specialist. What is more urgent for you right now is finding a way for your baby to sleep through the night so you are not so exhausted. You are also hoping to figure out a way to stop your older son from skipping school. What did I miss?"

Summaries function as a bouquet that you give back to your patients, but you choose the flowers. That is how summaries are goal-oriented/directive.

How do I summarize?

Attend to the most important information provided by the patient and provide a brief overview. Ask a follow-up question of clarification to be sure you are accurate: What did I miss? What would you add? How does that fit with your view of the conversation?

Informing and Advising

You care about your patients and are eager to pass along your knowledge and advice. However, it is easy to overestimate the amount of information and advice patients want and need. Providing too much information and advice, at the wrong moment or when the patient is not interested in receiving it, is one example of the Righting Reflex. The goal, therefore, is to determine the type and amount of information patients want and need and proceed accordingly.

Below are some common thinking traps regarding informing and advising, along with the MI consistent counterpart.

Informing and Advising Traps	MI Consistent Counterpart
I am the expert on why and how patients should change.	I have some expertise and patients are experts on themselves.
I collect information about problems.	I find out what information patients want and need.
I rectify gaps in knowledge.	I match information to patients' needs and strengths.
Frightening information is helpful.	Patients can tell me what kind of information is helpful.
I need to tell patients clearly what to do.	Advice that champions needs and autonomy is most helpful.

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How do I provide information and advice?

There is a relatively simple, MI consistent strategy for providing information and advice: Elicit-Provide-Elicit.

1st **Elicit:** Clarify information needs and gaps or ask permission to share information.
- What would you like to know about treating childhood behavior problems?
- May I tell you a little about why keeping up with vaccines is recommended?

2nd **Provide:** Prioritize information/advice based on the patient's requests and provide information in a clear, concise manner, and in small pieces.

3rd **Elicit:** Ask the client for a response and/or level of understanding.
- How does that sound to you?
- What do you make of that?
- I wonder what you think about what I've said.

The following two sample conversations demonstrate how the various MI skills described above can be used over the phone with parents in two different situations. There is not any one correct response to a statement or question made by a patient and you likely have ideas of other responses that would work well for you and your patients. These are simply examples of how using MI consistent responses and adhering to the MI spirit during conversations may increase parental engagement with the healthcare system.

Sample Conversation 1

Background: A nurse observed problematic interactions between a mother and her 18-month old son, Johnny, during a routine appointment. Specifically, the mother frequently yelled at the child for developmentally appropriate behavior, including attempting to grab toys out of her hand and wanting to be held. The mother did not hold the child despite the child's frequent attempts to climb in her lap.

The doctor contacted a care coordinator with a referral for the mother. The care coordinator's goal for the phone conversation with the mother was to connect her with resources to enhance her parenting skills and with professionals who could monitor her child's development. The mother is slightly annoyed about the phone call and does not immediately appear to have any concerns about her son.

> Mom: "I don't see why you are calling me. The doctor checked him out and everything seemed fine. He told me I don't need to bring him back until his 2-year checkup."

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- **Don't try to:**
  - Convince the mom that her child is not fine.
  - Immediately describe that the child's behaviors of reaching for toys and wanting to be held are developmentally normal.
- **Do try to:**
  - Understand or at least address the mother's reservations about your phone call.
  - Determine whether the mom has any concerns about her child.
- **Options for responding with MI:**
  - **Reflection of feeling/emotion:** It seems strange to you that you were told Johnny is healthy and then were referred for a follow-up call.

Let's try it:

> Mom: "I don't see why you are calling me. The doctor checked him out and everything seemed fine. He told me I don't need to bring him back until his 2-year checkup."

> CC: "It seems strange to you that you were told Johnny is healthy and then were referred for a follow-up call." **(Reflection of feeling/emotion)**

> Mom: "Well, yeah, he said everything is fine. My son had his whole physical and everything."

> CC: "You left that appointment with the view that the doctor thought Johnny was fine. How does that align with your view of him?" **(Reflection; Open Question)**

> Mom: "Well, now, I'm with him day in and day out. Of course there are some things that we are working on! We have some rough times now and then, but he's my son and I'm just relieved that he's good and healthy."

> CC: "It's important to you to take good care of him." **(Reflection; Affirmation)**

> Mom: "It sure is!"

> CC: "…and there are some things that you are working on improving." **(Reflection)**

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Mom: "Of course there are. He just cries, and knocks things over, and grabs at everything, and wants to be held all the time. It's exhausting and he's a big boy. I don't want him growing up crying over everything."

CC: "Those are things that are stressful to you and concern you a bit. The crying, knocking into things, grabbing, wanting to be held." **(Reflection of feeling)**

Mom: "It's time he outgrew all that baby stuff."

CC: " He's still doing things that he should have outgrown by now." **(Reflection)**

Mom: " Well, yeah. I don't know…I mean, he's 18 months old already!"

CC: "You're a little unsure, though." **(Reflection)**

Mom: "I am, I mean, he's my first, so I guess I might be a little unsure about what he's doing."

CC: "Given that you are a little unsure, I can share some information about what 18-month olds typically do, if you're interested." **(Reflection; Beginning to share information: Elicit)**

Mom: "Okay."

CC: "As you have noticed with Johnny, 18-month olds are full of energy. They are able to walk, even talk a little, and are curious about what is happening around them, which means they get into everything! Their motor skills though, meaning how they can control their bodies, are still developing, so we see them falling over, dropping things, or handling things roughly. How does that sound so far?" **(Provide information in small, understandable chunks; Elicit for understanding)**

Mom: "Sounds a lot like Johnny."

CC: "This is all sounding familiar to you. Would you like to hear more?" **(Reflection; Elicit again: Asking permission to share more information)**

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Mom: "Sure"

CC: "What we also know is that 18-month olds aren't too good at handling their emotions, so we see a lot of temper tantrums. We also see that they are trying to be more independent and do things on their own, but they also want to be around their parents a lot, for comfort. So it's kind of like they want two things at once: to do things on their own and to be really close to mom and dad. That can be really stressful to a lot of parents. What questions do you have about all of that?" **(Provide information; Elicit for understanding)**

Mom: "So what you're telling me is that those things he's doing are normal?"

CC: "It sounds to you like he matches up pretty well with what I just described. I agree with that."

Mom: "Okay, so that's good, I guess, but it's still exhausting."

CC: "It is exhausting and you have a lot going on. That brings me to another reason for my phone call. Can I share that with you?" **(Asking permission to share information)**

Mom: "Sure, but are we almost done, I have to go."

CC: "Definitely! You have a lot of things to do, and I appreciate the time you spent with me already." **(Affirmation)** "One of the reasons for my call was to see if you were interested in being connected with a social worker to help you manage the stress of parenting and to give you information about what to expect at each age…"

The care coordinator and mom can continue the conversation, to address mom's concerns about the referral and determine what works best for mom in moving forward. We see in this example that by reflecting mom's irritation at the beginning, and using reflections rather than immediately providing her with information about her child and typical 18-month old behavior, the CC and mom are able to have a collaborative conversation that is non-judgmental and makes the mom a partner in her child's health care.

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Sample Conversation 2

Background: An 8-month old girl is living with her mother and four older siblings. Her mother works two jobs to support the family and the baby is cared for primarily by an aging grandmother and 16-year old sister. Her biological father has a substance use problem and visits the home regularly. During the visits, he often becomes violent towards the children's mother, yelling and throwing things. Two of the baby's older siblings have severe behavior problems at school and the 16-year old sister is contemplating dropping out of school to care for the baby. The care coordinator is calling the mother to conduct the screening questionnaire and the results suggest that a referral for behavioral health evaluations and services would likely be beneficial for the children.

- **Don't try to:**
  - Immediately share a list of problems that the mom discussed and make recommendations for services or referrals
  - Warn the mom about the potential negative environmental consequences to her and her children
- **Do try to:**
  - Understand her current wants and needs
  - Increase her interest in allowing others to help her family

Let's try it:

> CC: Thank you for answering those questions." (Affirmation) "Is it okay if we discuss the results?" **(Asking permission to share information: Elicit)**

> Mom: "Sure."

> CC: "As I mentioned at the beginning, the reason I'm calling is to help ensure that you have all the resources you need, for both you and your kids. We talked a little bit about the stressful things you have going on with work, your relationship, and trying to do what's right for your kids. **(Summary)** Before I share what we can do, what do you have in mind about what would be helpful for you and your family?" **(Open question: Elicit)**

> Mom: "We are just doing the best we can. We'll get through it."

> CC: "It's hard to think about what someone else might do to help you through this." **(Reflection)**

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Mom: "There's nothing anybody can do. Nobody but me can solve our problems for us. Plus, I don't need anybody snooping around my business. I didn't even like answering your questions."

CC: "It feels like an invasion of privacy to bring someone else in to help." **(Reflection)**

Mom: "Sure does."

CC: " …and you are strong and determined to make things work out." **(Reflection)**

Mom: "That's right."

CC: "What are your goals then? What do you want to have work out for your kids right now?" **(Open question)**

Mom: "I want good things for all of them. I want them to be safe, to stay out of jail, and to stay in school…and for my baby, I want her to have opportunities I didn't have. Have a better life than mine."

CC: "…and you're working hard to make all of that happen." **(Reflection)**

Mom: "Sure I'm working hard; we're just not quite there yet."

CC: "You may need something a little extra." **(Reflection)**

Mom: "Like what?"

CC: "That's what I'm hoping to understand from you. You are working so hard and don't want other people snooping around in your business. At the same time, you're thinking that maybe a little extra help might be what you need to help get your kids on track." **(Brief summary/reflection linking what was just said to what was said earlier)**

Mom: "You have help like that?"

CC: "I can certainly connect you with people who can help, if you are interested." **(Asking permission to share information)**

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The conversation can continue with providing information about referrals and available resources. Notice how mom was asked for her ideas about what kind of help she needed, rather than the care coordinator immediately listing available services and referrals. If the care coordinator had started with a list of referrals, the response likely would have been mom's later statement that she does not want others snooping in her business and that she can handle the problems herself. By attempting to understand her reluctance first and reflecting her statements, we are able to generate the thoughts from her that more help may be necessary.

Questions To Consider

After reviewing the material in this handout and watching the video *Using Motivational Interviewing in Care Coordination*, it may be helpful to consider your responses to the following questions in order to guide your next steps.

- In what ways can MI be useful in exchanges between my patients and me?
- What have I learned that I can try using with my patients today?
- Why would I want to learn more about MI?
- What do I hope to gain with continued learning in MI?

WHAT TO EXPECT FROM CONTINUED LEARNING IN MI

If you choose to continue your MI learning, a reasonable next step may be to participate in a one or two-day beginning workshop. In those small and interactive workshops, you can expect:

- Significant practice with the basic skills: OARS.
- Live demonstration by skilled MI practitioners.
- Hands on coaching and feedback during the workshop.
- Information on MI research.

After participation in basic workshops, you may be ready to learn intermediate and advanced MI skills. In those workshops, you can expect:

- Review and practice of basic skills.
- Introduction to new topics including:
  - The four processes of MI.
  - Recognizing, eliciting, and strengthening change talk.
  - Reducing and responding to sustain talk and discord.
  - Application of MI in various settings.
  - Integration of MI with other techniques.
- Live demonstration by skilled MI practitioners.
- Hands on coaching and feedback during the workshop.
- More information on MI research.

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How Do I Learn More?

For a thorough review of the development of MI, in-depth review of strategies and skills, MI research, and applications of MI, refer to the book:

Miller, W. & Rollnick, S. (2013). *Motivational Interviewing: Helping people change*. New York, NY: The Guilford Press.

The following DVD series complements the book and includes brief educational clips by the developers of MI along with demonstration of the skills:

Miller, W. R., Moyers, T. B., & Rollnick, S. (2013). *Motivational Interviewing: Helping people change* [DVD]. United States: The Change Companies

Many practitioners find that practicing with colleagues helps increase familiarity with MI techniques. A highly recommended workbook is:

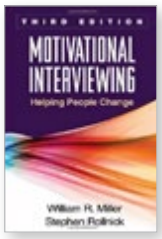
Rosengren, D. B. (2009). *Building motivational interviewing skills: A practitioner workbook*. New York, NY: The Guilford Press

Finally, the official MI website has information on upcoming MI training, recent publications and research in MI, contact information for MI trainers, MI books and workbooks, and much more. It can be found at www.motivationalinterviewing.org.

REFERENCES

The majority of information contained in this brief is based on the book:

Miller, W. & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change*. New York, NY: The Guilford Press.



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