Motivational Interviewing in Home Care

VNAA Best Practice for Home Health
Objectives

The learner will:

• Define motivational interviewing
• Describe the characteristics of a provider who is collaborative
• List MI principles and examples of application in practice
• Evaluate barriers and bridges to MI implementation
• Review one MI tool for initial steps of implementation
Presentation outline

• What is motivational interviewing (MI)
• The spirit of motivational interviewing
• Coaching versus teaching
• MI principles and application examples
• Barriers and bridges to implementing MI in practice
• Getting started: Use of Importance/Confidence Ruler
Self-management support as justification for MI adoption

• The systematic provision of education and supportive interventions to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting and problem solving support

Source: Institute of Medicine, 2001
What is motivational interviewing (MI)?

- Communication style to build rapport
- Not based on one scientific theory
- Blending of techniques from other theories and interventions
- Avoids labeling patients

Source: Sobell 2007
What does motivational interviewing do?

• Designed to enhance client motivation to change
• Especially effective for patients that are “stuck” – not making recommended health related behavior changes
• “MI is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence”
• MI helps activate the patient’s own motivations to change

Source: Rollnick, Miller, and Butler: Motivational Interviewing in Healthcare. 2008
Efficacy

- Effective in 75% of randomized controlled trials
- 94% of the trials used individual interviews
- MI outperformed traditional advice giving in 75% of these studies
- Effectiveness was shown even in brief encounters of only 15 minutes
- Effect was not related to clinician’s education background (physician vs. psychologist vs. nurse)

Source: S. Rubak, A. Sandboek, T. Lauritzen and B. Christensen
“Motivational Interviewing: a Systematic Review and Meta-Analysis”
British Journal of General Practice, April 2005
The spirit of motivational interviewing

• Therapeutic relationship:
  – Empathetic
  – Non-authoritarian
  – Collaborative
  – Supportive
  – Curious
Collaboration through COACHING:

• “An approach of partnering with patients to enhance self-management strategies for the purpose of preventing exacerbations of chronic illness and supporting lifestyle change” (Huffman, 2007, p. 271).
Coaching vs. Teaching

**COACHING**
- Facilitator
- Patient identified goals/timelines
- Patient/care partner centered
- Improved motivation
- Motivational interviewing

**TEACHING**
- Teacher
- Teacher identified goals/timelines
- “Expert centered”
How do you coach?

- Ask questions
- Listen...carefully
- Find out what is important to them and not just to you (Authentic listening)
- Identify ways to accomplish goals
- Can often later tie your clinical goals to theirs for a win-win situation
- Especially effective with “non-compliant” patients as they may have different goals you are not aware of
Characteristics of questions

• Open ended
• Focus on patient
• Asking for guidance from patient, not telling
• Allowing patient/care partner to identify priorities
The four basic principles of motivational interviewing

1. **Express Empathy**
   - Use reflective listening

2. **Roll with Resistance**
   - Accept pt’s point of view – never argue

3. **Develop Discrepancy**
   - Elicit and reflect change talk

4. **Support Self-efficacy**
   - Structure mastery experiences
Motivational Interviewing Principles

1) Express Empathy
- Where is patient in understanding their illnesses and their impact?
- Build trust and rapport
- Listen and ask patient to reflect on health status
- How hard is it on you and your family when you are in the hospital?
- I am sure it is very hard to control your sugar level with your diet. What types of foods is the hardest for you?

2) Develop Discrepancy
- Assist patient to see where they are and where they want to be
- Start patient goal setting (non-medical goals are appropriate)
- How does being sick so often affect your life?
- What have you tried before that has worked?
- Has not worked?
- What did you like to do before you got sick?
- I wonder what it would take so you could do that again?

3) Role with Resistance
- Don't argue or oppose resistance
- Try new approach or find areas of agreement
- Listen for underlying reasons
- Use open ended questions
- Tell me what do you think caused you to go back to the hospital?
- What do you think caused the symptoms to flare up?
- Tell me about the problems you have with taking your medications?

4) Support Self-Efficacy
- Support patient's goals, actions
- Use sense of trust and guide patient
- Use "My Action Plan" or other goal setting tool
- Tell me what you would like to do in the next couple of weeks?
- How do you think you can do it?
- How can I help you reach your goal?
- You did great this week on your goal. How confident are you to do it this week?

Reflective listening to express empathy

- So, I think you said . . .
- Are you saying that . . .?
- So, what you are telling me is that . . .
- So, what I heard you say is . . .
- Am I hearing you correctly that . . .?
- Okay, let me see if I’m getting this right . . .
Developing discrepancy

• Difference between the person’s core values and life goals and their health behavior
• Difference between where the person is now and where he/she would like to be in the future
• Cognitive dissonance is necessary for change to occur
• Good questions to ask:
  – “How does being sick affect your life? What would you like to be able to do that you can’t do now?”
How we can negatively effect ambivalence

- Studies show that patient resistance can lead to confrontational behaviors in the clinician.
- Pushing against resistance by arguing your point tends to amplify the negative part of the equation.
- Patient resistance is a predictor of poor patient outcomes.
Rolling with resistance

• Don’t lecture
• Acknowledge & validate how difficult it is to change life long behaviors
• “Back off”—ask open ended questions, don’t pressure or preach
• Clarify decision is the patient’s
• Making the effort to understand the causes of each patient's non-adherent behavior helps tailor an approach to removing obstacles
Supporting self-efficacy through goal setting

- May not be on first few visits, although most patients are often aware of what they want
- Write them down with specific steps agency and patient/care partner need to do
- Begin to tie your clinical goals to the patient goals
- Once goal/goals are completed, enter study number on sheet and put copy in study mail box
Provide options and tie to long-term goal

• These are some things you can do to help you with your long term goal. What would you like to work on in the next few weeks?

Diabetes Self Management
- Taking My Medicine to Control My Blood Sugar
- Eating Healthy
- Monitoring My Blood Sugar
- Stop Smoking
- Foot & Skin Care
- Regular Exercise

Exercise
HHQI – My Action Plan

1. Goal: Something I want to do: ____________________________
   ____________________________

2. Describe how: ____________________________
   Where: ____________________________
   When/How often: ____________________________

3. Barrier(s): ____________________________
   Plan to overcome barrier(s): ____________________________

4. Am I convinced that I can do this? Mark on the ruler:

   Totally Unconvinced  |  Unsure  |  Somewhat Convinced  |  Very Convinced  |  Extremely Convinced
Goal setting/action planning

• Make sure goal is achievable and realistic—use confidence ruler
• Work with the patient to visualize taking first step toward the goal
• Visualizing actions assists with identifying barriers and obstacles
• Discuss ways to minimize barriers and have the patient come up with solutions—this is problem solving
• A plan should be written down
Writing short-term achievable goals

• How to write a SMART Goal
  – Specific
  – Measureable
  – Attainable
  – Relevant
  – Time based

Source: CDC
Barriers to MI implementation

• Literacy issues
• Loss of control/role changes
• Time to master
• Need for practice
Health literacy

• Does your patient know who to contact in emergency?
  – Will they do it?
• Best/worst times to call MD office
• How to ask for what they need:
  – SBAR for patients
SBAR Communication Technique for Patients and Advocates

**Situation**
- I am ____________________________ (state your name)
- I am the ____________________________ (relative, advocate, friend, Medical Power of Attorney) for ____________________________ (state patient’s name)
- I am concerned about ____________________________

**Background**
- The patient came to the hospital because ____________________________
- The patient’s diagnosis is ____________________________ or is unknown at this time
- The patient’s physical or mental limitations are ____________________________
  - (Examples: dementia, hearing loss, difficulty walking, unable to communicate, language barriers)
- The patient is ____________________________ (Examples: on oxygen, receiving new medications, having procedures or surgery, awaiting test results)

**Assessment**
- New symptoms I have noticed are ____________________________
- What has changed in the patient’s condition is ____________________________
  - (Examples: pain level, vital signs (blood pressure, temperature, pulse), breathing, mental status, color of skin, sweating, agitation, dizziness, lack of energy)
- The patient seems to be ____________________________
  - (Examples: stable, stable, declining or deteriorating, in serious trouble)

**Request**
- I would like to discuss the following possible actions ____________________________
  - (Examples: consultation/evaluation, a second opinion, calling the Attending Physician, scheduling a family meeting, additional tests or monitoring, transfer to another unit or facility)
- If a change is ordered, how and when should I contact you if there is no improvement? ____________________________

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## Pill Card

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Important Information, in Simple Terms</th>
<th>Incorporating This Information into a Pill Card</th>
<th>Possible Graphics Used</th>
</tr>
</thead>
</table>
| Simvastatin  | • Take 1 pill at night  
• For cholesterol                                                                                           | • Picture of one pill at night/bedtime (shown by moon)                                                       | Night/bedtime          |
| 20mg         |                                                                                                         |                                                                                                              |                        |
| Eprosemide   | • Take 2 pills in the morning and 2 pills in the evening  
• For fluid                                                                                              | • Picture of two pills in the morning (shown by rising sun) and two pills in the evening (shown by setting sun) | Morning, Evening       |
| 20mg         |                                                                                                         |                                                                                                              |                        |
| Insulin      | • Inject 24 units before breakfast and 12 units before dinner  
• For diabetes (sugar)                                                                                   | • Picture of syringe in the morning (shown by rising sun) and evening (shown by setting sun).  
• Picture of bag of sugar                                                                                  | Syringe, Sugar         |
|              |                                                                                                         |                                                                                                              |                        |

### Loss of Control/Role Changes

#### Loss of Control/Role Changes for Patient
- Unable to resume housework, child care
- Perception of family as unable (perceived incapacity)
- Dependence on others for meeting care needs (negotiated autonomy)

#### Loss of Control/Role Changes for Clinician
- Patient centered goals
- Negotiated autonomy challenge-role as arbiter
- Less problem solving, more active listening
- Can then relate patient identified goals to
- Perception of taking longer—more effective in outcomes

Source: Collopy, Dubler and Zuckerman, 1990
Time to Master

Look back to Facilitation Slides
- Principles of adult education
- Use of PDSA to develop and implement
- Kotter’s Rules for Change

Must have buy in from staff
- Find the champions
- Start small
- Test
- Develop Process to make it “easy to do the right thing”
- Test, retest
Reference Cards

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Need for practice

• Very challenging for some nurses
• Allow time to role play with scenarios in groups with peers
• Give assignment to try with one patient, come back and share experiences with group
• Encourage to try with most challenging patient
• Schedule 3-4 inservice programs experienced over time to fully develop skill
• Competency Fair
What characterizes an “Informed, Activated Patient”?

They have the information, skills, motivation and confidence necessary to effectively make decisions about their health and manage it.
Examples of patient and clinician roles in Wagner’s model

Patients identify their preferences to guide care delivery

Team uses motivational interviewing to identify what matters most and resolve ambivalence

The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed, Activated Patient
- Productive Interactions
  - Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
ACP-ASIM Journals and Books
Getting started – use of Importance and Confidence Ruler
Tool: Importance/Confidence Ruler

• A tool to explore patient’s most common barriers – importance or confidence

• Identifies a patient’s importance and confidence regarding a specific behavior change

• Allows the clinician and patient to focus “energies” on the area of greatest need

• For example, if a patient smokes and is confident they can quit but it is not important to them, now is probably not the time to address this behavior change.
Start with level of importance

• Instruct: “Rate how important the behavior change is?”
  – If level of importance is > 7, assess level of confidence
  – If level of importance is < 7, ask:

• Questions to ask:
  – “Why didn’t you chose a (lower number than chosen) as the level of importance?”
  – “What would it take to move you to a (higher number than chosen)?”
If importance is low - informing

• Ask for permission to share information
• Offer choices
• Talk about what others do
• Scare tactics are not effective

Source: S. Rollnick, W. Miller and C. Butler Motivational Interviewing in Health Care. 2008
Next rate level of confidence

- The answer to these questions could help identify barriers:
  - “How would you rate your confidence in the ability to change?”
  - “Why did you give yourself a ___ and not 1?”
  - “What would help you get to a higher score?”
  - “How can I help you move up to a higher score?”
Assess patient’s readiness to change using the ruler

- Helps patient to discover their own motivation
- High Importance + High Confidence = Readiness to change

Not at all | Very
---|---
0 1 2 3 4 5 6 7 8 9 10
1. When all is said and done, I am the person who is responsible for managing my health condition.

2. Taking an active role in my own health care is the most important factor in determining my health and ability to function.

3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.

4. I know what each of my prescribed medications do.

5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.

6. I am confident I can tell my health care provider concerns I have even when he or she does not ask.

7. I am confident that I can follow through on medical treatments I need to do at home.

8. I understand the nature and causes of my health condition(s).

9. I know the different medical treatment options available for my health condition.

10. I have been able to maintain the lifestyle changes for my health that I have made.

11. I know how to prevent further problems with my health condition.

12. I am confident I can figure out solutions when new situations or problems arise with my health condition.

13. I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress.

Hibbard, J. et al. Health Serv Res. 2005 December; 40(6 Pt 1): 1005-1026 (Must obtain permission to use tool.)
Plan for barriers

- Make sure goal is achievable and realistic
  - Use confidence ruler
- Ask patient what may throw them off track
- Discuss ways to minimize barriers
  - Have the pt come up with ideas too - this is problem solving
- Goal setting plan should be written down and posted in home
Create a cascade of successes

• Work to promote a “cascade of successes”: Achievement of one goal creating and achieving additional new goals

• Creating a “cascade of successes” empowers patient to continue making behavior changes