

Motivational Interviewing:

Encouraging Positive Changes In Your Patients

Kathryn Anderton, BSN, RN, BC-RN, CCM
Clinical Lead, ThoroughCare
March 2023

Care Coordination and associated care planning can enable healthcare professions to tailor care aligned to factors that support a patient’s overall ability to manage chronic disease. This promotes necessary changes to better manage chronic conditions and improve patient outcomes. Treatment strategies designed to manage chronic diseases offer vast benefits that range from reducing the hospitalization rates to promoting a patient’s confidence in managing their conditions. A recent study found that a nonprofit healthcare center was able to significantly reduce overall hemoglobin A1C in their diabetic patients after implementing a chronic condition management program (Tillman, 2020). Chronic disease management is proven to enhance overall patient care, boost patient engagement, and improve patient outcomes.

While the benefits of managing chronic conditions are expansive, they ultimately hinge on the ability of healthcare professionals to successfully engage patients and motivate them to identify and make changes that improve their health. Motivational interviewing (MI) is a strategy healthcare professionals can implement that focuses on using patient-specific motivators and experiences to help guide and foster positive change. The co-founders of MI, William Miller and Stephen Rollnick (2013), describe it as:

... a collaborative, goal-oriented style of communication with particular attention to language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion. (p. 29)

Because of the elective nature of programs that manage chronic conditions, it is important for healthcare professionals to continue to empower patients and MI is an excellent way to accomplish this. MI has three distinct qualities:

- Gently guiding conversations while balancing active listening and advice
- Empowering change in patients by using patient-identified factors as motivation to achieve their goals
- Using respect and curiosity to advance positive patient changes while allowing room for autonomy

For healthcare professionals to successfully engage their patients, it is important for them to translate each of those three distinct MI qualities in their outreach. The MI process is very similar to that of managing chronic conditions and includes **engaging**, **focusing**, **evoking**, and **planning** while also understanding the process of change is not always linear (Miller & Rollnick, 2013). MI addresses lack of patient engagement and lack of a comprehensive care plan. MI also helps ascertain social determinants, promotes patient autonomy and investment as a part of their own care plan, builds patient-provider rapport, decreases subconscious bias and not “hearing” patients, and paints a decidedly more comprehensive patient picture for the provider. Motivational interviewing is crucial in this process and ThoroughCare’s care coordination software can act as a bridge to allow for a seamless integration between the two.



Engage

All successful programs for managing chronic conditions begin with engaging patients in their own care and treatment. Regardless of the quantity of relevant health information collected, care quality may suffer if the patient does not reciprocate engagement. A care manager builds a sense of mutual collaboration as an initial step in patient engagement by introducing themselves, the program, and asking open-ended questions designed to assess the patient's overall understanding of their chronic conditions.

During this time, the care manager is developing rapport, reducing resistance to change, and clarifying any questions or concerns the patient may have (Al Ubaidi, 2017). The care manager should continue to monitor the patient's engagement throughout the entire relationship by evaluating if they are creating goals with the patient, or for the patient, and monitoring the genuineness of patient conversations. Care managers who employ an engaged awareness foster a more comfortable environment which subsequently encourages and cultivates positive patient change.

GOALS

To help manage your Hypertension, let's choose some personal health goals to focus on. Here are some common goals that hypertension patients strive for. Which ones are the most important to you?

- Adhere to sodium restriction set by provider
- Check and log blood pressure daily to bring to appointments
- Exercise or be more physically active
- Follow my recommended diet
- Lower my blood pressure to my goal
- Maintain blood pressure at goal set by provider
- Quit smoking
- Take medications as prescribed
- Understand and implement lifestyle modifications to manage condition
- Understand signs and symptoms of when to call my doctor and when to seek emergency care
- Understand stress management and relaxation techniques

*Create and manage patient goals within ThoroughCare care plan

Build Engagement with OARS Technique

An effective patient-centered technique for care managers to foster patient engagement is **OARS**: ask **Open-ended** questions, provide **Affirmations**, use **Reflective** listening, and **Summarize** the conversation for the patient (MINT excellence in motivational interviewing, 2014, pp. 68 – 102). OARS is a motivational interviewing technique used within chronic disease management and designed to promote a positive change in patient behavior.

Asking **open-ended questions** of the patient allows the patient to direct the conversation, fostering autonomy and building a trusting relationship. Acknowledging and **affirming** patient strengths and behaviors that are conducive to change reaffirms and acknowledges those positive change-behaviors for the patient. **Reflective listening** is a closed-loop communication tool in which the care manager not only looks to understand the patient's concerns but also reflects those ideas back to the patient to confirm a true understanding. **Summarizing** the patient and care manager conversation for the patient provides a brief and concise overview to ensure both parties understand patient goals, elements to achieve those goals, as well as allowing space for the patient to discuss additional concerns.

Focus

Once the patient is engaged, it is important for the care manager to facilitate focus for the patient. A chronic condition diagnosis coupled with a long, daunting list of items to work on for that diagnosis can be overwhelming to the patient. In support of substantial lifestyle changes and collaborative engagement, the care manager assists the patient to determine their health goals and provides guidance to achieve them.

Supporting the patient to create self-directed goals accomplishes:

- Promoting patient autonomy in managing their health conditions and medical care
- Allowing the patient to assume greater responsibility and ownership in managing their chronic conditions
- Increasing patient motivation for change by working towards self-identified goals
- Advancing patient likelihood of long-lasting changes, improved outcomes, and overall health

While the care manager should grant space for the patient's own goals, they may also have additional or alternate goals that the patient can work toward. Part of the focusing phase is not just identifying goals but determining and maintaining a direction for the conversation that promotes change.

ThoroughCare software provides common predefined goals related to conditions and has the option to include personalized SMART Goals. Care Managers can utilize **SMART** Goals (e.g., **S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**imely) to facilitate actionable and purposeful patient-engaged goals (Doran, 1981).

ThoroughCare software supports the critical collaboration between the care manager and the patient to mutually identify meaningful goals, imperative for both MI and patient success.

What targeted SMART Goals would help us to achieve these outcomes...

- Maintain a blood pressure below 140/90
- Exercise 60 minutes for 3 days per week ✓ ✗

New SMART Goal

Search for a goal

- Exercise {days} days per week for 30 minutes
- Exercise {minutes} minutes for {days} days per week
- Achieve a daily step goal of {steps}
- Consume {calories} calories per day
- Consume {protein} grams protein per day
- Keep pain levels at or below {pain}/10
- Sleep for at least {hours} hours nightly
- Maintain a blood pressure below {systolic}/{diastolic}
- Maintain blood pressure above >{systolic}/{diastolic}

*SMART Goal application within ThoroughCare care plan

Evoke

With a patient-specific goal in mind, the care manager must then discover or evoke the patient’s motivation for change. While the motivation for change may be something as general as improving their physical health, it can also be more nuanced and specific to that patient’s life experience. For instance, a patient is motivated to control their high blood pressure because their parent suffered a stroke from undiagnosed high blood pressure, or a patient wants to be more physically active and feel more energetic to be more involved in their grandchildren’s lives.

The care manager “seeks to evoke the client’s own motivations for change rather than installing them” (Miller & Moyer, 2006). A core concept of MI is that “individuals are more likely to accept and act upon opinions that they voice themselves” (Bem, 1972). A patient will feel a stronger commitment to a self-directed goal as the motivation for change is internally motivated rather than from an external pressure.

Utilize Change Talk to Evoke Patient Goals

Change talk, language that signals movement toward a behavioral modification (MINT excellence in motivational interviewing, 2014, p. 111), acts as impetus for a patient’s motivation and signals their commitment toward change.

As care managers perform reflective listening and motivate change talk, they provide space for patients to verbalize their own motivations and plans for change. Once the patient’s motivations have been established, the patient then assigns a one to 10 value that indicates their numerical motivation to change and the care manager documents that numerical value within the goal section of ThoroughCare’s care plan.

The screenshot shows a digital care plan entry with the following details:

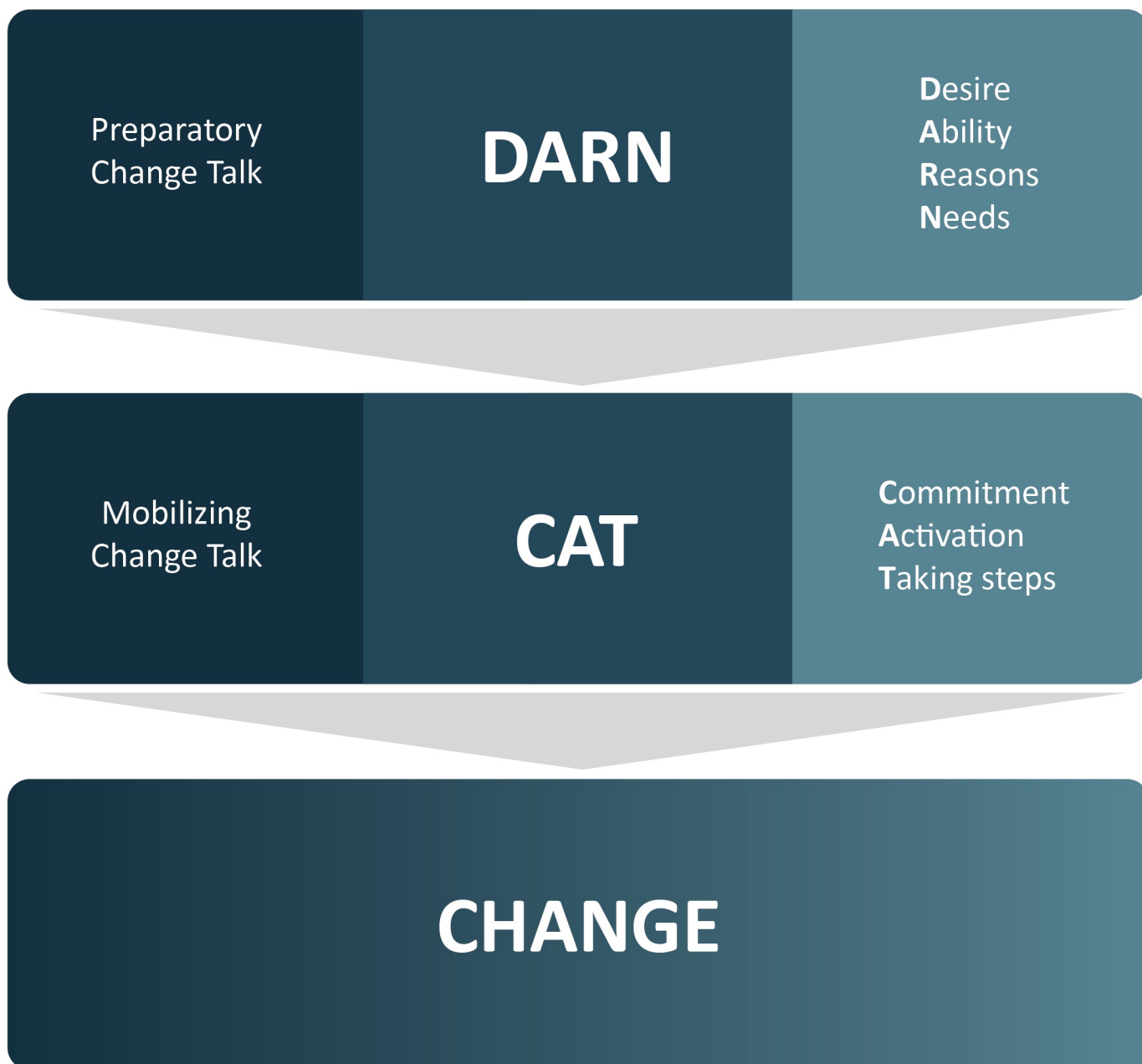
- Title:** Understand and implement lifestyle modifications to manage condition
- Status:** In Progress
- Date:** 02/22/2023
- Notes:** Pt reports that he is unaware of all lifestyle modifications and also has found it challenging to implement diet and exercise. Would like to focus on this goal.
- Previous Updates:** There are no updates...
- Motivation Scale:** A scale from 1 to 10, with '10' selected. The scale is labeled "Optional: On a scale of 1-10, how motivated is the patient to address this goal?".
- Assign to Current Problem:** Hypertension (High Blood Pressure / HBP / HTN)
- Action:** A 'Save' button is located at the bottom right of the form.

*Patient goal motivation capture within ThoroughCare care plan

In a study in which clinicians were trained to utilize MI and change talk, they found that they were able to “significantly increase the frequency with which clients offered statements indicating a desire, ability, reason, need, or commitment to change” (Glynn & Moyers, 2010). Care managers can evoke change talk with patients by utilizing a two-fold technique in motivational interviewing: DARN and CAT.

A patient first prepares to change by stating their **D**esire, **A**bility, **R**eason, and **N**eed to change (**DARN**). The change is then implemented by the patient through **C**ommitment, **A**ctivation, and **T**aking steps toward the change (**CAT**) (MINT excellence in motivational interviewing, 2014, pp. 115 - 122). By breaking down communication into a two-fold process of preparing to change and implementing the change, the care manager can increase the patient’s intrinsic motivation to change their behavior.

Change Talk



Plan

Subsequent in the MI strategy to engaging, focusing, and evoking is planning. Healthcare professionals can often identify the next appropriate steps a patient must take to improve their health, but simply directing the patient on next steps is not always adequate. ThoroughCare's care plan provides several interventions for both the care manager and the patient to allow both parties to not only be involved in the planning phase but also shoulder responsibility together.

How do we achieve those goals (Interventions)?

Care Manager Actions (3)	Patient Actions (2)	Services and Programs (0)
----------------------------	------------------------------	-----------------------------

- Keep a blood pressure cuff beside morning medications and set an alarm every morning as a reminder to check blood pressure and take medication
- Keep a detailed medication list of prescription, supplements, and OTC medications including dosage, route, and frequency to review with my provider at every appointment. Discuss any medication concerns with my doctor before discontinuing medication

New Intervention Search for Patient Actions

*Patient interventions addressed in ThoroughCare care plan

With the option to select from pre-populated interventions, the care manager remains present in conversation with the patient while having potential interventions readily available to share. Within the Goals Tab

Problems Current Program

Managing **CCM** **Condition**
Acid Reflux (GERD)

Managing **CCM** **Condition**
Hypertension (High Blood Pressure / HBP / HTN)

Hypertension (High Blood Pressure / HBP / HTN)
If everything goes as planned, what are some desired outcomes

- Reduce risk for having a stroke or TIA

New Desired Outcome Search for an Outcome

What symptoms are you experiencing?

- Asymptomatic

New Symptom Search for a symptom

What targeted SMART Goals would help us to achieve these outcomes...

- Maintain a blood pressure below 140/90

New SMART Goal Search for a goal

in the care plan, care managers document progress and view previous monthly progress notes. As the care manager can familiarize themselves with previously discussed topics prior to reaching out to a patient, they can also strategically focus their conversation to further support patients achieving their goals. When employing MI to encourage long-lasting changes, it is imperative for care managers to suggest various interventions and allow the patient to not only choose the best option for them but also propose alternate options that may work better for them. This will decrease resistance to change and increase the chances of successful behavior changes (Al Ubaidi, 2017).

*Document progress in ThoroughCare care plan



With a clear overlap between the process of motivational interviewing and chronic disease management, the benefits of implementing MI techniques in the treatment process are indisputable. Utilizing MI techniques is proven to foster patients' increased autonomy and confidence in managing chronic conditions while simultaneously improving rapport and the overall relationship between healthcare provider and patient. Integrating MI methods such as OARS, DARN, and CAT opens up patient conversations, allowing for a more comprehensive, holistic approach to patient care. With software that acts as a guided conversation, ThoroughCare's care plan can facilitate critical motivational interviewing techniques which are directly tied to improved patient outcomes.

About ThoroughCare, Inc.

Founded in 2013, ThoroughCare provides digital care coordination solutions to over 600 clinics and physician practices throughout the United States. ThoroughCare's intuitive software, mobile, and analytics applications are designed to support a holistic, continuum of care for healthy patients and thriving practices. Healthcare providers use ThoroughCare's SaaS platform to enable personalized health experiences, streamline value-based care delivery, and help identify the next best actions at critical moments.

About the Author



Kathryn Anderton,
BSN, RN, BC-RN, CCM
Clinical Lead, ThoroughCare

Kathryn Anderton is a Registered Nurse with ten years of experience. Currently employed at ThoroughCare, Kathryn serves as the Clinical Product Analyst. She is responsible for updating clinical content within the application ensuring it adheres to best practices, providing customer support in various workflows, and enabling sales with necessary clinical information.

Prior to joining ThoroughCare, Kathryn worked at Blue Cross Blue Shield of Michigan as a Certified Care Manager where she provided education, coordinated resources, and intervened appropriately with the Medicare population all while adhering to strict NCQA guidelines. She also has experience as an acute care RN working at Beaumont Hospital where she provided care to cardiac/neuro step down patients, performed duties as the Unit Educator, and was involved in various committees including the Professional Nursing Council.

References

- Al Ubaidi, B. A. (2017). Motivational interviewing skills: A tool for healthy behavioral changes. *Journal of Family Medicine and Disease Prevention*. Vol.3 (4).
<https://doi.org.10.23937/2469-5793/1510069>
- Bem, D. J. (1972). Self-perception theory. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 6, pp. 1-62). New York: Academic Press.
- Doran, G.T. (1981). There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review (AMA FORUM)* 70 (11): 35–36.
- Glynn, L. H., & Moyers, T. B. (2010, July 1). Chasing change talk: The clinician's role in evoking client language about change. *Journal of Substance Abuse Treatment*.
<https://doi.org/10.1016/j.jsat.2010.03.012>
- Miller, W. R., & Moyers, T. B. (2006). Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions*, 5(1), 3-17. https://doi.org/10.1300/j188v05n01_02
- Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping People to Change*, (3rd ed.). Guilford Press.
- MINT excellence in motivational training. (2014). *Motivational Interviewing Training New Trainers Manual*.
https://motivationalinterviewing.org/sites/default/files/tnt_manual_2014_d10_20150205.pdf
- Tillman, P. (2020, June 27). Applying the Chronic Care Model in a Free Clinic. *The Journal for Nurse Practitioners* Vol. 16, e-pp. 117-121. <https://doi.org/10.1016/j.nurpra.2020.05.016>

