CCNC Motivational Interviewing (MI) Resource Guide

“Everybody’s motivated about something”

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Introduction

"Motivational Interviewing 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 the person's own reasons for change within an atmosphere of acceptance and compassion."

Miller and Rollnick (2012)

Since 2011, Motivational Interviewing (MI) has been a key focus within CCNC – engaging, educating, and empowering the patients we serve is a core value. Each network has MI Champions who are focused on supporting the continuing roll-out of MI into the networks. As a part of that effort, the MI Champions have developed this MI Resource Guide specific to CCNC Care Managers.

You will have an introduction to MI in the Clinical Care Team Orientation at CCNC central office, but we suggest you do some pre-learning as soon as you begin work as a Care Manager. Reviewing the Principles and Spirit sections in this Guide and reviewing the article in the Appendix, "Dancing not Wrestling" are great ways to begin this journey. Your supervisor and MI Champions should be able to help orient you and explain basic skills even before any formal training. There are web-based resources and other tools embedded in this Guide which can also help.

We know that attending a one-day training is a step in the right direction, but that it takes time for MI to become a part of how we operate. MI is not "just one more thing to learn," but is a way of doing care management more effectively, leading to more sustained patient outcomes and less care manager burn-out. It's a freeing feeling to realize that a health behavior change is not up to you as the care manager but is in fact up to the patient.

There are many tools and techniques included within this guide. Don't feel like you have to use them all, but pick and choose what works best for you. Enjoy!

CCNC Central Office Clinical Leadership

The Spirit of MI

“People may not remember what you say, but they remember how you made them feel.”

The “Spirit” of Motivational Interviewing

Partnership

- MI is a collaborative partnering with patients
- See the patient as the expert on themselves
- Ask for permission
- Avoid premature focus
- Focuses on mutual understanding versus the care manager being right

Acceptance/Autonomy/Absolute Worth

- The care manager is a guide, but the patient must make their own decisions to change
- Respect patient autonomy – whether or not they change
- Inform and encourage choices without judgment
- See ambivalence as normal

Compassion

- Genuine care and concern
- Understand and validate the struggle

Evocation

- Instead of telling patients what to do, MI evokes the patient’s own motivation and resources for change
- Trust patient to be motivated for something
- Asking versus telling
- Avoid expert trap

You may not remember all of the processes and techniques of MI, but if you incorporate the Spirit of MI in all of your interactions with patients, you would have gone a long way in making a difference.

Key Principles

“People are usually better persuaded by the reasons which they have themselves discovered than by those which have come into the minds of others.”

-Blaise Pascal

1) **EXPRESS EMPATHY**: Understand where the patient is and then convey your understanding to them. Guide people to understand and listen to themselves.

- Acceptance facilitates change
- Skillful reflective listening is the essence of motivational interviewing (the concept and practice the clinician can return to over and over again)
- Ambivalence is normal and a critical element for all human growth

"Those are a lot of medications. I can see how it would be hard to keep all that straight."

"What you are saying is really important to me, tell me more about_____."

"Okay, I hear you...I would like to back up a bit. What do you think about talking about what concerns you the most about your condition?"

2) **DEVELOP DISCREPANCY:** Change is motivated by a perceived discrepancy between present behavior by a patient and their important goals and values. Developing discrepancy should be done in a non-judgmental way.

Common techniques used to create or develop discrepancies include:

- Asking the patient to look into the future and imagine a changed life under certain conditions (i.e., condition is well managed) or to look into the past and recall periods of better functioning.
- Ask the patient to consider the worst possible scenario resulting from not changing behavior or the best possible consequences resulting from trying to change. Reflect any movement toward change.
- Ask questions about behaviors that don't support goals set by the patient. Present discrepancies as legitimate conflicts or mixed experiences rather than as contradictions or judgments that prove patient has a problem.
- Use clear and articulate statements that capture the divergent elements a patient has said. Integrate the patient's specific discrepant statements using a supportive, non-judgmental tone.

"On one hand I hear you saying that you would like to walk your grandson to the bus stop in the mornings, and on the other hand you said it is hard for you to get up in the morning if you haven't been taking your medications regularly."

"It may be that the freedom to do _____ is so important to you right now that you are willing to deal with the consequences, no matter how severe." (Clinician's tone is validating patient's right to choose.)

"As I listen to you reflect on what challenges you will face if you make changes in _____, I am curious what strength you believe you showed the last time you faced sudden, unexpected changes."

3) **ROLL WITH RESISTANCE:** The resistance or disconnect a person offers can be turned or reframed slightly to create a new momentum toward change. The object that is in motion here, expressed as resistance, is not a person but a perception. So, roll, flow with it; no need to oppose.

- Avoid arguing for change (unnecessary stress for you and stress for the patient).
- It is a signal to RESPOND DIFFERENTLY, slow down...listen...breathe.
- New perspectives are offered—with patient permission—but not imposed.
- Remember and rest in the fact that the patient is the PRIMARY RESOURCE in finding answers and solutions. Validate and express empathy. "It is hard to imagine how I could possibly understand."

"It sounds like you have tried before and it hasn't worked for you."

"On the one hand, it seems you recognize there are some real problems here I'm trying to help with, and on the other hand, what I am suggesting is just not acceptable for you right now."

4) **SUPPORT SELF-EFFICACY:** It refers to a person's belief in his or her ability to carry out a task and succeed. It is a key element for change and can be a good predictor of treatment outcome. It is the hope that the patient holds that there is a possibility for change.

- A person's belief in the possibility of change or even a willingness to contemplate a different vision for themselves is a powerful motivator.
- It is the person, not the care manager, that will choose which change to make and will carry it out. Each person is an expert in his or her own life. The care manager offers a possibility which may or may not fit where the person needs or desires to be.
- The care manager's BELIEF in the person's ability to change, move, consider new possibilities is a powerful resource for the patient to choose to utilize and becomes a self-fulfilling prophecy.
- Confidence is a predictor of change.

"What is it about you that can help move you towards taking the next step in making this change?"

"May we take things one step at a time? If so, what do you think is the first step?"

"May I share with you what others have taught me? There is a variety of possibilities that people have used successfully to deal with what you are facing. (Share the information after permission is granted). Which of these do you prefer or speaks to you? Which do you think may work best for you?"

Four Processes and Practical-Stage Based Techniques

MI Processes

1. Engaging – empathetic listening
2. Focusing – targeting change
3. Evoking – client's ideas
4. Planning – getting to change

Change is a process, not an event. There are different stages along the change continuum. Where a patient is on the continuum determines what process and what interventions make the most sense. Often times the processes overlap, so use what works with a given patient at a given time.

Engaging

Relational foundation – establishing a helpful connection and working relationship

Goals

- Establish rapport and build trust
- Assess readiness
- Focus more on process vs. outcome
    - Key: health care provider empathy is a predictor of consumer success
    - May be too early to focus on desired health change; invite interim goals
- Orient provider to patient's concerns and patient to provider's role and function
- Promote patient's buy in and agreement to process, structure, and limits

Techniques

1. Rapport building
2. OARS

Rapport Building (First Contact)

- Welcome and "settle" in the patient
- Ask about the patient's concerns and priorities/understand their perspective
- Fit the assessment into the interview – conversational vs. question/answer
- Be honest regarding any limitations; clarify role as care manager
- Review plan for next session

"As we have about 15 minutes together, I'd like to be sure to understand what brings you here and what you would like to be sure we accomplish today."

Rapport Building (Follow-up Contact)

- Start with casual conversation
- Let patient know your goals for the visit; ask what they want to cover
- Follow up from last visit
- Review plan for next time

"Last time we talked about your concerns about how smoking might be affecting your child's health. What would you like to focus on today?"

OARS		

	Open-ended questions	• Evocative and inviting
		• Can't be answered with "yes" and "no"
		• Probing (rely on your curiosity)
		  o "Explain..."
		  o "Tell me about..."
		  o "Say more about..."
		  o "Clarify"
		  o Use "how" & "what" vs. "are," "do," "did," and "could"

	Affirmations	• Recognizes and reinforces success o Key: needs to be expressed with genuineness • Offers perspective in face of difficulties • Expresses optimism • Sees any progress as progress • "It takes a lot of strength to go through all you have been through."
	Reflective Listening (see example reflection stems on next page)	• Mirrors what patient is saying • States what the patient means • Shows collaboration and equity • Should be done frequently o Try to offer two reflections for every question you ask
	Summaries	• Lets patient know that you are listening and understanding • Pulls together and links relevant information • Allows patients to hear their own motivations and ambivalence • Helps to clarify any disordered thinking or communication • Helps to bridge and transition between topics • Focuses on priority content and feelings

MI Reflection Stems

- Sounds like...
- You're saying that...
- You're feeling like...
- This has been totally _____ for you
- Almost as if...
- Like a...
- For you, it's a matter of...
- From your point of view...
- You...
- You are...
- Must be...
- You really...
- Through your eyes...
- You believe...
- Your concern is that...
- Your fear is that...
- It seems that...
- You're not terribly excited about...
- You're not much concerned about...
- This really...
- It is so...
- You feel so...
- It's really important to you that...
- You're not really...
- You feel as though...
- What I heard you say was...

Empathy is saying more than the client said but not more than the client meant

Focusing

Strategic focus – develop and maintain a specific direction in the conversation about change

Goals

- Clarify patients' priorities and readiness
- Use more a following and guiding vs. directive approach
- Collaborate on the conversation
- Avoid 'premature focus' in areas of patient ambivalence

Techniques

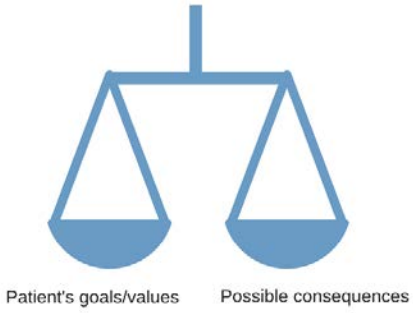
1. Identifying patient goals/priorities
2. Agenda mapping
3. Brief action plan
4. Giving information in MI/using an elicit model

Establishing the 'Patient Dilemma'

- Ask about your patient's goals or priorities
    - "If you could change something, what do you hope could be different with your health?"
- Focus on specific positive impact, consequence or physical symptom you patient has identified as being undesirable
    - "You mention not liking the feeling of being out of breath. What if we talk about that?"

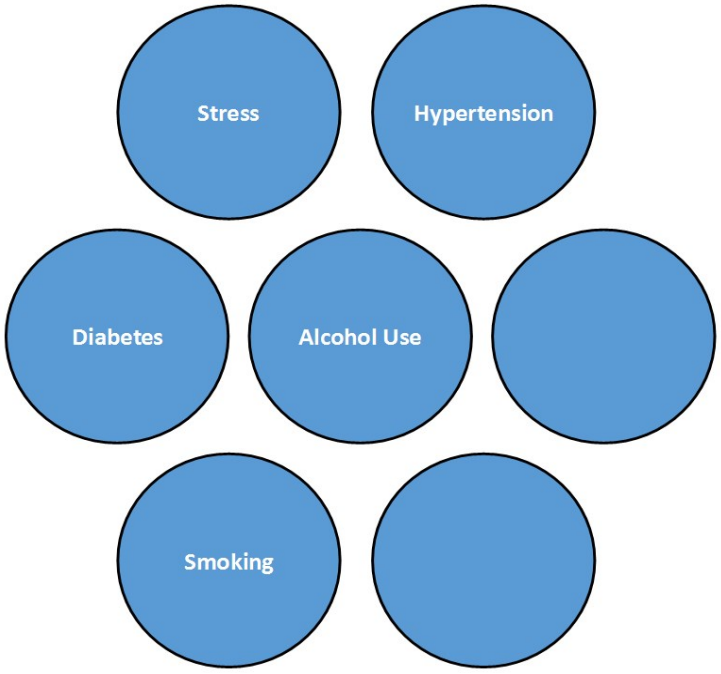
- Strategically use open-ended questions to focus on good things about changing and/or the consequences of not changing
- Use reflective listening skills carefully to highlight benefits of changing and/or the consequences of making no change
- Give permission to consider incremental goals
    - "One option is to consider a small step..."

Patient's dilemma



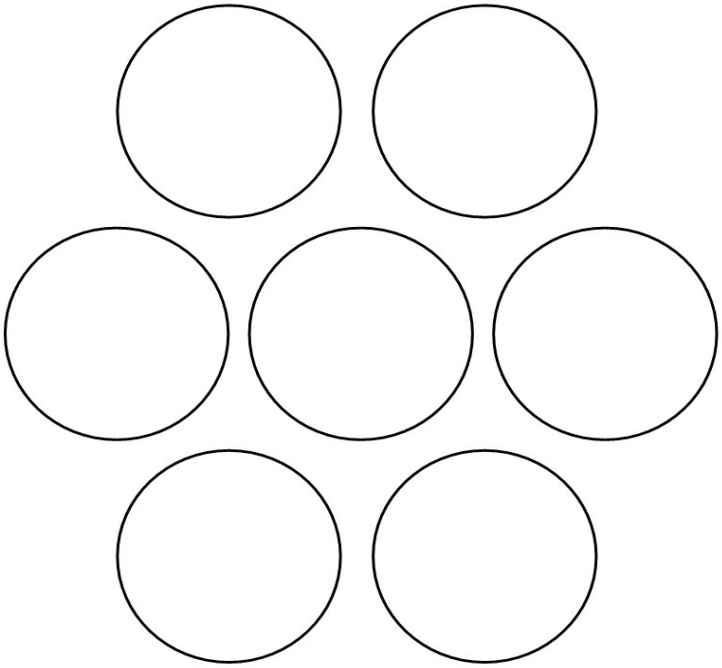
Agenda Mapping

Sample agenda map



Template agenda map

- Fill in the circles with possible patient goals, leaving two or three blank

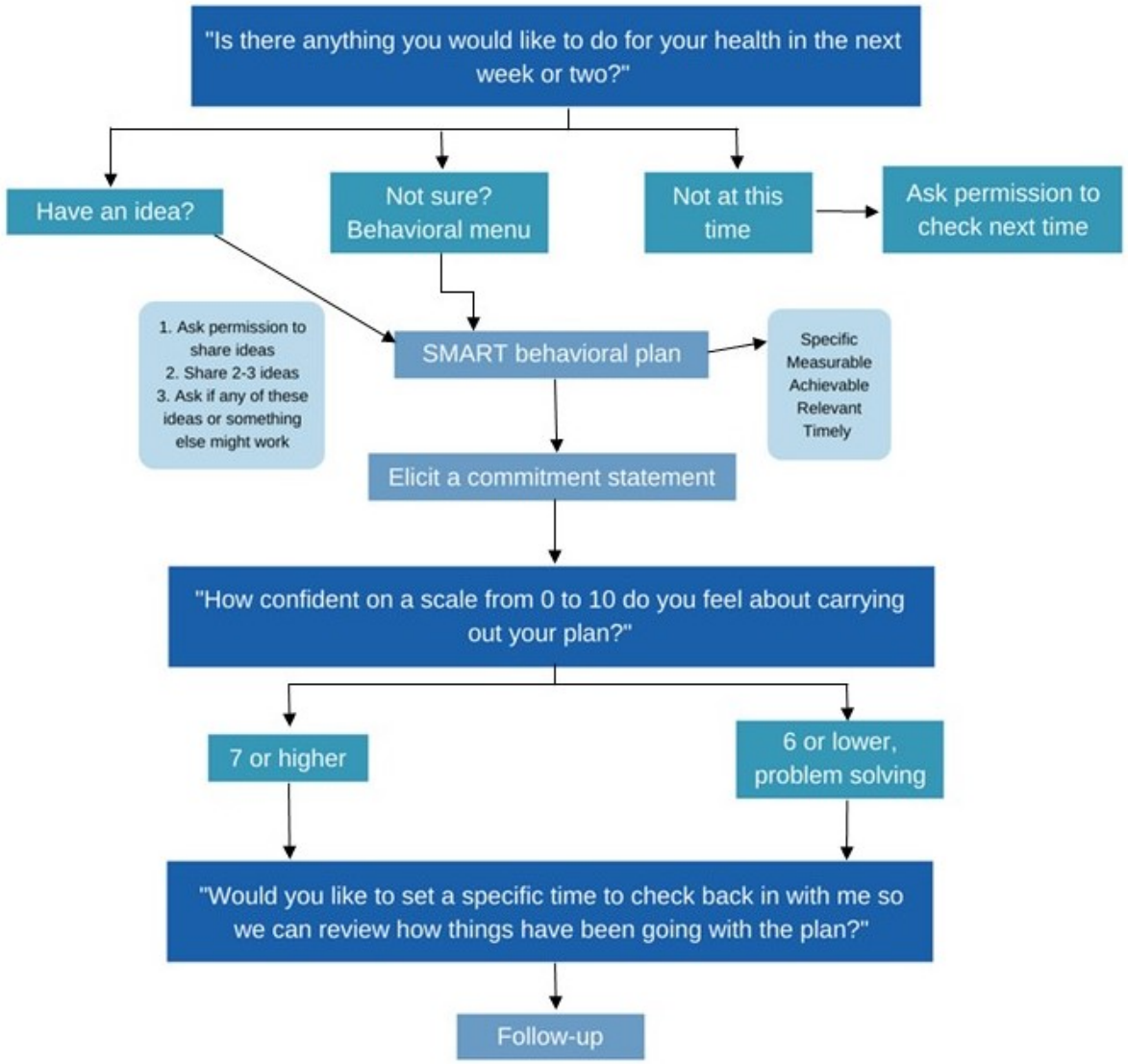


Brief Action Plan

The eight clinical competencies of BAP: Three questions and five skills

BAP is organized around three core questions and five skills delivered with the Spirit of MI. The flow chart displayed in Figure 1 presents an overview of the key elements. The three questions are highlighted in blue and the five skills are shown in yellow and green. The three questions and the yellow skills are applied during every BAP interaction, while green skills are used when clinically indicated.

Evidence has informed each question and skill in BAP. The explanations in this paper provide a brief overview of the rationale for each step and examples of commonly occurring clinical scenarios. Cited references provide interested readers with links to the evidence base for each competency.



Giving Information in MI**

- Ask for permission
    - "Can I share some information that might explain the difficulty you're having sleeping?"
- Tie information or advice to patient's concerns
    - "You talked about concerns about your breathing, would it be okay if..."
- Ask most helpful way to show and interpret data
    - E.g. numbers, pictures and metaphors
- Offer menu of options
- Check for patient understanding and reaction

**Giving information in MI can be very effective but should be done with caution. Remember that the patient is the expert on themselves. The model above incorporates an elicit/provide/elicit (or ask/tell/ask) model. This is a very effective way to give information that is consistent with the MI spirit.

Evoking

Eliciting and exploring the patient's motivation for change
Change talk – any client speech that favors change

Goals

- Use OARS skills to patient's motivation, goals, and ideas about their own reasons to change
- Identify and resolve barriers to change
- Focus on past successes
- Understand impact of significant others

Techniques

1. Questions to evoke/hypotheticals
2. Responding to change talk
3. Readiness rulers

Evoking Technique: Inviting Change Talk

Advantages of changing behavior	Consequences of not changing behavior
• "What are some reasons to cut back?" • "What good things about change can you name?" • "What benefits of making a change can you see now?" • "How has your primary care provider said your health would be better?"	• "What concerns you about not cutting back?" • "What symptoms would you not like to continue/get worse?" • "In what ways does this cause difficulty in your relationships with other people?" • "What has your primary care provider talked about that concerns you?"
Intention to act	**Optimism about the future**
• "What would a small step look like?" • "When do you think you could start?" • "What would the next step be for you?" • "Who could help you with your goal? How can I help you with your goal?"	• "How would your future be better if you cut back?" • "How could making a change improve your life? Your relationships?" • "What benefits in the next part of your life can you see?"

Responding to Change Talk

When you hear *change talk*, you should be all EARS:

- Explore
  - "What other benefits can you think of?"
  - "What else could you do if you felt better?"
- Affirm
  - "It's great that you are talking about making that step."
  - "You've done hard things before; it seems you can accomplish things once you decide."
- Reflect
  - "So making this change could really affect your goal of your child's asthma being better controlled."
- Summarize
  - "You've listed a lot of reasons to change. I heard..."

Open-Ended Questions Evoke Change Talk

- Desire
  - "What do you want to happen?"
  - "Tell me about what your wish would be?"
- Ability
  - "How capable to take steps do you feel right now?"
  - "What would make you feel more able to ___?"

- Reasons
  - "What are reasons to ___?"
  - "What would be better if you ___?"
- Need
  - "Do you feel that it is necessary to change?"
  - "Why could now be the right time?"
- Commitment
  - "How ready to start taking steps do you feel?"
  - "When do you plan to start?"
  - "What specific steps can you imagine taking?"
- Taking steps
  - "Tell me about the 'homework' you've done already."
  - "What have you already done?"

Using Readiness Rulers

Importance: How *important* is the behavior change to me?
Confidence: How *confident* am I that I can make the change?

0	1	2	3	4	5	6	7	8	9	10
Not at all			Somewhat				Very			Extremely

- Ask, "On a scale from zero to ten, how important is it to you to [target change]; where zero is not at all important, and ten is extremely important?"
  - Follow up: "Why are you at ___ and not [one number lower]?"
  - Follow up: "What might happen that could move you from ___ to [one number higher]?"
- Ask, "On a scale from zero to ten, how confident you are that you could ___; where zero is not at all confident and ten is extremely confident?"
  - Follow up: "Why are you at ___ and not [one number lower]?"
  - Follow up: "What might happen that could move you from ___ to [one number higher]?"
- Ask, "How could I be helpful to increase your confidence?"

<u>Intervention approaches to building readiness</u>

- Enhancing importance
  - Assess knowledge/understanding
  - Information/education
  - Point to consequences (linked to patient's priorities)
- Building confidence
  - Find previous successes
  - Establish small goals
  - Use affirmations
  - Identify barriers/problem-solve
  - Find social support

Planning

Bridge to change – developing commitment to change and formulation a concrete plan of action

Goals

- Clarify when someone is willing, able, and ready. Look for:
  - Increase in amount/strength of change talk
  - Diminished sustain talk
  - Taking steps
  - Questions about change
- Focus less on whether/why and more on about how
- Collaborate on incremental goals
- Develop a plan that includes adequate structure, accountability, benchmarks, and rewards

Techniques

1. Setting goals and planning smart
2. Change plan worksheet

Setting Goals: Plan Smart

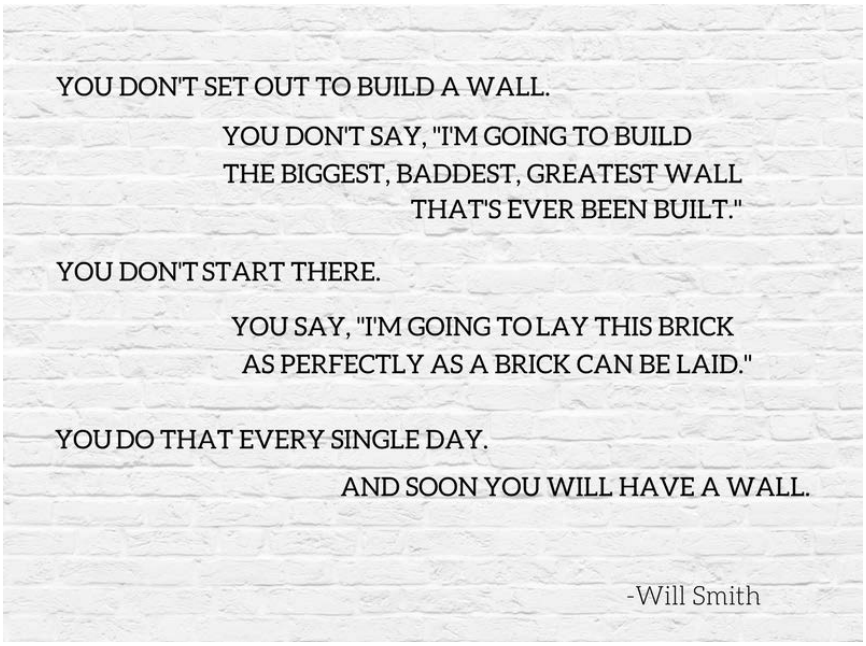
S – Specific

M – Measureable

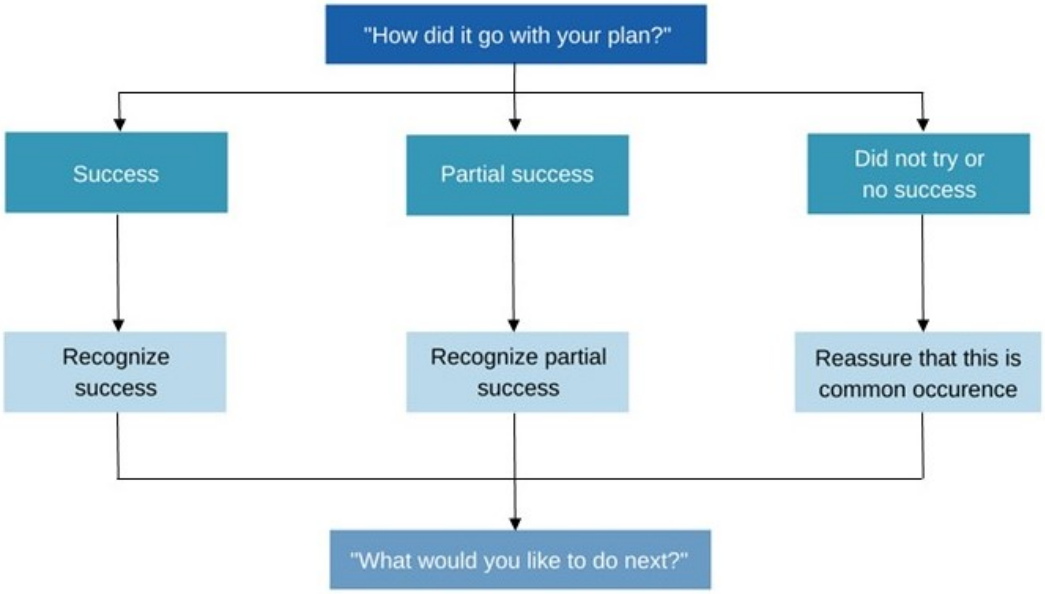
A – Attainable

R – Realistic

T – Timely



BAP follow-up



Change Plan Worksheet

Describe the change you want to consider:

Describe your main goals in making this change:

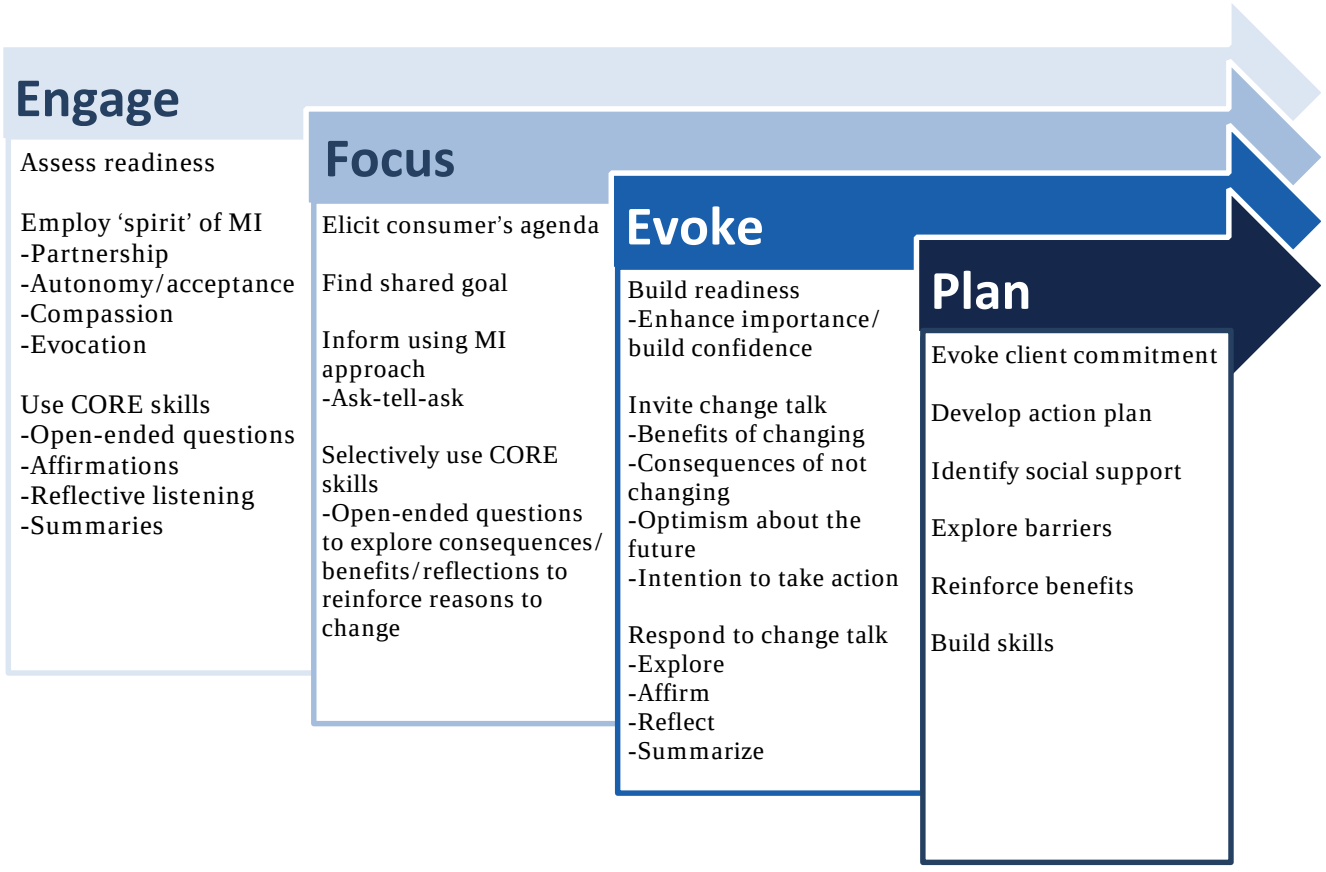
Identify possible obstacles to change and how to handle them:
Possible obstacles *How to respond*

Write down the names of people that could help you change and the ways in which they can:
Person *Possible ways to help*

Make a timeline for the things you plan to do to accomplish your goals:
Specific action *When?*

Identify the specific results that will let you know that your plan is working:

MI Processes and Intervention Approaches



Engage

Assess Readiness

- "What did you hear from your doctor that concerns you?"
- "What do you think about the situation?"
- "What problems do you face that you and I could work on?"

Employ 'Spirit' of MI

- "How can I help you with ___ identified problem?"
- "What things can I do that would help you/your family?"
- "You are the parent here, so I want to follow your lead."
- "You know more about your health than I do. What do you see as challenges for you?"
- "It's not easy to do the things we are 'supposed' to do."
- "Life can be pretty complicated – and the barriers we face make it tough for anyone."
- "If you were to think about something you want more/less of in your life, what would that be?"
- "If you had a 'magic wand' how would your life look?"
- "What would a successful case management experience look like for you?"

Core Skills

- Open-ended questions
  - "What would you call your main concern?"
  - "What was it like to hear the nutritionist's feedback?"
  - "Who can support you in this? How could they help?"
  - "What makes it difficult to think about ___ [making change]?"
- Affirmations
  - "It's great that you got here for your appointment today; that says something about your desire to get healthier."
  - "You've done a really good job at managing your child's ___ [condition]."
  - "You seem to have made some really important changes – these steps are excellent."
- Reflections
  - "Seems you are concerned about ___ [possible consequence]."
  - "You'd like to have more ___ [anticipated benefit]; is that right?"
  - "On the one hand you feel fine, but on the other hand hearing ___ [health risk] makes you concerned."
  - "Some part of you wants to ___ [change], but another part of you feels it would be hard without your wife's support."
- Summaries
  - "Seems you don't like what the doctor said and feel like you would like to do something about this."
  - "Sounds like you can't do it 'perfectly', but maybe you can think about cutting back on ___ [identified goal]."
  - "You want to keep thinking about the goal for yourself and you are willing to let me check back in a few weeks; is that right?"

Focus

Elicit Consumer Agenda

- "What do you want to get out of today's visit?"
- "What would you say is the most important issue for your nurse to understand?"
- "How could I be most helpful in the time we have today?

Selective Use of CORE Skills

- "Can you tell me what consequences the doctor talked about that concern you?"
- "What would you say are the 'good things' about making a change?"
- "If you were to make any initial step, what would the first step look like?"
- "I agree, you'd feel ___ [feeling reflection] if you could cut back."
- "Some part of you thinks about ___ [consequence] and thinks you might need to consider a change."

Evoke

Build Readiness Skills

- Enhance importance
    - Offer information
    - Reinforce consequences
    - Interpret results
    - Consider ask-tell-ask approach
    - Build confidence
    - Discuss small steps (incremental change)
    - Discuss problem-solve barriers
    - Reinforce previous successes
    - Allow interim goals
    - Use affirmations

Invite Change Talk

- "What are the 'good things' about changing?"
- "What would you say the benefits of changing are?"
- "Have you heard about any consequences that would concern you?"
- "What would your life look like if you don't change right now?"
- "What would your life be like if you didn't have to worry about ___ [consequence]?"
- "How might your life look easier if you were able to do ___ [health change]?"
- "What does the next step look like?"
- "Should you and I talk about a plan?"
- "What small steps seem possible right now?"

Respond to Change Talk

- "Tell more about..."
- "What else might be good about..."
- "You're right, you probably would feel better if ___ [name change goal]."
- "Sounds like there would be many benefits."
- "Feels like you'd be relieved to not have to worry about ___ [stated consequence]."

Plan

Evoke Commitment

- "Shall we talk about a goal?"
- "What would you say your goal in this is?"

Develop Action Plan

- "What will you do?"
- "When can you start?"
- "What is the specific action that feels possible?"

Enlist Social Support

- "Who can help with ___ [goal]?"
- "How can they support you?"
- "What can I do that would feel helpful?"

Explore Barriers/Reinforce Benefit

- "What will make reaching your goal tough for you?"
- "What can you do about ___ [barrier]?"
- "You can definitely find a reason to change if you can stick with your goal."
- "Some other people have found ___ [additional benefit] when they have cut back."

Build Skills

- "Would it help for you and I to practice?"
- "What have you done in the past?"
- "Some people have tried ___ [specific tools] to achieve a similar goal."
- "What else have you heard people do to reach ___ [identified goal]?"

Resources

Dancing, Not Wrestling

CCMC

IssueBrief

VOLUME 3, ISSUE 2

Dancing, not wrestling:

Motivational interviewing helps case managers cultivate relationships and elicit change

You cannot "fix" a client.

Of course, every professional case manager knows people cannot be "fixed." Sometimes, we think we can. But we can't.

No matter how skilled, passionate and talented board-certified case managers are, they cannot solve all their clients' problems; patients need to be part of the process. And case managers possess the expertise to guide clients toward finding their own solutions, to give them the tools to self-manage and to make transformative changes.

This truth lies at the heart of motivational interviewing (MI)—collaborative, client-centered conversation that strengthens the client's own motivation to change. Ultimately, it's about effective, two-way communication. Communication includes talking *and* listening.

"Communication is an essential skill for all health care professionals involved in the provision of case management services...and it's at

"Communication is an essential skill for all health care professionals involved in the provision of case management services...and it's at the heart of this relationship-based model of care."

—CATHERINE M. MULLAHY, RN, BS, CRRN, CCM, PRESIDENT OF MULLAHY & ASSOCIATES, LLC.

Why it matters

Communication is essential to effective case management, Mullahy explained. As defined by the Commission for Case Manager Certification, case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services required to meet the client's health and human service needs. (See figure on page 7.) It is characterized by advocacy, communication and resource management, and promotes quality and cost-effective interventions and outcomes.

Communication is necessary to assess needs; establish goals; create an effective care plan; collaborate with clients and their families, providers and payers and others involved in the care; and to optimize potential for improved outcomes and enhanced client satisfaction, Mullahy said.

Poor communication, however, impairs outcomes and increases costs. It creates a stressful environment for clients and their families; it leads to confusion, anger and frustration, and to fragmented care—including unsafe discharges and transition-of-care failures. Poor communication increases errors and complications; it results in less-than-desirable or unanticipated outcomes, all of which result in increased costs due to hospital readmissions, ER visits and other negative outcomes.

the heart of this relationship-based model of care," explained Catherine M. Mullahy, RN, BS, CRRN, CCM, president of Mullahy & Associates, LLC. It comes down to engaging clients one individual at a time, Mullahy said. But that doesn't happen naturally; case managers need to master effective communication techniques and one of the most important, she says, is motivational interviewing.

Motivational interviewing is a clinical method, a guiding process that seeks to bring forth and strengthen a person's *own* motivation for change, explained Michael G. Goldstein, MD, associate chief consultant for preventive medicine, Veteran's Health Administration (VHA), National Center for Health Promotion and Disease Prevention.

MI is client-centered, collaborative and fully respectful of the client's autonomy and preferences, he said. It helps clients sort through their thoughts, ideas and often-ambivalent feelings about their current situation and possibilities for change.

The technique has gained acceptance across various fields, including public health, health promotion and case management. It is not an intervention itself, but an amalgam of principles and techniques drawn from existing models of psychotherapy and behavior-change theory.[1]

MI was first developed to work with substance abuse, Goldstein said. Eventually, it became clear that the set of skills used in the technique was associated with better outcomes, regardless of interventions. A 2005 literature review found significant support for MI's efficacy.[2]

> ***MI is client-centered, collaborative and fully respectful of the client's autonomy and preferences. It helps clients sort through their thoughts, ideas and often ambivalent feelings about their current situation and possibilities for change.***

That study found the greatest impact came when MI was brought to bear immediately following treatment; the effect was less obvious—but still significant—when used during follow-ups after about a year. Of particular significance, outcomes were better when no manual was used. "The checklist method doesn't work as

[1]Resnicow, et. al. Motivational Interviewing in Health Promotion: It Sounds Like Something Is Changing Health Psychology 2002, Vol. 21, No. 5, 444–451

[2]Hettema, J., et al., Annu Rev Clin Psychol, 1, 91-111, 2005

well," Goldstein explained. MI must be tailored to the needs of a particular client. And that, he said, gets to its spirit.

The spirit and principles of MI

To practice MI, one must understand its spirit; Goldstein identified three core elements of that spirit:

Collaboration: Collaboration is key to both communication and client-centered care. The conversation is non-authoritarian and nonjudgmental. "We want to support them even when they are not following through the way we would like them to."

Evocation: The client is the expert, and the case manager must explore what is important to that client. When clients express their reasons for change, they are more likely to take action. One test of how well you are doing this, said Goldstein, is to ask, "Who is doing most of the talking?" If it is not the client, you may not be doing MI, he cautioned. The client's own experience may be the answer to helping enhance motivation. "After all, it is their health."

Autonomy: It is the client who is in charge. The encounter doesn't involve coercion or argument. Clinicians remain nonjudgmental about whether their clients choose to change, and the case manager seeks client permission before moving forward. Any decision is entirely up to the client. This approach acknowledges a basic truth, Goldstein said: "Clients will end up doing what they want to do."

This spirit informs the principles and practice of MI, from listening and understanding to planning and "change talk." (For more on change talk, see sidebar **Listen to the "change talk."**)

The basic principles of MI reflect its spirit; they are summarized with the acronym RULE:

- **Resist the "righting reflex."** It is easy to assume the role of the expert in exchanges with clients. "We sometimes fall into the trap of trying to fix them rather than help them understand themselves," Goldstein said. But even though you may indeed be the expert and have the client's best interest at heart, "people just do not like to be told what to do," he warned. "If we are to help guide the client to make their own decisions in their best self-interest, we have to avoid correcting the client's behavior." Instead, seek to …
- **Understand your client's motivations.** Work from where

> ***"If we are to help guide the client to make their own decisions in their best self-interest, we have to avoid correcting the client's behavior."***
>
> —MICHAEL G. GOLDSTEIN, MD, ASSOCIATE CHIEF CONSULTANT FOR PREVENTIVE MEDICINE, VHA, NATIONAL CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

Learning Motivational Interviewing

COURTESY OF: Michael G. Goldstein, MD, associate chief consultant for preventive medicine, Veteran's Health Administration, National Center for Health Promotion and Disease Prevention.

the client is now, not where you want the client to be. Understand what the client thinks and feels about the issue at hand. What is important to them? What are their feelings and concerns? Ask, Goldstein said. Don't tell...

- **Listen to your client.** Specifically, engage in *reflective* listening: Listen, then reflect back what you think the client said or meant. This is how you find out why the client might—or might not—want to change a particular behavior. This can help you...
- **Empower your client.** Build confidence. Support the client's ability to change or improve health behavior. Make it clear you have every confidence in their ability to change, and review and emphasize past successes. This must be genuine and sincere, not patronizing.

> ***"One of the hardest things for us is recognizing that change doesn't occur overnight."***
>
> —MICHAEL G. GOLDSTEIN, MD, ASSOCIATE CHIEF CONSULTANT FOR PREVENTIVE MEDICINE, VHA, NATIONAL CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

The motivational interview process

Goldstein warned there's no shortcut to the MI process. He acknowledged that case managers often have limited time with a client, but emphasized that the MI process cannot be rushed. "I wish we could make the change happen faster. One of the hardest things for us is recognizing that change doesn't occur overnight."

Rushing the process can backfire. "If we try to push too hard when the (client) is not ready, we end up going backward," he said. One strategy to try to move the process forward is to ask the client about prior successes, and tap into that response for ideas to engage and motivate. But change happens in its own time, he said. "I wish I could say there is a fast way. It really requires a period of knowing one another and building relationships."

The process has four stages:

1. **Engaging. To get the client engaged** is essential, and a prerequisite to everything else.
2. **Focusing in on something the client is willing to work on.** This process includes collaborating on an agenda, finding a strategic focus, addressing ambivalence and then sharing information and advice.
3. **Evoking the client's motivation.** This is where the desire for action begins to be expressed.

Listen to the "change talk"

"Change talk" is an important element of MI and, when expressed by the client, a strong predictor of subsequent change, Goldstein said. He identified five elements of change talk; the acronym for these elements is DARN-C:

- **Desire—the client's expression of wanting to change.**
  For example: "I *want* to stop coming to the hospital over and over."
- **Ability—the confidence for change.**
  "I *can* take better care of my diabetes. I have done it before."
- **Reasons—why the client wants to change.**
  "Drinking gets me in trouble, makes my blood pressure higher and makes my family not want to be with me."
- **Need—taking the desire and reasons to the level of high priority.**
  "I *need* to take my meds so I can stay healthy and be there for my family."
  "We really like hearing statements that reflect need," Goldstein said.
- **Commitment—verbs associated with action.**
  "I will plan the meals I eat." "I will quit smoking on a certain date."
  This is the highest level of change talk and most likely to be associated with change, he said.

This involves listening, selective responding and selective summaries.

4. **Planning.** The last phase. It involves moving to an action plan that addresses barriers. It also involves obtaining commitment.

Although each phase is important to the process, the first is both fundamental and essential: Nothing happens without engagement.

Engagement: building a relationship

The goal of engagement is to build a therapeutic relationship and understand the client's reality—feelings, beliefs, values, concerns about change. Engagement provides the opportunity to identify what's important to the client and his or her level of confidence about taking action, Goldstein said. Recognize and affirm strengths and motivation, and accept *without judgment* what you have learned.

"Distill the motivation that is there, accept ambivalence when it's there," he counseled. "Roll with resistance."

He shared four strategies that are central to engagement—and that are core skills of MI. The acronym for these four strategies is OARS:

- **Open-ended questions.** This is key to understanding the client's perspective and motivation—and eliciting "change talk."
  - —*"What are you currently doing that helps you to manage your diabetes?"*
  - —*"Tell me more about your interest in staying healthy."*
  - —*"What worries you the most about your heart condition?"*

  The questions go to motivation and current activity—as well as to what worries them. Such questions identify opportunities for and barriers to change.
- **Affirmation** involves recognizing and reinforcing the client's efforts and strengths by making statements that support her ability to follow through with what she wants, or recognize her strengths, past and present. But the affirmation must be genuine and real–not patronizing. He offered some examples:
  - —"I am pleased that you were willing to come in today to check on your blood pressure, despite all that is going on."
  - —"I appreciate your honesty about not taking the medication. I would like to hear more about your concerns or what got in the way."
- **Reflection**—or **reflective listening**—is the intentional use of listening to seek, clarify and deepen understanding. It allows for hypothesis testing and creates awareness of gaps in understanding for both the client and the case manager. MI is built on this skill, he said. However, "it is one of the harder things to learn. Reflective listening requires not only attention and active listening, but also reflecting back what we hear in an effort to confirm, clarify and deepen our understanding of the meaning of what the person is saying."

How will you know you're doing MI right?

- ✓ Client is doing most of the talking
- ✓ Clients are making a lot of "change talk" statements
- ✓ Resistance is minimized
- ✓ Clients are doing most of the work toward change

"If we try to push too hard when the [client] is not ready, we end up going backward."

—MICHAEL G. GOLDSTEIN, MD, ASSOCIATE CHIEF CONSULTANT FOR PREVENTIVE MEDICINE, VHA, NATIONAL CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

After making a reflection, it is important for the listener to wait for the speaker to respond. This allows the speaker to verify, correct and elaborate as needed. Note the difference: "So, you are trying to please your spouse?" vs. "So, you are trying to please your spouse." The latter is a reflective statement of understanding. It's a *statement*, and the voice goes *down*.

There are various levels of reflection, he explained:

- — Simple: repeating the words back to the client.
- — Complex: reflecting feelings, concerns, values and deeper meaning (e.g., "It's really important for you to make sure you are there for your wife and kids.").
- — Summaries: reflections that contain a summary of the speaker's statements.

- **Summary**, a form of reflective listening, entails understanding, eliciting more and reinforcing "change talk." It is a way to begin to move the interaction—increasing focus and/or planning (e.g., "So, where would you like to go from here?"). It also gives the case manager a chance to collect herself and check her assumptions.

  Goldstein likens summaries to a bouquet. The case manager gathers flowers—each of which represents a piece of "change talk"—then puts them in a bouquet. He offered the following example:

  "So, you mentioned several reasons for working on healthy eating and meal planning, including being able to reduce the number of meds you are taking for your diabetes. You also want to gain better control over your diabetes and want to avoid the complications your mother had. You are frustrated by previous attempts to work on your weight, but you have had some success in the past. I would like to help you develop a plan that will work for you."

Moving beyond frustration

Sometimes, case managers need to deal with their own attitudes that may create barriers to engagement, Goldstein said. "When we become frustrated or judgmental, we become less effective." Remember that change is challenging.

He offered these strategies for moving beyond frustration:

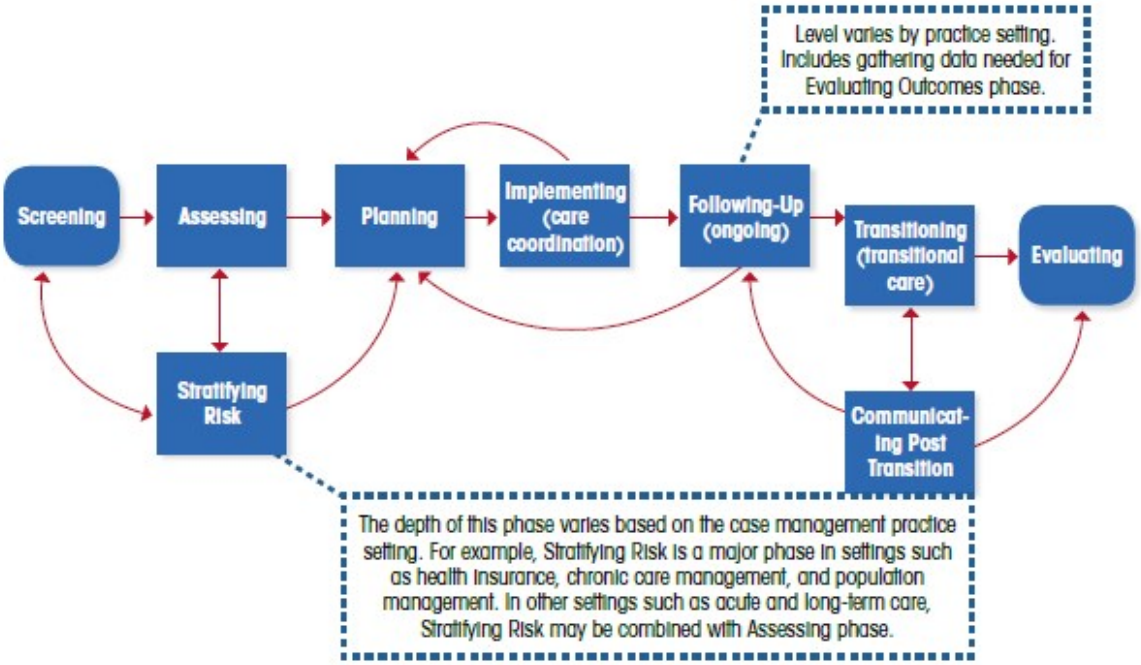
- Ask the client what it would take to be more actively involved. Ask about what is going on that makes it difficult to change.
- Seek to understand rather than assume.
- Recognize that clients are often doing the best they can.
- Give up the need to fix everybody. "We can't fix everybody," he said. But by using strategies that draw out the client's own motivation, the case manager can keep the focus on the client.

An example of a summary "bouquet"

"So, you mentioned several reasons for working on healthy eating and meal planning, including being able to reduce the number of meds you are taking for your diabetes. You also want to gain better control over your diabetes and want to avoid the complications that your mother had. You are frustrated by previous attempts to work on your weight, but you have had some success in the past. I would like to help you develop a plan that will work for you."

COURTESY OF: Michael G. Goldstein, MD, associate chief consultant for preventive medicine, VHA, National Center for Health Promotion and Disease Prevention.

Case Management Process (High Level)



Dancing, not wrestling

"MI is conducted by working *with*, rather than *at*, the client." The interaction represents a collaborative effort in the interest of the client, and can be viewed as a partnership—it is, Goldstein explained, like dancing, not wrestling.

"We are in sync, linked, connected, moving together. We take one step forward, hoping the client comes with us." And sometimes, he added, being in a dance means following the client's lead for a while. "It becomes a collaborative, even artistic, way of working together."

As with dance, achieving this level of coordination and partnership takes time and practice. Done well, you will have a client who is engaged, activated, motivated, empowered and confident, he said. "If we dance with the patient by working with him or her rather than directing—guiding rather than wrestling—we are much more likely to promote meaningful change and be satisfied with the result." ■

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About the Experts

Catherine M. Mullahy, RN, BS, CRRN, CCM, president, Mullahy & Associates, LLC

With more than four decades of experience managing health care, Catherine M. Mullahy, RN, BS, CRRN, CCM is a consultant to case management firms, managed care organizations, hospitals, health care providers, government agencies including Veteran's Health Administration and Indian Health Services.

Mullahy's direct case management experience spans home, hospital, hospice and critical care settings. Her firm, Options Unlimited, provided utilization management, case management, disease management, employee risk review and other programs to corporations. The firm was acquired by Matria Healthcare, Inc. in 2003 and began serving as its Case Management Division.

She is a past chair of the Commission and served as its representative to the Foundation for Rehabilitation Education and Research and on ongoing expert panels in connection with the development of the CCM® credential. She served on the Case Management Advisory Committee for URAC and was a board member of the Foundation for Rehabilitation Education and Research from 2001 to 2005.

Mullahy was named the Distinguished Case Manager of the Year by CMSA and received CMSA's Lifetime Achievement Award. She served as president of CMSA's board from 2001-2002. She is author of *The Case Manager's Handbook*, now in its fourth edition. Editor of *The Case Manager*, she serves as contributing editor for *Case Management Advisor* and other publications.

Michael G. Goldstein, MD, associate chief consultant for preventive medicine, Veteran's Health Administration (VHA), National Center for Health Promotion and Disease Prevention

Goldstein supports elements of a new VHA initiative to enhance the integration of preventive care within Patient Aligned Care Teams the VHA's version of a patient-centered medical home. He is also an adjunct professor of psychiatry and human behavior at Alpert Medical School, Brown University.

He is trained in both primary care internal medicine and psychiatry and also completed a fellowship in medicine and psychiatry, all at the University of Rochester. Throughout his career, he has worked at the interface between medicine and psychiatry, serving as a consultation-liaison psychiatrist, a medical director of a behavioral medicine clinic, a teacher of patient-centered communication and counseling skills, and as a researcher in the areas of tobacco cessation, physical activity adoption, clinician-patient communication and delivery of preventive services.

He was a member of the Public Health Service's Tobacco Dependence Treatment Guideline Panel and the FDA's Risk Communication Advisory Committee. Goldstein is a past president of the Society of Behavioral Medicine and a fellow of the American Psychiatric Association, the Society of Behavioral Medicine and the American Academy on Communication in Healthcare.

Disclaimer: *Dr. Goldstein's comments and opinions are his own and do not represent the official views or positions of the Veterans Health Administration.*

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Brief Action Planning

This white paper is available for download at: www.centreCMI.ca

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Overview

This white paper defines Brief Action Planning (BAP), describes the eight clinical competencies to use it effectively, explains the rationale for its development, and discusses ways to use it in health care and medical education, health care systems, and Patient Centered Medical Homes. An appendix provides a demonstration clinical vignette.

What is BAP?

Brief Action Planning (BAP) is a highly structured, patient-centered, stepped-care, evidence-informed self-management support (SMS) tool based on the principles and practice of Motivational Interviewing (MI).

Health care professionals and peers can use BAP in diverse settings to encourage people to set their own goals to self-manage chronic conditions and adopt healthier behaviors. Throughout this paper we use clinician to refer to helpers using BAP and patient to refer to people being helped, recognizing that other terms may be more commonly used or preferred in different settings.

Using BAP Requires Engagement and the "Spirit of MI"

Effective use of BAP requires that clinicians first engage their patients by establishing rapport. Most healthcare professionals do this already, but some styles of engagement are more supportive of self-management and healthy behavior change. Engagement and rapport are not sufficient conditions for behavior change.

The overall approach to care that most effectively facilitates health behavior change is described as the Spirit of Motivational Interviewing (Stott et al, 1995). Four elements comprise Spirit: Compassion, Acceptance, Partnership, Evocation (sidebar). Using BAP effectively requires the establishment of basic rapport and maintenance of the Spirit of MI throughout the entire process.

The Eight Clinical Competencies of BAP: Three Questions and Five Skills

BAP is organized around three core questions and five skills delivered with the Spirit of MI. The flow chart displayed in Figure 1 presents an overview of the key elements.

The three questions are highlighted in blue and the five skills are shown in yellow and green. The three questions and the yellow skills are applied during every BAP interaction, while green skills are used when clinically indicated.

Evidence has informed each question and skill in BAP. The explanations in this paper provide a brief overview of the rationale for each step and examples of commonly occurring clinical scenarios. Cited references provide interested readers with links to the evidence base for each competency.

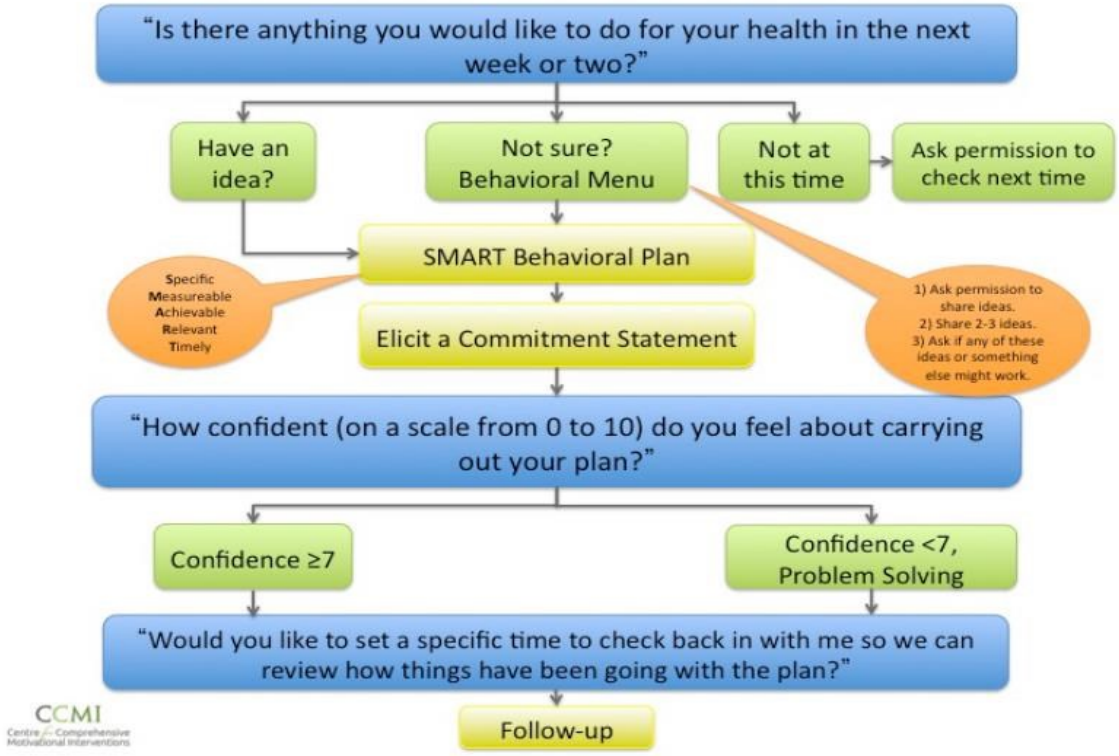

Figure 1. Brief Action Planning Flow Chart

Question 1: "Is there anything you would like to do for your health in the next week or two?"

This broad question elicits a patient's preferences and desires for behavior change and functions as a powerful motivator for change. The question encourages the patient's interest in personal health or wellness. In some settings a broader question such as "Is there anything you would like to do about your current situation in the next week or two?" may be a better fit, or a more specific question may naturally follow the prior conversation, such as "about your diabetes, asthma, etc." Responses to this question generally take three forms (Figure 1).

1. **Have an idea**. A group of patients immediately state something they are ready to do or consider doing. The content, domain, or depth of the plan itself is far less important than the critical step of initiating a plan for change and experiencing the success of carrying the plan to fruition. In order to nurture and maintain momentum for change, clinicians must acknowledge, respect, and affirm the patient's own ideas for change, even if they are small and may not be specific to current health issues. This may require a paradigm shift for both the patient and the clinician. For example, when asked to think of doing something for health, a patient with diabetes may think of cleaning up his basement. If a clinician seems disappointed in the plan or pushes for more, they have missed the point. Research suggests that once a person makes a statement that he or she is willing to do something, this initial statement of interest usually leads to a concrete action plan (Locke & Latham, 2002). Having a respectful conversation can help patients come up with a specific action plan. Patients who successfully complete one action plan are more likely to attempt another. For patients who respond with an idea, clinicians can proceed directly to skill #2, SMART Behavioral Planning.

2. **Not sure**. Another group of patients may want or need suggestions before committing to something specific they want to work on. For these patients, clinicians offer a Behavioral Menu (described below).

3. **Not at this time**. A third group of patients may decline interest in making a change at this time. This could be because they are healthy and don't need to make a plan, they have other priorities right now, or their situation is complex. The specifics of managing complex situations is beyond the scope of this paper and requires additional communication skills and motivational approaches.

<u>Skill 1: Offering a Behavioral Menu</u>

If the response to Question 1 is "I'm not sure," then offering a Behavioral Menu (Rollnick, Miller & Butler, 2008) may be helpful. A behavioral menu allows the clinician to offer some suggestions or ideas that will ideally trigger the patient to discover their own ideas. There are three distinct steps to presentation of a Behavioral Menu which reflect the Spirit of MI:

1. Ask permission to offer a behavioral menu
2. Offer several ideas or suggestions in differing domains.
3. Ask if any of your ideas appeal to the patient as something that might work for them, or if the patient has new ideas of their own

Asking permission respects the patient and avoids putting the clinician in the expert role, consistent with the Spirit of MI. BAP aims to

Three Steps of a Behavioral Menu
1. Ask permission to share ideas. *"Would it be ok with you if I shared some ideas that have worked for other patients I work with?*
2. Offer several brief suggestions or ideas. *"Some patients I work with have tried to modify their diet, some have included exercise into their daily routine, and another patient stopped taking the elevator.*
3. Ask if the patient has his or her own idea. *"Would you like to make a plan around any of these, or perhaps you have an idea of your own that would work for you?"*

elicit ideas from individuals themselves, but some people need or want other ideas to help jumpstart independent thinking.

An example of how a clinician might approach offering a behavioral menu is illustrated on the bottom of page 36.

Some clinicians have found it helpful to design behavioral menus with visual prompts (Rollnick, Miller & Butler, 2008). These ideas include those changes others have made as well as blank choices to elicit additional changes not listed. One example of a simple visual behavioral menu is shown in Figure 2.

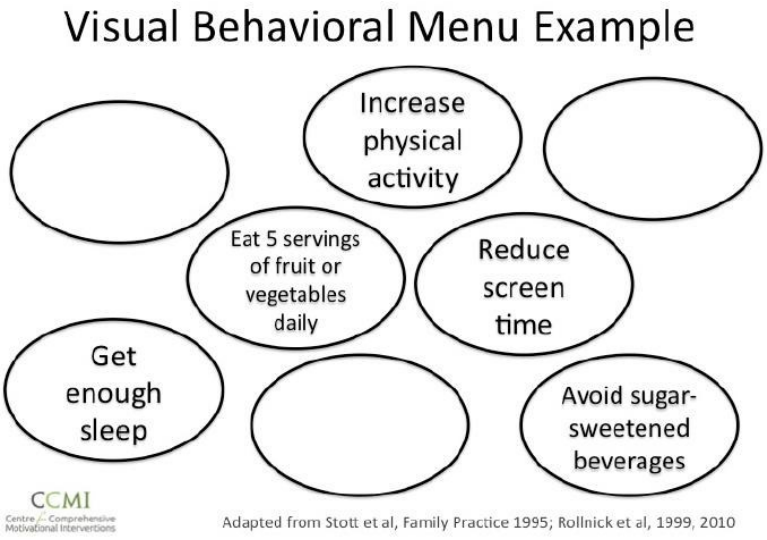

Figure 2. Example of a Healthy Weight Behavioral Menu

Skill 2: SMART Planning

BAP works over the long term by building a person's sense of self-efficacy or self-confidence through the successful completion of action plans. More specific plans are more likely to be followed (Bodenheimer & Handley, 2009). By being very specific, the patient understands what success looks like and thinks through the key components of what needs to happen for success. Patients often identify potential barriers as they work to specify what action they will take.

By ensuring that an action plan is SMART – specific, measurable, achievable, relevant, and timed – a clinician can increase the likelihood that patients will succeed in making the desired change. A common tactic to gain specificity is to encourage patients to answer these questions (Lorig et al, 2012):

_____ What?
_____ When?
_____ How much or how long?
_____ How often?
_____ Where?
_____ When will they start?

Guiding to SMART

Mrs. Jones has diabetes and is obese. She is worried about her weight and decides that being more active would help her lose weight. She states that her goal is "I want to walk more." The clinician guides her to a specific goal by asking questions about the plan and she ends with a plan, stating "I will walk for 20 minutes, in my neighborhood, starting Monday and then on every Monday, Wednesday and Friday before dinner." Mrs. Jones has a much clearer idea of what she is trying to do and will know that she has been successful each time she walks in her neighborhood as she intends.

Patients often benefit from guidance to be specific until they have some experience with goal setting. A brief example (sidebar) illustrates turning a vague plan into a SMART plan.

Skill 3: Elicit a Commitment Statement

Once the patient has developed a SMART plan, the clinician asks them to "tell back" the specifics of the plan. This process is called elicitation of the commitment statement. The clinician might say something like, "Just to make sure we understand each other, would you please tell me back what you've decided to do?"

A clear "commitment statement" is a predictor of subsequent behavior change. The strength of the commitment language is the strongest predictor of success of an action plan (Aharonovich et al, 2008; Armhein, 2002). For example saying "I will" is stronger than "I will try." An example is in the sidebar.

People are more likely to believe what they hear themselves say, and are more likely to resist what they hear others say (Miller & Rollnick, 2013). Saying the plan out loud may lead to an unconscious self-reflection about the feasibility of the plan, which sets the stage for Question #2 of BAP.

Eliciting the Commitment Statement

In the example of Mrs. Jones, she might have said "I **could** walk for 20 minutes, in my neighborhood, every Monday, Wednesday and Friday before dinner" which may indicate that she has doubts about being able to follow her plan. Instead, Mrs. Jones indicated a higher level of commitment with her statement "I **will** walk for 20 minutes, in my neighborhood, every Monday, Wednesday and Friday before dinner."

<u>Question 2: "On a scale of 0 to 10, where 0 means you are not at all confident, and 10 means you are very confident, how confident do you feel that you can carry out your plan?"</u>

After creating a SMART plan and eliciting the commitment statement, the next step is to assess how confident patients feel about plans they have made. This scaling question provides yet another opportunity for any uncertainty to surface. The scale of 0 – 10 allows individuals to quantify their confidence and higher confidence levels are associated with increased likelihood of success in carrying out the plan (Lorig et al, 2001; Miller & Rollnick, 2013). The word "sure" is often substituted for "confident."

<u>Skill 4: Problem Solving for Low Confidence</u>

Since BAP aims to build self-efficacy, clinicians use methods to maximize the chances of successful completion of every action plan (Lorig et al, 2012).

When a person's confidence level is low (<7), the next step in Brief Action Planning is to collaboratively problem solve to make modifications to the action plan to increase the chance of success. Figure 3 and the sidebar on the next page illustrate problem solving for low confidence.

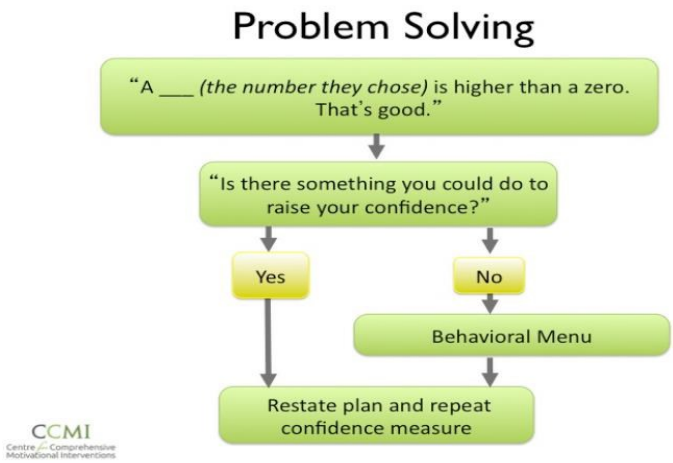

Figure 3. Steps to problem-solve low confidence

Patients may address barriers, modify their expectations, or decide that they want to focus on something else as a result of the problem-solving process.

Question 3: "Would you like to set a specific time to check back in with me to see how things are going with your plan?"

This question or its equivalent reinforces the idea that the clinician considers the plan to be important. It also incorporates patient accountability. People are more likely to do what they say they will do if they choose to report back on their progress (Strecher et al, 1986). This check-back maybe with the clinicians or a support person of the patient's choice. The patient may also plan to be accountable to themselves by using a smart phone, calendar or diary.

Guiding to Improve Confidence

"That's great that you feel a confidence level of 5. That is much higher than a zero. I wonder if there are some ways you could modify the plan so you might get to a confidence level of 7 or more." If the patient doesn't have ideas, a behavioral menu is offered after permission is given. "Perhaps you could choose a less ambitious goal, ask for help from a friend or family member, or think of something else that might help you feel more confident about carrying out the plan? Or maybe you have a new idea about your plan?"

Skill 5: Follow up

Follow-up communicates the clinician's genuine interest and conveys acceptance, respect and concern for the patient's health. Providing support regardless of how successful the patient has been in actually completing the plan can build self-efficacy (Artinian et al 2010). The conversation during follow-up includes a discussion of how the plan went, reassurance and next steps (Figure 4). The next step is often a modification of the current BAP or a new BAP.

BAP Core Attributes

1. The plan is patient-centered, representing what the patient actually wants to do, not what the clinician wants them to do.
2. The plan is behaviorally specific.
3. The patient's confidence in the plan is 7 or greater on a 0-10 scale.
4. The plan is associated with specific follow-up.

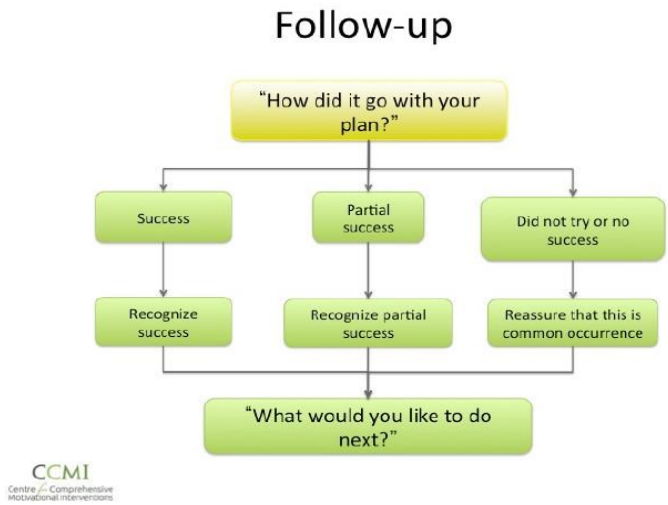

Figure 4. Follow-Up

BAP in Practice

Skilled and experienced clinicians who use BAP routinely report that how often they use BAP varies considerably from patient to patient, depending on the urgency, complexity, and severity of the clinical issues at hand; the context of the visit; the amount of time available; and the specific desires of the patient. Clinicians who use BAP find that the questions and skills fit naturally into a typical patient encounter once rapport has been established.

Learning BAP

Training in BAP typically includes introduction to the Spirit of MI, a description of the process, explanation of the steps, demonstration, practice and feedback. Training can be conducted via an online course or face-to-face training. Most clinicians require additional practice and feedback before becoming proficient. Practice can occur on the telephone since BAP was developed to be used in virtual interactions. Certification through demonstration of skills with a standardized patient and independent rating of the skills demonstration confirms proficiency.

Why was BAP Developed?

Despite strong evidence supporting the efficacy of MI and efforts to disseminate MI into healthcare systems, motivating busy clinicians to change the way they speak to patients about behavior change has been challenging. Many clinicians rightly feel that they do not have time to have motivational conversations, since it takes time to elicit patient preferences and have collaborative conversations about goal setting. In addition, learning MI and figuring out how to incorporate it into a short clinical encounter takes time, practice, feedback and re-practice.

BAP evolved because of the need for an efficient and effective tool to facilitate patient-centered goal setting in time-pressured clinical settings. Based on evidence from multiple theoretical frameworks, including self-management support research, behavioral psychology, and motivational interviewing, BAP has been tested by many clinicians in numerous healthcare settings. First developed by Steven Cole in 2002, with contributions from Damara Gutnick, Connie Davis, and Kathy Reims over the last 10 years, BAP provides a structured approach to behavior change.

How Has BAP Been Used?

Hundreds of clinicians have learned and used BAP in diverse clinical settings with multiple patients with varying conditions. This includes acute care including emergency department, home and community care, public health, mental health and substance use, primary care and specialty care. Peer mentors are also using BAP in community settings. Several university-based medical training programs integrate BAP education into core curricula and several large healthcare organizations integrate BAP training and clinical approaches into routine patient care. Topics addressed include increasing healthy behaviors such as physical activity, or decreasing unhealthy behaviors such as a high-fat diet. BAP is ideal for addressing the multiple concerns of patients with chronic conditions, such as diabetes, depression and asthma.

From a system point of view, organizations adopting BAP decide how they want to use BAP as a part of their overall self-management strategy, providing training for designated staff and then designing workflows to ensure patients benefit from patient-centered practices. Some organizations focus on physician training; others train all health care team members including nurse practitioners, physician assistants, nurses, medical assistants, community health workers and health coaches. Some practices already designated or working toward designation as Patient-Centered Medical Homes (PCMH) find BAP training helpful for their care teams as they work toward the new self-management support roles and responsibilities inherent in the PCMH model (Cole et al, 2010).

Summary

Brief Action Planning is a highly structured, patient-centered, stepped-care, evidence-informed self- management support tool based on the principles and practice of Motivational Interviewing. It can be used to help clinicians build patient self-efficacy for healthy behavior change and managing chronic illness care. It is useful for clinicians interested in providing patient-centered care as described in the Patient Centered Medical Home.

More Information about Brief Action Planning

Publications

Cole S, Gutnick D, Davis C, Cole M: Brief Action Planning (BAP): A Self-Management Support Tool. In Bickley L. Bates' Guide to Physical Examination and History Taking, 11th Edition Lippincott, Williams, and Wilkins. Philadelphia, 2013.

Cole S, Bogenschutz M, Hungerford D. Motivational interviewing and psychiatry: Use in addiction treatment, risky drinking and routine practice. FOCUS 2011;9:42-54. Available at http://focus.psychiatryonline.org/data/Journals/FOCUS/4266/foc00111000042.pdf.

Cole S, Davis C, Cole M, Gutnick D. Motivational interviewing and the patient-centered medical home: A strategic approach to self-management support in primary care (chapter) in Steidl J (ed). Transforming patient engagement: Health information technology and the medical home. Patient-centered primary care collaborative, 2010. Available at http://www.pcpcc.net/files/pep-report.pdf.

Video

Annotated video demonstrating the three core questions and two of the five skills of BAP: http://www.youtube.com/watch?v=w0n-f6qyG54&feature=youtu.be

Experience using BAP in a busy internist practice: http://www.youtube.com/watch?v=0z65EppMfHk

Training Resources and Tools

Centre for Comprehensive Motivational Interventions web site: http://www.centrecmi.ca/

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Rollnick S, Miller WM, Butler CC. Motivational Interviewing in Health Care: Helping People Change Behavior, Guilford Press, NY, 2008.

Stott NC, Rollnick S, Rees MR, Pill RM. Innovation in clinical method: Diabetes care and negotiating Skills. Fam Pract, 1995;12(4):413-418.

Strecher VJ, McEvoey Devellie B, Bcker MH, Rosentstock IM. The role of self-efficacy in achieving health behavior change. Hlth Educ Quart 1986;13(1):73-91.

Additional Resources

References

Miller, William and Rollnick, Stephen, Motivational Interviewing: Helping People Change. Third Edition. New York: Guilford Press, 2012.

Prochaska, J., Norcross, J. and DiClemente, C. Changing for Good. New York: Harper and Collins, 1994.

Rollnick, S. and Miller, W.R., What is Motivational Interviewing? Behavioural and Cognitive Psychotherapy, 23, 325-334, 1995.

Rollnick, Stephen, Miller, William, and Butler, Christopher, Motivational Interviewing in Health Care, New York, Guilford Press, 2008.

Rosengren, David, Building Motivational Skills: A Practitioner Workbook, Guilford Press, 2009.

Motivational Interviewing Training for New Trainers:
http://www.motivationalinterview.org/Documents/TNT_Manual_Nov_08.pdf.

Also see: www.motivationalinterview.org.

MI Video and Audio

Ineffective versus Effective Physician Encounter:
http://www.youtube.com/watch?v=80XyNE89eCs&feature=plcp
http://www.youtube.com/watch?v=URiKA7CKtfc&feature=plcp

Ineffective versus Effective Pharmacy Encounter:
http://www.youtube.com/watch?v=dmmvAR6K1TQ&feature=plcp
http://www.youtube.com/watch?v=5UU63mfNnD4&feature=plcp

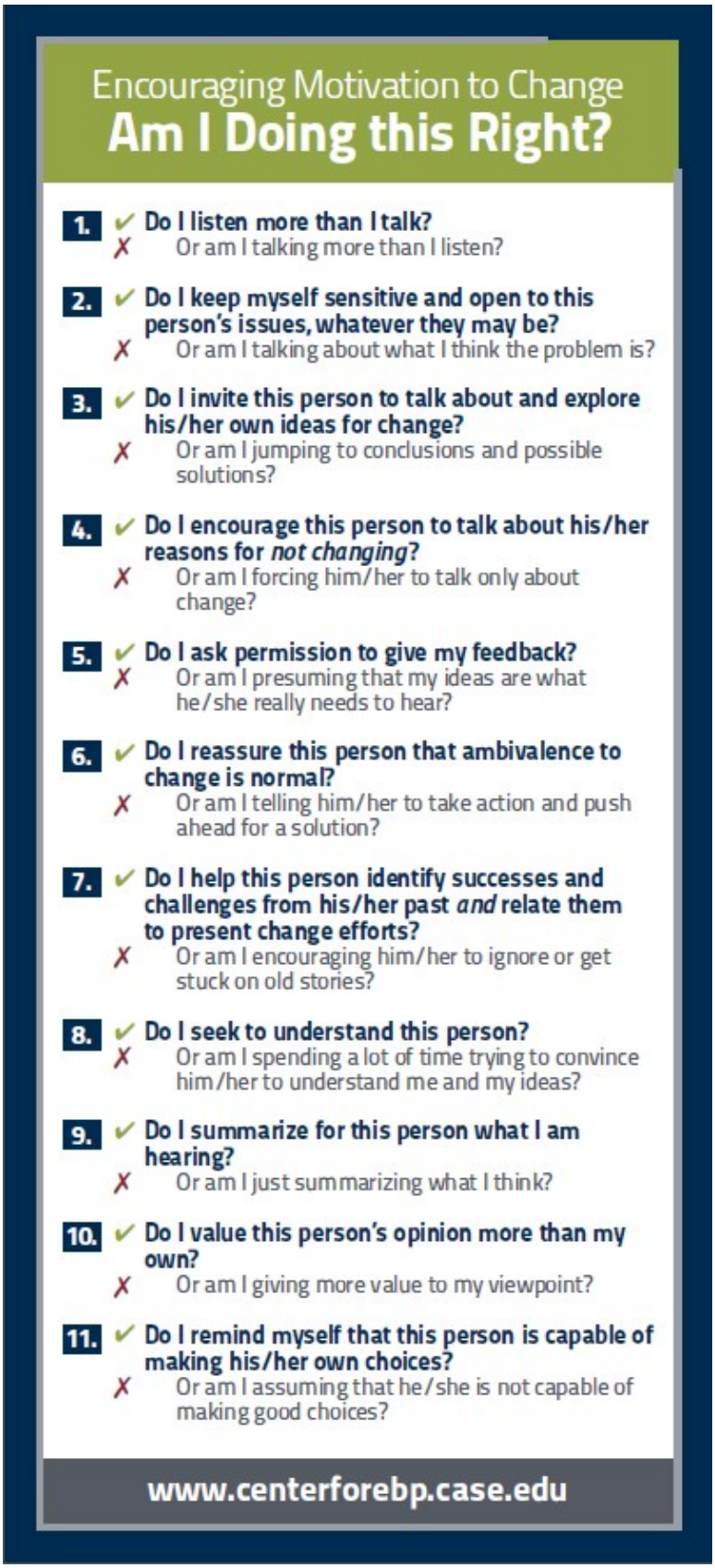
Ineffective versus Effective Dental Encounter:
http://www.youtube.com/watch?v=3xrEaFPbYC8&feature=plcp
http://www.youtube.com/watch?v=f8QSA_5PEFM&feature=plcp

Empathy:
http://www.youtube.com/watch?v=cDDWvj_q-o8&feature=youtu.be

Why is brief MI the foundation for patient-centered effective care?
https://www.youtube.com/watch?v=nwctPFfyG8M

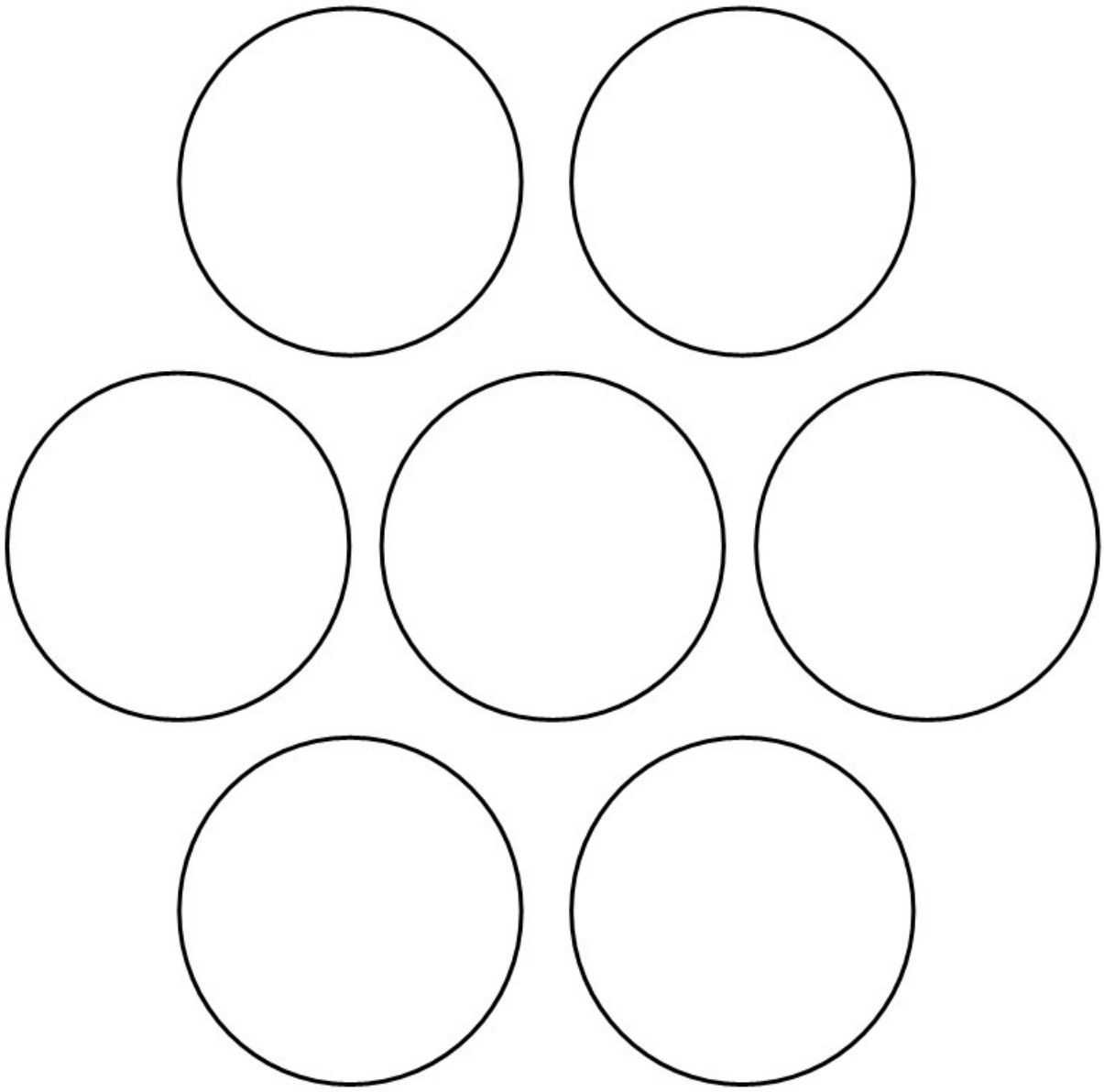
This particular website has some sound bites with success stories, etc. surrounding MI. There's a particular one about Discharge planning- (which continues to be a target of focus for our networks/program) and the sound bite talks about using MI approach vs. the directive approach for a frequent ED utilizer. The reason this sort of "stuck" out as maybe something to use is thinking about that change or shift in culture (for our networks from the top down) that we have (in that we know what needs to happen/be put in place for folks not to continue over utilizing these services, but we may not be approaching it as much as we could be in the collaborative efforts with patients (i.e., what do they need?).

MI Checklist: Am I Doing this Right?



Materials

Agenda Map Template



Change Plan Worksheet Template

Describe the change you want to consider:

Describe your main goals in making this change:

Identify possible obstacles to change and how to handle them:

Possible obstacles	*How to respond*

Write down the names of people that could help you change and the ways in which they can:

Person	*Possible ways to help*

Make a timeline for the things you plan to do to accomplish your goals:

Specific action	*When?*

Identify the specific results that will let you know that your plan is working: