

# CASE IN POINT

Leading the Care Coordination Team with Knowledge, News and Learning

## PATIENT ENGAGEMENT

### Using Engagement Techniques to Partner With Patients, Improve Care

How motivational interviewing, therapeutic practices promote patient buy-in

BY DR. SHARYL ALTUM AND MARY KOLOROUTIS

An RN care manager and a veteran are meeting at a VA Primary Care clinic. In a previous visit, the veteran, a 59-year-old male in good general condition, was told that he's at risk for diabetes. At that time, he was offered a consult with a nutritionist, but he refused. He takes pride in taking care of his health, and thought the consult was unnecessary. On this visit, his hemoglobin levels show that his condition has progressed and medication is now recommended. Given this diagnosis, the nurse's goal in talking with this veteran is to have him start monitoring his blood sugar daily and take medicine to reduce his hemoglobin A1c.

Is there any chance that the nurse's goal is the same as the patient's goal?

No. Not this time. The patient has goals that relate to what he wants to do with the rest of his life. This veteran wants to stay healthy enough to enjoy his retirement, play with his grandkids, and travel with his wife. People don't typically have the life goal of monitoring blood sugar or taking medication. Those things will only matter to patients if we, as healthcare providers, can relate them to what is important to each individual in our care.

#### PATIENTS AS PARTNERS

A medical home model allows clinicians to know their patients well enough to understand what matters most to them. In order to discover this information, clinicians must establish relationships with their patients. There is a difference, however, between collecting infor-

mation and being in a relationship. A relationship involves listening to learn about patients, what matters to them, and what will motivate them to take ownership of their own health.

There are two bodies of knowledge that clinicians at the Cincinnati VA are finding extremely valuable in establishing an effective clinician/patient relationship. They are the practices found in motivational interviewing (Miller & Rollnick, 2012) and the therapeutic relationship as defined in the workshop of the same name and the book *See Me as a Person* (Koloroutis & Trout, 2012).

Motivational interviewing (MI) is a "person-centered, goal-oriented approach to facilitating change through exploring and resolving ambivalence" (Miller, 2006). It includes the practices of listening to the patient and reflecting back what he has said. In doing so, it helps the patient explore what matters most and what reasons he might have for making a change.

The therapeutic practices that have been identified as being fundamental to the formation of therapeutic relationships (TR) are attuning, wondering, following and holding (Koloroutis & Trout, 2012). These practices are not used in order to facilitate change in our patients, but are instead therapeutic interventions in and of themselves. When we attune to our patients, we're likely to learn something of value about what they're experiencing right now. When we wonder about them, there is no question that we'll ask more intelligent, meaningful questions. When we follow, our patients will feel

seen, heard and valued. When we set the intention of holding our patients in our care, they are very likely to feel safe and seen as a unique person. In order for MI to be effective, it must be practiced within a warm, nonjudging, empathetic relationship. TR creates just such relationships.

TR helps deepen and "heart-wire" the practices that help MI occur naturally. The practices of attuning, wondering, following and holding are what comprise authentic human connection. These practices can be learned, practiced and integrated into MI to make every patient interaction a dance of full partnership, with both parties focusing holistically on not only what's "best for the patient," but on what the patient is most willing, able and likely to wholeheartedly commit to.

#### THE OPEN DOOR OF AMBIVALENCE

Both TR and MI help clinicians to see a patient's apparent resistance as something other than an enemy. In MI, resistance has been redefined as discord in the clinician-patient relationship (Miller & Rollnick, 2013). It occurs when the patient may be ambivalent or more focused on sustaining a behavior and the clinician is moving toward change. If a patient is confronted with evidence that he should quit smoking, he is ambivalent. He probably loves to smoke, and he may be keenly aware of how difficult it will be to quit. Alternatively, he's concerned about the risk of pulmonary disease since his father, a lifelong smoker, now has it. He wants to quit...but he also doesn't want to quit. The MI process understands and appreciates that ambivalence and guides clinicians to

help patients resolve it. The goal of MI is to facilitate fully informed, deeply thought out, internally motivated choices – not to change behavior (Resnicow, et al., 2002).

TR also helps us see resistance differently. TR teaches that there are five typical human responses to illness and injury: fear, powerlessness, grief and loss, pain, and difficulty coping (Koloroutis & Trout, 2012). It's easy to see that none of these responses is a very effective starting point to enact change. If we go into a patient encounter with the thought that the patient (who may be feeling weak, remorseful or even ashamed) must follow a specific protocol in order to experience better health, we'll have taken everything into account except for all of the current realities of the who the patient is, what she cares about, and what she's willing to do.

## WHY USE BOTH MI AND TR?

While these two bodies of knowledge are complementary, the purpose of each is different. MI is a specific process for facilitating behavioral change in the patient, and TR is a way of thinking and being that facilitates authentic connection with the patient. An authentic and therapeutic connection is essential for the MI process to succeed. A key distinguisher between the two is that MI has an agenda: to facilitate well thought-out choices. TR calls for clinicians to intentionally suspend their agenda. By adopting both TR and MI, the VA primary care teams determined they would have a stronger knowledge base for meeting the veteran exactly where she is and engaging her as a true partner.

## PUTTING IT ALL INTO PRACTICE

Let's go back to our original case study. In this real-life scenario, it happened that Dr. Sharyl Altum, who teaches both MI and TR at the Cincinnati VA, was in the office coaching the nurse who wanted to teach her patient about

how best to manage his diabetes. The nurse began the visit by reviewing events from the past several months, his lab work, and the diagnosis. Before she could finish, the veteran interrupted and expressed his disbelief. He repeatedly questioned how and why this had happened to him. The nurse started to give information about diabetes and its causes: heredity and eating behaviors. He again interrupted and explained how he doesn't like to take medication every day – how he is a determined person who would rather make changes to fix a problem instead of take medication to manage it. The nurse paused for a moment to check the medical record, and then reminded him that he was offered a nutrition consult several months ago and he declined. At this point, the nurse seemed to be experiencing some distress in her efforts to address this veteran's concerns. The veteran continued to share his disbelief and frustration, becoming more animated and a little louder.

Dr. Altum had been listening and observing the interaction. She began to interact with the veteran, following his cues and reflecting back to him his disbelief, frustration and, perhaps most importantly, his self-determination. The veteran started to slow down, lower his voice, and share more about his feelings and beliefs. Dr. Altum asked, "What would it mean if you would need to take medication every day?" He worried about getting sick before he retires and of not being able to enjoy retirement with his wife. He shared that this is already starting to happen with his wife's own diabetes.

In his mind, taking medication was equated with failure to take care of his health and would lead to disability. As Dr. Altum continued to attune, follow and reflect, the veteran started to consider options and wonder aloud about the pros and cons of delaying the medication. Because he was able to share his ambivalence, the information the nurse provided was not perceived as instruction.

At the end of the visit, the veteran and his nurse created a plan that he was committed to: He will see the dietician, monitor his eating with a food diary, and revisit the issue of medication after that. When we connect with our patients and facilitate their ability to work through their fears and ambivalence, we increase their ability to cope with their situation and stay on the path to greater wellness – a path of their own choosing.

## REFERENCES

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