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Motivational Interviewing: Creating a Leadership Role for Social Work in the Era of Healthcare Reform

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ABSTRACT
To better address the needs of individuals with a range of complex health conditions, the Affordable Care Act has shifted the focus from acute care to prevention through behavior change and promoted the integration of physical and behavioral healthcare systems. Central to healthcare reform is delivering person-centered care, which means actively engaging people in their treatment decisions and managing their wellness. Motivational Interviewing (MI) is perhaps the most widely used intervention to promote behavior change. Although MI is utilized across most health disciplines, social workers are uniquely positioned to lead dissemination and on-going training efforts in this area.

KEYWORDS
Healthcare reform; evidence-based practices; health and mental health

Healthcare delivery is undergoing a sea change as the Affordable Care Act (ACA) picks up momentum and innovative ways to integrate and coordinate care are being implemented throughout the country. With these changes, come expectations for the healthcare workforce to orient themselves to a different model of healthcare delivery. There has been a growing realization that fragmentation and a predominantly acute care approach is failing to meet the healthcare needs of many Americans (Institute of Medicine, 2001). The resulting poor health outcomes and high costs are now driving a new emphasis on chronic care, prevention, and care coordination (Koh & Sebelius, 2010). One of the key shifts in this new approach is actively engaging people in their care and working with them, their families, and communities to manage their wellness. Social workers have much to offer in this regard with their person-in-environment perspective and emphasis on relationship as a way to engage and change behavior. The alignment between social work values and skills and the needs of the new healthcare workforce provides an opportunity not only for social work involvement but also social work leadership. Social work leaders and policy makers are now urging social workers to demonstrate and document the ways they can contribute to the implementation of the Affordable Care Act (Andrews, Darnell, McBride, & Gehlert, 2013). This article highlights the important role that Motivational Interviewing (MI) can have in integrated health settings and how social workers are uniquely qualified to train other healthcare professions in this valuable intervention.

The ACA is designed to address the poor performance of the U.S. healthcare system. Although spending twice as much as other industrialized countries on healthcare, the United States persists in having some of the worst health outcomes among this group (Davis, Stremikis, Squires, & Schoen, 2014). The poor return on investment is partly due to the expensive but ineffective care that people with chronic illnesses receive. Although making up 15% of the Medicaid population, people with chronic and comorbid illnesses account for 44% of the costs (Kaiser Commission on Medicaid and the Uninsured, 2013). The U.S. healthcare system has been traditionally oriented to acute care driven by...
funding incentives and professional specialization, which results in people only receiving treatment when their symptoms are severe. An alternative approach is the chronic care model that provides continuous coordinated care that engages people and encourages healthcare providers to partner with people to manage their disease (Wagner, Austin, & Von Korff, 1996). The anchor for effective care is “informed, activated patients . . . who have goals and a plan to improve their health, along with the motivation, information and confidence required to manage their illness well” (Anstiss, 2009, p. 88).

Accounting for 40% of our health outcomes, one of the most crucial and mutable aspects of well-being is behavior (Schroeder, 2007). Thus, healthcare interventions that target behaviors that undermine well-being such as poor nutrition, lack of exercise, smoking, and substance use, have the potential to significantly improve health outcomes.

Although targeting health-related behaviors can improve health outcomes for people with chronic illnesses, healthcare has traditionally focused on addressing health problems when people have symptoms rather than prevention. Many healthcare professions, including physicians, have not considered engaging people in behavior change related to nutrition and exercise to be within their scope of practice (Eng, 2015). When providers do address these issues, the communication is often one directional taking the form of advice or directives reflecting how the medical model has traditionally viewed people as passive in their healthcare decisions. A recent review of studies testing the effectiveness of community-based dietary and lifestyle interventions found that only two out of 26 interventions resulted in weight loss (Bartels et al., 2013). Many of these lifestyle interventions involved didactic education such as pamphlet distribution, attending classes, and listening to speakers discussing the importance of behavior changes. These didactic methods of intervention have not resulted in significant positive behavior changes (Bishop & Jackson, 2013). Addictions have also proven resistant to prevailing treatment methods, leading to high rates of relapse and a strong perception that there are no good medical interventions for substance use (Tai & Volkow, 2013). Therefore, shifting away from the more traditional paternalistic notions of treatment to a more active and collaborative partnership between providers and service users is an important priority for the ACA.

### Integrated healthcare

One of the key features of healthcare reform is integrating primary and behavioral health to address the complex relationship between the mind and body. Integrated care has been defined as “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population” (Peek & National Integration Academy Council [NIAC], 2013, p. 2). This approach aligns with the chronic care model, which proposes a system of care that promotes and responds to the “activated” service user, persons engaged with their care, informed, and who makes decisions in close collaboration with their providers (Wagner et al., 1996). To truly understand and respond to people’s needs in a holistic way, providers must coordinate their care. Coordination requires close communication among providers, teamwork, and infrastructure supports such as electronic health records and colocation or networks of providers. The ACA has promoted the structural integration of healthcare through various delivery models and financial incentives. Innovations such as Accountable Care Organizations, Patient-Centered Medical Homes, and Health Homes create the conditions required for providers to coordinate care and have one unified treatment plan that seamlessly addresses physical and behavioral health needs. The ACA has also significantly expanded the reach of mental health parity by making it an essential healthcare benefit ensuring that behavioral healthcare will be covered for an additional 30 million people (Buck, 2011). These reforms are aimed at achieving a continuum of integrated primary and behavioral healthcare services, from close collaboration across sites to fully integrated systems where services are all offered in one physical site.

Although these system changes are necessary for integration, they are not sufficient. Clinical integration requires a shift from medical model thinking to the acquisition of new professional competencies to implement coordinated care. Moreover, these competencies no longer fall solely along
professional lines. The centrality of teamwork means there are certain knowledge sets and skills that must be shared by the team to be effective (Xenakis, 2015). As a result, we are seeing a greater emphasis on interdisciplinary professional education and training initiatives designed to promote the goals of the ACA. Failure to integrate at the clinical level often occurs because professions have differing cultures and approaches to care. Cross-training enables providers to communicate, understand each other’s roles, build a shared culture of care, and learn team level skills that promote integrated care. One competency that each provider, whatever the discipline, must possess is the ability to deliver person-centered care and a focus on how people can manage their wellness (Center for Integrated Health Solutions, 2014). The latter is often referred to as “self-management,” which refers to the tasks that persons with a chronic illness needs to complete to live well. The simplest way to help people with these tasks is to provide education and resources. The more complex aspect of helping people improve their quality of life involves engaging individuals in conversations about health behavior change. Person-centered care requires assessing the highly unique facilitators and psychological roadblocks to wellness behaviors while communicating deep respect for the lived experience and strengths of individuals. This joint effort between providers and service users can inspire new energy and confidence to attempt or reattempt behavior change. Eliciting information about people’s unique experiences requires communication skills made particularly explicit in the evidence-based practice of Motivational Interviewing (MI).

Motivational interviewing

Gaining greater attention in recent years, MI is an evidence-based practice that provides structure for collaborative conversations related to health behavior change. Miller and Rollnick (2013) describe MI as skillfully attending to natural language about change, exhibiting an “MI Spirit” and using a four-process method. The MI Spirit embodies “habits of the heart” as practitioners hone a person-centeredness style of work that includes elements of partnership, acceptance, compassion, and evocation. The specific skills of MI are well explicated and consist of proceeding through stages of engaging, focusing, evoking, and planning while adroitly using five key communication skills (asking open questions, affirming, reflecting, summarizing, and providing information and advice with permission) (Miller & Rollnick, 2013). Person centeredness is a core principle to the practice of MI, demonstrated by the proscription on giving advice without permission, disagreeing, arguing, shaming, labeling, or questioning someone’s honesty (Gordon, 1970; Miller & Rollnick, 2013). MI is a practice that needs ongoing reinforcement via observation of actual practice, documentation of fidelity, and continued clinical supervision. Fidelity can be ascertained using a variety of reliable and valid tools (Madson & Campbell, 2006; Miller & Rollnick, 2013).

Although MI has been in existence for several decades, it is increasingly empirically supported for use with a broad range of problem behaviors. In a recent systematic review and meta-analysis to investigate MI’s efficacy in medical care settings, behaviorally linked outcomes such as HIV viral load, dental outcomes, body weight, alcohol and tobacco use, sedentary behavior, self-monitoring, and confidence in change were all positively affected (Lundahl et al., 2013). Furthermore, effects of MI were durable, even after 2 years. Hardcaste, Blake, and Hagger’s (2012) study investigating the effectiveness of using MI within primary care settings to increase physical activity among lower socioeconomic status groups reported significant increases in total physical activity, walking, vigorous physical activity, stage of change, and social support from baseline to follow-up. Hence, a great diversity of health practitioners are interested in learning and implementing MI. Nurses, social workers, probation officers, and physicians are among providers regularly engaged in conversations about health behavior change. Such health professionals greatly benefit from being equipped to competently deploy MI in efforts to help persons explore individual-level factors that might influence behavior change and by integrating MI into systems of care.

Integrating MI into primary care can contribute to higher levels of healthcare performance. Anstiss (2009) outlines a number of ways in which MI can help healthcare systems with the task of integration:
MI can contribute toward the building of more integrated teams, helping different professional groups work together toward a common purpose; MI can help clinicians integrate evidence-based medicine with person-centered care and shared decision making, help integrate physical and behavioral healthcare, help clinicians integrate treatment with prevention, help integrate treatment with wellness and well-being approaches, help integrate clinical care and self-care, and help more fully integrate models for detecting and treating substance abuse into primary care settings. Screening, brief intervention, referral, and treatment (SBIRT) has gained new prominence with healthcare reform as a tool to ensure substance abuse problems are detected and addressed in primary care settings. MI is considered a key part of the brief treatment process to help people address the reasons for their current use patterns and become open to changing their behaviors (Madras et al., 2009). As federal initiatives support the adoption of SBIRT in a broad array of healthcare settings, there is an increased need for providers to be trained in MI (Center for Integrated Health Solutions, n.d.). The trust built between clinicians and service users through repeated primary care encounters can provide a strong foundation for clinicians to incorporate MI methods and address risky health behaviors that lead to chronic diseases (Bishop & Jackson, 2013). The principles and methods of MI appear to be highly valued by practitioners frustrated with the ineffectiveness of the traditional prescriptive advice giving (Elwyn et al., 2014).

**The empowerment paradigm of MI**

Beyond individual factors, MI allows for discussion of environmental and policy-related factors that may inhibit or enhance persons' ability to change. For example, unstable housing, access to transportation, or hours a medical facility is open could pose barriers to following through with after care post-in-patient hospitalization. Providers expertly using MI are required to consider such social determinants of health when creating a plan to address continuity of care for specific health conditions. In this regard, not all healthcare providers are equally positioned to take up the practice of MI due to the different ways that health providers are socialized within their professions. For example, nurses and physicians are more likely to have had an orientation to the medical model, a reductionist perspective that views diseases as independent of social behavior (Engel, 1977). Anderson and Funnell (2005) have written about the influence of being socialized to paradigms (such as medical model) in healthcare and the substantive barriers to later adoption of an empowerment paradigm. Other research specifically acknowledges present limitations in medicine pedagogy and calls for development of a new “structural competency” in medical education toward participating more fully in micro- and macrolevel negotiations about structural issues with patient populations (Metzl & Hansen, 2014).

All of the health disciplines are called to reflect upon pedagogy and paradigms used to socialize new practitioners into present healthcare reform frameworks as well as to consider requisite efforts to modify practices in their existing workforces. Although calls are being made in medicine and nursing to learn innovative evidence-based practices that are person-centered and promote collaborative engagement with patients, changing from a diagnosis and pathology-oriented approach to interacting with patients from a person-centered framework is far from straightforward. Having historically embraced the primacy of the collaborative relationship toward self-management, social work is well positioned to lead training on MI and other person-centered practices across healthcare disciplines.

**Social workers' unique aptitude for MI**

Social workers have always been attuned to the social determinants of health as part of their person-in-environment perspective. To actively engage persons in behavioral healthcare, social workers typically conduct biopsychosocial assessments to ascertain environmental and contextual conditions making it easier or more challenging to change behavior. Social workers are also professionally socialized to a paradigm consonant with the “MI Spirit.” Above all, social work venerates human relationships and attributes the therapeutic relationship strength as key to efficacy. In fact, in MI, the clinician’s ability to exude empathy is closely linked to improved behavioral outcomes. MI has been included in educational
curricula and considered an excellent fit for inclusion in social work programs (Hohman, 2011; Hohman, Pierce, & Barnett, 2015; Manthey, Knowles, Asher, & Wahab, 2011; Wahab, 2005). Furthermore, MI is congruent with the social work code of ethics and broadly applicable to the variety of populations and types of settings where social workers practice. Hohman (2011) provides a systematic overview of how social workers are philosophically positioned to adopt MI skills as part of their training springing from principles and inherent professional values. For example, central social work principles of maximizing client autonomy and self-determination correlate with MI aspects that clients should be doing the majority of talking in an MI encounter and, with the guidance and collaboration with the social worker, driving their own change plans. Thus, social work is uniquely prepared for the interdisciplinary role of helping to integrate MI into primary care via training and educational efforts.

**Leading MI workshops**

Evaluation data from trainings led by two of the authors of this article, who are licensed social workers and members of Motivational Interviewing Network of Trainers (MINT) demonstrated the need for this training among medical professions. Participants in the workshops comprised nursing students (229), some were medical students (23), and remaining participants were field instructors or graduate students in social work. Following the MI workshops, quantitative and qualitative evaluation data was collected from 291 participants over the course of 2 years. The evaluations contained close-ended questions assessing participants’ satisfaction with the content, style, and usefulness and open-ended questions that allowed participants to elaborate on the training. Both types of data were aggregated to an Excel file for analysis.

Although the medical and nursing students rated the workshop content as “excellent” (75% of participants) and hands-on activities as “excellent” (69% of participants), what was more striking was the consistency of commentary indicating that MI experiential skills training was novel to their educational experience. The majority of medical students claimed that the MI role plays were of most use and indicated the need for such activity in their educational programs. When commenting on what would make this a better experience, one medical student wrote, “Doing it for everyone when we start clinics.” Another medical student stated, “It would have been helpful to have this workshop earlier in the semester before having Standardized Patients.” Nursing students made similar comments. One nursing student stated that this was “therapeutic communication relevant to all of nursing.” Another stated that these MI skills are “communication skills that are otherwise not spoken of in nursing school.” Yet another remarked that the MI skills are “valuable to all aspects of nursing.” Several students reported that “we need this at the beginning of our program.” Finally, another wrote that the most helpful hands-on activity was “practicing asking open-ended questions and realizing how automatic it is to ask closed-ended.” Overall, the evaluation demonstrated how new and valuable MI skills were for nursing and medical professionals.

**Discussion**

The ACA’s new emphasis on social determinants of health, which refers to any nonmedical factors that contribute to our health such as behavior, living conditions, education, or social support, aligns with social work’s focus on the psychosocial (Stanhope, Videka, Thorning, & McKay, 2015). Also, a core social work value is self-determination, which translates into the new terminology to person-centered care, focusing on the relationship to understand people and empower them to make decisions around their own care (Social Work Policy Institute, 2012). The social work approach not only makes us important members of integrated care teams, but also qualifies us to play a leadership role (Lundgren & Krull, 2014). Part of that leadership role is to cross-train other health workers who lack experience in how to reach people who are experiencing mental illness, substance use, marginalization, and the effects of poverty, and how to engage them consistently in care. In a recent survey of Health Home providers in New York State, 30% said that providers’ lack of ability to communicate effectively with clients was a major staffing challenge (Silverman, Schaub, & Lowenstein, 2015). Communication skills are a core
competency of social workers, and MI is a specific tool that social workers can bring to integrated healthcare teams through role modeling and training other professions. Providing affirmations that are authentic, precise, and communicate the MI Spirit is natural fit for social work as resonates with our strengths based approach (Tennille, Solomon, & Bohrman, 2014).

Positioning ourselves as competent to deliver MI requires that we embed effective curriculum into social work education and ongoing professional development activities. The first step in the process is to ensure that social work students are extensively educated in MI in the classroom and that this learning can be supported in their field placements. With the shift from content to competency and the increasing focus on teaching students evidence-based practices in the Council on Social Work Education and Policy Accreditation Standards, there is clear support for embedding MI into the practice curricula and field placements. A recent study of undergraduate BSW students showed that after a course on MI, students made significant positive changes in their MI proficiency by the end of the semester (Hohman et al., 2015). Social workers should also have access to professional development opportunities to ensure that they can acquire and build on MI skills to the extent they can take the lead in infusing MI into their settings. The Social Work Policy Institute (2012) recently called for more postdegree education that will prepare social workers for the changing healthcare environment and one example of this would be train social workers on the role of MI in integrated health settings.

Playing a lead role in dissemination and sustainability of MI among interdisciplinary teams will be a major task if social workers are to be perceived to be central in vesting and maintaining this practice. One strategy garnering increased attention is the creation of communities of practice (CoPs) focusing on MI among social workers and other types of healthcare providers to create continued capacity for interdisciplinary skills training and paradigmatic support. CoPs have received increasing attention in healthcare (Li et al., 2009; Piat, Briand, Bates, & Labonté, 2015) as a means of creating informal networks to support skill development, maintenance, and implementation. Li et al. (2009) discuss several aspects of CoPs including support for informal and formal interaction among novices and experts, an emphasis on learning and sharing knowledge, and investment to foster a sense of belonging among members. Related to this is the formation of practice-research networks in which researchers and providers can collaborate to document the effectiveness of social workers as MI trainers in interdisciplinary settings. We are now 5 years into the ACA and despite frequent attacks, the legislation continues to evolve and for the most part improve healthcare settings. Andrews et al. (2013) articulate the challenge for social workers, “The time has come for our profession to develop a well-coordinated strategy to communicate the evidence demonstrating social workers’ effectiveness in advancing ACA aims” (p. 71) and leading efforts to disseminate MI can be one part of that strategy.

References


