Motivational Interviewing Is a Promising Framework for Collaboration in the Patient-Centered Medical Home

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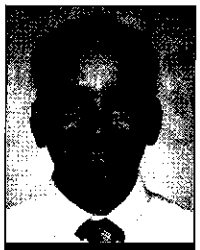
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The patient-centered medical home (PCMH) model of primary care embraces team-based approaches to wellness, with new certification standards that highlight the need to integrate psychological and medical services ("Joint Principles," 2007; NCQA, 2014). Optimal patient outcomes in a PCMH system depend on effective interprofessional collaboration where knowledge and methods from different disciplines are joined to develop solutions (Bronstein, 2003; D'Amour & Oandasan, 2005; Interprofessional Education Collaborative Expert Panel, 2011). For example, an adult with poorly managed diabetes and recurrent major depression, who is also at risk for homelessness, may benefit most by meeting with the team's psychologist, social worker, dietitian, and physician to develop a coordinated plan that includes housing resource support, behavioral activation, and nutritional counseling.

The conceptual basis for good collaboration in integrated settings includes mutual trust, respect, role clarity, flexibility, and clear, concise communication (Bronstein, 2003; D'Amour et al., 2005; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Allport (1954) observed that simply putting people from different backgrounds in the same room was insufficient to promote cooperation. His contact hypothesis identifies common goals, equal status, and low levels of competition as conditions critical for strengthening relationships among group participants. In translating Allport's (1954) theory into interprofessional training, Mohaupt et al. (2012) found that jointly discussing a case and developing procedural guidelines led to more positive attitudes toward collaboration among students from different medical backgrounds. These activities were designed in part to help participants learn about one another's roles, expectations, and competencies.

In working with support group cofacilitators, Banach and Couse (2012) specifically set aside time for this type of interpersonal learning prior to service delivery. The authors pointed out the importance of building relationships by sharing approaches and ideas during this phase. In the PCMH model, the previsit "huddle" provides a similar opportunity for trust and mutual respect to develop among team members as they participate in care-planning discussions. Huddles have been rated one of the most helpful resources for PCMH implementation (Gale et al., 2015). Reviewing collaborative interactions in debriefing sessions can also open communication channels and may lead to additional improvements in care coordination.

Developing positive collaboration in a PCMH may start with structured activities such as previsit huddles, but it may also require close attention to the conversational styles nested within those activities.

With their expertise in relationship building, psychologists are uniquely positioned to foster a patient-centered care environment, one characterized by respectful, effective interactions between providers (Nash, Khatri, Cubic, & Baird, 2013). Developing positive collaboration in a PCMH may start with structured activities such as previsit huddles, but it may also require close attention to the conversational styles nested within those activities. Typically regarded as a patient-focused behavior change intervention, motivational interviewing (MI) (Miller & Rollnick, 2013) offers a way to enhance colleague-centered communication. MI spirit encompasses the relational principles of acceptance, partnership, and evocation, whereas MI method addresses the corresponding active listening skills that help establish this mutually respectful, person-centered atmosphere. These skills are represented by the acronym OARS: open questions that invite elaboration, often beginning with "what," "why," and "wow"; affirmations or verbal acknowledgments of personal strengths; and reflective listening statements that convey understanding, periodically gathered in the form of summaries. As a framework for provider-to-provider communication, MI does not elicit language in favor of a particular health behavior change. Nevertheless, one might think of MI as helping to evoke positive change talk and attitudes around the idea of working together in an interdisciplinary setting.

MI-based communication carries a tone of reciprocal interest and valuing that can strengthen a sense of acceptance, sending the message that psychology and other allied disciplines are more than "guests" (Hughes-Reid & Lines, 2015) in the PCMH system. Collaborators might ask open questions about each other's professional knowledge base and affirm the importance of each other's roles in patient care. Responding to coworkers' frustrations with reflective listening represents a potentially powerful form of accurate empathy, another key component of acceptance. Reflection and nonjudgment may enhance trust through empathic attunement to concerns or attitudes related to medical home challenges (Young, 2013). Autonomy support, a crucial part of Miller and Rollnick's (2013) concept of acceptance, can mean expressing support for a colleague's decision-making control within his or her domain of expertise (e.g., a physician's prescribing decision or a psychologist's referral to a specialty mental health provider). This could occur within the process of role clarification that is thought to contribute to effective interdisciplinary practice (San Martin-Rodriguez et al.,

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2005). MI spirit is instructive in that it encourages balancing one's professional assessment and expertise with openness to others' input (e.g., "It seems Mrs. Jones would benefit from intensive group therapy, but how do you think it might affect her diabetes and renal care?").

In the context of integrated care, the MI concepts of partnership and evocation suggest establishing shared ownership of treatment goals while defining or recognizing a common mission (Bronstein, 2003). The elicit-provide-elicit (EPE) process of information exchange in MI can foster respect, consensus, and power sharing as these goals take shape. In the first step of EPE, a provider might ask permission to share ideas for treatment or learn what other collaborators deem as the most important, relevant, or desirable data within that clinical domain (e.g., "Mrs. Jones is suffering from depression, limited family support, and financial distress. While depression seems like the most pressing concern, what area would the team want to know more about in terms of her diabetes management?"). The last step in EPE involves soliciting reactions to the information provided, maintaining a climate of openness to alternative ideas. EPE's "evoke-first" principle can also be useful in exploring conflicting views of a patient's presenting problem. Reconciling divergent perspectives before treatment planning can circumvent tensions that could disrupt future collaboration (McDaniel, Doherty, & Hepworth, 2014).

Health-care providers in large PCMH systems are beginning to receive formal training in MI, removing the sole responsibility from psychologists for modeling and teaching this mode of communication (Cucciare et al., 2012). Although MI training has traditionally focused on patient-provider interactions, infusing integrated settings more broadly with an MI-based conversational style promises to improve cohesiveness, cooperation, and communication flow within team-based care.

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