

# IOMSN News

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A Publication For – and By – IOMSN Members

## Bone Health in MS



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ANP-BC, MSN, MSCN,  
Reviews Common  
Bone Diseases  
That Can Co-Occur  
with MS

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## A QUICK VIEW OF THE CMSC ANNUAL MEETING SCHEDULE



### CMSC/IOMSN Annual Meeting

May 30-June 2, 2018

Nashville, Tennessee

To register for the Annual Meeting or to obtain more information, call 201-487-1050 or visit <http://www.mscares.org/>.

#### Wednesday, May 30

8:00-9:30 AM MS Navigator

10:00-11:30 AM Independently Supported Symposium

11:30 AM-1:00 PM Opening Ceremony, Luncheon, and Lecture

1:15-3:15 PM John Whitaker Research Track Platform Presentations  
and Clinical Courses

3:30-5:00 PM Independently Supported Symposium

4:00-6:00 PM Opening Reception

6:00-7:30 PM IOMSN Awards Reception

#### Thursday, May 31

7:00-8:00 AM Independently Supported Breakfast Symposium

8:00-8:45 AM Presidential Lecture

9:00 AM-12:00 PM Clinical Courses and Symposia

12:15-1:15 PM Product Theater

2:00-4:45 PM Clinical Courses Continued, Symposia

5:00-6:30 PM Independently Supported Symposium

6:30-7:30 PM Poster Session

#### Friday, June 1

7:00-8:00 AM Independently Supported Breakfast Symposium

8:00-8:45 AM John Whitaker Memorial Lecture

9:00 AM-12:00 PM John Whitaker Research Track Faculty  
Presentations, Educational Courses, and Symposia

12:15-1:15 PM Product Theater

2:00-4:00 PM Platform Presentations, Educational Sessions

4:15-5:45 PM Independently Supported Symposium

6:00-7:00 PM CMSC Election Results and Awards Reception

#### Saturday, June 2

7:00-8:00 AM Independently Supported  
Breakfast Symposium

8:00-9:00 AM Roundtables

9:00-11:45 AM Educational Sessions,  
Symposia, Workshops

12:00-12:45 PM Luncheon and Donald  
Paty Memorial Lecture

12:45 PM Official CMSC Meeting  
Adjourns

1:00 PM MS Coalition Multiple Sclerosis  
Summit Begins



Photos Courtesy of Nashville Convention & Visitors Corporation

## COVERING ALL OF THE BASES IN MS NURSING

It's not always easy being an MS nurse. With the expanding armamentarium of disease-modifying therapies (DMTs) for relapsing and now even progressive MS, there's a lot of new information we need to keep up with (and don't we know it!). Plus, we want to deliver the best, most-compassionate care to our patients that we can while bonding with our nurse colleagues in the IOMSN. Oh, yes, and balancing all of that with a fulfilling personal life!

In this issue of *IOMSN*ews we attempt to offer you some guidance and insights on the nursing side of your life: We cover a clinical topic, offer highlights of an effective communication technique that can make your visits with patients more efficient, and give ourselves a pat on the back by recognizing our peers with a new social media initiative. Specifically, the lineup for this issue includes:



**Marie Moore,**  
MSN, FNP-C, MSCN  
Editor, *IOMSN*ews

- A review of bone health and MS by Denise Bruen, ANP-BC, MSN, MSCN, covering both osteoporosis and arthritis and incorporating tips on counseling patients at risk for bone issues and falls.
- A complementary article that looks at rehabilitative services for people with MS from Megan Weigel, DNP, ARNP-C, MSCN, an expert in integrative medicine. She reviews when to order physical therapy, occupational therapy, and speech therapy for patients with MS, and key counseling and follow-up tips.
- Insights into the IOMSN Listserv (also called the Forum or Google Group) and a new social media initiative that puts the spotlight on MS nurses, courtesy of our Communications Committee Chair Rachael Stacom, MS, ANP, MSCN.
- An overview of the Motivational Interviewing (MI) technique and how MS nurses can apply it to their practices, from MI expert Colleen Harris, MN, NP, MSCN.
- And, last but not least, a look into the practices of two of our long-standing and most illustrative members: community MS nurse/nurse practitioner Barbara Bishop, MS, ANP-C, MSCN, CNRN, and IOMSN founding member Patricia M. Kennedy, ANP, MSCN.

On top of this great lineup, we have this year's annual Consortium of Multiple Sclerosis Centers' (CMSC) meeting at hand, which will be held in Nashville, Tennessee, from May 30th to June 2nd. We have scheduled a number of MS nurse-specific sessions—including a clinical course on infusion therapies and an advanced practice symposium on management of acute exacerbations—and our annual IOMSN Reception will be held on Wednesday, May 30th from 6:00 PM to 7:30 PM. I truly hope you will be able to join us at this wonderful annual gathering, which is good for both the mind and the spirit!

Sincerely,

*Marie*



# BONE HEALTH IN MS

Denise Bruen, ANP-BC, MSN, MSCN  
Department of Neurology—MS Clinic  
University of Virginia Health System  
Charlottesville, VA

**W**hile maintaining bone health is essential for everyone, it is especially important for patients with multiple sclerosis (MS). Features of the disease, such as compromised mobility, as well as some of the medications used to treat MS, place patients at a higher risk to develop osteoporosis compared with the general population. Additionally, neurological symptoms of MS, such as weakness, spasticity, limb numbness, and vertigo, can increase the risk of falls and potential bone fractures.

In general, osteoporosis risk factors include:

- sex—women have a higher risk than men due to their smaller bone structure and bone loss associated with menopause;
- age—age-related bone loss occurs as both women and men get older;
- body size—small, thin people with a low body mass index (BMI) are at greater risk;
- ethnicity—non-Hispanic white and Asian women are at greatest risk, but African-American and Hispanic women are at risk as well;
- a family history of fracture;
- sex hormone dysfunction, such as amenorrhea or low estrogen levels in postmenopausal women or hypogonadism in men;
- a diet low in calcium and vitamin D, two nutrients essential for bone health;
- cigarette smoking; and
- alcohol abuse.

Risk factors for osteoporosis specific to patients with MS include:

- decreased mobility, namely, a lack of weight-bearing activity and exercise; and
- prolonged use of corticosteroids, which affect the metabolism of calcium and vitamin D.

## Bone Disease Is Common in MS, But May Be Underrecognized

Although bone disease occurs frequently in patients with MS and causes considerable morbidity and sometimes mortality in those affected, it is underrecognized and undertreated. While many primary care providers typically do a good job of screening women and postmenopausal females with MS for osteoporosis, they may overlook the risk of the bone disease in male patients, and especially in individuals who are nonambulatory. It is commonly thought that bone mineral density (BMD) decreases as a patient's disability increases, so it is important to remember that people who are primarily wheelchair-dependent or bedbound are at a higher risk of expedited bone loss simply because they are not building up their bones by ambulating.

Additionally, arthritis is very common in patients with MS as a downstream effect of mobility issues caused by the disease and may frequently be overlooked by clinicians. Although many patients are still very active and can destroy a joint just like people without MS, people with mobility issues are at a heightened risk for arthritis. Because MS can make a limb more difficult to use and thereby hamper movement, patients may compensate by walking or using their upper extremities in ways that are not ideal to promote good joint health. For example, individuals may hyperextend a knee or circumduct a leg while walking, which can exert more pressure on joints and ultimately cause injury over time. Likewise, people with MS who use assistive walking devices, such as walkers or canes, often develop arthritis in their shoulders, neck, or elbows, or experience carpal tunnel issues from the repetitive motion of pressing on the device as they walk.



**Denise Bruen,**  
ANP-BC, MSN, MSCN

## Key Counseling Points on Bone Health

### Identifying and Counseling Patients at Risk for Bone Disease

When I screen patients with MS for bone health, I pay close attention to the major risk factors for osteoporosis. For example, is the patient a white, postmenopausal woman? Does the individual smoke? Does he/she have a past or current history of corticosteroid use? Does the person's diet lack adequate amounts of calcium and vitamin D? Is he/she wheelchair-bound? If the answer is yes to any of these questions, I usually refer patients back to their primary care provider or to an endocrinologist for further screening and treatment. To reiterate from earlier, when patients are non-ambulatory, I have found that they may not be receiving bone-disease screening in the same manner as mobile patients. In these cases, I identify patients who do not walk and confirm with their primary care providers that they will have a bone density scan performed every 2 years.

Although primary care clinicians or endocrinologists typically provide the bulk of treatment for people with MS who have osteoporosis, I still take time to remind my patients during clinic visits on the importance of reducing their risk factors for bone loss and encourage practices to help keep their bones healthy. For example, smoking is the biggest risk factor for osteoporosis that can be modified regardless of age, degree of progression of MS, or sex, so each time a patient who is a smoker visits the clinic, I counsel on smoking cessation.

Additionally, patients with MS, no matter what their physical ability level, should be

encouraged to participate in some kind of exercise or weight training to try to maintain as much bone volume as possible. Remember, any amount of exercise is better than none at all. Even if patients cannot walk, they can still exercise with modifications or participate in light weight training to strengthen their upper extremities and help improve their bone health. Individuals with MS can often benefit through a supervised physical therapy (PT)

*“We want to keep our patients as safe, independent, and ambulatory as possible for as long as possible, and MS nurses are in an excellent position as educators to counsel patients on bone health and strategies to reduce fall risk.”*

— DENISE BRUEN,  
ANP-BC, MSN, MSCN

program that can be custom designed to improve bone health.

### Decreasing the Risk of Falls and Fractures in Patients with MS and Bone Disease

In the MS population, falls are common and are a significant factor that contributes to bone fracture. Along with balance issues, weakness, numbness, and pain associated with MS, some of my patients also have poor vision or problems with depth perception, which can compound the risk for a fall. Fractures have serious consequences in people with MS, and especially in those with poor bone health. Fractures can often transform a person who is mobile with an assistive device to a wheelchair-dependent state because the restricted activity caused by a broken bone may lead to physical deconditioning and a decline in function to a point where ambulation is no longer possible.

Individuals with MS and their families need to be educated and made aware of the dangerous consequences of falls and fractures. We want to keep our patients as safe, independent, and ambulatory as possible for as long as possible, and MS nurses are in an excellent position as educators to counsel patients on bone health and strategies to reduce fall risk.

*(Continued on page 6)*



One of the most important strategies MS nurses can advocate for fall prevention is the use of appropriately fitted assistive devices for walking. A variety of styles of orthotics, canes, crutches, and walkers are available to provide support. I do find that some patients resist using a device due to embarrassment or the fact that they do not want to draw attention to themselves in public. However, I reinforce that these devices can provide needed stability and safety and improve confidence in walking.

MS nurses should also keep in mind that just because wheelchair-bound patients are not walking, they are still at risk for falling and breaking bones. For example, individuals with MS may fall out of bed or a chair, or they may sit down too hard and cause a fracture in their spine. Furthermore, caregivers and family members unintentionally may cause damage to the patient's bones during transfers, so they should also be advised of this risk.

## Tips For Fall-Proofing Home and Environment

**M**any falls can be prevented by identifying key contributing risk factors and then taking steps to minimize or eliminate them. Below is a summary of practical strategies from the National MS Society you can recommend to patients to manage or reduce the likelihood of falls.

### Home Safety

#### Entryways and Doors

- Check entryways and thresholds to identify uneven or slippery surfaces. Keep floors free of clutter and avoid using throw rugs, or affix them securely to the floor with double-sided tape.
- Consider installing railings on both sides of stairways to provide support.
- Install lever door handle hardware that will allow opening the door with one hand and with minimal strength and dexterity.

#### Bathroom

- Install grab bars on bathroom walls and beside tubs, showers, and toilets.
- Consider installing a raised toilet seat to facilitate easier transfers on and off the toilet.
- Apply a non-slip bathtub coating or pad in the shower or bathtub to reduce fall risk while bathing or showering.



- Keep the bathroom well lit. Leave a light on at night, or use a nightlight.
- Place soap in an old nylon that is tied to a grab bar, or use soap-on-a-rope or liquid soap to prevent having to bend down to pick up dropped soap.
- Exposure to very hot water in the shower or bath may temporarily increase fatigue or weakness. Use caution when getting out of the shower or bathtub.

#### Bedroom

- Turn on lights to avoid walking through dark areas, and make sure the light switch is easily accessible.
- Make sure that the light by the bed is within easy reach, or keep a flashlight handy.
- Use nightlights or sensor lights along the path from the bedroom to the bathroom.
- Keep the path clear around the bed and other walkways, and ensure that dresser drawers and closet doors are closed to avoid running into them.
- Keep a phone by the bed with a list of emergency numbers handy.
- If pets sleep in the bedroom, be aware of their location before getting up to avoid tripping over them.

#### Kitchen

- Store frequently used items at a level that avoids stretching, bending, and lifting.

Additionally, consider placing an order for PT and/or occupational therapy (OT) to perform a home evaluation and safety assessment in patients with MS and osteoporosis. PT and OT professionals can assess each room of the patient's home to identify hazards that can be modified to help prevent falls. They can also recommend and prescribe balance-aid equipment, such as grab bars for the shower, bath seats, and bedside commodes and urinals that improve safety and facilitate ease of movement.

Finally, MS nurses should provide patients with practical advice that they can implement into their daily lives to help minimize fall risk. Simple practices, such as making sure that clutter in the home is cleared so items do not impede the walking path, can be essential to preventing falls. That also goes for pets. While pets are our best friends, they sometimes can unintentionally jump up and knock a person to the ground or trip a patient by being underfoot, which may lead to a fall and fracture. 🌐

- Use a long-handled reacher to get lightweight items down from high shelves or to pick things up from the floor.
- Clean up spills on hardwood or linoleum floors immediately. Use a reacher and a towel to avoid bending.

### Stairways

- Install sturdy handrails on both sides of stairways.
- Fix loose or uneven steps.
- Install lights and light switches at both the bottom and top of the stairs and make sure the light is bright enough.
- Periodically check carpets and runners on the stairs to ensure that they are fastened securely.
- Make sure that the edge of each step is easily detectable. Place brightly colored tape on the edge of the steps if needed and consider adding treads or another skid-resistant surface on non-carpeted steps to avoid slipping.



### Additional Living Areas

- Arrange furniture to allow a clear path for walking and in a layout that reduces the number of steps needed to enter and exit the room. Avoid furniture on wheels or with swivels.
- Clear clutter. Shoes by the front door, dog toys in the middle of the floor, or a pile of

wet towels on the floor, for example, can be significant fall hazards.

- Be aware of where pets are in the room to avoid tripping over them.
- Keep electric cords, telephone wires, and other electrical connectors untangled and near the walls and away from walking paths.

### Tips for Staying Safe When Out in the Community

- Wear flat or low-heeled shoes with rubber soles for more solid footing.
- Be especially careful during and after stormy weather. Wear shoes or boots with non-skid soles.
- When moving on slippery surfaces, take slower, smaller steps.
- A heavy backpack or purse can challenge balance. Avoid carrying too much at once.
- Uneven surfaces and changes in ground height are major causes of trips. Even a small change in walking surface of 1/4 inch is enough to cause a trip. Curbs, cracks in the sidewalk, ramps, and single steps pose possible tripping hazards. Stop at curbs and check the height before stepping up or down.
- When taking public transportation, always use handrails when available. Wait until the vehicle stops moving before getting up to exit.

Adapted from "Minimizing Your Risk of Falls: A Guide for People with MS" available at: <https://www.nationalmssociety.org/NationalMS-Society/media/MSNationalFiles/Brochures/Brochure-Minimizing-Your-Risk-of-Falls.pdf>.

# REHABILITATIVE SERVICES FOR PEOPLE WITH MS

**Megan Weigel, DNP, ARNP-C, MSCN**  
**Baptist Neurology, Beaches Division**  
**Jacksonville, Florida**

A comprehensive approach to treating multiple sclerosis (MS) includes not only medical management with disease-modifying therapies (DMTs) to improve symptoms and reduce relapses, but also rehabilitative interventions to stabilize or improve function. Modalities such as physical therapy (PT), occupational therapy (OT), cognitive rehabilitation, speech therapy, vocational rehabilitation, and complementary services such as massage therapy, meditation, or biofeedback help to preserve function and promote overall well-being and quality of life. As MS progresses, the objectives of these services are revised to accommodate patient needs through all stages of the disease. For example, early in the disease course, the focus includes interventions that help patients adapt to physical and psychological changes associated with MS and offer strategies to be more functional at work. Later in the disease process, rehabilitative measures are designed to maximize function and prevent complications.

The following list outlines a few of the rehabilitative programs that have been shown to benefit people with MS.



## Physical Therapy

While exercise training to improve fitness and health is important for everyone, it is especially beneficial to patients with neurological disorders, such as MS, Parkinson's disease, dyskinesia, and others. PT programs for MS are supervised by a physiotherapist and use exercise to prevent deconditioning and maintain muscle mass and bone density. PT exercises are individualized to address the unique motor function ability of each patient and can be home- or clinic-based, or may be offered online through telemedicine.

While newly diagnosed patients with MS typically have low disability scores, as the disease progresses over time and disability increases, they often need a variety of interventions to help with walking and mobility, strength, balance, and posture. Hence, PT also may include gait training and instruction on the use of mobility aids and/or other assistive devices.

In addition to the functional benefits PT can provide, research shows that it and other types of exercise training can also help to improve numerous symptoms of MS, such as fatigue, pain, depression, anxiety, spasticity, and bowel and bladder function. Exercise can also prevent or improve the complications of leading a sedentary lifestyle, such as obesity, diabetes, hypertension, hyperlipidemia, and cerebrovascular disease. Therefore, all patients with MS, regardless of their functional ability, should be encouraged to utilize some type of exercise therapy on a regular basis.

## Occupational Therapy

I refer my patients with MS to an OT program when they begin to notice that they are having difficulty with performing activities of



**Megan Weigel,**  
DNP, ARNP-C, MSCN



daily living (ADLs), particularly those related to mobility, such as ambulation, transfers, bathing, grooming, and dressing. If a patient is right-hand dominant and becomes uncoordinated on his/her right side, for example, it may be difficult to carry out even simple tasks like teeth-brushing or picking up objects. OTs can introduce patients to new methods to perform these types of activities that enhance productivity and independence. I also suggest OT for individuals who experience fatigue while trying to perform ADLs. OTs can coach patients on techniques to conserve energy and instruct them how to use assistive tools and devices to streamline tasks at home and work. For example, if a patient becomes fatigued while trying to cook meals, OTs may suggest a simplified sequence to food preparation that expends less energy by reducing or consolidating some of the steps involved. Likewise, OTs can recommend various assistive and adaptive devices for other ADLs that can help with energy conservation, such as reaching tools with magnetic tips, dressing aids that eliminate the need to bend, or dining utensils that provide greater hand control for individuals with weakness or lack of hand coordination. OT is also useful for people who are affected by cognitive dysfunction and have a hard time organizing and multitasking.

## Speech Therapy

Speech therapy programs assess and treat speech and/or swallowing dysfunctions that result from neurological damage caused by MS. The goal of this type of therapy is to facilitate ease and clarity of speech as well as foster safe swallowing practices.

Speech problems in MS can be caused by spasticity, weakness, and/or lack of coordination of

the lips, tongue, vocal cords, and diaphragm, and may cause slow speaking rate, dysarthria, imprecise articulation or intelligibility, and changes in voice qualities, such as hoarseness. When speech impediments begin to complicate a patient's ability to communicate and hamper his/her quality of life, I refer the individual to a speech-language pathologist (SLP) for evaluation and treatment. SLPs focus on improving muscle function of the mouth and throat and teach patients various therapeutic activities, such as oral motor exercises and voice training techniques, to enhance pronunciation and articulation and manage speaking rate. For patients who have severe dysarthria, therapists may also recommend augmentative and alternative communication (AAC) tools, such as voice amplifiers or "type and talk" devices.

Individuals with MS who experience speech limitations also commonly develop dysphagia. Evaluation of swallowing impairments typically includes a videofluoroscopic study to track the movement of food during the patient's swallowing process and to identify problems with mouth and throat muscle coordination. The test helps the SLP assess limitations in swallowing to provide recommendations on types of foods and food consistencies and textures that are safest for patients to eat. SLPs can also instruct patients how to modify head or body position during eating to make swallowing easier.

## Key Counseling Points on Rehabilitative Services

Although the rehabilitative services available to patients with MS are diverse and can provide

*“I have found that once patients know that I am interested in their welfare, they are often more inclined to continue in a rehabilitative program. I try to encourage them any chance I get by telling them that I support their efforts and am excited to see their progress.”*

— MEGAN WEIGEL,  
DNP, ARNP-C, MSCN

*(Continued on page 10)*

## Rehabilitative Services *(Continued from page 9)*

multiple functional benefits, they are often underused. A top reason for underutilization is lack of access. For example, people with MS may live in rural areas and not visit their MS specialist frequently, so the clinician does not gain insight into the degree of patients' functional decline and, therefore, does not order PT, OT, or speech therapy. Cost is another access-to-care issue that limits the use of rehabilitative services. PT copays can be as much as \$50 or more per visit, so individuals with MS who live on fixed incomes may not be able to afford frequent sessions. There are also restrictions on the number of therapy visits allowed each year for Medicaid and Medicare beneficiaries, as well as individuals with private insurance.

To support patients for whom the out-of-pocket cost of PT is an issue, I make an effort to always keep my eyes open for any type of exercise classes designed for individuals with MS that are offered in my community. I suggest MS nurses become familiar with free exercise services available in their communities that are sponsored by the National MS Society or other local MS centers and keep a list handy to provide to patients. For example, in my city there is a nonprofit organization that offers free yoga classes for people with MS. Additionally, the National MS Society partners with my local YMCA to provide complimentary twice-weekly exercise classes that are tailored to patients with MS. For patients who prefer to work out at home, MS nurses should consider seeking out online resources for exercise programs that are either free of charge or inexpensive. A popular exercise streaming service is available online at: <https://www.msworkouts.com>. This program was developed by PTs and personal trainers and includes a range of exercises for patients with MS of all functional levels, from newly diagnosed to those

in wheelchairs. While this service requires a subscription, the fee is nominal.

In addition to care access limitations, patients may lack motivation to participate in exercise or other rehabilitative interventions or may not realize the benefit in maintaining function without achieving vast improvement. While it is human nature to believe that if there is no improvement, there is no value, I try to educate patients on the benefits of stabilizing function in MS. Similarly, some patients' lack of motivation may stem from embarrassment or anxiety about taking

part in rehabilitation with a disability. In these cases, I try to motivate them by letting them know that nearly everyone, not just people with MS, have functional challenges that they need help with as they get older, and people who proactively address these problems before they worsen oftentimes have an improved quality of life and a sense of well-being. I also add

that exercise is one of the best ways to relieve depression and anxiety without drug therapy.

Above all, MS nurses should remember to stay engaged in patients' rehabilitative progress. I have found that once patients know that I am interested in their welfare, they are often more inclined to continue in a rehabilitative program. I try to encourage them any chance I get by telling them that I support their efforts and am excited to see their progress. Once patients start PT or other rehabilitative services, I ask to see them back in the clinic within 4 weeks to track their advances and to continue to encourage program participation. MS nurses are in an excellent position to facilitate follow-up communication between clinic visits through phone calls and emails. Patients need MS nurses behind them to provide compassion, motivation, support, and cheerleading, and these are the very things that we do best! 🌍





**IOMSN**  
International Organization  
of Multiple Sclerosis Nurses

# 5 Reasons to Join the IOMSN Today

## 1 Professional Development

Each year, the IOMSN provides dozens of webinars, live programs, and print resources that convey the latest evidence-based information on the assessment, diagnosis, and treatment of MS.

## 2 Collaboration

The IOMSN is dedicated to fostering working relationships between nursing professionals. One of many means of doing this is the IOMSN Forum—commonly referred to as the IOMSN Google Group—an online resource for members to exchange ideas, ask questions, and share their knowledge.

## 3 Connections

Participating in IOMSN activities is a great way to network, stay up to date on important trends and career opportunities, and forge enduring professional relationships and personal friendships.

## 4 Support

The IOMSN offers a limited number of scholarships for members preparing to take the MSCN examination. It also provides financial support for members' research endeavors, and provides a host of resources that enhance nursing professionals' ability to advocate for themselves and their patients.

## 5 Recognition

In conjunction with the Multiple Sclerosis Nurses International Certification Board (MSNICB), the IOMSN has developed an examination for registered nurses that leads to designation as an MS Certified Nurse, or MSCN. Additionally, each year the IOMSN recognizes outstanding individual contributions to MS nursing through its annual awards program.

*When you consider the benefits of joining the IOMSN, it all adds up—and we want to count you among our numbers!*



For more information:

- Visit our website at <http://iomsn.org/>;
- Call us at 201-487-1050;
- Email us at [info@iomsn.org](mailto:info@iomsn.org);
- Stop by the IOMSN booth at the Annual Meeting of the CMSC in Nashville, May 30-June 2, 2018

# THE POWER OF SOCIAL MEDIA IN CONNECTING MS NURSES

If you're not on social media, you may be missing out on current events in MS nursing and patient concerns. That's what the IOMSN Communications Committee has learned, according to its chair, Rachael Stacom, MS, ANP, MSCN. "Our IOMSN Google Group or Forum—or Listserv, as we tend to call it—serves an important function for MS nurses working in the real world, where we have to help patients find a medication that works for them, cope with side effects and comorbidities, and deal with a complex healthcare system," she says. "The Listserv is a place where MS nurses can say to their community 'Can I run this by you?' and get responses from other members about how they are dealing with everyday challenges."

The Listserv may be particularly important to members working in rural areas or community settings where they don't have access to local MS experts. "You can pose a question and have fast weigh-in from other nurses about their practice decisions and rationale," Ms. Stacom says. And the forum is truly an international affair: "We recently had a nurse from the United States post a question about how to support a patient with a long-standing history of MS who was diagnosed with neuromyelitis optica, and an IOMSN member from Australia replied," she reports. "The Listserv helps us see how broad-reaching our MS nursing community is. Most of our members are from the US and Canada, but we also have members from Europe, the Middle East, and Australia."

## Expanding to Facebook, Instagram, and Twitter

The IOMSN Communications Committee launched a new initiative on social media—Facebook, Instagram, and Twitter—on February 1, 2018 called #caughtyoucaringiomsn that is designed to celebrate peer-to-peer recognition.

Ms. Stacom shared the group's announcement with *IOMSNNews*:

*"We are constantly hearing about the great things MS nurses are doing for their patients. We*

*also see and hear from our members that the comradery and support we receive from one another is so welcoming and helps keep us in a field that can sometimes be challenging to navigate. We have wanted to share these stories so that they can help motivate, inspire, and sustain us. In that effort, we are starting a new movement, #caughtyoucaringiomsn, so that MS nurses, IOMSN members, or those whose lives are touched by an MS nurse can have a forum to celebrate one another. We hope you will join us as we acknowledge the incredible work MS nurses do every day in big and small ways!"*



**Rachael Stacom,**  
MS, ANP, MSCN

## How to Celebrate an MS Nurse

- Send an email to [caughtyoucaring@iomsn.org](mailto:caughtyoucaring@iomsn.org) or send a message through our Facebook page.
  - Please include a few words on why you are nominating the person. If you have a picture of the nurse, please send that too!
- Please note that IOMSN membership is not required to nominate a nurse. People from all disciplines are welcome to join in celebrating MS nurses. 🌐

## How to Join the IOMSN Listserv

- You must be an active IOMSN member to join.
- Request entry to the group by emailing Leny Almeda at [leny.almeda@mscare.org](mailto:leny.almeda@mscare.org) or by going to the IOMSN website and scrolling to the bottom right part of the page and signing up under the "IOMSN Google Group Signup" form.
- Once your membership status is verified, you will be able to post and receive emails from the group at [iomsrt-forum@googlegroups.com](mailto:iomsrt-forum@googlegroups.com).

# MOTIVATIONAL INTERVIEWING FOR MS NURSES

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University of Calgary MS Clinic  
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You've likely heard of motivational interviewing (MI), a gentle yet effective counseling technique for improving provider-patient communication. In multiple sclerosis (MS), it can help nurses assist their patients in making positive changes in their health behaviors.

MI was first described in 1983 and developed as a brief intervention for problem drinkers. Stephen Rollnick and William R. Miller, two psychologists, and Christopher C. Butler, a physician, authors of *Motivational Interviewing in Health Care*, write that "MI is not a technique for tricking people into doing what they do not want to do. Rather, it is a skillful clinical style for eliciting from patients their own good motivations for making behavior changes in the interest of their health." MI was designed as an empathetic, non-judgmental technique to work in a collaborative way with patients while honoring their autonomy.

Over the past decade, my colleagues and I have come to recognize the value of MI in creating motivation for patients with MS to embrace change.

The most obvious application in MS is in helping our patients adhere to their medications. It's also useful in our discussions with patients who are reluctant to start treatment or who don't accept the need for treatment. MI builds on Prochaska's Transtheoretical Model of Stages of Change—pre-

*“Even if you use just one of the core tenets of MI—effective listening—you'll have made the first step. And I've noticed in my own practice that if I'm truly listening and using MI, I am ultimately more efficient and it's easier to get through my day.”*

— COLLEEN HARRIS,  
MN, NP, MSCN

contemplation, contemplation, preparation, action, maintenance, and termination. It helps providers encourage patients to move along from precontemplation to action to lasting change in achieving a healthier lifestyle.

Cardiac science put MI on the map by showing that effective communication strategies around diet and smoking cessation could change behavior and outcomes. MI is now an important aspect of nursing, particularly for patients with chronic diseases such as MS that require lifestyle changes and medication adherence, and it can be used in both in-person and telephone interactions with adults and children. There have been several clinical studies published showing the value of MI in MS in increasing health-promoting behaviors. In addition, the new buzz phrase in healthcare is "patient-centered care," and the MI communication style ensures that care is centered on the patient.



Colleen Harris,  
MN, NP, MSCN

## RULE: The Guiding Principles

The acronym RULE is used to delineate the guiding principles of MI:

- R=Resist the righting reflex
- U=Understand your patient's motivation
- L=Listen to your patient
- E=Empower your patient

The first tenet refers to the urge to correct another person's course of action, which is often an automatic response, especially since health professionals have a desire to make things right, to heal, and to prevent harm. Commonly, health professionals argue for change and patients resist change—particularly today when patients want to be empowered to engage in the decision-making process rather than lectured on how to improve their health. Instead, MI suggests that we should help patients work through their ambivalence to change.

(Continued on page 16)



### **Motivational Interviewing** (Continued from page 15)

The second tenet encourages the healthcare provider to understand the patient's own reasons for change, as those are the reasons that are most likely to trigger lasting behavior change. Asking "Why would you change and how would you go about doing it?" is one way to engage with the patient around motivation. It is important that the patient rather than the practitioner voice the arguments for behavior change.

The third tenet, effective listening, is actually a complex clinical skill. It involves developing an empathetic interest in making sure you understand what the patient is saying. It's been shown in clinical studies that when effective listening is used, behavior change is more likely.

The fourth tenet, empower your patient, highlights the need to make the patient an active participant in the consultation and the change discussion. Again, outcomes are better when patients take an active interest in their health. They have to make the right decisions and understand why they are making changes in order for lasting change to be created.

### **Communication Styles**

Three main communication styles have been identified for healthcare encounters. You may shift between these styles a number of times as appropriate during a single visit with a patient.

- **The Following Style** centers around listening, seeing, and understanding through the patient's eyes and allowing the patient to take the lead.
- **The Directing Style** is one in which you as the healthcare provider take charge. It acknowledges that there is an uneven relationship between the participants in

the conversation, with you, as the expert, having greater knowledge, expertise, and authority. This approach may be needed to save lives, and patients may depend on you to adopt this style in certain situations.

- **The Guiding Style** is well-suited to helping people solve behavior change problems, acknowledging that in human relationships you can influence that which you do not personally control. MI is a refined form of guiding—for instance, you as the healthcare provider have a specific behavior-change goal in mind and you gently guide the patient to consider why and how he or she might pursue that goal.

### **Core Communication Skills**

Three core communication skills can be developed using MI principles: listening, asking, and informing.

**ACTIVE LISTENING:** This is a true skill that can be difficult to develop. Roadblocks to effective listening to patients can include agreeing, disagreeing, instructing, questioning, warning, reasoning, sympathizing, arguing, suggesting, analyzing, persuading, approving, shaming, reassuring, and interpreting.

The following scenario highlights an active listening style characterized by reflecting back what the patient is saying:

**Patient:** I just hate these pills. I mean, I take them most of the time, but there are days that I just can't stand the thought of taking one more pill to control this stupid disease, and now I am going to pay the price.

**Practitioner:** You are feeling that the reason you are having a relapse is because you miss taking your medication at times and you are perhaps feeling a bit guilty.

**Patient:** Yes, guilty and a bit scared.

**ASKING:** It is essential to ask open-ended questions to elicit the greatest amount of information from patients. For instance, instead of asking "Have you been taking your medication regularly?" a closed question that will produce a "yes" or "no" response, you might have the following conversation around medication adherence:

**Practitioner:** How have you been doing? (open-ended question)



**Patient:** I am hanging in there except when I have a relapse...

**Practitioner:** What happens then? (open-ended question)

**Patient:** Well, I get really scared that my medication isn't working and I am going to end up in a wheelchair.

**Practitioner:** Why do you think your medication is not working? (open-ended question)

**Patient:** Because I don't always take my pills.

**INFORMING:** This is a skill that all healthcare providers are familiar with and can take the form of telling the patient what happened or is going to happen, clarifying, breaking bad news, sharing evidence, obtaining informed consent, and giving advice. Although we are experts at informing, we must recognize that patients may not hear what we have to say because they are too bewildered, passive, depressed, or anxious to absorb the information. The MI paradigm instructs that to be an effective informer, you must give information at a slow-enough rate that the patient understands it, and you should strive for an information exchange rather than an information download. Consider the priorities of the patient, work in positive, hopeful messages, and deliver the message

with care. It's also important to ask permission to inform before diving in—the patient must be willing and ready to receive information or your efforts will be for naught. It's helpful to also offer choices, such as “Sometimes it is easier to start your site rotation from leg to leg and then go to the abdomen, but it would be fine to start on your arms as well.” Finally, you might want to talk about what others do: “Some patients find taking the medication at night works best for remembering, but others like to take it in the morning after a shower.”

Two other strategies for informing include:

**The Chunk-Check-Chunk Technique.** When you utilize this technique, you provide a chunk of information, check to make sure the patient understands it, and then provide another chunk, and so on.

Here's a sample conversation in the Chunk-Check-Chunk Technique:

**Practitioner:** In order to reduce the number and severity of your relapses, it is important to take your medication as directed.

**Patient:** I know, but I find it hard to take pills every day.

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## MI Resources

**A**s nurses, we have been trained to be empathetic listeners, so you may already be incorporating some MI techniques into your interactions with patients. If you'd like to learn more, you can enroll in an intensive in-person or online course, visit MI-related websites, and read MI texts like the ones listed below.

### Books

- Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Health Care*. New York, NY: Guilford Press. 2008.
- Fuller C, Taylor P. *A Toolkit of Motivational Skills*, 2nd ed. London, UK: Wiley & Sons. 2008.

### Online

- SAMHSA: Enhancing Motivation for Change in Substance Abuse Treatment. [https://www.ncbi.nlm.nih.gov/books/NBK64967/pdf/Bookshelf\\_NBK64967.pdf](https://www.ncbi.nlm.nih.gov/books/NBK64967/pdf/Bookshelf_NBK64967.pdf)
- SAMHSA-HRSA Center for Integrated Health Solutions: Motivational Interviewing. <https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing>
- Motivational Interview: All About Motivational Interview. <http://motivationalinterview.net/clinical/whatismi.html>
- Motivational Interviewing Network of Trainers. <http://motivationalinterviewing.org/>
- Professional Patient Advocate Institute: Motivational Interviewing: An Emerging Trend in Medical Management. An Action Guide to Eliciting Powerful Behavior Change. [http://www.patientadvocatetraining.com/wp-content/themes/patientadvocate/static/pdf/ppai\\_specialreport\\_mi.pdf](http://www.patientadvocatetraining.com/wp-content/themes/patientadvocate/static/pdf/ppai_specialreport_mi.pdf)

# MEMBERPROFILE

Barbara Bishop, MS, ANP-C, MSCN, CNRN



## WORKING AS AN MS NP IN A COMMUNITY SETTING

If you ask Barbara Bishop, MS, ANP-C, MSCN, CNRN, about the advantages of working as a nurse practitioner (NP) in a private neurology practice versus a hospital or multiple sclerosis (MS) center, she'll keep your ears buzzing. Ms. Bishop has worked in a community setting for close to three decades—and she wouldn't have it any other way. "Although I don't have the luxury of having multidisciplinary resources—a physical therapist, an occupational therapist, a social worker—right in my office, or even just next door, as you do at an MS center, I like that I can be both the nurse and the NP to my patients," she says. "I can offer nursing care, as well as diagnose and prescribe. I also like the autonomy of the small practice setting and that I can manage my schedule as I like." On the downside, Ms. Bishop says that the worst part of being in a community setting is dealing with insurance companies. "It's exhausting," she explains. "In MS centers and hospitals, you have a billing department and someone who is assigned to do preauthorizations for medications. But I have to steer that ship myself in my practice."

Ms. Bishop, who works at Virginia Beach Neurology, is the MS expert in her office, which consists of two neurologists and herself. "I have about 300 to 400 MS patients in my practice, and two-thirds of the MS patients who visit the office see me," she says. On a daily basis, that translates to about two or three people with MS out of 15 daily visits on her schedule. "Another thing I like about being in the community is that I am in a general neurology practice where I see patients with other neurological conditions, such as Parkinson's disease (PD), Alzheimer's disease, migraine, and neuropathic pain. That keeps things interesting for me and gives me a broad perspective about neurologic disease that extends

beyond MS and allows me to think outside the usual pathways." For example, if a patient with MS has an unusual presentation, such as falling without significant weakness or balance problems, she might use a paradigm from another pathology to assess the problem. "I start to think about cardiovascular pathology, such as orthostatic hypotension, which we frequently see in patients with PD, or heart arrhythmias, or epilepsy as a possible cause," she explains. "I have a patient who has a traumatic spinal cord injury, MS, and a recent diagnosis of lung cancer, which is currently in remission. He started arguing to me that his disease-modifying therapy (DMT) was not working and he was having episodes daily where he would end up on the floor because his legs gave out and it would take minutes to hours before he could get up and it was always worse in the heat." Ultimately, Ms. Bishop discovered that the patient had rather significant autonomic hypotension that was probably attributable to a late effect of the spinal cord trauma and had



nothing to do with his MS or the efficacy of the DMT he was using.

Likewise, she says that patients with MS often come to the office thinking they are having a relapse consistent with optic neuritis when in fact they are having ocular migraine or visual aura associated with classic migraines or possibly symptoms related to a transient ischemic attack. “Sometimes our patients are developing another disease in addition to MS, and the symptoms can be difficult to tease out. For example, I have patients who have MS who ultimately are diagnosed with PD, gammopathies, neuropathies, or early-onset Alzheimer’s (as opposed to MS-related cognitive impairment),” she says. Having an in-depth background in understanding other pathologies and associated presentations helps her to do a comprehensive differential diagnosis, which is essential to getting to the right diagnosis and, ultimately, the correct treatments for patients.

### The Road to an MS Specialty

Ms. Bishop, who was in the inaugural Multiple Sclerosis Certified Nursing (MSCN) class of 2005, obtained her nursing degree from Pennsylvania State University and her NP degree from the University of Maryland in Baltimore. “I started in the neurocritical care unit at Johns Hopkins Hospital while I was getting my master’s degree. Most NPs at the time I graduated went into primary care, but I gravitated toward internships where I was treating neurology outpatients. I’ve never worked in a large MS center—they were few and far between when I started my career anyway, and Kathy Costello had that position wrapped up already at the University of Maryland!—and I always knew I wanted to work in a community-based neurology practice,” she explains. She connected with Terry Dietrich, a neurologist with an interest in MS practicing on Maryland’s Eastern Shore, and worked with him in the early 1990s before coming to Virginia Beach in 1995. She first joined a large practice in the area, Southeastern Neurology, before moving to Virginia Beach Neurology in 2000.

Since she began her practice, the most exciting development has been the vision of hope for a normal life that clinicians can now offer people with MS. “Clearly, our understanding of MS

“*The paradigm has shifted from the idea that the disease is going to get worse, to one where it’s not acceptable if a patient is progressing. We have become much more aggressive in managing MS and starting treatment as early as possible, and we’ve had to step up our risk tolerance in relation to treatments.*”

— BARBARA S. BISHOP,  
MS, ANP-C, MSCN, CNRN

has changed and we know that it is not a quiescent disease as we once thought. Even the definition of the disease has changed: We called it a neurological disease at first. Now we refer to it as an autoimmune process that targets the central nervous system, impacting both the white and gray matter,” she says.

In addition, she notes how the DMTs have changed the course of the disease.

“The paradigm has shifted from the idea that the disease is going to get worse, to one where it’s not acceptable if a patient is progressing. We have become much more aggressive in managing MS and starting treatment as early as possible, and we’ve had to step up our risk tolerance in relation to treatments.”

In keeping with that, she notes that “The newest DMTs have forced MS providers to have an understanding of immunology, rheumatology, oncology, and hematology to keep up with the diverse mechanisms of action, adverse effects, and monitoring needs with their use,” she says. “There has been a big shift in the risk profiles from the injectable DMTs to the newer oral and infusible drugs. But it’s been very exciting, and the treatment of MS has progressed seemingly exponentially, and it continues to develop.”

### IOMSN Matters

Ms. Bishop is a long-standing member of the IOMSN and grateful for the connection, stating unequivocally, “I am where I am today because of the IOMSN and its founding members like June Halper and Pat Kennedy. Being part of the

*(Continued on page 22)*

# FROM MY PERSPECTIVE

Patricia M. Kennedy,  
ANP, MSCN



## PATRICIA M. KENNEDY, REFLECTS ON AN MS NURSE'S CAREER

Throughout her 30-year career in MS as a nurse practitioner (NP), Patricia M. Kennedy, ANP, MSCN, says she has witnessed many exciting improvements in MS care.

“When I started working in MS in the 1980s, there weren’t medications for which people with MS could be hopeful,” she says. “We tried to make patients’ lives better through a lot of counsel-

*“Nurses involved in the MS field are very knowledgeable, but we all have strengths and expertise in different areas. No one alone can have all the answers. The more we collaborate and share our knowledge with one another, the wiser we become.”*

— PATRICIA KENNEDY,  
ANP, MSCN

the introduction of the first disease-modifying therapies (DMTs). The expanded understanding of the disease and the advances in drug devel-

ing, rehabilitation, and family interventions, and used corticosteroids to manage symptoms, but in the absence of effective and safe treatment options, patients typically faced a devastating decline in function and a grim quality of life.”

Ms. Kennedy says that the face of MS began to change in the 1990s. The field ballooned with the development of new technology to detect and measure MS and with

opment fundamentally altered the approach to treating MS and dramatically improved patient function. She recalls that prior to the mid-1990s, the waiting room at her practice was full of people with MS with walkers and crutches, in wheelchairs, and even on gurneys. “By 2000, that had changed, and I watched my waiting room transform to one that held far more mobile individuals, fewer patients in wheelchairs, and no people on gurneys. It was so encouraging and a very exciting time,” she says. “We finally had treatments that could significantly reduce relapses and provide hope of an improved quality of life for patients.”

While the Food and Drug Administration (FDA) approvals of DMTs represented a major medical breakthrough in MS treatment, Ms. Kennedy admits that learning the science of the new therapies and their efficacy and safety profiles, while still being responsible for caring for patients on a daily basis, was challenging. “When MS strikes, no matter what you are trying to learn as a clinician, the fact remains that patients wake up every day and still have MS and need your help,” she explains. “I had to figure out how to come up to speed on the science of new drugs and concurrently continue to take care of patients’ individual needs that I had been taking care of all along when we had no treatments. Although the DMTs that became available at that time were a major step forward in treatment, patient education and counseling on drug therapy began to become much more complicated.”

## Coping with Today's Challenges in MS Nursing

When Ms. Kennedy accepted a position in 1986 as an advanced nurse practitioner (ANP) at the Rocky Mountain MS Center in Denver, Colorado, she says she knew very little about MS. "Although I had been a nurse since 1964, and an adult gerontology NP since the 1970s, becoming knowledgeable about MS was a big mountain to climb—the learning curve was so steep," she says.

She believes the learning curve remains steep for MS nurses who are starting out in practice, and the expanded responsibilities entailed with their jobs related to all of the treatment options are more demanding than when she first started in the field.

"An MS nurse in today's clinical environment really does have to be a cut above the rest in many ways. Not only are MS and its treatments extremely complex, but MS nurses face additional issues involved with the job, such as drug monitoring, imaging tests, and insurance reimbursement, that present them with a heavy load to carry," she says. "Among the many responsibilities they have to juggle, above all, nurses have to ensure that patients and their families receive the counseling and education necessary to function and cope with the disease."

To effectively address the needs of patients with MS and their families today, Ms. Kennedy advises that nurses keep the whole patient in view and think outside the box. "This has always been my motto because MS patients do not fit in a box," she says. "As a provider you have to be creative and determine alternative ways to help patients as their disability progresses and activities of daily living become harder for them to do," she explains. "For example, if patients are working, think of ways to help them stay active and continue to work for as long as possible. Also, think about resources that you can provide to patients' families that help them cope with liv-

ing with a loved one with MS on daily basis." For ideas, Ms. Kennedy suggests that nurses start by connecting with the local community to seek out available services. "Make an effort to search the community for programs and events that are available to patients and become a resource expert," she says. "Be the person patients and their families come to when they need answers on, for example, rehabilitation services, support groups, wellness workshops, or exercise classes that are offered in the community."

Additionally, she urges MS nurses to never stop learning and to take advantage of educational opportunities provided by the International Organization of MS Nurses (IOMSN) and other professional MS organizations. "Educational programs and workshops not only improve your knowledge and keep you up to date on MS sci-



ence and patient management, but also serve as ideal opportunities to network and make friends with others who face the same hurdles in clinical practice," she explains. She says that having a network of MS professionals that she could turn to was beneficial when she faced challenges throughout her career. "Sometimes I would be absolutely perplexed about a patient or treatment issue, but if I picked up the phone and called one of my colleagues that I had met at an IOMSN meeting, together we almost always came up with a solution," she says. "Nurses involved in the MS field are very knowledgeable, but we all have strengths and expertise in different areas. No one alone can have all the answers. The more we collaborate and share our knowledge with one another, the wiser we become." 🌐



**Member Profile** (Continued from page 19)

IOMSN and getting my MSCN certification gave me credibility in the medical and patient communities as an MS expert.” She notes that the MSCN exam is very comprehensive and challenging, covering the basics of MS, pharmacologic and nonpharmacologic treatments, symptom management, psychosocial assessment and intervention, research and education initiatives, and patient advocacy. In addition, she recalls that when she sought her MSCN certification, there was minimal to no fellowship training in MS for physicians. “Doctors specialized in MS mostly by default because they had an interest in it rather than training,” she explains. “The IOMSN took the lead and set the standard for MS training and specialization.” Today, there are MS fellowships for physicians but still none for nursing, nor is there an undergraduate or graduate MS track, so the MSCN remains the only way to show that you, as a nurse, are an expert.

Ms. Bishop also appreciates the standards of care established by the IOMSN and Consortium of Multiple Sclerosis Centers (CMSC), and the flow of information from the two organizations to providers all over the country and the world. “It takes longer to change the quality of care in the community setting than in an academic or hospital setting, and it’s up to individual providers to push the community along to adopt new diagnostic and monitoring methods and treat-

ments,” she says. “In these scenarios, it’s really helpful to have the IOMSN standards that we can refer to when talking with other providers.”

Ms. Bishop is an active participant on the IOMSN Listserv (also known as the IOMSN Forum or Google Group; see page 12 for more details). “Sometimes I feel isolated in my practice—the closest university to Virginia Beach is in Richmond two hours away—and participating in the forum allows me to ask other IOMSN members for their opinion on tough cases and to pick their brains to see how they are handling common management chal-

lenges,” she says. “I also appreciate the opportunity to share my knowledge with other members and weigh in on other people’s posts.”

Even though she enjoys it, she regrets that she is not able to attend the Annual CMSC Meeting in person every year. “Unfortunately, I don’t get an educational stipend from my practice the way a provider does at an MS center, a hospital, or a university. I try to attend the meeting whenever it is close by, like a couple of years ago when it was in the Washington, DC/Maryland area, but often I have to miss it. That’s too bad, because I find it to be so worthwhile—not only for the opportunity to network with other MS providers face to face, but for all of the educational and research presentations. But my income is based on my productivity, and if I am away at a meeting, I don’t get paid for that time,” she explains, adding that because of that, the IOMSN is all the more important to her. “I keep up to date by visiting the website and utilizing the resources there and participating on the Listserv.”

Ms. Bishop encourages new MS nurses to also take advantage of IOMSN resources, such as the mentorship programs and the liaisons who are available in several regions across the country. “The best thing you can do is to find a strong mentor to help you move along professionally so you don’t get frustrated. There’s a lot to know, and you won’t become an expert in MS in a year, so be patient and keep learning,” she advises. 🌐



**Practitioner:** Yes, I know, but you need to have the medicine in your body to have it impact your immune system. How many pills are you missing?

**Patient:** Well, a few.

**Practitioner:** We may need to consider another treatment if you are unable to take the medication on a regular basis.

**The Elicit-Provide-Elicit Technique.** Another technique entails asking an open-ended question to focus your informing, providing the information the patient requires, and then asking another open-ended question to determine the patient's response to the information provided. A typical scenario might unfold like this:

**Practitioner:** How are you feeling about your medications and injections?

**Patient:** I am trying to take the shots on a daily basis.

**Practitioner:** It is not easy to self-inject. Are you having trouble with the shots?

**Patient:** Sometimes—big trouble. It hurts and reminds me of this stupid disease.

**Practitioner:** It's important to take the shots daily. There are strategies to help with the discomfort. Have you been told about them?

**Patient:** Well, maybe, but can you tell me again?

## In Summary

Having read through this article, you may be saying that you don't have time to learn a new communication technique and incorporate it into your encounters with patients. But even if you use just one of the core tenets of MI—effective listening—you'll have made the first step. And I've noticed in my own practice that if I'm truly listening and using MI, I am ultimately more efficient and it's easier to get through my day.

You can keep doing what you're doing and trying to educate patients, even those who don't want to be told what to do by a health-care provider, but if you don't really home in on a patient's motivation, he or she may simply keep doing the same thing over and over again and never make an intentional behavioral change. And you'll be stuck on the hamster's wheel along with this patient, which can be frustrating and disheartening for you as a provider. Yes, there is a learning curve with MI. Yes, you may feel a tad awkward when you start using MI techniques with your patients. But you will also find that using these techniques transforms your practice and your relationship with your patients for the better. 🌍

## IOMSN Resources at the Ready!

The IOMSN is dedicated to helping MS nurses advance in their careers and take on new challenges. Here are some of the resources you can take advantage of as a member.

- IOMSN Mentorship Program
- Nurse Leadership Program
- IOMSN scholarships to fund members to prepare for the MS Nursing Certification (MSCN) exam and attend CMSC and IOMSN meetings, and to support research projects that advance MS nursing research



- Clinical practice guidelines
- Enduring materials, such as *IOMSN*News, the *International Journal of MS Care*, and *MS Counseling Points*
- Patient education materials, including the website *LiveWiseMS.org* that focuses on management of MS symptoms, and the patient publication *MS Perspectives*
- Online, complimentary CE modules
- Webinars
- IOMSN Forum (Google Group or Listserv)
- Annual and regional meetings

For more information, call 201-487-1050, or visit <http://iomsn.org>