Using Motivational Interviewing to Support Individuals with Complex Health Needs:

A Spotlight on MMM of Puerto Rico and Camden Coalition

What is Motivational Interviewing?

Motivational interviewing (MI) is a person-centered approach that health care providers can use to explore their clients' priorities and values. MI emphasizes creating partnerships in which providers acknowledge individuals' autonomy and foster supportive relationships grounded in trust and mutual respect.[1,2] This allows individuals to collaborate with their providers to identify actions that align with their health improvement goals.

Individuals with complex care needs—for example, multiple physical chronic conditions, behavioral health challenges, or significant social needs—often use health care services at higher rates and experience poorer outcomes than their peers.[3,4] Health plans pursue a range of approaches (e.g., intensive care management, interdisciplinary care teams) to proactively engage with such enrollees and connect them to services that address their full range of needs.[5] Research suggests that, regardless of the specific engagement strategy, clinicians who support their patients in gaining the knowledge, skills, and confidence needed to fully engage in their treatment realize better outcomes. This concept, referred to as patient activation, can strengthen a person's preparedness and commitment to managing their own health.[6,7]

Compared with enrollees in Medicare alone, individuals dually eligible for Medicare and Medicaid require more complex care, have higher rates of unmet social needs, and have poorer health outcomes—all while facing the added burden of navigating two programs to access services.[8,9,10] These factors can impede their level of patient activation and their confidence in making care decisions.[11,12] Motivational interviewing (MI) is a style of communication that differs from traditional top-down clinical consultations in that it recognizes and promotes the individual's expertise in their own lives.[13] The "spirit" of MI includes four key elements: partnership, evocation, acceptance, and compassion.[14] MI aims to identify and overcome a person's ambivalence by eliciting their internal motivation to change. In so doing, it offers an evidence-based approach for building trusted, supportive relationships that facilitate ongoing engagement, activation, and health-promoting behaviors across a broad range of conditions.[15,16] Health plans are increasingly interested in engaging dually eligible individuals via MI because of its potential to enhance care coordination efforts.

Resources for Integrated Care had the opportunity to meet with representatives of two organizations that serve dually eligible populations and people with complex care needs:

- *Gladys Antelo-Allen, LPN, Associate Director of Education and Training with **Camden Coalition**'s National Center for Complex Care and Social Needs, and*
- *The following leaders from **MMM of Puerto Rico**:*
  - *Dharma C. Lacén Carrión, MSW, Assistant Vice President of Mental Health Operations*
  - *Dr. Jose Ortiz, MD, Medical Director of the Integrated Mental Health Department*
  - *Mario Beltran, MHS, MBA, Regional Director of Mental Health*

Read on to learn how they successfully incorporate MI into their work with dually eligible individuals.

The Organizations - MMM of Puerto Rico (MMM) and Camden Coalition

MMM of Puerto Rico

Using MI to Engage Individuals in Better Managing Their Conditions

MMM is a Puerto Rico-based Dual Eligible Special Needs Plan (D-SNP) serving more than 380,000 individuals dually eligible for Medicare and Medicaid (i.e., 77 percent of MMM's total client population).

MMM developed an MI program, targeting individuals with a primary diagnosis of Type 2 diabetes and a secondary diagnosis of depression. Consisting of up to six one-on-one counseling sessions, this program aims to help individuals better manage their diabetes and reduce medical costs.

Camden Coalition

Using MI to Build Authentic Relationships

Camden Coalition is a community-based nonprofit organization located in New Jersey, whose mission is to improve the health and well-being of individuals with complex health and social needs by providing person-centered and data-driven care.

For over a decade, Camden Coalition has integrated MI strategies throughout its organizational culture and daily interactions. In doing so, it seeks to deepen the relationship between individuals and their care providers and to support whole-person health.

Organizational MI Perspectives

The following text reflects the questions Resources for Integrated Care (RIC) posed to representatives of MMM and Camden Coalition, as well as their responses. RIC specifically asked about how each organization developed, piloted, and refined their distinct approaches to using MI, as well as lessons learned throughout their implementation processes.

RIC: How did your organization initially explore using MI?

MMM: We had previously used MI for successful substance use disorder (SUD) treatment and wanted to leverage that experience in the primary care setting. Diabetes is highly prevalent in our population, affecting roughly 30 percent of our enrollees. Population health data suggest that patients with diabetes have an elevated risk of depression, which can exacerbate their physical and mental health challenges, increase medical costs, and impede their drive to meet their own health needs.[17,18,19] Knowing that the American Diabetes Association endorses MI as an effective strategy to engage people with both diabetes and depression, we recognized an opportunity to improve outcomes by focusing our MI efforts on these enrollees.[20]

Camden Coalition: Our care management team is responsible for supporting and coordinating care for individuals following a hospital discharge and upon return to the community. When we started using MI over a decade ago, we knew we wanted to use a community-based, person-centered approach, which we think works well with our clients: individuals with complex health and social needs that include mental health conditions or SUD and a history of trauma. So, we launched multiple pilot programs and quickly determined what skills our staff needed to support these individuals. We identified MI as a key approach we could incorporate into our existing services.

RIC: Once your organization decided to use MI, how did you start integrating it?

MMM: Our approach was to create a small MI pilot program for enrollees with poorly controlled diabetes and moderate to severe major depression. We designed the pilot to include up to six MI sessions, led by MMM's MI-trained behavioral health (BH) providers. Our team also created a structured facilitation manual for the BH providers leading those sessions. The MI manual offers a standardized curricula and explains evidence-based MI practices alongside specific example scenarios. Eligible enrollees attended individual MI sessions about every two weeks, either via telehealth or at in-person visits. BH providers used the MI manual to guide their sessions with the enrollees; they also documented enrollees' participation, along with details about the specific intervention and appropriate diagnosis codes, in the individual's electronic health record.

We also share ongoing education about MI with primary care providers (PCPs) who see our enrollees so that they can support individuals' diabetes management and BH needs. We find that this continued engagement helps providers address both physical and BH conditions with equal attention.

Camden Coalition: Our earlier efforts also targeted individuals diagnosed with poorly controlled diabetes. Our interdisciplinary team took a training on MI principles and foundational engagement skills that draws from the Transtheoretical Model's Stages of Change—which suggests that facilitators should tailor the MI strategies to individuals' level of motivation to take action.[21] We then administered the University of Rhode Island Change Assessment Scale (URICA), a readiness-for-change self-assessment tool, to identify where on the readiness continuum individuals were regarding managing their diabetes.[22] After evaluating the results, we invited those individuals to participate in regular MI sessions that focused on helping them identify and follow through on actions they could take to better manage their diabetes and ultimately reduce their hemoglobin A1C levels.

RIC: What did you learn from your pilot programs about using MI?

MMM: We found MI to be a useful tool for us. The 945-participant pilot resulted in improved health outcomes over a 12-month period. Based on that, we expanded the program to 92 primary medical groups serving 3,732 individuals. We continued tracking specific clinical data (e.g., hemoglobin A1C levels) and financial indicators (e.g., per-enrollee, per-month costs) and compared the six-month intervention period to the six months prior. Noting that a normal A1C level is below 5.7 percent,[23] MMM found that 96 percent of pilot participants with an A1C level between 8.0 to 9.0 percent either experienced improvement or saw no deterioration in their A1C levels; it also identified that 30 percent of pilot participants in the most severe category (i.e., nine percent or higher) saw improvements in their hemoglobin A1C level. From a financial perspective, relative to a control group, MMM saw a 15 percent reduction in pilot participants' medical costs, even after accounting for increased medication usage.

Camden Coalition: We worked closely with a team of academic researchers to identify and define the characteristics and role of authentic healing relationships in care management through a mixed-methods evaluation of 30 individuals with complex health and social needs.[24] The researchers interviewed participants about their experiences working with the Camden Coalition's care team and concluded that the providers' ability to build trusting relationships with participants positively influenced the participants' motivation to change behaviors and better manage their health.

That link tying an individual's relationship with providers to their engagement in self-care prompted us to think creatively about other opportunities to replicate this experience. The core skills providers use in MI, like asking open-ended questions to truly learn the individual's story and offering judgment-free responses, are key drivers of the kind of authentic healing relationships we want to encourage throughout our organization. With this realization, Camden Coalition trained all staff—from administrative team members to clinicians to executive leadership—in MI techniques, which we infuse into our interactions with patients, community partners, and stakeholders alike. It is important for everyone to have an understanding of MI that is appropriate to their roles. For example, while social workers receive in-depth skill-building training because of their robust engagement with enrollees, we train all staff in MI because it is everyone's responsibility to contribute to a person-centered culture.

RIC: What did you learn from your experience implementing MI?

MMM: We learned valuable lessons about successful MI implementation. For example, we realized we had to preemptively communicate the value of our MI initiative by providing targeted educational outreach to PCPs. We conveyed MI's value in addressing both physical and BH, since they affect each other, and also noted its potential to reduce primary care costs. We came to understand that engaging PCPs in the BH referral process was critical to recruiting participants, especially given some possible cultural sensitivity around BH service use.

Using MI to Deepen Person-Centered Care and Change Organizational Culture

"MI shifted the way I approach the people we serve. I now try to see things from their perspective versus trying to fix everything for them. MI has taught me how to be patient and connect with the person."

- Gladys Antelo-Allen, LPN, Associate Director, Education and Training, Camden Coalition

We also discovered additional benefits that the MI program offered program participants beyond the scope of our pilot. Because MI encourages the individual to consider social and environmental factors affecting their health, we found that participants cultivated a deeper understanding of their broader needs, which we believe will help make the improvements in their hemoglobin A1C levels sustainable.

Camden Coalition: One of our learnings was that MI is not a one-size-fits-all solution and that a prescriptive MI protocol is not the most universally effective approach in every situation for our complex population. Instead, we must be flexible and draw from various tools to best serve each person's unique circumstances. We would not employ MI with someone in an acute crisis, for example, but once the urgency passes and the individual is ready to address long-term goals, MI could be a great technique for them.

RIC: What recommendations do you have for health plans considering MI as a strategy to better serve dually eligible individuals?

MMM: A first recommended step would be to ensure you have a thorough understanding of the population you serve—including common comorbidities and factors contributing to adverse outcomes. You can then use those insights to help select a goal that targets a high-priority challenge. Once selected, we recommend consulting with organizations with expertise in areas aligned with your goals

(e.g., the American Diabetes Association) to determine if they endorse MI as an evidence-based method for promoting health improvements specific to the condition you plan to target. We found this endorsement facilitated leadership buy-in for the program. It is also important to share the vision for using MI with staff and to offer educational resources that help familiarize them with the approach.

In reflecting on the MI program, several early steps bolstered our success. We established specific, measurable, achievable, relevant, and time-bound (SMART) goals and designated clear and measurable key performance indicators (KPIs) that we shared with providers. This helped align everyone involved, focused our efforts, and established parameters that supported our subsequent program evaluation. We also suggest piloting an MI intervention to learn what works well with a small population, then use that knowledge to establish (and continuously improve upon) standardized processes before expanding MI efforts more broadly.

Camden Coalition: An important factor in our success was leadership buy-in, which promoted buy-in among supervisors and frontline staff alike. Buy-in helped ensure access to the resources we needed to support the work. Ultimately, our use of MI supported our organization's person-centered culture. As a small organization, it may have been easier for us to affect organization-wide culture change among our 80 employees; we would suggest larger organizations consider opportunities to leverage existing supports to help affect culture change. That said, in each client interaction, we used MI to help us transition away from *transactional* activities (e.g., checking boxes on a form) to *relational* activities (e.g., having a conversation with the individual to understand their unique experiences and needs). This is a shift all plans and providers can make at different scales using MI.

Finally, plans and providers may wonder about the time commitment required to add MI to other enrollee interaction and care activities. While all providers have limited time, we found that once you begin weaving MI into conversations and workflows, it becomes a natural part of the process. We leverage key frontline staff (e.g., certified medical assistants, licensed practical nurses), who typically spend more time interacting with individuals, and empower them to build strong relationships by using MI techniques.

Summary and Reflections

MMM and Camden Coalition's experiences illustrate that MI can be a complementary or additive modality within a broader toolbox of person-centered practices that promote positive outcomes for dually eligible individuals. Moreover, the distinctive ways that MMM and Camden Coalition used MI techniques to improve patient activation and agency—that is, MMM's approach of training providers in a primary care setting using a formal MI curricula and Camden Coalition's approach of training all staff and infusing MI as a tool to support building authentic healing relationships—offer a view into MI's versatility. Both organizations started their journey by identifying MI as a good fit for their respective populations, establishing organizational buy-in, and selecting a target population of individuals with both diabetes and BH diagnoses for their pilot efforts. They then used MI to understand and attend to each enrollee's individual needs and, in doing so, strengthened their person-centered culture.

Below are questions that plans and providers may consider prior to incorporating MI into their services to support individuals and promote a person-centered culture.

Embedding MI into your Services: Questions for Consideration

- What common health challenges or diagnoses does your enrollee population experience that you might target with an MI intervention? What unique needs do such individuals in your community experience? How might using MI support these individuals?
- What are your organization's specific goals—for example, improving care utilization, cost savings, health outcomes—in implementing an MI program?
- Do you have buy-in from your leadership and from frontline staff for an MI intervention? If not, what steps can you take to secure it?
- What resources and structures exist within the organization that you can build upon to create an MI program? What new resources and structures might you need?
- Who will need MI training? What options do you have to ensure that the appropriate providers or staff receive that training? What ongoing coaching and support can you provide?
- How might you leverage and integrate staff members' existing skills into your MI approach?
- What data are available to track progress and measure success? What KPIs might you use to monitor the program?

Resources to Support the Adoption and Use of MI

Health plans and providers serving dually eligible individuals that are interested in embedding MI into programs and services may find the following useful.

The RIC website offers resources on MI with dually eligible populations:

- Integrated Care in Action: Foundations of Motivational Interviewing: This podcast explores how providers, including care managers and community health workers, can use MI to engage clients in a wide variety of settings—behavioral health care, primary care clinics, and communities. It provides details on MI—what it is, what it looks like in action with individuals, and how it fosters positive behavior change.
- Motivational Interviewing Podcast Resource Guide: A companion to the *Foundations of Motivational Interviewing* podcast, this resource guide provides information on how individuals working in a variety of settings, including frontline staff at health plans and health systems (e.g., care managers, care coordinators, community health workers), as well as PCPs, can use MI.
- Promising Practices for Utilizing Motivational Interviewing (MI) to Improve Care Coordination and Address Social Determinants of Health (SDOH): This webinar explores how MI can improve communication in integrated care settings and relationships between health plans, providers, and dually eligible individuals; promote the increased utilization of MI and person-centered techniques to better engage members and understand the complex lifestyle factors that impact health behaviors; and encourage the improvement of member retention rates as well as health outcomes for dually eligible individuals.

Government agencies and professional organizations offer additional MI resources:

- This Motivational Interviewing brief from the Administration for Community Living provides considerations for organizations interested in adopting MI—including cost and benefits, training costs, organizational fit, and cultural adaptability.
- Many condition-specific associations offer resources that can support use of MI. For example, the American Diabetes Association identifies MI as an evidence-based tool to support people with diabetes; the Obesity Medicine Association endorses the use of MI in obesity management.

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The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This spotlight is intended to support health plans and providers to integrate and coordinate care for dually eligible beneficiaries and spread promising strategies. It is not meant to convey health plan or provider requirements. For additional information or to share your feedback, visit https://www.resourcesforintegratedcare.com/ or email us directly at RIC@Lewin.com.

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