Innovations in Member Engagement in Rural Areas

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November 27, 2018

Innovations in Member Engagement in Rural Areas

Overview

- This session will be interactive (e.g., polls and interactive chat functions), with 40 minutes of presenter-led discussion, followed by 20 minutes of presenter and participant discussions.
- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com.

Accreditation

- **Individuals are strongly encouraged to check with their specific regulatory boards or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.**
- The Centers for Medicare & Medicaid Services (CMS) is accredited by the International Association for Continuing Education and Training (IACET). The Centers for Medicare & Medicaid Services complies with the ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation, the Centers for Medicare & Medicaid Services is authorized to issue the IACET CEU.

Continuing Education Information

- **CMS is evaluating this activity for continuing education (CE) credit. The number of credits awarded will be calculated following the activity based on the actual learning time. Final CE information on the amount of credit will be available to participants within the Learning Management System (LMS) after the live activity.**

- Complete the post-test through CMS' Learning Management System with a score of 80 percent or higher by midnight on Monday, December 17, 2018.

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) 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. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com.

Introductions

- **Terry Cumpton**
  Regional Rural Health Coordinator, CMS Seattle Regional Office

- **Jamie Hanes**
  Clinical Service Assistant Manager for Case Management, Upper Peninsula Health

- **Jen Bundy, RN, MSN**
  Director of Care Management, PrimeWest Health Plan

- **Elizabeth Warfield, RN**
  Manager of Special Needs Plan Care Management, PrimeWest Health Plan

Learning Objectives

- Identify barriers and challenges to member engagement in rural areas
- Recognize strategies for engaging dually eligible beneficiaries in rural areas
- Identify effective approaches to building trust such as addressing social needs
- Recognize strategies for using case management to engage rural members in managing their health

Webinar Outline

- Introduction
- Polls
- Member Engagement in Rural Areas
- Making Contact and Building Trust with New Members
- Community-Based Care Management and Addressing Barriers to Care in Rural Areas
- Q&A
- Evaluation

Engaging Rural Beneficiaries

Terry Cumpton

Regional Rural Health Coordinator, CMS Seattle Regional Office

Rural Communities and Dually Eligible Members

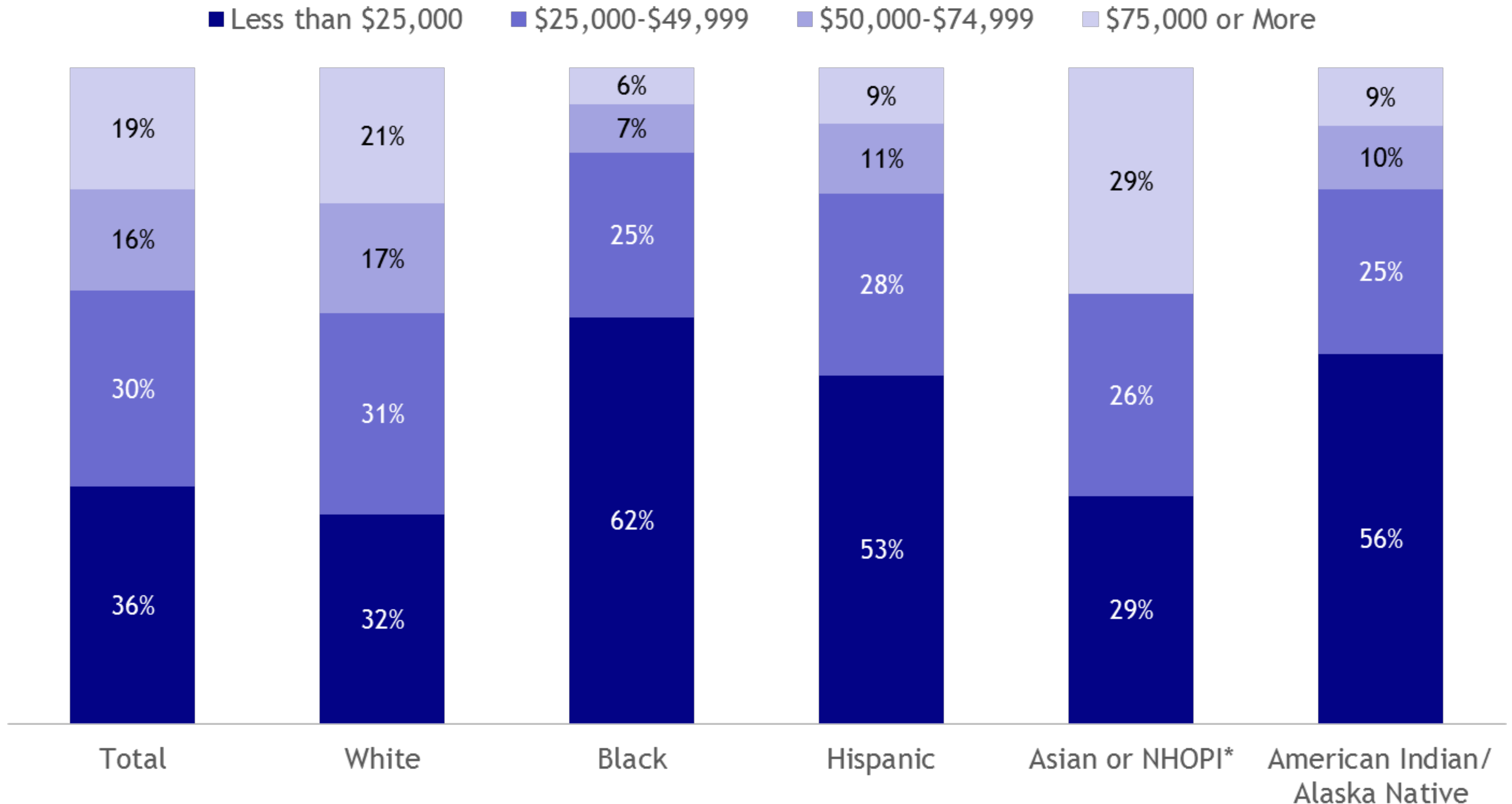
- Rural is defined as all population, housing, and territory not included within an urbanized area or urban cluster[1]
  - More sparsely populated and remote areas
  - Lower mix of residential and nonresidential land use (parks, schools, commercial, retail, or industrial uses)
- Both dual enrollment in Medicare and Medicaid and residence in a rural area are social risk factors for poor health outcomes[2]
- Member engagement strategies can improve access to quality care and empower rural dually eligible members to make decisions about their health care

Sources:
1. Ratcliffe, M., Burd, C., Holder, K., & Fields, A. (2016, December). *Defining Rural at the U.S. Census Bureau* (Issue brief).
2. Office of the Assistant Secretary for Planning and Evaluation. (2016). *Report to Congress: Social Risk Factors and Performance under Medicare's Value Based Purchasing Programs*.

Resources for Integrated Care

Resources for Plans and Providers for Medicare-Medicaid Integration

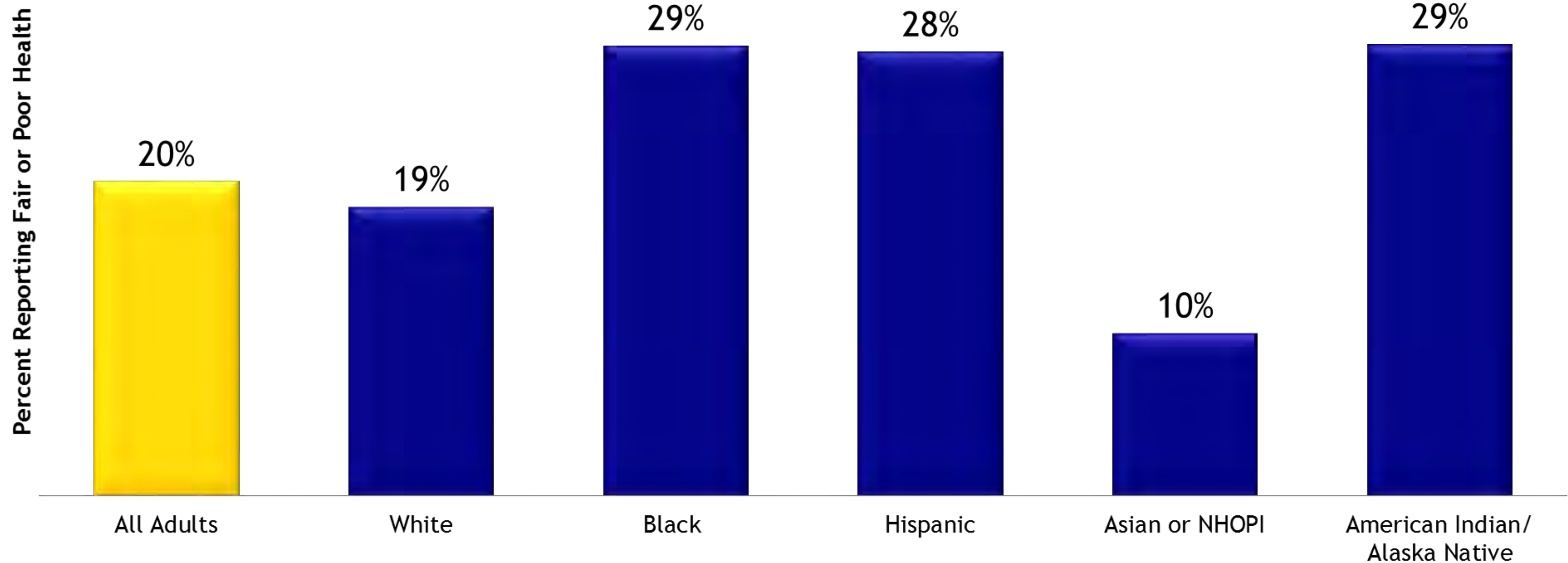
Income Distribution of Rural Adults by Race and Ethnicity, 2012-2015[2]



Source:

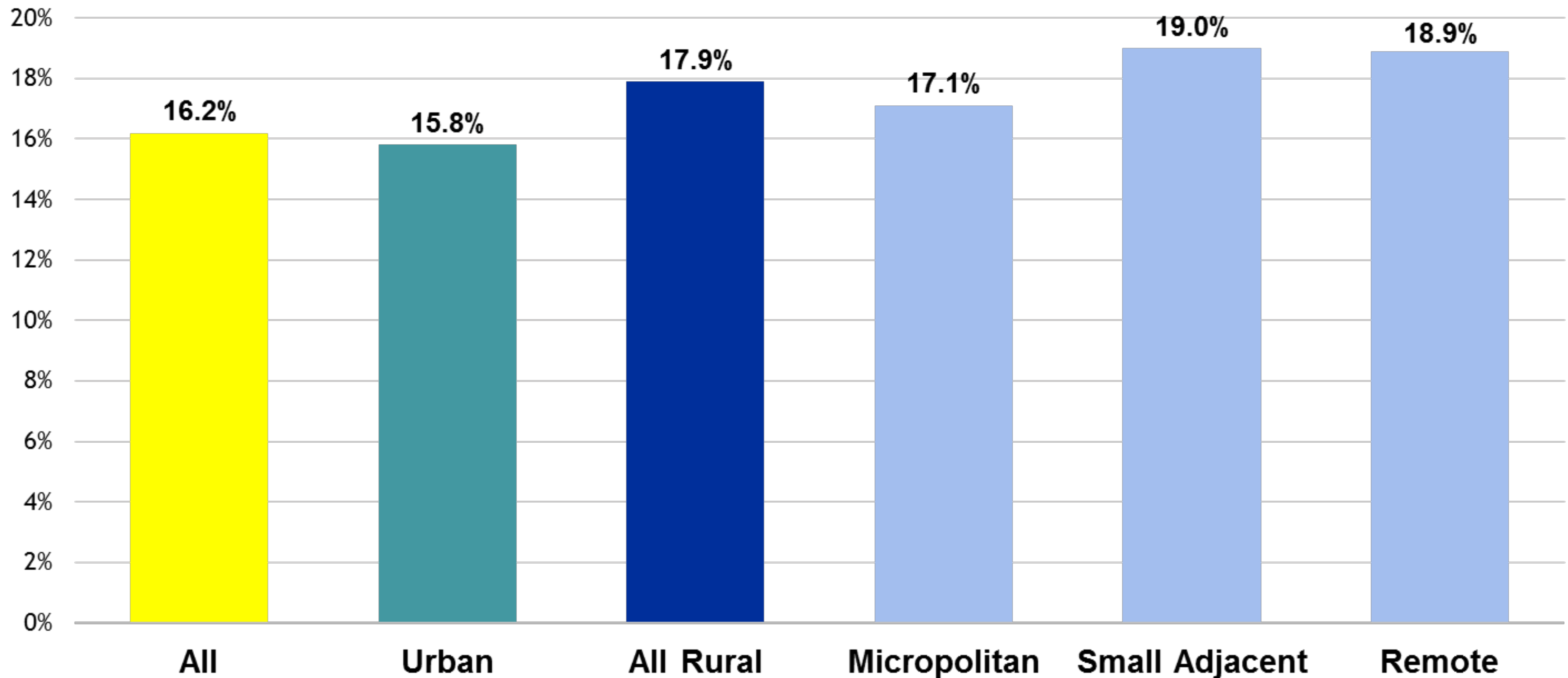
3. James, C., Moonesinghe, R., Wilson-Frederick, S., Hall, J., Penman-Aguilar, A., & Bouye, K. (2017, November 27). *Morbidity and Mortality Weekly Report (MMWR).*

Fair or Poor Health Status Among Rural Adults by Race & Ethnicity, 2012-2015[1]



Source:
3. James, C., Moonesinghe, R., Wilson-Frederick, S., Hall, J., Penman-Aguilar, A., & Bouye, K. (2017, November 27). *Morbidity and Mortality Weekly Report (MMWR).*

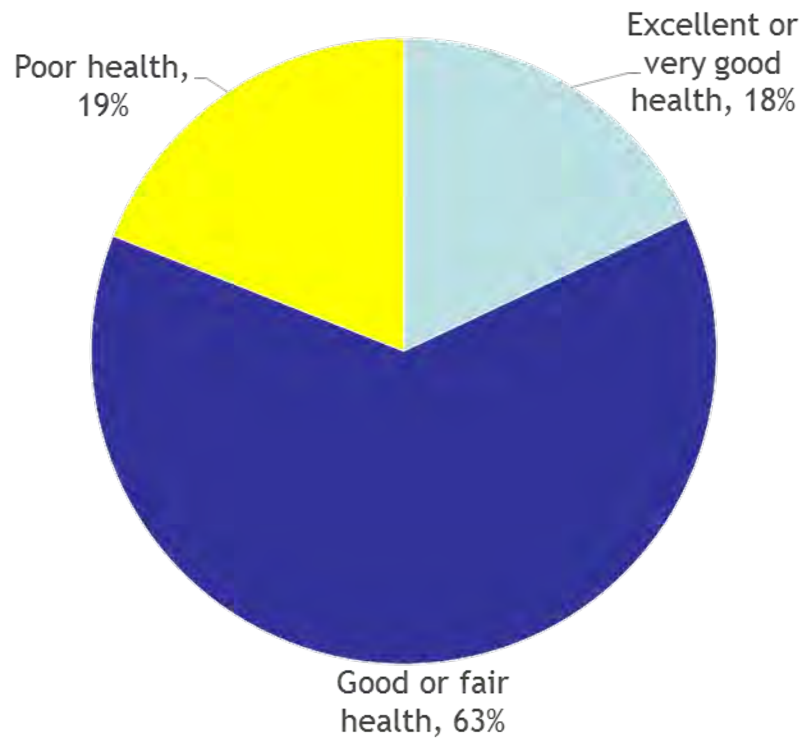
Dual Eligibility by Rurality

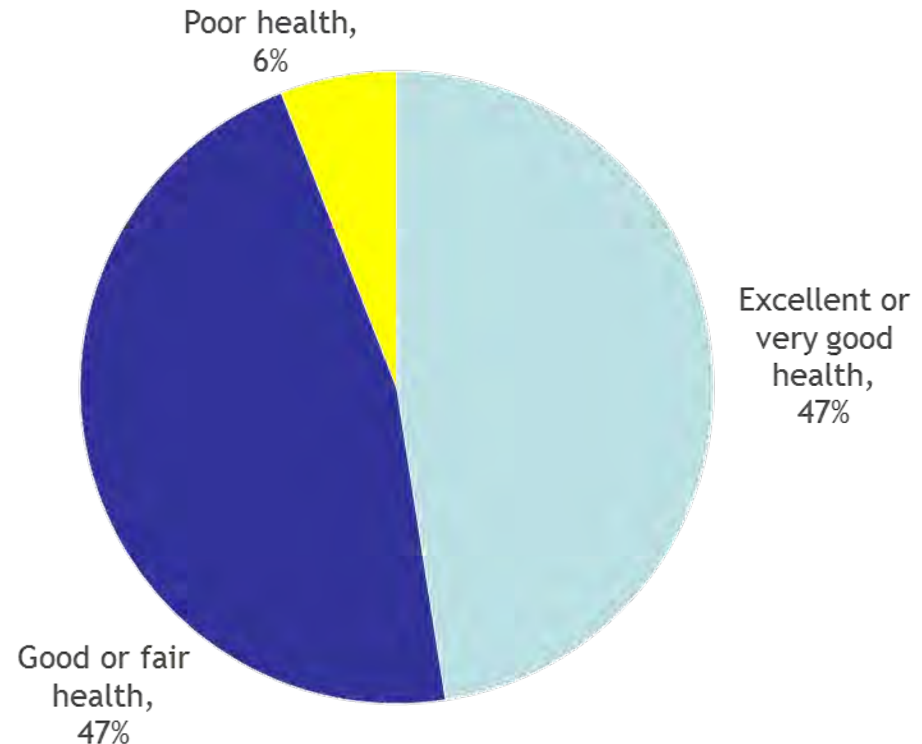


Source:

4. Bennet, K., Robertson, A., Probst, J. (November 2014). *Characteristics, Utilization Patterns, and Expenditures of Rural Dual Eligible Medicare Beneficiaries.*

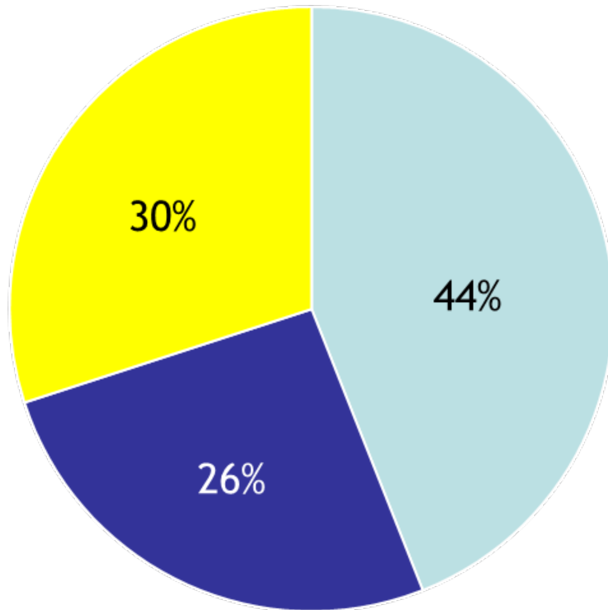
Health Status Among Dually Eligible and Non-Dually Eligible Beneficiaries, 2015[3]

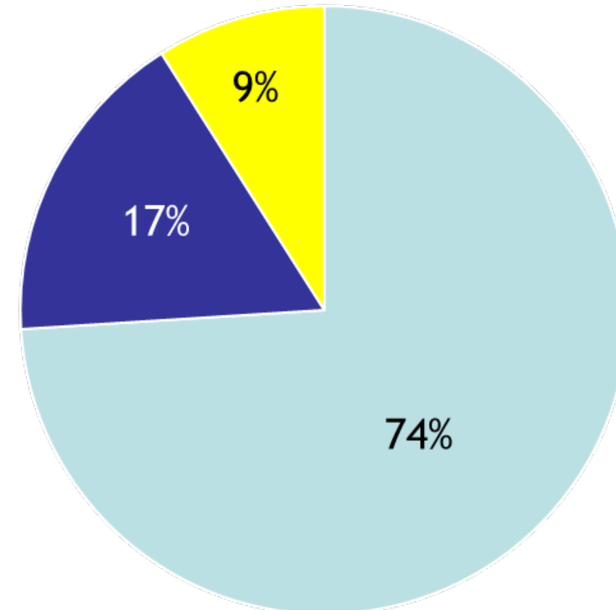




Source:
5. Medicare Payment Advisory Commission. (2018). Dual-eligible beneficiaries. A Data book: Health care spending and the Medicare program.

Limitations in Activities of Daily Living (ADL) Among Dually Eligible and Non-Dually Eligible Beneficiaries, 2013





Source:

6. Medicare Payment Advisory Commission & Medicaid and CHIP Payment and Access Commission. (2018). *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.*

Elements of Member Engagement

- Meeting people where they are
  - Members' and families' expertise about their priorities should be valued and incorporated
- Focus on cost and quality
  - Ensure members understand their coverage and the benefits of integrated care
- Engaging trusted information sources
  - Healthcare providers, senior organizations

Value of Member Engagement

- Implemented effectively and sustained over time, member engagement is key to transforming the delivery system in ways that work for consumers, caregivers, health plans, and provider groups
- Member engagement that honors members' voices ensures that members are active participants in their own care
- By engaging members in their care, plans and providers can address the outcomes that matter to members

Barriers to Member Engagement

- General member engagement challenges:
  - Inaccurate contact information
  - Mistrust of outreach from unfamiliar people, including plan staff
- Member engagement challenges specific to rural areas:
  - Greater geographic distances between the member and services
  - Limited affordable, reliable, or public transportation options
  - Limited availability of health care professionals, particularly for specialty care

Rural Health Resources

- go.cms.gov/ruralhealth
  - Coverage to Care (C2C) and other resources include strategies for improving health and health access in rural areas
  - Includes data on health care access, quality, and outcomes for rural populations

Making Contact and Building Trust with New Members

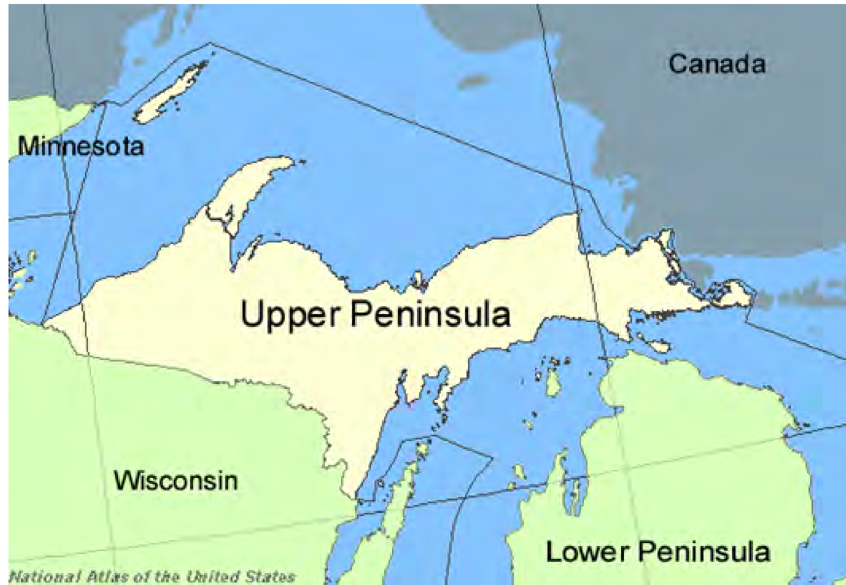
Jamie Hanes

Clinical Services Assistant Manager, Upper Peninsula Health Plan

Overview of Upper Peninsula Health Plan

- Upper Peninsula Health Plan (UPHP) is a managed-care and provider-service organization based in Marquette, Michigan
- The health plan manages the care of nearly 50,000 Upper Peninsula residents, 4,207 of whom are dually eligible beneficiaries
- UPHP employs 22 care managers to work with this population
  - Each dually eligible member has their own assigned care manager
  - Care managers assist with service provision and navigation across the continuum of the health care system

UPHP's Service Area



- The Upper Peninsula's 15 counties comprise 1/3 of Michigan's land mass, but only 3% of its population
- Upper Peninsula (U.P.) is six hours across end to end and is bounded on the north by Lake Superior, on the east by St. Mary's River, on the south by Lake Michigan and Lake Huron, and on the west by Wisconsin
- Much of the land is undeveloped
- Most of Michigan's densely-forested land is in the Western U.P., where over 90% of the surface is forested. This high concentration of forested land inhibits cell service and service provision.

Person-Centered Member Engagement at UPHP

- Person-centered care is essential to serving dually eligible members
  - Supports and services are designed and delivered in the highest quality setting possible that provides the least amount of restriction and the maximum amount of independence and control
- This is achieved by:
  - Seeing the person, not the client
  - Maximizing the individual's independence
  - Assisting the individual in maintaining their community connections
  - Working towards achieving individual's dreams, goals, desires
  - Meeting the individual where they are with regards to goal development
  - Recognizing the individual's cultural background
- The process is collaborative, reoccurring, and involves an ongoing commitment to the whole person

Challenges to Member Engagement

- Challenges making initial contact include:
  - Incorrect or missing contact information
  - Members who may be mistrustful of unsolicited contacts and unfamiliar telephone numbers
  - Members with spotty cell phone service or limited minutes
- Ongoing challenges to member engagement:
  - Engaging members in follow-up care, particularly after care transitions
  - Skepticism or mistrust of plan

Promising Practices: Making Initial Contact

- UPHP makes **5 outreach attempts** to all dually eligible members **within 45 days of enrollment**
  - UPHP tries to connect with members during different times of the day over multiple days, with some call attempts made outside of normal work hours
  - Attempts are more successful in the beginning of the month as members may have more minutes left on their phone plan
- Contact information may not always be accurate. In addition, some members are transient or homeless and often change phone numbers and residences
  - When phone numbers are inaccurate or the member is difficult to reach, UPHP care managers use claims data to identify primary care provider offices, Department of Health and Human Services, pharmacies, Prepaid Inpatient Health Plan and other sources to find a current phone number or contact information

Promising Practices: Outreach through Local Phone Calls

- UPHP initially used an outside vendor for initial outreach calls
- However, members would not always answer unsolicited calls from unknown, out-of-area phone numbers, as many members were distrustful of a phone call coming from a non-local area code
- After moving outreach efforts in-house and using the local area code, attempts to establish contact with members were more successful

Promising Practices: Alternative Outreach Strategies

- Phone contact may be difficult when members have limited minutes or spotty cell phone service. To reach members through other means, UPHP:
  - Sends “Unable to Reach” letters to the home address requesting contact and explaining their enrollment in the health plan and their assigned case manager
  - Mails a letter to the primary care provider on file indicating that their patient’s UPHP care manager is trying to contact them
  - Monitors claims data internally and from the state to identify members with high ER utilization and then makes contact with the member at the hospital
    - Case managers also receive automatic data transfer (ADT) feeds from hospitals for their members

Promising Practices: Transitions of Care Program

- The Transitions of Care program provides members support prior to, during, and after transitions between care settings and between different providers of the same service
- UPHP staff visit hospitalized members to help them make informed choices about their transitions and preferences for care after discharge
  - UPHP's established relationships with local hospitals and other providers facilitate coordination of the transition
- Care coordination that begins before discharge ensures members can access the services they need and have continuous engagement and communication throughout transition and recovery
  - Beginning engagement in-person before discharge is critical, as communication may become difficult after discharge

Promising Practices: Building Trust with Members at Home

- During home visits, case managers identify additional unmet needs and work to connect members with community resources
  - The case manager helps connects members with food assistance, heating, home weatherization, transportation, literacy barriers, and housing
- Showing genuine interest in the member and demonstrating the plan benefits available to them helps members feel more comfortable with the home visit
- The case manager asks the member for their preferences for who should be involved in the home visit, such as family members and informal supports
- Involve Area Agency on Aging and Community Action Agencies, as these are familiar organizations in the community

Promising Practices: Building Trust with Members who are Homeless

- UPHP identifies members who may be homeless through case manager assessment and referrals from shelters, hospitals, and emergency rooms
- UPHP partners with the Area Agency on Aging and other community organizations to connect members who are homeless to housing and other resources
  - Include local churches, homeless shelters, and warming centers that provide meals

Promising Practices: Building Trust with Members in the Community

- To establish a community presence and build trust with members, UPHP:
  - Employs care managers who live in members’ communities by contracting with the local Area Agency on Aging
  - Hosts office hours in community mental health agencies for face-to-face communication opportunities with members
  - Facilitates relationships with community organizations
    - UPHP sponsors community projects and participates in community service activities

Transportation Program

- For members and their caregivers providing their own transportation, UPHP provides transportation reimbursement
  - Reimbursement includes mileage and, for overnight trips, hotel costs and food
- UPHP also provides transportation through a pool of local volunteer drivers
  - Volunteers are recruited through advertising in local papers and social media
- To request transportation, members can ask their case manager, fill out a form online, or directly call the transportation department

Case Study: Alex's Story

- 60-year-old, dually eligible member living in a rural town
- Member with depression, anxiety, uncontrolled diabetes, and chronic pain
- Extremely hard to reach in 2016 (no contact for over a year)
- When hospitalized in 2017, UPHP facilitated contact through transitions of care process and identified member need (transportation)
  - The care manager was able to address this need, which opened the door for relationship building and rapport
- Member was again hard to reach in 2017
- The care manager knew where member frequented in the community and drove to where she knew the member would be
  - Additional needs were identified during this meeting and member was again receptive to contact
- Outcomes are positive – no hospitalizations since 2017 and last ED visit was April 2018

Community-Based Care Management and Addressing Barriers to Care in Rural Areas

Elizabeth Warfield, RN,

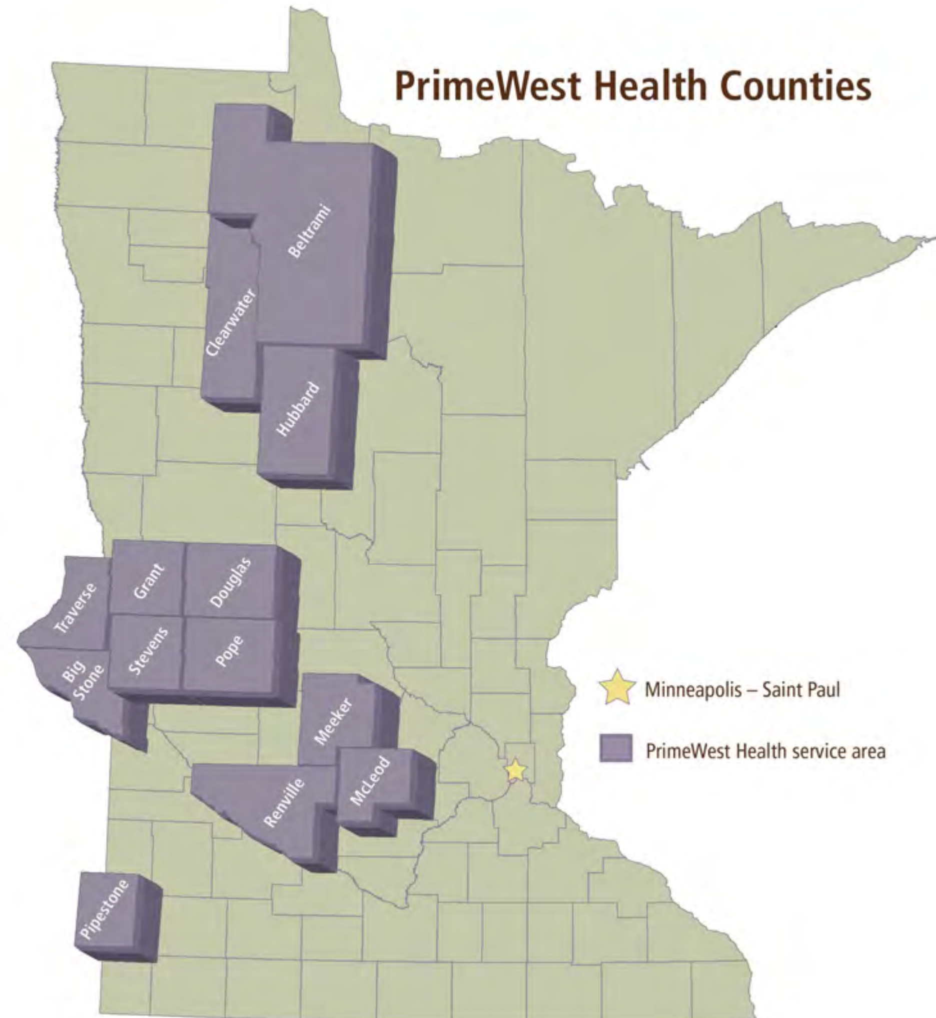
Manager of Special Needs Plan Care Management, PrimeWest Health

Jen Bundy, RN, MSN

Director of Care Management, PrimeWest Health

PrimeWest Health

- County-Based Purchasing (CBP) health plan owned by the 13 rural Minnesota counties we serve
- Headquartered in Alexandria, Minnesota
- Over 42,000 Medicaid participants, including over 2,000 dually eligible older adults
- Service area totals 10,525 square miles, 13% of Minnesota; home to 4% percent of the total population of Minnesota



PrimeWest Health – Dually Eligible Population

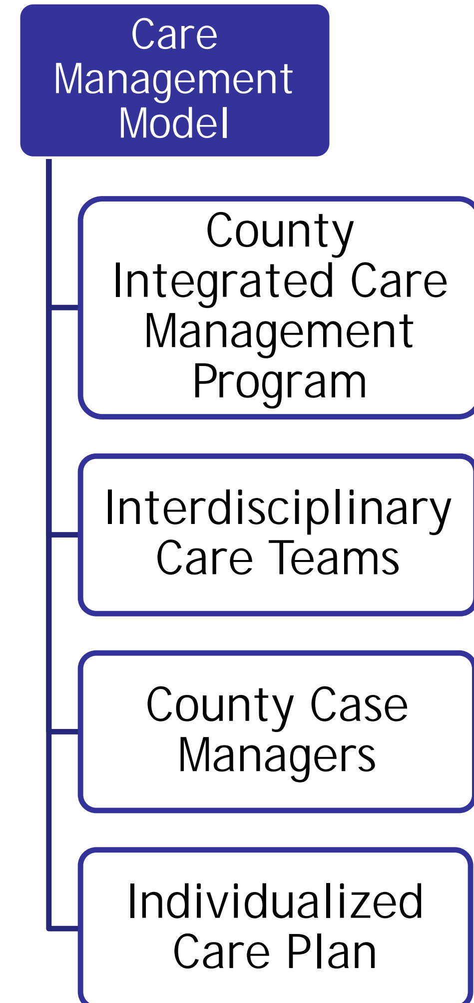
- Approximately 2,000 members
- Average age is 81 years
- High probability of no Internet use
- High probability of both hearing and vision deficits
- High probability of mobility challenges
- High probability of transportation issues
- Probability of having two or more chronic conditions (heart disease primary) with possibility of a mental health diagnosis
- Average of nine prescriptions per month (includes over-the-counter)
- High probability of receiving additional HCBS services
  - Chore assistance and Meals on Wheels to allow the member to live in a community setting and avoid institutionalization
- Potential for physical or emotional challenges affecting social activities

Strategies for Engaging and Supporting Members in Rural Areas

- Identify members' needs, preferences, and barriers to care, such as lack of transportation, long distances to travel, and limited number of providers in rural areas
- Help members overcome barriers to accessing care
- Provide care management to connect rural members to healthcare and social services
- Help members access services when provider availability is limited through outreach and engagement with community resources

Member Engagement through Care Management

- Care management is the core of PrimeWest Health's approach, which promotes members' engagement in the direction and self-management of their care
- All PrimeWest Health dually eligible members receive County Case Management, a program in our County Integrated Care Management Model



Care Management Model: County Integrated Care Management Program (CICMP)

- The CICMP is the foundation of PrimeWest's efforts to provide members timely access to a coordinated set of services specific to the member's assessed needs
  - "County Integrated" refers to the integration of PrimeWest's Minnesota Health Care Programs (MHCP) payer, care management, quality management and utilization management functions within the counties' case management functions and responsibilities
- County public health departments and social services are embedded in the CICMP, which helps rural providers organizing and manage the integration of health services

Care Management Model: Interdisciplinary Care Team (ICT)

- The member (and caregiver, if appropriate) consult with their case manager and primary care provider to determine the composition of the ICT
- ICTs include county case managers, Accountable Care Organization care coordinators, providers, and PrimeWest Health specialist care coordinators
- ICTs include the providers necessary for the member to achieve optimal health outcomes, based on the member's specific needs, living arrangement, and availability and needs of a caregiver
- The ICT works collaboratively with the member to develop and implement care plans to meet individuals' medical, behavioral, long-term care, and social service needs

Care Management Model: County Case Managers

- Each PrimeWest Health dually eligible member is assigned a County Case Manager (CCM) who:
  - Lives in the community and has first hand knowledge of community resources and service providers
  - Builds ongoing relationships with members through face-to-face interactions and regular check-ins
  - Connects members to resources such as transportation, housing assistance, food assistance, community events, and churches
  - Coordinates services for members, preventing gaps in care and maximizing the use of high quality services that lead to improved health outcomes

Care Management Model: Electronic Individualized Care Plan (ICP)

- CCMs and members work together to create a person-centered care plan based on the member's needs and preferences. The ICP:
  - Serves as the blueprint for coordinated and ongoing member contact and engagement
  - Helps members achieve their health and quality of life goals
  - Is available electronically, allowing real-time communication amongst all the ICT members
- CCMs and members update the ICP together during regular face-to-face and telephone check-ins
- The CCM follows up with members at a frequency determined by the member to evaluate the effectiveness of the plan

Addressing Barriers to Care in Rural Areas: Transportation

- In rural areas, members have limited transportation options. This can lead to missed appointments or delays in receiving services
- Members in rural Minnesota may reside on farm land, often far from provider offices. Winter weather also contributes to increased travel times, presenting an additional barrier to care
- To improve transportation access, PrimeWest Health has partnered with county agencies, volunteers, and community organizations to:
  - Connect members with local transportation providers, including volunteer drivers, city buses, and contracted transportation vendors
  - Reimburse volunteer drivers for no-load mileage (miles driven without passengers), particularly in sparsely populated areas where volunteer drivers are the most efficient means of transportation
  - Provide grants to organizations (including a long-term care facility and county transportation authorities) to purchase transport vehicles

Addressing Barriers to Care in Rural Areas: Low Provider Availability

- In rural areas, low provider availability for specialty and dental care can limit provider access for members
- Geographic barriers to care and lack of transportation compound access issues
- To improve dental provider availability, PrimeWest Health:
  - Operates a mobile dental clinic, which visits skilled nursing facilities, public health, and adult foster care
  - Conducts outreach to providers
  - Provides dental services care coordination to members
  - Leverages community partnerships to identify developing access issues and address them proactively, such as when a dental provider is closing
  - Provided a grant to an existing clinic to expand and add a location in a PrimeWest Health community

Case Study: Sam's Story

- 69-year-old member living in rural Beltrami county
- Sam has been a PrimeWest Health member for 4 years; he has had the same county case manager (CCM) since enrollment
- Sam's CCM contacted him via telephone for a regular check-in
- During the check-in, Sam mentioned he had an eye appointment coming up but had no way to get there. He'd recently lost his driver's license because of a failed vision test
- The CCM reviewed Sam's benefits and determined he was eligible for addition diagnostic visits, transportation, lenses, and frames
- With Sam's permission, the CCM contacted the county's transportation coordinator to arrange transportation to and from Sam's eye appointment

Case Study: Sam's Story

- Concerned there may be other impacts related to Sam's change in vision, the CCM asked Sam additional questions and learned he had fallen twice in the past month and didn't have much food in the house because he couldn't drive to town to get groceries
- Sam agreed to a home visit from the CCM the next day to complete a Health Risk Assessment, which helped the CCM identify additional supports and services to meet Sam's needs
- The CCM reviewed the results with the rest of the ICT and updated the care plan to reflect Sam's additional supports and services
- With Sam's consent, the CCM coordinated with Sam's family and a volunteer driver who were able to assist with Sam until he had his new glasses and was able to return to his previous level of functioning

Strategies for Sustaining Member Engagement

- Member engagement goes beyond initial outreach. Strategies for maintaining member engagement over time include:
  - Building and maintaining trusting relationships with members
  - Multiple methods of member engagement such as face-to-face meetings, phone calls (outbound and inbound), and mail
  - Person-centered planning and including members in health care decisions
- Sustained member engagement improves use of appropriate services, reduces hospitalization and emergency department visits, and enhances members' experiences with care

Audience Questions

Resources for Integrated Care – Additional Webinars

- Stay tuned for our upcoming webinar:
  - ***Palliative Care for Older Adults Dually Eligible for Medicare and Medicaid– December 5, 2018, 12:00 – 1:30 PM ET***
    - https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar/Palliative_Care
- Visit https://resourcesforintegratedcare.com/ to view previous Member Engagement webinars. Webinars include:
  - ***Hard-To-Reach Populations: Innovative Strategies To Engage Isolated Individuals***
    - https://resourcesforintegratedcare.com/behavioral_health/member_engagement/webinars
  - ***Hard-To-Reach Populations: Innovative Strategies To Engage Homeless Members***
    - https://resourcesforintegratedcare.com/member_engagement_2016/webinar2/hard_to_reach_populations_engaging_homeless_members

Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at: https://www.resourcesforintegratedcare.com

- For more information about obtaining CE credit via CMS' Learning Management System, please visit: https://resourcesforintegratedcare.com/MemberEngagement/2018_ME_Webinar/Rural_Health

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Webinar Evaluation Form

- Your feedback is very important! Please take a moment to complete a brief evaluation on the quality of the webinar. The survey will automatically appear on the screen approximately a minute after the conclusion of the presentation.
- We would also like to invite you to provide feedback on other RIC products as well as suggestions to inform the development of potential new resources: https://www.research.net/r/MVGNWVJ

Sources

1. Ratcliffe, M., Burd, C., Holder, K., & Fields, A. (2016, December). *Defining Rural at the U.S. Census Bureau* (Issue brief). Retrieved from : https://www2.census.gov/geo/pdfs/reference/ua/Defining_Rural.pdf
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