RESOURCES FOR INTEGRATED CARE
Resources for Plans and Providers for Medicare-Medicaid Integration

Meaningful Consumer Engagement Webinar Series

Hard to Reach Populations:
Innovative Strategies to Engage Homeless Members



Overview

- This is the second session of the “Meaningful Consumer Engagement Webinar Series”

- Each session will be interactive (e.g., chat functions, time for questions at the end of the presentation, survey), with 10 minutes intro, 60 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: www.resourcesforintegratedcare.com

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to ensure that beneficiaries enrolled in 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 Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series.

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

POLL 1

How would you best describe your professional area or the setting in which you work?

- ❑ Health Plan Staff
- ❑ Healthcare Provider
- ❑ Consumer Advocate
- ❑ State, Local or Government Official
- ❑ Community-Based Service Organization Staff
- ❑ Other

Introductions

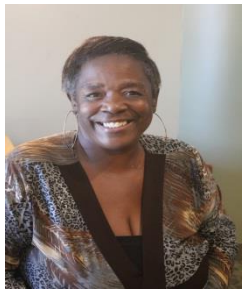
- **Rosa Palacios**, Moderator, Consumer Engagement Specialist, Community Catalyst

- **Toyin Ajayi**, MD, MPhil, Chief Medical Officer, Commonwealth Care Alliance

- **Jessie Gaeta**, MD, Chief Medical Officer, Boston Health Care for the Homeless Program

Introductions

- **Amy Turk**, Chief Operations Officer, Downtown Women's Center



- **Denise Smith**, Health Team Leader, Downtown Women's Center

- **Julie Bluhm**, Director, Medical Administration, Hennepin Health

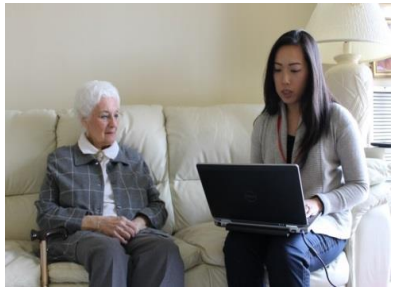
Webinar Outline/Agenda

- Commonwealth Care Alliance
  - How CCA Engages Hard to Reach Members
- Boston Health Care for the Homeless Program
  - Engaging Homeless Individuals in Health Care
- Downtown Women Center
  - Making the Linkage to Healthcare
- Hennepin Health
  - Care Coordination and Other Innovative Strategies
- Q&A

Toyin Ajayi, MD, MPhil
Chief Medical Officer
Commonwealth Care Alliance

Commonwealth Care Alliance (CCA)

- Serves **Massachusetts** residents with complex health needs across the lifespan and is a pioneer in **integrated, person-centered care**
- Established in 2003 when CCA's senior leaders came together with Health Care for All, Boston Center for Independent Living, and Community Catalyst to found CCA



Senior Care Options (SCO): Serving Medicaid eligible seniors 65+ since 2004

One Care: Serving dual eligible people aged 21-64 since 2013
(Passive and voluntary enrollment; more hard-to-reach members than in our SCO program)

Commonwealth Care Alliance

How Our Programs Work

Monthly (capitated) premium payments from Medicaid (MassHealth) and Medicare for each member based on their health status

Services: We provide all standard Medicare and Medicaid services, plus:

- Person-centered care management
- Additional services such as full dental, supplemental behavioral health
- Transportation to all medical appointments

Enhanced primary care for most complex members, often based in the home and with a strong focus on transitions of care

Interdisciplinary care team includes primary care providers, behavioral health care, nurses, long term services and supports, and health outreach workers

One Care Population

One Care Enrollment

Approximately 10,000 Medicare-Medicaid beneficiaries under age 65 enrolled with CCA (of 90,000 eligible)

Key demographics contribute to making many of our members hard-to-reach:

- Over 70% have a behavioral health diagnosis
- 45% screen positive for depression
- 15% are schizophrenic
- 15-20% have a substance use disorder
- 7% homeless

One Care Member Engagement

First major contact with members

- **Initial health risk assessment** – in-person assessment of member health and needs; considers social determinants of health
- **Care plan** – member-driven care plan focusing on their goals

Standard approach to reaching members for assessment and care plan:

- **Phone calls to schedule assessment visit** – at least three calls at different times of day and days of week, during a two-week period
- **"Trying to reach you" letter** – CMS-approved letter lets members know we must do the assessment to assess their needs. "Soft" letter gets some response; second letter - more strongly worded, noting that unless we conduct the assessment all further services may require prior authorizations - has been more effective

How We Engage Hard-to-Reach Members

Meet members wherever they are willing

- In home or community; where members feel comfortable
- At hospital or in crisis stabilization unit, if needed

Overcome language and cultural barriers with diverse workforce

Engage caregivers or household members to support

Be persistent - try again to call and engage members on a quarterly basis

Conduct research - Our special researchers focus on finding members. Approaches include:

- Review claims to find and contact providers members are already linked with
- Contact pharmacies for updated member contact info; *Remedia* software can show us the last pharmacy where the member picked up a prescription

How We Engage Hard-to-Reach Members

Build organizational awareness of members we are trying to engage to ensure all CCA staff that may link with the member know that we are trying to engage them for an assessment. For example:

- **Member Services** – flag members who have not yet been reached for assessment in our central databases so if members call to request transportation (a frequent request), Member Services will transfer the member to an assessment team to schedule an appointment
- **Service Authorization team**– If a service request comes in from a vendor (e.g., for home-based skilled nursing), we use the opportunity to connect the member with the assessment team
- **Inpatient coordinators** – If a tough-to-reach member is admitted to a hospital or crisis stabilization unit, our inpatient coordinators notify the assessment team so they can meet the member while admitted

Member Engagement Case Study

CASE STUDY

Early Resistance

- Woman with poorly controlled diabetes; bad complications including heart failure
- Frequent hospitalizations which she would leave against medical advice
- Engaged for initial assessment but politely declined or avoided further meetings at hospital, home or community despite multiple contact attempts
- Little engagement with PCP or other providers

Breakthrough: A multidisciplinary care team meeting with member, CCA care team and the team at the Boston hospital where she was inpatient at the time.

Member Engagement Case Study

CASE STUDY (continued)

Ongoing Engagement

- CCA care team now sees member at least once a week (though she still sometimes cancels); provides primary care and home skilled nursing care
- Putting in place a health outreach worker to help with housing and benefits; formalizing daughter as personal care attendant
- Building rapport with daughter

Impact

- Better pain and heart failure management in the community, reducing hospitalization; CCA nurse adjusts diuretic doses if needed.
- Working on diabetes management including blood sugar monitoring and med management.

One Care Community Partnerships - "Health Homes"

What	One Care delegated care management sites
Who	7 community-based partners across Massachusetts, including behavioral health/human services providers and primary care sites (such as Boston Health Care for the Homeless – BHCHP) with strong behavioral health integration
Why	Partner expertise in engaging members with complex behavioral health needs, members who are homeless; long-standing member relationships
When	Since One Care launch, Oct 2013
% of CCA network	18% (1,800 members)
Staff	Nurses (RN level), behavioral health staff, health outreach workers, administrative coordinators
Responsibilities	Designated care coordinator for each member, annual assessments, ensuring member has all services needed, facilitating care transitions

Commonwealth Care Alliance

Community Partner Approaches to Engaging Members

Primary Care & Specialty Linkages:

- Community partners that provide primary care themselves track when members come in for primary or specialty care, and engage them then.
- **Co-location:** Some behavioral health partners co-locate staff at primary care sites and similarly piggyback on primary and specialty care appointments.

Behavioral health linkages: Care management teams of some community partners link closely with in-house behavioral health and rehabilitation teams who often engage members on a weekly basis. They may also partner with residential (e.g., group home) staff.

Homeless service linkages: Several partners link with shelters and homeless outreach/street teams to engage homeless members. BHCHP is an innovative leader in this area; you'll hear details about their great work later during this webinar.

Community Partner Approaches to Engaging Members

Home outreach by health outreach workers (HOWs)

- Sometimes members that won't answer the phone, or for whom we lack an accurate phone number, will answer the door if we knock
- Creative contact (for example, throwing acorns at the member's third-story window so the member who has no phone or doorbell can throw the entryway key down to staff)
- Leaving a note under the door has resulted in members calling
- Neighbors may direct HOWs to locations where they can find the member

Alter staff schedules to find members outside business hours

Demonstrate usefulness of services early in relationship to encourage engagement

Address concerns of members experiencing disorganized or paranoid thinking, or symptoms of mania, depression or PTSD in meetings held to address other issues

Improving Engagement Rates

One Care members documented as "unreachable" or "refused assessment"		
Jan 2015	July 2015	Present
34%	20%	15%

In early 2015, **34%** of new CCA One Care members had been documented as "unreachable" or "refused assessment." The majority of these members came to us through passive enrollment.

CCA held aggressive "campaigns" to reach them using the methods described. By July 2015, we reduced that number to **20%**; today, that number is at **15%.**

(5% refuse to meet; 10% do not respond to calls and letters or have unknown phone/address.)

Looking Ahead

No magic wand - Engaging members takes persistence, continual outreach, and relationship building

Ongoing challenges

- One Care population continues to "churn," temporarily losing MassHealth coverage and then becoming re-enrolled when they access services
- Members move or change phones frequently and CCA may be unable to contact for a period

Organizational commitment to reaching and engaging our members because there is so much to gain; we know that when we engage members, we often:

- Meet critical unmet service needs
- Help members stay healthy, avoiding crisis or hospitalization
- Help members meet their goals

Jessie M. Gaeta, MD

Chief Medical Officer

Boston Health Care for the Homeless Program

Increased Mortality

Seven large scale mortality studies in USA

- Drug overdose has replaced HIV as the emerging epidemic
- Cancer, heart disease next most common

Mortality rates 4.5 – 9.0 times that of the general public
Average age at death in Boston = 51

Death from complications of substance use and undertreated medical illness

Baggett TP, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Internal Medicine 2013; 173(3): 189-195.

Health Implications

- Increased mortality
- Severity of illness
- Exposure
- Violence and victimization
- Competing priorities
- Chronic stress
- Stigmatization by health care providers
- Medication difficulties

QUICK TIP

HOW CAN I SCREEN FOR HOMELESSNESS?

- Rather than, “Are you homeless?”
- Instead ask, “Where do you stay?”
- Or, “I sometimes have patients/clients who have no fixed place to stay and it can affect their health, so I ask everyone about where they sleep at night.”

Other Sample Question

What is your housing situation today?

- I have housing of my own and am not worried about losing it
- I have housing of my own and am worried about losing it
- I do not have housing of my own (staying with others, in a hotel, on the streets, in a shelter)

Key Aspects of a Care Model

- Engagement
- Outreach
- Framework of prioritization
- Patient-centered goal setting
- Connection to housing opportunities

Engagement

- Respectful, non-judgmental approach
- Avoid re-traumatization
- Resist stigmatization
- Offer token gestures that address basic needs
- Recognize link between social issues and poor health

Outreach

Framework of Prioritization

- Set realistic care plans (consider limitations of environment)
- Modify treatment to account for extreme circumstances
- Explore barriers to compliance
- Encourage ANY positive change
- Care planning with community-based organizations

QUICK TIP

HOW CAN INSULIN BE MANAGED WITHOUT A FRIDGE?

- If insulin can't be refrigerated, it works about 70% as well as usual
- Prescribers should titrate dose accordingly
- Patients should keep insulin in the outer pocket of a bag, out of sunlight, and off the body
- Can be stored at room temperature up to one month

Patient-Centered Goal Setting

To elicit self-management goals from your patient, try to ask very open questions that prompt them to think about what they want to do. Your goal is to help your patient walk through the identification of a problem they want to work on and a plan they can use to achieve that goal.

Remember that questions expressed by WHAT or HOW are better than WHY,which can lead the client to feel defensive. The goal of the nurse or provider is to understand meaning or significance rather than just facts. Some examples are below, but feel free to use your own approach.

To begin the conversation....a nurse or provider might ask:

- What concerns you most about_____?
- What have you noticed about your _____?
- How can I help you with_____?
- How would you like things to be different with _____?

As the conversation continues, they might ask:

- What are the good things about_____?
- What are the things about _____that cause you concern?
- What do you think you would lose if you give up _____?
- What have you tried before to make a change?
- What would you like to do next?
- How would you like things to be different a ____ (day/week/month/year) _____ from now?

Connections to Housing

- Build relationship with the local shelter and housing networks

QUICK TIP

HOW CAN I LEARN ABOUT HOUSING RESOURCES?

- Reach out to your local housing authorities and ask to meet to learn about the application process
- Contact the shelters in your area to find out about resources. Ask for their “housing specialist”

Conclusions

- People who experience homelessness have extremely poor health
- Adapting care to this population is essential
- The relationship with the patient is everything
- Treatment planning must be led by the patient and often requires outreach and creativity

Downtown Women's Center
Making The Linkage to Healthcare

Amy Turk, LCSW, Chief Program Officer
Denise Smith, DWC Health Team Peer Leader

DWC Programs & Services

DWC is nationally recognized as a prototype for unique and effective programs serving homeless women and ending homelessness. DWC serves over 3000 women every year.

DROP-IN DAY CENTER

- Meals, showers, phones and mail
- Case Management

HEALTH AND WELLNESS

- Integrated Medical and Mental Health Services
- Trauma Recovery Center

HOUSING

- Community Based Housing
- Onsite Permanent Supportive Housing

PERSONAL & FINANCIAL OPPORTUNITY

- On-the-job training in DWC's Social Enterprise
- Competitive job placement

Evidence Based Practices

- Trauma Informed Care
- Critical Time Intervention
- Harm Reduction
- Housing First

System Change Advances

- Medicaid Expansion
- Housing *is* Health Care
- Integration of the Triple Aim
- Closer intersection of systems for Integrated Care

DWC Approaches

- Healthcare provision co-located and convenient
- The only healthcare clinic dedicated to women's health
- Flexibility and creativity
- Holistic care
- Partnerships
- Involvement in systems change and innovation
- Chronic disease self-management interventions

DWC Most Effective Approach

- Elevating voice of individuals served
- Health Team Peer Leaders

DOWNTOWN WOMEN'S CENTER
Homelessness ends here.

Amy Turk
AmyT@DowntownWomensCenter.org

Hennepin Health
PEOPLE. CARE. RESPECT.

Julie Bluhm, MSW, LICSW
Director, Medical Administration
Hennepin Health

What is Hennepin Health?

Prospective enrollment via managed care choice or default

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MHP®

Hennepin County Medical Center

- Defined Provider Network, Shared Electronic Health Record
- Risk-Sharing Funding Model, Alignment of Finances
- Integration of Medical and Social Services to Address Social Determinants
- Consensus-Based Governance Model

NORTHPOINT Health & Wellness Center

Capitated Reimbursement from State Medicaid Agency

HSPHD Human Services and Public Health Department

Hennepin

Population Served

- Current Enrollment ~ 11,000 members
- Medicaid Expansion in Hennepin County
- 21 - 64 year-old Adults, without Dependent Children
- At or Below 133% of the Federal Poverty Level (≤ 75% prior to 2014)
- Not Certified as Disabled
- Families and children enrolled in Medicaid beginning 1/1/16

Care Model: Care Coordination

- Based on a Primary Care Medical Home with a Strong Community Health Worker Role Inside and Outside the Clinic
- Referral to “Ambulatory ICU” Clinic for Most Complex
- Supplementing Clinic Care Coordination with Targeted Behavioral Health and Social Service Interventions
- Documenting and Communicating in Shared Electronic Health Record (EHR)

Prospective Risk Stratification

- Development of predictive risk tiering model using CMS Hierarchical Condition Category (HCC)
- Risk prediction using HCC versus crude tiering based on utilization
  - Calculates a score based on previous 12 months to predict expenditures in next 12 months
  - Preliminary analysis predicts cost (predicted to actual)
- Model is based on:
  - Diagnoses codes that include mental health and chemical health
  - Age, gender, disability status, and Medicaid status (as a proxy for income)
- Future development of an “unstable housing” indicator to account for social determinants

Innovation Highlight: Outreach Community Health Workers

Community Health Workers employed by providers but working in community settings

- Correctional facilities
- Shelters
- Emergency Department
- Health Plan Lobby

Innovation Highlight: ED-InReach

- One hospital embedded Social Worker and one case manager contracted through local non-profit.
- Goal: Identify and target individuals in acute settings with case management services to assist patients in finding a medical or behavioral health “home”.
- Lessons learned:
  - Where we connect with individuals
  - Staff characteristics

Thank You!

Videos, newsletter, and more information:
http://hennepinhealth.org/

QUESTIONS

Survey

Thank you for joining our webinar. Please take a moment and complete a brief survey on the quality of the webinar.