Question & Answer for Member Engagement Webinar 3
Hard to Reach Populations: Innovative Strategies to Engage
Isolated Individuals with Behavioral Health Needs
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Speakers
Julie Bluhm, Hennepin Health
Laurie Lockert, CareOregon
Bill Dean, Community Catalyst

Mental Health

Q: What role do local community mental health centers play in the Hennepin system? If no significant role, how do you meet the needs of people with serious mental illness?
A: Julie Bluhm: Our public health department offers a Mental Health Clinic, and our Federally Qualified Health Center (FQHC) and hospital partners have behavioral health services integrated to various levels at their sites. Hennepin Health offers an open behavioral health (BH) network, so our members can benefit from BH services offered by any provider who is credentialed as a state Medicaid provider.

Q: Have you contracted with community mental health organizations? If not, how do you meet the mental health treatment needs of people with mental illness?
A: Laurie Lockert: No. Our job would be to work with the client if they want to go to any kind of specialty care, or through Motivational Interviews try to help them arrive at that decision for themselves. We would attend the initial appointment or more if they want support or help with advocacy.

CareOregon's PopIntel Registry

Q: Could you describe the PopIntel Registry used by CareOregon, mentioned in the presentation?
A: Laurie Lockert: The PopIntel registry system is a .net website that was built in-house to track the work of CareOregon. It tracks clients through a workflow progression with a date attached to each step ("status") through the program, so we can understand what type of dose of the intervention a client received. At every "end" status, either completion or decline from the program, we track a discrete categorical reason so we can better understand the nature of that resolution.

To access the diagram handout titled *Status Mapping and Definitions* please scroll down to the Attachments section of this URL:
https://www.resourcesforintegratedcare.com/node/251

Q: For PopIntel Registry are there issues sharing psychological information regarding what triggers a client, how to approach them, etc. Do you have framework for what's included to share?
A: Laurie Lockert: No, access to PopIntel is by authorization per each individual, and "need to know".

Q: Do you have an example of the data entered into the PopIntel registry which you can share?
A: See these two attachments:

1) Health Resilience Program - Encounter Documentation Form
2) Health Resilience Program - Intake and Goals Form

To access the two handouts related to the Health Resilience Program please scroll down to the Attachments section of this URL:
https://www.resourcesforintegratedcare.com/node/251

Q: Does the PopIntel registry denote where individuals generally stay, i.e. if they are living on the street or staying in another temporary residence?
A: Laurie Lockert: Our staff input information that is more pertinent to data we want to collect for our program, e.g., number of touches, where, interventions, history of trauma, housing ("transitional" vs. "staying with mother awaiting low income housing").

<u>Operating Processes</u>

Q: Do you track positive life outcomes such as length of time in independent supported housing, competitive employment, number of new outside relationships, number of community groups, activities, hobbies, etc.?
A: Julie Bluhm: Our Lifestyle Overview Assessment has questions related to social connectedness. Connecting individuals into meaningful relationships and helping them find meaningful ways to get involved in their community is still a challenge.

Q: How many community health workers (CHWs) are employed by Hennepin Health? What is the case load for each one?
A: Julie Bluhm: Hennepin Health employs 20 CHWs, and each one has a caseload of up to 200.

Q: How often do the staff of Hennepin County meet the members?
A: Julie Bluhm: Hennepin Health has 12,500 members enrolled. Some will never use health services. Others we "see" when they attend health care visits within our provider network. We do have a patient/member advisory group that meets at the health plan to get feedback about the member's experience. Care Coordination staff meet with the members as often as needed, based on their care plan.

Q: Do you use any particular training to help staff learn the "soft skills" needed to successfully work with clients?
A: Laurie Lockert: We use Behavioral Interviewing in order to get the most qualified candidates, and so we get experienced staff. We do provide ongoing Motivational Interviewing training for all staff, and ongoing training on addictions and recently 'Pain Management'.
Q: Could you describe the four categories you placed members into, and how that sorting was done?
A: Julie Bluhm: The categories are Extreme, High, Rising Risk, and General. The Extreme risk category we determined is the classic 5% of the client population who represent 40% of our costs. The Extreme and High risk groups are the smallest percentage of the population with the highest percentage of cost.

The categories allow us to prioritize. Some people in the Extreme priority category are there because they've got unavoidable utilization or high costs, so we're really telling our staff "We know that you're really overwhelmed. You need a way to prioritize the people who are coming to you. We're focusing on these Extreme and High Risk, but look at the patient and their history and use your clinical judgment to prioritize the best that you can." We're trying to identify those really avoidable utilizations.

We also had to accept the fact that we're not going to be able to provide Care Coordination to everybody who needs it as our population expands. We found that some key staff in clinics are sucked dry given how many people they could potentially be working with. When using someone like a community health worker who's not necessarily trained in setting boundaries with higher-ranking clinical professionals, we found that the risk-tiering categories helped them explain that we're trying to prioritize those two highest categories.

We are hoping that the clinics - via the medical assistants, the receptionist at the front desk, and the other normal Primary Care staff - can take the time to work with some of those lower-tier members or patients to meet the needs they have.

Q: What percentage of these clients, if any, have been assisted in placement into sober living environments?
A: Julie Bluhm: We placed 123 members directly into housing, we do not track whether the environment was sober.

Q: How many patients do your Nurse Care Coordinators typically carry on their panel?
A: Julie Bluhm: 150.

Q: What measures were taken to overcome the challenges associated with 5 different flow processes and the 5 different electronic medical records (EMRs) to coordinate care across the various partners/collaborators?
A: Laurie Lockert: Over time, working with clinics, we developed some common practices which could accommodate different EMR's and unique clinic workflows. For instance, we knew that it takes about 3-6 months for a Health Resilience Specialist (HRS) to become a true part of the clinic team. First, we collaborate with the clinic leadership every step of the way, meeting weekly to discuss new workflows. Second, it is the job of the HRS to get to know the clinic first off. The first month is spent shadowing all aspects of the clinic work/staff. Clinic leadership introduces them and takes them to all huddles, etc. We are clear from the beginning that this is collaboration and we work together with the Leadership to make the staff an active member of the clinic. We also have a Doctor Champion at the clinic, whenever possible, who takes ownership, believes in the program goals and will make sure that his/her peers understand and use the program. At every opportunity that first year, we have Providers and HRS share cases together to the clinic at All Staff to inform everyone about how to utilize the HRS.

Q: Did you have any barriers when stationing caseworkers in the Emergency Rooms?
A: Julie Bluhm: I mentioned a number in the webinar. It is important to find a few "champions" in the emergency department to make referrals. We had the case manager attend their staff meetings and build relationships with the social workers, which made a big difference.

<u>Cell Phones</u>

Q: Could you explain further the challenges and successes tied to giving clients cell phones?
A: Julie Bluhm: The biggest challenge is the fact that you probably aren't going to get the cell phone back. Initially, we had a system to keep track of the cell phone by numbering each one. We had to determine a period of time in which we would shut it off if we weren't in contact with the member. We did ask staff to do their best to try to get the phone back, but that hasn't been successful. Essentially, we're giving the member the cell phone and we're acknowledging that they're probably going to use that cell phone and they can use that cell phone for other calls. I think that that's been somewhat of an incentive and I think that that is a benefit to engagement. We had to decide if someone wasn't engaging at call we would turn it off after a month. If they were engaging for a while and that was critical to the engagement with the worker, we would continue to have the cell phone on until they ended services.

Q: How do you fund the cell phones you give out to perspective patients?
A: Julie Bluhm: They are funded through the savings left over when our members' health costs are covered. They are essentially administrative funds.

Q: Did you limit the number of minutes on the cell phones distributed?
A: Julie Bluhm: Yes, 300 minutes. They ran out fast, but were useful for establishing an initial path for contact.

Resources

Q: Where can we access the recording of this presentation?
A: See the Resource for Integrated Care website link here:
https://www.resourcesforintegratedcare.com/node/251

Q: Can you recommend an outstanding "Cultural Competence" training resource?
A: Bill Dean: We recommend Georgetown's National Center for Cultural Competence:
http://nccc.georgetown.edu/
Laurie: No, I am afraid not. We try to hire culturally diverse workforce who share their unique areas of expertise with the team. We send staff to culturally specific trainings.

Q: Is there a particular approach that works to convince decision makers to invest in embedded staff?
A: Bill Dean: This tool by Community Catalyst on "Creating Buy-In" should be helpful to you.
http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement/creating-buy-in-and-making-consumer-engagement-a-top-priority

Q: Are there any other helpful tools to utilize while engaging the hard-to-reach population that you have found most successful?
A: Laurie Lockert: I can't stress enough the need for a Trauma-Informed and Trauma-Responsive trained staff. That is truly a major key to our success!
A: Julie Bluhm: All of the tools we have found to be effective were presented.