

The Lewin Group
Innovations in Member Engagement in Rural Areas
November 27, 2018 1:00 p.m. EST

Alana Nur: Thank you. My name is Alana Nur. I am with the Lewin Group. Welcome to the webinar, "Innovations in Member Engagement in Rural Areas."

Today's session will include a 40-minute presenter-led discussion, followed up with 20 minutes for discussion among the presenters and participants. This session will be recorded. A video replay and a copy of today's slides will be available at <http://www.resourcesforintegratedcare.com>.

The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access the number, click the black phone widget at the bottom of your screen.

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This webinar is supported through the Medicare/Medicaid Coordination Office at the Centers for Medicare & Medicaid Services. MMCO is developing technical assistance and actionable tools based on successful innovations in care models such as this webinar. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time, I'd like to introduce our speakers for today's webinar.

Terry Cumpton joined the Centers for Medicare & Medicaid Services in 2002, and for the past 10 years has been the Rural Health Coordinator in the Seattle region office where she acts as a liaison between the agency and rural health providers and beneficiaries. She provides information to stakeholders about CMS' payment, coverage and participation rules to rural health clinics, federally qualified health centers and critical access hospitals in Alaska, Idaho, Oregon and Washington. She is also a member of the CMS Rural Health Council and advises the chairperson about issues and concerns of rural providers.

Jamie Hanes has 17 years of case management experience and has been employed by Upper Peninsula Health Plan, a managed care organization, since January 2013. She now serves as the Clinical Services Assistant Manager for Case Management at the health plan, with a specific

focus on the dually eligible population. Jamie has a Bachelor's of Social Work degree and worked for several years as a foster-care case manager before switching to focus on the dually eligible population. Jamie worked with home- and community-based waiver programs for seven years prior to her employment with Upper Peninsula and has managed a home- and community-based waiver program for the dually eligible population at the health plan since March 2015.

Jen Bundy has been a nurse for over 16 years and has been employed with PrimeWest Health, a managed care organization, for over 11 years. She is the Director of Care Management. She earned her Master's in Nursing at the University of Alabama. Jen has worked in a variety of rural settings, including home care and skilled nursing facilities.

Elizabeth Warfield has been a nurse for over 15 years and has been employed by PrimeWest Health since May of 2015. She is a Special Needs Plan Manager. In her role, she provides education for county case managers in PrimeWest Health's 13 rural Minnesota counties. She has a Bachelor of Science in nursing and is a certified public health nurse.

After the presentation from each of the speakers today, you will be able to 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; and recognize strategies for using case management to engage rural members in managing their health.

Today's webinar will start with some polls, and we'll move to a presentation from Terry Cumpton on member engagement in rural areas. After Terry, Jamie will show strategies from Upper Peninsula Health Plan on making contact and building trust with new members. Next, Jen Bundy and Elizabeth Warfield will present on PrimeWest Health's community-based care management and addressing barriers to care in rural areas. And lastly, we'll have ample time for questions and answers.

To begin with, some polls. If you could answer: Which of the following best describes your professional area? I'll give everyone a minute to answer. If you could show the results. Wonderful.

Thank you, everyone, for joining today. It looks like we have a number of health plan case managers and care coordinators as well as health plan administration and management, and a number of others as well. Thank you so much.

For the next poll, please answer: In what setting do you work? Great. If we could show the answers to those as well. Wonderful.

It looks like we have a number of folks from health plans today as well as community-based organizations. Thank you, everyone, for joining us today and for sharing.

We will now move to the presentation from Terry Cumpton. Terry, I will pass it off to you.

Terry Cumpston: Thank you. Hello, everyone. I appreciate being with you here today. Let's get started. Next slide.

Believe it or not, the federal government has over a dozen definitions of "rural." Some of them are very technical and used only for a specific situation like for a certain grant or for protected lands, but for our purposes today, we're going to use the Census Bureau's definition there, that first bullet. Rural America is sometimes isolated by mountains, desert, forest or farmland. Other times, it's within a 40-minute drive of a metropolitan area.

While many of these areas fall within the Census definition of "rural," their community character and needs are different. That being said, there are many common characteristics among people in rural areas. They tend to be older, sicker and have lower incomes than their urban counterparts, and many of them are enrolled in both Medicare and Medicaid. Next slide, please.

On this chart, you can see that over one-third of rural adults across the country have incomes below \$25,000 a year, and note the income disparities by race and ethnicity, with over half of black, Hispanic and American Indian/Alaska Native rural adults with incomes under \$25,000 a year. Next slide.

When you add that with the number of adults in rural areas who report poor health, you can see that, again, black, Hispanic and American Indian/Alaska Native rural adults report poor health status compared to just 19% of white rural adults. Next slide.

This chart shows us that there are a higher percentage of duals in rural areas, with the three light-blue bars on the right representing towns of 10,000 to 50,000, and remote or frontier areas are a further breakout of that all-rural bar. So, micropolitan, small adjacent and remote indicates lower population areas that are just a greater distance from urban centers as you move out. Next slide.

This chart represents all duals across the country. You can see by the large yellow slice that dual-eligible beneficiaries are more likely than non-duals to self-report a poor health status. Next slide.

Here, you can see among duals across the country, they're more likely to have limitations in activities of daily living, with 56% of dual-eligible beneficiaries having at least one limitation, compared to only 26% of non-duals.

So, that's some key data on how many people in rural areas are older, sicker and poorer. We've seen that dual-eligible beneficiaries also tend to be sicker and have limitations in daily activities. So, how can we talk to them about being active in their own health and health care? We do that by building trust. Next slide.

An important part of any interaction is meeting people where they are, and I mean that in a social sense where you spend time gaining an understanding of a person's circumstances and priorities, but I also mean physically engaging them where they are. Face-to-face communication is very important to people in rural areas. We know that many people in rural areas have very strong ties

to their communities and tend to have less trust of people, organizations and institutions outside their own communities.

In Alaska, for example, they actually use the term "outside" when describing an organization that is not in Alaska. Often, instead of saying that something's from the Lower 48, they'll say it's from outside. The first time I ever saw a headline in an Alaskan newspaper, it said something like, "Accounting Irregularities at the Parks Commission, Will Use a Firm From Outside." I was very surprised. It's a term that underscores the sense of community that all Alaskans have.

Where I grew up in Montana, we used to call everyone who wasn't from Montana "tourists." Even a doctor who may have grown up in neighboring Idaho and then went to medical school in Seattle, once she came back to our town here in Montana, she was a "tourist." We didn't expect her to set down roots or stay like the rest of us. But if she bought a house, maybe went to a PTA meeting and then, over coffee in the living room, told us how she voted on the school levy, she became one of us, and in future, we'd have coffee in the kitchen, like all friends do.

That was a long time ago, and with the Internet and cell phones, communication is so immediate that there's fewer strangers, but it's still important to understand the sense of community and, where possible, have face-to-face conversations with people in rural areas. Demonstrating commitment to a rural community can build trust. It doesn't have to be buying a house in town; it can just be being regularly available to the member and their family.

We saw earlier how people in rural areas tend to be poorer, so understanding cost and coverage is key, especially for people who are very low income. Dual-eligibles may not seek care because they don't think they can afford it. At the same time, others with dual coverage think that everything will be paid for and don't understand there may be co-payments for certain services or frequency limits, step therapy or other formulary restrictions for medications. So it's very important to communicate coverage and benefits clearly to members and to their families to gain trust, and that knowledge will give them the confidence to seek care.

It's also important to engage their health care providers and help providers understand coverage for their dual-eligible patients. Health care providers are trusted information sources and can help patients understand coverage and benefits that help them improve their health. Benefits like diabetes prevention programs, for example, letting patients know that enrolling in a diabetes prevention program that costs the patient nothing but provides information, support and encouragement so they eat better, get regular exercise and can ward off a devastating disease. If they hear about the full coverage and benefits from their insurer and their clinician, they may be more inclined to take action.

In my work with rural clinicians and health care facilities in the Pacific Northwest, I found it valuable to partner with senior organizations in these communities as well. Key partners in small communities for people with Medicare and Medicaid are county aging programs, senior centers and libraries. So talking to the directors about a new program or a new health benefit can be very helpful, and they might help you better understand their communities. Next slide.

The health care environment is changing rapidly. Medicare is incentivizing integrated care, making single bundled payment for an entire episode of care, and funding accountable care organizations that require a high level of interaction and coordination between health care providers. Some health plans initiated these kind of payment structures before Medicare did, while others are implementing them now. Helping patients understand what this means for them ensures they stay engaged in their own care and is a key element of successful system transformation.

Each year, several people in our office take a week and we go on what we call a rural road trip. We travel through a rural area of our region, stopping at small towns along the way and meeting health care providers and Medicare beneficiaries. We share a little information, explain what's new in Medicare, but mostly we're there just to answer their questions and listen, with the intention of solving problems and clearing the air. We hope we can teach them how to resolve any problems they're having on their own, kind of teach them to fish.

We make a conscious effort to ensure our travel team reflects the diversity and the voices of the people we're making these connections with. Honoring their voices helps engage them in their own care, and by engaging them in their care, you can address the outcomes that matter to them. We're all busy, but we know this kind of in-person engagement is important to the people we serve. Implemented effectively and sustained over time, member engagement is key to transforming the delivery system in ways that work for everyone. Next slide.

I talked a lot about gaining trust. However, people in rural areas also face other unique barriers, too—the distances they travel, reliable transportation options and a lack of providers—so it's important when talking to members of your plans or the potential members that you're clear what doctors and hospitals are covered by the plan and what costs, if any, will be incurred if they see somebody outside the network.

If telehealth benefits are available, help patients understand what that is and that it might help them meet a specialist that's not available in their town. Telehealth offers a lot of promise to improve access to care in rural areas, and CMS recently made it easier for health plans to provide telehealth services. But recent studies have shown that rural patients in particular for some reason are less likely to embrace these services. Encouraging them might help them find a provider that can help them. With provider shortages, especially in behavioral health and substance abuse treatment, telehealth offers access to professionals trained in the specialized care needed. Next slide.

The effort to transform the health care system to reduce costs and improve patient outcomes is gaining speed. It's not slowing down. Engaging every member in their care is an important part of this effort, and ensuring no one is left behind, no matter their circumstances, is something all of us can help with. If you'd like to stay abreast of CMS' work with rural providers and patients, we have a rural health page at the address you see here, and you'll find information and announcements along with links to our resources like coverage to care materials, which help people understand the language of health insurance and how to engage in their own care. You're welcome to download and print them or order them from us to hand out to people you talk with.

With that, thank you for listening, and I'll turn it over to Jamie from Upper Peninsula Health Plan.

Jamie Hanes: Thank you, Terry. Good afternoon. My name is Jamie Hanes, and I'm the assistant manager for case management here at the Upper Peninsula Health Plan, or UPHP for short. I appreciate the opportunity to speak a bit about how we make contact and build trust with our new members.

UPHP is a managed care and provider service organization based in Marquette in the Upper Peninsula of Michigan. The health plan manages the care of nearly 50,000 Upper Peninsula residents, approximately 4,200 of whom are dually eligible beneficiaries. UPHP employs 22 case managers to work with this population, with each dually eligible member assigned their own care manager. Care managers assist with service provision and navigation across the continuum of the health care system, and they also ensure that members understand their benefits. Next slide, please.

Like I said, Marquette is located in Michigan's Upper Peninsula. The Upper Peninsula, otherwise known in Michigan as the UP, is unique in that all 15 counties located in the peninsula comprise one-third of Michigan's land mass but only 3% of Michigan's population lives here. The Upper Peninsula is six hours across end to end by car and is bounded on three sides by water. Lake Superior is to the north of us, on the east is St. Mary's River, on the south by Lake Michigan and Lake Huron, and on the west we're attached to Wisconsin.

Much of the land is undeveloped, with 90% of the western UP covered by dense forest. It's very beautiful up here, but this high concentration of forested land inhibits self-service and service provision. Next slide, please.

UPHP uses the philosophy of person-centeredness when it comes to member engagement. UPHP believes person-centered care is essential to serving dually eligible members. A kind of canned definition of "person-centered" is supports and services designed and delivered in the highest-quality setting possible that provide the least amount of restriction and the maximum amount of independence and control.

UPHP achieves this by seeing a person rather than a client or a diagnosis. We focus on assisting the member and maximizing or maintaining their independence, by having an open discussion about goals that are important to them. For instance, a member may be experiencing food or housing instability, and addressing social determinants of health first often becomes the gateway to building trust, which then allows us to work on health goals with better health outcomes to be the focus.

We also assist individuals in maintaining their community connections. Often this is fleshed out by discussing with the member their dreams, goals and desires. Like Terry had mentioned before, we meet the individual where they are with regard to goal development. We identify what goal is most important for them to start working on so that we're better able to get our foot in the door and build some of that trust.

Recognizing the individual's cultural background is also important. For instance, UP residents are often very stoic and will not often feel an acute need to address symptoms until it's at a critical level. By offering a level of understanding as well as education about the member's chronic health condition, always keeping in mind the health literacy of the member, UPHP's case managers begin a process that is meaningful, collaborative and involves an ongoing commitment to the whole person. Next slide, please.

Some challenges to member engagement can be varied. They include incorrect or missing contact information. Oftentimes the contact information UPHP receives from state files when a member comes on plan with us is no longer accurate or it's not available. In addition to this, members may be mistrustful of unsolicited contact and unfamiliar telephone numbers, and there's always the challenge of spotty cell phone service, or the member may have limited minutes on their phone plan.

Ongoing challenges to member engagement include engaging members in follow-up care, particularly after care transitions, and I'll get into more detail about UPHP's transition of care process in a later slide.

And there's always a bit of skepticism or mistrust of a new insurance plan. Next slide, please.

Some promising practices in making initial contact that UPHP employs is making at least five outreach attempts to all dually eligible members within 45 days of enrollment. These attempts are made by phone to contact members during different times of the day over multiple days, with some call attempts made outside of normal work hours. Our care managers have noticed, too, that attempts are more successful in the beginning of the month as members may have more minutes left on their phone plan.

If the member is unable to be reached, a note is made in the case management system, and those folks are grouped under passive case management, and then follow-ups are scheduled for those people for claims reviews in an attempt to glean any additional contact information in the future.

Again, contact information may not always be accurate. In addition, some members are transient or homeless and change phone numbers and residences often, which is an additional challenge.

When phone numbers are inaccurate or the member is difficult to reach, UPHP care managers will use claims data to identify primary care provider offices, which may be useful in obtaining current member contacts.

We also look to the Department of Health and Human Services, pharmacies, the prepaid inpatient health plan, and use those as other sources to find a current phone number or contact information. Just recently, UPHP reached a previously unable-to-reach member during a routine claims review, in which it was discovered the member had recently had an eye exam. The case manager noticed this during the claims review and reached out to the eyecare provider, and that eyecare provider was able to provide a current and working phone number for the member, and our outreach with that member was successful. Next slide, please.

UPHP initially used an outside vendor for initial outreach for our dual-eligible population. However, we found members would not always answer unsolicited calls from an unknown, out-of-area phone number. Many members were distrustful of a phone call coming from a non-local area code.

Attempts to establish contact with members were more successful when the call came from UPHP. One advantage we have in the UP is that the entire Upper Peninsula has only one area code, so the population will identify that area code as local and hometown and one which people can trust more readily. When we started making those phone calls internally, we saw a much better level of connection than we did additionally. Next slide, please.

Phone contact can also be difficult when members have limited minutes, like I mentioned before. To reach members through other means, the care manager will send an unable-to-reach letter to the home address we have on file. That letter requests contact and explains the enrollment in the health plan and also provides information on how to contact their case manager. The care manager also includes a business card with each letter as an additional form of contact information.

The care manager will also mail a letter to the primary care provider we have on file. This letter indicates that their patient is a UPHP member and that their care manager is trying to contact them.

The case manager will also monitor claims to identify members with high ER utilization, and they also use ADT feeds that inform the case manager of recent emergency room visits and hospitalizations. This can also be successful in member contact and follow-up. Next slide, please.

Some promising practices also include UPHP's transition of care program. This transition of care program provides member support prior to, during and after transitions between care settings and between different providers of the same service. UPHP's transition of care process regarding member contact when a member is hospitalized will often prove successful in member contact and engagement. Staff providing transition of care services inform the member of his or her right to live in the most integrated setting. They'll inform the member of the availability of services necessary to support his or her choices, and those often include home- and community-based options as well as other settings considered by the member. This process also serves to identify any barriers or needs the member may have.

UPHP staff, in coordination with the provider discharge planning staff, help members make informed choices about their transitions and preferences for care after discharge. This sometimes will involve a case manager visiting the member in the hospital to perform assessments and identify needs. UPHP has established relationships with local hospitals and other providers to facilitate this coordination of the transition.

UPHP feels strongly that case coordination that begins before discharge in these situations ensures members can access services they need and have continuous engagement and communication throughout the transition and the recovery. Beginning engagement with the

member before discharge is critical, as communication may become difficult after discharge. The goal here is to educate the member about additional services that may be available to them and to set up in-home assessments as agreed upon by the member to ensure service provision.

Case managers also use this time to review discharge instructions to ensure barriers to follow-up appointments or medication issues are addressed. Next slide, please.

During home visits, case managers identify additional unmet needs and work to connect members with community resources. Some of those resources can include food assistance, heating assistance, home weatherization, transportation, literacy barriers and housing assistance. Showing a genuine interest in the member and demonstrating plan benefits available to help them helps members feel more comfortable with the home visit. In addition, UPHP ensures that members can call their case managers directly and that typically if the member has to leave a voice message, the care manager will most often call back the same day, if possible. Our members have commented that they appreciate this ease in connecting with their case manager, and it goes a long way in building trust as well.

Prior to a home visit, the case manager has a discussion with the member regarding their preference for who should be involved in their meeting or in service provision. This is the framework in which an integrated care team is developed with the member, and it's important in helping the member become comfortable during the assessment process.

UPHP also involves and contracts with the Area Agency on Aging. We also are in close contact with community action agencies and other familiar organizations in the community, ones which members easily identify as trusted entities. Next slide, please.

An additional challenge in working with dual-eligible members is when a member is homeless. UPHP does identify members who may be homeless through case manager assessments as well as referrals from other agencies. Sometimes our state eligibility files will identify a member as homeless.

Again, we partner with the Area Agency on Aging and other community organizations to connect members who are homeless to housing and other resources. Some of those organizations might include local churches, homeless shelters and warming centers that provide meals.

And just to provide a snapshot of the homeless demographic in our area, I found a little bit of information. In 2017, the Housing and Urban Development Report indicated 84 people in Marquette County, which is the largest county in the UP, were living in places like a shelter, transition home or directly on the streets. However, local shelters show different numbers. For instance, the warming shelter located in Marquette sees approximately 20 to 25 people a day, and the number of homeless could be much larger, considering those living in cars or couch surfing.

Statistics from the local Police Department in Marquette alone indicate that officers responded to 400 calls regarding homeless incidents in 2015 and 2016 combined. In the first six months of 2017, police responded to 369 such calls, so the problem continues to grow within our region. Next slide, please.

To establish a community presence and build trust with members, UPHP has a presence with their contact with the Area Agency on Aging and all 15 counties in the Upper Peninsula, and UPHP relies on the Area Agency of Aging and their knowledge of their specific local areas and ability to meet with members face to face in their homes.

We also host office hours in community mental health agencies by placing a case manager in those agencies for face-to-face communication opportunities with members. This goes a long way in facilitating care coordination between physical health and mental health, as the UPHP care manager often works closely with the behavioral health care manager in these instances.

UPHP also sponsors community projects and participates in community service activities and events to build relationships. Some of those things are Toys for Tots, the Can-a-thon food drive and homeless-shelter fundraisers. UPHP also sponsors several projects throughout the community, such as the National Drug Enforcement Agency Medication Take Back Day, a Night Out for the Women's Center, which benefits survivors of sexual and domestic violence, and the National Alliance on Mental Illness Walk, which helps raise awareness of mental illness and raises funds for people in need of mental health services. Next slide, please.

Another feature of the UP health plan is its transportation program. Transportation is a challenge almost everywhere but significantly so in rural areas. Because of this, UPHP has an entire department dedicated to providing transportation for its membership for medical care. For members and their caregivers providing their own transportation, UPHP provides an option for transportation reimbursement. This reimbursement could include mileage, and sometimes our folks need to travel quite a ways away, so if there's an overnight trip, UPHP will help assist with defraying hotel costs and food costs.

UPHP provides transportation also through a pool of local volunteer drivers, and these drivers are recruited through advertising in local newspapers and on social media.

UPHP also offers several avenues to request transportation to make it a little bit easier for membership. Members can ask their case manager directly. They can also go to UPHP's website and fill out a form online, or they can call our transportation department directly.

UPHP is proud of its transportation program, and we're often able to accommodate almost all requests, given our five-day advanced-notice rule for non-emergent transportation needs. Next slide, please.

This is just a brief case study just kind of outlining our attempts at contact for somebody who is hard to reach and the resolution. This is someone who is 60 years old and dually eligible. She was very difficult to get a hold of in 2016. She would isolate herself a lot from the public and from interacting in her community. In 2017, she was hospitalized, and due to our transition of care efforts, the care manager was able to make contact with her.

Through this contact, the case manager was able to educate the member, set up services and assessments so her needs could be met better. The member and the case manager built a rapport

through ongoing phone contact. She then had an event where she needed additional wound care, and she was unable to be reached again, but because we had a strong relationship with our Triple A, that case manager was familiar enough with the member to know that she frequented a dumpster that she used to like to sit by. So, that case manager found her there, had a talk with her right there outside by the dumpster, identified some additional needs and services, and those services were able to be put in place.

After that contact, this member had all her needs met. She has had no hospitalizations since 2017, and her last year ER usage was in April of 2018. So it was through this trust that she had previously established with UPHP, we were able to reconnect with her again, and to date she is medically stable and responsive to our outreach calls.

So that wraps up my part of the presentation, and I'll turn it over to PrimeWest.

Jennifer Bundy: Thank you, Jamie. My name is Jennifer, the Director of Care Management at PrimeWest Health. Next slide.

PrimeWest is a county-based purchasing health plan owned by our 13 rural Minnesota counties we serve. We're governed by a Joint Powers Board composed of two county commissioners from each of the counties. We are headquartered in Alexandria, Minnesota, with over 2,000 dually eligible older adults. Our service area is comparable to the size of Massachusetts, which has a land mass of 10,255 square miles. Next slide.

This slide highlights the characteristics of our population, including the average age is 81 years young. These members don't commonly use the Internet. They typically have hearing and vision deficits, along with mobility and emotional challenges that may affect social activities. They're also likely to have transportation challenges, which we will discuss further in the subsequent slides. These members also typically have two or more chronic conditions, fill an average of 10 medications monthly and receive home- and community-based services such as chore assistance or Meals on Wheels. Next slide.

Given the challenges we just discussed, engaging members can be difficult. Our main strategy is providing care management through outreach to identify member needs, preferences and address any barriers in accessing care. This is done by connecting members to health care and community resources such as public health and social services. Next slide.

Our engagement strategies are incorporated into our model, which you can see outlined on the right. The model is broken out into the four areas shown, which will be touched on on the following slide. Next slide.

"County integrated" refers to the integration of county public health and social services in our model. This provides members timely access to a coordinated set of services specific to their assessed needs. Through the county integrated care management program, members are navigated through person-centered processes for establishing providers, assessments, prioritizing their needs, monitoring progress towards goals and evaluating the effectiveness of the county integrated care management program from the individual member perspective. Next slide.

Now we will touch on the interdisciplinary care team, or ICT. This team is selected by the member based on their assessed needs and recommendations from their county case manager. The ICT members include county case managers, clinic care coordinators, providers and PrimeWest Health care coordinators who work collaboratively with the member to develop and implement care plans to meet their needs and achieve optimal health outcomes. The ICT members meet in a variety of ways, including in-person, telehealth and telephone calls, at a frequency based on the needs and preferences of the member.

I will turn the rest of the presentation over to Elizabeth Warfield, who is the Special Needs Plan Manager for PrimeWest.

Elizabeth Warfield: Thank you, Jen. Next slide, please.

Each PrimeWest Health dually eligible member is assigned a county case manager. Our county case managers are public health nurses and social workers with typical caseloads of one to 50 community members or one to 75 skilled nursing facility members. They live in the communities that they serve and have firsthand knowledge of community resources and service providers. They build ongoing relationships with members through face-to-face interactions and regular check-ins, making it more comfortable for members to interact with their plan. They utilize motivational interviewing and person-centered planning to help members develop person-centered goals, and coordinate services for members to improve health outcomes by preventing gaps in care and facilitating appropriate utilization of services. Next slide, please.

The interdisciplinary care team, including the county case manager and member, develops the member's individualized care plan based on the assessed needs and preferences of the member. PrimeWest Health's care plan was developed using an electronic platform. This allows for real-time updates and communication between interdisciplinary care team members.

The individualized care plan serves as the blueprint for coordinated services and support, and enhances member engagement. Updates are made by the county case manager and member during regularly scheduled interactions. The frequency of these interactions can vary greatly, depending on the needs and preferences of the member. However, a frequency of monthly or every three months is commonly seen. Next slide.

Shifting gears, we're going to talk about how we address some barriers to care. Members in rural Minnesota often reside on farms, which can be far from provider offices. Snow and ice in the winter can also contribute to increased travel times or reluctance to travel. In addition, limited transportation options can often lead to missed appointments or delays in receiving services.

To address this barrier, we've partnered with counties and communities to connect members with local volunteer drivers and contracted transportation providers. We reimburse the volunteer drivers for no-load mileage, or miles driven without passengers, and have provided grants to organizations to purchase transport vehicles. Next slide, please.

In addition to the difficulty with transportation, there is a low availability of dental providers in rural Minnesota. To improve dental health provider availability, PrimeWest Health supports mobile dental clinics, which visit places like skilled nursing facilities, public health and adult foster care. We also have a dedicated dental services care coordinator who works with members, county case managers and providers to coordinate services.

PrimeWest Health works with communities to identify developing access issues and address them proactively. One example of this is a grant opportunity we've provided to an existing clinic to expand and add a location in a PrimeWest Health community. Next, please.

To show our model in action, we have a case study we'd like to share.

Sam is an elderly male living alone in rural Minnesota. Like many older Minnesotans, Sam was stoic and reluctant to reach out for help. However, a trusting relationship had been established with his community case manager, and during a regular check-in, Sam mentioned he had an eye appointment coming up but no way to get there. He'd recently lost his driver's license because of a failed vision test. He allowed his county case manager to contact the county transportation coordinator to arrange a ride for the appointment. Next slide, please.

Concerned there may be other impacts related to Sam's vision change, the county case manager asked some additional questions and learned that Sam had fallen twice and wasn't able to get to town for groceries. The next day, the county case manager met with Sam to complete a health risk assessment and was able to identify additional supports and services that could be put into place until Sam had his new glasses and was able to safely return to his previous level of functioning.

This example illustrates the importance of routine contact with members. It not only allows county case managers to follow up on the effectiveness of the plan of care but also allows for identification of acute or emerging needs. Next slide, please.

To sum up, we believe initial engagement is only the beginning. Our model works to sustain member engagement by building and maintaining trusting relationships using multiple methods of member engagement and encouraging members to remain actively involved in their health care decisions.

Thank you.

Alana Nur: All right. Thank you so much, Terry, Jamie, Jen and Elizabeth, for your presentations. This has been incredibly informative. Thanks so much for joining us today. And with that, we now have a few minutes for questions from the audience.

At this time, if you have any questions for our speakers, please submit them using the Q&A feature on the lower left of the presentation platform. Type your comment at the bottom of the Q&A box and press Submit to send it.

I'll get started with some of the questions that have come in already. A question for Jamie: Can you describe your partnership with your local Area Agency on Aging for care management?

Jamie Hanes: Sure. UPHP has set up a contract with our Area Agency on Aging. We did this because this Area Agency on Aging has a presence, like I said, in all 15 counties in the Upper Peninsula, so they have a presence in all the local areas where our membership lives. They're also very well versed in home- and community-based services because they run their own programs that are similar to some of the programs we run here at the health plan.

So we work very closely with them. We work in tandem with their case managers. Their case managers will often be our eyes and ears and our first line of really needs identification. They'll communicate all of that information back to us, and then we build our case plans from there.

Alana Nur: Great. Thank you, Jamie. This can go—I'll start with you, Jen and Elizabeth from PrimeWest, but, Jamie, feel free to jump in as well. One of the issues that comes up in rural areas is low specialty provider availability. PrimeWest, you spoke about improving access to dental care, but are there things that you do to help improve access to specialty care as well?

Jennifer Bundy: We do provide the transportation to the specialist that the member may need to go see.

Jamie Hanes: I would second that. This is Jamie. We often have to send folks out of the service area because we do have a lack of certain specialists in our areas, so we do provide the transportation reimbursement for defraying hotel costs and food.

Alana Nur: Great. Thank you. And both of you, Upper Peninsula and PrimeWest, you both use volunteer drivers. How do you go about recruiting volunteer drivers, and is there anything that you do to vet the drivers that are selected?

Elizabeth Warfield: Hi, this is Elizabeth at PrimeWest. That's actually something we delegate to the counties. They have transportation coordinators there who do some of that outreach and find volunteers to help with that.

Jamie Hanes: Here at UPHP, we have our transportation department in-house. We do advertising through local papers, word of mouth, through social media. There is a vetting process as far as applications and interviews. I don't want to speak out of turn. I don't work for that department, but I would question if we also do background checks. I believe we do.

Alana Nur: Thank you so much. Jamie, this is a question for your presentation from Jessica from Pennsylvania. Do you run into any HIPAA compliance issues when you're reaching out to primary care providers to connect with a member?

Jamie Hanes: No, when we do outreach to the primary care provider that we have listed on the enrollment file, the treatment payment operations covers anything of that nature. When we're talking about behavioral health, we do obtain consent that allows us to speak freely with the behavioral health component of our integrated care.

Alana Nur: Thank you. This goes for any of the speakers. How do you address—I think some of you mentioned health literacy, but how in general do you address literacy or language barriers, particularly when mailing written materials to members?

Jamie Hanes: This is Jamie again. All of our correspondence is written at a Sixth Grade reading level. We do run our standardized letters through those literacy checks, just to ensure that there's a level of understanding across the span of our entire membership.

Jennifer Bundy: This is Jen at PrimeWest. We have the same criteria, that we have to run our information through the literacy checks. We're at a Seventh Grade reading level or below.

Alana Nur: Thank you. Terry, this is a question for you. You mentioned the importance of honoring members' voices as an important part of member engagement. Can you say a little bit about maybe some recommendations or strategies for honoring members' voices?

Terry Cumpton: I think really the crux of that is listening to them and having some cultural awareness. If you're working with American Indian or Alaskan Natives, for example, understanding that what the health care environment is in their tribal community and how that might be different from accessing care outside the tribal community, and engaging the family, not just the member. Hearing the trust that they have in their community providers, tribal community providers, and trying to make those linkages perhaps even through the provider with other providers that they might need to see outside that tribal community is important. Listening to their stories is very important as well and just gaining a good understanding of where they're coming from.

Alana Nur: Thank you, Terry. So for either Upper Peninsula or PrimeWest, do either of you contract with outside transportation or ride-share companies such as Uber or Lyft?

Jamie Hanes: This is Jamie. We're so rural that we don't have Lyft or Uber. We do work with our local transportation, our bus service, in a few of the areas here in the Upper Peninsula, and we also contract with taxi services as well.

Jennifer Bundy: That's the same for us. It's a great idea but not something we're doing at this point.

Alana Nur: That makes sense. Do the folks at Upper Peninsula or PrimeWest, do any of you use peers or peer supports in extending your outreach or engaging members as part of any of your programs?

Jamie Hanes: Can you clarify what you mean by peer support?

Alana Nur: I think that's open to any way that you might engage peers or other older adults that you might engage in your programs to work with members and maybe complement your case management. I'm interpreting the question hopefully correctly.

Jamie Hanes: No, UPHP doesn't use peers. Through our dual-eligible program, the folks, our case managers, all are required to have a certain licensure to work with our members, so we haven't engaged in any of the community health workers or peers of that nature.

Elizabeth Warfield: This is Elizabeth at PrimeWest Health, and what Jamie said is actually accurate for us as well.

Terry Cumpton: This is Terry. If I could just add, a lot of times they were talking about working with the Department of Social Services or Department of Health and Human Services and the county aging organizations. Those are oftentimes folks who engage volunteer organizations like Statewide Health Insurance Benefits Advisors, are what they're called here in this part of the country. Those are volunteers that are basically a peer network. Same with Retired Senior Volunteer Program, if you're dealing with aged folks. Running information through them or engaging those groups can also be helpful in communicating.

Alana Nur: Great. Thank you, Terry. On a related note, you mentioned the importance of engaging trusted information sources, and you mentioned senior organizations. Can you say a little bit about what you might recommend if plans are looking to begin engaging with senior organizations and where they might start?

Terry Cumpton: Sure. I know that here, a lot of plans connect with the departments of insurance and their information channels in terms of education, just explaining plans' benefits, the populations that they reach. It's usually done rather informally, but it's a good way to make yourself available and give them a connection point if they have questions or need some follow-up as they work with people in the community.

So I would say they're either Senior Health Insurance Benefits Advisors or State Health Insurance Benefits Advisors, and they're usually attached to the Office of the Insurance Commissioner, although sometimes with county aging organizations.

Alana Nur: Great. Thank you, Terry. I only have two minutes left. I think I just wanted to open it up for either PrimeWest or Upper Peninsula, are there any strategies that have stood out to you that maybe other plans might not yet have thought of or that are particularly helpful? With your rural focus, I know all of you have had significant experience in rural areas engaging members. Anything that you haven't yet covered that you might add?

Jamie Hanes: This is Jamie from UPHP. I can't think of anything I would add. We've just really found that once we're able to do something for our membership, either through a benefit that we provide or a service, typically through transportation—a lot of our contact comes from our transportation department—that really is the door-opener for a lot of our hard-to-reach members.

Alana Nur: Thank you, Jamie. Anything from Jen or Elizabeth?

Jennifer Bundy: I think we were just going to reinforce what Jamie was saying earlier about calling. They had called an eye doctor to try and get an updated phone number for a member. We call pharmacies, eye doctors, home-care agencies, just so we can connect with that member.

We've found once we can connect with the member and they see our value, that relationship starts to build and we are able to create the assessments and the care plans and follow the member and assist them in what they need.

Alana Nur: Great. Thank you so much. Thank you, everyone. That concludes the end of our Q&A period. At this time, if you have additional questions or comments, please email RIC@lewin.com. Please also visit the Resources for Integrated Care website for additional resources. You can find a spotlight on PrimeWest Health on their innovative member engagement strategies for rural areas on the Resources for Integrated Care website, if you'd like to learn more, and you can also find a spotlight in the resource list on the left-hand side of your screen now.

To view previous webinars on engaging hard-to-reach populations, please visit the link on this slide.

And please register for our upcoming webinar next Wednesday at 12 PM Eastern on palliative care.

The slides for today's presentation, a recording and a transcript will be available on the Resources for Integrated Care website shortly.

At this time, the post-test for this webinar is open. Additional guidance about obtaining credits and accessing the links to the post-test can be found within the Continuing Education Credit Guide in the resource list on the left-hand side of your screen or at the Resources for Integrated Care website.

Thank you, everyone, so much for joining us today. Please complete a brief evaluation of our webinar so that we can continue to deliver high-quality presentations. If you have any questions for us, please email us at RIC@lewin.com.

Thanks again to all of the speakers. Have a wonderful afternoon, and thank you so much for your participation.