The Lewin Group
Hard-To-Reach Populations: Innovative Strategies to Engage Isolated Individuals
September 15, 2015 - 2:00pm to 3:00pm

Amy Herr: Thank you and welcome everyone. My name is Amy Herr and I work at The Lewin Group. Thank you for joining us today for the "Meaningful Member Engagement Webinar Series," and today's webinar on "Hard-to-Reach Populations: Innovative Strategies to Engage Isolated Individuals with Behavioral Health Needs."

This webinar is the third in the series presented in conjunction with Community Catalyst and the Lewin Group and supported through the Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare & Medicaid Services. MMCO is developing technical assistance and actionable item tools based on successful innovation care models, such as the webinar series. To learn more about our current efforts and resources, please visit www.ResourcesForIntegratedCare.com for additional details.

The website www.ResourcesForIntegratedCare.com also has complete bios for each of the speakers on today's call. Within a few days we'll be posting a recording of this presentation, the slides and the Q&A from the call on our website. If you have any questions or additional comments, please email us at RIC@Lewin.com after the call. During the call, you can use the Q&A function on the Web platform.

Before we get started, I'd like to remind you that microphones will be muted throughout the presentation, but there will be a question-and-answer opportunity at the end of the call.

At this time, I'd like to introduce our moderator. William Dean is the Delivery Systems and Consumer Engagement Manager at Community Catalyst. William?

William Dean: Thanks, Amy. Hello everyone and thanks for joining us today. As Amy said, I'm with Community Catalyst, which is a national nonprofit consumer health advocacy organization, working in over 40 states to bring the consumer voice to any discussion that impacts their healthcare. Whether that be at the federal or state policy level, at the delivery system or health plan level, or the individual patient-provider level.

I want to thank the Lewin Group and the Medicare-Medicaid Coordination Office for working with us to put out this series. I invite attendees to check out our Consumer Engagement Tools at www.CommunityCatalyst.org.

I'm joined today by Julie Bluhm, the Clinical Operations Manager for Hennepin Health, an award-winning Safety Net Accountable Care Partnership serving the Medicaid expansion population in Minneapolis, Minnesota. Laurie Lockhert is the Health Resilience Program Manager at CareOregon, the recipient of a Center for Medicare-Medicaid Innovation Grant and delivery system to Medicare-Medicaid and dually eligible beneficiaries across 11 counties in Oregon.

Right now, I'm just going to outline an agenda for today's discussion. After I give a brief overview of other resources that are available that will help you strategize on finding and engaging your members, Julie will present on Hennepin Health and take a deep dive into their

Care Coordination Model and other innovative strategies that they're using. Then Laurie will present on CareOregon's approach, their Health Resilience Program, and how they've succeeded to find and engage members and develop trusting relationships with them. After Laurie's presentation, we'll do a couple of interactive polls to learn a little bit more about you before we dive into a question-and-answer period.

Before we get started, I wanted to make sure that you all know about some really helpful resources on today's topic that are out there, since we know that this can be a really challenging issue for many of you. First, Resources for Integrated Care has a terrific brief available on their website entitled "Locating and Engaging Members: Key Considerations for Medicare-Medicaid Plans." If you haven't already done so, please take a look at that.

The Center for Health Care Strategies with the help of the Commonwealth Fund has brought together seven particularly innovative health plans you see on your screen. Together, these plans make up the PRIDE consortium. They've developed two webinars and related briefs, so please take a look at these at www.CHCS.org.

Now, I'd like to turn it over to Julie from Hennepin Health. Julie?

Julie Bluhm: Good afternoon and thank you so much for having me. I'm here to talk about Hennepin Health, which is a healthcare demonstration project taking place within our Hennepin County that is the largest county in Minnesota and encompasses Minneapolis.

Hennepin Health is a partnership among four county-owned organizations. Our county-owned Medical Center, which is a Safety Net Hospital; a county-owned FQHC Clinic located in an underserved area of Minneapolis called Northpoint. Our Human Services Public Health Department from Hennepin County, which includes public health clinics as well as case management and eligibility; and then a county-owned managed health plan called MHP.

We operate as a Medicaid expansion MCO option and we operate upon prospective enrollment via managed care choice, and we're also the default option in Hennepin County for individuals in Medicaid expansion. We have a Capitated Reimbursement from our State Medicaid Agency. We are looked at as having a very defined and small provider network that is united by a shared Electronic Health Record.

We have been able to get our human services employees on the Shared Health Record with the hospital and the clinic, which has been really important, as well as the managed care organization. Our Risk Sharing Funding model allows us to align our resources towards avoidable utilization. Essentially, we realized that at one point that our human services and hospital were really unable to work in alignment towards the same goals of reducing avoidable utilization, since so much of the hospital is dependent upon those resources.

We've based the model on integrating medical and social services and focusing on addressing social determinants of health. We're operating on a consensus-based governance structure among all four partners.

We're looking at a current enrollment of around 11,000 members and we're serving the Medicaid Expansion population in Hennepin County; so 21 to 64 year-old adults without dependent children who are nondisabled at or below the federal poverty level. Our population character sticks are mainly male and racial and ethnic minorities. We see a lot of common overlapping issues such as mental health conditions, chemical dependency, lots of homelessness and unstable housing, chronic physical conditions, and a general lack of social support resulting in a lot of use of the emergency department to access care.

Our premise at Hennepin Health is that we need to be able to meet these individuals' basic needs before we can meaningfully impact health. This has really helped us to focus on this population in a way that we haven't necessarily been able to focus on before.

Hennepin Health is based on a Care Model with Care Coordination. Essentially, we've chosen to do an embedded in-the-clinic model, so our Care Coordination teams are in the Primary Care Medical Homes. We have chosen to rely upon a strong community health worker role, both inside and outside of the clinic.

Hennepin County Medical Center has also pioneered what we refer to as an "Ambulatory ICU." It's a completely team-based care clinic for our highest utilizing members and highest utilizing residents of Hennepin County in general; so not just those who are in Hennepin Health.

We've really been working on supplementing the clinic Care Coordination teams with targeted behavioral health and social service interventions. We also supplement the teams with clinical coordinators who are RNs and social workers, and we've found that to be a really nice complement of skillsets to work together as a team to meet our members' many needs. All of these providers are documenting in a shared Electronic Health Record.

Essentially when Hennepin Health was formed, we thought if we build this really great clinical Care Coordination model within the clinics our members will come and be excited to be in these clinics and stay. We quickly found that that wasn't the case. A lot of the members, particularly due to unstable housing and the fact that we're the default enrollment plan, are unstably housed and live very transient lifestyles. We're getting poor demographic information and having a really hard time connecting those individuals to care.

Additionally, we found the need to start to prioritize and help our staff in the clinics prioritize their interventions, because very quickly we realized that by putting really great Care Coordination teams within the clinics that they were highly valued by the physicians and they quickly became quite overwhelmed.

To respond to some of this being overwhelmed in the clinic and need to prioritize our Care Coordination, we developed what we call a Prospective or Predictive Risk Tiering Model using CMS's Hierarchical Condition Categories, or HCC risk scores. Essentially, we were able to use these HCC risk scores to create tiering based upon risk for future healthcare costs.

We decided to break it into four different tiers. We have an Extreme, a High, a Rising Risk and a General Priority category. We have chosen to target and prioritize the two highest tiers with the Care Coordination staff who are located in the clinics.

One criticism of this model that we are continuing to work on or hone is because our model is really based on this idea of social determinants of health being such an integral part of what we're doing. We are continuing to work on the development of an unstable housing indicator that will be incorporated into this hierarchal risk score and tiering, so we can ensure that we're prioritizing people with unstable housing as well.

To my earlier comment that we thought if we build it they will come, we found out quickly that that wasn't necessarily the case. We had to put our innovation hats on and take on some community health workers that we could put into outreach locations. We decided to have the community health workers employed by the providers.

We're looking at a model in which the community health workers aren't representing the health plan, but instead are representing the healthcare delivery sites at which they are employed. We found this to be really important because they were representing those clinics to the members and, thereby, representing Hennepin Health. At the same time, kind of running out I guess a warm, red carpet to those members who we were finding in other outreach locations back into those facilities, rather than seeing it as health-plan-facing.

We knew that we would have to build some relationships with community organizations and providers in which we felt or knew or suspected where many of our members were. The locations that we were able to work out a relationship with and locate community health workers are listed here. We have an adult correctional facility through Hennepin County where we found a lot of our members were spending time. When they were in the correctional facility, they were no longer enrolled in the health plan and so we lost sight of them. The Care Coordination teams at the clinics were saying, "I've got this case I'm working really hard on it and all of a sudden they just disappear and I'm not sure where they are."

Fortunately, the correctional setting is also on the Electronic Health Record and so we've been able to do some work to bridge that. The community health worker is working and spending some of their time in the correctional facility, as well as these other locations; a local homeless shelter, our emergency department, and our hospital. We're focusing on diverting dental needs and then also in our health plan lobby, which has an interesting phenomena of having a lot of members come and hang out in the lobby. We thought that that might be a really great place to start.

As far as how did we go about building the relationship, particularly with the shelter and the correctional facility, we really had to look at it as what's in it for them. What we found is that a lot of these organizations are looking to increase their capacity for health and wellness education and that this is something that community health workers were able to provide. It was a nice vehicle for them to interact with the members or the people who, once they were discharged from the correctional facility, would probably be coming back on the Hennepin Health plan.

Additionally, we found that there's a lot of motivation from these community partners to be able to attend to the whole person. A lot of times they are focused on their small part of the individual, but we're realizing more and more that we need to treat the whole person and sometimes that means for them treating diabetes or heart disease when that's really not what they're experts in. We found that by sending someone who represents a clinic that there was a lot of motivation in partnering with us.

The next program I'm going to talk about is what we call our ED-InReach program. Essentially, this is a program that we started to address what we knew was high utilization that was avoidable and preventable of the emergency departments. We knew that if we were going to try to accrue quick cost savings to support our model that we were going to have to address over-utilization of the ED.

We embedded one social worker in the emergency department. Our hospital also has what we call "APS." It's the Acute Psychiatric ED. That social worker is the person who is kind of stepping outside of the chaos of the emergency departments and the psychiatric ED and seeking to find individuals who are enrolled in Hennepin Health and looking from a systems' perspective of why are people showing up there for preventable things to help us identify and target some of these problems and patterns.

We also have that social worker in the ED connect with a case manager that we have contacted through a local nonprofit. That case manager we call the "ED-InReach Case Manager." The goal is to identify and target individuals in those settings where we think that case management services will help someone get back into a medical or behavioral health home. Their goal is reducing that utilization and finding preventative services to meet their needs.

We had a lot of lessons learned from this pilot project. Initially, we thought there are all of these people in the ED, so if we just put a worker there to meet with them who is engaging that they would not pass up the chance to work with them and get their needs met. Essentially, that wasn't the case and it took us some time to really find the right worker and we went through a couple of workers before we found the right person to get this off the ground.

Lessons learned is that connecting with someone in the ED is not always the best opportunity. A lot of times we're looking at people who have altered mental status and are just not in a place when they're admitted to the ED, or even when they're waiting in the ED, to talk to someone to engage with them.

One thing that we've found is that by giving them cell phones while they were in the ED that that was one strategy that often took off pretty quickly. We weren't sure, but we programmed cell phones with the ED-InReach Case Manager and then also our Psychiatric and Mental Health Crisis line and the hospital contact, and asked them to follow up with the worker. That's actually been quite successful.

Additionally, we had had this ED-InReach Case Manager working outside of the ED. In Minneapolis we've got a great nonprofit organization called St. Stephen's that does street

outreach and so they've been able to connect this case manager to a lot of the people who we're targeting simply by going where they are at. Sometimes that's homeless camps or places where the homeless are.

Other lessons learned is that it takes a very specific staff person in order to infiltrate the emergency room culture and the hospital and really connect with the individuals we're trying to serve. What we found is that we really needed someone who could fit into the hospital culture; someone who had some experience or understanding of the healthcare environment.

One of my favorite stories is that when we first brought this pilot onboard the worker was not as familiar with healthcare settings and we couldn't figure out why the emergency room wasn't connecting with her and wasn't giving her referrals. I kind of found out in a word-on-the-street way that the first day she came to work she was wearing open-toed shoes and this made her a pariah in the ED with the staff. It was just one of those simple things that really put up some major barriers and so that was a really interesting lesson, and so essentially someone who has some of that cultural knowledge of working in an ED environment.

We also found that you need to have someone who's quite assertive and not afraid to talk to people and get to know them and who can engage with clients very well, but also being able to engage and build relationships with the staff in the hospital. It was really important that they became integrated.

One of the other things was having to be very reliable. We found that when they can document in the medical record the same way and with the same standards of documentation that the hospital is using, is that that really made their work quite apparent. When someone had made a referral to this program and when they would see that documentation of work being completed in the record, that really built their confidence that this work was happening and that it was worthwhile and it was helping their patients. That was a really important lesson learned.

With all of that, being able to fit in with the culture and getting to know and build relationships, we found that it's really effective to have this worker attending the in-hospital huddles in some of the clinics. As we're asking them to bring people into the medical home or preventative care setting, that this worker is someone who is working with those staff and so attending their meetings and their case consultations has been really important.

Thank you so much for having me today. I'll be here for question-and-answer at the end. Now, I will turn it over to Laurie.

Laurie Lockhert: Thanks very much. That was really interesting to hear and I certainly connect with some of your lessons learned. There are some similarities definitely in the work we're doing and what we're finding out.

Since Bill already introduced a little bit about my background, let me just get started with the program that I'm managing. CareOregon's Health Resilience Program has been in existence about four years now. We started out at CareOregon and after the first year that CareOregon said we want to do this, we want to help our members and the providers out in the community; we

applied for and were awarded as Bill said a CMI grant, which has supported our growth and learning and development over the past three years.

We just came off that on June 30th of this year. CareOregon is the largest Medicaid-serving plan in Oregon and you can see the numbers here with a small amount of Medicare and dual members. The Health Resilience Program is a trauma informed program, and I highlight that and I will talk more about that and why that is the focus of our work and our intervention.

We have 30 direct service staff embedded in 23 clinics and one specialty clinic. We also started out with trying to embed someone in an emergency room, but didn't have the success that Julie has had. We quickly moved to how can we support our members getting access to and building relationships with their primary care providers.

We also have the struggle of working across five healthcare systems, which are five different at least EHRs, five different methods of approaches. We serve the most high risk, complex patients in our program who have avoidable utilization. The criteria is at the bottom [of the slide] of one or more non-OB hospital admissions with or without ED visits within 12 months, or 6 or more ED visits with or without a hospitalization within 12 months.

Let me back up just a minute to further clarify. I'm sure many of you already know about trauma-informed care. When I say that, it means that we're operating with the four values or fundamentals of trauma informed care; transparency, offering choices, empowerment, and working in collaboration. We do that both with our clients and our providers. That is one of the main drivers of our approach to working with the systems.

We know that drivers of utilization for this population are usually multiple psychosocial issues and there is a huge amount of trauma history in the background of the people we work with. As the research demonstrated, for people who have trauma histories they have a difficult time trusting others, especially authority figures. We see that played out, as I'm sure you do, over and over again in trying to build a relationship with someone in a few minutes in a Primary Care setting.

Our initial focus has been on establishing a trusting relationship with someone as quickly as possible, and we tend to work with people about 6 to 9 months. The 30 staff typically have a caseload around 20 to 25 clients. As I said earlier, we are embedded in Primary Care and are in collaboration with them. We have our Health Resilience specialist become a member of that team.

We do most of our work outside the four walls of the clinic and walk with the patient in their world, really letting them know that we understand the struggles that they have. We can then bring that information back to the clinic and it has really helped providers get a much deeper understanding of why their treatment plans aren't working and where the gaps are. Most of these members do not feel comfortable talking about deficits or deficit skills that they don't have. They don't understand English. They don't understand the treatment plan. They don't understand their medications.

We work with adults and we based our utilization criteria on CareOregon's members. Every community has a different profile and so we're specifically looking at our members. What we found was that most of these members with high utilization who are not getting the care they need have at least two or more chronic medical conditions, as well as mental health and addiction issues as Julie said.

We saw almost immediately the need for a triage coordinator. When I talk about case finding, I'll talk more about that. We hired our staff for their engagement skills. They're good at building trust and engaging people. We found early on they were not so good at doing case finding. We shifted gears and hired people who were very good at sifting through daily ED and inpatient reports that come to CareOregon and then finding referrals for our staff and getting it out to them.

The next slide shows you just a current snapshot of the number of people we've served since the beginning of the program. The CMMI grant required us, as I said, to focus predominantly on the Medicaid population with some duals who we were helping. When the grant ended June 30th of this year, we were able to now ramp up our focus on our dual members, who were in just as much need and had just as many psychosocial barriers as our Medicaid members.

Approximately as you know here, two-thirds of those who we encounter and outreach to -- and outreach meaning "We see that you're having problems. We see that in our ED and we know you've been going to the hospital. What can we do to help you?" It's a voluntary program. We invite people and if they want our help we join with them and start with them where they're at around addressing what they perceive are the health problems that they're having.

The strategies for finding members; we use multiple case finding strategies. We use utilization and the criteria that I have on the first slide. We also look at the medical, a deeper dive in talking with the doctor about what's going on medically with this person. We look at the utilization from claims data and have an eye for, "Wow, why are they going? This doesn't make sense. They've been to the ED three times for falls; something's going on there. They were admitted to the hospital for their diabetes out of control, or their COPD out of control, and they keep going back in for that." Those are things that alert us, like detective work. Something is wrong here.

We then have the Health Resilience specialist, in talking with the doctor, say "Let me meet with the person, and let me ask them if they want some help." Then, we're able to get into a deeper dive and hear about what the client needs and what they see the problem is with taking care of their health.

When we go into a clinic, at each clinic we do a case finding just through the claims data utilization. We sit down with the list of names of clients and meet with the doctors in the clinic and talk about what they see as the problem. We work closely with the leadership of the clinic and that is what really helps give our Health Resilience specialists the leverage they need and the boundaries around their work to target the highest utilizers and the population the clinic is having the most difficult time getting a hold of.

We also have the triage coordinators looking at the daily ED reports and giving our staff daily referrals when they see people utilizing the ED or admitted to the hospital. That has been much more helpful to our staff, the more real-time referral source for them.

Finally, once the clinic is understanding the high-risk population management approach, they start becoming the natural providers in the clinic. They are the ones who see what's happening with their patients; they're curious. Maybe they aren't at that target criteria, but they see them ramping up and that's very important for us to see and address before the patients become the high utilizers.

We also have one of our supervisors and one of our triage coordinators visiting two shelters where we know homeless members are repeatedly discharged to from the hospital. Then, they cycle back into the hospital because they aren't getting the care they need. Once a week the supervisor and triage coordinator go and meet at the clinic and actually help people know what health plan they have, what insurance, and if they're a part of our CareOregon membership we do a warm handoff to the Health Resilience specialist at the clinic they're assigned to. We make sure they don't get lost. We don't just give them a piece of paper. There's an outreach effort made to hold someone's hand per se and help them get into the clinic.

We finally have the PopIntel Registry, which is not so much a referral, although it does act as a referral mechanism for us. The Registry was developed during the grant and we saw it as critical for each Health Resilience specialist to track their clients by a list. It was also a place to document critical details about the life of the patients. Whether it's the ever-changing cell phones; it's where they hang out when they're homeless.

They're sort of the psychosocial notes and more so boxes, because we really wanted to also track our interventions; what we were doing, how many times we were touching people; what we were doing with them; where we were doing it. This is a holder of information that does not necessarily have the same place in all the different EHRs that our staff use at the different systems of care that they're located in.

We also can provide details about what triggers a client; how to approach a client; so that we can remember to share that if we lose track of the client or we need to let someone know. "Remember, it's best if you approach Fred and ask him about his aunt who he's taking care of." That will really help cement a personal relationship for you.

The other thing is it's given us metrics with which to provide stakeholders, as well as inform our learning around what we're doing with our clients. That's how we know we have a 70% engagement rate. That's how we know we spend about 60% of our time out in the community versus in the clinic. That has been an incredibly helpful tool for our program.

I've highlighted, as Julie also mentioned, hiring the right staff for this work. Our intervention is really about hiring trauma-informed staff; staff who understand how people behave with trauma histories. What we see is that so many of this high-risk population are either getting fired from their Primary Care clinics, are not going, or go once, or aren't telling their providers what's really going on with them.

We feel that being able to recognize those symptoms and help both the provider and the client have a safer visit and be supported in sharing information has been a critical tool for us in our engagement rate. This isn't about simply making contact with patients, but helping them establish and build a trust with the Primary Care provider and that team at their clinic.

The other thing is we have time to build a relationship. We do not go in and do an intense intake. It's about doing a lot of listening at first. Our staff are primarily master's level in psychology or social work. Although they're trained as therapists, they do not do therapy with the patients. They use their therapeutic skills to empower and motivate people to change; to build trust; to be able to give feedback and support to the clients who have many, many skill deficits as we all know.

We don't see this as a quick fix. We don't even see it as a fix, per se, of anyone's longstanding history, but what we're doing is starting to do a reset for these clients and helping them develop a safe relationship with their Primary Care system or their specialist. We find that the staff we've hired, who have a background in community mental health, they seem to be best equipped. That is my background and I can appreciate that all the work and the clients that we encounter were already trained in establishing trusting relationships.

We now have knowledge of mental health and addictions, treatment, as well as symptomatology. We have cross-cultural training. We have a lot of experience in conversations about boundaries with compassion. We also have a lot of knowledge of local ever-changing resources. We provide weekly supervision to the staff, because again as Julie said, the high rate of burnout in this field is well known amongst those of us who have been in it and work in it. Providing that weekly supervision and support and ideas so that our staff don't get too far down the path of trying to do too much, but more of a high level systems' connectivity and supporting and laying down some future foundations.

Over and over the staff talked about how important it is to just listen at first and we share that information with the providers and the clinics. We also get to see by spending our time in the community with the clients what their world actually looks like and how it works. We can manage the misperceptions that come up in the Primary Care clinics around why people aren't showing up, why they aren't cooperating with the treatment despite the best intentions of the providers.

What is critical for our staff, as I said, is walking alongside the clients. That builds the relationships so much. We go to appointments with clients if they want us to, but most do because they don't understand how the medical system works. We attend specialist appointments. We attend social service appointments. We help connect people into mental health and addiction treatment. We're teaching communication skills. We're explaining the system to them. We do a lot of translation time around what the provider is saying, what their medical team is saying and breaking it down so that the clients really understand what it is that they're being told. We know that providers don't have time to spend with people and so that's where we're an extension for them.

We also know that many providers are really frustrated with these clients and so don't end up listening to them or necessarily treating them that well, because they're very frustrated and they're not sure what else they can provide, which is a really normal thing to have happen. We've found that we have become a support to the providers in the clinic.

When the client is better managing their health, what we've noticed is they gradually stop contacting us and they're contacting the clinic more often. We introduce them to peer specialists if they would like to continue some support and, in part, we work with such a socially isolated group of people that what we see is they need help connecting to safe communities. Our peer specialists are very valuable in doing that and can follow through a little bit longer than we can.

The next two slides are some of the early results from 2013 of our program. I just wanted to give you an idea that we've seen an impact on the clients of the work we're doing, although both show about a 35% reduction in either hospitalizations or ED visits. What we found in our close work with Jeffrey Brenner, who we modeled our team on four years ago, is that we can certainly guess there's going to be a 20% regression to the mean.

Even if we're breaking even, so to speak, in terms of our costs and are able to impact reduction of utilization and increase the attendance to Primary Care, we feel like we are doing so much to help providers in the community. That's the feedback we also get, that our support and communication to the Primary Care clinic about their most difficult population has been incredibly valuable to them. In fact, a number of comments about providing hope to them about patients they've lost hope in. That's our ED results, which you can feel free to go and look at after my presentation.

What I'd say in wrapping up is I think the key elements of our program are that we have a foundation of a trauma informed approach and building trust with people. It's client-centered; we start with where the client wants to start with their health goals. We work in collaboration with clinics. We have access to the EMR and we have a Registry that helps us document those psychosocial issues that are going on and that are critical to engaging this population.

The Registry is very essential in gathering metrics to show our stakeholders and to improve our learning about the population we're working with. The other caveat is that we're not working on a billable hour. Working on a billable hour I think we can all agree does not allow for us building a trusting relationship. We have time to do this and go at the pace of the client, instead of expecting the client to go at our pace.

These are a couple of videos I have on here that can tell you a little bit more about our program and feel free to contact me or ask questions. Bill, I'll pass this on to you. Thank you very much.

William Dean: Thanks, Laurie. Thank you both, Laurie and Julie, for such a great presentation and really awesome tips on how you've used outreach and other workforce, as well as leveraged your data and Electronic Health Records and building strong community partnerships to find and engage your members.

Amy, I'd like to know if we should move on to a question-and-answer period, or if you'd like to do the poll that we had planned? I know that we're running a little bit short on time, so I'm wondering if we should jump right into questions.

Amy Herr: Maybe do one of the two polls, Poll No. 1?

William Dean: Poll No. 1, great. This is just a question to get a little bit more information about you all as attendees here on the webinar just to give our presenters a little bit of information about what you're thinking about and what you're doing right now on the ground. This one looks back at the work you've been doing up to now. Which of the following have you found most successful to find and/or engage your members? Pick all that apply:

Community Health Workers
Embedded in or Outreach Staff at Community Based Organizations
Expanded Access to Electronic Health Records
Use of a Registry or Some Kind of Priority Tiering of Hard-To-Find Members
Free or Low-Cost Cell Phones to Give to Members
None of the Above

Pick all that apply and I'll give you a couple of moments to select your answers. We've got several hundred people on our webinar today and we've got almost 65% using community health workers, so that's fantastic. Only about a quarter are using either a registry or priority tiering, or free or low-cost cell phones, so it might be an opportunity there.

Let's jump into questions right now and I'll pass it over to Amy to lead that discussion with our presenters. Thanks again.

Amy Herr: Thank you, Bill. As a reminder, if you have questions there are a few ways that you can submit them. You can utilize the Q&A feature on the Web platform, or you can use our AT&T operator. Operator, at this time would you remind our participants how to ask a question over the phone?

Operator: Thank you. Ladies and gentlemen, if you wish to ask a question over the phone, please press * then 0 at this time. Once again to ask a question, press * then 0.

Amy Herr: While we wait for the questions to queue up, we have one question that's come in through the Q&A feature. For Julie, could you say more about the challenges or successes tied to giving members cell phones?

Julie Bluhm: Yes, I can. There are lots of challenges with giving members cell phones. I'd say the biggest challenge is the fact that you probably aren't going to get the cell phone back. Initially, we came up with a system and we still try, we keep track of the cell phone. Each one is numbered and we know who has it. We had to determine a period of time in which we would shut it off if we weren't in contact with the member. Then, 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.

Amy Herr: Thank you. Operator, are there any questions on the phone?

Operator: Yes, we do have a couple of questions and, once again if you do have a question, press * then 0. At this time, our first question comes from the line of Michelle Allen. Please go ahead.

Michelle Allen: Hi, I just had a question about the cell phones as well. I work with the TANF population here in South Carolina, so they're getting the government cell phones. This cell phone is in addition to the cell phone they already have?

Julie Bluhm: Yes. We've got government cell phones as well, that they lovingly call the "Obama phones" here. A lot of the people are engaging with this ED-InReach. They may have a phone, it's not working, or they've lost it. We're seeing if they have a phone first and, if they don't have phone, then we would give them the phone. Sometimes it's an addition, but for the most part we've assessed that they don't have a reliable way for us to connect with them. Probably the phone is lost or gone.

Michelle Allen: Even though when they do have the government cell phones, is it every time that they get a new phone or they add minutes that the phone number changes? It's like the phone number will change three or four different times, or they'll call me and they'll say, "Oh, I just got this new cell phone and the number's changed."

Julie Bluhm: We find that a lot. I mean that's been just a challenge with this population in general is that like at the first of the month people use all of their minutes right away. Their numbers change constantly. We get a lot of calls of, "Hey, I'm going to be waiting by this phone. If you call me right now, here's the number." Of course, you get the message a day later and you can't find that person. We did find that giving them the phone from the health plan has just been one of those things that we just know that there's going to be some abuse of that. I guess it's probably been just one of the most direct ways to do the outreach.

Michelle Allen: Yes, I mean that's an awesome idea too. Thank you so much.

Operator: Thank you and next we'll go to the line of Anita Holmes. Please go ahead.

Anita Holmes: Hi, this is Anita Holmes. My question was for Julie in regards to the four different models you were saying that you guys are using; the Extreme, High, Rising Risk, and General. I just wondered if you could talk a little bit more about each one.

Julie Bluhm: Sure. When you're using these hierarchal condition categories, you can cut and slice them. I'm not in the analytics' group, so I will speak to this the best I can. Essentially, our analysts looked at all of the costs and we were able to slice the population into those tiers. The Extreme priority category we determined that those are the classic 5% who are costing us 40% of our costs. That is in the two highest risk groups we're noticing the smallest percentage with the most percentage of cost.

We decided to put them into those four tiers. I think of it as a funnel. It's just a way of starting to do that prioritization. Because some of the people who are 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 just had to accept the fact that we're not going to be able to provide Care Coordination as our population expands to everybody who needs it. I don't know if this is true in a lot of other clinics, but we've found that you put some of these key staff in clinics and they are just sucked dry as far as how many people they could potentially be working with.

Putting someone like a community health worker who's not necessarily trained or would be expected to set boundaries with the providers who are asking these things of them, we found that the risk-tiering categories were actually really helpful in putting those limits with the higher-ranking professionals they work with to be able to say we're trying to prioritize those two highest categories. We are hoping that the clinics via the MAs, or the receptionist at the front desk, can take the time, and the other normal Primary Care staff can take the time to work with some of those lower-tier members or patients to provide the needs that they have. I hope that helps.

Anita Holmes: Yes, it did. Thank you. I also was wondering as far as the presentation, unfortunately I was not able to pull it up, is there a website to go to or to get that later after this?

Amy Herr: Yes, it's available on the ON24 platform. There's a green icon that has a little folder at the bottom of your screen. You can download the PDF and it'll also be available on the www.ResourcesforIntegratedCare.com website within a few days.

Anita Holmes: Thank you.

Amy Herr: We have another question here for both Laurie and Julie. You both talked about the importance of hiring the right staff. Have you experienced any challenges finding or hiring staff who fit this role? Laurie, do you want to start?

Laurie Lockhert: Sure. Let's see, yes. It's hard to answer. I'm very proud of how we've been able to hire the right staff for the most part. We have only had out of 30-some people one person who just didn't fit we realized. They weren't able to remain neutral and that's really critical here and not taking sides against the patient, against the healthcare system. It's like "Let's just focus on what's happening right now for you. Everybody is doing the best they can."

One person couldn't maintain that sort of Switzerland stance. The other three, when they got here it wasn't really the kind of work they wanted to do. It wasn't what they thought it would be. This is definitely more in the case management realm and walking alongside people for a while and dealing with people who have addictions and mental health treatments as well. That was a little out of their scope. They weren't comfortable with it.

Other than that, we do behavioral interviewing, so we really can hear if people walk their talk. We ask, for instance, what would you do with a patient who is noncompliant? What I'm looking for one of those responses to be is, "Well, I would sit down and ask them what they're having trouble with. And I don't like the word 'noncompliant'." so listening for let's see how we can equalize the relationship and take some of the judgmental words out of the conversation. Does that help a little?

Amy Herr: Yes, thank you. Julie, did you have anything you wanted to add on that question?

Julie Bluhm: Sure, just real quick. I think it's really important we've found that while you have to hire for certain positions if you're requiring a social worker or community health worker for example, we have found that licensure level of the field that someone is in is not actually the most important part. We've found similar to what Laurie has said, you just really need to have someone who is passionate about this work, who understands that a lot of this work is not about "this is not my job" or "this is below my scope." It's about just doing what needs to be done and being willing to do that with the patient. I echo everything Laurie said about a trauma-informed approach and nonjudgmental and it's very patient-centered.

Laurie Lockhert: Let me add one other thing, Julie, you made me think of. Early on, we did hire non-master's-level people, and at the same time some community mental health master's-level people came over; not licensed but master's level. We were able to see the different skill sets, kind of like a microcosm next to each other; a little tiny experiment. We still have employed those. One left, but we still have four people who don't have master's degrees and they're great.

Julie Bluhm: Yes, I agree. Some of our most talented and valued staff are community health workers. In Minnesota, their certification is just a six-month program. They are the kind of people who are just so patient-centered and mission-driven. I just really think it's about the individual.

Amy Herr: Thank you. We have time for a couple of more questions. I wanted to mention to the audience we have our Participant Survey link up on the slides. We'd really love it if you would take a few minutes to give us some feedback on this webinar to inform our future work. Thanks.

I have another question for Julie. Can you say more about how Hennepin Health developed its priority tiering algorithm and how you use it?

Julie Bluhm: Yes. That slide talks about hierarchal condition categories, which is a tool that's available from CMS. We've got an Analytics Center for Excellence working out of our Safety Net Hospital, and they chose to use the HCC scores as a starting point, because there is free software and analytics available around those scores. That's about what I know about that detail.

Essentially, what we're really looking for as I said in the presentation is, how do we even start that predictive rather than being reactive when looking at past utilization. The HCC scores are based on diagnoses that the patient is given, as well as demographic characteristics and it generates a score about risk for future costs. We did do an analysis of that, so we were looking back at people who had had those scores and they matched up pretty well. We are fairly convinced that this is accurately predicting future costs.

Amy Herr: Thank you. At this time, I think we're at the end of our hour here. I wanted to thank our speakers again; Bill, Julie and Laurie. Thank you, everyone, for your participation. As we said earlier, please fill out our Participant Survey to inform our webinars in the future.

If you have any questions now or after the call, you can email us at RIC@Lewin.com. As a reminder the slides, a recording, and a transcript will be available on our website after the call at www.ResourcesforIntegratedCare.com. Have a great afternoon and thank you so much for your participation.