Health Plan Approaches to Locating New Medicare-Medicaid Enrollees and Building Trusting Relationships

January 13, 2015

Promoting Integrated Care for Dual Eligibles (PRIDE) is supported by The Commonwealth Fund.
About the Center for Health Care Strategies

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care.
Introductions

Sarah Barth, JD
Director of Integrated Health and Long-Term Services
Center for Health Care Strategies

Hany Abdelaal, DO
President and CEO
Visiting Nurse Service of New York (VNSNY) CHOICE (New York)

Anthony Evans, RN
Vice President for Integrated Health Services
CareSource (Ohio)

Maria Raven, MD, MPH, MSc
Assistant Professor of Emergency Medicine
University of California San Francisco
I. Welcome and Introductions
II. Tips on Contacting Hard-to-Locate Medicare and Medicaid Members
III. Innovations at the Ground Level – Building Relationships with Health Plan Members
IV. Community Engagement Strategies and the Role of Navigators
V. Patient Engagement: Social Determinants of Health and the Role of Community Outreach
VI. Questions and Discussion
Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to panelists.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Promoting Integrated Care for Dual Eligibles (PRIDE)

• Supported by The Commonwealth Fund
• Brings together seven health care organizations to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees
• PRIDE participants:
  - CareSource (OH)
  - Commonwealth Care Alliance (MA)
  - Health Plan of San Mateo (CA)
  - iCare (WI)
  - Together4Health (IL)
  - UCare (MN)
  - VNSNY CHOICE (NY)
Medicare-Medicaid Enrollees Face Challenges to Engagement

- 10 million Americans dually eligible for Medicare and Medicaid
- High need population:
  - 20% have 3+ chronic conditions
  - 30% have mental illness
  - 44% receive long-term services and supports
- Many have unstable housing situations and supports
- Lower education and literacy levels
- Social determinants may affect ability to maintain health
Tips for Contacting Hard-to-Locate Members

1. Identify current providers from data
2. Maximize community partnerships
3. Send staff into the community
4. Use outreach staff
5. Target calls early in the month
6. Engage a broad group of partners
7. Establish electronic flag mechanisms
8. Assign specific staff
9. Knock on doors

Innovations at the Ground Level – Building Relationships with Health Plan Members

Dr. Hany Abdelaal
President, VNSNY CHOICE

VISITING NURSE SERVICE OF NEW YORK

CHOICE
Health Plans
Founded in 1893, VNSNY is the largest not-for-profit home and community-based care organization in the United States.

Provides a wide range of services across the continuum of care from birth to end-of-life.

VNSNY CHOICE (“CHOICE”) health plans serve over 40,000 members.

Approximately 17,000 employees working in interprofessional teams serve the most vulnerable and needy individuals.

Serve over 65,000 patients per day.

Co-developing population health initiatives with health systems, health plans, and a national post-acute integrator through at-risk and bundled payment contracts.
Visiting Nurse Service of New York
Not-For-Profit Parent Organization

- Visiting Nurse Service of New York Home Care
  - Largest Certified Home Health Agency in New York metropolitan area
- Partners in Care Services
  - Licensed Home Care Services Agency
- VNSNY Hospice and Palliative Care
  - Largest hospice program in the New York metropolitan area
- VNSNY CHOICE
  - Health plans include two MLTC plans\(^1\), four MA plans, and a HIV-SNP plan

\(^1\) Includes CHOICE’s Managed Long-Term Care plan and VNSNY CHOICE Total, a Medicare HMO SNP and a Medicaid Advantage Plus FIDE-SNP plan, for dual eligibles
Plan Snapshot

Since its founding, CHOICE has become the MLTC market leader in New York State and expanded its plan offerings to include four MA plans and a Medicaid HIV-SNP plan.

Plan Overview

<table>
<thead>
<tr>
<th>Plan</th>
<th>MLTC</th>
<th>MA</th>
<th>HIV-SNP</th>
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<tr>
<td>Members</td>
<td>~17K</td>
<td>~19K</td>
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CHOICE currently serves members in 23 counties and is licensed in an additional 10 counties.

- CHOICE MLTC, MA, and HIV-SNP plans
- CHOICE MLTC and MA plans only
- CHOICE MLTC plans only
- CHOICE MLTC granted approval but currently no membership

New York City (Bronx, New York, Queens, Kings, Richmond)
VNSNY CHOICE Care Management Philosophy

- Health plans need to *partner* with community-based organizations rather than just *contract* with them
- VNSNY CHOICE uses both professional and non-professional staff to create a holistic care plan
  - Care coordinators (RNs)
  - Home health care workers (PCAs)
Tailoring Outreach to Specific Populations

- VNSNY CHOICE is committed to the health and wellness of the communities we serve
- Take into account demographics and diversity of the population served
- For cultural reasons some members may be unlikely to take advantage of community or health services
The VNSNY Chinatown Community Center (since 1999) and Flushing Community Center (since 2012) are each open seven days a week

- Offer health screenings and educational workshops for over 2,000 CHOICE members
- Counsel on housing issues and mental health concerns
- Provide access to medical professionals and consultation with social workers
- Answer benefits questions and connect members to health plan staff, including care managers
- Offer a variety of classes and groups
- Host civic and social events
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Open House
Health Workshop
Asian Health and Social Service Council Monthly Meeting
VNSNY CHOICE Outreach Strategy

Member Retention

Retention unit was created to reduce the VNSNY CHOICE Health Plans disenrollment rate, increase member satisfaction and impact the Stars scores

- In 2015, the Retention Department will see an expansion as we will help retain our MLTC and FIDA members
- With these new programs, we will accomplish the following:
  - Disenrollment Surveys
  - Home Visits
  - Eligibility Verification
  - Educational Events
  - Medicaid assistance
  - Member Search
  - Member outreach
Supporting the Larger Community

- VNSNY Community Centers are open to the community at large – not just plan members
- Community centers create partnerships with other community based organizations to assist with social and economic issues:
  - Help pay bills
  - Explain letters from CMS and other entities about eligibility and benefits
  - Connect people with social service organizations (SNAP, energy and housing assistance)
## VNSNY CHOICE Retention Unit Structure

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<th>Title</th>
<th>Number of Staff</th>
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<td>Manager of Business Operations</td>
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<tr>
<td>Associate Program Manager</td>
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<tr>
<td>Supervisor of Medicaid Eligibility Coordinator</td>
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<tr>
<td>Program Assistant</td>
<td>7</td>
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<tr>
<td>Member Retention Representative</td>
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# Types of Services Retention Staff Provide

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<tr>
<th>Member Retention Representative (Office Staff)</th>
<th>Member Retention Representative (Field Staff)</th>
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<tr>
<td>• Welcome Calls</td>
<td>• Outreach Events</td>
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<tr>
<td>• Orientation Calls</td>
<td>• Change-of-Options</td>
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<tr>
<td>• Member Information Updates</td>
<td>• Member Home Visits</td>
</tr>
<tr>
<td>• Medicare &amp; Medicaid Eligibility</td>
<td>• Community Outreach Vehicles</td>
</tr>
<tr>
<td>• Outbound Call Projects</td>
<td>• Medicaid, MSP, LIS, Community Services Assistance</td>
</tr>
<tr>
<td>• Disenrollment Surveys</td>
<td>• Surplus/ Income Pool Trust Assistance</td>
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<tr>
<td>• Transportation Assistance</td>
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<tr>
<td>• Community Centers</td>
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Thank You

Hany Abdelaal
hany.abdelaal@vnsny.org
212-290-6437
Community Engagement Strategies and the Role of Navigators

Anthony Evans
VP Integrated Health
1/13/2015
CareSource

Non profit, mission-driven
Began Ohio’s first mandatory Medicaid MCP in 1989
One of the largest Medicaid HMOs in the US
Medicaid, Medicare, Exchange
Operations in Ohio, Kentucky, Indiana

- >1,000,000 Ohio Medicaid members
- >24,000 members in MyCare demonstration

28,000+ contracted providers
1,800+ employees

Headquarters based in Dayton, Ohio with regional offices in Cleveland, Columbus, Louisville and Indianapolis
Care Coordination in Managed Care:

- Largely telephonic
- Low % of member participation
- High CM/member staffing ratios: 1:100s
- Minimal or no face to face interaction, limited environmental/social factor verification or assessment
- Medical and diagnosis/utilization driven care planning and interventions
- More focus needed on community based care, access, and transitions of care
Emerging “High Touch” Models

• More members are actively care managed
• Intensive interdisciplinary team approach focusing on *in-person* institutional and community based interactions
• Full integration and coordination of physical, behavioral, LTSS, social, and informal supports
• CM staffing ratios: 1:25 at highest acuities
• Targeted performance and quality measures
• Member engagement is a critical factor in achieving outcomes—*relationships matter*
Comprehensive Approach

- Strong community presence
- Well trained, visible and accessible staff
- Close collaboration with key stakeholders
- In person educational events and forums with:
  - Members (institutional and in community)
  - Community agencies, housing, and advocacy groups
  - Providers
- Cooperation with “safety net” organizations
- Deployment of community-based Navigators
Historical Perspectives on Patient Navigation

Original concept pioneered in 1990 by Dr. Harold P. Freeman

Oncology Nurse Navigator movement (National Coalition of Oncology Nurse Navigators)

Patient Navigator Outreach and Chronic Disease Prevention Act of 2005

Affordable Care Act required “insurance navigators” for marketplace
Navigation Defined

• “A strategy to improve outcomes in vulnerable populations by eliminating barriers to timely diagnosis and treatment of cancer and other chronic diseases”

• CareSource: The Navigator provides one-on-one guidance, support, education, referral, coordination of care, and other assistance to members as they move through the healthcare continuum, as directed by the CareSource Care Manager. As a member of the CareSource Care Team, Navigators are accountable for collaborating with other members of the team and contributing to the implementation of the member’s care plan.

Principles of Navigation

• Part of a member-centered care management model
• Scope of practice distinguishes the role and responsibility of the Navigator from other Care Team members.
• The primary function of the CareSource Navigator is to *develop member relationships* and assist the Care Team in identifying gaps in care
• Navigation is a cost-effective means to enhance the person-centered approach and maximize the impact and effectiveness of the Care Team

Examples of Navigator Activity

• Accompany members to appointments and other social service encounters when necessary
• Coordinate logistics for care plan adherence – reminders, transportation, and childcare arrangements
• Ensure that adherence issues/barriers are addressed by ongoing reporting of issues to Care Manager/Care Team
• Contribute to assessments by gathering information from the member, family, provider and other stakeholders
• Assist in education of member/caregivers regarding healthcare access and benefits
Who Can Be A Patient Navigator?

• Individuals at any level of education may be employed as navigators.

• However, functions must be commensurate with their level of education, experience, and training

• Not a regulated profession
  – No professional standards
  – No national or state licensure
  – No nationally recognized credential
CareSource Navigator Qualifications

Education:
- High School Diploma or General Education Diploma (GED) is required

Experience:
- Two years of experience in either volunteer or paid position working in community settings with at risk populations providing coordination of services is preferred

Certification/Licensure/Background Check:
- Harold P. Freeman Patient Navigation Institute Certificate, or equivalent approved (internal) training program
- Employment in this position is conditional pending successful clearance of a driver’s license record check and criminal background check.
The Right Talent

- Recruiting appropriate skill sets at all levels is critical in order to manage complex populations
  - Connect and communicate with diverse populations (Cultural, literacy, social issues, language proficiency)
  - Understand community and local resources: live in the neighborhoods in which they serve
  - Inquisitive, proactive, and self motivated
  - Look beyond the medical to identify psychosocial and socioeconomic needs.
  - Problem solving
  - Caring, compassionate relationship builders

CareSource
Success Stories
The Care Team

“No one can whistle a symphony. It takes the whole orchestra to play it.”

~ H.E. Luccock
Patient Engagement: Social Determinants of Health and the Role of Community Outreach

Maria Raven, MD, MPH, MSc
Assistant Professor of Emergency Medicine
University of California, San Francisco

January 13, 2015
Outline

• Social determinants of health and the role of the health care system
• Outreach strategies
• Engagement and trust-building tips
• Comprehensive assessment: what and how
• Maintaining connections
Social Determinants of Health

The Centers for Disease Control defines social determinants of health as:

“Life enhancing resources such as food supply, housing, economic and social relationships, transportation, education and health care, whose distribution across populations effectively determines length and quality of life.”
Social Determinants of Health

• Implications:
  • Patients (people) need access to care, insurance coverage, food, income, housing, and transportation
  • We’re getting better at access to care and insurance coverage
  • But how much does it matter if these other things are missing?
Role of the Health Care System in Addressing Social Determinants

• We are used to having relationships with patients in health care settings
  • Offices, ED, inpatient, etc.

• Or over the phone
  • Many health plans and providers attempt telephonic outreach and health care maintenance

• Operating within these realms leaves us unaware of key aspects of people’s lives that are directly affecting their health care
Role of the Health Care System in Addressing Social Determinants

• Health plans and providers are not in patients’ homes and communities

• Physical environment helps determine length and quality of life: providers often unintentionally make assumptions that can influence health outcomes
  • Mold, domestic violence, access to safe outdoor space, danger of eviction, homelessness, technology

• Increasingly, we’ll need to reach outside of our systems (and comfort zones) to truly “reach” people
Health System-Community Partnerships
Key to Outreach, Engagement

• Health system is entry (and under-used intervention point) for homeless and other vulnerable populations
  – Despite repetitive use of health care system, little is done to address underlying contributors to disease
• Partnerships improve communication, reduce care fragmentation
• Partnerships will often involve data sharing agreements
  • Don’t let this scare you
  • Health plans may have advantages
Outreach Strategies

- Often, individuals who could most benefit from improved connections to health care services can be the most challenging to find.

- Individuals may be unaware of:
  - Auto-enrollment into health plans or other networks of care
  - Eligibility for coverage and other benefits

- Individuals may have had poor experiences with the health care system in past and be hesitant to respond to outreach attempts.
Outreach Strategies

• In person outreach

• “Vet” individuals using multiple databases if accessible
  • SFHP as example

• Consider appointments or providers as potential points of contact

• Technologic innovations
  • Cell phones, patient alert system, unified EMRs

• Outreach to and data sharing with community organizations
  • MOUs likely needed
Once Contact Is Made: Engagement

• Simple way to engage and build trust
  • Understand health and community services networks where eligible patients can receive needed services right off the bat

• If in person, offer a cup of coffee

• Hire and train the right staff

• Take the needed time
  • Often, more than one visit will be needed
Comprehensive Assessment: If You Don’t Ask, You’ll Never Know

• Multiple examples exist of validated question sets and surveys that cover multiple domains relevant to social determinants of health
  • Social Support
  • Legal Issues
  • Housing history and living environment
  • Substance use
  • Mental Health
  • Transportation access
  • Technology access
Social Support Question Examples

I would like to learn a little bit more about your relationships with friends and family over the course of your life.

• In your life now, do you have a close friend or family member in whom you can confide or talk to about yourself and your problems?

• How many close friends or relatives do you have?

• Is there someone who will lend or give you money if you need it?

• Do you have someone who will take you in if you need a place to stay?
Housing Question Examples

The next few questions are about where you have stayed in the last 6 months, and about the last time you had a stable place to live.

- On the streets, a park, a vehicle, an abandoned building, a bus/train/BART station/airport, or anywhere outside or inside not meant for human habitation
- In a garage, backyard, porch, shed or driveway
- In a homeless shelter for single adults or families
- In transitional housing for homeless adults or families (where you pay rent and can live up to two years and receive services)
- In permanent housing for formerly homeless people (such as Shelter plus Care, the Harrison Hotel, or UA Homes)
- In a hotel or motel or campground paid for by an agency, church or other service provider for a short stay of one week or less
- In a hotel or motel arranged for and paid for by you or a family member where you stayed for less than 30 days in a row or the hotel asked you to move out after 28 days
- In a hotel or motel room arranged for and paid for by you or a family member where you had stayed for more than 30 days in a row
- In a room you rent in a house or apartment
- In an apartment or house you rent
- In an apartment, condo or house that you own
Comprehensive Assessment and Implications of Asking

- If you ask, then you need to be prepared to:
  - Listen
  - Intervene

- Multiple techniques exist for approaching patients in ways that can allow for trust to be built
  - Time is important: the 15 minute office visit is probably not the right setting
  - Motivational interviewing
  - Trauma informed care

- Intervening can mean a lot of different things
  - Asking about housing does not imply you need to provide housing if someone is homeless
  - It may mean you should determine housing eligibility or refer to someone who can
Maintaining Connections: Phones or In-person?

- Telephonic management alone does not work, especially for homeless and other vulnerable populations
- Difficult to find, keep in contact with
- Studies show mobile phones more common than landlines
  - Mobile phone possession and service can be intermittent
- That said, consider connecting eligible individuals to free low-income phone services
Mobile Phone Project

Identified Calls (All Participants)

- Medical: 14.52%
- Mental Health: 20.64%
- Housing: 8.36%
- Substance Use Disorder: 3.30%
- Resource Centers/Church/Spiritual: 4.16%
- Legal/Corrections: 5.73%
- Instrumental Activities of Daily Living: 16.72%
- 911 Emergency: 2.08%
- Other: 24.49%
Maintaining Connections: Staff Matters

- Consider that non-licensed staff may be more willing and more effective in some situations
- Experience counts
- Interview candidates carefully
- Train staff appropriately
  - Local resources
  - Housing question set
  - Motivational interviewing
  - Trauma informed care
- Assure non-licensed staff have adequate supervisory support
Maintaining Connections: Assessment and Community Connections

• Comprehensive assessment is a living document
  • Updates, changes, indications of goal completion or new goal/intervention input should be expected

• Consider interval reassessments to evaluate progress

• Establishing connections with individuals’ other providers (e.g. housing, PCP, case manager) is key

• Continue to be aware of changing community resources
Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to panelists.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Contact Information

- Sarah Barth  sbarth@chcs.org
- Hany Abdelaal  hany.abdelaal@vnsny.org
- Anthony Evans  anthony.evans@caresource.com
- Maria Raven  maria.raven@ucsf.edu
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