Health Home Program
Washington

Outreach and Engagement Strategies

June 8, 2017

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

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Today's Presenters

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This Presentation was Adapted in Part from

Hints on Engagement
Center for Health Care Strategies
Rethinking Care Webinar

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Monica Stanley, Research & Data Analysis
Washington State Department of Social and Health Services

http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261169

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Acknowledgements

- Our trainers from our Lead Organizations
- Care Coordinators from across the state
- Advanced Home Care Aide Specialist Project

Health Home Program
Washington

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Purpose

Provide strategies and approaches to reaching out to clients so that they engage in the Health Home Program

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Objectives:

Identify strategies for locating clients

Introduce techniques for engaging clients at the first contact

Provide tips for successful home visits

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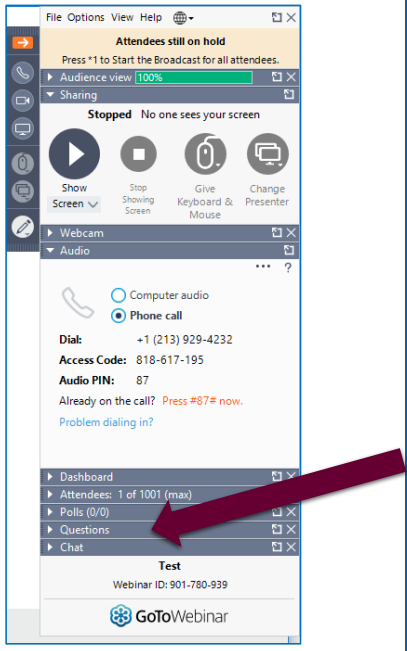
Share Your Experiences

- What approaches have you used to reach out to new clients?
- What hasn't always worked so well?
- What approaches have you used to increase engagement?
- What hasn't always worked so well?



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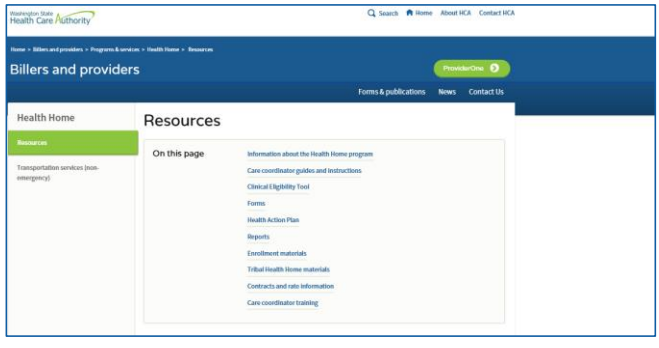
Due Diligence

- Check with your Lead Organization and/or your agency for their policy on due diligence
- Also visit the HCA website for guidelines located at:

https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes



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Initial Outreach and Engagement is Part of Tier 1 Services

Tier One	Tier Two	Tier Three
Initial engagement and action planning	Intensive level of care coordination	Low level of care coordination
$252.93	**$172.61**	**$67.50**

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One Approach to Outreach and Engagement

- Phase One: Research
- Phase Two: Introduction Letter
- Phase Three: Making Contact
- Phase Four: Face-to-face Visit

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Another Care Coordinator's Experience

- Make sure you are speaking to the right person (client, parent, guardian)
- Hardest part is getting your client to call you back
- Many clients do not recall receiving outreach documents
- Keep the call short – the goal is to schedule a home visit
- Document your attempts to contact
  - Important to track due diligence

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Another Care Coordinator's Experience (cont.)

- Free benefit that you can take advantage of
- Care Coordinator can help with things that are important to you
- Care Coordinator can work not only with you but providers and caregivers
- Care Coordinator can be your advocate
  - With medical and other providers

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Locating Clients

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Initial Contact

- Some Lead Organizations will locate the client prior to assignment and provide a “warm handoff” to the Care Coordination Organization (CCO)
- Some Leads and CCOs utilize Outreach Specialists to complete the initial calls to clients
  - Case is then handed off to the CCO and assigned to the Care Coordinator

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Locating Clients

- Use existing sources of data within your own agency
  - Area Agencies on Aging may use data from the CARE or TCARE programs, the ProviderOne payment system, and Respite Programs
  - Multi-service centers or medical clinics may have client contact information in other departments
  - Billing departments may have contact information
  - Use PRISM to identify:
    - Pharmacies
    - Name of case manager and phone number contained in the CARE tab

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Locating Clients (cont.)

- The Department of Social and Health Services (DSHS) Financial Services Specialists(FSS) may have more up-to-date information on the client's address and/or phone number
  - Information Sharing Consent form may be scanned into the electronic case record, allowing the FFS to release information
  - Inquire about contact information
    - Is there a representative, payee, or guardian listed in ACES?
  - Be prepared to describe Health Homes to the FFS

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Locating Clients (cont.)

- The DSHS FFS may have other collateral information in the documents contained in the electronic case record
  - Inquire about rent verifications: does it include contact information for the landlord?
  - Do bank statements contain the same or a different address for the client?

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Locating Clients (cont.)

- The DSHS Social Service Specialist or Community Nurse Consultant may have information in CARE
  - Ask for current address and telephone
  - Inquire about collaterals including family, friends, guardians, and payees
  - Ask if the case manager can identify current or previous providers, the client's placement in a residential care or nursing facility, or other type of facility for discharge address
  - Ask if they are willing to assist with outreach, can they provide your contact information?

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Locating Clients (cont.)

- Contact Community Service Officers in your local police department or Parole Officers
- Contact local emergency departments (EDs) if the client is known to frequent the hospital
  - Review PRISM to identify ED usage patterns
- Respond rapidly to EDIE or PreManage reports when client enters a hospital
- Leave your card with a note asking the client to contact you, using first name only at shelters

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Welcome Materials

- Managed Care Organizations send their own enrollment information
- Fee-for-Service letters and booklet are sent by the Health Care Authority (HCA)
- Care Coordination Organizations may also create their own letters and welcome materials approved by their Lead Organizations
  - Business cards help identify you as a trustworthy professional
    - Carry an agency identification card

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HCA and DSHS Publications

Consider carrying a supply of your welcome materials when you meet new clients

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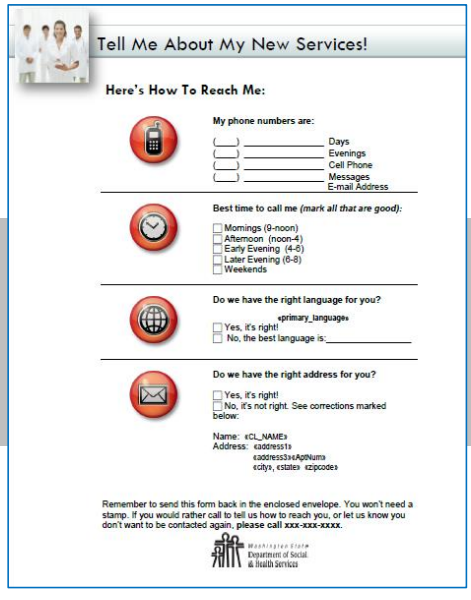
Give Clients an Opportunity to Tell You How to Contact Them



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Tips for Success

- Use a common logo or theme on all letters and forms
- Send a second letter
- Consider including a handwritten note to personalize the letter
- Provide call back numbers and locate in a prominent place on the correspondence
- Mail letters on Tuesday
- Make a follow up call 4-7 days after mailing any correspondence

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Key Words or Phrases for Letters and Calls

- Did you receive the welcome letter
  - Would you like me to send it to you?
- Free – no extra cost
- Local
- Choice - voluntary
- Benefits you don't want to miss
- Does not impact any other services or medical care

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Key Words or Phrases for Calls or Letters (cont.)

- Part of your Medicaid coverage
- Use as much or as little, now or in the future
- The process: what to expect
  - Does not require they complete an application
  - We meet you in your home or location of your choice
- You may want to get a pencil and piece of paper for notes

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Key Words or Phrases for Calls or Letters (cont.)

- A simple verbal “yes” is all that is needed today.
- If yes, a Care Coordinator will call you. (If using Outreach Specialists)
- Would you like to receive a free health survey?
- Can I send you additional material?
- Is there something I can help you with now?

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Other Tips

- Call client as soon as possible after assigned
  - Clients move frequently
  - Run out of cellular minutes later in the month
  - Call at different times during the day and on different days of the week

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Making Contact

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One Care Coordinator's Experience

- First calls felt like a sales pitch
- Once benefits were realized the approach was more conversational
- More listening and less talking
- What does the client need help with?
  - "We can help you with that!"
- Be friendly - spend time

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Develop Your Script

- Practice with other staff
  - What is your "elevator speech"?
  - Be enthusiastic
- Suggested phrases for clients enrolled with a Managed Care Organization:
  - " Your health plan (insert name of the plan) has asked me to call you."
  - "We are calling on behalf of your current health care plan."
  - "We are calling to let you know of some additional health care benefits. You are eligible . . ."

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Develop Your Script (cont.)

- Key phrases to consider:
  - Encourage enrollment now as a safety net for the future
  - Emphasize that their family or others may want this safety net for them
  - Client determines how, when, and where services will be provided
  - Stress that you value their time and other obligations

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Develop Your Script (cont.)

- Key phrases to consider:
  - Ask them about their challenges and describe how Health Home Services can help
  - Opting in and out is easy
- If the client declines offer to send them information or a call back at a future time

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More Ideas for Outreach

- If a client identifies a need before the face-to-face visit provide some service or resource at the first visit. For example:
  - Dentists that accept Medicaid can be difficult to locate: https://www.wahealthcareaccessalliance.org/free-clinics
  - Information about assistance with paying for hearing aids
  - Food banks or meal sites
  - Transportation programs

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More Ideas for Outreach (cont.)

- Share examples of some of the services other Health Home clients have received:
  - Health education and materials on their conditions
    - Pain reduction
    - Increased feeling of well-being
    - Better control of their diabetes
  - Achievement of long and short term goals
    - For example, a client wanted to be able to walk far enough to shop in the local mall.

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Key Considerations for Eliciting Interest in Health Home Services

1. Briefly state the purpose of the call and shift the conversation to their needs
   - Clients may be more likely to participate if they sense your interest in them and their needs
   - Use a reference they may trust
     - Do you work with case managers or another professional where they receive services?
   - Ask them if they received the brochure from HCA, Lead Organization or health plan

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Key Considerations for Eliciting Interest in Health Home Services (cont.)

2. Avoid the use of acronyms and use simple language to communicate
   - Use words that contain fewer than three syllables when possible
   - Avoid jargon and slang
   - Consider that clients may have hearing impairment, have limited English proficiency, or may be distracted
   - Outreach Specialists should take notes to share with the Care Coordinator if calling on their behalf and add them to the client file:
     - Information which may appear unimportant may provide insight for the Care Coordinator

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Key Considerations for Eliciting Interest in Health Home Services (cont.)

3. Show respect for their time and understanding
   - Check with the client to see if this is a good time to talk
     - If not, offer a telephone appointment

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Key Considerations for Eliciting Interest in Health Home Services (cont.)

4. Ask the client to share their concerns and experiences using the Medicaid program and/or their medical providers
   - By identifying barriers you may be able to identify an opportunity to offer assistance through Health Home Services
     - Including legal, housing, transportation, and other services

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Key Considerations for Eliciting Interest in Health Home Services (cont.)

5. Use the client's identified issues or concerns to:
   - Explain how this program may:
     - Help them gain better service
     - Improve their health
   - Ask them what they fear they may lose by participating
   - Ask them what they may gain by participating

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Key Considerations for Eliciting Interest in Health Home Services (cont.)

6. Ask questions to elicit their concerns about their health
   - Explain how Health Home Services can help
7. After asking a few questions ask them if they have time to answer a few more questions
8. Review PRISM data to identify hearing impairment or the need for an interpreter prior to contacting
9. Use your Motivational Interviewing skills
   - Empathic approach

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Take Time to Listen

The greatest compliment you can give a client is to listen

- Do not call if you cannot devote the time
- Complete calls when you expect the fewest interruptions
- Mix closed ended questions with open ended questions
- Repeat back to the client to check for understanding

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Take Time to Listen (cont.)

- Ask the client to determine how they would like to receive information
  - Written communication
  - Follow-up call
  - Will the client agree to a face-to-face visit?
    - Who should be present at the visit?
    - Can you contact this person or persons to schedule a visit?
- When asking questions to elicit personal information explain why they are being asked
  - Assure them that their answers will not result in a loss of benefits
  - There is no penalty if they choose to decline now or in the future

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Consider How Your Client Makes Decisions

- Some clients base decisions on information
  - They may need more facts about the program
  - Consider sending written material
  - Refer them to the HCA and/or DSHS website
- Some clients depend on the guidance or opinions of others to make decisions
  - Explore with the client who they trust
  - Request permission to contact this person/s

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First Contact

- If you speak with the client request alternate numbers where they can be reached
- Request information about collateral contacts and ask for verbal consent to contact when appropriate
- Document the verbal approval until you can complete a Information Sharing Consent form (HCA-22-852)

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Tips for Improving Engagement

- Listen to the client
  - Asking the same questions may signal that you are not listening
- Avoid interrupting or finishing their sentence
- Avoid talking too fast
  - There may be a language barrier or hearing impairment
- Avoid interruptions and placing the client on hold
- Show your enthusiasm for the program and its benefits
- Share what your other clients have said about the program

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Closing the Contact

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Client Agrees to Participate

- Summarize the conversation before ending the call:
  - Repeat the date, time, and location of the visit
  - Offer to contact collaterals that they may want to be present
  - Ask for e-mail addresses to send a confirmation
  - Ask if there is any further information they would like or if they have any questions
  - Provide your name and contact information
  - Thank them for their time
  - Follow up with an appointment letter
    - Ask if someone else should receive a copy
  - Call to confirm that the letter has been received and to provide a reminder of the appointment

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Client Declines to Participate

- If the client remains hesitant to commit to a face-to-face visit
  - Assure them that they do not have to participate
  - Offer another telephone contact
  - Follow up with a letter
  - Ask if there is someone else you should contact
- Offer to mail the Opt-Out form with a self-addressed stamped envelope if the client is absolute about not participating
  - Or complete the form and file in the client's record

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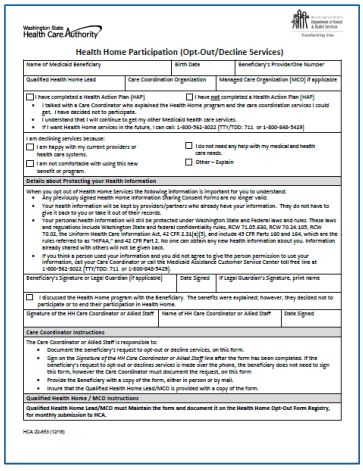
Opt-Out Form

- Client may fill out the form
- If client does not wish to complete the form, fill it out and file it in the client's file
  - Allied staff may also complete the form



Washington State Health Care Authority

Health Home Participation (Opt-Out/Decline Services)

Name of Medicaid Beneficiary	Birth Date	Beneficiary's ProviderOne Number
Qualified Health Home Lead	Care Coordination Organization	Managed Care Organization (MCO) if applicable

☐ I have completed a Health Action Plan (HAP) ☐ I have not completed a Health Action Plan (HAP)

- I talked with a Care Coordinator who explained the Health Home program and the care coordination services I could get. I have decided not to participate.
- I understand that I will continue to get my other Medicaid health care services.
- If I want Health Home services in the future, I can call: 1-800-562-3022 (TTY/TDD: 711 or 1-800-848-5429)

I am declining services because:

☐ I am happy with my current providers or health care systems.
☐ I do not need any help with my medical and health care needs.
☐ I am not comfortable with using this new benefit or program.
☐ Other – Explain

Details about Protecting your Health Information

When you opt out of Health Home Services the following information is important for you to understand:

- Any previously signed Health Home Information Sharing Consent Forms are no longer valid.
- Your health information will be kept by providers/partners who already have your information. They do not have to give it back to you or take it out of their records.
- Your personal health information will still be protected under Washington State and Federal laws and rules. These laws and regulations include Washington State and federal confidentiality rules, RCW 71.05.630, RCW 70.24.105, RCW 70.02, the Uniform Health Care Information Act, 42 CFR 2.31(a)(9), and include 45 CFR Parts 160 and 164, which are the rules referred to as "HIPAA," and 42 CFR Part 2. No one can obtain any new health information about you. Information already shared with others will not be given back.
- If you think a person used your information and you did not agree to give the person permission to use your information, tell your Care Coordinator or call the Medicaid Assistance Customer Service Center toll free line at 1-800-562-3022 (TTY/TDD: 711 or 1-800-848-5429).

Beneficiary's Signature or Legal Guardian (if applicable)	Date Signed	If Legal Guardian's Signature, print name

☐ I discussed the Health Home program with the Beneficiary. The benefits were explained; however, they decided not to participate or to end their participation in Health Home.

Signature of the HH Care Coordinator or Allied Staff	Name of HH Care Coordinator or Allied Staff	Date Signed

Care Coordinator Instructions

The Care Coordinator or Allied Staff is responsible to:

- Document the beneficiary's request to opt-out or decline services, on this form.
- Sign on the *Signature of the HH Care Coordinator or Allied Staff* line after the form has been completed. If the beneficiary's request to opt-out or declines services is made over the phone, the beneficiary does not need to sign this form, however the Care Coordinator must document the request, on this form.
- Provide the Beneficiary with a copy of the form, either in person or by mail.
- Insure that the Qualified Health Home Lead/MCO is provided with a copy of the form.

Qualified Health Home / MCO Instructions

Qualified Health Home Lead/MCO must Maintain the form and document it on the Health Home Opt-Out Form Registry, for monthly submission to HCA.

HCA 22-653 (12/16)

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Working with Collateral Contacts

- If you reach someone other than the client ask probing questions to find out the most recent contact information and best methods and times for reaching the client
  - Express appreciation for their role with the client if appropriate
- Be aware of confidentiality
  - "I am working on behalf of the client's health plan."
  - Provide general information about the program
  - Is there anything they want to share about the client?
  - Leave your contact information

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Face-to-Face Visits

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Successful engagement results when you are able to get clients to share information not give them information.

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Goals for Engagement

- Meet the client
- Introduce yourself and your role
- Explain the purpose of the visit
- Explain the benefits of the program
- Encourage the client to accept or consider accepting Health Home Services

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Scheduling and Reminder Calls

- Schedule visits allowing plenty of time for travel and traffic delays
  - Example of a reminder call: "I will be there around 10:00. However, depending on traffic it could be earlier or later, so expect me some time between 9:30 and 10:30."
    - Take cell phone if going to arrive outside of the timeframe or if an earlier appointment cancels
- Consider using allied staff for calling to save your time
- Send an e-mail reminder
- Contact a collateral and remind of visit

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Scheduling and Reminder Calls

- Ask for directions, a description of the residence, if there are any pets, where to park
- Ask if someone else lives with them or will be present during the visit
- Ask if there is anyone else they would like to have present

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Upon Arrival

- Legally park your car in a safe place
- Be aware of your surroundings and the neighbors
- Knock so that the client can hear you, allow time to get to the door
- Ask if someone else is in the home: you want to ensure confidentiality

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Upon Arrival (cont.)

- Produce identification
  - Program brochure
- Speak slowly and consider language and hearing ability
- Show respect: where should I sit? Would you like me to remove my shoes?

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Letter for Residential Providers

- As a professional courtesy introduce yourself to staff at nursing facilities, assisted living facilities, and adult family homes
- Ask if staff is willing to introduce you to your client
- Provide a copy of this letter
- Letter is on the HCA Health Home website:

https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes

Health Home Program
Washington

Dear Administrator or Staff,

I am a Health Home Care Coordinator with _____

I am here because one of your residents is eligible for the **Health Home Program**. The program is voluntary and is provided at no cost to eligible Medicaid and Medicaid/Medicare clients. The state identified one or more of your residents who are eligible to receive my services.

The Health Home Program **helps residents** who have one or more chronic diseases. These residents are at risk for other health problems and higher medical costs.

Care Coordinators help your resident(s) create a Health Action Plan, which includes personalized health goals. I can **assist you** by providing Health Home activities such as:

1. **Teaching** your resident about their health
2. **Coaching** family members to support your resident and you
3. **Referring** your resident to services outside of routine care
4. **Helping** you with care transitions when your resident returns from a hospital or nursing facility

Your resident may receive monthly visits and phone calls as part of their Health Home services. I look forward to working with you to **support** your resident in reaching their health goals.

Washington State Health Care Authority

Optional Use by Facility

Resident Name	ID#

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During the Visit

- Explain the purpose of the visit
  - What to expect: required screenings, optional screenings
- Explain the program
- Explain the process
  - How much time will it require
  - Contacts and follow-up
- Provide a resource
  - Is there something that you can help them with immediately?

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Wrapping Up the Visit

- Explain next steps
  - Schedule the next home visit
  - Offer an appointment card or letter
  - Write the appointment on the client's calendar or offer to do it with them
- Thank them for their time
  - Do they have any further questions
  - Ask them if the process worked for them

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Tips for Staying On Track

- Listen for their complaints: use this as a way to identify what they want which will help them focus
- Interruptions from others in the home, pets, and TV noise
- Offer the screenings as a way to further the process
  - May wish to offer after they have signed the Information Sharing and Consent form
    - Helps with focus and better use of energy at the beginning of the visit
- Use the short term goal to guide conversation

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Developing Community Contacts

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Outreach Includes Networking with Community Partners

- DSHS: local Community Services Offices, Home and Community Services, Children's Administration and the Developmental Disabilities Administration
- Area Agencies on Aging
  - Aging and Disability Resource Centers (ADRC)
- Hospital and nursing facility discharge planners
- Law enforcement and corrections
- Mental Health and Substance Use clinics and providers
- Community Health Centers and other clinics

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Provider Letters

- Develop a letter to providers and community partners that:
  - Describes the Health Home Services
    - Process for enrolling
    - How it benefits clients
    - How it benefits the provider
  - Provide an example of a success story
    - Describe services, interventions, and outcomes
  - Provides contact information
  - These letters and outreach materials must be approved by your Lead Organization/s

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Resources from the HCA Website

Materials are posted on the website located at:

https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes

Information about the Health Home program

Materials and resources that can be used to educate providers and clients about the Health Homes program.

- Health Home services
- Frequently Asked Questions
- Fact sheet about the Health Home program
- Care Coordination: For Providers
- Care Coordination: For Clients
- Information for Medical Providers
- Information for Behavioral Providers
- Information for Long Term Services and Supports
- Health Home fact sheet for residential providers
- Information for Nursing Facilities and Hospitals

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Let's See What Other Approaches Participants Have Shared

- What approaches have you used to reach out to new clients?
- What hasn't always worked so well?
- What approaches have you used to increase engagement?
- What hasn't always worked so well?

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Summary

- Lots of ideas were shared on initial outreach and engagement
  - One approach is to speak to how your clients listens
  - Keep it short but be prepared if your client or collaterals want more information
- Authenticity is the key to engagement

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Informational Websites

Health Care Authority:
https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes

DSHS Health Homes:
https://www.dshs.wa.gov/altsa/washington-health-home-program

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Contact Information

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Required Ongoing Training Topics

Outreach and Engagement Strategies	June 9, 2017
Navigating the LTSS System: Part 1	July 13, 2017
Coaching and Engaging Clients with Mental Health Needs	August 10, 2017
Navigating the LTSS System: Part 2	September 14, 2017
Cultural and Disability Competence Consideration	October 12, 2017
Assessment Screening Tools	To Be Determined
Medicare Grievances and Appeals	To Be Determined

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Certificate of Completion

Outreach and Engagement Strategies

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Department of Social and Health Services – Aging and Long Term Support Administration

Webinar aired on: June 8, 2017 in Lacey, Washington
for Health Home Care Coordinators and Allied Staff

Training Credit of 1 Hour

Please sign and date to attest that you reviewed this PowerPoint

_____ _____

Your Signature Date

_____ _____

Supervisor's Signature Date

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Post Webinar Discussion

- What are your best practices for locating and contacting clients?
- What experiences have you had telephoning your clients?
  - What key phrases have worked?
  - What has not been as successful?
- What other methods do you use to reach clients (e.g. letters, brochures, etc.)?
- What success have you had with reaching out to community partners and informing them about Health Home services?

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