STATE OF TENNESSEE

Health Link: Member Engagement

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Content

- Barriers to engagement and treatment
- Preparing for engagement, enrollment and operations
- Outreach and enrollment
- Enrollment and engagement case study in Iowa

What Are the Historical Systemic Barriers?

- Social barriers
- Lack of transportation
- Lack of reimbursement methods for coordinated care
- Lack of reimbursement for health education, support and family services
- Inadequate services to support self-management
- Poor coordination between physical and behavioral healthcare systems

- Primary care providers (PCPs) can be uncomfortable with or don't have much experience managing individuals with behavioral health conditions
- Primary care office staff are often uncomfortable with people with behavioral health conditions
- General lack of communication between behavioral and physical health makes medical management of members with behavioral health conditions more challenging

Your Vision and Plan

Preparing for Engagement, Enrollment and Operations

- Support from leadership, providers and staff is essential to the success of better coordinated behavioral and physical health services
- Do you have a clear vision for coordination of behavioral and physical health care?
- Do you have an operational plan?
  - Co-location
  - Partnerships with organizations with complementary clinical expertise
  - Staffing plan and/or staff hired
- Clear understanding throughout the organization of the goals of the program and the measures of success

Preparing for Engagement, Enrollment and Operations (Cont'd)

- Communicate throughout the organization how coordinating behavioral and physical health into the practice aligns with what matters to each of them.
  - Holistic care for all of the members' needs
  - Better access to physical health care for ambulatory care
  - Better communication and coordination between physical and behavioral health providers
  - Assistance for ambulatory physical health providers and staff with the behavioral and emotional aspects of care and for behavioral health staff with the physical health aspects of care, especially for high-risk, complex individuals
  - Better outcomes for individuals with behavioral health and physical health conditions such as chronic illness and serious mental illness

Preparing for Engagement, Enrollment and Operations (Cont'd)

- Communicate with providers and staff that there may be challenges or hiccups during the transition to coordination
- Anticipate questions about how coordination will impact daily operations and workflows
  - Physical health providers and staff often assume there are more individuals with behavioral health needs than the behavioral health provider will be able to handle
  - Behavioral health providers may not know where to refer members with physical health conditions
- An initial spike in referrals is common
  - Help providers and staff think about which individuals may benefit from coordination, especially among those with chronic physical health problems or behavioral health conditions other than depression, anxiety, and other common mental health problems.

https://integrationacademy.ahrq.gov/playbook/develop-your-game-plan

Preparing for Engagement, Enrollment and Operations (Cont'd)

- Traditionally, behavioral health providers often have limited training about chronic physical health conditions
  - Psychologists, therapists, social workers and counselors have different training from nurses and physicians
  - Education about common chronic conditions may help providers feel more comfortable with coordinating care
  - What questions are relevant for common conditions and what do you do with the response?
- Develop a process and workflow for who will engage members and how
  - Who will engage them?
  - Who will follow up?
- Do you have a culture of collaboration?
- Do you have a culture of flexibility to meet member needs?

Engagement, Outreach and Enrollment

Who, What, When, Where and How

Engagement is Marketing

- Know your “customers”
  - What are their needs?
    - What do they perceive they need?
    - What do you think their needs are?
    - What value will you add?
  - What services, activities and benefits will be attractive to them?
  - What ways do they communicate to you and you to them?
  - What is the best way to reach them?
- What is you elevator speech?
  - Short, targeted and simple
- Motivational interviewing

Stakeholder Map

Stakeholder Map—what matters to whom regarding your integrated behavioral health program?

***Appeal to what already matters*—and find out what that is.**

1. Ask yourself who the stakeholders are in your program—the ones who are depending on you for results, have a stake, and will benefit.
2. Then ask yourself if you know what matters most to each stakeholder. *If you don't know, find out.*
3. Then ask yourself how your integrated behavioral health program appeals to what matters to those stakeholders. If there are major gaps where your program does not appeal to what matters most, consider changing or featuring things to create a better match.
4. Finally, ask how the stakeholder's own role and "job" can help bring success—what part they can play that will help them get the benefits.

	What matters most to that stakeholder	How (and how well) your program addresses what matters to that stakeholder	How the stakeholder's own role and "job" can help make your program a success—their part to play
Stakeholder 1			
Stakeholder 2			
Stakeholder 3			
Stakeholder 4			
Stakeholder 5			

Common examples of stakeholders in an integrated behavioral health program:

Your patients and the public
Your PCPs and staff
Your organization's leaders
County/State human services
Local specialty mental health clinicians
Your payers-health plans
QI reporting/convening folks
Your hospital or ACO partners
Behavioral health community resources
Local or state policy people

Identify the stakeholders you most need to know, understand, and do something for. Be specific, e.g., which payers you actually have. Start with these and go from there. Don't *make up* what you *think* matters to people (or what *should* matter)—go find out and verify this instead.

One of many references: Brugha R. & Varvasovsky Z (2000) Stakeholder analysis: A review. Health Policy and Planning 15(3):239-46. http://www.ncbi.nlm.nih.gov/pubmed/11012397

Initial Engagement – Who Are Our Members?

- What data do we have about them?
  - Visits to behavioral health providers
  - Visits to physical health providers
  - Visits to the emergency room (ER)
  - Prescription claims
- Community knowledge
  - Community centers
  - Public housing
  - Peer support centers
  - Substance use centers

Initial Engagement – Build On All Interactions

- Build on existing relationships and trust
  - Behavioral health providers
    - More frequent contacts than physical health for people with behavioral health conditions
    - More comfortable setting for people with behavioral health conditions
  - Physical health providers
    - Chronic illnesses
    - Acute admissions
- ER visits
- Substance use treatment
- Pharmacists

Initial Engagement – Build On All Interactions (Cont'd)

- Case managers- expanded role in Health Link to include focus on whole health
- For children – school staff
- Criminal justice system
- Community organizations

Community Outreach – Who Knows the Member or Where to Find Them?

- Community health workers
- Care coordinators
- Case managers
- Peer support specialists

Mine Existing Data and Real Time Information

- Engage members in the ER
  - Use real time notification whenever possible
  - Position staff in high volume ERs
  - Identify advocates in high volume ERs
- Participate in discharge planning
- Support transitions of care
- Engage high volume providers
- Collect data on enrollment – what is absent from the medical record?
  - Demographics
  - Clinical
  - Social
  - Financial
  - Housing

Methods and Incentives

- Outreach from trusted person
- Technology
  - Texting
  - IVR
  - Patient portal
- What incentives have your organization offered?
- Support through member benefits
  - Transportation
  - Visit accompaniment
  - Help with prescription adherence
  - Help with life skills (e.g., food shopping or budgeting)

Team Approach

- Clear roles for each person on the team
- Common data source to track outreach and contacts
- Identify key member needs and the team member best able to address them:
  - Peer support for in person interactions to increase contacts and early engagement
  - Case manager to support holistic benefits and alignment
  - Care coordinator to gather information from all providers and coordinate care

Some Lessons from the Field

- Not everyone wants to get all their care in one place. Some will prefer to have their behavioral and physical health care provided separately.
  - How will care be coordinated?
    - What is the communication vehicle?
    - Who will be responsible for follow-up?
- Listen carefully for member needs that could be met
  - Partnerships with supermarkets for shopping and dietary support
  - In-person counseling at the pharmacy
  - Social interactions
  - Housing related needs (e.g., air conditioners, durable medical equipment)
  - Special group classes

Tools for Tracking

- Member Record – Care Coordination Plan
- Care Coordination Tool
- Tickler for follow-up
    - Attend upcoming appointments
    - Were follow up appointments kept?
    - Were prescriptions filled?
- Disease registries
- Quality measure tracking
- EPSDT tracking

Marketing Requires Persistence

- People may not recognize the value when first approached
  - Fine tune message based on experience
  - Use teachable moments to promote the program
    - Benefits applicable to specific situation
    - Avoidable adverse events
- Relationships matter
  - Engaging around member needs
  - Showing interest in more than the clinical needs

Resources: SAMHSA-HRSA Center for Integrated Health Solutions *CIHS*

http://www.integration.samhsa.gov/

Resources: AHRQ

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

The Academy
Integrating Behavioral Health and Primary Care

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Integration Playbook Now Available

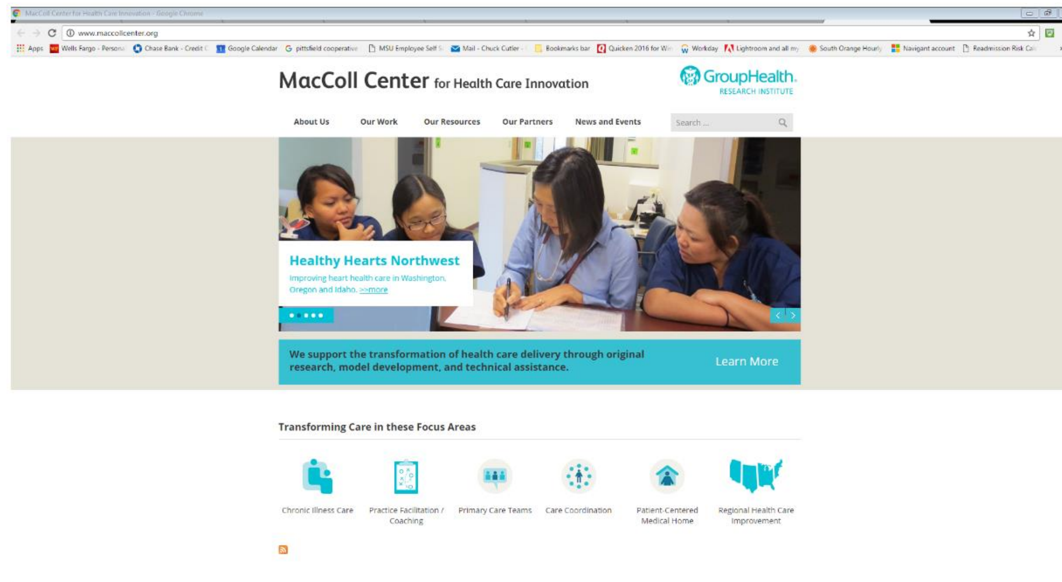
AHRQ's Integration Playbook, a new interactive guide to support the integration of behavioral health care in ambulatory care practices, is now available on the portal. Topics include planning for integration; preparing your practice's infrastructure; establishing protocols and clinical workflows for integration; and developing processes for tracking patients, monitoring outcomes, and maintaining engagement. The Integration Playbook video provides an overview of the Playbook's content areas and features.

The Integration Playbook, or "Playbook" for short, offers tips, resources, and real-world examples of how other practices are integrating behavioral health; provides guidance on "what not to do" while integrating behavioral health; an interactive self-assessment checklist that practices can use to assess their current state of integration and plan their approach for implementing behavioral health integration; and access to the Academy Community for peer networking and sharing.

Access the Playbook at: http://integrationacademy.ahrq.gov/playbook

https://integrationacademy.ahrq.gov/resources/new-and-notables/integration-playbook-now-available

Resources:
MacColl Center for Health Care Innovation



http://www.maccollcenter.org/

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