MedZed's Member Outreach Approach

Enhanced Care Management

Building on Experience with High-Risk, High-Need Patients

MedZed ECM Programs

End-to-end integrated care provider focused on serving high-risk, home-based patients with chronic conditions and complex social needs.

Partner with Medicaid and Medicare Advantage health plans.

Customized solutions, including:

- Delivering in-home tech-enabled primary care and behavioral health support
- Coordinating and providing wraparound social services
- Closing specific care gaps

Our ECM services build on our work with Whole Person Care and Home Health Pilots. They are grounded in our Longitudinal Social Care solution, a technology-driven Community Health Navigator (CHN) program that executes a comprehensive SDoH service plan for patients in conjunction with a plan's clinical personnel.

Current ECM Programs

11

Contracts

17

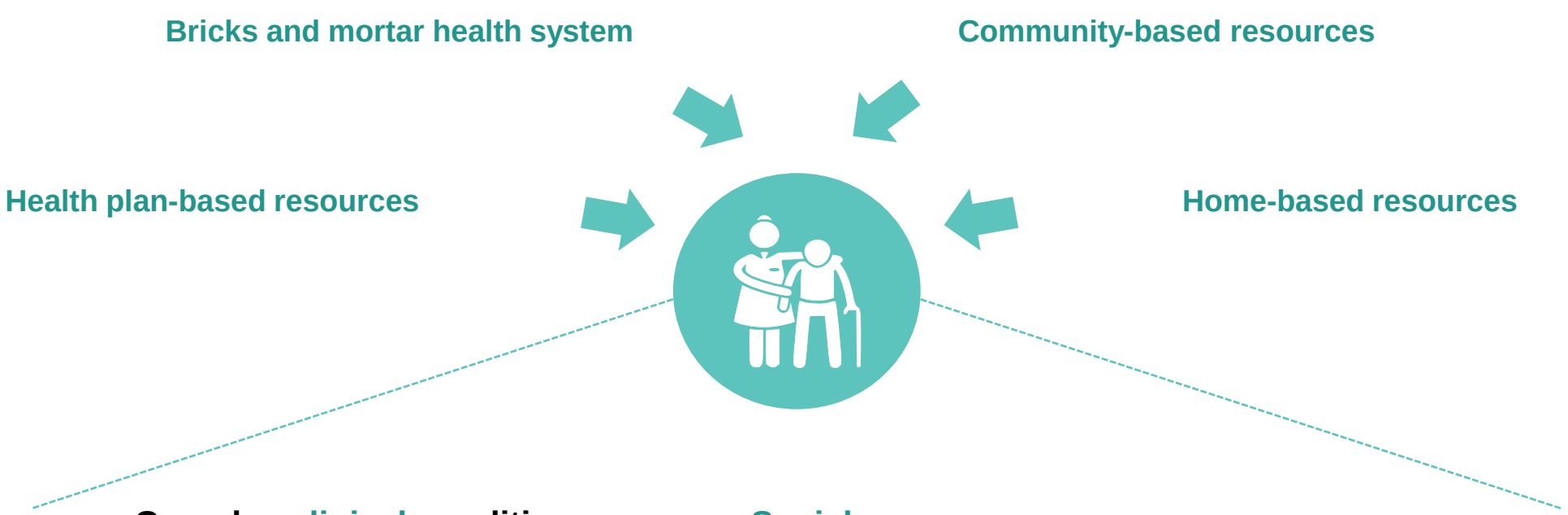
Counties

3,500+

Members Enrolled

Complex Members Slipping Through the Cracks

Struggling to Access and Coordinate Care and Services from Many Sources



Complex clinical conditions

- Multiple chronic diseases
- Behavioral health conditions
- Substance use disorders

Social concerns

- Food insecurity
- Housing insecurity
- Health literacy
- Safety and physical environment
- Access to health care
- Support networks

Enhanced Care Management Pulls All the Pieces Together

ECM' s Comprehensive, Coordinated Interventions Target SDoH

ECM Program Elements

- Outreach and Engagement
- Comprehensive Assessment and Individualized Care Plan
- Comprehensive Transitional Care
- Enhanced Care Coordination
- Referral to Community and Social Support Services
- Individual and Family Support
- Health Promotion

Community Health Navigators Provide Ongoing Support

- In touch with local culture, environment, challenges, plus resources and organizations
- Member-focused, committed, and compassionate
- Build a trust-based relationship to help patient navigate and "own" their health journey

- Meet urgent needs and overcome obstacles
- Follow up to ensure support services are rendered
- Coordinate with Case Management
- Develop strategies to reduce avoidable admissions
- Help member develop trust in providers
- Educate and empower member, build self-management skills

Cracking the Code on Engagement

A Method and Determination to Find the “Hard-to-Reach”

Telephonic Outreach

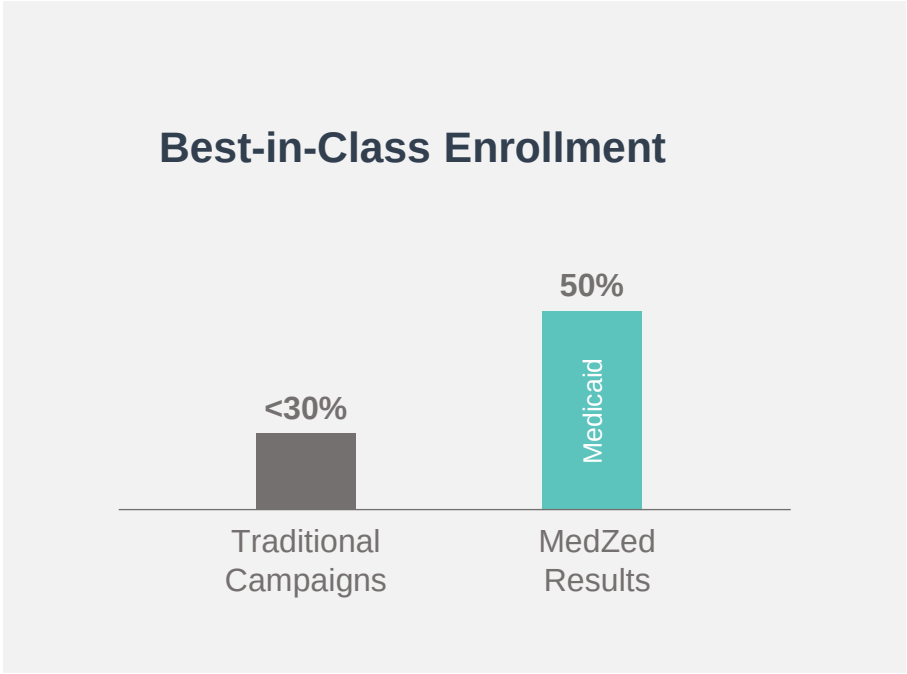
- Use proven relationship scripting in outbound calls
- Attempt minimum of 5 calls
- Rotate call time-of-day and day-of-week
- Conduct calls in member’s preferred language

Community Outreach/Fieldwork

- Visit known addresses
- Attempt minimum of 5 “door knocks”
- Network with local social, and other organizations to find transient members
- Visit member bedside when admitted

Lead Tracing

- Utilize available technology platforms to find alternative contact information
- Collaborate with health plan for previous addresses
- Conduct background checks



Best Practice: Finding & Engaging

- Explain the program short & sweet, but be prepped to explain further
  - Free service to member
  - On behalf of *their plan name*
  - List some benefits (i.e. connect to PCP, follow up on concerns, DME)
  - Be confident
- If they decline, ask why
  - Do they see their PCP regularly? Do they see their dentist regularly?
  - Do they have access to enough food? Do you need help with housing?
  - Check if you can outreach in a month to follow up
- Our plan for children & youth:
  - emphasize medical needs
  - Be confident & provide more information from the start to build confidence with parent/guardian
  - Emphasize building rapport with support system (parent, guardian, family, etc.)

Best Practice: Assessments

- Complete in person
  - Look for body language
  - Look for response
  - Observe their surroundings
- Sensitive questions: give member a heads up before asking
  - i.e. “I am going to ask you some questions around substance use, is that okay?”

Best Practice: Assessments for C&Y

- Our plan for children & youth:
  - Plan for all assessments to be in person & if not, complete a home visit within the first 30 days
  - Observe the body language & response from member and parent/guardian
  - Don’t push for a response on sensitive questions (build rapport & revisit)
  - Be sensitive to member's age when asking questions
  - Address questions to the appropriate person (parent/guardian vs member/child)
  - Keep in mind important questions to ask members

- Referring back to pediatrician is especially important

Challenges

- Finding Members
  - Homeless members are hard to find – if they are at a shelter, leave info with shelter personnel for member
    - Build a relationship with shelter staff
  - Utilize Fast People Search, people finder services, collective medical or other health plan portals
  - 5 phone calls & 5 door knocks
    - More attempts to get in touch with member as we do not know their preference
- Health Plan recognition and validation of trusted ECM Provider partner
  - Be confident & explain program thoroughly
  - Utilize flyers & other resources when offered by health plan
  - Call member services with member

Anticipated Challenges

- Children will present their own unique challenges when attempting engagement and enrollment
  - Do not push too hard to get member enrolled but focus on building rapport & asking if child's needs are met medically & socially
  - Seek to partner with parents/guardians
    - Understanding the family situation and the barriers faced by the family will provide an opportunity to build trust and rapport.
- Completing enrollment in a timely manner
  - Families tend to have limited time for these activities, especially when working hours may limit their availability
  - Make them aware of enrollment periods & deadlines for completing assessment & reviewing a care plan together