HEALTH INSURANCE TELECENTER: SAN MATEO COUNTY

Hannia Casaw, Katherine Sanchez & Tara Smith*

EXECUTIVE SUMMARY

BACKGROUND

This case study provides a review of the San Mateo County's Health Insurance TeleCenter (HIT), which was established in November 2003 to provide better customer service for clients, to meet Medi-Cal caseload maintenance needs, and to continue to provide services despite declining funding.

San Mateo County's continuing Medi-Cal caseload has increased by 68% since the implementation of Welfare Reform in 1995. Levels of funding have not allowed for an increase in staff relative to the increase in case volume. Staff members have struggled to perform mandated functions with caseloads that do not allow for completion of that work according to state regulations. San Mateo's human services challenge is facing many counties as they continue to be strained economically in their attempts to respond to the myriad of public services expected by residents.

In addressing this case study, we obtained technical information that helped us understand that by calling an 800 number and pressing one button, Medi-Cal clients can now immediately be in contact with a Benefit Analyst, who can respond to their ongoing case needs. All continuing cases are maintained in a records retention area that relies on a Holga movable system that is used in hospitals. Only when a case needs attention, it is transferred into a Benefit Analyst worker number.

While the technical understanding was valuable, this experience provided an insight to the clearest lesson: the importance of achieving organizational change through significant planning efforts that included stakeholders at every opportunity.

RECOMMENDATIONS

Three BASSC interns from Alameda, Santa Clara and Sonoma Counties studied San Mateo's HIT Center with the goal of discovering ways in which this approach could successfully be adapted in our respective counties. Each of us brought a different perspective to this review.

ALAMEDA

Alameda County would like to use the San Mateo HIT model and adjust it to launch a retention strategy to help Medi-Cal clients keep their health coverage. Rather than using a Phone Benefit Analyst as in San Mateo, a Case Management Assistor (CMA)[1] can be hired to take a proactive role to ensure that our Medi-Cal recipients do not lose their coverage. The objective is to model what our Application Assistors are currently doing with our No Wrong Door Intake project. Personalized assistance is provided to clients as they are walked

*Hannia Casaw is a Management Analyst with the Work Force & Benefits Administration Department at Alameda County Social Services Agency.
Katherine Sanchez is the Deputy Financial Officer at the Santa Clara County Social Services Agency.
Tara Smith is a Planner Analyst with the Sonoma County Human Services Department.

[1]Case Management Assistor (CMA) can be our Eligibility Support Clerks (ESC)

through the enrollment process. We would like to offer the same type of personalized assistance during the case management phase.

Case Management Assistors would proactively contact Medi-Cal clients to help them with any case maintenance needs as well as help understand any paperwork that may need to be completed for the mid-year status reports and re-determination. If a case becomes complicated, the CMA will speak internally with the Eligibility Technician assigned and attempt to resolve the issue. If necessary, they will call the client to obtain further documentation or clarification.

This new process, while slightly different from the HIT model, may provide significant positive outcomes for Alameda County's Medi-Cal recipients including:

- Better clients' understanding of the requirements in order to avoid discontinuance of their health coverage plan.
- Better customer services for clients who do not necessarily understand the process or paperwork.
- Improved staff satisfaction as they feel they are helping clients who are lost in the system.
- A significant increase in retention rates, thus ensuring that our clients stay enrolled in Medi-Cal.
- A decrease in re-enrollment rates. If clients are able to maintain their coverage, they do not need to re-apply. This avoidance potentially saves time and resources for our agency.

In general, the HIT model in San Mateo provided insightful ideas for Alameda to begin building a new or adjusted model that can be used to launch strategies that fit with our department's priorities. Retention is currently a priority for our county and using aspects from HIT to fit our needs have proven extremely useful for us.

SANTA CLARA

In the past 6-months, as we completed the case study of the San Mateo County experience, it confirmed there are applicable findings for Santa Clara County.

- Overall Planning—Because the service delivery is changing so radically, consistent leadership that includes all stakeholders in a meaningful manner throughout the planning process is needed to successfully guide in the development of the new business model.
- Program Needs—Because the introduction of this new initiative requires understanding, changing and even letting go of many portions of the former continuing case management business model, the support of an experienced call center vendor who has successfully implemented call centers is needed to ensure program needs are met while maximizing program staff resources.
- Infrastructure Considerations—Because the service delivery strategy will require intense integration of technical resources in new ways, the design and implementation of all parts of the technical solution must be positioned to gather, evaluate and share information in a timely and reliable manner.

The San Mateo planning, program and infrastructure lessons are especially valuable as Santa Clara's Social Services Agency moves aggressively forward in implementing its own Medi-Cal Service Center using a special project team comprised of representatives from program, information services, fiscal and administrative central services. In many ways it will be configured similar to the San Mateo HIT.

The Social Services Agency leadership began work in October 2003 on this service delivery change. The Agency is using a combination of existing resources and additional federal and state revenue, to launch a Medi-Cal Service Center in June 2004.

SONOMA

Call centers are not new; they are used by businesses and other government agencies as a way to streamline the provision of services to customers. As an organization, we need to work smarter and not harder by adapting a call center.

We have to keep in mind the big changes that are headed our way with Medi-Cal Redesign and also the implications that CalWIN will bring in September of 2005. Following are my recommendations:

- Additional funding for Medi-Cal positions should be spent on clerical assistance rather than Eligibility Workers.
- Convert the EWIII to an intake worker. All EWI/II would become continuing workers.
- Conduct our own cost benefit analysis; which would include start-up expenses for software, hardware and fixtures.
- Develop strategies on how best to implement.

CONCLUSION

Ways to address the continuing Medi-Cal program is of interest to counties because the current caseload continues to escalate but there is no correlating increase in state funding under the existing service delivery business model. While our individual counties, Alameda, Santa Clara Sonoma and San Mateo, differ in many areas, we all consistently emphasized one thing: Providing efficient and effective services to Medi-Cal families.

The San Mateo County Health Insurance TeleCenter is a valuable model for providing insights on how to respond to a growing continuing Medi-Cal caseload in an era of limited resources. Other counties should be encouraged by its successful use of its stakeholder partnerships and emphasis on information sharing to build acceptance of the new service delivery model. In 16-months it took its Director's vision to streamline the provision of Medi-Cal continuing caseload management services to a reality "Where excellent customer service is just a phone call away."

HEALTH INSURANCE TELECENTER: SAN MATEO COUNTY

Hannia Casaw, Katherine Sanchez & Tara Smith

INTRODUCTION

A review of the San Mateo Health Insurance TeleCenter (HIT) was conducted by BASSC interns from Alameda, Santa Clara and Sonoma Counties. The HIT in San Mateo represents a new business model for providing continuing case maintenance service to the clients enrolled in the Medi-Cal program, which provides health care coverage to eligible low-income families and individuals. The review was conducted as Alameda, Santa Clara and Sonoma all face many challenges to meet increased demands for services in an era of direct budget cuts, funding shortfalls, and higher public scrutiny. We are pleased to present this case study as a team. Each of us has brought a different perspective to this review, which has complemented each other very well. Hannia Casaw (Alameda) brought a planning and policy perspective, Katherine Sanchez (Santa Clara) brought her expertise in the financial and infrastructure areas, while Tara Smith (Sonoma) brought her experience as a Medi-Cal Program Analyst. These perspectives were crucial to help us create a comprehensive case study.

BACKGROUND

Alameda County

Alameda County is much bigger in size, population, and diversity than San Mateo County. In 2002, our population was 1,444,656. From 1990 to 2002, we saw a population increase of 12.9%. Alameda's clients' languages include not only Spanish and Chinese, but also Vietnamese, Cambodian, and Farsi.

Alameda County has a current caseload of 70,000 cases, which represents a 12,000 case increase from 2001. We have seen this significant increase in Medi-Cal enrollment partly due to the various countywide enrollment strategies that have taken place under the leadership of Supervisor Alice Lai-Bitker. Supervisor Lai-Bitker's goal is to enroll as many uninsured individuals and families; thus considerably aiming at reducing the number of uninsured in our county. The Children and Families Health Insurance Task Force was formed and charged with this task in 2002. Members of this task force include the Social Services Agency, Health Care Services Agency, and several nonprofit organizations including the Alameda Alliance for Health, the Alameda Health Consortium, as well as various community health clinics. It has been an important entity to help us prioritize enrollment efforts through several initiatives including the community-based enrollment events, the Social Services Agency No Wrong Door pilot project, and the more recent Public Benefit Fund enrollment events. All these enrollment activities have been implemented in partnership with the members of the Children and Families Health Insurance Task Force.

As these activities continue to demonstrate successful enrollment in Medi-Cal, we do anticipate a significant increase in our caseload. Currently, 85% of our cases are housed at the Benefit Center where Eligibility Technicians (ET) III[1] provide on going

[1] ETIIIs in Alameda and EW or Eligibility Worker in Santa Clara and Sonoma have an equivalent function as San Mateo's Benefit Analyst.

case management. The remaining 15% of the ongoing cases are housed at the Medi-Cal Center in East Oakland.

One of our county's priorities includes increasing client retention. In addition to increasing our enrollment, we are also committed to increasing retention and thus strengthen our efforts to decrease the number of discontinuances. We believe we can use the HIT model to not only provide better customer services during case management, but also provide personalized services to assist clients retain their health coverage.

Santa Clara County

Santa Clara encompasses 1,312 square miles. As of April 1, 2000, the County's population was approximately 1.7 million, making it the largest of the nine Bay Area counties (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Solano, and Sonoma). San Jose is the County's largest city, with a population of nearly 900,000.

The ethnic composition of Santa Clara is also diverse. According to the U.S. Census as of 2000, approximately 54% of the population was White, 26% Asian, 3% Black, 0.3% Native Hawaiian or Pacific Islander, and 17% of the population was of some other race or two or more races. The Hispanic or Latino population consists of 24% of the total population listed in the above figures.

Within the County's Social Services Agency (SSA), the Department of Employment and Benefit Services has been successful in increasing the number of families and children currently enrolled in the Medi-Cal program. There are currently 89,700 Medi-Cal cases, up from 80,000 a year ago. The SSA Medi-Cal program caseload has increased dramatically during the two years, from 61,782 in July 2001 to 86,600 in July 2003, a 40% increase in two years and funding levels do not allow for an increase in staff relative to the increase in caseload volume. Santa Clara County has not added any extra eligibility workers during this caseload growth period.

Bargaining unit representatives for SEIU Local 535 Worker Chapter, SEIU Local 535 Supervisory Chapter, SEIU Local 715, and County Employee Management Association (CEMA) are all important stakeholders in Santa Clara. A workload agreement is in place with Local 535 worker chapter for individual caseload maximums of 190 to 394 for Medi-Cal FBUs (Family Budget Units).

As Santa Clara's Social Services Agency presents a budget for fiscal year 2004–2005, it is being asked locally by the five member Board of Supervisors and the Office of the County Executive to examine its core services for families and individuals, and explore how to respond in ways that are consistent with the goal of the county to provide high-quality, cost-effective services in a creative manner. As per the state mandate, the county must, for the first time, implement an accountability system that has high performance standards related to application processing and eligibility re-determinations. While this will improve service, the county is challenged to evaluate, plan, and implement a business model that will ensure that the new mandates are met.

Sonoma County

Sonoma County is three times larger in geographical size than San Mateo County. Yet San Mateo County's population is about 60% greater; nonetheless the strength of their economy is very similar to

that of Sonoma. We experienced very similar drops in CalWORKs participants after Welfare Reform, as well as sharp increases in Medi-Cal recipients.

We also, had an approximate growth rate of 68% in Medi-Cal cases over the past five years. Furthermore, the program has gotten increasingly more complex, yet the levels of funding have not allowed for an increase in staff relative to the increase in caseload volume with the caseload guidelines previously utilized. A large portion of our cases are "banked". If we didn't have any banked cases our continuing caseload would be 800+ cases just as San Mateo had prior to opening the HIT Center.

As with most counties our biggest priority is how "to serve clients better with less".

SAN MATEO ENVIRONMENT

The Goal

The San Mateo Human Services Agency (HSA), under the leadership of Maureen Borland, has focused its efforts to reduce the number of uninsured in the county. Together with the County Health Care Services Agency, labor unions, and community-based organizations, HSA has launched aggressive strategies to provide health coverage to every child and their families in San Mateo County.

In San Mateo County, the consistent philosophy is that children come first. San Mateo will consistently spend up to its allocation rather than under-spend its Medi-Cal allocation. San Mateo over spent its allocation by $700,000 last year and but this was reconciled when the State reallocation process was completed.

The call center was a concept that advanced the HSA Director's philosophy that every child in the county will have health coverage. The Central Regional Manager remarked, "Our goal is to have every child in this county insured."

In prioritizing its services with the Director's vision, San Mateo County had been one of the first counties to notify the State it would emphasize its resources on placing new people on to the Medi-Cal program. It was not going to be devoting resources to taking people off Medi-Cal by doing re-determinations. This meant that San Mateo had stopped doing renewals two years earlier. The caseload without renewals was 550. The bargaining unit agreement caseload standard target was 295. The HSA financial staff reviewed its growth over the last five years. The HSA experienced +10% average growth. In the county the conditions were that it had an agreed upon target caseload of 295 for continuing. The addition of 38 staff to the FY2002/2003 level of staffing would be required, if San Mateo resumed the renewal work to manage the caseload standard. This was a problem, the Medi-Cal allocation would not have been sufficient to support the old business model.

As the caseload grew and the allocation did not, the caseload was floating to 800+ per worker. The ability to give meaningful customer service is jeopardized with this model. The HSA knew it would be audited as a result of its stance with the State. The HSA Director relayed the call center concept to her management team. She knew that health insurance companies use the call center concept to serve their customers. She saw the call center as a concept that would allow the HSA to save a lot in performing the ongoing re-determinations in order to continue to dedicate resources for intake.

With this in mind, the HSA Director was aware that in order to allocate resources for enrollment (front-end), a new strategy needed to be sought in order to save money in the back-end or case maintenance. Her vision was to make the ongoing case maintenance cost effective, which meant looking at a very different way to providing services. This new model needed to reflect the values of the organization, as well as a business model that reflected their needs, and most importantly, a model that provided the best possible customer service for their clients.

In order to quantify the cost effectiveness of this model, a cost-avoidance analysis was done by the HSA Financial Director. It is estimated that this new model would provide over $22 million in savings over a period of five years. An annual case growth of 10% was included in this analysis. While the costs were high as the project was launched, many of these expenses were one-time expenses that will not be incurred in the subsequent years.

This cost-avoidance analysis was presented as the organization began to obtain buy-in from the key stakeholders including staff, the Board of Supervisors, labor unions, and community groups.

MATRIX MANAGEMENT—THE MEDIUM

Locally, implementing the HIT in San Mateo relied heavily on the communication and organization emphasized in matrix management. Matrix management does not use the traditional top down hierarchy. Instead, the emphasis in the organization is placed on communication, broad based team centered communication. Change is an accepted daily process. A shared vision is accepted by all. Looking at the organization in this manner helps employees let go of old concepts of how work is done.

For us, it was crucial to understand how San Mateo Human Services operates. As we interviewed the different key players, one theme kept emerging in our conversations: matrix management.

A senior manager described matrix management as follows: "It is getting outside the mind set of function; it is a greater whole...keeping in mind the big picture and understanding your peers' functions, not just yours." This implies a strong sense of collaboration towards a common objective.

As we conducted this analysis, we discovered matrix management heavily impacted the organizational culture; it is a management approach that involves everyone. It was best described by the HSA Deputy Director..."it is about getting people involved and seeing the problem as our problem, not as someone else's problem. It is about sharing and finding solutions in collaboration, not in isolation. It is a philosophy of sharing responsibility."

The planning phase of the HIT represented a concrete project where this philosophy was put into practice. As we engaged in discussions with the different workgroups, we confirmed that it was this philosophy that was largely responsible for the successful implementation of the HIT. This attitude should be taken as an example to move towards increased collaboration and shared ownership and accountability in our own counties.

We believe that this philosophy and business approach has been fundamental in the successful implementation of the Health Insurance TeleCenter. While we acknowledge and understand that this system change shift was not easy and represents a limitless number of challenges, it is something to think about for our own agencies. It is a business model that is different from the traditional hierar-

chical structure of welfare organizations. It is a model that needs to start at the top to set an example for staff. It is a model that requires joint decision-making and excellent communication. It is about joint ownership and accountability.

We were pleased to know that San Mateo Human Services Agency had been successful in changing the way they do business towards a more effective approach. This medium or approach has allowed them to continue to reach their goals and objectives. As representatives from agencies in which the traditional approach is still prevalent, we appreciate the innovation and the will to move towards positive and effective change.

HIT GOALS

The Health Insurance TeleCenter's main goals include the following:

- Provide best possible customer services for Medi-Cal clients;
- Provide case management relief for its eligibility workers carrying at times 800+ cases at a time;
- Implement a new case maintenance business model that is cost-effective; thus providing savings that can be used for enrollment efforts.

Overall, San Mateo Human Agency Services Agency's objective was to find a different and more effective way of providing customer service to their on-going clients. This new business model is a reflection of their organization's values as well as their commitment to maximize resources as much as possible, especially in the challenging budgetary environment that exists today.

HOW HIT WORKS

The planning of the HIT Center took about 16 months and involved over 70 agency staff. An oversight committee was formed as well as several other subcommittees including technology, policies and procedures, facilities, communications, and training. In addition, a call center consultant was hired to become part of the team.

The HIT Center serves over 22,000 families or 32,000 recipients. It is staffed by thirty-five Benefits Analysts[2], four Supervisors, fourteen Office Assistants, two Lead Office Assistants, one Quality Control Specialist, one Coach/Trainer, one Secretary and two Managers.

Applications for Medi-Cal are approved at the regional offices. Once the case is approved, it is transferred to the HIT. It is not assigned to a specific worker. When the file is received, an Office Assistant files it into a special Holga movable system that is commonly used in hospitals. By calling an 800 number, the recipient will hear a simple phone tree and by pressing one button, recipients can immediately be in contact with a Benefit Analyst who can respond to their ongoing needs. Recipients' calls result in changes of addresses, adding and deleting recipients, and replacement of lost Medi-Cal cards. In addition, mid-year status reports and re-determinations are processed at the HIT Center. Even during non-business hours, clients can access the 24-hour 800 number to learn about Medi-Cal eligibility requirements and where to apply.[3]

[2] Equivalent to Eligibility Technician or Eligibility Worker.
[3] Please see Attachment A for a graphic flow of HIT.

HIT PHONE SYSTEM

HIT uses the latest generation of Meridian phone instruments to support the center. The phone equipment can be restarted remotely and San Mateo's HIT phone system has rotary caller support. The HIT uses Meridian 3900 phone instruments, a PBX Optimum 1 and an automated call system. Units integrate with the existing phone system and it is configured to grow in increments of 24 trunks. The HIT is configured to allow 10% to 20% growth in its current deployment. If it grows beyond this size it will trigger a phone equipment installation increment.

Phone expenses are concentrated in-house. Phone assistance/repair is a county communication department responsibility. Maintenance can be handled by in-house technicians and support is available from vendor as well. No additional phone technicians were added to implement the HIT phone system. The HIT was tested for two weeks prior to going live. The San Mateo County Voice Project Manager conducted 1-1/2 hour classes on how to use the phone instrument in classes of 12 employees.

County communications installed the phone instruments. An outside vendor provided the installation and integration of the software with the hardware. This was chosen by San Mateo because the county communications wanted to concentrate its technicians on customer phone trouble assistance and leave the troubleshooting of integration to the vendor. This preserved license and training warranties with the hardware and software manufacturer.

STAKEHOLDERS

As mentioned earlier, planning and launching the HIT in San Mateo required the contribution of more than 70 staff during a 16-month period. The ability to collaborate was key to launching the new business model in the 16-month timeline. The HSA Director, received Board approval for the HIT in an August 2003 memo to the Board of Supervisors

As discussed earlier, the HSA matrix management is used routinely for decision-making. The familiarity managers had with working across program lines was a necessary skill used to involve stakeholders in a meaningful manner. The project stakeholders were brought together in April 2003 by the HSA Supervisor/Project Lead, using various workgroups. Workgroups in the topic areas—communication, technical, facilities, policy and procedures were identified in April 2003. The Supervisor/Project Lead chaired an Oversight Committee that met every two weeks to perform follow-up and ensure the workgroups were on schedule. The chair of each workgroup was a member of the oversight committee, plus the HSA Chief Financial Officer, an HSA Budget Analyst and the IT Director. Invitations were made to the SEIU and AFSCME labor organizations to serve on the communications committee. The labor organizations did not decline but they also did not appoint any members to represent them on the committee.

As a result of the workgroup structure, there was a vehicle for making the employees better informed about the call center, to become less afraid for themselves and their client. "People had a certain philosophy about how to help a client," said the HSA Public Information Officer, who led the communication workgroup. She also served as a member of the oversight committee workgroup. The

employees expressed to her a concern about clients, "Would they get the same attention when they called a number?" Concern and uncertainty were commonly expressed at the outset of the communication workgroup. As the communication workgroup continued to meet, its members in turn returned to their worksites and shared information.

Staff members were major stakeholders in the HIT implementation. Their selection was done in accordance with the labor agreements. Labor representatives and management discussed the call center concept at their bi-monthly "Success" meetings. Labor and management discussed the call center in terms of whether the call center was a way to get around the caseload standard "targets".

As planning moved forward, the goal was to identify staff by June 2003. It was completed by September 2003. The HSA managers and labor representatives addressed the potential for geographic dislocation of employees. Letters of notification went to SEIU and AFSCME. The HSA Supervisor/Project Lead planned for the employee selection by performing the work needed to accomplish a geographical displacement. Before using this selection method, she emailed for volunteers to agree to be reassigned to HIT. She repeated this two more times. Staff was identified in three rounds of emails requesting volunteers. As a result, staffing the call center was completed with employees who volunteered to be reassigned. The Central Regional Manager took staff as long as they were not under any disciplinary action. There were no geographical displacements.

Clients, as important stakeholders, were notified of the upcoming change in service three to four months prior to launching the HIT. The communication workgroup chair emphasized that staff education took place prior to notifying the clients. "There was no way we would send out information to the client unless our staff is educated first".

The communication workgroup also identified community stakeholders. The purpose was to present the call center service change to community meetings. The workgroup focused on ensuring there was as little or no duplication due to overlap. The workgroup was specific on which community groups would be given a presentation.

The HSA Public Information Officer (and communication workgroup chair) also arranged to brief HSA supervisors and management analysts about the HIT at agency staff meetings. While agency wide newsletter articles and emails were being circulated, she wanted to ensure that staff in other parts of the agency focused on how the call center might benefit their clients. She stated, "It was a consistency in sharing, continuing to send the message, the bottom line is we are trying to serve our clients better."

The staff who support the HSA infrastructure were also key stakeholders who contributed to the HIT implementation. The HSA Administrative Services Manager, who oversees the facility office, stated his group was successful in supporting the launching of the 12,000 square foot HIT because the facilities office completely plugged into the ISD components and the program business staff. He commented that, from his perspective, the technical and program pieces were developmental and for the facilities group "we were more in partnership than driving it". He stated that the HIT implementation represented a new model. Normally in HSA, the "oversight workgroup" for a new facility is a responsibility that belongs to the Facilities office. HIT was so different that program took that responsibility. The HSA Administrative Services Manager

stated, "We would look at what program produced, for example a schedule, then we in facilities would translate on what could be done for our part of the project".

The matrix management and workgroup structure was evident even in this infrastructure area. For example, facilities coordinated the case file movement. The HIT would service 32,000 case files. The facilities workgroup recognized the former way of doing business was changing. In the former world, each worker has their own filing to do, their own storing method. At the HIT this would be a coordinated work process and the facility had to be laid out to support that business model. In preparation for the opening of the HIT, program managers advised staff to purge files and take out duplicates and to archive ongoing cases. The Facilities Project Supervisor for HSA spoke with regional managers on how to coordinate the move to the HIT. The staff and cases were moved into the new HIT center by regions, one site each day: North, Central, and South.

POLICIES IMPACTING HIT

The approach the HSA took to implement the HIT focused on addressing staff job satisfaction as a priority. The Central Regional Manager emphasized her philosophy in planning the work environment to create a call center that offered the same employee benefits enjoyed at remote locations: flexible staffing, job rotation, and adequate training. Standup meetings with staff were conducted by the HIT managers. The agency has three regions. Northern region held an all staff meeting. The communication workgroup's contribution is credited by the HSA Supervisor/Project Lead for heavily influencing the staff's positive view of the HIT work assignment.

In planning, the Central Regional Manager highlighted the importance of maintaining relationships with the other programs. She demonstrated this by not rejecting cases from the remote sites unless the case could not exist without it or if the omission would become an issue in an audit. She furthered her relationship with the outlying programs by arranging to have her best person help set up a case correctly to get them as clean as possible before being brought to the call center.

The Central Regional Manager acknowledged the work of the communications workgroup and said that efforts coupled with the emphasis on maintaining relationships, and making the call center a good place to work with flexible staffing all contributed to a successful HIT.

Local planning of the technical support also required HSA staff to rely on its practice of using the resources offered by County partners. The County Information Systems and the County Telephone Communications Group were important players in the implementation of HIT. The HSA used the county's technical concept of standardization and simplicity of equipment acquisition, replacement and change. It is a local equipment strategy used to operate the county phone decisions according to the County Voice Project Manager.

Looking at how decisions at the state level impact San Mateo programmatically, the state under-funding of Medi-Cal eligibility workers has led to high caseloads in all counties. Many tasks such as re-determination of eligibility became difficult to accomplish. This delay in processing re-determinations has left many clients on Medi-Cal that the tate believes are no longer eligible for the Medi-Cal program. In legislation, SBX1 26, passed in May 2003, the State proposed that the cost of a Medi-Cal eligi-

bility workers be fully funded rather than be tied to Medi-Cal program performance standards. In addition, counties would lose funding or be sanctioned for failure to perform according to the state standard.

This change at the state level is driven by the state's recognition that continued under funding was actually costing them more in provider costs than what they were saving in administrative costs. This is because of their managed care per capita rate system, the State pays, whether the client uses the service or not.

MAJOR SUCCESSES & CHALLENGES FOR HIT

The HIT represented a new business model. In order to implement HIT, HSA hired 20 new FTEs in FY2003/2004, most were clerical. The old business model would have required 38 Benefit Analysts. In working through the proposed change with staff, the Agency acknowledged that staff had a relationship with a few clients. However, due to the "putting out the fire" nature of their work to manage the caseload, there were only a few of them who developed relationships with clients. The HIT center represented a way to accomplish work with greater job satisfaction.

This theme, that the HIT represented a different work environment and caseload handling, was carried through to the decision to not use in-house training resources. Instead, HSA chose to use the services of a call center vendor. The professional services of InTellegy were obtained by amending an existing county agreement. The vendor had had successfully worked with the Child Support Services, after that department struggled for 10 years. Initially, 35 staff were trained, beginning in October, for a November opening. HIT continues to train using this vendor. The HIT has been successful in using a coach trainer for mini-training sessions as needed in this new environment.

LESSONS LEARNED

For a program that has been operating for less than six months, the San Mateo Health Insurance TeleCenter (HIT) has realized impressive success. Since the launch in November 2003 to February 2004, call volume has increased 18%, the average wait time to reach a Phone Benefit Analyst is 14 seconds, the number of caller abandoned English calls has decreased 60%, and Spanish abandoned calls have decreased 74%.

But these trends are only part of the picture. The HIT launched with a remarkable change in organizational culture. The Public Information Officer stated the HSA's use of the workgroup structure helped manage the uncertainty presented by a very new program: San Mateo's HSA "believes in having consistent information sharing." She advised organizations to "raise the bar of expectations." She went on to explain how the communication workgroup dynamics evolved, "It changed dramatically, from the start of the committee to when we launched. Ten months later and people can't wait to be part of it. People were engaged. The more informed they were, the more we heard they wanted to be part of this initiative. That doesn't happen very often."

The Central Regional Manager echoed this theme of involvement: "I have a philosophy I try and impart. To try to have staff happy here and to be included into what affects their lives." The Central Regional Manager remarked that her staff members are comfortable with using the voice-processing unit (VPU).

In the third phase of development, the HIT's technology will allow the phone and the computers to speak to each other. This is the computer telephony integration (CTI). HIT computers and phones do not speak to each other now. Integrated voice recognition (IVR) has many aspects and various complexities. The IVR could be voice-activated or could be activated by keypunch. In reviewing the HIT operation, the Central Regional Manager stated that since launching the HIT, the most challenging aspect is the effort required for mailing the client renewal packet. It requires two full days for staff to complete this task, which could be made more efficient with the introduction of a mail inserter machine. The Central Regional Manager is pursuing the purchase of a machine with IS and county purchasing that can perform the task in 45 minutes.

The implementation in San Mateo had an important strength that became obvious in the review. The organization had people willing to work together. The Administrative Services Manager commented this was a key, or this type of project would have been difficult to accomplish. Facilities office had to look for common ground with its partners. Program, technical, and the landlord all worked well with facilities. The Administrative Services Manager also emphasized the importance of housing the HIT in 12,000 square feet of space in a 20,000 square foot building where the HSA was already leasing other suites. Additionally, the space had existing modular workstations. All of this contributed to the ability of his group to work within the short planning deadline.

Recalling the fact that the (HIT) represented a new business concept, a new way of doing business-managers remarked on the importance of recognizing the need to learn enough throughout the project to ensure the staff are not overwhelmed. This was expressed in various ways during the review of the HIT:

- The County Voice Project Manager advised organizations to provide for one (1) month of telephone hardware and software testing. Work early with the hardware and software integration. Do not attempt to install the hardware and software in-house, concentrate the in-house staff on responding and providing customer service.
- The HSA Information Technology Supervisor advised organizations considering this business model to implement a basic call center first. He advised organizations not to try to launch along with the imaging, and the integrated voice response (IVR) at once. It is important to remember that workers are learning new ways of retrieving and handling files, new way of processing work over the phone. It is a change in how the county does business. Once the workers learned the phone and the new way of doing business in a call center, it is then appropriate to bring in enhanced support of imaging and computer telephony. In this way, the employee is not overwhelmed.
- Both the HSA Project Lead and Central Regional Manager stated the importance of maintaining current reference materials. Since launching the HIT, the managers and supervisors have continuously devoted time to adjust HIT documentation so it can remain useful to the staff.
- The HSA Supervisor/Project Lead highlighted pursuing the introduction of call monitoring after launching the San Mateo HIT. Call monitoring (supervisors listening to client calls) would enhance management's ability to operate the HIT. It was being introduced after the HSA worked with the appropriate bargaining units.

The HSA agreed with labor to obtain a signature from employees to begin call monitoring.

VALUE OF MORALE BUILDING

As mentioned earlier, one of the workgroups that was formed in preparation for the HIT center was the Communications Workgroup, which was lead by the HSA Public Information Officer. She stated, "The workgroup gave me feedback into ideas of a call center". She added, "At the outset of the workgroup forming it (the workgroup) was important for buy-in because there was not a lot of information but a lot of concern". In the beginning, the workgroup focused on the internal concerns and came up with pros and cons for the call center. This helped her to better understand issues and to take steps to resolve the issues. "Our culture is to solicit feedback from staff. You have to think about your own culture and see how it can work."

The workgroup members returned to their workplaces and dispelled rumors that some folks had. The HSA Public Information Officer also sent out agency wide emails after workgroup meetings, highlighting major points and what was ahead. As of April 2003, there was always an article about the HIT in the agency wide newsletter.

As a result of the workgroup structure, there was a vehicle for making the employees better informed about the call center, to become less afraid for themselves and also their clients. "People had a certain philosophy about how to help a client", she said. "Would they get the same attention when they called a number?" She added, "It is changing a mindset by sharing information."

Originally, when the seed of the HIT was planted in the minds of line staff, there was a lot of apprehension. They anticipated that staff would have to be drafted based on low seniority. When the HIT opened, two staff actually had to have their transfers declined due to all of the positions being filled. The Central Regional Manager, the assigned HIT Project Manager, believes staff had a change of heart because many realized she was a straight shooter who believes in sharing virtually all information with her staff. She strives to provide a positive open environment where workers are happy to come to work. She also did not question the quality of the workers that were volunteering and made certain that no special work schedules would be altered due to the transition. She believes it is important to provide good training and support as well as team-building socials that include pizza and drinks. Her staff members are the ambassadors to the HIT.

IMPLICATIONS FOR OUR AGENCIES & RECOMMENDATIONS

San Mateo filled a void that had been growing in serving its continuing Medi-Cal program clients by using the various skills of staff and managers to implement a new service delivery model. Its experience offers our organizations useful strategies.

Alameda County

Alameda County has a Phone Center at the Benefit Center where 85% of our Medi-Cal and 100% of all other aids (CalWORKs, Food Stamps, General Assistance) ongoing cases are housed. While I see a tremendous benefit to replicate HIT in Alameda County, I would like to propose an adjusted version of HIT that can be implemented in Alameda County with a particular emphasis in retention strategies. We have been successful in enrolling individuals and families through the *No Wrong Door* pilot pro-

ject and would like to use some of the same techniques in the case management phase or back end. Coupled with some aspects from HIT, I strongly believe that a retention project can be implemented in order to strengthen our efforts to ensure that individuals and families keep their health coverage.

As mentioned earlier, Alameda County Social Services Agency has been implementing the *No Wrong Door* pilot project (NWD) since July, 2002. NWD is an innovative and effective intake enrollment process staffed by Application Assistors (AA)[4] and Eligibility Technicians (ETIII). Application Assistors provide direct application assistance for clients that apply for Medi-Cal. They are screened not only for Medi-Cal, but also for Healthy Families, our local plan Family Care, and our County Medically-Indigent Services Program (CSMP). Clients are then connected with an ETIII for determination if they are eligible for Medi-Cal.

We have demonstrated that this model has been successful mostly because clients are walked through the process. The use of AAs validates this approach because clients have a better understanding of the enrollment process; which in turn leads to more positive outcomes including higher approval rates, faster processing time, and increased collaboration from our clients. Approval rates have increased significantly from the traditional average of 59% to 84% using the NWD model. Processing time has decreased from the 45 days mandated time period to an average of 7-15 days. In many cases, applications are processed in less than five days.

We believe that this technique can be replicated for our ongoing Medi-Cal cases. Instead of using a Phone BA as in San Mateo, a Case Management Assistor (CMA)[5] can be used to function as our *No Wrong Door* Application Assistors. Case Management Assistors (CMA) would take a proactive role to ensure that our Medi-Cal recipients understand the re-determination process in order for them to be able to continue to receive health coverage. CMAs will call ongoing Medi-Cal clients on a proactive basis to offer personalized assistance for maintenance needs such as change of addresses or replacement cards, and when clients need to complete any required paperwork during re-determination and mid-year status reports.

If the CMA is faced with complicated cases, the CMA will have an internal discussion with the assigned ETIII. If necessary, the client can be called to resolve any pending issues.

The San Mateo HIT model provided insightful ideas for Alameda to begin building an infrastructure that could be used to launch strategies that fit our department's priorities. Retention is a strategy that our agency is committed to implement and goes hand-in-hand with our countywide efforts to not only increase enrollment but also keep families and individuals insured in spite of requirements including the mid-year status reports and the regular yearly re-determinations.

This retention pilot along with the existing Benefit Center Phone Center will continue to provide good customer services to our ongoing Medi-Cal clients. It is also important to note that as our retention rate increases, it also creates savings as many families and individuals who get discontinued do not need to re-apply. This process of re-applying because

[4] Application Assistor's county classification is Eligibility Support Clerk or ESC.
[5] Case Management Assistors can be our county Eligibility Support Clerks or ESC.

clients do not understand the case maintenance processes is costly for our agency.

In addition, there are several aspects that may be replicated from the HIT model to help us with the implementation of this retention project. They include the following:

- A cost-avoidance analysis should be conducted in order to measure effectiveness both programmatically and financially.
- A similar communication workgroup should be established as the project is implemented. We have seen that the work of the communication workgroup in San Mateo was excellent in ensuring the key stakeholders understand and become involved in this process. In turn, the institutional change that occurs as a result of this new project is better understood and accepted. After all, both of these agencies are trying to find a different way of doing business in order to provide the best service possible to our clients.
- A similar equipment infrastructure can be replicated both with the retention project and at the existing Phone Center. The hardware and software used in the San Mateo HIT would be of great benefit for us here in Alameda County.

Action Steps—Implementing the Retention Project:

- A small task force should be formed by July 2004 with a lead person already working with ongoing Medi-Cal cases. A Program Manager at the Benefit Center would be a good recommendation. Tasks for this group would include the following:
- Develop a detailed implementation plan by the end of August 2004 with specific action steps to launch this project.
- Select volunteers who would like to function as Case Management Assistors
- Make any necessary negotiations with labor and get them involved in the planning process.
- Form a communications workgroup to ensure the pilot is known both internally and externally. This workgroup would address questions and ensure constant and precise information is disseminated to the appropriate parties.
- Work in collaboration with the Board of Supervisors and the Alameda County Children and Family Task Force members for support and resources.
- Develop a cost-avoidance analysis.
- Develop a fundraising plan to explore obtaining seed funds from private and government funders to implement this project. Private grants may be useful to fund one-time expenses such as hardware and software. This would allow us to upgrade our equipment and systems at the Benefit Center.
- Pilot this project with one unit of workers first for six months. This would allow us to evaluate and make any adjustments as needed before it is expanded to all ongoing Medi-Cal units. Launch of the pilot can be as early as January 2005.
- Collect quantitative and qualitative outcomes after six months of piloting this project. Results, both quantitative and qualitative, will facilitate a smoother expansion to other units.
- Evaluate pilot and launch expansion with adjustments as needed after the first six months. Expansion can be launch by mid-2005.

As we launch this retention project, the following are the outcomes we can expect:

- Better clients' understanding of the requirements in order to avoid discontinuances.
- Increased in retention rates; thus, creating a significant decrease in discontinuances.

- Better customer service for clients who do not understand the processes involved.
- Improved staff satisfaction as they feel they are helping clients who are lost in the system.
- Decreased re-enrollment rates.

Overall, I feel confident that this retention project will yield positive results for our staff and our clients. Ultimately, we are seeking what San Mateo was looking for when they launched the HIT:

- Excellent services to Medi-Cal clients
- Decrease in the number of uninsured families and individuals in our county
- Organizational change that is positive, effective, and beneficial for all

Santa Clara County

An abundance of detailed information in the San Mateo Health Insurance TeleCenter experience was of particular interest to the County of Santa Clara Social Services Agency. This is because Santa Clara is implementing a Medi-Cal Service Center in many ways similar to San Mateo's model. This is due to a critical need to reorganize case processing to provide enhanced service to clients and to support compliance with state performance standards. As in other counties, Santa Clara is impacted through financial sanctions if it fails to meet the new state standards.

The SSA expects the following outcomes as a result of implementation:

- Improved quality of services through a quicker response time;
- Consistency of information given to clients through a centralized staff;
- Immediate ongoing identification of staff training needs;
- Consistency of processes and procedures in a centralized location; and
- Reduced amount of uniqueness and training required.

In the last six months, planning has been aggressive. It began with a October 2003 concept paper from the Agency Director. This was followed by the presentation of a recommended salary ordinance amendment to the Board of Supervisors at the end of October 2003 adding 64 additional staff. Santa Clara has continued to move forward with its timeline of opening a Medi-Cal Service Center in June 2004. Key has been the discussions with labor regarding the re-engineering of its Medi-Cal continuing caseload service delivery. Santa Clara expects there will be approximately 58,000 cases at the Medi-Cal Service Center. It is estimated that 4,000 to 6,000 re-determination packets will be mailed monthly. As in San Mateo the client contact will be based on the telephone transaction.

Based on the January 2004 authority granted by the Board of Supervisors, Santa Clara's Medi-Cal Service Center will be housed in a leased site in the eastern portion of San Jose. Planning with stakeholders continues as the building tenant improvements, and equipment purchases are pursued to ensure May and June completion dates. Additionally the electronic workflow logging system, outgoing phones, staff, case files and call center voice communication needs demand the coordination of a myriad of county and contract staff inside and outside the Social Services Agency. For example the call center voice communications will be provided through the Santa Clara Valley Health and Hospital System's (SCVHHS) Aspect call system. Santa Clara is scaling its Service Center to accommodate 50 phone agents. A total of 250 staff will be located at the Service Center per-

forming a variety of continuing case processing functions in addition to phone agent responsibilities.

It is recommended that Santa Clara use the insights offered by San Mateo in the areas of planning, program and infrastructure in the following ways:

• Overall Planning—It is recommended that the Social Services Agency executive team continue to support the implementation of the Medi-Cal Service Center by making the Center's progress a part of its weekly executive team meeting discussions. In Santa Clara the efforts of the specialized planning implementation team should continue because it acknowledges the vital role of all stakeholders, and provides a stable forum for exchanging information and building acceptance of the new business service delivery model internally and externally. This planning implementation team in Santa Clara is comprised of representatives in programs, information systems, fiscal operations, and administrative central services. At the executive team's weekly meeting the SSA executive managers can briefly hear of the progress of the planning implementation team's work. As a result of the hearing the summary report, any "championing", i.e. removal of obstacles can take place through the guidance and influence of the executive team.

• Program Needs—It is recommended that the SSA continue to strive to understand the opportunities for program service delivery restructuring presented by the implementation of the Medi-Cal Service Center business concept. This focus on understanding program needs is to acknowledge the valuable components of the current service delivery model and assist the program side of the organization navigate with labor toward a new way of doing business.

• Infrastructure Considerations—It is recommended Santa Clara continue to make every effort to ensure technical and facility related stakeholders work on a regular basis in specialized subgroups with program stakeholders. This is important from the onset of the strategy and design phase through implementation and post go-live because it strengthens professional networks through successful partnerships. The interdependent but very different stakeholders, must exchange critical information and clarify their understanding, or their ability to respond to program needs is compromised.

In Santa Clara funding for the Medi-Cal Service Center lease was obtained by the closure of another Social Services Agency leased facility in the northern part of the county. This made it possible for the Agency to absorb the rent cost and the amortized tenant improvements within its existing approved budget. Funding for the additional Medi-Cal Service Center staff was secured through the recognition of additional federal and state revenue.

In the long-term, support from the County of Santa Clara Board of Supervisors will be required to address the case load standards agreements currently in place with labor. This is because of the very different way of doing business represented by the call center environment.

SONOMA COUNTY

Call centers are not new. Frequently every one of us calls some form of a call center to inquire about our investments or even our own health insurance. As an organization, we need to work smarter and not harder by adapting a call center.

We must be mindful of the implications that Medi-Cal Redesign may bring. However, as we continue to prepare for the conversion to CalWIN in September 2005, we find ourselves in a unique situation in that we already have a banked Medi-Cal caseload that could be converted to a call center in its existing location. I recommend the following actions based on what I have learned in San Mateo.

By the end of July 2004 a Steering Committee should be formed of Medi-Cal Managers to closely review the information that was learned in San Mateo County. The Steering Committee would establish subcommittees similar to San Mateo County. These subcommittees would be chaired by supervisors and/or managers and would include line staff if appropriate.

Tasks for the Steering Committee and/or subcommittees would include the evaluation of the following:

- Development of a detailed implementation plan by the end of September 2004 with specific action steps and timelines to launch the project.
- Development of a fundraising plan to explore possible one time grant monies for fixed start-up costs.
- If and when we are able to hire more Medi-Cal staff, they should be clerical positions rather than Eligibility Workers.
- Conversion of the function of the EWIII to an intake worker. All current EWIIs in intake units would become part of the Call center.
- Continue to get information from San Mateo as they begin to include continuing Food Stamp cases into their Call center.
- Without the SMART system, we are unable to document actions on a case without writing it in the case file. We would need to explore what other databases could be developed to document actions in case files, or do we wait until CalWIN. If CalWIN is delayed, our IS department does have the ability to develop a case documentation database.
- Conduction of our own cost-benefit analysis, which would include start-up expenses for software, hardware and fixtures.
- Identify what telephone enhancements would need to be made to establish a call center.
- Contract with the InTelegy Corporation to do training on the functionality of a call center.
- Development of strategies on how best to implement.

I was very fortunate to be allowed to participate on this project. The knowledge that I gained by visiting San Mateo County along with the great networking relationships that were established will stay with me for a long time.

ACKNOWLEDGEMENTS

We would like to sincerely thank the following individuals in San Mateo County for their generosity and gracious hospitality while we completed our research:

Madelyn Martin, Assistant Director, for the full-day orientation that was extended to all BASSC interns and for her support and encouragement of the BASSC program.

Barbara Joos, Supervisor/Project Lead and Mary Ann Tse, Central Regional Manager, for facilitating our internship, for providing us with a very comfortable work environment during our stay and endless information on the policies and procedures of the HIT Center.

Harold Hernandez, Senior InTelegy Consultant for sharing his expertise of how any Call center functions, private or public.

Penny Pavis, Voice Project Manager and John Jones, Information Technology Supervisor, for sharing their bounty of information on technology.

Jennie Loft, Public Information Officer/Legislation Analyst, for sharing her hands on experience in the communications arena.

John Joy, Director of Financial Services, and Sofia Gomez, Financial Management Analyst, for closely reviewing their Cost Analysis of the HIT Center.

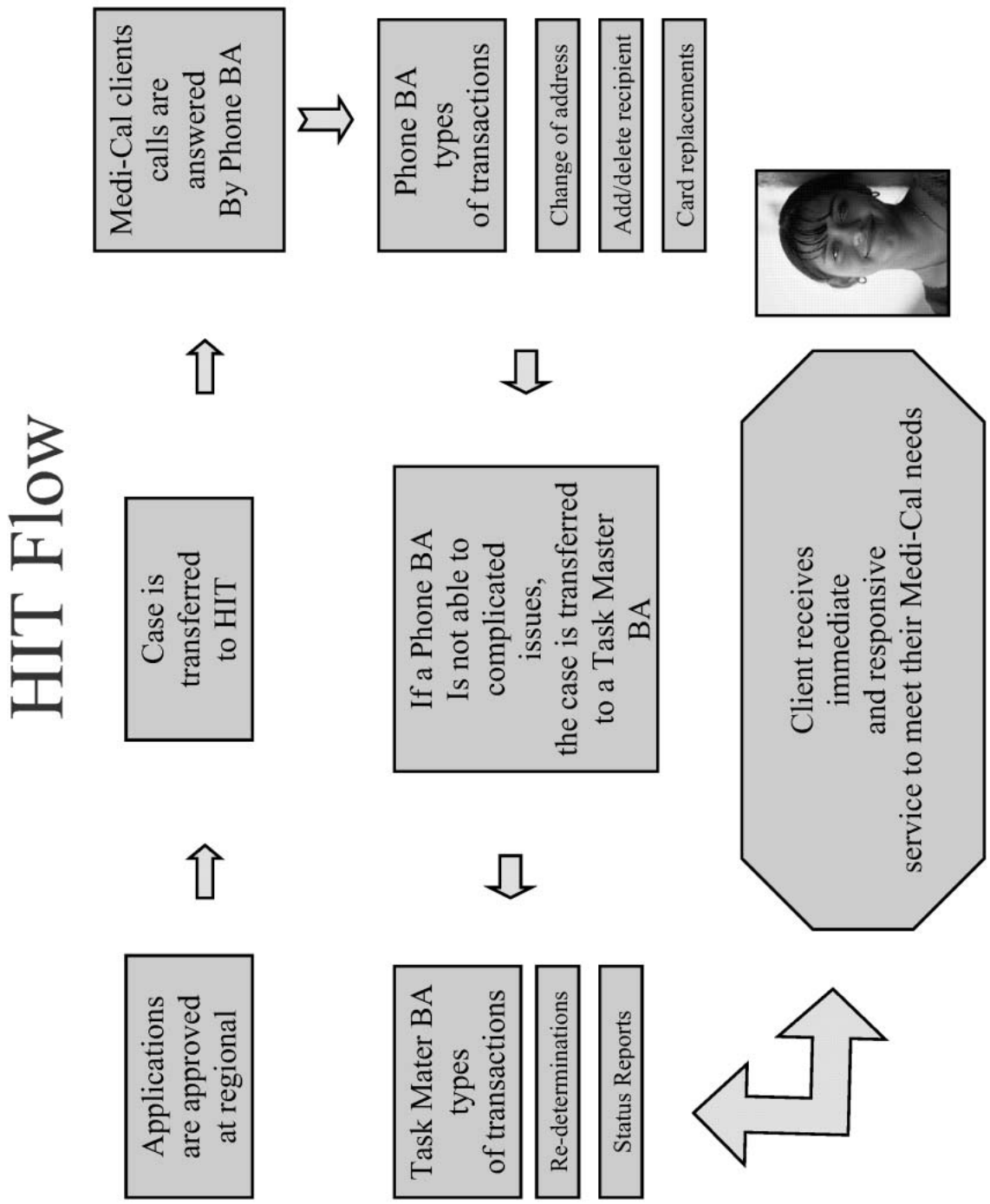
Phillip Naylor, Administrative Service Manager and Alicia Cummins, Facilities Project Supervisor, for the time they spent explaining how the physical move and set up of the HIT Center was accomplished.

We would also like to thank the eligibility staff at the HIT Center for allowing us to "job shadow". They were all friendly and inviting.

Cynthia Burcher from Sonoma County Human Services Agency deserves special thanks for the invaluable help she provided in word processing support during the production period of the case study.

Last, but not least, we would like to thank our respective counties for your interest in our career development and for allowing us to participate in the 2003-2004 BASSC Executive Development Training program.

APPENDIX


HIT Flow
Applications are approved at regional
Case is transferred to HIT
Medi-Cal clients calls are answered By Phone BA
Task Mater BA types of transactions
Re-determinations
Status Reports
If a Phone BA Is not able to complicated issues, the case is transferred to a Task Master BA
Phone BA types of transactions
Change of address
Add/delete recipient
Card replacements
Client receives immediate and responsive service to meet their Medi-Cal needs