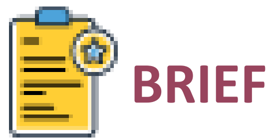

BRIEF

Key Considerations in Engaging Hard-to-Reach Members

Engaging hard-to-reach members is a primary focus of many health plans, including the 20 health plans and provider organizations that joined the 2021 Integrated Care Community of Practice (ICCoP).[1] The COVID-19 pandemic made in-person engagement much more difficult and exacerbated member health and social needs. It also made reaching members both more pressing and more challenging. This issue brief summarizes promising and innovative practices in engaging hard-to-reach members that emerged from this learning community.

Health Plans and COVID-19 Vaccinations

Health plans and provider organizations can use strategies in this brief to engage members in discussions about COVID-19 vaccinations and barriers to vaccination. Outreach strategies specific to COVID-19 vaccination can be found here.

Why are Dually Eligible Individuals Often "Hard-to-Reach"?

"Hard-to-reach members" are those whom health plans have difficulty locating, and those who are not consistently engaged in their health care and care management. Health plans may face challenges engaging members for many reasons. For instance:

- A member may be experiencing homelessness, have a serious mental illness (SMI) diagnosis, face food insecurity, or have a complex combination of physical and behavioral health needs.
- The member may speak a language other than English as their primary or only language, have low health literacy, or have mistrust in the health care system for personal or cultural reasons.
- Lack of access to technology, including cell phones with sufficient minutes, may also contribute to engagement barriers since technology can facilitate connections to the health care system.
- Unstable housing, resulting in frequent changes of address, may make consistent communication a challenge.

Most of these factors overlap with characteristics common among individuals dually eligible for Medicare and Medicaid. As a population, dually eligible individuals have a higher prevalence of chronic medical conditions and are almost three times more likely to be diagnosed with SMI than those who are eligible for Medicare only.[2] The dually eligible population also has a larger number of co-morbid

conditions.[3] Dually eligible individuals experience a disproportionately large number of negative social drivers of health, including living in poverty, being food insecure, and having lower levels of education.[4] Additionally, the dually eligible population overall is far more racially, ethnically, and linguistically diverse than the Medicare-only population,[5] and as such, may experience discrimination or exclusion, which impact access to services and experiences with the healthcare system.

The challenge of engaging hard-to-reach members may also be attributable to factors on the health plan side. For example, health plans may need to improve their outreach strategies, boost cultural competence, develop meaningful partnerships with community organizations, and address high staff turnover.

Given the complex health and social needs of the dually eligible population, health plans can improve outcomes by engaging members in care coordination/care management.[a] Care coordinators connect members to plan benefits and services and work with the member to develop care plans and work towards goals.

Successfully Contacting Members

Health plans report challenges both in obtaining accurate member contact information upon enrollment,[b] and with losing contact with members over time, as members may not always keep their contact information up to date with the plan. Health plans must proactively seek out their members or alternate sources of member contact information in order to engage them in care coordination. After locating members, health plans report challenges keeping members engaged in care. Members may decline care coordination or may later refuse or ignore plan attempts to reach them through calls or letters.

Some of the same characteristics noted previously (e.g., frequent changes of address, lack of a reliable phone) contribute the problem, but health plans also cite the "member abrasion" associated with multiple health plan staff interactions, including perceived repetitive health assessments. ICCoP participants provided the following strategies they had employed to locate hard-to-reach members and re-establish contact with members, including:

---

[a] For example, an evaluation of the Minnesota Senior Health Options (MSHO) program found that care coordination improves outcomes for dually eligible beneficiaries, by reducing the prevalence of inpatient and ED use and improving access to outpatient primary care. More information can be found here.

[b] Plans have noted that contact information is more likely to be accurate when received directly from members who enroll themselves (opt in), versus passively enrolled members, for whom plans receive data from the state, which may be outdated or inaccurate.

- **Partnering with trusted community-based organizations (CBOs):** Several plans established partnerships with CBOs located in neighborhoods with lower levels of plan engagement or that specialize in a specific member sub-population. For example, one plan contracts with the AIDS Foundation of Chicago, a CBO that serves people living with and vulnerable to HIV and other chronic conditions. As a trusted community organization, the AIDS Foundation may have more success building trust with members and making initial contact. The AIDS Foundation conducts outreach, via telephone and face-to-face, to high-risk members whom the plan has not been able to reach and educates members on the plan's benefits. The CBO shares all updated demographic and contact information as well as identified member needs with the plan, so the assigned care manager can then address these issues.
- **Meeting members in emergency departments (EDs):** Several plans have made efforts to locate members in the ED and engage with them while they are still there. Plans use multiple strategies to identify when members are in the ED including monitoring admission-discharge-transfer (ADT) feeds, leveraging software (e.g., "PatientPing") that provides a notification of an ED visit or hospital admission, and establishing formal partnerships with hospitals to embed plan staff in the ED who can directly engage members while they are there
- **Adding a hard-to-reach "pop-up" message:** One health plan created a "hard-to-reach" pop-up message in their system that is visible to all health plan staff interacting with members. This pop-up indicates why the plan has been trying to reach that member (e.g., to complete an HRA, to update demographic information, to discuss medication adherence, to confirm eligibility). While the customer service department most often triages these members to the staff/department who activated the pop-up button, all staff members are trained to be aware of the pop-up and, with member permission, can transfer to the requesting person/department. In the event that a member has been unable-to-reach (UTR) for multiple departments, the first staff person to connect with the member will clear the associated note on the pop-up button and leave any remaining notes active. Then, this staff member will either transfer the member (with permission), or if preferred, contact the remaining departments with the member's preferred contact method. This allows the plan to leverage every contact with staff and helps consolidate the number of outgoing calls members receive from different health plan staff, thereby helping to reduce "phone fatigue" or "member abrasion."
- **Providing easily accessible care coordinator information to members:** One plan, at the suggestion of their member advisory committee, created a "Welcome Card" with a personalized message from

Leveraging Member Advisory Committees

Member advisory committees can be a useful resource in understanding member perspectives and gathering feedback on current health plan strategies, as well as future member engagement approaches. One health plan gathered feedback from their member advisory committees around health risk assessment (HRA) completion. The member advisory committee's suggestions included emphasizing the importance of HRA completion within unable-to-reach letters, mailing a hard copy of the HRA, and providing a financial incentive for members that call the plan to complete the HRA. More information on how to develop a successful member advisory council can be found here. Additionally, information on how engage members in plan governance during the COVID-19 pandemic can be found here.

their care manager to send to new plan members. The card includes a magnet that can be placed in an easy-to-see location and includes information about "Who We Are," "What We Do," and "Program Benefits" along with the care manager's business card. The "Welcome Card" is in its trial phases but feedback from new members has been positive. Care managers report members have mentioned receiving the card and they were expecting a call from their care managers because they received the card first.

- **Establishing partnerships with external vendors:** One plan uses a specialized external vendor that employs multi-layered phone campaigns to reach members who are difficult to locate. This includes a "contact tracing" style of phone outreach; the vendor contacts other individuals who may be associated with the member, including providers and pharmacists, to get updated contact information for the member until they are able to reach the member. The vendor also conducts outreach during weekend and appropriate after-hours times to increase the chances of reaching the member at a convenient, available time.

Delivering Tangible Supports

A lack of member familiarity and trust with the health plan can further exacerbate challenges engaging hard-to-reach members. Effectively communicating the value of health plan benefits and services, including care coordination, can assist members in gaining trust in the health plan, and result in them further engaging with the plan over time. ICCoP participants named several approaches for delivering tangible supports to build relationships and trust:

- **Demonstrating the benefits of engagement:** Clearly demonstrating the tangible value of care coordination to members and effectively messaging this value can improve engagement of hard-to-reach members. To support this messaging, one plan delivers annual workshops and quarterly newsletters to educate primary care providers on communicating the value of care coordination, as members often trust their providers' input more than the plan's. Other plans have collaborated with their member advisory committees to develop messaging, leveraging the unique insight that committee members have into the most effective messaging and outreach strategies about the value of care coordination.
- **Providing members with technology and support:** Several plans work to overcome technology barriers to engagement by providing members with phones or tablets. As the COVID-19 pandemic made technology more central to member engagement, some plans also reached out to members to provide detailed guides or one-on-one support in using technology.

Technology Assistance

CareOregon, a Dual Eligible Special Needs Plan (D-SNP) in Oregon, realized that members became harder to reach during the COVID-19 pandemic in part, because so many lacked knowledge and experience with technology. To address this issue, the plan worked with its member advisory committee to create a basic guide to using technology. The guide provides information on common icons and symbols across a variety of technology platforms as well as advice for video and phone appointments. CareOregon distributed the guide at resource and health fairs and shared hard copies with community partners, such as food pantries and clinics.

- **Addressing members' most pressing social needs first:** Many health plans noted improvements in establishing relationships with members after first identifying and meeting members' social needs, rather than beginning with care coordination activities or other plan priorities. Once demonstrating the value of the health plan to meeting their needs, members were more open to engaging in care coordination. For example, some health plans distribute food in their member communities, which helps to establish initial relationships with members. Some health plans collocated food distribution and COVID-19 vaccinations. Other plans have worked to connect members experiencing homelessness to housing resources (see Engaging Members Experiencing Homelessness section for more detail) as a foundational step to building a trusting relationship.
- **Building a physical presence in the community for walk-in services.** Two plans created multiple "community resource centers" or "connection centers" within the communities they serve. These centers offer free fitness and wellness classes, member service support, and care coordination services. They also served as food and supply distribution centers during the beginning of the COVID-19 pandemic and some hosted vaccine clinics. In addition to promoting visibility in the community, these walk-in centers provide additional opportunities for members to interact positively with the plan.

Engaging Members Experiencing Homelessness

Members experiencing homelessness, and the plans serving them, face unique challenges related to engagement, which may include lack of permanent mailing addresses, mistrust in the healthcare system, and limited access to traditional healthcare delivery settings. Health plans seeking to successfully engage members without access to stable housing need unique engagement strategies to meet members where they are. Examples from ICCoP plans included:

Partnerships with Homeless Shelters

Upper Peninsula Health Plan (UPHP) developed partnerships with two homeless shelters in their service area to support members who frequently stay at the shelter. UPHP began by approaching shelter house managers with the idea of conducting social determinants of health (SDOH) screenings to better support members, which included assisting members in acquiring safe housing and applying for additional benefits. With support from one shelter, UPHP was able to secure a room for Community Health Worker (CHW) office hours three days a week, two hours a day to meet with members. In another shelter, UPHP CHWs assisted with a Feeding America truck that was scheduled at the shelter twice a month and conducted SDOH screenings with visitors of the food truck. UPHP was then able to establish regular office hours at this shelter, and also partnered with the shelter and the local pharmacy to support a pop-up COVID-19 vaccination clinic in the area.

- **Partnering with homeless shelters:** One plan provided grants to community partners operating homeless shelters to purchase laptops for the shelters. Setting up the laptops at the shelters allows members visiting the shelter to connect with health plan navigators during weekly evening "virtual office hours" for assistance with navigation, and education, as well as for telehealth appointments.
- **Hiring staff to specialize in housing:** One plan has begun hiring housing coordinators to serve as liaisons between the housing authorities in each county they serve and their members. These relationships have yielded greater contacts with members who are at risk of homelessness. Another plan reported hiring CHWs who have background experience in housing to support members experiencing homelessness.

Engaging Members with SMI

Housing Supports

In July 2019, SCAN Health Plan launched the Housing and Homelessness Care Management Initiative to serve older adult members at risk of or experiencing homelessness. The health plan uses several approaches to identify and target members experiencing or at risk of homelessness: analyses of health risk assessment and SDOH data (e.g., Z codes[c]), as well as assessments of information collected by member-facing teams and providers and CBOs with whom they partner. Following initial outreach for scheduling, members meet with a CHW or social worker at a location convenient to the member (e.g., community organization, park) to complete an initial assessment and prioritize the member's needs. The plan's homelessness care coordination team then partners with trusted CBOs to connect the member to housing, social, and health care services. To date, the initiative has placed nearly 40 members in permanent housing and has been successful in establishing care with the members' care teams.

SMI impacts members' lives in substantial ways and health plans seeking to better engage and serve members with SMI can tailor their approaches to meet members' needs and circumstances. Over forty percent of dually eligible individuals have a SMI diagnosis, such as bipolar disorder, schizophrenia, or major depressive disorder—almost three times the rate of SMI compared to individuals eligible for Medicare only.[6] Many ICCoP plans have specific strategies to engage members with SMI, and promising examples of tailored engagement strategies include:

- **Following up with members during or after an inpatient admission:** Almost all plans reported efforts to engage members with SMI at the time of discharge from an inpatient admission. Inpatient admissions represent a time of higher need for many members and an opportunity for health plans to support members through additional resources and engagement. One health plan worked to obtain discharge dates from behavioral health facilities to in order to initiate follow-ups with the members at the time of discharge, ideally connecting with members while they are still in the facility.

---

[c] SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.). For more information on using Z codes, refer to this CMS guide.

- **Forming partnerships with behavioral health organizations:** Many plans have contracted with behavioral health organizations to better engage members with SMI, which have facilitated improved coordination and communication between the health plans and behavioral health organizations. Through this arrangement, plans have implemented joint case conferences with staff from both organizations to discuss a member's needs.
- **Developing community-based alternatives to hospitalization:** One plan developed two Crisis Stabilization Units (CSU) in partnership with a CBO that provides services for people with developmental disabilities, SMI, homelessness, aging-related needs, and substance-use disorders. Members that were unengaged with the plan prior to arriving at the crisis center may become more engaged after accessing services and learning more about the plans' services, including referrals to primary care, behavioral health, or substance use services in the community.

Providing Community-Based Support

Commonwealth Care Alliance's (CCA) CSUs are an alternative care setting that provide support to members going through acute psychiatric crises. CSUs are less restrictive than traditional inpatient psychiatric settings and reduce the need for inpatient admissions. CCA provides oversight of the CSUs and partners with human service providers to hire nurse managers and mental health workers. More information on the CSUs can be found here.

COVID-19 Vaccine Outreach

Health plans serving dually eligible individuals are uniquely positioned to facilitate access to COVID-19 vaccines for members. Many plans participating in the ICCoP have had previous success engaging hard-to-reach members through in-person strategies, such as visiting a member's last known address or having care coordinators meet members in familiar community locations. However, due to the ongoing COVID-19 pandemic, plans have had to rely on virtual and telephonic strategies to reach and engage members. Health plans that successfully build trust with members may also have more success in engaging members around COVID-19 vaccines, and in connecting members to vaccination resources and/or appointments to get vaccinated. Over the course of the ICCoP many health plans enlisted care management staff and CHWs to conduct member outreach and assist with COVID-19 vaccine education, as well as to schedule transportation and vaccine appointments. Many ICCoP participants also trained staff on COVID-19 vaccines so that staff may help members overcome vaccine anxiety or fear.

Additional strategies ICCoP participants used to support engagement related to the COVID-19 vaccine include:

- **Designating vaccination as a care goal:** Many plans' care management teams discussed the COVID-19 vaccine with members and, if the member agreed, added it as a goal within the member's care plans. By doing so, the vaccine became a priority and any staff in contact with the member would be reminded to discuss vaccination during member interactions.
- **Partnering with CBOs:** Nearly all plans have partnered with CBOs, including faith-based groups, on outreach and delivery of the vaccine. These partnerships have been particularly critical in reaching members from Black and brown communities, who have reason to mistrust the health care system and are more likely to engage with trusted community organizations than with health care organizations.
- **Conducting outreach to local providers:** One plan developed information packets for providers who could assist with making calls to health plan members about COVID-19 vaccinations. These packets included scripts, lists of high-risk members, and educational information.
- **Providing incentives for vaccination.** One health plan provided $100 incentive gift cards to increase vaccination rates among the plan's Medicaid population. The health plan partnered with CBOs and a local pharmacy to offer vaccinations at community health fairs, churches, and at pop-up events outside of Dollar General stores. The plan provided the gift card to any member who received a vaccination and found that members responded positively to the offer.
- **Supporting community education and engagement regarding COVID-19 vaccines:** In partnership with local CBOs, one plan offered Question & Answer sessions with a local pharmacist to answer members' questions about the COVID-19 vaccine. Another plan holds frequent town hall meetings with members to answer member questions and understand the barriers members face to getting vaccinated. Other plans focused education efforts in Black and brown communities, which have been disproportionately impacted by the COVID-19 pandemic.[7] For example, one plan sponsored a Spanish-language talk on the vaccine by a well-known and trusted physician serving the Latinx community.

Home-Based COVID-19 Vaccinations

Health plan staff, including CHWs and care coordinators, from the CCA conducted proactive COVID-19 vaccine outreach to all members having difficulty leaving their homes to educate them about the vaccine and schedule vaccination appointments. Nurses, nurse practitioners, and paramedics with existing contact with these members then administered the vaccines in members' homes. CCA's success in administering vaccines led to an arrangement with the state of Massachusetts to administer COVID-19 vaccines to non-CCA members across the state who were also unable to leave their homes. By the end of July 2021, the plan had vaccinated over 4,300 people across every county in the state. More information on CCA's home-based COVID-19 vaccination program can be found in this Resources for Integrated Care COVID-19 Vaccination blog post.

Looking Forward

Identifying effective and member-centered engagement practices remains paramount for health plans, particularly in light of the ongoing COVID-19 pandemic. Successfully locating and engaging hard-to-reach members requires an ongoing commitment from plans to meet members where they are in terms of physical location, resources, and experiences. Foundational to this success is seeking to understand members' goals, needs, and preferences rather than making assumptions.

Future Vaccine Efforts

Strategies summarized in this brief could also help health plans and provider organizations working to engage beneficiaries for COVID-19 boosters and annual influenza vaccinations.

By late summer 2021, some of the ICCoP plans had begun reinitiating in-person engagement and other plans noted that resuming in-person engagement would be critical to reducing the numbers of members they are unable to reach. In addition to in-person outreach activities, many plans are focused on building strong and successful relationships with their member communities by taking the time to listen to member feedback—in the form of one-on-one outreach from care coordinators, robust discussions with member advisory councils, and partnering with trusted local community organizations. Engagement strategies informed by member feedback are much more likely to be successful, as demonstrated by the ICCoP participants' experiences.

Additional Resources

Locating Members

Locating And Engaging Hard-To-Reach Members During COVID-19: A Panel Discussion

This Resources for Integrated Care webinar features speakers from health plans, serving individuals dually eligible for Medicare and Medicaid, who shared strategies related to engaging hard-to-reach members during the COVID-19 pandemic.

Locating and Engaging Members: Key Considerations for Medicare-Medicaid Plans

This Resources for Integrated Care brief describes strategies for locating and engaging dually eligible members from seven health plans across the country

Organizational-Level Consumer Engagement: What It Takes

This set of case studies from Community Catalyst highlights three health care organizations that have undertaken concerted efforts to meaningfully engage consumers at the system level.

Person-Centered Engagement at the Organizational Level: Change Package

This change package from Community Catalyst is a guide for leaders and staff at organizations across the health care spectrum – hospitals, large medical practices, health clinics, health plans, accountable care organizations, and more – to aid in developing meaningful person-centered engagement structures at the organizational level.

Engaging Members Experiencing Homelessness

Hard-To-Reach Populations: Innovative Strategies to Engage Homeless Members

This Resources for Integrated Care webinar focuses on strategies for health plans to locate members who may be experiencing homelessness and connect them to the primary and behavioral health care, social services, and long-term services and supports they may need.

COVID-19 Vaccination Outreach

COVID-19 Vaccination Blog

This Resources for Integrated Care blog highlights promising practices shared by health plans and other experts related to COVID-19 vaccinations for dually eligible individuals.

Partnering for Vaccine Equity

This CDC page provides various technical assistance resources focused on supporting equitable COVID-19 vaccination uptake, and other COVID-19 health equity resources.

Overview of Barriers and Facilitators in COVID-19 Vaccine Outreach

This ASPE research report describes lessons learned from vaccine programs, presents evidence on COVID-19 vaccine outreach, and shares examples of programs that could serve as potential models for designing new vaccine outreach strategies.

COVID-19 Vaccination Clinical & Professional Resources

This CDC page compiles a variety of resources for providers and other professionals who are supporting the administration of COVID-19 vaccinations. Resources include vaccination clinic guidance, vaccination considerations for specific populations, and provider requirements and support.

Special thanks for contributions to this brief:

This brief was developed in partnership with Community Catalyst and was made possible through the contributions of the following organizations participating in the 2021 ICCoP: Aetna, Amerigroup, Banner, Blue Cross Blue Shield - New Mexico, CareOregon, Centene (including Buckeye and Meridian), Cigna, Community Health Plan of Washington, Commonwealth Care Alliance, Gateway, Health Alliance Plan, Health Plan of San Mateo, Humana, Inland Empire Health Plan, Neighborhood Health Plan of Rhode Island, Providence Health Plan, SCAN Health Plan, Sentara, South Country Health Alliance, Tufts, UCare, United Healthcare Massachusetts, Upper Peninsula Health Plan, and Viva Health.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to www.resourcesforintegratedcare.com. Please submit feedback to RIC@lewin.com.

---

[1] In March 2021, Resources for Integrated Care launched the 2021 Integrated Care Community of Practice. The learning community focused on strategies that outreach and care coordination staff may use to connect with hard-to-reach members and engage them in primary and specialist care, social services, and long-term services and supports. The additional complexity of engaging members during the COVID-19 pandemic, the new availability of COVID-19 vaccines, and challenges in reaching high-risk members informed ICCoP discussions. Participants in the ICCoP included leaders from 20 health plans and provider organizations serving individuals dually eligible members in 19 states. Participants met six times from March to October 2021. Experts from four leading health plans serving dually eligible beneficiaries also served as faculty, highlighting innovative practices at their own health plans.

[2] Center for Health Care Strategies. (2020). COVID-19's Effect on Dually Eligible Populations. Retrieved from https://www.chcs.org/covid-19s-effect-on-dually-eligible-populations/.

[3] Kaiser Family Foundation. (2010). Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Sending. Retrieved from https://www.kff.org/health-reform/report/chronic-disease-and-co-morbidity-among-dual/#:~:text=The%20health%20reform%20law%20contains,most%20severely%20disabling%20chronic%20conditions.

[4] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2016). Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Retrieved from https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf.

[5] Centers for Medicare and Medicaid Services (CMS), Medicare-Medicaid Coordination Office (MMCO). (2020). Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019. Retrieved from https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.

[6] CMS. (2021). MMCO FY 2020 Report to Congress. Retrieved from https://www.cms.gov/files/document/reporttocongressmmco.pdf.

[7] Centers for Disease Control and Prevention (CDC). (2021). Health Equity Considerations and Racial and Ethnic Minority Groups. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#fn2.