Question & Answer (Q&A): Locating and Engaging Hard-to-Reach Members During COVID-19

Webinar participants asked these questions during the December 2021 "Locating and Engaging Hard-to-Reach Members During COVID-19" panel discussion. We have edited speakers' responses for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website: **https://www.resourcesforintegratedcare.com/2021_Webinar/Locating_Engaging_Hard-to-Reach_Members_During_COVID-19_Panel_Discussion**

Featured Speakers:

- Lauren Easton, VP–Integrative Program Development and Clinical Innovation; Commonwealth Care Alliance (CCA)
- Tashau Asefaw, Manager, Community Programs; Community Health Plan of Washington
- Jen Klopstein, SNP Administrator, Health Services; Viva Health

Best Practices for Locating and Engaging Hard-To-Reach Members

Q1: Do you have any recommendations for reaching rural hard-to-reach members during the COVID-19 public health emergency (PHE)?

Jen Klopstein: Some rural members may experience resource limitations (e.g., landline telephone access, limited cell service or internet coverage, or constraints due to limited cell phone minutes), so Viva will send a staff person if the member requested a face-to-face interaction. This interaction could focus on an assessment or respond to concerns about COVID-19 infection. We also have staff – called Connect for Quality nurses – at the primary care offices, depending on that office's particular PHE protocols. These nurses can gather information and make sure that the primary care provider (PCP), the member, and our organization are on the same page.

Q2: Do you have any best practices or strategies that have been beneficial in reaching out to caregivers to engage hard-to-reach populations?

Tashau Asefaw: We obtain a signed release of information so that we can engage the caregiver in the member's plan of care and future interactions. We have learned that it can be helpful to reach out to the caregiver and share with them information that highlights the value of support services available to them.

Lauren Easton: With member consent, we aim to incorporate caregivers into a member's treatment plan, so the caregivers are part of the care team. If a member becomes symptomatic for COVID-19 or experiences other medical or psychiatric illnesses or complexities, the caregivers always have access to our care partners to obtain information about treatment options. In addition, we are very cognizant of caregiver burnout, so we try to incorporate different strategies to support caregivers.

Q3: How do you prioritize member voices to better understand the needs of hard-to-reach members?

Lauren Easton: CCA has a designated member voice program that incorporates members who are interested in participating in the development and implementation of our programs, including our clinical model. Through this program we discuss features of innovative clinical models, and the members provide input or suggestions for the development of the program. During the PHE we pivoted to virtual care, and the members in this program helped us test technology that would be appropriate for other members, including members who may be hard-to-reach.

Jen Klopstein: Twice a year, we complete a member experience of care survey through the random selection of members who have engaged in our care management programs. Member responses may indicate plan management successes and areas for improvement, as well as feedback on our face-to-face or telephonic interaction. We review the survey responses about our face-to-face or telephonic interactions with all our staff at least once a year to let them know the “temperature” of those interactions. We are considering incorporating the voices of our members into the overall plan strategy and decision-making processes, as well.

Q4: How has CCA adjusted your approach to meeting members in the field during the PHE?

Lauren Easton: At the beginning of the PHE, we had to quickly shift to virtual care, which came with its challenges because many of our very high-risk members were used to in-person visits and interventions. We identified a field team of clinicians and Health Outreach Workers (HOWs) who were willing to continue going into the community with appropriate personal protective equipment (PPE), and we focused on engaging the high-risk members.

Additionally, our staff conducted phone calls to each member to ensure that they were connected to their care team. We also completed assessments by phone to help connect members to any needed resources. Overall, we noted a 78 percent increase in interactions with members in 2020, as compared to the year prior. Encounter data supported our ability to work with members who had food access, transportation, and pharmacy needs, and we experienced success in connecting with members that are typically difficult to engage.

Q5: What are your health plans doing to reach out to hard-to-reach members and let them know about the availability of COVID-19 vaccinations and boosters?

Jen Klopstein: We contact members to discuss how to access a COVID-19 vaccine, address hesitancies, and, if the member is participating in social activities, encourage them to spend time with others who are vaccinated. When a member contacts us and speaks with our Medicare Member Advocates (formerly referred to as Customer Service representatives), one of the things we discuss with the member is whether they completed their COVID-19 vaccination series. We offer information for those who express hesitancy, provide resources to schedule vaccine appointments, or refer the member to our care management team for more in-depth needs. We mail out quarterly member newsletters to all members to share information addressing COVID-19 vaccine hesitancy, in addition to other relevant topics.

Lauren Easton: Much like our initial outreach around COVID-19 vaccinations, we utilize our HOWs or our care partners, who have strong relationships with our members. These staff work to educate, reassure, talk through any anxieties, or concerns that members have about getting vaccinated, discuss COVID-19 variants, and address member anxieties around the PHE.

Tashau Asefaw: Based on Centers for Disease Control and Prevention (CDC) guidance, our care management teams educate members on vaccination and where they can receive a vaccine. The teams use motivational interviewing tools to explore vaccination ambivalence and address safety, efficacy, and hesitancy.

Q6: Some members may not fully trust the healthcare system. What types of information have been helpful to share with members in terms of gaining their trust and helping them feel more supported by the healthcare system?

Lauren Easton: Many of our members have experienced past trauma and are often unintentionally re-traumatized when seeking to meet their needs through some systems of care. For example, they may not feel believed or heard when they are looking for care. As a result, a trusting, lasting relationship is so important for our members, and we always treat people with trust and respect and consider their dignity of choice and risk. It is important to add immediate value, respond to needs, and to be reliable and predictable. For example, if a member is having a behavioral health crisis or medical issue but note that they are also experiencing hunger, we help them access food immediately and then support all their other needs. This provides immediate value and builds a reliable and trusting relationship to provide support in a nonjudgmental way.

Jen Klopstein: Our care management team is integral in assisting our members to navigate the complexities of the health care system while addressing historically driven health care mistrust. The care managers act as liaisons, advocates, educators, and empathetic supporters by building rapport and providing education to our members who may be hesitant to engage with the health care system. We encourage open discussion about causes of member distrust and assist the member with confronting the issues identified via motivational interviewing.

Q7: Member fatigue associated with frequent outreach is a common problem plans may face. How does your plan address the potential of your outreach leading to fatigue among members?

Jen Klopstein: We have created a "Customer Experience" committee that meets regularly and is currently working to adjust the various forms of member communication we complete (telephonic, mailed, electronic, etc.) to be more precise, efficient, and effective. While health plans are required to provide certain documents to a member, we are working to streamline our communication where possible. Also, we developed our electronic health record (EHR) in-house to better address member needs and make relatively fast changes via our development team. For example, the "Hard-to-Reach" button in our EHR allows our team to quickly review information regarding member contact efforts and streamline communication efforts across plan staff. We can communicate activation of the button to all departments to demonstrate who is trying to reach the member and the reason for this outreach. This presents an opportunity to address the identified task with the member immediately (should the member choose) and offer a warm transfer or coordinate at a time that is more convenient for the member.

Lauren Easton: The CCA care partner is a single point of contact, is the primary connection to the member, and is responsible for coordinating care and communication. However, if there are other team members or community-based providers involved, we work to collaborate with these stakeholders and ensure there is not redundancy or too many individuals contacting the member.

Q8: Has your organization tried "drop-in" visits to members' homes when you could not reach them by phone? If so, how were these visits received? How have you adjusted your strategy in light of the PHE?

Tashau Asefaw: We conducted visits out of the member's house wearing PPE, and we looked for open spaces to have conversations with the member once the member was located. Some of the members were appreciative and willing to talk to us. Some of the members were surprised and had mixed feelings about the visit. Some members would not open the door and only talked to us through the window. The team dropped off "thinking of you" cards to a member's house or mailbox explaining why we wanted to connect with them. Some of those members called back and we were able to schedule a home visit. Because of the PHE, we had to limit our face-to-face time with the members. We had to adjust how we typically do things by looking for available resources outside of what we typically offer (for example, picking up groceries and bringing them to members' homes).

Lauren Easton: We have not done drop-in visits to homes; however, we may go to a shelter, day program or other provider locations to meet with a member who we have not been able to engage. We try to connect with any facility or provider that may have an existing relationship with the member to start engagement. Additionally, we have staff located in four Emergency Departments (EDs), and we can often engage a member in person if they are utilizing the ED.

Jen Klopstein: We have not done drop-in visits during COVID-19 case surges, and all face-to-face visits require screening and approval until further notice. Screenings are completed telephonically by our VCare Care Managers, and the Care Management supervising team provides approval of face-to-face visits. When we do face-to-face visits, these are completed outdoors (member's porches, lawn chairs in the yard, etc.), or in larger indoor settings (libraries or community centers) to ensure social distancing. We can also meet the member at their PCP's office.

Collaborating with and Supporting the Health Care Team

Q9: Community Health Workers (CHWs) provide support to members, particularly members who may be living with serious mental illness. Does your organization provide any trainings on motivational interviewing, trauma-informed care, and person-centered language for your CHWs?

Tashau Asefaw: We had an external trainer provide training on motivational interviewing to care management staff – both clinicians and non-clinicians, including our CHW team. We regularly engage the CHW team in conversations and scenarios regarding use of motivational interviewing tools so that we can understand their perspective and ensure that staff are comfortable using those methods. All our work is trauma-informed, and we take the time to frame care to the member's experiences. We regularly offer training to teams engaging members, and we have audit processes to ensure that teams are operating in alignment with the training. We also hold regular trainings on person-centered language and engage in practice scenarios or role play. Overall, we make sure that there are regular efforts to provide training and practice for our workforce so that they can apply their skills for our members.

Q10: How have you developed or managed relationships with hospital systems during the PHE, especially given periodic surges in COVID-19 cases? What is the most efficient way to be notified that a member is in the ED?

Jen Klopstein: We continually assure the hospitals that we are here to assist them, because that working relationship is really what makes the hospital successful in avoiding readmissions and our members successful in their health outcomes. We utilize admission data reports, hospital censuses, and access to hospital portals to track our members' inpatient and ED admissions. We review admission data, and our EHR has a built-in predictive analytics report that can be used to identify additional management opportunities.

Lauren Easton: We have a hospital-to-home program, which facilitates a partnership between plan doctors and doctors at the emergency department to make a shared decision as to the best level of care placement for members. Through this program, our doctors were able to continue to work in-person in the hospitals throughout the PHE. However, our HOWs and behavioral health clinicians did not have access to the hospital. They have very good relationships with the care management department as well as the ED, so as our patients entered, the outreach workers and behavioral health clinicians were called or contacted to evaluate, assess, or do virtual consults by phone. For members who have complex needs and go to the ED, having a face-to-face visit with the behavioral health clinician or a HOW to determine their needs was critical, particularly when they were in an acute psychiatric crisis or experienced anxiety or nervousness going to the ED. Although we were able to pivot and manage throughout the PHE with a hybrid approach with doctors in person and our other staff engaging virtually, it did come with challenges.

Q11: How have you combined the use of technology with engagement through community health workers or other resources?

Lauren Easton: We utilize the HOW to meet with members and educate them on virtual care. For initial visits – and ongoing, if needed – the HOW may be in the members home to conduct the virtual visit with another provider (physician or advanced practice clinician (APC), or behavioral health clinician).

Jen Klopstein: We utilize a secure telehealth application called Amwell to complete video meetings with our members who have access to technology, in addition to connecting with members via telephone. We also have our Viva Cafes available for members to complete interactions with our staff. Our Viva Cafes are a place where our members can have a cup of coffee and speak directly with our Sales and Marketing team about their plan benefits, address eligibility questions in-person, or meet with our Care Management team if it is preferred by the member versus meeting in their home. We also utilize these eight locations throughout the state of Alabama to host member appreciation events where members are able to access health and wellness services such as flu shots, blood pressure checks, eye exams, and diabetic testing.

Tashau Asefaw: The ability to text members helped support member engagement efforts, as members may prefer texts over phone calls. Utilizing iPads in the field has also been supportive. When we talk with members and identify a need, we can use the iPad to find a resource while we are still with them, rather than having to wait until we get back to our computers to review available resources. We also can connect members with their providers using our phones for their telehealth appointments.

Q12: How does your health plan share and communicate care plans with partners, including community-based organizations (CBOs), behavioral health specialists, or PCPs?

Jen Klopstein: There are three primary ways we communicate with the CBOs, behavioral health specialists, and PCPs. The VCare Care Managers engage partners after identifying a member's need and link our members with the resources partners may offer. For example, a member may need a wheelchair ramp after a hospitalization. Our Transitional Care Managers may identify a mobility change during the hospitalization and contact a partner organization to help coordinate building a ramp for the member at their home and will assist with material and labor donation. As a result, this organization would be incorporated into the care plan to resolve the mobility concern.

A second way we communicate with our partners is via our Connect for Quality Registered Nurses (RNs). The Connect for Quality RNs are embedded in the PCP offices and actively communicate the preventive care screenings needed by the members. If the office's COVID-19 protocols do not allow the Connect for Quality RNs to be present in the office, the nurses communicate with the PCP telephonically and by secure email.

The third way is via a Centers for Medicare & Medicaid Services Special Needs Plan (SNP) requirement for care plan communication. The PCPs are sent a copy of the member's care plan after the completion of the health risk assessment either by mail or secure fax, whether actively managed by VCare or not. The PCPs are encouraged to reach out to Viva Health if there are additional concerns about the care plan. This approach is layered on top of other coordination to ensure that all updates are shared, and as a prompt for partners to reach out with any updates of their own.

Tashau Asefaw: We ask members about other agencies from which they receive services to determine if any collaboration needs to take place for care coordination needs. If members consent, we share their plan of care with external organizations.