The Lewin Group
Locating and Engaging Hard-to-Reach Members During COVID-19: A Panel Discussion
December 14, 2021

Laurel Ruesch: Thank you, and welcome, everyone, to the webinar Locating and Engaging Hard-to-Reach Members During COVID-19: A Panel Discussion. My name is Laurel Ruesch and I'm with the Lewin Group. Today's session will include presentations, followed by a panel discussion and live question-and-answer with the presenters. This session will be recorded, and we will be posting a video recording along with today's slides at www.ResourcesForIntegratedCare.com.

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At this time, I'd like to introduce our moderator for today. Renee Markus Hodin is the deputy director of Community Catalyst Center for Consumer Engagement and Health Innovation. For the past 20 years, Renee has worked to bring the consumer perspective to the forefront of health and health innovation. Renee?

Renee Markus Hodin: Thank you, Laurel. And I just want to add my welcome and my gratitude for everyone who was able to take time out of this busy season to join us. I'm so pleased to be with you all today for this webinar on engaging hard-to-reach members during COVID-19. As Laurel mentioned, I'm the deputy director of the Center for Consumer Engagement and Health Innovation at Community Catalyst, a national healthcare advocacy organization working to elevate the voice of consumers in health and healthcare.

And I've had the pleasure of working with the Lewin Group and the Medicare and Medicaid Coordination Office over the last several years on a variety of webinars we've made into the topics of today's webinar. So, this year I also had the extreme pleasure of facilitating the Integrated Care Community of Practice, a learning community of health plans, each of which serve low-income, older adults and people with disabilities, some of whom we might classify.

And I want to point out that classification is for a wide variety of participants, so to speak hard-to-reach. The Community of Practice participants were plan staff that hold responsibility for developing, overseeing, and implementing strategies for engaging members in care, and we met six times over eight months to share challenges and promising processes.

The Community of Practice launched in March, about a year after the pandemic began, and just as vaccines were becoming more widely available. So, this topic was very much in the forefront of participants' minds and daily experience. In today's webinar, we'll share lessons that emerged from that Community of Practice.

So, I'll first take a few moments to introduce today's speaker -- speakers, rather -- and offer a roadmap for our time together. We'll start out with brief overviews from each of our three organizational representatives. First, we'll hear from Lauren Easton, the Vice president for Integrative Program Development and Clinical Innovation at the Commonwealth Care Alliance in Massachusetts, or CCA.

As the behavioral health leader for the plan, Lauren has been largely responsible for developing CCA's behavioral health integration across care models. She's also been responsible for creative a responsive network, and for creating many innovative programs, some of which we'll be talking about today. Lauren served as a guest faculty member for the Community of Practice earlier this year.

Next, we'll hear from Tashau Asefaw, from Community Health Plan of Washington. Tashau is the manager of community programs at the plan, working to advance health equity by addressing social determinants of health. Tashau leads the direct services team, working to support members managing chronic conditions and addressing members' social needs. Tashau was a member of this year's Community of Practice.

Next, we'll hear from Jennifer Klopstein, from Viva Health in Alabama. Jen is a Special Needs Plan, or SNP administrator, at the plan. Jen provides support for Viva staff working with their D-SNP enrollees and monitoring the activities associated with their D-SNP as outlined by their model of care. Like Tashau, Jen was a member of this year's Community of Practice.

I know that you're all going to enjoy hearing from this incredible line-up of speakers. Lauren, Tashau, and Jen, thanks so much for being with us today. Why don't we go to the next slide?

So, our next slide is our learning objectives for today's session. So, by the end of today's webinar, participants should be able to identify strategies for locating hard-to-reach members, including through the deployment of community health workers and through partnerships with community-based organizations.

They should also be able to identify strategies for addressing unmet social needs and building trust through tangible supports for members, for developing information system approaches for contacting hard-to-reach members, for reaching members with limited English proficiency, those experiencing homelessness, or those with serious mental illness, and finally, for providing COVID-19 vaccine outreach and education to hard-to-reach members. And if you go to the next slide, we'll look at the agenda for today's program.

So, as we start, as we typically do, that is, we start with some polls to get a sense of who's in the audience. Then we'll get brief overviews from each of our three organizational representatives. We'll hear from Lauren first, followed by Tashau, and then Jen. Each of them will share with us information about their plans, some basic information about their models of care, as well as some of the challenges their plans face in engaging hard-to-reach dually eligible members.

The bulk of our time today, however, will be spent in a conversation I'll have the privilege of moderating among Lauren, Tashau, and Jen, in which we'll pick up where their presentations left off -- the strategies their plans employed to address the challenges of locating and engaging their harder-to-reach members during the pandemic. Following that discussion, we'll save plenty of time for Q&A from all of you. And finally, as always, we ask that you all stay on to complete a brief evaluation of the webinar. So, if we go to the next slide, we'll start with our polls to understand who's with us today.

So, first poll is which of the following best describes your professional area -- are you in a health plan, are you customer service, pharmacy, medicine, nursing, physician assistant, or other types of provider, social work, advocacy, health plan case manager or care coordinator, health plan administration or management, or something that's not listed. If you can choose the one that best describes, we will see where most of our audience is from.

Okay. Looks like the responses are coming in, and we're seeing that nearly half of our participants are from health plans. Almost 10% from social work. Let's see, a few from the advocacy world. A large number, about 30%, health plan case managers or care coordinators. And again, approaching 10% on health plan administration and management. Perfect, why don't we go to the next poll, please.

And next, let's talk about the settings that you work in. Is it the ambulatory care setting, home care agencies, long-term care facilities, academic or research environment, a consumer organization, a community-based organization, a health plan, or something that's not listed there? You can make a selection of the one that best describes the setting in which you work. We'll just give it a couple more seconds. Okay. Why don't we go to the poll results on the next slide, and we'll see where folks are from?

Okay. Well, it's very clear here, we have nearly 80% that are from a health plan, followed by the next nearest, which is almost 10%, from community-based organizations. A good number that we didn't quite capture, and then a scattering across the rest of the settings. Okay. Thanks for filling out our polls. We're really pleased to see that we have a diverse set of professional areas, if not from a diverse set of settings, that is.

But I think that the folks on the call today will have a lot to gather from our speakers. And speaking of that, let's go to our next slide and I will turn things over to our first speaker, Lauren Easton, from the Commonwealth Care Alliance. Lauren, you can take it away.

Lauren Easton: Thank you so much, Renee. Good afternoon, everybody, I'm so pleased to be here with you this afternoon. My name's Lauren Easton, I'm the vice president of Integrative Program Development and Clinical Innovation. I have been fortunate to work for Commonwealth Care Alliance for about 18 years now. Next slide, please.

A little bit about Commonwealth Care Alliance. We are an integrated care system serving members who are dual-eligible for Medicaid and Medicare that are truly the most vulnerable members across the state of Massachusetts. We are in a unique position as both a payer and provider, and our roots started as a provider in primary care. We have four primary care sites across the state of Massachusetts.

We had two crisis stabilization units serving 26 beds, and we have a unique model of what used to be called our CPA complex transitional care, but now our hospital-to-home program, which I'll talk a little bit about later in the presentation. Next slide, please.

A little bit about our plan demographics. As I mentioned, we really do serve the most vulnerable populations across the state of Massachusetts. We currently have two products in the state of Massachusetts. We have a senior care options product, serving members that are 65 and older who are dually eligible, and we have a one-care product, which are serving dually eligible members under the age of 65.

As you can see, over 74% of our folks have a behavioral health disability or physical disability; 70% of our folks in one care have a severe SMI, a severe mental illness, and 30% documented have a substance use disorder. We do think that's a higher number; however, this is documented.

In our senior care option program, about 60% of our folks have a physical or behavioral health disability, and many of these are nursing home certifiable, but are living in the community, getting services through our model of care. Next slide, please.

So, a little bit about our model of care. Again, being in a unique position as both a payer and provider, all of our members have access to a community-based inter-professional team that consists of APCs, PAs, behavioral health clinicians, health outreach workers that are similar to community health workers, and OT and PT.

But not only do they have access to a clinical team in the community, we really have a coordinated effort to collaborate with all services along the continuum of care, so including primary care, inpatient services, outpatient services, emergency department, our hospital-to-home program, we have co-located doctors and health outreach workers directly in the emergency department, partnering with physicians in the emergency department. In addition, every single member has a care partner, so when they enroll with us, they're assigned a care partner, and have access to that care partner on a daily basis. Next slide, please.

So again, as I mentioned, a little bit about our model. We really try to meet our members where they're at, so much of our work is done in the community. So, we may see people in their homes, we may see people in shelters, at their day program, we may see people who are homeless or marginally housed, at a Dunkin' Donuts, or even under a bridge.

We have, again, as I mentioned, seamless integration of care and coordination through our care partnership. We are consistently collaborating with, again, transitions of care, human service providers, community-based organizations, to ensure that our members have a seamless continuity of care.

We really focus on trusting relationships. Many of our members have had difficulty getting access to care in systems or have a lot of gaps in care in the system and have a distrust of the services that they often don't have access to. So, we really focus on that individualized, long-term relationship, and building trust with our members.

Ultimately, through our clinical models, our facilities, and our collaboration with community partners, we really see a decrease in overall utilization, and member satisfaction and better outcomes. Next slide, please.

So, in terms of our health risk assessment, every single member that enrolls with us has a face-to-face assessment within 90 days. However, through the pandemic and due to COVID, some of these assessments are now done over the phone, and these are done by a registered nurse.

The assessment really helps drive the care plan. And the care plan, we focus on an individualized care plan driven by our members. But the initial assessment, which is inclusive of medical assessment, a social determinant assessment, as well as the behavioral assessment, really drives that care plan and gives us an understanding of the resources that are necessary for each member.

As I mentioned, we have a hospital-to-home program, so when our members are utilizing the emergency department, we are notified and our doctors partner with doctors at the emergency department to make a shared decision as to the best level of care placement, whether that is inpatient or, if they are able to transition back into the community with intensive clinical service, we are able to offer that through our inter-professional team.

In addition, our health outreach workers are there to support the doctors in doing an SDOH assessment to determine levels of resources that are necessary in the community as well. Next slide, please.

So, some of the challenges that we occurred -- again, many of our members are very challenging to locate, and have difficulty building relationships. As I mentioned, they have had a distrust of the system and often can be stigmatized when seeking services. So, it's really important for us to be able to build those longitudinal relationships, and it was challenging to think about how we were going to do this when we weren't able to see people in person, initially.

Many of our members are changing addresses, phone numbers, we don't have accurate demographic information. So, we really have to work to -- with locating when they're going to the pharmacy or transportation to figure out what their address is or their phone number is.

And additional, many of our members have Department of Mental Health services coming in, or a personal care attendant coming in, or V&A services coming in, so they've got a lot of people coming into their homes, and sometimes it's difficult to be thinking about one more person involved in their care. Also, our members often are seeking -- because of their barriers to care, they're seeking their care through the emergency department instead of their primary care providers or human service providers.

But they're going all over the state at various hospitals. We only have access to immediate notification at four hospitals in the state of Massachusetts. It can be difficult to track these members and engage them on a consistent basis. Next slide, please. And with that, I'm going to turn it over to Tashau. Thank you very much.

Tashau Asefaw: Thank you, Lauren. Hello, everyone, my name is Tashau Asefaw, I'm the manager of community programs at Community Health Plan of Washington. Happy to be here with you all today. Next slide, please.

Community Health Plan of Washington is a local not-for-profit organization providing access to quality Medicaid and Medicare coverage for Washington's underserved residents in their own communities. We have nearly 30 years of experience and long-established roots in health equity.

We have over 270,000 members covered under our Apple Health Integrated Managed Care, which is our Medicaid plan. Our Medicare Advantage plan, which includes our dually eligible beneficiaries, and our Behavior Health Services Only plan. We were founded by and are still governed by Community Health Centers, which in turn are governed by community members.

The health of our members is our primary concern, and we are committed to improving their health and well-being. The foundation of our integrated health services approach is locally delivered, whole-person care which recognizes the broad needs of our members and provides support in the communities in which they live. CHPW aim is to advance health equity and improve the lives of the people we serve by addressing the barriers to health and well-being. Our members come first. Next slide, please.

Community Health Plan of Washington serves over 7,000 dually eligible, special needs plan beneficiaries; 48% of them identify as nonwhite, 59% identify as female, 34% live with a serious mental illness, and the average age is 67 years old. Our programs are designed to proactively identify and address behavioral, social, and medical needs of our members, and to support the whole person's needs. We make decisions that are motivated by the best interests of our members, providers, and communities within the state of Washington. Next slide, please.

We provide comprehensive support for our most vulnerable members. Our models of care provides holistic support for members and brings clinical case managers and providers into collaboration. This collaborative support is comprised of special health services, case management, and care coordination.

All dually eligible members are enrolled in special needs plan case management and are assigned to a case manager during enrollment. The health risks assessment is completed within the first 90 days and annually thereafter. Case managers will also complete a new health risk assessment for members with a change in health status.

The health risks assessment assesses for special kinds of health needs, mental health, emotional health, health habits, and health improvement. Community Health Plan of Washington also utilizes community health workers to locate hard-to-reach members with behavioral health diagnoses. Our community health workers complete the health risk assessment and then complete the warm transfer to Community Health Plan of Washington case managers. Next slide, please.

So, some of the challenges that we experience, engaging hard-to-reach members throughout the COVID-19 pandemic. So, members have limited access to communication, including the internet and phones. So, limited access to technology and communication. So, our members have limited phone minutes. Many of them utilize phone service with a phone benefit, where they don't have unlimited amount of time to talk and communicate with us and service providers. In addition to limited access to the internet.

So, during the pandemic, free internet access and Wi-Fi sites shut down, so there was limited access there for folks to be able to use the internet. Members have a lack of trust in the healthcare system, so Lauren shared this as well in her information presenting. Some of our members have not had the greatest experience with the healthcare system in general, so there is a lack of trust.

Some of what we experience is with a general lack of information available at the onset of the pandemic, presenting some challenges for engagement. One of the other challenges we had, members were preferring to have case managers and others on our team just for immediate needs, while not wanting to answer or engage in a health risk assessment or health-specific questions.

So, we had members only focused on what can you do to help me with a doctor's appointment that I might need to change, how can you help me get connected to food or some other services. Not interested in really talking about some of those other health needs.

And lastly, limited face-to-face contact. So again, with shutdowns and things being closed and social distancing, not being able to get out into the community to find and engage hard-to-reach members was a barrier for us. Thank you, and I will pass it over to Jen.

Jen Klopstein: Thank you, Tashau. Good morning, everyone. My name is Jen, and as mentioned previously, I'm the special needs plan administrator for Viva Health. So, Viva Health was founded in 1995, and we are a health insurance company as well as an affiliate of the University of Alabama-Birmingham.

We serve over 100,000 residents in the state of Alabama for their health insurance needs in a variety of ways, including a commercial line, our Medicare line, which includes our D-SNP, with about 19,300 members, and our Medicaid line, which is a management service for the Alabama Coordinated Health Network.

Our D-SNP plan is voluntary, and it covers about 30 counties across Alabama currently. In 2022, we expect two more counties to come on board, making it 32. Recently, we achieved a five-star rating, so we're very excited about what's coming in 2022 and the ways that we can impact our members.

Just some demographics about our population within the state of Alabama. The majority of our members in the D-SNP plan, which would be about two-thirds, are female, and the remaining third is male. A little over half of our members identify as Black, just under half identify as white, and then the remainders are just under 1% of the population.

When it comes to education of our members, we do also pay attention to that, due to health literacy concerns; 40% of our members have a high school diploma or GED, 25% have some high school education but did not graduate, and 16% of our members have an eighth-grade education or less. About a third of our members are under the age of 59, so our D-SNP plan does have some use to it. About the same amount is in that median range, which is 60 to 69 years, and then just a little bit over a third are 70 years or older.

Another aspect to consider for Alabama is 59% of Alabamians living in urban areas, and contrasted with the 41% in rural areas, which will impact the things we speak about in a bit. Next slide, please.

Our model of care really places emphasis on providing opportunities for our members to become successful self-advocates as well as independent navigators of their health. We strive to make communication with our members as effective and efficient as possible. Our HRAs, for example, are an area we attempt to leverage every opportunity of interaction to complete this within our SNP.

This is a pivotal point to our care plans as well as our ICT. So, we really, really want to make sure we focus on the HRA completion. However, there are hard-to-reach members, and no matter how hard we try, sometimes we don't reach those members. So, what we have done to be creative is creating a hard-to-reach button that is -- spans across all of our EHR, and it is something that we can hover over so every member of our team can see it. This would be something if another department is interacting with a member, that they would know that this is something we need to collect, as it is so essential to our care.

When it comes to collecting our HRAs, it's not something that we're doing on every single interaction, but it is something that we want to make sure we're collecting at least every six months, or if it's coming due with that annual. If we have a member that's experiencing transition, we want to make sure that we're using a tool that can effectively assess for any changes.

And then, of course, the initial HRA, which might lead into that hard-to-reach button, is completed telephonically with our outreach team. Our HRAs, like everyone else's, I'm sure, cover the five domains, but we also included a free text question that we can collect information and bring attention to any needs beyond those primary or core questions, including opportunities to request intensive care management by our member.

Intensive care management is complete by our VCare team, which consists of nurses as well as social workers, and it is there for eligible members needing assistance with a variety of things, such as transitional care, medical education or needs, and behavioral health.

At this time, our intensive care management, or VCare team, is considered a voluntary program, so it's not something that someone is automatically enrolled in. A member may be referred to this program by a variety of ways. They may self-refer, they may be referred by a PCP, a specialist, or some other provider. Our predictive analytics that we utilize may also indicate there could be a need for management. Or a member may be experiencing a transition.

And of course, as I mentioned, the member must accept these services. It is not mandatory. Viva Health really focuses on equity and partnering with local groups working in our underserved areas to improve access to care. We like to find out where our members of need are, and focus our needs throughout the state of Alabama, where our concentrations are. Next slide, please.

So, some challenges that we have come across and are very similar to the other two presenters would be streamlining our communication to members. This has been a focus, because the COVID-19 pandemic really transitioned a lot of our care, which used to be face-to-face and very community-based, to a more telephonic style, and we really want to work on streamlining it prevent any phone fatigue.

Another challenge that we have faced is getting updated demographic information. Sometimes, date data may be outdated, or it may have duplicate information. So, we really want to focus on trying to find as much new and usable information with our SNP members, and this can be very difficult.

Reaching out to members who are admitted in inpatient behavioral health settings can also be a challenge, and this is understandable because of the heightened protection for this population's privacy. But we work on relationships within the neighboring hospitals to ensure that we can try to reach out to our members.

And the last challenge to mention would be those chronic hard-to-reach members. They are not only hard to reach at the initial engagement, but they can be very, very difficult if we were to engage with them and maintain that engagement. So, keeping our members communicating with us can also be a challenge. And now, back to Renee for the next topic.

Renee Markus Hodin: Thanks so much, Jen, and thanks, Lauren and Tashau, and of course, you, Jen, too, for providing us with some background about your plans, your models of care, and of course the challenges of locating and engaging harder-to-reach members over the last -- I think we're at 21 months now -- since the pandemic really began here in the United States.

So, those presentations really provide us with a perfect launch pad for our next section, in which we're going to just dig a little bit deeper on the issues that you flagged in your presentations. But really focus most of our energies and our time on strategies that each of your plans have used to find and engage these members since March of 2020.

So, if it's okay, we'll just jump right into the conversation. And I guess I'll start with where Jen left off, and then where each of you left off in your presentation, which is around the common challenges. And it seemed that, looking across each of your slides there, that locating hard-to-reach members was one of the most common challenges. So, I'm hoping that each of you can elaborate on how this challenge was exacerbated by the pandemic, and Tashau, if I can start with you?

Tashau Asefaw: Yes, thank you, Renee. Most of us know and experience how quickly many of us became reliant on technology to deliver services or to connect with our own loved ones after the pandemic started. The COVID-19 pandemic exacerbated challenges for us in locating hard-to-reach members, especially those with limited access to phone and technology.

It became even more difficult to engage with members when face-to-face interactions were limited, and members could not be reached reliably via phone or technology. Prior to the pandemic, one of the ways we could connect with members would be events -- for example, recreational time at shelters, time that's open for meals or games. Well, those were canceled, and continue to have barriers to entry and limitations due to the ongoing pandemic. So, this presented a barrier for engagement and continues to present a barrier to engagement for us.

Renee Markus Hodin: Sounds very familiar. Jen, why don't I take it over to you, and then we'll have Lauren follow.

Jen Klopstein: So, as previously mentioned, the pandemic really changed up a lot of things for these vulnerable members, and we had to heavily rely on telephonic outreach. Prior to the pandemic, we were very face-to-face and in the community with our members, so this did dampen some of our efforts and we had to be much more creative on how we would reach out, and much more efficient with how we reach out.

We also have several members that are in rural areas, and they may rely on, like, a landline telephone. I know it seems like a thing of the past, but there are several that do have that, and that would limit our ability to contact them if they weren't at home, or where that number is.

Members with cell phones may have limited coverage as well, because it is rural and very mountainy in some areas of Alabama, or just very sparse. There may be a limitation on those phones because of the minutes, so that can put constraints on not only meeting with us, but the member also having to watch those minutes to work with their providers telephonically. And then another thing would be just the general lack of consistent access to the internet for a lot of our members.

Renee Markus Hodin: Thanks, Jen, I really appreciate you bringing in the rural aspect of this. Lauren, why don't I turn it over to you to talk about some of the unique challenges that CCA faced?

Lauren Easton: Thank you, Renee. Very similar to Jen and Tashau, but in addition to technology challenges, our typical outreach efforts, as I mentioned earlier, were difficult to impossible due to COVID-19 safety protocols. Typically, we conduct many of our visits for our member population in their homes or residential programs or day facilities, shelters, or elsewhere -- basically, mostly in the community.

With many of these locations shut down or unavailable during the pandemic, locating hard-to-reach members became even more difficult. In addition, many interventions with our members occur face-to-face within the emergency department, so we had to shift away from engagement in that setting as well. So, for many of our members who we had established trusting relationships, we had unpredicted success with transitioning to virtual care.

CCA pivoted very quickly at the beginning of the pandemic into a virtual care modality. But for folks with whom we hadn't had an established relation or trusting relationship resulting from at least one face-to-face engagement, it was very hard to connect with them. Like Jen and Tashau, many of our members do not have access to technology or phones.

Renee Markus Hodin: Thanks, Lauren. You actually gave us the perfect segue to talking about strategies that your plans use to overcome these pandemic-induced challenges. So, if we can start talking about those strategies with you, Jen, and then we'll go to Lauren, and then Tashau.

Jen Klopstein: Sure. So, we focused on a telephonic outreach that was for our entire population, just to complete a wellness check. These calls were framed more of a conversation. We didn't really want it to feel like we were diagnosing someone or just focusing on the medical. We wanted to know how our members were handling the stress, and really put out a human interaction so that our members understand we care about them, but also that there are other people that can help them in the pandemic.

We would provide resources during that interaction if it were to come up in the conversation, and this could be things like transportation or food insecurity as well as just general COVID education. Like I mentioned previously, we have that hard-to-reach button. This was created slightly before the pandemic, but it really seemed to come in handy with that, so that we could make sure we know who our hard-to-reach members are.

And if that member were to call in for something, we know why they're calling in, we know who also needs to talk to them, and then get to them as quickly as possible so that we can take care of everything within that call. This button is built-in, like I mentioned, to every aspect of our EHR.

So, if someone is lacking their HRA, we can hover over that and we see that they need to be transferred to our HRA outreach group. If they need to update the demographic information, discuss medication adherence with our pharmacy, or complete things like update their address and email, that their eligibility is still true, we can do that all within that hover, and try to address everything as efficiently as possible.

The hard-to-reach button has been very impactful for that streamlining, as well as communicating throughout our organization, because we are spread out across the entire state of Alabama. When it comes to adding and removing that button, we really try to get that taken care of within 24 hours.

That way, we can quickly see if the member were to call back that they need to complete something like an HRA or present an unnecessary transfer for that member having to sit, like if we had already completed it, but it wasn't taken off. This has allowed us that effective communication and also allowed us to demonstrate how much we are for and respect our members' time.

Renee Markus Hodin: Wow, it sounds like it was really useful, both for your internal purposes but more importantly for the member experience with the plan. So, thanks for sharing more about that, I was really intrigued. Lauren, why don't we turn to you for some of the strategies that CCA used to overcome the challenges you described earlier?

Lauren Easton: Thank you. Although we were trying to reach out to every single member in the organization, we prioritized outreach to our members at higher risk of adverse outcomes associated with COVID-19 infection, or those with greater risks due to psychiatric or medical complexity.

As we assessed higher-risk members, we had a team in the field, with appropriate PPE, that spanned the state that could conduct a home visit for those with whom we couldn't connect telephonically or were at higher risk and necessitated a home visit. Because of the barriers of going into the community, staff who would have typically been in the field could now spend more time calling members or providing support to our care partners. We did many wellness checks to assess for needs related to social determinants of health, including food access, housing, transportation needs, and pharmacy needs.

Renee Markus Hodin: Oh, thanks, it sounds like the wellness checks, both telephonic and in-person, for both you and for Jen, were really very helpful. Why don't we turn it to you, Tashau?

Tashau Asefaw: Thank you, Renee. Similar to Lauren and Jen, at the onset of the pandemic, we reached out to every single one of our members to ask them about their needs. Again, similarly there, it was very conversational, really asking them what is it that you need from us, what would be the most helpful.

We would address those needs by leveraging our community health workers and case management teams, providing resource education, and connecting members to services. One of the ways that we worked to mitigate the challenges with technology was to create a shortened assessment. As I mentioned previously, many of our members have limited phone minutes, you know, if they do have cell phones, and we wanted to ensure that we were addressing, again, the member's immediate need, what they valued, what they felt was most important at the time, and ensure that they knew how to get in contact with us for additional support.

Prior to the pandemic, we had two teams. One was primarily in the community and the other was primarily engaging in telephone-based outreach efforts. As the pandemic evolved, our community-based team experienced pauses and restarts with face-to-face interactions. At times, the community-based team had to rely more on telephonic-based outreach efforts.

Renee Markus Hodin: Thanks, Tashau. Okay. I want to switch up to another topic, which has been sort of alluded to in both your presentations, but also in this conversation so far. So, can you describe, or can each of you discuss, how you partnered with community providers to meet the needs, including some of the unmet social needs that many of you described before, of hard-to-reach members during the pandemic? And for this one, why don't we start with Lauren?

Lauren Easton: Thanks, Renee. CCA is overseeing, in collaboration with the state, a statewide isolation and recovery site for all individuals who met financial and clinical eligibility requirements and tested positive for COVID-19. These individuals were either homeless or marginally housed and could not return to shelters or other facilities for care. Individuals are provided with a hotel room and three meals per day, clinical oversight, behavioral health services, and linkages to additional services as needed, including recovery coaches or detox.

As a result, we could flag CCA members if we identified they needed additional support after discharge. We also are integrated with many hospitals, so we identified members going into the emergency department, and we could help successfully transition them out of the hospital and back home and provide them with necessary services within the community.

We have partnerships with what CCA defines as health homes -- not the typical definition of health home, but human service organizations and community health centers across the state and partnered with shelters to identify our hard-to-reach members. We work with these organizations outside of the pandemic, and our collaborations were heightened during the pandemic.

Renee Markus Hodin: Thanks, Lauren. I know that during the community practice, we've heard, kind of live, about the isolation and recovery sites, so it's great to be able to share that with this audience as well. Why don't we turn to Tashau next, and then to Jen after that, to talk about partnerships with community providers?

Tashau Asefaw: Thank you, Renee. So, members that had unmet social needs in the context of housing or other needs due to limited financial resources prior to the COVID-19 pandemic, those needs were exacerbated by the health crisis. The pandemic resulted in many changes for those in the workforce, and what we saw was an increase in individuals looking to access social services.

As a result of shutdowns and increase in folks seeking to access services, we began to experience delays in responses from social programs. With the initial stay-at-home or shelter-in-place orders in the state of Washington, we saw a lot of need related to food security. Individuals were concerned about going out in public, or they didn't have transportation. We leveraged our team to pick up and drop off groceries.

One of the other things that we did, we also expanded our partnership with a local organization to deliver prepared meals to members who were quarantined due to a presumed or confirmed case of COVID-19 and were experiencing food insecurity. We also received daily notifications of our members that tested positive for COVID, and we outreached to them to notify them and coordinate the food benefit.

We also partnered with a community-based organization that primarily serves refugee and immigrant women. In collaboration with this community-based organization, we put on a series of webinars in five different languages -- Arabic, Dari, French, Swahili, and Amharic for these women that focused on a healthy lifestyle. COVID-19 was an area of discussion in the webinars, but we also focused on overall health, including mental health, substance use, sleep hygiene, exercise, diet, and what you can discuss with your doctor.

We partnered with county health departments to have our case managers assigned to isolation and quarantine sites so that we could connect with members who did not have a home in which to quarantine. Case managers would access our dashboard for information on our members at these sites, and then they would connect with the on-site coordinators to get members engaged in case management services.

Renee Markus Hodin: Tashau, thanks. Really wanted to underscore your partnership with the community-based organization that serves the African refugee and immigrant population. So, that's really a terrific partnership, and certainly a trusted organization. Thanks for that. So, Jen, why don't I turn to you next?

Jen Klopstein: Well, food insecurity proved to be a big issue for our members and connecting them with agencies within the community was really essential to addressing this. For example, if we were to determine there was a donated food site where we had resources available in an area, and we knew there was a high concentration of members, our care managers, if they were working with a member, especially during the intensive care management, could share this information about those organizations and how aware or when they could get that resource.

They could also share this information during their weekly care manager meetings within the team, so that other resources that might be available for another person's patient or member could be utilized. We really made sure that we were mindful of local churches as resources, the Salvation Army, there's also the Community Food Bank of Central Alabama, and then other shelters that might have had food available that were donated.

So, we spent a lot of time leveraging those relationships to make sure that the information could get disseminated to our members. Social media can also and was also a very helpful resource for our team in gathering information quickly, and a good way to confirm availability and then communicate that to the members.

Prior to the pandemic, we had also staffed -- had staff situated in the hospitals throughout Alabama as kind of an early warning system for our transition. So, what we did throughout the pandemic was assure the hospitals were still conducting our outreach and were still providing care management to the members. Just noted that it may not be the traditional face-to-face like we would do, but rather telephonic.

We are still working with those hospitals to make sure we can reintroduce our staff within their COVID protocol. Another thing that was very helpful was an over-the-counter benefit that we had prior to the pandemic, but really seemed to shine during the pandemic.

This is a benefit that allowed our members to get things like personal hygiene items, such as toothpaste, body wash, masks, mouthwash, and it could be shipped directly to their house, so that they would not have to worry about traveling to a pharmacy and potentially being exposed to COVID. We hoped that this benefit would help alleviate some of the members' stress or worry about COVID-19 because they are chronically ill and a high risk.

Renee Markus Hodin: Thanks so much, Jen, and thanks for ending that on some of the items that we don't necessarily think of right away when we think about unmet social needs. I want to just shift gears a little bit now in our conversation. As I mentioned in the introduction, this Community of Practice started meeting just when vaccines were becoming more widely available. So, I wanted to have you guys talk about a recurrent topic within the Community of Practice, and that's about COVID vaccine outreach and engagement.

So, I'm hoping that each of you, and we'll start with Jen this time, can share some of the strategies at your plans, and any of the providers that you work with use to support those COVID-19 vaccination outreach and education processes. So, again, we'll start with Jen and then go to Lauren and then Tashau.

Jen Klopstein: What we did is incorporate care plans into our telephonic outreach that would reiterate evidence-based messages from the CDC. Some was valid information about the pandemic. In the beginning, these goals would focus on handwashing, social distancing, or other guidance provided at that time. And then once the vaccines became available, we would help inform members of good information sources about the vaccine, support the members in things like assisting to schedule their vaccinations.

We also focused on hesitance and providing education about the vaccine, and one method was our social media accounts, such as Facebook or Instagram. Our chief medical officer would talk about concerns or misinformation people had. One of the rumors, for example, was the infertility fears that people had from getting the vaccination, and we really worked hard to debunk those myths. We also had opportunities where our staff, such as our chief medical officer, would appear on the local news stations to discuss some of the hesitancy and factual information.

And whenever we would make contact with our members and this topic came up, we made sure to direct them to their local health department, the CDC, the NIH, et cetera, for more valid information about COVID and the vaccine.

Renee Markus Hodin: Thanks for that, Jen. Lauren, why don't I turn to you next?

Lauren Easton: Thanks, Renee. CCA used the entire inter-professional team, including and highlighting our health outreach workers, to educate members about vaccinations, answer questions, or address anxieties about the vaccination. Many individuals were anxious or were experiencing severe isolation, so behavioral health specialists worked with folks telephonically around vaccination and other issues related to the pandemic, like social isolation, not being able to see family, friends, or peers.

We identified CCA members that were homebound and were able to do at-home vaccinations. In addition, the state of Massachusetts asked us to support them in at-home vaccinations for non-CCA members. We quickly pivoted to that, although this was often challenging to get enough nurses that could disperse from our four geographic locations across the state of Massachusetts.

Even though these are home visits, it could still be challenging to reach all members in order to use each day's allocation of vaccinations, so we had to be prepared to be able to utilize all of the vaccinations each day. So, I had emergency lists to accommodate that. Staff at the previously mentioned COVID-19 isolation recovery sites, the hotels, provided education on COVID-19 vaccination and connected participants to community providers, who then could support participants in getting the vaccine in the community. At the time, we were unable to give vaccinations at the hotel sites because of the limited time the guests were staying with us.

Renee Markus Hodin: Thanks, Lauren. Tashau, why don't we turn to you to find out how the Community Health Plan of Washington rolled out its vaccination engagement efforts?

Tashau Asefaw: Yeah, at the onset of the pandemic, we provided information to members based on available guidance at the time. Once vaccines became available, we assisted members in scheduling appointments and/or arranging transportation to vaccination appointments.

Over time, our outreach became more targeted to specific populations. One tool that enabled us to be more targeted in our efforts was a dashboard that we created to track vaccination rates by area and provider. We used the tool to identify communities with disparities in vaccination rates, and then we reached out to and collaborated with providers and community partners in the area to serve these populations.

We also communicated with members via text in their preferred language to provide information about vaccine efforts or events in their communities, and we also collaborated with our local health department by providing data on members who are unable to leave their homes to ensure they could receive vaccinations through the health department's mobile vaccine efforts.

Renee Markus Hodin: Thanks, Tashau. You know, to close out this section, I think it's of course worth mentioning that we're speaking about these efforts in the past tense, but I just want to acknowledge, of course, that all three of your plans are, I'm sure, using some of these same approaches as you work to get people their boosters.

But let's why don't we shift gears one more time here and talk about a couple of subset populations. As we said earlier, the harder-to-reach population is quite varied. People are hard to reach for a whole variety of reasons. But two sub-populations may be exceptionally hard to reach, and those are people experiencing homelessness, or those with serious mental illness.

I wanted to invite each of you to talk about some of the specific examples of strategies that your plans or your affiliated providers employed to engage either one or both of those populations. So, why don't we start with you, Tashau, and then we'll go to Jen, and then to Lauren.

Tashau Asefaw: Thank you, Renee. One of the exacerbated challenges during the pandemic for us was engaging members living with behavioral health conditions, particularly engaging with members in case management services. We really were working to determine the best way to connect with these members.

To address the staff of not being able to engage, we leveraged our community health workers to locate these members. Our case managers coordinated with our community health workers, and once a member was located, the community health worker completed a health risk assessment to help risk assessment help the case manager develop a plan of care after the warm handoff.

We recognize the importance of building trust and being consistent in our relationships with members experiencing homelessness or living with behavioral health conditions. To build trust with our members, we work to address the most critical needs before we discuss behavioral health needs. This helps to show members that we're dependable and consistent.

Once we establish an initial relationship with members, our community health workers use a variety of strategies to support members' behavioral health needs. This includes using recovery-oriented and strength-based, person-centered language, using motivational interviewing tools, connecting members to behavioral health providers, and working to help members understand how to use their behavioral health benefits.

We also provide educational and peer support, helping members understand the value of connecting with another person who lives with a mental health or substance use condition, and how that could be helpful in their recovery journey.

Renee Markus Hodin: Thanks, Tashau. Why don't we turn to Jen?

Jen Klopstein: Viva works closely with hospital staff in the area and provides support and outreach to our members. We really work, as I mentioned previously, to foster that relationship with the hospitals, as it's particularly important to the members with serious mental illness. We work and continue to work to make stronger connections with those hospitals and had regular staff meetings prior to the pandemic to really kind of concrete those relationships to make a more successful outreach with members of a group that can be hard to reach.

Our VCare team, which are intensive care managers, contact the hospital discharge staff. They can contact shelters and members' family members, their caregivers or group home leaders, to assist in locating alternative housing options for members with mental illness. Stable housing can be quite an issue. The result of this coordination is very helpful during a transition.

We also have that warm handoff, where the member of going directly from their discharge planner at the hospital helping them to our staff seamlessly getting them back into the community. And we hope that this not only decreases the stress of the member having to figure out how to navigate their discharge, because it can be very complicated, but also increase the likelihood of a positive outcome.

Our care manager is able to follow the member after for 30, 60, 90 days or longer, depending on the specific situation of the member, to ensure that that is a really solid discharge plan. Members can also contact their care manager. Say they aren't necessarily in the hospital, but it's several months down the line and a new issue comes up, they can reach out to them, and they can have someone to provide support while they're tackling these new challenges after discharge.

Our care managers are excellent advocates and supporters of our members, and we're very proud of them for that. And we really feel that also by having that strong support after, it helps provide a positive accountability for the hospital, where they want to make that discharge plan very solid.

We connected with members to determine what community organizations they're utilizing, and we make sure that we're passing our information along to these organizations, just to better wrap the interdisciplinary care team around the member who may be experiencing that behavioral health challenge, and it helps us to eliminate the gaps in their plan of care by doing so.

If providers and CBOs in the field have knowledge of the services we're able to provide as a result of our communication and outreach, we hope that they will then share that benefit of our care coordination with the members whenever they come upon the information they may have about our plan. We hope that this reduces the chances that the member will fall through those cracks, and also increase the capability of the treatment team to work with the CBO on shared goals that they may also have with the member.

An example of that would be transportation. It is essential to a variety of aspects for ongoing stability as well as disease management. So, our CBOs are informed of our non-emergency transportation benefit with a group called MTA within the Birmingham and full state, and then Ride Help, which is more in the Huntsville area, for our SNP members.

So, we hope that by having that benefit, not only is it benefiting the member to ensure that they have consistent transportation to their appointments, but also preventing the CBO from utilizing what resources they may have, as they may be limited, for the transportation to the appointment.

Renee Markus Hodin: Great to underscore the importance of transportation, which I know we talked about a lot with respect to the COVID-19 vaccination, getting people to the COVID vaccination sites. So, thanks for raising that, Jen. Lauren, why don't we have you close out our discussion on these particular populations?

Lauren Easton: Thank you. So, all of our members at CCA have access to a licensed behavioral health clinician as well as a health outreach worker. Many of our members have barriers to get into facilities, and if they miss appointments, they are not able to return to the facility for six to eight months to get another appointment. So, they have access to our own clinicians that are able to provide crisis management, diagnosis and assessment, connect them to resources in the community, and most importantly, be able to do home visits and conventional therapy in their home.

Renee Markus Hodin: Lauren, did we lose you?

Lauren Easton: -- hear me?

Renee Markus Hodin: Now we can, yeah.

Lauren Easton: Okay. All right, so in addition, we have developed a 26-bed crisis stabilization unit that we operate with a partner, a human service provider, to treat members with psychiatric and substance use issues. This allows us to divert members from emergency departments and unnecessary inpatient stays to this unit, which is more of a community-based setting than an institutional setting.

In Massachusetts, a typical crisis stay is three to four days. However, our CCA patients can stay for as long as their needs require, and we can provide additional wrap-around services as they transition back into the community. Previously, we saw people go between emergency departments to get treatment for their psychiatric concerns or substance use.

Members that were disengaged prior to arriving at the crisis units may become more engaged after accessing these services and learning more about the support the plan can provide. We often connect them to primary care, behavioral health services, or substance use services in the community, as well as their care team in the community.

Additionally, we have a behavioral health clinician and recovery coaches on-site in the emergency department who offer face-to-face contact and engagement. This allows us to transition members to our crisis unit or do a warm handoff to our community team.

Renee Markus Hodin: Thanks, Lauren. Wow, it sounds like there are a really wide variety of approaches that each of your plans are using across a wide spectrum to reach and engage these two populations. Thanks for that.

I think we're going to close out with one last question for everyone. I wanted everybody to look forward a little bit and ask you each to share what you've learned about engaging hard-to-reach members as a result of the pandemic, and what strategies you might continue to use moving forward that you may not have been using before. I think everyone talked about getting creative, and so I just wanted you all to reflect on how those strategies might be able to be used in the future. Lauren, why don't we start with you? We'll go to Tashau, and then to Jen after that.

Lauren Easton: Thanks. So, at CCA, we had to pivot quickly to virtual care. We initially didn't think members would be receptive to virtual care, given their distrust of the system and wanting to see people face-to-face. We were happily surprised that a good percentage of members were receptive and able to utilize telehealth services. For members that have been receptive to virtual care, we will continue a hybrid method, both in-person and virtually.

This allows for more staffing efficiency in terms of supporting all of our members across the state. We are also thinking about device allocations and Wi-Fi for our members who do not have access to technology. Many members typically still want at least a quarterly in-person visit but are happy to utilize virtual care.

CCA anticipates expanding all of our care and services throughout all of our facilities, including groups, to conduct hybrid care where possible and desired. We are reflecting on lessons learned from our isolation recovery sites and our ability to connect 95% of those folks to resources for longer-term care, even though they were only with us for a short time, 10 to 12 days.

CCA did a lot of analysis around food insecurity and found increase during the pandemic. We are looking for creative and innovative ways to support members through our engagement center or other organizations to help manage their food access.

Renee Markus Hodin: Thanks for that, Lauren. Let's go to Tashau.

Tashau Asefaw: Thank you. So, we plan to continue to grow the role of our community health workers as part of the care team and leveraging our connections to communities to enhance our ability to get members what they need, when they need it. Our community health workers reflect the diversity of our membership and they're well connected within our communities.

The foundation of our are approach is to locally deliver whole-person care, as I mentioned earlier, and our efforts to create regional care teams is an integral part of our integrated care approach. We are in the early stages of developing regional care teams, which include staff in various roles, including regional case managers, community health workers, field case managers, and we'll also be exploring other roles as a part of the regional care teams as we move forward.

But the regional care team staff live in the communities they serve and support the expansion of our in-person services programs for our members. So, it goes beyond just the community health worker living in the community; it's the whole regional care team. The staff on the regional teams have relationships with providers and other member-serving organizations, and we've worked together to support members in achieving optimal health outcomes.

While this is not new for us, we plan to continue to collaborate with external organizations. That's something that--that's foundational and core to us. Our expanded meal benefit and our partnership with county health departments are great examples of working with others to meet the various needs of our members.

We have been spending time working to develop a long-term social determinants of health strategy, which includes partnering and collaborating with a range of stakeholders, government entities, and community-based organizations.

Renee Markus Hodin: Thanks, Tashau. And Jen, you get the final word on this.

Jen Klopstein: Okay, thank you. Well, one helpful thing, I think, that really stood out was the streamlining our contact with our members, and it's something that would really positively and does positively impact our member experience. Because telephone contact was that primary resource of communication, we really focus on being mindful of how many times we're reaching out to the member, and really collaborating as a team to reduce that fatigue.

Our hard-to-reach button, as I've mentioned before, was really supporting of those efforts, and it also went to us being much more cohesive in our outreaches, instead of having multiple contacts from the same company to the same member. Similar to that hard-to-reach button, we implemented a COVID-19 vaccine button.

It's another hover-over, and that was something where we could look at claims, we could look at claims, we could gather the information from the member, we could look at information gathered from the PCP or providers to see if that member is partially, fully refusing or hesitant of the COVID vaccine, and we could take that information and put it in that hover button, and then show that we can communicate.

Whether that's something we might want to address, whether in the care management, whether with our connect for quality, which is our outreach team for preventive care. That was something that we just really wanted to globally make available without having to put a lot of information in a very small spot, we can be very precise and effective with that information.

Renee Markus Hodin: Well, thank you, Jen, and that was a great way to close us out for our panel discussion. I wanted to thank all of you for this conversation, and in particular, for your participation in the Community of Practice. It's really been an honor for me, and I know for my colleagues at the Lewin Group to work and learn with you guys and your peers over the last year, especially since it's been a pretty difficult period of the pandemic.

So, thank you again, and I'm going to shift now again. Instead of me asking questions, we're going to take questions from our participants. I'm going to turn the program back over to Laurel, who will moderate this section. Laurel?

Laurel Ruesch: Thank you, Renee. And thank you, Lauren, Tashau, and Jen, for sharing all of your great insights. With that, we do have some time for questions from the audience, and thank you to everyone who's already submitted questions, either through the Q&A feature or during registration. But if you do have any additional questions, please submit those now using the Q&A feature in the lower left of the presentation screen.

You can type your comment at the bottom of the Q&A box and then press Submit to send it. But I'll start out with a few questions that we've received thus far. A lot of participants have asked some questions about how to best support folks living in rural areas, where cell phone access may be limited, and some members may only have access to mail on a monthly basis. So, Jen, this question is for you. Do you have any recommendations from your experience in reaching rural hard-to-reach members in particular?

Jen Klopstein: One thing that we have started doing again, which there are face-to-face interactions, and those rural members, they don't have a lot of resources sometimes. So, what we can do since July of this year is send our staff out if the member requests it, and we have an assessment or concerns about infection for COVID specifically. But we are, if the member is willing, reintegrating our staff and doing that face-to-face.

We also have staff at the primary care offices, depending on that office's particular protocol for COVID. They're called Connect for Quality nurses, and they're there to get a lot of global information and make sure that the PCP, the member, and us are on the same page about their care. So, meeting them at their primary care office can be another option, and I think front porch visits are always a good thing, too. You're out in the fresh air, but it also provides that distance.

Laurel Ruesch: Great, thank you, Jen. This next question is for Jen and for Lauren as well. Maybe Lauren, we can start with you. Could you speak a little bit about how your plan helps you incorporate member voices in an effort to better understand the needs of hard-to-reach members?

Lauren Easton: Sure, thanks. So, CCA actually has a designated member voice program, where we incorporate members who are interested in participating in development and the implementation of really all of our programs, including our clinical model. So, we'll discuss features of innovative clinical models, and they will, at the beginning of the journey, be giving input, suggestions to the end of the process and development of the program, where they're helping us to pick furniture and facilities and appropriate colors for the facilities.

In addition too, during the pandemic, as we pivoted to virtual care, they were helping us to test technology that would be appropriate for members and their peers. So, we really do incorporate our members who have identified as wanting to participate in helping us to evolve our clinical model, evolve our technology, and be involved in the facilities and programs that we're developing.

Laurel Ruesch: Great, thank you, Lauren. Jen, do you have anything to add there, based on your experience?

Jen Klopstein: Sure. Two times a year, we complete a member experiences care survey, and this is to randomly select the members who have been engaged in our VCare or intensive care management. That's something that we can get a lot of information -- what's working in our plan when it comes to our management, and that face-to-face interaction or telephonic as well, but also what isn't working.

And it's something that we actually review with all of our staff at least once a year, just to let them know kind of the temperature of those interactions, something else we're considering at the Consumer Advisory Committee, in order to incorporate the voices of our members into the overall strategy and decision-making process.

Laurel Ruesch: Thanks, Jen. This next question is for Tashau and Lauren. Tashau, we'll start with you. Do you have any best practices or strategies in your experience that have been beneficial in reaching out to caregivers in an effort to engage hard-to-reach populations?

Tashau Asefaw: Yes, thank you. So, for us, reaching out to the caregiver and sharing with them information, what is available, and highlighting the value of caregiver support services, like how that can support them in being a caregiver, we found that to be helpful. Also, a requirement to getting a signed release of information, so that we can continue to engage them in the plan of care and future interactions with the member.

Laurel Ruesch: Great, thanks, Tashau. And Lauren, I know you mentioned working with members who were unable to leave their home. Do you have any strategies for reaching out and working with caregivers in those situations?

Lauren Easton: Yeah, sure. So, I think obviously with member consent, we really incorporate caregivers into the treatment plan and into the members' treatment. So, they really are a part of the care team, so again, with the members' permission, the caregivers are really a part of the care team. We often do a lot of education with the caregivers around treatment intervention, thinking about symptoms.

They always have access to their care partners to give information. If our member does become symptomatic, whether that is through COVID or other complexities, medical or psychiatric illness, they always have access to our care partners to give that information.

In addition, we are very cognizant of caregiver burnout, so we really also try to incorporate different strategies for our caregivers to help them with caregiver burnout.

Laurel Ruesch: Great, thank you. This next question is around boosters, which is probably top of mind for a lot of folks right now. Lauren and Jen, can you both talk a little bit about now that boosters have been approved for everyone over 16, can you say a little bit about what your health plans are doing to reach out to hard-to-reach members and let them know about the availability of boosters, and help to support them in that way? Jen, we can start with you.

Jen Klopstein: We incorporate informative discussion with our members about how to get the vaccine, addressing hesitance, and encouraging the members to surround themselves as much as possible with others who are also vaccinated, just to protect that chronic illness vulnerability.

So, I think it's just a lot of encouragement that we do, and encouragement of the member to express their concerns about someone who may or may not be vaccinated being around them, or around their inner circle. So, I think it's just kind of creating that moment of thought for them, where they can kind of think about it and then approach it as they feel comfortable.

Laurel Ruesch: Yeah, that's great. Thank you, Jen. Lauren, do you have anything to add there?

Lauren Easton: No, I think we do very similar things, so much like our initial outreach around vaccinations in general, we really do utilize our health outreach workers, who have really good relationships with our members, or our care partners, to educate, reassure, talk through any anxieties or concerns that they have about the booster, and also give them more, hopefully, understanding of the variants and their anxieties around the illness.

Laurel Ruesch: Yeah, that's great, Lauren. One more question for you, Lauren. We had an audience member ask about how CCA has adjusted your approach in meeting members where they are during the pandemic. You had mentioned, previous to the pandemic, engaging members at local Dunkin’ Donuts, that kind of thing. Could you talk a little bit about how those strategies had to shift during the pandemic, and how you're meeting members where they are?

Lauren Easton: Sure. At the beginning of the pandemic, we did have to very quickly shift to virtual care, which again had come with its challenges, because our members were used to -- many of our very high-risk members were used to in-person visits and interventions. So, we did have to shift to virtual care. We did have a team, what we identified as a field team of clinicians and health outreach workers that volunteered to continue to go into the community with appropriate PPE, and we really focused on more high-risk folks.

But that could be medical complexity or psychiatric complexity. Additionally, our staff was able to conduct multiple phone calls per day to each member to ensure that they had connectivity to their team, as well as being able for us to do assessments over the phone and get the resources they need.

We had significant encounter data in terms of being able to work with people around food access, transportation, pharmacy needs, really good success in outcomes in terms of that connectivity with our folks that are typically very difficult to engage.

Laurel Ruesch: That's great, thank you, Lauren. Our next question is for Tashau. You had mentioned some of the support that your CHWs provide to members, particularly members who may be living with serious mental illness. An audience member had a question about if you provide any trainings on motivational interviewing, trauma-informed care, and person-centered language for your CHWs, and what that looks like.

Tashau Asefaw: Yes, thank you. So, we have had an external trainer come in and train everyone in care management on motivational interviewing, and some of us are also clinicians. Our CHW team is a team of non-clinicians, so some of us who are clinicians have also been trained, or have had training prior to that, like through continuing education.

So, we leverage the training for the whole staff, but one of the things that we do specifically with our community health workers, we regularly engage them in conversations and scenarios regarding using motivational interviewing tools, so that we can check for use and experience and ensuring that staff are comfortable using those methods.

For trauma-informed care, all of our work is trauma-informed. All of our work with members across teams and within our care management department, we're always thinking about what happened to you, right? Like, that's the foundation of trauma-informed care.

And again, through our teams, we have regular training and auditing processes to ensure that when we're engaging with members, like through our documentation and phone calls, that teams are operating within the context of our care. And for person-centered language, similarly, we do have regular trainings, kind of refresher trainings, practice scenarios, but sometimes it's role-play.

So, I would say it's a combination between those, just making sure that there's regular engagement, making sure that we're reviewing, checking, and rechecking for competency, practicing, and making sure that folks are able to apply licensed skills.

Laurel Ruesch: Great, thank you, Tashau. Lauren and Jen, this next question is for you. You both talked a bit about coordinating with hospital systems and kind of placing staff in hospitals to help engage hard-to-reach members. Can you talk a little bit about how you managed those relationships during the pandemic, and particularly maybe how those had to shift in light of surges in hospitals related to COVID cases? Jen, we can start with you.

Jen Klopstein: Sure. There was actually a surge shortly after we had returned to the field in July, and everybody was sent home from the office, everyone was back to that more telephonic-styled outreach, so that's something that we just kind of go with the ebbs and flows of what the protocols may be. And then once the numbers came back down, we started incorporating everyone that we could back into the field.

But of course, we just continually assure the hospitals that we are here to assist them, because that working relationship is really what makes not only the hospital successful in their readmission aspect, but also our members successful in their health and the outcomes of their health.

So, we just kind of reverted back to that fax, telephonic, secured email communication with the discharge planners, and maintained what relationships we had already established prior to COVID.

Laurel Ruesch: Thanks, Jen. Lauren, how about you? Do you have anything to add here, based on your experience in working with the system?

Lauren Easton: Sure. So, for our hospital-to-home program, our doctors, our CTA doctors are actually credentialed at the hospital. So, in fact, they were able to continue to work in the hospitals throughout the pandemic, in-person. However, our health outreach workers 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 emergency department, so as our patients entered, they were called or contacted to evaluate, assess, or they may know the patient, and so were able to do virtual consults over the phone, in combination with the care management departments at the hospitals, or the ED, or our CCA doctor, who was able to go in person.

I will say that that came with challenges. So, for our members who are so complex and going into the emergency department, having that face-to-face visit with the behavioral health clinician or a health outreach worker to determine their needs, their social determinate needs or behavioral health needs, was really important, particularly when they were in, perhaps, acute crisis psychiatrically, or anxious, nervous about going in terms of the emergency department for medical symptoms.

So, although we were able to pivot and manage throughout the pandemic with both hybrid or doctors in person and our other staff virtually, it did come with its challenges. We also have a transitions of care program that generally, our nurses are in the hospitals. That had to shift completely to virtual. They did not have access to hospitals. So, that was virtual care working with the inpatient units as well as the social work team and care management teams at the hospital.

Laurel Ruesch: That's wonderful, thank you for all that detail, Lauren, that's really helpful. One more question for you, Lauren. You had mentioned in your presentation that a lot of members that you serve have mistrust in the healthcare system, just based on their prior experiences. In your experience, do you have a sense for what types of information have been helpful to share with members in terms of gaining their trust and making them feel like the healthcare system is set up for them? Do you have any type of information that it seems like they need the most?

Lauren Easton: Yeah, thank you. I think so many of our members have experienced trauma in their past and are often re-traumatized when, in some systems of care, obviously never intentionally, but when they're getting their needs met, they may sometimes feel not believed or that they're med-seeking or that they're not heard when they're looking for care.

And so, oftentimes that is re-traumatizing for them. I would say from our perspective, as I mentioned in the presentation, that trusting, longitudinal relationship is so important for our members, and I think what we do is obviously always treating people with trust, with respect, thinking about dignity of choice, dignity of risk. It's really important to add immediate value to what their needs are and be reliable and predictable in that.

And so, if they're -- certainly if they're having a behavioral health crisis or medical issues but they say, "I'm hungry," helping them to get access to that food immediately, and then supporting all of their other needs. So, I think it's that immediate value that we can add to start building that trust, and then being reliable and predictable in their lives and continue to support them in a nonjudgmental way.

Laurel Ruesch: Thank you, Lauren, those are great points. Appreciate your perspective on that. I think that's about all we have time for in terms of our Q&A session. Thank you for everyone who submitted questions. There's a lot of great ones in the chat. But if you do have any additional questions or comments, please email RIC@Lewin.com.

Additionally, the slides for today's presentation, a recording, and a transcript will be available at the Resources for Integrated Care website shortly. And thank you again so much for joining us today. If you are able, please complete the brief evaluation of our webinar so that we can continue to deliver high-quality presentations.

And again, if you have any questions for us or the speakers today, please email us at RIC@Lewin.com, and follow us on Twitter for more detail @Integrate_Care. And again, big thank you to all of our speakers and to the audience and thank you so much for your participation today.