**The Lewin Group**
**Strategies for Health Plans to Support Access**
**to COVID-19 Vaccines for Vulnerable Populations**
**April 1, 2021**

Moderator: Ladies and gentlemen, thank you for standing by. Welcome to the Strategies for Health Plans to Support Access to COVID-19 Vaccines for Vulnerable Populations. At this time, all participant lines are in a listen-only mode, and they will remain so throughout the duration of this conference. Should you require assistance, please press star and then zero. I would now like to turn the conference over to Laura Maynard. Please go ahead.

Laura Maynard: Thank you, and welcome, everyone, to this webinar, Strategies for Health Plans to Support Access to COVID-19 Vaccines for Vulnerable Populations. My name is Laura Maynard and I'm with the Lewin Group. Next slide. Today's session will include presentations followed by panel discussion, and then a question and answer time with the panelists and participants. This session will be recorded, and we will be posting a video recording along with today's slides at the link you will see on that slide, ResourcesforIntgratedCare.com.

The audio for the presentation automatically streams through your computer, but phone lines are also available if you need one. You can access the number by clicking the black phone icon at the bottom of your screen. On the next slide, this webinar is supported through the Medicare/Medicaid coordination office at the Centers for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs.

To learn more about current efforts and resources, please visit our website or follow us on Twitter for more detail, @Integrate_Care, and you'll also find us on LinkedIn, and the link there is on the slide. On our next slide, we'll introduce to you all of the presenters and panelists that we'll be hearing from today.

We'll be hearing from Marvin Figueroa, who's director of intergovernmental and external affairs with Health and Human Services Office of the Secretary, and from Shelly Winston, who is a health insurance administrator in the Division of Part D Policy with the Centers for Medicare and Medicaid Services.

Then from our health plans, we are having a panel, and from CareSource we have Jennifer Anadiotis. Jennifer is the director of Integrated Care Post-Acute Strategy with CareSource. And also Dr. Beejadi Mukunda, who is the medical director with MyCare Ohio at CareSource. Then from the L.A. Care Health Plan we have Dr. Alex Li, who's the deputy chief medical officer, and Misty de Lamare. She's the director of communications there.

Next slide shows our objectives for this session as a result of attending this webinar. You'll be able to identify strategies to promote equitable access to COVID-19 vaccines, including effective collaborations with community partners. You'll also be able to describe how to use data to identify high-risk members and to target your outreach to encourage the uptake of the COVID-19 vaccine. And also to identify key considerations for effective communication and outreach strategies to increase vaccine confidence.

To begin, let's use a couple of polls to get an understanding of who's attending the webinar today. So, first we'd like to know which of the following best describes your professional area. Choose from one of the options that's listed and just click there which one best describes the professional area that you're in.

Are you a health plan case manager or care coordinator? Are you in customer service, are you health plan administration management, medicine, nursing, physician assistant, or other provider? Are you with pharmacy, social work? Which one comes closest to describing your professional area? So, we'll give you just a moment to click on those. Give you time to click so that we can then see the responses and get a feel for our group today, and who's represented.

All right, let's go ahead, then, and close that one out and see what we got as a result to that. So, almost half are health plan administration or management, followed by 27% that are health plan case manager or care coordinators. With a bit of other representation, a few of you from the other categories as well. Then our second poll that we would like to launch is asking what settings, in which settings do you work.

So, just pick one of the options provided. Are you working with a health plan, are you in an ambulatory care setting? Go right ahead and click on which one of these best fits. Home care agency, community-based organization, a consumer organization. Which one best fits your situation? And we'll give you a moment to click those, again, just so that we have a sense of who we're with today. Just a few more seconds to click on that.

And let's close out that poll and see what results we have from it. Almost all – 76% -- from health plans, with oh, a good 9% from community-based organizations, and then a few from long-term care. So, thank you all so very much for sharing in the poll so that we know who's in the group today. We're gonna next show you the outline of today's event.

So, following these introductory polls and a bit of introduction and comments, we're going to share some background information on equity and access to vaccinations, and what health plans can do to support that equity. Then we'll hear from our two federal speakers covering updates from the Department of Health and Human Services, and then also an overview of the COVAX data-sharing project.

Representatives of two health plans are then going to share their strategies related to promoting access to vaccination for individuals dually eligible for Medicare and Medicaid. And that's followed by a panel discussion with them. Then there'll be opportunity for you to ask questions and to share your ideas with each other.

To get you started on that sharing of ideas with each other, on the next slide we want to encourage you to use the Q&A box, not just for questions to our presenters and panelists, but also for your comments and responses. So, if you have a question for someone who's speaking, put that question right there into Q&A. And if it's for a particular presenter, put their name in front of your question so that we'll know exactly to whom we should direct that question.

But now we'd like you to go into that Q&A box and answer this question. How is your organization promoting equity in access to COVID-19 vaccines? Just enter what your response, what your organization is doing to promote equity. Put that in, and we'll have a chance to share some of these ideas out with the group verbally once you've entered them.

So, we appreciate you going ahead and typing that right on into Q&A as we move on forward with our presentation. So, on the next slide, just a bit of background information. The COVID-19 pandemic is disproportionately impacting dually eligible individuals, racial and ethnic minority groups, and people with disabilities. CMS data indicates that COVID-19 cases are about two and one-half times more likely among the dually eligible population than other Medicare beneficiaries, and that hospitalizations are approximately three times more likely for that group.

Dually eligible individuals across demographic categories, whether it's race, age, sex, disability, other categories, these folks have been hospitalized with COVID-19 at a considerably higher rate than their Medicare-only counterparts in the same demographic groups. Dually eligible individuals face unique barriers to COVID-19 vaccination, and this is due to the prevalence of complex health issues or chronic conditions, and also unmet social risk factors.

Many dually eligible individuals contend with multiple social risk factors; things like food insecurity or homelessness, lack of access to transportation, and low levels of health literacy. Many of these factors are worsened for those with a disability. For example, dually eligible individuals with a disability are more likely to cite a lack of transportation as a barrier to receiving care than those without a disability.

On the next slide, let's think about how health plans can support vaccination and equitable vaccination. Health plans actually play really critical role in supporting this equitable distribution of the COVID-19 vaccine, and some things that you can do are engaging with your members. Discuss their questions, their concerns on COVID-19 vaccination, and to include the engagement of your consumer advisory committees.

Also, analyzing data to inform your actions. Using data to monitor which members have received vaccinations and collecting data on COVID-19 outcomes, and that data being stratified by gender, race, ethnicity, preferred language, disability status, and other demographics.

Health plans are encouraged to utilize data you may receive from multiple sources. CMS data, if you're a Medicare plan, state Medicaid agencies, state vaccine registries, your health plan's own data collection -- use all of that to inform your actions. Another thing health plans can do is to learn from one another, to better understand best practices and actions, things that are already happening for targeting vaccinations.

And also focusing on cultural competence, utilizing the CDC resources and other resources that are out there for accessible messaging in multiple languages, and partnering with local community-based organizations.

On the next slide, the executive order that was signed January 21, 2021, is to address the disproportionate and severe impact of COVID-19 on communities of color and other underserved populations. This executive order establishes a COVID-19 health equity task force within the Department of Health and Human Services to provide recommendations for strengthening equity data collection, reporting, and use related to COVID-19.

For assessing response plans to determine if resources such as PPE and tests and vaccines have been or will be allocated equitably. Modifying plans and policies to advance equity. And partnering with states, localities, tribes, and territories to explore ways to provide greater assistance to people experiencing disproportionate economic or health effects from COVID-19.

So, that provides a little bit of an overview and a little bit of background information, some framing. But now, I'm very pleased to introduce our first speaker. And so on the next slide, I'd like to introduce Marvin Figueroa. He's the director of intergovernmental and external affairs with the HHS Office of the Secretary. So, Marvin, I'll turn it over to you.

Marvin Figueroa: Thank you. And thank you for the opportunity to speak with you all today about the work to reduce barriers to COVID-19 vaccinations. The entire US government family is dedicated to making sure that every American that wants to get a vaccine has access to one. As of yesterday, there have been more than 195,500,000 vaccine doses delivered, and close to 150,300,000 administered, and that number has surely ticked up at least by one, with me having gotten my vaccine early this morning.

In terms of percentages, this roughly equates to 29.4% of the population having received at least one dose, and 15.4% of the population is fully vaccinated. Those numbers are even more impressive when considering the percentage of the population of 65 and older, with 73.5% of that population having received at least one dose, and 50.8% fully vaccinated.

But we're not stopping there. President Biden has set a goal for us to reach 200 million doses administered by his hundredth day in office, and we're 66% of the way there. Through the Health and Resources and Services Administration, the Biden-Harris administration is accelerating the delivery of vaccines to underserved communities and

disproportionately affected populations through direct allocations to federally qualified health centers.

That, as you know, serves high proportions of low-income and minority patients. These centers provide services to rural, frontier populations, operate tribal urban Indian health programs, and/or utilize mobile vans to deliver services. In addition, just this week, the president announced expansion of vaccines to 20,000 more local pharmacies, bringing the total to nearly 40,000 pharmacies across the country.

This means that by April 19, there will be a vaccine site within five miles of 90% of all Americans. He also launched a new effort to get the nation's most vulnerable and at-risk seniors and people with disabilities vaccinated, expanding senior and disability services to provide the high-intensity assistance needed to get these individuals scheduled for and transported to vaccinations.

We continue to allocate tens of millions of doses each week to states, existing federal pharmacy partners, and federal agencies to vaccinate both the federal first responders and to deploy in mass vaccination sites, and continue to support the responsible jurisdiction with funding for logistics, supplies, and educational programs.

As was presented at the beginning of this presentation, equity is at the heart of our efforts. We know a person's ZIP code is a strong driver of health. We will continue to prioritize getting the necessary resources to those areas and communities that have been hardest hit and are highest risk.

So, why are we here, and how can health plans help? I wanna second most of what was said at the beginning, but I wanna give you some additional. We know that 12.2 million dually eligibles, this population is low-income, over the age of 65, or disabled. This means that the dually eligible population spans young and old, as well as individuals with physical, mental, and developmental disabilities. Communities of color are disproportionately represented within this population.

You understand this constituency better than most, and you know that because the dual eligible population is not homogenous, their unique circumstances and needs must be considered when developing vaccine strategies. Help us develop and execute those strategies so that we make sure that we increase the rate of vaccination in our communities.

Second, continue to promote getting the vaccine through your normal channels. There are toolkits available on the CDC website, and our office is happy to also collaborate with you on messages that you might need. Third, today the vice president launched a Community Corps program, an HHS initiative to galvanize trusted messengers to increase confidence in COVID-19 vaccines, and encourage measures to slow the spread. If you're interested in becoming an ambassador for getting people vaccinated or help us leverage existing messaging to encourage dual eligibles to get vaccinated, partner with us.

Finally, we are beginning to think critically about how we as a society share certified vaccine credentials as more people get vaccinated. There are ongoing conversations at the White House and the department, and we welcome thoughts that you may have on secure, interoperable solutions.

There's a lot going on, so I'll end it there. But I hope that the message that you're receiving from us is that we welcome your ideas, we wanna partner with you, because we know that we're all in this together. With that, I open up the floor for questions. Thank you.

Laura Maynard: Thank you so much for that great information, and we have a few questions that have come in. First wanted to ask, we've heard that the administration is increasing access to COVID-19 vaccinations through the federally qualified health centers and dialysis centers Can you say a bit more about that?

Marvin Figueroa: I can. Well, the administration is working to ensure that vaccinations are brought to the communities rather than just having communities come to the vaccine. So, we're working to increase the vaccination rates for some of the most vulnerable communities, which include populations that are served through FQHCs and dialysis centers.

So as you know, over 91% of the health center patients are individuals or families living at or below 200% of the federal poverty guidelines, and nearly 63% are racial and ethnic minorities. So, since the launch of the program and the partnership with FQHCs, we have invited over 950 health centers to participate, and by participating, they receive direct allocation from the federal government.

Additionally, the dialysis center effort is another important step in making sure that vaccines reach the most medically vulnerable communities, and that equity continues to anchor our efforts to end COVID-19. So, why dialysis centers? People on dialysis who contract COVID-19 often have severe adverse health outcomes.

Half require hospitalizations, and 20% to 30% die from COVID-19. And so dialysis clinics provided trusted innovative pathways to help COVID-19 vaccines reach populations that have disproportionately been impacted by the pandemic.

Laura Maynard: Thank you. Also, how are you all working with tribal governments to ensure access to COVID-19 vaccines?

Marvin Figueroa: So, that's a great question, and recognizing tribal sovereignty and the authority of tribal nations to provide for the welfare of their people, the federal government supported how much vaccine should be allocated for individuals via tribal and urban Indian health program sites, collectively known as ITUs.

So, the IHS vaccine plan and distribution strategy aligned with CDC recommendations, with advice from the CDC advisory committee on immunization practices for priority populations. However, tribal nations also had the sovereign authority to determine their own priority populations.

So, ITUs sites coordinate with their local IHS vaccine point of contact to determine their vaccine allocation and ordering, and the IHS vaccine task forces and CDC vaccine task forces communicate regularly to ensure coordination and delivery of equitable vaccines to ITUs.

Laura Maynard: Thank you. And a question came in related to one of the comments that you made about partnering with HHS, and one of our participants has asked how do they do that, how can they partner with HHS in these efforts.

Marvin Figueroa: So, many different ways, and much of the responsibility of my office is to ensure that we are listening to individuals who are doing the work in order for their experiences and their insights then inform the work that we do. So, I'm not hard to find, but I'll still tell you my email here.

So, it's Marvin.Figueroa, which is my last name, @HHS.gov. And we welcome your input, and if I don't have the answer, or -- I'm happy to connect you with someone within the department that has the answer, and kind of work through whatever recommendations you may have on how we can improve outreach and ensuring that this population gets vaccinated.

Laura Maynard: Thank you. And that makes me think, in that listening that you mentioned, what are some of the innovative approaches to advancing equity in access that you've heard so far? What are some ideas that maybe are new ideas or somewhat more innovative ideas about advancing equity in access to the vaccine?

Marvin Figueroa: So, what I mentioned earlier, I mean, even when you look at the dialysis program, that is a conversation that came about from the outside in. And we were able to operationalize it, so that now it's an actual program. So, that is an example of us listening to what's happening on the ground, and then working internally to make sure that we can operationalize it and it works as intended.

We're also hearing more about the data that you mentioned earlier that is available to the health plans, and trying to figure out how do we use that data to do exactly what I mentioned as well, which is not wait for people to come to the vaccine, but bring the vaccine to individuals. And we have several different proposals that we're considering right now, and trying to figure out how to make it work.

Laura Maynard: Excellent, thank you so much. And one more question that has come in through the Q&A from a participant wanting to know about the ambassador program that you mentioned. Could you talk a little more about that, and share a little more about the ambassador program?

Marvin Figueroa: So, the program that we launched earlier today. Around 11:00 the vice president launched the ambassador program, Community Corps. And the idea behind it is that, in order to increase confidence in the vaccines so that individuals take the vaccine whenever it's offered to them, it requires us not only to work in government to make sure that our messaging is consistent, but also work with trusted messengers to make sure that individuals are receiving multiple communications.

And so, we're developing toolkits, we're working on social media ads, we're working on ads themselves for television, but also working with partners to ensure that whatever information we make available, that those partners are able to translate it so that it reaches the intended population that they serve.

And so, if you email me, I can direct you to kind of the website that we recently launched, where you're able to sign up for updates and you'll get additional information on how you can be involved, and how you can be helpful in this effort.

Laura Maynard: Thank you very much for sharing this great information, for sharing this very current update. We appreciate it. In the interest of time, we're gonna move on along with our presentations, but we're very grateful for your information, and thank you so much for answering the questions that have come in

Marvin Figueroa: Thank you.

Laura Maynard: At this time, I'd like to introduce our next speaker, Shelly Winston, who is the health insurance administrator with the Division of Part D Policy with the Centers for Medicare and Medicaid Services. Shelly?

Jennifer Anadiotis: Thank you, Laura. What an uplifting message that we got from Mr. Figueroa, and I'm just so happy to continue to speak about what CMS and HHS is doing. So, next slide, please.

So, I've been asked to give a brief overview of the COVAX project, which is the project through which CMS shares COVID-19 vaccine data with health plans. And we're going to go over how it came to be, who's using it, and give some hint of the data that we can get at this point and discuss next steps. Next slide.

So, what created the need for the COVAX project to begin with? So, generally Medicare plans would have vaccine data for their enrollees, because they pay the claims. But in the case of the COVID-19 vaccines, CMS determined that the government had already paid for the vaccines themselves, and that we would pay for vaccine administration through the Medicare administrative contractors, or MACs, and the claims would therefore not go through the plan's usual claims payment system, but would come to CMS.

And so, while plans were happy about that when this was announced in late October of 2020, plans came to us and sought a way to play a more active role in helping patients get

vaccinated, and they asked for data on their enrollees. So, CMS wanted to respond to those requests. Next.

So, when designing the project, we wanted to make the vaccine data available to plans, and we wanted to get the data that was processed through the MACs and map each vaccine to the appropriate beneficiary and Medicare plan. And we also wanted to present that data in a secure portal, or perhaps we considered an API that would be available to plans for data and sharing, where authorized representatives could receive the reports.

And on the back end, which plans don't see, we wanted to perform various analyses, as needed. We also wanted to assimilate pharmacy transactions into the flow. Why? We knew the critical role that pharmacies would play in administering the vaccines. In addition, pharmacy data is processed in real time and in a standard format.

The standard format is the NCPDP, National Council for Prescription Drug Plans, and all pharmacy transactions throughout the country use that same format. So, when we looked at all these factors we thought that we should use an existing portal because time was of the essence. And the ABII -- A-B-I-I, as in Dear Abby -- ABII portal was already being used for plans for different purposes, and people were familiar with it, and individuals were already credentialed. So, we thought we would try and leverage that existing tool. Next.

For those of you who are visual, here is how the system looks. So, if you look and you see the providers, all the Medicare claims, including those for MA/MAPD, PACE plans, go through the MAC for payment. Then we would process those and then send them to this ABII COVAX portal, clients would log in and access the data.

And this is certainly a viable model. That's pretty much what we're doing now. But timing considerations were important, because we wanted the plans to get the most contemporaneous information possible. And keep in mind when we used data that was from the MAC, we wanted to use the data that was accepted on the front end rather than waiting for the claim to be adjudicated in the interest of time.

But what we still missed was the speed that pharmacies use in processing transactions. So, all of us who have been to a pharmacy know that pharmacies communicate with payers in nanoseconds. So, you leave the pharmacy with the drug, no additional invoices are forthcoming. So, we wanted to look at how to leverage that standard transaction and the speed that came with it. Next.

To put a little bit of skin on those bones slide-wise, just to orient you, on the left side of the slide we have a summary of how many days exist before a claim appears in our data. You can see the NCPDP, the pharmacy data, the great majority, over 85% of that data is seen within a day of date of service, whereas the second column, which is just claims received by the MAC, just received, you can see that in the second column.

And the third column is those claims that are adjudicated. So, you can see that there is a substantial advantage to using pharmacy claims, and unadjudicated, I'd say yet to be adjudicated, other Medicare claims. Next.

So, to leverage the speed that goes with pharmacy claims, here's what we did. So, if you look at the left side, you see the pharmacy, Rx, NCPDP transactions, and each pharmacy has a pharmacy switch. This is standard infrastructure that pharmacies have. And the switch, the sole job of the switch is to route the claim to the right payer

So, we have the pharmacy switch routes the claim to the MAC -- this is always for payment. But we also went to the switches and said, you know, can you send us a copy? Our contractor, Relay Health, would then send that pharmacy claim within hours to CMS. And therefore, we have pharmacy claims to process, to analyze, within hours.

And we've never used pharmacy claims in this way before, but of course I think we all agree these are extraordinary times, and that's through this system. We now have data for purpose of analysis within hours, which is, of course, quite useful. But we also thought that we could do better in terms of meeting health plan needs. Next slide.

So, this slide shows we did exactly the same up-front process. So, a claim is processed, one copy is sent to the MAC and billing takes place. Another copy is sent to Relay, just in the other model, but Relay Health sends a zero-dollar claim directly to the plan. That routing and that claim is available to a plan within seconds.

So, the next question is plans are now using all these data, so next, please. What are they doing with it? We can confidently say that the majority of Medicare plans are downloading the reports, and plans attest that they need the reports to coordinate care and improve the health and wellbeing of their enrollees. Next.

The data does have some limitations which we really have to acknowledge. One, there can be duplicate claims. From the sides that I've shown you, I'm sure you can imagine that a pharmacy claim is received directly from Relay Health, but then goes through the payment process of the MAC, so we're better at de-duplicating those instances, but of course there's still duplication.

And also, neither CMS nor plans receive data on Medicare beneficiaries who are vaccinated at some mass vaccination sites. That is a limitation. And the other issue is that though we do calculate a plan vaccination rate, we realize that there's some limitations, because comparisons of vaccinations between plans are so dependent on many other factors, including the supply issues, the state in which they live, and so on. Next.

So, there's been some analysis of this, and this is from a not-for-profit Surgo Advisors, and it's now being used by the CDC. And it really says that -- it indicates that it captures 28 supply-and-demand factors, and it tries to attribute how difficult might it be within a state or even with a ZIP code to get a vaccine. They looked at historic under-vaccination, sociodemographic barriers, health system constraints, health accessibility barriers, and so

they developed this approach just to say each area's different, and we have to approach every single patient in a different fashion. Next.

So, initially, plans said that they needed this data for care coordination or care improvement. What now? We know that many plans use the data in a very passive sense. Nice to have, they use it in some ways when messages come in to the call centers. But really what we want to focus on and I think this whole seminar is about is beneficiary messaging and active engagement. Next.

We are starting to look. From a CMS view, we're beginning to compare data from fee for service beneficiaries to Part C, and initially -- and this is very early data -- it appeared that fee for service beneficiaries, which are represented in blue, have a higher uptake in vaccines for the first and second doses than those enrolled in Part C plans. But we don't believe this is gonna hold, and we continue to do charts and analyses like this. Next.

Similarly, we also see some patterns for dual eligibles. They seem to get fewer first doses, but seem to be better off on the second doses. Again, we're looking to see what patterns hold, which plans impact these dynamics, and there will be more to come. Next slide.

Now, this slide represents a critical concept. The data is from, again, from Surgo Advisers, but also updated with Kaiser Family Foundation. So, looking to the right, we have the skeptics. Those are the ones that will take much longer to convince, and we're just gonna let them stay aside for now. We're gonna continue to counter misinformation, but let's focus on the orange and the blue bars.

So, the orange represents a vaccine enthusiast. These are the people who are beating down the door to get vaccines, and of course the approach is to make it as easy as possible, and provide logistical support, bring vaccines closer, and so on, but the persuadable.

So, we're seeing a movement from the persuadable to being persuaded, and now they're the vaccine enthusiasts. So -- and their attitudes can be different. It's not one group, one attitude. There's some that we're watching to see how these vaccines fared. There's cost-sensitive, and we might wanna dismiss that and say what are you talking about, it's always free.

Well, that may be true, but you have to get to the vaccine site, you have to take time off, you may be concerned that if you're feeling ill after the vaccine you won't be able to work at an hourly job. And all of those areas need to be addressed. And then there's the distrustful. So, our goals, really, are to change the persuadable to a vaccine enthusiast, and give them the support they need.

In addition to a proactive approach, I'd also like to suggest that some good strategies I've heard about do not end in the vaccination itself. Studies show that some enrollees are socially motivated. So, looking at peers being vaccinated is good, but it also might be

effective if a vaccinated individual is shown to be playing with a grandchild or resuming their bridge games. So, it might be more motivated not just getting the vaccine, but seeing the impact in their social spheres. Next.

So, what is CMS' -- what are our next steps? Well, we continue to add sources of information available to health plans. A lot is under consideration. And behind the scenes we continue to stratify by groups, by demographics, by location, and of course part of what we need to do is monitor best practices, and of course this seminar is all about that. And thank you very much.

Laura Maynard: Thank you, Shelly. We appreciate it so much. Participants, as you are typing in questions for Shelly, know that we will address those a little later in the webinar. We have a time designated for Q&A, and we will raise your questions for her at that time. If you have other questions for her, please go ahead and be typing those in to Q&A, and we'll surface those during the Q&A segment.

But we also want to hear from you. How are you using this data, and what other data do you use to identify members for specific outreach? So, let us know in that Q&A box how you do that. You had responded previously to our earlier question. Some great ideas have come in. We'll mention some of them a little later on, but some, I think, were really just very, very interesting.

Ideas like running a volunteer opportunity, where you'll be taking mobile vaccination clinics, taking buses into underserved areas for vaccine distribution. So when we are looking at how are you promoting equity in access, taking it to the people rather than expecting the people to come to the vaccines, doing that through mobile units and buses.

Also had mentioned having care managers who have been contacting your members to assist with scheduling, to identify access sites, and to identify any barriers to assist as needed, and that you're sending mail-outs and adding resources to your member website landing pages.

So, just some of the multiple ways that you've suggested that you are addressing the issue of equity in access to vaccines. Now, type in there for us as well how you're using the data that's available to you, and which data you're using. And as you're doing that, we're going to move on ahead and hear from a couple of our health plans.

So, first, on the next slide, we will hear from CareSource, and I'm happy to introduce our presenter, Dr. Beejadi Mukunda. He's the medical director at MyCare Ohio with CareSource.

Beejadi Mukunda: Thank you, Laura. Good afternoon, everyone. My name is Beejadi Mukunda. I'm the medical director for MyCare. I am also in the part-time currently actively practicing internal medicine, and I have been serving many of the members that had COVID. I am now very happy to be involved in the vaccination effort. Next slide, please.

Now, at CareSource, our mission is to make a lasting difference in our members' lives by improving their health and wellbeing. We are a nonprofit health plan and a national leader in managed care. We have over 30 years of history of serving lower-income populations across multiple states and multiple insurance products. Currently we have over 4,500 employees located across 40-plus states, and we have multiple products and a total of over two million members. Next slide, please.

Our service area includes these states -- Georgia, Indiana, Kentucky, Ohio, and West Virginia, and Ohio is the largest member population that we serve among all the states. Next one, please. Under MyCare Ohio, under CareSource, we have dually eligible members, and the program serves people that have Medicare and Medicaid.

The participants in this program are about 30,000 members, and each of these members are case-managed. The CareSource provides person-centered integrated care model approach for this population that have many complicated healthcare needs. And we have the case managers that are actively involved in education and discussion with the medical directors, and we have an open-door policy for medical advisements and interactive sessions any time that's needed. Next slide, please.

We have multiple efforts to improve the vaccination among our members, and this is a snapshot of the major highlights. In terms of education and advocacy, we are focusing on health equity. We have been reaching out to the members that are hard to reach and hard for them to have access to the healthcare services.

Vaccination appointment scheduling and reminder assistance are provided by the case managers. We have multichannel communication with members, providers, and staff via phone, email, text, mail, and various social media. We have developed multiple community partnerships, working with FQHCs, local health departments, community-based organizations, and the major health systems.

We have a CareSource volunteer program where over 200 of our case managers and other professionals from the organization are volunteering through medical reserve corps with multiple local health departments and health systems, and they're supporting vaccination clinics -- not only the mass vaccination clinics, but we are also getting involved in mobile vans.

We are expanding transportation benefits for our members, and we are also coordinating with Area Agencies on Aging to provide case management. We are using the analytics. As was pointed out, we do use COVAX dashboard. We also get very interactive data from the healthcare providers, the large healthcare systems such as Cleveland Clinic.

They have been providing us data about the members who have received the vaccine, and that helps our case managers to provide assistance setting up the second vaccine doses. We are using various reporting tools to aid outreach to the members that have multiple complex healthcare needs. Next one, please. Thank you.

Laura Maynard: Thank you, Dr. Mukunda. We appreciate that. And now I am happy to introduce Misty de Lamare. She's the director of communications at the L.A. Care Health Plan. Misty?

Misty de Lamare: Hello and good afternoon. Thank you for having me here today. As Laura mentioned, my name is Misty de Lamare. I'm the director of communications at LA Care. Next slide, please.

So, LA Care is an independent public agency and we were created to support low-income residents in LA county. We're actually a hyper-local health plan, so we serve exclusively LA county residents, and we currently have more than 2.3 million members, which is around one out of every four Angelinos is covered by LA Care. We have four different product lines -- MediCal, which is Medicaid at the federal level, is by far our largest.

Within MediCal we do have dually eligible members. We also have our Cal MediConnect program, which is the duals demonstration pilot at the federal level. And we have a little more than 18,000 members in that product. We have our LA Care Covered product, which is the ACA exchange product.

And then we also have our PASC-SEIU plan product, and this is interesting -- these are the IHSS workers. So, this is an interesting opportunity where we provide health coverage to individuals who support our Cal MediConnect or our dually eligible members. So, there's a lot of great opportunity there. And we are dedicated to providing access to healthcare for these members and their communities, as well as supporting the safety net required to achieve that purpose. Next slide, please.

So, at LA Care, our goal is to really be a trusted source of truth for our members and their communities around the vaccine, and we are aiming to build trust in the safety of the COVID-19 vaccine. We are aiming to dispel common myths, share facts about the vaccine's safety and availability so that our members can decide to get the vaccine. We want to provide reliable information that is respectful of the communities that we serve, as well as help them make informed decisions regarding getting vaccinated. Next slide, please.

So, how are some ways that we're doing that? Through a lot of targeted member outreach. Our messaging and tactics are rolling out in alignment with the phases of the state and the county public health departments regarding in California, there were several tiers and target populations that have been identified in a different -- a variety of ways.

And so we are ensuring alignment with our local public health departments, and we've also established an internal vaccine command center to centralize and coordinate our various communications and outreach efforts. And so that is something that we have found to be very successful. It's a very successful model, where we have key subject matter experts from different departments and different parts of the organization who come together on a regular basis to ensure alignment of our messaging and our outreach.

As our colleagues at CareSource mentioned, we also are supporting and hosting COVID-19 vaccine clinics across the county, and we have also expanded our transportation benefit to ensure that our members can have access to and from walk-up clinics. So, we use a rules-based identification system for large-scale community and member outreach, and this includes the utilization-based diagnostic information and machine-learning modeling to stratify members by risk for COVID-19 severe illness.

And it allows clear identification and encourages the individuals at the highest risk for severe COVID-19 experiences, it allows us to reach out to them and help them get educated to get vaccinated. Next slide, please.

Laura Maynard: Thank you, Misty, I appreciate it. And that's very helpful information from both of our health plans today. Now we're going to move into panel discussion time. So, representatives from both of the health plans are going to respond to some questions, have a little bit of dialogue, share a little bit more detail. So, we're really looking forward to that.

Also wanted to continue to say, type into that Q&A box if you have questions for the panelists or presenters, or if you have comments on how you are approaching this in your organization. Please put those in, and as we move into more discussion time now, we'll be reading more of those out.

So, next slide, please. Let's begin our panel discussion with our first question. Our first question is about challenges -- what challenges around vaccine access and uptake are you seeing, especially related to the dually eligible population? And so on that first question I'll turn first to CareSource and call on Dr. Mukunda to answer this one.

Beejadi Mukunda: Oh, thank you, Laura. Initially for the dually eligible members, the main issue was access to vaccine was the availability of the vaccines themselves. But now as the vaccines are becoming more readily available, what we are finding is that these members have difficulty either registering or getting an appointment close to home.

Maybe this is due to lack of technology or lack of comfort with the available technology, and here, our case managers are able to help. In terms of the transportation of members that are homebound, there are various efforts to address those, including some of the larger healthcare systems that are directly reaching out to the members, and they are communicating with us, and we are collaborating with the healthcare systems.

In terms of the uptake, vaccine hesitancy is real, and what we have found is education is really what moves the needle here. Not only the education of the members, but their support system. Their caregivers, their trusted healthcare providers, and improving the access and vaccination of the supporting caregivers and the healthcare personnel is helping us to improve the uptake among these members. I'll turn this over to you, Laura.

Alex Li: Laura, this is Alex Li from LA Care. I'm happy to chime in and add to Dr. Mukunda's comments about addressing vaccine equity. I think first off, I just wanna thank CMS for having us on the panel today, and I just wanted to also acknowledge that we just had our one-year anniversary with the pandemic, unfortunately. To begin with, I think this pandemic really showed what we can do as a community in terms of being humanistic, having kindness, empathy, and working together.

It also kind of displayed a lot of the ugliness around health disparities and inequities. And I think that kind of evokes, I believe, a sense of range in terms of values, whether it's anger, injustice, or be inspired by a need to do good. I think these are all value systems we can tap into to really kind of create a culture to address inequity.

I think -- and that's just to highlight. I think -- another point I think Dr. Mukunda and I both as practicing physicians kind of saw was that initially, we had a crisis with care or resources of ICU and vent machines, but really, I think as we're now moving into it's now a little bit more out of crisis and getting the vaccine into arms quickly and equitably, and really try to end this pandemic.

So again, I think just to highlight some of the things I think many of us here experienced besides the vaccine shortage is that we saw clearly people of color communities, low-income communities were hit especially hard with COVID. There was issues around initially, very much so, with how the vaccine scheduling system was designed here, at least in California.

It was very much a web -- internet-based system, where navigating and access to Internet really dictated one's ability to get the vaccine or schedule for a vaccine and thereafter get the vaccine. We also noticed that -- and I'm just using California and LA as an example -- most of our vaccine sites initially were drive-throughs. So again, this particularly impacted people who are disabled, homebound, or people who experience homelessness.

Obviously, if you don't have a car, going through a drive-through will be very difficult. Or if you're in a wheelchair or immobile, you know, making sure you had the right vehicle to get there would be critical. Again, I think to further highlight, I think, some of the points that were raised, we definitely need to make sure that as a health plan we're connected to the right stakeholder group or workgroup or participate in a way I think that's value add.

So, again, the way we kind of thought about it is that we have our staff members participate at a state level with the California Department of Public Health, at the local level, with Department of Public Health. We also lead and coordinate and collaborate with our other local health plans in LA county to make sure that we're all aligned and amplifying public health messages, as Misty mentioned.

Making sure that we have reliable and trusted information will be critical. We really believe that the first 50% or 60% of the people who are dosed who are anxious to get the vaccine, they were ready. It's really the next 30% that are more the vaccine-hesitant

individuals that we have to be really pushing that and making sure that message is accurate and truthful, evidence-based and urgent, so that people are ready when their turn comes up.

And finally, I think as we have seen, now that the eligibility criteria has expanded across, at least in California and many -- whatever many other states, it's really no longer about segmenting the populations, perhaps, by race, economics, or geography, but it's really ensuring that there's continued equity and equitable distribution of the vaccine across the different sectors of our community or geography of our community.

And that really takes good data and real-time data, as our CMS partners have clearly identified as a need. So, I'll pause here and I know there's many other questions, there's many other things for us to say. But Laura, I'll turn it back to you.

Laura Maynard: Thank you so much, Dr. Li. That's a lot of really good, helpful information, appreciate it. I know that some of the comments that have been typed in by participants also speak to some of the points that you and Dr. Mukunda have made when we talk about the difficulty of accessing appointments, and not everyone being able to have easy internet access, or not easily navigating that.

A couple of the folks that typed in had indicated that they're having their case managers and their care coordinators and really giving hands-on help to their members in getting registered and following through to get them to those vaccination appointments. So, looks like a lot of the plans that are on the all are also participating in some of these same activities that you all are mentioning and addressing the challenges.

On the next side, we're going to jump to one of our next questions, and this has to do with what was mentioned about hesitancy is real. And as you open up more categories, as the vaccine becomes more available to more people, there also is that issue of how are we going to address vaccine hesitancy. So to begin the responses to this one, I'm gonna turn to L.A. Care and ask Misty to respond to this one first.

Misty de Lamare: Sure. So, we have data from the larger health systems in LA county as well as from our own research of our member population that show about 20% to 30% of healthcare staff have chosen not to get vaccinated, even though the vaccine was readily available to them very early on.

And similar, we've seen anecdotal information from the local health department and long-term care facilities that about 20% to 30% of their staff chose not to get vaccinated. That's really in alignment with a lot of the other data that we've heard today. So, all this information shows that there is a certain amount of vaccine hesitancy that we are really going to have to address.

So, we have not only been focusing on our LA Care members and their communities, but we've also created a web page for our providers, to encourage them to get vaccinated when they are eligible. And we are sharing information on that website, including an

upcoming CME credit training that we'll be doing around vaccine hesitancy, health advisories, and, of course, the all-important billing FAQs.

So, we're trying to make that, like, a one-stop source for our providers to get all of their vaccine-related information. And for beneficiaries, as Dr. Li mentioned, we are leading a county-wide collaboration with five other health plans. This includes hospitals, the county health department, and this group is coordinating messaging and education around vaccine hesitancy, including we are close to completion of three educational videos that will discuss the vaccine.

One of those videos is going to address common myths of the vaccine, one of those vaccine videos is going to talk about the two different types of vaccines and how they were made, essentially. This is based upon the research that we've done that shows that our members and others really want to have clear information that they can feel confident in the vaccine.

So, LA Care is going to be sharing those videos with the public on YouTube, on our websites and social media. We're also gonna be sharing it with other health plans and allowing them to co-brand the video, and then they'll be able to share it with their audiences as well.

So, this is really kind of a county-wide effort that we are leading, and the videos are gonna be available in English, Spanish, Korean, Mandarin, and Kumai. We also did a survey of our consumer advisory council members, and are going to be using the results to inform our vaccine messaging, particularly our vaccine hesitancy messaging, and we are also, for our LA Care employees, we have a regular Friday COVID Q&A session with our chief medical officer, or with Dr. Li, our deputy chief medical officer.

And we typically have more than 300 staff who attend regularly, so we're trying to ensure that all of our various audiences were able to address their vaccine hesitancy questions.

Laura Maynard: Thanks, Misty. And can you, for just a quick follow-up question, can you tell us a little more about those weekly Q&A sessions? What are some of the topics that have come up, and what sort of results are you seeing from those?

Misty de Lamare: Absolutely. So, those have been a really fantastic way to hear directly from our employees what their daily concerns are. And we started those pretty much as soon as the pandemic hit, and we have monitored them over the course of the past year in terms of whether or not we felt like they were still adding value.

And we do assess them, and we have determined that they continue to add value because individual employees are hearing the same confusing messaging that those in the community are. And so, this is a way for us to address those questions, address those myths, and really address the concerns that people have about themselves and about their own families and their own current situations.

And so we have found them to be very successful in really providing accurate information to our own employees, who then can feel confident in their communication with their families and with our members and with others.

Laura Maynard: Thank you so much, really appreciate that. And now to turn to CareSource for this question. Dr. Mukunda, could you tell us a bit about how CareSource is addressing hesitancy among your beneficiaries, staff, and providers?

Beejadi Mukunda: Oh, sure, thank you, Laura. So, the members that are in long-term care facilities, as Mr. Figueroa mentioned, one of the major trusted voices for the members are the healthcare workers. And what we found in Ohio, just like in the rest of the country, only 30% to 40% of the healthcare workers are getting vaccinated.

We also found that increasing the vaccination among the healthcare workers does help to increase the vaccine among the community members. And one of the recent surveys shows that compared to December of 2020 and March of 2021, the amount of trust that the community has as trusted voices for healthcare workers has actually gone up.

So, we focused a lot of the effort on educating the long-term care healthcare workers to get the vaccinations. We had a roundtable with the long-term care leadership to understand what exactly is the hesitancy there, and it turns out that a lot of the hesitancy among the healthcare workers in the long-term care space is around the fertility, pregnancy, lactation, and the effects of the vaccine on those.

And to address that, some of the leaders had webinars or town halls which included fertility experts, infectious disease specialists, primary care physicians, and pharmacists to address the questions and answers, and to educate the healthcare workers to understand the benefits of the vaccine. And we are now moving that to the statewide effort.

And in terms of the members that are at home, they're improving the communication and education to the caregivers and their support. It's really helping to address the vaccine hesitancy, because there, a lot of the members are having concern with their other medical problems and other allergies, where involving the supporting caregivers and communication with the primary care physicians, along with the education from the case managers who have a longstanding relationship with the members. These are helping to address the vaccine hesitancy.

Laura Maynard: Thank you. Thanks very much. And we'll move on, then, to our next question, to ask about how are you supporting equitable access to the vaccine. How do you prevent or mitigate the risk of disparities in access to the COVID-19 vaccine? So, on this question I think we'll start, again, with CareSource and Dr. Mukunda, if you could begin, and then we'll have Jennifer pitch in a little bit.

Beejadi Mukunda: Sure, thanks, Laura. So, CareSource conducted targeted outreach to encourage groups that historically had low vaccination rates and vaccine hesitancy to attend town halls. CareSource looked at factors such as race and ethnicity data and

location, such as [inaudible] to prioritize outreach. Jennifer, I will turn this over to you, please.

Jennifer Anadiotis: Absolutely, thanks, Dr. Mukunda. So, in addition at CareSource it is very important for us to understand our members and meet them where they are. So, we did expand our consumer adviser council meetings into those virtual town halls. These meetings were used to gain insights about vaccine access concerns and questions from a member perspective.

CareSource did use an outside facilitator who was very highly skilled at asking the right questions to manage the session. Using that facilitator allowed CareSource staff to focus on listening to our members and acknowledging their concerns about vaccination. Dr. Mukunda actually participated in those meetings and utilized active listening techniques to develop a rapport with each group.

This allowed member concerns to be identified prior to shifting the session towards education to address the concerns raised during the discussion. Important for everyone to know is that we did have the ability, or our members had the ability during these sessions to chat questions and provide context and information comments back to what was shared, which really added to the texture of the conversation.

A couple of high-level points, though, bubbled to the top from our members about the vaccine. Those included concerns about the speed at which the vaccine was approved, belief that embryonic cells were used in the vaccines' development, and there were also concerns about historic healthcare issues that negatively impacted communities of color.

Dr. Mukunda, during the meetings, was able to share facts about the vaccine that were meaningful to the participants of the meeting. In addition to the discussions about the vaccine itself, during those town halls we were able to obtain feedback from members about how they preferred information to be communicated to them.

They identified that they liked to have information mailed to them in addition to the phone outreach being completed by our care management staff, as well as electronic communications. They also shared, as Dr. Mukunda mentioned earlier, and we've heard it a few different times this afternoon, is that it was extremely important to our members to receive information from trusted medical professionals, including their PCPs, as well as community leaders, both about the vaccine and the benefits of vaccination, not just about becoming vaccinated and scheduling the appointment.

A key takeaway for us from these sessions was the crucial importance of effective listening to understand and address member questions and to use this feedback to shape action on the part of the plan. The other point that I wanna make really quickly is that Dr. Mukunda mentioned earlier that CareSource has undertaken a plan to increase access to vaccination by working with large health systems that serve underserved populations, and to provide support to members and patients about vaccination availability and scheduling.

Our organization has focused on ensuring that health equity training is provided to CareSource staff who interact with members, really to help shape the conversations and provide education.

Laura Maynard: Thank you so much, appreciate that. And let's see, wanted to turn this now to LA Care, and ask how you all are supporting equitable access to the vaccine. Dr. Li?

Alex Li: Sure, thank you, Laura. I mean, I think early on, I think, in the pandemic we were partnering with whatever agency, whether it's local department of public health or vaccine clinics across the county, to really help with outreach and communication for our high-risk members.

We've done a lot of work to constantly update and enhance our risk stratification tool to really have a sense, out of two-plus million individuals, who is most likely to, as Misty mentioned before, be at risk for severe COVID disease. And given that we're a Medi-Medi and MediCal plan, most of the individuals that are beneficiaries of our plan are mostly low-income and people of color.

So, I feel like our approach was we'll take all comers and we'll leverage and lean resources into and support our members when possible, and we try to do it for our high-risk members first. I think as time went on, we had to kind of shift and pivot our strategy a little bit as vaccine available -- became more available. I think just to give you an example, we'd probably take a two-step approach now, as we kind of figure out who our key partners are with regards to vaccine administration and support.

Number one is we use the -- and partner with the local department of public health to take a look at where and what's the [codes] are at or behind, for example, with regards to [get pairs] with regards to vaccine administration. We also take a look at where our membership is high, where there's high disease burden, and then try to do some matching and try to figure out okay, do we help out with south LA here, or do we help out with Palmdale or Santa Monica or Beverly Hills?

You know, again, I think these are just examples of the diversity of LA County. So again, I think as time went on, we became a little bit more strategic with our partnerships. We focused mostly in -- for example, right now, with south LA as well as southeast LA corridor, as Misty mentioned. We also have leaned in and committed organizational resources and staff to sponsor vaccine clinics ourselves in target areas that we believe are also -- where we have a high number of our members who are vulnerable.

And we also provided grants for different community agencies whether they're federally qualified health centers or others, who really have areas where we have vetted and felt that we should commit resources to help address the health equity concerns for vaccine access. Laura, happy to turn it back to you. I mean, those are just examples where health plans can make a concrete effort and intentional approach to address health equity, from our perspective.

Laura Maynard: Yes, thank you so much for sharing those examples. That is very helpful. Going to move on now to our next question, and ask about strategies for conducting outreach to members, including those that you've identified as high-risk. And as a part of this question, to also ask how are you ensuring cultural competence in your messaging to your beneficiaries? So, to answer this one first, I'd like to ask CareSource Jennifer, if you could speak first to this one.

Jennifer Anadiotis: Absolutely, thanks, Laura. So, in addition to following Ohio's vaccination rollout, CareSource used data analytics to identify individuals at increased risk for adverse outcomes from COVID-19. Those indicators included members' race and ethnicity, where the member lives, assessed risk stratification based on historical utilization, comorbid conditions, and disabilities and homebound status.

We combined this data with the prevalence of COVID-19 in the areas across the state to assist in targeted outreach to members to provide education about the vaccine through direct phone outreach, texting and email campaigns, and other types of member communication. In addition, we shared this data with healthcare providers with attributed members to complement outreach efforts between the systems and the plan, to connect with members about vaccination.

For the second part of the question, to address the need to support cultural competency in messaging beneficiaries, all CareSource case managers were asked to view the one-hour CDC webinar on the topic of cultural sensitivity and health disparities. In addition to watching that webinar, case managers were encouraged to explore the additional links shown on the website to further their knowledge about cultural competency.

In addition, prior to any of our volunteers, our CareSource staff wanting to volunteer in COVID-19 vaccination clinics, all those staff members must sign an attestation that they have viewed the CDC webinar. We also had done some testing and vaccination work earlier in 2020 and 2021, and again, we used that CDC health equity education in collaboration with other Ohio Medicaid MCOs to prepare health plan volunteers across the different plans to engage in volunteer work.

At CareSource, we see the importance of health equity education really to help remind staff of the reality of health disparities and to encourage respectful and culturally appropriate communication with all members of the communities we serve, and to increase volunteer knowledge to deliver equitable and compassionate care.

Our health equity education is available to our staff through our education platform, which we call CareSource University. And then lastly, we also offer a series of webinars that Dr. Mukunda hosts to our case management teams. Those webinars happen about every 60 days and cover a variety of topics related to COVID-19.

But most recently we used the time to discuss motivational interviewing and really support bidirectional communication between Dr. Mukunda and the case management

staff to walk through how to best support our members in making the decision around being vaccinated.

Laura Maynard: Dr. Mukunda?

Beejadi Mukunda: Oh, yes, thanks, Laura. Two very important aspects of collaborating and sharing the knowledge what we have been doing is one, through a weekly call of the chief medical officers and medical directors of all the managed care plans in Ohio.

Initially, Ohio was organized into three regions during the COVID testing, and we are following those three regions and have distributed medical directors to get information from each of the regions, and we meet once a week to basically share the recent information on vaccination rates, challenges in vaccination, and any promising practices that would address equity and distribution of the vaccine.

And we are able to get the best practices through this way through the chief medical officers and the medical directors. One other area of import is the health plan volunteers that are working with the various health departments and the healthcare systems all through the state. They have a huddle once a week where they discuss what are the best practices that they are seeing in terms of addressing the equity and outreach. And that information, again, is brought back to the team, and we share it with the rest of the plans. And I'll turn this back to you, Laura.

Laura Maynard: Thank you. Thanks so much for sharing that. And we'd like to then call on LA Care to respond to this question as well in regard to strategies to conduct outreach to members and ensuring cultural competence in those strategies. So, Misty, would you like to start?

Misty de Lamare: Absolutely. So, at LA Care we have a very robust social media campaign where we're conducting outreach, and this includes an upcoming series of Facebook Live events, featuring our medical doctors as well as educational videos. We host our Facebook Live in English and Spanish, and we also include an ASL interpreter on the screen.

And we take into consideration our target audience when identifying the panelists and interviewers, to ensure that they are in alignment with that audience. When members call to LA Care, they can hear a prerecorded message with update information regarding the vaccine in both English and Spanish, and all live calls can be coordinated with LA Care's linguistic vendor, which provides translation in most all languages.

LA Care, we have a dedicated webpage that provides up-to-date vaccine information. We like to call that our source of truth, so we try to keep that as up-to-date as possible. And we have also developed trainings, including a targeted training for our LA Care community health workers, as well as some of our partner organization community health workers.

And it allows those individuals to be educated about vaccine as well as some vaccine hesitancy messaging, so that they can connect directly with our members and the community. We're also, as I previously mentioned, going to be conducting a training for our provider audience to support vaccine hesitancy messaging for their patients, and we are going to be transitioning our campaign efforts.

Our phase one of the strategy was really focused about the vaccine rollout, who's eligible, how to access the vaccine, and phase two is gonna be focused a lot on vaccine hesitancy and those individuals who need a bit more information and a bit more encouragement. And we're gonna be using the data and the results that I mentioned and the survey that we conducted to help support those efforts. I can now turn it over to Dr. Li, who can speak a little bit more in detail about some of these issues.

Alex Li: Thank you, Misty. I think the way I would think about it is that you probably should have an internal organizational strategy, as Misty highlighted, where you have a fair bit of control over your resources, your messaging. But you also need to have a really robust external strategy and approach, where you have to take account for the fact that we're a health plan, we know a fair bit of clinical information, other demographic or data information utilization, but really, you need to kind of really find nodes or cohorts of high-risk or populations that you really wanna focus.

For example, we have seven regional centers here at LA County. These are social service agencies that support people who are disabled, as well as those who have both physical and intellectual disabilities. So, this is an example where they have -- they're really great at social service issues for food and transportation, but they really needed help with getting them help with partnering and other types of vaccine efforts and outreach.

So, just an example, we were fantastic with working with the department of public health and broker some of those relationships, and make sure that these disabled individuals are vaccinated, as an example. Another one is perhaps with people who are experiencing homelessness, which is -- unfortunately, LA County is a fairly significant challenge and issue.

And again, this is working with shelters or home-based -- other kind of outreach and advocacy groups to really kind of plot out how do we divide a county into different quadrants or neighborhoods, and who's gonna be doing what so that we're efficient with regards to our vaccine efforts.

And I think every health plan probably has their high risk as well as their kind of cultural as well as other structural challenges, and it's really just, again, trying to be thoughtful and systematic with your resources and identifying the right partners, as well as kind of organizing, again, as I mentioned at top of the hour, the sense of value systems and missions and kind of tap into the – perhaps the right emotions that really motivate staff and align as much of the resources and really the passion that we all have here to end the pandemic and address the social inequity and health inequities and make the magic happen in many ways. So, Laura, I'll turn it back to you.

Laura Maynard: Thank you so very much.

Alex Li: Yeah.

Laura Maynard: Yes, thank you, I appreciate that very much. We have one more discussion question, and I'm wondering if at a very high level we might go ahead and ask quickly, because we do wanna have a minute for Q&A and to wrap up. But if you could very quickly indicate how you've partnered with community-based organizations such as local public health departments or other community-based organizations to promote vaccine uptake and equitable access. So, I'll turn it first to CareSource and Jennifer for a quick response.

Jennifer Anadoiotis: Absolutely, thanks, Laura. So, at CareSource, we have partnered with FQHCs, local health departments, hospital systems, and other local providers across the state to actually support vaccine administration activities. We actually allow and encourage our clinical staff to volunteer up to 40 hours of time that's paid for, so that they can support these vaccination clinics and activities.

For our non-clinical staff, they're actually eligible and encouraged to volunteer up to 12 hours that would be paid for. The other piece that I just wanted to mention very quickly is that we do work very closely with our Area Agency on Aging partners. Some of our AAA partners do provide case management services to MyCare, our dual members, but they also utilize the education that we talked about that CareSource has offered, really to help collaborate in helping our members understand and seek appropriate healthcare.

And they are also working with the Ohio Department of Health to access online scheduling and provide education to our community. So, I will pause there and give Misty a chance to respond as well.

Misty de Lamare: Absolutely, thank you so much, Jennifer. So, at LA Care, as Dr. Li mentioned, we have been partnering with several community-based organizations, including the regional center partners and the department of public health. We've also had several hospital systems come to us, and health systems, asking for our help in outreaching to our members for their vaccine clinics, which I think speaks just to the valuable partnerships that we've developed pre-pandemic that have strengthened with the pandemic to help get our members care they need.

And then we are also partnering with the University of Southern California's pharmacy program to host 16 COVID-19 vaccine clinics across LA County, and we are also partnering with other organizations to host those events at their locations, as well as one of our partnering health plans, Blue Shield Promise. And this is in conjunction with our community resource centers, which are standalone sites that are hosted and that live across LA County in the communities where we live and serve.

So, that's something that is taking off next week. We're very excited about those. And it just speaks, I think, to the variety of partnerships that we have had to develop and strengthen throughout the pandemic.

Laura Maynard: Thank you so much. Thank you all for this. This has been a wonderful panel discussion with a lot of great information. On the next slide, if we can move to that one, want to hear again from our participants. How are you partnering with community organizations to promote vaccine uptake and equitable access to the COVID-19 vaccine? So, type that into the Q&A, and I will say that as you'll notice, we're at the very end of our time, so we won't be able to do live questions and answers, and we won't be able to read out verbally all of the great comments that we've seen come in.

But we will compile that information and find a way to share it with you on the website, along with the recording of this event. So, know that we're gonna capture your comments and we're gonna answer those questions from those, but we're going to not be able to have time to do it today. We've just had such a wealth of great information.

So, if we could jump over to slide 59, so jump a slide. We'll move into our wrap-up here quickly. I'm gonna refresh so I see that slide. So, thank you all so much for attending today. The video replay and the slide presentation will be available at ResourcesforIntegratedCare.com. If you have questions, please email RIC@lewin.com, and we'll respond to those questions.

You can follow us on Twitter @Integrate_Care to learn about upcoming new products and new webinars and activities. And remember, from the beginning of the webinar, we have that COVID vaccination blog that is also on that RIC website, ResourcesforIntegratedCare.com. Updates, ongoing information, new examples in sharing from health plans will be in that blog post. So, we will be doing that, and we're gonna move on here to the next slide.

Really, really want to say at this point please evaluate this. Your feedback's important to us, so we'd like for you to complete the survey that will appear on the screen about a minute or so after the conclusion of the presentation. And we'd like for you to provide feedback on other products that we have as well, at the link that's provided on this slide.

So, at this time I really wanna extend our deep gratitude to our panelists today, Dr. Li and Misty de Lamare from LA Care, Dr. Mukunda and Jennifer Anadiotis from CareSource. Thank you so much. That was great examples, wonderful information. We also really appreciate our federal speakers, Marvin Figueroa and Shelly Winston. Thank you for those informative presentations.

And again, the slides for today's presentation, a recording, and a transcript will be available on Resources for Integrated Care website soon, and we will pull together some information from your comments and your Q&A to share in that space as well. Thank you so much for attending and participating, and this concludes our webinar.