The Lewin Group
Promoting Disability-Competent Care during COVID-19
April 22, 2021

Jennifer Kuo: Great. Thank you and welcome everyone to our webinar, Promoting Disability-Competent Care during COVID-19. My name is Jennifer Kuo with The Lewin Group, and I'll be serving as your facilitator for today's event. Next slide, please.

Today's session will include presentations followed by a live Q&A with our presenters and participants. This session will be recorded and we'll be posting a video recording along with today's slide to the ResourcesForIntegratedCare.com website. Next slide, please.

I wanted to take a moment just to quickly review the audio options for today's webinar. There are two ways to listen to today's presentation, and they're both listed here on this slide. The first is that audio should automatically stream through your computer's speakers. Just make sure that your computer is connected to reliable internet and that your computer's speakers are turned on.

If the computer audio portion isn't working for you, there is a dial-in option available. To access this option during today's event, just click on the black Phone widget that's located at the bottom of the webinar platform screen. You can see a screenshot of that Phone widget here on this slide. And then when you click on it, a phone number and an access code should appear and you can call this number, follow the prompt and then listen to the presentation through your phone. And feel free to also chat us through the platform. Just click on the red Ask widget at the bottom of the screen and we'd be happy to assist you. Next slide, please.

So we're pleased to be able to offer one continuing education credit hour through NASW for social workers that are participating in today's webinar. We encourage everyone to check with your specific regulatory boards or other agencies to confirm that courses taken from this accrediting body will be accepted by that entity. Next slide.

In order to receive the continuing education credits, individuals must complete the pre-test at the beginning of the webinar and also complete a post-test with the score of 80 percent or higher by 11:59 p.m. Eastern Time tomorrow April 23. Next slide, please.

This webinar is supported through the Medicare and Medicaid Coordination Office, or MMCO, at the Centers for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless and high-quality healthcare that includes the full range of covered services in both programs. To learn more about our current efforts and resources, we invite you to visit our website, ResourcesForIntegratedCare.com or follow us on Twitter for more detail. Our Twitter handle is integrate_care. Next slide, please.

So I now would like to introduce our esteemed speaker panel. We have five presenters for our webinar today. Chris Duff is a Disability Practice and Policy Consultant. He has served as a consultant to the Resources for Integrated Care Team for the past several years on disability-competent care related topics.

We also have Jose Hernandez joining us today. He is our participant speaker representing the United Spinal Association. Next slide.

We have two speaker joining us from Inland Empire Health Plan, Gabriel Uribe, Director of Community Health and Anna Edwards, Clinical Director of Care Management. Next slide.

And our final presenter today is Stephanie Rasmussen. She's the Director and Vice President of Long-Term Services and Supports at Sunflower Health Plan in Kansas.

The next slide lists the learning objectives for today's webinar. So at the end of today's event you'll be able to define the DCC model and its core values and functional area pillars, recognize the challenges and risks that individuals of disability face during COVID-19, describe the effects of social isolation and interventions to help promote connectedness, describe strategy for identifying, monitoring and addressing caregiver and care partner availability and back-up. And lastly, identify strategies for increasing access to in-person and virtual health and social services.

All right, next slide. Before we turn to our speakers, we did want to ask a couple of poll questions to get a better understanding of who's in attendance today. So you should be seeing the first poll question here on your screen. The question is -- which of the following best describes your professional area? And the answer choices include health plan case manager or care coordinator; health plan member service; health plan administration and management; medicine nursing, physician assistant or other provider; pharmacy, social work advocacy and other. So I will give folks a few more second to indicate their answer choice.

And why don't we go ahead and show the results.

All right, it looks like the majority of our webinar participants today are health plan case managers and care coordinators. That is, let's see, followed by social workers at 18.7% and health plan administration management at 18.1%, and advocacy at 10.8%. All right, well, welcome to everyone.

Our second poll question is -- in what setting do you work? And the answer choices are health plan; ambulatory care setting; long-term care facility; home care agency; community-based organization; consumer organization; academic research, and other. So again, I will give folks a few more second to select their answer choice.

All right, let's go ahead and see the responses. All right, not surprising given the answer to the last question. We have 61.4% working in a health plan setting and 14.8% in

community-based organizations, and 16.5% for other. All right, well, thank you for answering those poll questions.

The next slide provides an outline for today's event. We'll first turn to Chris who will provide an overview of the disability-competent care model. And then we'll hear from Jose who's our participant speaker who will share challenges experienced by persons of disability during COVID. He'll be followed by Inland Empire Health Plan's presentation and then we'll hear from Stephanie of Sunflower.

Following our two health plan presentation, Jose will join us again to share his responses to and reflections on the two health plan presentation. And then we'll open it up for Q&A with our audience members and presenters. Feel free to submit questions throughout today's presentation via the red Ask widget at the bottom of your screen to get your question in the queue. So with that, let me go ahead and turn it over to our first speaker, Chris Duff to have you provide a review of the DCC model. Chris?

Chris Duff: Thank you, Jennifer. It is great to be back doing a disability-competent care webinar. Since we haven't done a DCC webinar in quite some time I have been asked to give a brief overview of the DCC practice model. It was originally developed and piloted over 20 years ago by four health plans that targeted dual eligible working-age adults. In the mid-2010s we rolled out a detailed description of the model and specific practices. They were subsequently field tested in numerous settings and we developed and presented over 40 webinars focusing on various components of the DCC model. These can all be found on the Resources For Integrated Care website.

The model at its core is participant-centered, delivered by an interdisciplinary team, and focused on maximizing independence as desired by the participant. The team completes a comprehensive assessment with the participant, develop plan to support them in living as they choose at home and in the community. The practices address the individual as a whole, focusing on function, not illness nor diagnosis.

The DCC model is organized in seven pillars as outlined on this slide. The first pillar describes the necessity of understanding the lived experience of persons with disability and the individual participant in particular.

The second pillar describes an approach to participant engagement using a comprehensive assessment as a mean to understanding their experiences, goals and preferences. Without a strong, respectful relationship with the participant the outcomes desired will not be optimally achieved.

Access, the third pillar, focuses on addressing barriers to obtaining care and support. The barriers are physical, attitudinal, equipment, communication, both language and alternative formats, and the navigational and coordination of services.

The fourth is timely and proactive primary care focused on maintaining health and preventing avoidable episodes of illness.

The fifth is care coordination, which is the means to which the participant is supported in developing and implementing their comprehensive plan of care. The art of care coordination is knowing when and how the participant needs support and assistance in getting their needs met.

The sixth is long-term services and support commonly called home community services focuses on personal care, durable medical equipment, wheelchair services, housing and other services and supports needed to function in the community. These are seen as the means to avoid institutionalization and maintain as independent a life as the participant desires.

Lastly, behavioral health are the services and supports required to address mental health, chemical abuse and behavioral function needs. The integration of these services into the comprehensive plan of care is vital to the success of the participant to live their life as they choose.

Let me demonstrate the model in practice by basically walking through the initial process. The first step is engaging with the participant by phone or email explaining that you would like to meet them, get to know them and conduct an assessment. Preferably, before meeting with the participant, collect and review any background information you can obtain.

This first conversation is casual and informal in nature. I usually start asking them to tell me a bit about themselves, which will give you a sense of how they view themselves. Proceed to ask about their disability, when it occurred if not at birth and how it affects their daily life. I proceed to ask them about where they live, who they live with and those who are important to them. I then ask about what they expect from my work with them.

I proceed to work through the assessment always focusing on function rather than diagnosis. Upon completion, I discuss the services and supports they require and ask if they are wanting to keep their current providers and arrangements for doing so. I try to conclude this first visit by asking when and how they wish to receive support from myself and the rest of the care coordination team. This includes frequency and means of contact. I make sure they know who is on their team, how to contact the team and who will be their lead contact.

With that brief introduction, I will now turn it over to Jose Hernandez who will discuss the unique issues experienced by persons with disability during this COVID epidemic.

Jose Hernandez: Hello. Can you hear me?

Jennifer Kuo: Yes, we can hear you, Jose.

Jose Hernandez: All right, good. Hello everyone, my name is Jose Hernandez. I just wanted to be clear that I work for United Spinal Association and I experienced a spinal

cord injury roughly 25 years ago and utilized 24-hour home care to be able to live independent in the community.

So I'm going to share a really personal aspect of me that happened at the beginning of the pandemic. So roughly in March, I live in New York City and we were the epicenter. And one of my homecare workers came down with COVID-19and passed away two weeks after contracting it. Fortunately, I was not infected but that's where my struggle began. I needed to find someone to cover when he took off.

So I had one home care working seven days a week. I shifted one worker that was working on the weekends to five days a week and I shared another worker with one of my friends. This is possible because I'm also under the consumer directive model and I hire my own personal care attendants.

This is a challenge that many individuals with disabilities faced at the beginning of the pandemic and workers realized that they needed to be safe. So a lot of them stopped working or became sick. And they stopped working also and went on unemployment because they could make more money with the COVID relief plans that they were -- at the time. So this created a big hiring challenge.

It was three months before I was able to even hire someone. And that process was daunting. My agency required that I print out a 40-page application, get that filled out and then get it back to them somehow. And who owns a printer now these days. Everyone does everything on the smartphone. Thankfully, I work a lot from home in my normal job so I had access to a printer and was able to scan it and send it back to them, but even that took a month before my worker was able to start. So that's one challenge.

Another challenge would be the PPE. Home care agencies are required to send gloves because the plans, technically in New York, they don't pay for PPE or gloves. Can you imagine I'm a spinal injury who requires bathing and help with toileting and they don't pay for gloves, and now we're in this global pandemic and everyone is required to wear masks, gloves for overall hygiene and safety and there was a big scramble to get that to our members, our participants.

So another big challenge was obtaining COVID-19 information in multiple languages. I live in New York with the melting pot. In my neighborhood alone, you have English, Spanish and multiple other languages. So I live in one of the hardest hit areas in the Bronx and we were the last ones to get the information. And the information we got was half information. We didn't know about the shutdown. What we knew is what the news was telling us or whatever was posted on the hallways. No one took the time to explain the severity of the situations.

Even I myself as an advocate thought that the COVID-19 pandemic was just like the flu and it was going to pass and I consider myself a highly intelligent person and it wasn't until my home care worker really passed away where I realized -- wow, this is something really serious.

Next challenge was accessing healthcare. At the beginning of the pandemic, no one knew what it was going to look like having appointments. Everyone was afraid. And for myself, I required 24-hour home care, like I said it before, and if I needed an in-person visit, they weren't allowing my home care worker to go with me. Now, if I needed assistance to get a medication or to get my wallet or even to open a door, they weren't being allowed. So we needed to scramble to make sure that these places, the hospitals and centers knew that home care workers were essential and needed to be allowed in with members and people with disabilities.

Another thing that was exposed was the digital divide. A lot of individuals with disabilities and the vulnerable don't have access to the internet, computers or smart devices. So accessing virtual appointments was difficult to say the least. Thankfully, the FCC realized this and worked online helping to bridge that gap.

Transportation, even before the pandemic, individuals with disabilities and the vulnerable always have had difficulties getting around but it was really difficult during the pandemic because of the limitations and inaccessibility of the entire system.

So when they started handing out the COVID-19 vaccines, so it was like, yes, you qualify for the COVID-19 vaccines but how are you going to get there? So taking that into account.

And valuing the lives of people with disabilities, so during the pandemic resources became really scarce. There was 800 lives being lost every day and decisions needed to be made. Unfortunately, people with disabilities were being left out of that equation. They automatically assume because you have a disability your quality of life isn't going to be the same as that of a person that doesn't have a disability. So if you were eligible to get a ventilator, the likelihood that you were going to get it was not very good. There was a case in Texas where a nursing home decided not to see a person because they considered his quality of life not important. Next slide.

Education around the vaccine. In the beginning, January of this year the vaccine rolled out in New York was pretty good. They started with the essential workers, but somewhere along the line things got kind of blurred. And they prioritized the economy and businesses over individual's lives and really needed to educate people how to get vaccinated and the importance of it. So even to this very day there's people who have language barriers or transportation barriers or just elderly in general who still haven't been vaccinated. And thankfully those things are being addressed by having home vaccination visits, but still individuals have to know about it and have access to the internet or a family member that's able to make those appointment visits for them.

So that's where having the information in multiple formats comes in. Even having the ability to have someone knock on an individual's door or a health plan and say -- hey, Ms. Delgado, are you capable of receiving the vaccine? So that's all basically what I had to say and not sure who I'll hand it off to, but I'm here if you have any questions.

Jennifer Kuo: Great. Thank you so much, Jose, for sharing your very powerful personal story, very much appreciated. And, Chris, thank you for your overview of the DCC model. If folks do have any questions for either Chris or Jose, please go ahead and submit them. You can click on the red Ask widget at the bottom of your screen and we'll go ahead and get your question in the queue.

So now let's go ahead and turn to Inland Empire Health Plan. So Gabriel and Anna, you're up next.

Gabriel Uribe: Good morning, my name is Gabriel Uribe, Director of Community Health at IEHP and I would like to thank Jose for that great opening and kind of setting the tone as to what the situation has been over the last year in regards to COVID-19 and where we are as a health system addressing some of the needs of dual eligible and seniors and persons with disability.

A little bit about IEHP if we can go to the next slide. IEHP is one of the largest dual health plans in the country, with a network of over 6,000 providers and 2,000 employees. We provide healthcare for about 1.3 million folks in California's Riverside and San Bernardino County and about 30,378 are dual eligible members as of this March. And with that, I'd like to pass it over to my colleague, Dr. Anna Edwards who will get us started on some of the interventions that IEHP engaged during COVID-19. Next slide.

Anna Edwards: Well, thank you everyone, good morning and good afternoon. I am Anna Edwards. I am the clinical director for the behavioral health and care management at IEHP and work very closely with Gabriel. So he gave you a kind of a framework introduction to IEHP, and on this slide we're taking a look at some of the demographics, specifically around our dual eligible population of which we have over 30,000. And so you can see that we have a large number who are considered having a disability and then we have a Hispanic population as predominant. And for our top three chronic conditions, this is probably pretty similar across kind of the United States with diabetes leading the diagnosis.

But I think one of the most important things on this slide is towards the right when we talk about the social determinant of health concerns and for our membership, the top is food and food and security, additionally, housing, availability for funds for gas and utilities. So that'll kind of lead us into the next slide where we talk about what IEHP has been doing around food insecurity.

So in general, across the Inland Empire regions which encompass those two counties, San Bernardino and Riverside County, about 10% of the entire population according to 2019 data is food insecure. So what do we know about food insecurity? We know that food insecurity is more prevalent among vulnerable populations. Also certainly with persons with disabilities, they may have some unique challenges relating to food access. Additional issues that may impact our dual eligible population with disabilities are considered unemployment or underemployment, physical, cognitive, sensory limitations

and of course the transportation challenges that Jose was highlighting a few minutes ago. Additionally, Medicaid recipients are more likely than non-Medicaid recipients to experience food insecurity. And Medicaid recipients are also more likely to have multiple unmet social needs and chronic conditions. Food insecurity overall will negatively impact health outcomes.

So when we take a look at what happened during the COVID-19, we know that prior to the pandemic there was a food insecurity problem. But it was further exacerbated by the pandemic. And why? Because there was increased unemployment and therefore there were more people who were qualifying for Medicaid and therefore more people were competing for the same resources to address their food insecurity. Next slide, please.

So Inland Empire Health Plans' response to this food insecurity problem was to develop and implement a food insecurity resource linkage program which was started in June of 2020. The major components of our program really focused on training our care management department which also is including our behavioral health team members. So the program focused on using a standardized screening tool, the Hunger Vital Sign, which is only a two-question tool guiding all of our team members in a decision support algorithm to really think through the urgency and immediacy of the food insecurity problem versus is a chronic issue and also considering certain family members. So not just the one person that may be in the household but expanding into looking at the whole family.

In addition, a resource tool was programmed for our care management staff to kind of make it easier for them to find the resources quickly for our members. And finally, we wanted to make sure there's a standard documentation process because we wanted to capture the data to make sure that we are asking the question about food insecurity, we are following up with the member to make sure that they receive the resource.

So another thing that we have been doing at IEHP is making sure we are shoring up our strong community partnerships to secure food resources and I'm going to go ahead and hand it back over to my colleague, Gabriel, for the next slide.

Gabriel Uribe: Thanks, Anna. And on this slide we see a picture of some of our outreach team doing some food resource campaigns out in the community. And as Anna mentioned, as we saw the pandemic take on, we know that there was a disconnect between the access to food not simply because of financial resources, although that is a big part of the problem, but to some of the comments that were shared earlier, the lack of assistance for transportation or caregiving services that connected folks with food in the past made it very difficult for dual eligibles to be able to reach some of the food resources that they might reach in the past.

So IEHP really has to really think about the system as a whole, how do we get food to people, especially during the beginning of the pandemic, to their doorstep in an environment that was not necessarily conducive in terms of a reimbursement perspective or from a health managed care model to get folks that resource outside of medically-

tailored meals. And we had to develop quickly a network of partnerships with organizations across both counties to meet the need. And that was achieved by really working closely with existing infrastructure that perhaps we hadn't really worked with as a health plan because it was kind of on the outside of the traditional work that an MCP does. And working with the local food banks was an experience developing infrastructure to have food refrigerated, to have equipment, such as pallet jacks, provided to some of the CDOs that were moving high volumes of food and getting them into folk's doorsteps was a significant challenge but something that was achieved by leveraging the coalition that the disability community in this space and health plan in this space and other CDOs had forged prior to the pandemic. And with that I'll pass it back to Anna on our innovative member outreach strategies in the next slide.

Anna Edwards: Thank you, Gabriel. So IEHP is really founded on innovation and it's really exciting that we are encouraged to really think outside of the box and we were extremely member-focused at the beginning, at the very, very outset of the pandemic and making sure that we developed call campaigns, and those call campaigns were to have a well check and also to educate, to Jose's point, to educate about the pandemic and what they should do and just provide that information. We also make sure to follow up with our members post-hospitalization, we were getting that stream of data and everybody was very hyper focused. A really, really wonderful thing is IEHP had staff members across kind of the organization, everybody was coming together to help to support our members' needs and particularly those dual eligible and with disabilities.

Our call campaigns were focused originally on those who were 75 and older to help them with making vaccine appointments. We know it's going to be challenging for people to do online appointment registration and so forth, so our team members were there to call and actually make the appointment for members who needed that assistance. Kind of a unique thing that we did was to put it out there to the entire organization to make cards for our members who are in skilled nursing facilities. So that is an ongoing effort and it's something that everybody and even their family members can pitch in and make some cards to put a smile on our members faces who live in those skilled nursing facilities.

We have an upcoming picture of one of our cheer parades outside of the skilled nursing facilities. So the staff and the skilled nursing facilities would make sure that the windows were open so they could see our team kind of parading outside and trying to have a ray of cheer shared with those residents.

One very nice thing that we have is we have three community resource centers and we do offer virtual classes when we were forced to kind of limit the in-person interaction, but that is available for our dual eligible and also the community can register for those classes. And one very exciting thing is we have multiple partnerships with both counties and other providers to help staff their vaccination site with our employee volunteers. There's definitely a huge spirit of volunteerism that IEHP has and it's been a historical but certainly amped up during this time.

In late February, IEHP became a vaccination super site in partnership with one of our counties and that is ongoing event daily within our building. We have a great partnership and we have volunteers from our team members across the organization, both clinical and non-clinical. So these are some really exciting things, again, out-of-the-box thinking is really important when we are faced with so many challenges in this pandemic. Next slide, please, and I think we have a picture.

Yep, and there is one of our pictures of our cheer parade for our skilled nursing facility. And the next slide please, we'll have a picture of our card campaign. You can see we're holding up the cards. So thank you for letting me present on the innovation that we have done. And the next slide?

Before I start talking about supporting caregivers, I just wanted to say thank you, Chris, for framing the discussion today. I think it was really important to bring back that DCC model and a big thank you to Jose for sharing your story. I think it's so important and you brought up the importance of the caregivers and what a difficult challenge that was in the beginning. And IEHP also recognized that we need to focus on our dual eligible members with disabilities and their caregivers because we know the important role of these caregivers. So we focus training for our care management and behavioral health team members by providing a caring for the caregiver training. We also encourage our team members to participate in any of the great webinars from CMS.

And when we talk about the PPE issue Jose brought up, we provided hand sanitizers for our in-home supportive service and public authority caregivers early on. We partnered with our IHSS public authority caregiver registry to provide additional funding or differential pay for emergency backup caregivers. So we were kind of thinking about this at the very onset of what is going to be the impact of the caregivers.

Another thing we did to support the caregivers during this time was to assess our caregivers and provide them resources. So, we want to make sure that we are, with our members' permission, bringing in the caregiver and screening for possible burnout. And if they are burned out, we want to provide resources whether it be in-home respite or out-of-home respite or additional LTSS services or other resources specifically for the caregiver. Next slide, please.

Again, we wanted to provide education and resources and those took place through trainings, through our community resource centers. And that was prior to the pandemic that we have a caregiver toolbox that was created in partnership with the Inland Caregiver Resource Center and also Alzheimer's Training by the Alzheimer's Association. We made sure to curate caregiver resources, tools and also videos and guides to make them available to the caregivers and our team members as well. So those are at their fingertips, so when they're talking to our members and their caregivers, they can give those to them.

And then finally, it's really important to educate the providers about caregiver resources, so we notified our providers, obviously, when we screen members and may screen positive for cognitive impairments, making sure that communication feedback loop is

there. And we make sure to educate our providers on our long-term services and support and we are there, we have a specific unit that dedicated towards that to make sure our providers have that awareness. Okay, so next slide, please.

And I'm going to go ahead and turn it back over to Gabriel.

Gabriel Uribe: In terms of addressing social explanation and helping resource and service administration, posting an article that spoke to about 43% of seniors feeling lonely on a regular basis. And as you know the pandemic exacerbated this feeling of loneliness due to the connection loss. And there are also some direct connections between physical health and being lonely. Some researchers, at least, from BYU, have made the connection that being lonely on a regular basis have the same impact of smoking 15 cigarettes a day in terms of the physical impact on a person's body as we're navigating through that.

So we knew that addressing social isolation was key during the pandemic. And we partnered with a local university social work program to sponsor Chromebooks and other devices and assisted senior than in different spaces on how to utilize those Chromebooks in order to connect via Zoom or via other social medias with the family so that they would have those connections in place. We leveraged about nine college student from the same university to connect with seniors via staying connected calls in less tech ways and a more traditional telephonic approach to engagement. And we did that because we knew that many folks during this situation were losing family members, were losing friends in facilities and really could benefit from that continuous social connection as a piece of their recovery.

And I know we're running out of time, so we could maybe go next to the key considerations for health plans and Anna will help us close out with that slide.

Anna Edwards: Okay, great. Well, thank you everybody. So again, touching on exploring innovation and thinking outside of the box -- super important for health plans to consider -- partnering with our community to make sure we're addressing social issues, using data to look at those disparities and then asking on the data to address the disparities. And again, build that culture of enthusiasm within your organization especially around volunteerism and partnering. So thank you so much. Sorry to run over.

Jennifer Kuo: Thank you, Gabriel and Anna, very much for your presentation. If you still have questions for Inland Empire, go ahead and get your questions in the queue. Just click on the red Ask widget and submit your question to us.

All right, so, I'm going to turn it now over to Stephanie with Sunflower Health Plan for her presentation. Stephanie?

Stephanie Rasmussen: Thank you, Jennifer. And this is Stephanie with Sunflower Health Plan and I appreciate being part of the presentation this afternoon.

A little bit about Sunflower Health Plan, we are part Centene Corporation which is a national managed care organization that has health plans in 50 states. We are based in Kansas and we provide integrated behavioral health, physical health and long-term supports and services as supports to about 155,600 individuals on Medicaid. Within that Medicaid population we offer support, so cover supports for several different populations of individuals who receive common community-based services including those with intellectual disabilities, persons who are elderly, individuals with physical disabilities, individuals with brain injuries and children that have technology assistance or have severe emotional disturbances.

We also support individuals that participate in the Centers of Medicaid Buy-In Program for individuals with disabilities that are employed and we support individuals in nursing facilities, about 3,200. Of the individuals in these population, about 11,000 are dually eligible.

We also have a small Medicare Advantage membership of 750 individuals and a dual special needs program of approximately 1,700 individuals. Next slide, please.

So starting in about March of 2020 we really started to recognize that our individuals that we support who have disabilities really were facing some unique barriers related to the pandemic. Many of those have been identified already by Jose and Gabriel and Anna, but we did see the same barriers with access to educational information, personal protective equipment, connectivity and equipment and education and support for using telehealth platforms. We really saw individuals who either feared or had actual challenges with finding direct support caregivers, including both providers and individuals who were receiving their care who really struggled with finding caregivers who would come to their home to provide that care.

And then more recently, we have seen the same challenges that have been talked about already with individuals being able to have access to getting the COVID-19vaccine.

We also recognized that individuals with disabilities needed some flexibility in how they receive their care during the pandemic, that they may need to receive it in a different location or from different people. And we had some individuals who really needed support while they were in an in-patient setting. Next slide, please.

I think one of the most important things that we did as a health plan was that we certainly immediately set up weekly meetings with our LTSS stakeholder groups that do continue to occur bi-weekly. We started at the end of March of 2020. We facilitated the group with our member advocates, our provider associations, the state and the other managed care organizations, to really talk on a regular basis about the barriers that individuals with disabilities were facing and to develop some key partnerships for helping to address some of the needs that individuals had.

Sunflower Health Plan was able to develop partnerships with our Kansas Community Developmental Disability Organization, the Aging and Disability Resource Center, our

Centers for Behavioral Health, and our Centers for Independent Living to get necessary supplies out to our members. We were able to deliver about half a million masks and several hundred boxes of gloves as well as tablets and food supplies to individual members in the homes and receive common community services as well as to our HCBS providers and to nursing facilities.

We really saw these organizations that we partnered with were very flexible in how they distributed the items. If you're familiar with Kansas, we have a couple of urban areas of the state that were primarily a rural state. And so organizations use methods such as direct mailing to get supplies to members as well as hosting drive-thru pickup locations. Next slide, please.

This is a slide of the state of Kansas and you can see with each of the little individual icons the different hubs that we developed with our providers in the state with the more north eastern part, as I said, being urban and the south central, but we were able to also partner with providers from the rural locations in western Kansas and southeast Kansas to be able to distribute supplies as well. Next slide, please.

So I wanted to share a couple of individual stories as what their supply distribution and the impact that it had. In July 2020, we had a small nursing facility in western Kansas that was in a very rural location that really didn't even have a Walmart store that was nearby or a Dollar General, and they identified that over half of their residents and several of their staff were positive for COVID-19. They were in dire need of PPE and most typically they had contacted, as we said, they had just run out of gloves. They didn't have any more gloves available for their staff to use. So we've contacted the providers that we have partnered with across the state and we were able to gather 30 boxes of gloves that was still available and get them shipped overnight to the facility. The director of nursing let us know that they really appreciated all of the extra support provided to them.

And then in September of 2020 one of our employees delivered a food box to one of our member. And the member handed the employee a gift in a bag. The employee said -- I can't accept presents but the member said -- don't worry about it. There's no monetary value associated with this present. In the bag are three painted rocks. I have not paid anything for them. I find them, paint them and give them away as gifts. It's been my therapy during the quarantine of this pandemic and you can see a photo of the rocks that she gave to our employee. Next slide, please.

To address some of the barriers around COVID education, we worked with our LTSS stakeholder group to jointly offer education about the virus and more recently about the vaccine in multiple formats for educating those individuals who receive services and also educating those who are caregivers. We were able to put together a resource list of websites. We had brochures and fliers that went out. We also had some recorded videos that individuals could watch and listen to and live virtual seminars. We try to cover a variety of topics for all that education, including the signs and symptoms of the virus, safety guidelines for having caregivers come in to the home, information about the

vaccine, access to ongoing healthcare, and then how to access some of the PPE resources that we have provided.

Centene also nationally partnered with the National Council on Independent Living to develop a series of written guides and companion videos on the specific challenges for individuals with disabilities face regarding the pandemic. And this was intended to educate those participants and the providers. And we provided the links to the videos and to the guides within this slide deck.

Centene also provided $200,000 for a few states including the state of Kansas to implement emergency back-up caregiver services for individuals to self-direct their care and employ their own caregivers in their homes. We offered the grant to two of our Centers for Independent Living in Kansas that then provided the service in three counties as a pilot. Two of those counties were rural and one was urban. And they worked in collaboration with our transformation team to educate all of our members in those counties to self-direct their care, about how they could access the back-up support if they needed it. They had a hotline number that the members could call and then they had employee direct care workers to be able to send out to the homes if their caregiver wasn't available to work and if they needed that support. Next slide, please.

We also had, as I mentioned, recognized that our members in home- and community-based services needed some different options for how they receive services. Specific to the IDD population, we saw that a lot of day service providers were either frozen temporarily or moving to alternative schedules. And we had individuals who worked in group residential settings who maybe wanted to receive their supports temporarily in their family members' home for in a location that was more where they could isolate a little bit more and protect themselves.

So we partnered with our State Department of Aging and Disability Services to identify some ways that we could improve services and into alternative settings. And we received their approval to offer day services in a home or residential provider setting to be able to approve those to be offered. We also were able to authorize for family members who were not traditionally able to be paid to provide care to be able to receive pay and provide the direction needed. We were able to receive approval to expand some benefits for home-delivered meals that previously weren't covered for this population. And we were able to authorize home- and community-based services, and primarily attendant care while an individual was in an in-patient hospital setting. And this was really, again, to help the individual with understanding their treatment and being able to receive the daily care they needed while in the hospital.

We educated our members about these changes through telephonic contacts from our care coordination team and then review their service plans with them and help identify the changes that we needed to make to make sure that they could receive the ongoing supports they needed.

For the other home- and community-based service(inaudible)were also given permission to authorize the family members to be paid to allow exemptions for those temporary workers for using the state-required electronic visit verification system that they have to use to clock in and clock out their time. We were able to allow them to use paper time sheets instead. We were also able to approve services following a hospital setting. And then specifically, for individuals on the brain injury waiver, we were able to authorize some of those therapy services to be provided through telehealth, and that previously wasn't an option. Next slide, please.

We also had to move our care coordination from in-person to telephonic and through televideo and support both our team members with using video conferencing and help support our individual members with disabilities with using video conferencing options through providing education.

And more recently and regarding the barriers around vaccine access, our primary mode of education with members has been telephonic. Contacting our members with disabilities and seniors and making sure they have information about the vaccine, finding out what their challenges are and then trying to address those challenges.

We also have a COVID-19 page on our website. We recognize that individuals in Kansas who reside in nursing facilities have opportunities through state-coordinated initiatives to be able to get the vaccine in their facility. So we really turned our attention to individuals who receive in-home support and offered options for them as they became available to getting the vaccine in their home. We also assisted our members who self-direct their care by helping them provide employment verifications for their caregivers to get the vaccines in the phase one offering of the vaccine. And then we've worked with our State Pharmacy Association and some of our pharmacies to be able to provide vaccines at the location where the member is. Next slide, please.

So we think some key considerations for health plans are, again, that one of the most important things we did was to facilitate regular communication with stakeholders, to find out what the ever-changing barriers were for individuals with disabilities and then try to partner together to address those challenges. We think health plans can be a leader in offering a variety of easy-to-understand educational materials, can lead initiatives for developing strategic partnership for getting needed supplies out to individuals and for working with state and federal regulators to offer changes to covered benefits that need to be made so that individuals can continue to receive the services they need in the location where they are. In general, we think health plans really need to make sure they have the resources in place to make quick changes to meet urgent needs and just, as Gabriel and Anna said, to have a willingness to think outside of the box and go beyond traditional standard processes.

Thank you again for the opportunity to just speak today and to share how we've addressed some of the challenges in Kansas. And, Jennifer, I will turn it back over to you.

Jennifer Kuo: Great. Thank you very much, Stephanie. If folks have questions for Stephanie, again, go ahead and get your question in the queue. Click on the red Ask widget at the bottom of your screen and go ahead and get your questions submitted.

So now I'm going to turn it back over to Jose. He's going to provide his responses to and reflections from both the Inland Empire and Sunflower Health Plan presentation. Jose?

Jose Hernandez: Thank you very much, Jennifer, and I want to thank the plans. They seem to be doing the right things and talking about the right progress. No matter what from this time forward, the landscape of healthcare is going to change and it has to change to adapt to something was outside of our control. The global pandemic has definitely shown us that we were lacking in so many things. Food delivery, a big one. Those who receive food assistance, they have limitations to access their food, their food delivery. You need to go out and expose yourself to get food. But another thing that was a thing that no one foresaw was the increase in food prices. So those funds that you receive, the SNAP benefits or the funds that you receive from unemployment or whatever the case didn't go as far. And again, you need access to toiletries and all these other items that kind of flew off the shelves.

Another thing I wanted to discuss was, just in general, homecare workers, they need to be elevated and this is something that's probably not in the control of the healthcare plans, but in New York at the lockdown they didn't even know that they were part of the essential working force. And that was a problem because a lot of them had showed up to work on Monday the beginning of the lockdown. So maybe if plans can uplift them and make sure that they know that they are valued parts of their workforce.

And the same goes with the participants. I've been paralyzed for 25 years and everyone and every agency that I have been with has made the decisions for me. And seldom do they ask my input. They tell me how I am supposed to live my life. And as you guys can hear or have an idea, I live a very productive life. I work, I drive as a high level quadriplegic. I just do it differently than everyone else. So I say that saying that when you build policies, try to build it with our input. There's a saying that goes around. Nothing for us without us. And that's basically the core of it. Develop a set of resources and advisory boards to include us in the conversations when you make these decisions. And with that, I want to thank you guys for including me and including the perspective of individuals with disabilities and me as a participant of your services. So with that I had to thank Jennifer. Thank you very much.

Jennifer Kuo: Great. Thank you, Jose, for providing your reflections and insights. And a big thank you to all of our speakers.

So as promised, we're now going to transition over to the Q&A portion of our event. I know that we've already received some questions from folks, so thank you for submitting them. If people have any additional questions, again, click on the red Ask widget at the bottom of your screen and go ahead and get your questions submitted.

So our first question, Stephanie, it's actually for you. Someone asks how your emergency back-up pilot program, how it will be sustained and whether it will be applied to future emergencies.

Stephanie Rasmussen: Thank you, Jennifer. Actually, that is currently in the process of being reviewed. We've shared information with our state officials about the pilot that we manage for the emergency back-up worker program in hopes that maybe we can have conversations about whether it should be included as a covered common home- and community-based services benefit in the future. They've let us know that they really appreciated that value support and the ability to take a look at the positive impacts it may have.

Jennifer Kuo: Great. Thanks, Stephanie. The next question we have is for Gabriel and Anna. What are some examples of any unique and innovative approaches you all are undertaking to ensure that preventive and well care occurs for the dually eligible population with disabilities during the pandemic?

Anna Edwards: Hi, this is Anna. I'll go ahead and respond and, Gabriel, feel free to add to it. But I think in the beginning of the pandemic and then throughout our phone conversations have been focused on kind of the immediacy of the need and rightfully so. So, as we progress and things are getting better we certainly are addressing -- hey, have you been able to schedule an appointment with your primary care provider or follow up with your specialty providers? Do you need assistance with transportation? Do you need assistance with scheduling any appointments for lab work and so forth?

So those conversations are emerging as like a predominant but in the very beginning we were just trying to help people with the immediate needs. With that being said, we've been, again, looking at innovative ways, can we get home health providers to go in and assist with things like lab work or we're looking at vaccines in the home as well. So I think the conversation certainly has turned out of emergency mode and we're able to help to focus on any assistance that our members, particularly those with disabilities may need.

So another way I think, Gabe, you might be able to talk about some of the community resource work and kind of the community partnership work to help support, preventive care and well care and so forth.

Gabriel Uribe: Yes, definitely. One of the things that Jose mentioned about nothing about us without us is incredibly key and talking about in the past with our consumer groups that are providing feedback continuously to the health plan to inform us about what are some of the realities that they're experiencing on the ground. And we do have these quarterly meetings with folks who are dually eligible, persons with disabilities who come to the plan and basically share some of the struggles that they have in even accessing care, literally. A lot of folks have chronic conditions that they have to be continuously monitoring and they share their struggles in terms of getting interpretation services while they're connecting with the healthcare providers that they're interacting

with. They talked about the importance of having some level of access to digital options that they may not have had in the past in order to get proper examinations. Again, in the disability community we know that exams often are not as thorough because there is a lack of access of equipment or accessible equipment in some of the clinics. So one of the other things that is not necessarily the response to the pandemic but continued work that we continue to do with the health plan is ensuring that there is that accessible equipment in physical spaces where people interact with clinicians, but also starting to look at what is the responsibility of the health plan in terms of making also accessible virtual equipment available to folks as they're engaging the healthcare system. And I think that's a conversation that is going to continue to develop in the years to come as we move towards hybrid models from what we've learned from the pandemic.

Jennifer Kuo: Thanks, Gabriel.

Anna Edwards: I'm sorry, Jennifer, there is one more thing I think is really important to address, when we're thinking about well care and promoting health, is we have our saying that we adhere to is that there is no health without mental health. And so, addressing innovative interventions to help members get connected to services and support is really key in the conversation. So it's not just focused on the physical health but also on the mental health. And one of the things that we are doing is we're partnering with an organization called Fix Health and that is going to be focused on using technology to basically reach members who feel socially isolated and lonely. And so that's another thing that we are doing at IEHP. Thank you.

Jennifer Kuo: Great. Thanks for mentioning that last part, Anna, about the mental health impacts of COVID for this population. Definitely, an extremely important aspect when we think about overall health, so thank you.

All right, our next question is for Jose. What are some ideas on how to accommodate individuals with disabilities who want the COVID vaccine but are hesitant? Any thoughts?

Jose Hernandez: I guess connect them with peers, someone that has already had the vaccine like myself. I was hesitant at first. And just to really focus it, people with disabilities and those who are Hispanic and of African descent they are fearful of the vaccine, which is understandable. But connecting with people like myself. I got the vaccine and I let them know this, and I got a little bit of side effects from my second shot because I didn't really have any side effects from the first one and let them know that although you get those side effects it will prevent you from being infected or experiencing severe symptoms from the COVID-19. I myself as a high-level quadriplegic have limited upper respiratory functions. So I knew that I was going to get the vaccine. So connecting them with peers like myself to reassure them and let them know that it is safe and also to let them know that if you don't get it you run the risk of really having severe reactions to the actual virus itself.

Jennifer Kuo: Great. And now let me ask Stephanie and Gabriel and Anna anything within Sunflower and IEHP efforts you all are undertaking in terms of addressing COVID vaccine hesitancy among your dually eligible members with disabilities?

Stephanie Rasmussen: We've been very fortunate in Kansas that we have a pharmacy provider here who has been very willing to go out to locations where individuals are. Now, admittedly, these are locations where multiple individuals are located such as residential homes for persons with intellectual disabilities or day service programs. But they've been very willing to go out to where the individual is located in a setting that's comfortable for them and to help support providing vaccines to individuals who might be fearful just of getting a shot, not necessarily fearful of the vaccine itself but just getting an injection.

We've also really started to put together a resource list and contact our members as we see more and more opportunities occurring with local health departments for getting vaccines out to individuals in their homes. And then we had a vaccine event scheduled actually for today for individuals with brain injuries and their therapy provider was going to actually pick them up and bring them to a location where the vaccine could be provided and unfortunately we had to postpone because the supply we had available was the Johnson & Johnson vaccine. But I think health plans can really take a leadership role in the coordination of getting the vaccine to locations where individuals are comfortable receiving it.

Jennifer Kuo: Great. Thank you, Stephanie. Anna and Gabriel, I'll turn to you next.

Gabriel Uribe: Yes, if I can add to some of Stephanie's comments and sentiments, we agree. Leveraging trusted sites and trusted partners in this space is incredibly helpful. We've been working very closely to both counties that we interact with regularly to stress the importance of having events, for example, for folks with intellectual and developmental disabilities, having it at our regional centers which are the lead providers for services for this population in our two counties. And also offering the vaccine in formats like was shared before at home but also for folks with some disabilities it might be more appropriate do it in a drive-thru model and what does that look like. Or perhaps doing it indoors for different environmental reasons. So just kind of picking a note of what the community is sharing with you, what are some of the access and functional needs that our population has when engaging in these clinics. Often a lot of these equity clinics are conducted in trusted sites but some of these sites tend to be churches or not necessarily under the guise of the ADA or the purview of the ADA. So leveraging some of the health plan resources to make sure that we have eyes on the ground, do site visits prior to engaging in these clinics is incredibly important.

And finally, I think the transportation component. One of the things that we've done at IEHP is really work closely with our UM department for a transportation benefit to make sure that there is also this understanding that for drive-thrus our transportation companies may be providing a different kind of service than they were providing in the past where it's just the drop-off and a pick-up. So what does that look like from our network of

transportation providers, having those conversations up front and sharing the importance of leveraging some of the existing infrastructure in the absence of being able to inoculate everybody at home quickly.

So a lot of different things to kind of navigate through as we're looking at this specific population.

Jennifer Kuo: Great. Thank you, Gabriel. Our next question is also for our health plan speakers. Any additional examples you all can provide of innovative and promising practices from member-focused emergency planning and response during COVID? So either Stephanie, Gabriel or Anna, please feel free to chime in.

Stephanie Rasmussen: Jennifer, I don't know if this is a necessarily upcoming, promising practice but certainly it's extremely important on an ongoing, regular basis for individuals to make sure they have a good emergency support plan in place. And one of the first things we had our care coordinators do when we realized the impact of the pandemic on caregivers and caregiver availability is we had them reach out to individuals, go over their emergency back-up plan includes information about what would you do if you don't have caregivers available, and review whether those supports were still in place and the availability of those supports given the pandemic. It's not always foolproof but I think it's one of the core foundational pieces that individuals with home- and community-based services need to be able to get the ongoing care.

Anna Edwards: And this is Anna and I 100% agree with what she said. In addition, Inland Empire is located in California. In California, particularly in the summer months, has high winds and unfortunately big fires. And so, we have been prepared kind of long ago by taking a look at and partnering with our data team. So we use geomapping and our ICD10 codes so we can, at the ready, have a list of our members who have critical equipment, such as ventilators, such as hospital beds and so forth. So we have a finger on the pulse of where are our members located geographically and especially those members who are maybe at most vulnerable and need our assistance right away. So we've taken advantage of that even in the pandemic time period.

Gabriel Uribe: Anna, that's exactly what I was going to highlight as well with IEHP, so developing apps and resources to handle the response in a data-driven way. And also I think for organizations that are on the line that have financial alignments demonstration, really leveraging some of the care plan options available during the pandemic. One of the first things that in order to address some of what Jose said in terms of the shortage of caregivers, in California we have a model where the county and the state are responsible for in-home support services personnel. And we don't directly contract with them. It's kind of a benefit that is administered through fee for service. And we knew that there was going to be shortages. We knew that there was going to be the need to leverage other systems. And one of the things that we did specifically for our dual population is we made sure that we had open lines of communication with private agencies such as Home is Better or some of the other agencies that do caregiving services to be on call in case some of our members needed access to immediate services. And we could leverage that

financial alignment demonstration benefit to make those connections happen in a quick way.

So I think I go back to listening to what the needs are of the population longitudinally understanding what that is by spending more time with folks who are dually eligible but also during the emergency itself having those conversations and calling those ad hoc meetings to see what is happening that might be specific to the region that you're working with in addition to the best practice that have been shared in seminars like this for a while now.

Jennifer Kuo: Great. Thank you, Stephanie, Gabriel and Anna. A question for IEHP, beyond the greeting cards and the cheer parades at the SNF were you all able to help the SNFs with life-saving interventions regarding their infection protection processes and procedures as these sites where were a lot of the unfortunate deaths of individuals with disabilities occurred?

Anna Edwards: Yes, this is Anna, so, I mean, thank goodness we are in a better space now, but we know of the dire straits that were happening in the very beginning and towards the middle of the pandemic focused on skilled nursing facilities. And I do know that the departments that work very, very closely with all of those facilities were in constant communication and did help when we needed to mobilize members and so forth and taking a look at any way that they could possibly help, which included PPE being given and anything that we needed to do to help the facilities which help our members who lived in those facilities.

Jennifer Kuo: Great. Thank you, Anna. All right, a question for both of our health plans. Looking back over the last year, what additional interventions would you have implemented to assist individuals with disabilities experiencing challenges due to COVID? Stephanie, you want to go first?

Stephanie Rasmussen: Yes, I think one of the things, we have a small pilot right now going on. I hesitate to use the word pilot. We have a small program going on right to try to get a televideo option available to some seniors who are doing some activities to try to alleviate social isolation. And I think one of the things that I would do differently is maybe try to target and address that specific need a little more quickly. How can we help individuals during a pandemic like this who are isolated in their homes with having more and better social contact, and maybe have some more questions when we contact them targeted around the impacts that it might be having to them and with their mental health?

I also think we do a lot of work around identifying the emergency backup supports for our individuals who self-direct their care and making sure they know what their back-up plan is. But I think I would like to on a more ongoing basis gather more information from our providers about what their back-up plans are when we have a state of emergency like this.

Gabriel Uribe: Hi, this is Gabriel, I think for kind of retrospectively we had done a lot of work with emergency planning with the counties in the past. And it was primarily around some of the environmental issues in Southern California. But I think having kind of some of the structural conversations about the importance of having managed care plans, being a critical part of even the emergency response efforts at the county level to ensure that folks with disabilities are addressed at the beginning and then in the forefront of some of the emergencies that occur. Because they do have a higher mortality rate as a group than other groups whenever there is any type of disaster. So understanding what are some of the resources that the health plans can leverage to address some of the complications that will come up in a pandemic or in any type of environment or disaster is critically important.

And I'm thinking, one of the things that keeps coming to mind that we struggled with significantly was, again, just transportation and getting folks to testing early on just when testing was hard to get to. So even developing that plan with our transportation companies on how do we safely transport folks who may be infectious and may be exposing your team to this, how do we get you the proper PPE and what is the protocol to get those things to the site is incredibly important.

And another piece too is how do we reimagine our system of care delivery in a kind of in a different way. Restaurants were kind of forced to go outside and provide services in that way, but what is our overall networks plan to provide care in the future in a situation like this knowing that there is a digital divide that needs to be addressed, knowing that there are opportunities to improve the care from a preventative model and also from a chronic model for folks that are really in the chronic side of care.

Jennifer Kuo: All right. Thank you, Stephanie, Gabriel and Anna. We do unfortunately have to wrap up today's event given the time. I want to first, again, give a very big thank you to all of our speakers today, Chris, Jose, Gabriel, Anna and Stephanie. Also, a big thank you to everyone who attended today's webinar. As I mentioned earlier, the video replay, the slide presentations as well as the transcript from today's event will be available shortly at our ResourcesForIntegratedCare.com website. If you are applying for NASW credit, please complete the post test in order to receive credit. If you have any questions, feel free to send us an emailatric@lewin.com.

Well, also, please take just a moment to complete our brief evaluation form for this webinar. That will help us to continue to deliver high-quality presentations. The survey should appear on your screens following the conclusion of this session.

We also invite you to provide feedback on our other RIC products as well as suggestions to inform the development of potential and new resources. The link to that is provided here on this slide.

The next two slides provide a list of some relevant resources from today's event. I know that many of these were referenced by our speakers today and we also had pushed some out for the participants in the chat. I do want to note, the first resource listed here is a

resource from the Centers from Disease Control on COVID-19 and people with disabilities.

Here on the next slide we list some newly released HHS guidance and resources to ensure and expand access to COVID-19 vaccines for people with disabilities.

And then lastly here on the final slide, just wanted to let everyone know that Resources For Integrated Care does have two upcoming webinars. On May 5, there will be a webinar on diabetes care assessment, planning and management during COVID and then on May 12 a webinar on supporting the preventive healthcare needs of dually eligible women with disability. You can register for both of those events on our resources for integrated care website.

Again, thank you everyone for attending and participating in today's-event. This concludes our webinar.