COVID-19 Vaccinations: Using Dashboards for Tracking and Monitoring Tip Sheet

COVID-19 dashboards and reporting systems are essential tools most health plans use to better identify members' COVID-19 vaccination status and conduct targeted outreach during the public health emergency. They also allow health plans to understand the sub-populations for which they should focus their efforts to improve member vaccination rates. We share some tips and success stories from health plans on COVID-19 dashboard development and how they leveraged dashboards to facilitate member outreach and engagement. You can find an infographic that includes real-world examples of health plan dashboards linked **here**. We would like to thank LA Care, Commonwealth Care Alliance (CCA), and Molina Healthcare for their contributions to the development of these resources.

Display data elements that capture vaccination status, member demographics, health conditions, and health data

Example data elements:

- Vaccination status (e.g., not vaccinated, partially vaccinated, vaccinated without booster shot, vaccinated with booster shot)
- Member demographics: member location, sex, age, race/ethnicity
- Member health conditions: chronic disease status, homebound status
- Member health plan data: delegated participating provider groups, assigned primary care physicians, authorization data

Incorporate external "social vulnerability" indices to better identify and understand communities with high risk for health inequity

- Social vulnerability refers to communities where there are potential negative effects caused by external stresses on human health such as natural or human-caused disasters, or disease outbreaks.
- Accounting for social vulnerability can help health plans identify and address inequities that may exist in some communities.
- Example indices includes:
    - CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI)
    - CDC/OMH Minority Health Social Vulnerability Index (SVI)
    - Dignity Health and IBM Watson Health's Community Needs Index
    - CMS OMH Tool: Mapping Medicare Disparities

Develop an algorithm for identifying high-risk members

- Identifying high-risk, unvaccinated members is important to target outreach phone calls or text messages to support members who are the most vulnerable.
- Many health plans used data such as diagnosis codes and procedure codes to identify at-risk members with a chronic disease or who are homebound.
- LA Care developed a custom machine learning model to apply a member level risk score that predicts the likelihood of the member being hospitalized if they contract COVID-19.

Supplement claims data with self-reported information gathered during member outreach

- Using self-reported information (e.g., feedback on a member's social supports and challenges) can help plans supplement claims data with more detailed information such as members' social determinants of health, chronic conditions, or vaccine hesitancy.
- ***Example questions to members to solicit supplemental information:***
    - What family/personal supports do you have?
    - Have you experienced any service interruptions?
    - Review medication and treatment management
    - What successes/barriers are you experiencing with daily activities such as eating, bathing, dressing, and moving/walking around?
    - Do you have any respiratory needs? (i.e., concentrator, tanks, vendors)
    - What concerns do you have that might be impacting your health? (i.e., social isolation, food instability, financial concerns, etc.)
    - Are you adhering to social distancing guidelines?
    - Are you engaged with a primary care provider?
    - Have you had and/or been exposed to COVID-19 in the past 30 days?
    - Have you been vaccinated for COVID-19? If not, what is your willingness to be vaccinated?
    - What is the best way to contact you?

Share aggregate observations, trends, and patterns with public health partners to inform on-going outreach and communication strategies

- Understanding health plan subpopulations can inform member outreach and engagement
- Many plans shared their COVID-19 dashboard weekly reports internally to bring attention to areas (either geographic or among certain populations) where disparities in vaccine uptake existed.
- Health plans may consider communicating their COVID-19 response efforts on their public websites, for example this page on response efforts from LA Care Health Plan or this page on COVID-19 alerts from the Commonwealth Care Alliance.

COVID-19 Data Dashboards: Successes, Challenges, and Key Takeaways

LA Care	
Dashboard Goals	• Identify members who are at risk for chronic disease or homebound to provide care • Target subpopulations that are more vulnerable during the COVID-19 public health emergency
Successes	• Collaborated with retail pharmacies to provide outreach and vaccination for unvaccinated members • Developed vaccination incentive programs • Shared observations and trends with Los Angeles County public health partners to inform public health strategies • Data validated the need for the plan to target the Black population due to lower vaccination rates • Identified unvaccinated, high-risk members to target for phone call and text message campaigns
Challenges	• No definitive approach on how to "flag" high-risk COVID-19 members during the early stages of the public health emergency. However, over time, LA care developed a custom machine learning model to apply a member-level risk score that predicted the likelihood of the member being hospitalized if they contracted COVID-19 • The State of California collected public requests for in-home vaccinations, which was in turn provided to health plans. However, the state did not always provide this data consistently, and the health insurance information within was not always accurate. Access to vaccines in rural or high desert areas is more difficult
Takeaways	• LA Care plans to use the COVID-19 data dashboard as a template for reframing how they approach other preventative services, such as flu vaccination
Commonwealth Care Alliance	
Dashboard Goals	• Understand homebound population needs • Have the ability to do wellness checks on members (food, heat, medication)
Successes	• Incorporated publicly available wastewater data from treatment plants to identify potential hotspots for breakouts (the COVID-19 virus can be detected in fecal matter found in wastewater, so wastewater surveillance data served as an early warning of COVID-19 spread in a community) • Used medical claims data to identify members within specific cohorts who were eligible for vaccination • Behavioral health specialists did wellness outreach to 15,000 people
Challenges	• Monitoring challenges as both a health provider and a health plan; access to data varied depending on whether CCA operated as a plan or provider in outreach
Takeaways	• CCA was building a vaccination data model for the flu prior to COVID-19 public health emergency, so they were able to adapt this model to use for COVID-19
Molina Healthcare	
Dashboard Goals	• Identify which members have or are suspected of having COVID-19 • Understand how many members are impacted by the public health emergency, including the impact on medical costs, and impact by demographic group (race, age)
Successes	• Identified vaccination status of members • Identified which members were impacted by COVID-19 or considered to be high-risk • Data is available and used at both the corporate level and the plan level
Challenges	• Difficulty integrating multiple data sets into a cohesive model • Keeping up with government mandates and incorporating into the data dashboard
Takeaways	• Similar to LA Care, Molina Healthcare plans to use COVID-19 data dashboard as a template for reframing how they approach other preventative services, such as flu vaccination

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