Resources for Integrated Care
Promising Practices for Promoting Person-Centered Communication and Care Coordination
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Katie Palmisano (Facilitator)

Hello everyone. My name is Katie Palmisano (Facilitator), and I am with the Lewin Group. I am honored to serve as your event facilitator today. Before we begin, we would like to orient you to the webinar platform. Audio should automatically stream through your computer speakers. Please make sure that your computer is connected to reliable Internet and that the speakers are turned up.

If you are experiencing any difficulties with your connection, please turn off your network VPN for the duration of the event. There is not a phone dial in option, but a recording of today's event will be available soon.

In the center of your screen, you will see the slides for today's presentation. Below the slide presentation are resources to download including a PDF of today's slides and a FAQ document. There is also a Q&A box where you can enter questions for our presenters or chat with the web and our team. Should you need support, our team will also share helpful messages throughout the event via the Q&A box.

Closed captions are also available. If you select the Resources icon, you can move the windows around to fit your screen and if you minimize the box and would like to bring it back, you can click on the associated icon on the bottom of your screen.

Welcome to the webinar *Promising Practices for Promoting Person-centred Communication and Care Coordination*. We are grateful that you took the time to join us today and we look forward to sharing promising practices for promoting person-centred care coordination with an emphasis on communication focused strategies that health plans and providers serving duly eligible individuals can use to overcome common barriers.

Today's session will include presentations from our esteemed presenters, a panel discussion, and finish with live Q&A with panellists and participants. This session will be recorded and the recording and a copy of today's slides will be available at resourcesforintegratedcare.com.

This webinar is supported through the Medicare Medicaid Coordination Office at the Center (MMCO) for Medicare & 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 support providers in their efforts to deliver more integrated, coordinated care to duly eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

To learn more about current efforts and resources, please visit our website resourcesforintegratedcare.com or you can follow us on Twitter, recently rebranded as X. Our handle is @Integrate_Care and you may also find us on LinkedIn.

The road map for our time together today is as follows. We will start by collecting some information from the audience via polls and reviewing background information. Then our presenters will share the following: Kim Kunz from My Choice Wisconsin (MCW) will present about the health plan's approach to care coordination and learning, and improvement in action. Karla Argandoña from Inland Empire Health Plan (IEHP) will then present IEHP's approach to language access.

After these presentations, our presenters will offer their perspectives in a guided panel discussion before we engage in some Q&A leveraging questions that you, the audience, submits throughout today's event. If you have questions, please type them into the *Ask a Question* box as we go and we will answer as many as we can.

We will close by sharing helpful resources and requesting your feedback on the information shared today.

At this time, I'd like to introduce our presenters: Kimberly Kunz is the Director of Care Management for the Family Care Partnership, Dual Advantage, and SSI program of My Choice Wisconsin. She holds a bachelor's degree of science in social work from the University of Wisconsin, Milwaukee. She's a licensed social worker within the state of Wisconsin and has extensive experience with frail, elderly individuals with physical and

intellectual disabilities. She has 20 years of experience in the healthcare industry and a demonstrated history of working in Medicaid and Medicare funding models.

Karla Argandoña is a Senior Analyst at the Inland Empire Health Plan Community Health Team and is responsible for the implementation and development of enterprise-wide social support programs. She's a leading expert in healthcare communication accessibility for people with access and functional needs and has been with IEHP since 2015.

The event will accomplish the following learning objectives: First, understand and implement actionable strategies for member outreach and engagement. Second, identify approaches to structuring interdisciplinary care team communication and information sharing to promote care coordination. And finally, recognize strategies for facilitating continued member engagement during transitions of care.

As noted earlier, we're going to poll the audience before we launch. You should see a pop-up on your screen asking, “Which of the following options describes the care setting in which you work?” To ensure all participants are able to participate in the poll, we're going to read through all responses for polls and folks can chat in their responses or click the button corresponding to their response.

The goal of this question is to get a better sense of our audience members today, the options you may select from are: health plan, ambulatory care setting, long term care facility, home care agency, community-based organization, consumer organization, academic/research, or other. I'll give it just a minute so we can see the top response come in.

Again, we're asking folks to either select the button on your screen with the poll pop-up or you can send in these responses via the Q&A hub. We'll just give it one more moment for the top response to come in.

Looks like our top responses are health plan and community-based organizations. So, thank you everyone for entering your response to that first poll.

The second poll asks, “Which of the following best describes your professional area?” Response options include: health plan case manager or care coordinator; health plan customer service; health plan administration or management; medicine, nursing, physician assistant, or other provider; pharmacy; social work; advocacy; or other. Again, you are welcome to select the button that corresponds with your response to this question. Otherwise, feel free to enter your response in the Q&A box and we will tally up those responses and share the top two with you shortly.

The top two responses were health plan case manager and social work. So, welcome to all of our case managers and social work professionals here today.

Our final poll asks, “How familiar are you with communication-focused strategies to promote care coordination for dually eligible beneficiaries?” For example, supporting interdisciplinary care teams, information exchange, hiring or contracting translation services. Your response options include very familiar, somewhat familiar, or not familiar. Again, you're welcome to select the button corresponding with your familiarity with these communication focused strategies. Otherwise, please feel welcome to enter your response in the Q&A box and we will gather and tally those responses and look for the top response here in just one moment.

It looks like there's generally familiarity amongst our audience. So, somewhat familiar, and very familiar were the top two responses. We’re hoping to use today's presentations to really share some additional information about those strategies with you all today.

I will now provide some background on dually eligible individuals and care coordination and communication.

As noted in available literature, dually eligible beneficiaries have a higher prevalence of complex health conditions and unmet social needs than their Medicare only or Medicaid only peers. They're also at high risk of fragmented care due to navigating multiple settings, care providers, and different coverage policies between Medicare and Medicaid.

Care coordination for dually eligible beneficiaries refers to managing care transitions, coordinating benefits across the Medicare and Medicaid programs, and ensuring social needs are addressed.

Communication accessibility serves an integral role for successful care coordination. Health plans and providers of dually eligible beneficiaries must meet communication accommodations aligned with federal

regulations, and communication accommodations include providing available or accessible formats tied directly to care coordination activities such as health risk assessments and care plans.

The literature indicates that communication and language barriers are associated with decreased quality of care and poor clinical outcomes in the general Medicare population. And dually eligible beneficiaries, in particular, are more likely to need communication accommodation relative to individuals only eligible for Medicare, and they represent 21 percent of the total population enrolled in Medicare or Medicaid with limited English proficiency or LEP.

Our Resources for Integrated Care team recently hosted a Community of Practice focused on care coordination. The Community of Practice consisted of approximately 20 health plans serving dually eligible beneficiaries and included health plans serving diverse populations across the United States.

The Community of Practice explored a range of care coordination topics, including communication focused strategies for engaging hard to reach members and supporting seamless care transitions. Health plans participating in the community of practice identified strategies to enhance care coordination and communication, including increasing interdepartmental communication within health plans, developing dedicated teams to conduct member outreach or respond to member inquiries through multiple modalities such as texting campaigns, expanding outreach to members during the evenings or the use of personal assistance lines, and fostering community and health system partnerships to promote member engagement and facilitate access to community resources, support identification of member communication preferences and up-to-date contact information, and improve care transitions.

I'm looking forward to some engaging presentations from our speakers. Without further ado, I will turn things over to Kim Kunz of My Choice Wisconsin. Kim, the floor is yours.

Kim Kunz

Thank you very much. Hello, everyone. My name is Kim Kunz, and I am the Director of Care Management for My Choice Wisconsin. I'm going to be reviewing our approach to care coordination and sharing some learning and improvement in action steps today. Next slide please.

So, providing a little history here on My Choice Wisconsin. My Choice Wisconsin is a managed care organization that serves government funded programs to seniors and adults with disabilities in over 50 counties. Some of our programs include Family Care Partnership, Family Care, Medicaid, SSI, and Medicare Dual Advantage.

My Choice Wisconsin offers two plans for our dually eligible beneficiaries. We have a fully integrated dual eligible special needs plan which is referred to as a FIDE-SNP. The FIDE-SNP integrates Medicare, Medicaid acute and primary health, long-term care, and waiver services through our Medicaid contract with the Wisconsin Department of Health Services. The IDT includes care management, registered nurses, and others are engaged as needed. For example, nurse practitioners, dietitians, and behavioral health providers.

Coordination only is called the CO D-SNP, so [it] enrolls full benefit dually eligible beneficiaries and provides Medicare acute and primary health services, while coordinating across the continuum through collaboration with Medicaid providers. There are also some additional supplemental benefits with that plan. Members are assigned to a care coordinator as a primary and we have an RN and others that are engaged as needed, as well. Next slide please.

Now, I'm going to move into the plan demographics for My Choice. You can see we have a total eligible member population of 1,400 for our FIDE-SNP and 800 for our D-SNP. So, it breaks it out here in some member characteristics. So, female versus male, it lays it out as 64 percent versus 36 percent. We have the age groups from 18 to 64, 65 to 85, and 82 to 100 with that middle age group that's 65 to [85] coming in with the highest percentage. Race and ethnicity: we have the White/Caucasian, African American, and Unknown/Other, with White Caucasian being the highest percentage at this time. Language also as follows is English, Spanish, and Unknown/Other. English at 93 percent is the highest percentage for our plan demographics.

Beneficiaries who enroll in the My Choice Dual Advantage program - the D-SNP - are often also enrolled in our Family Care program (that's currently a 58 percent enrolment) and SSI has 20 percent of those dually eligible members enrolled in their plans. This helps to ensure they receive comprehensive services through these FIDE-SNP fully integrated plans. Next slide, please.

So, we're going to move into just some challenges and some strategies to meet population needs that we've gone through here. A common challenge in providing care coordination for dual eligible beneficiaries are as follows. We have members that have multiple morbidities with mental health conditions and a lot of social factors that impact their care needs. We have limited health literacy. We have workforce shortages and fluctuations and enrollments in caseload sizes. Another challenge here is barriers to access up-to-date member information. That continues to be a really difficult barrier that we continue to try to get creative with.

Strategies to help meet the dual eligible beneficiaries' care coordination and communication needs include building capacity within the matrixed IDT so they have time to work through all of those things that the members need in their complex care. Leveraging [the] health information exchange [HIE] system and community care plans [CCP] to support coordination. I'll get into that a little bit more specifically further on in the presentation as well. And then implementing initiatives to address health literacy and cultural competence. Next slide please.

So, moving on to our first strategy here that I'm going to dive a little bit more deeper in, is building capacity within matrixed IDTs. Next slide please.

So, here's some of our composition and activities that have helped with that strategy. So, our overall composition includes care manager which is a CM [Case Manager] and RN, subject matter experts that include nurse practitioners, physician assistants, and pharmacists, who are consulted to partner the care for beneficiaries with their complex needs. We also have other subject matter experts from our behavioral health and member health and safety team as well that I would like to add on to there along with a lot of other ad hoc subject matter experts that we pull in based on the unique member needs. IDT care coordination activities include, but are not limited to, creating and updating care plans as needed, based on the beneficiary's preference and changes in conditions. We try to keep those documents living, breathing documents, so at any time they're completely reflective of the member's needs and current care. Setting up health and safety goals, accessing the providers and the treatment and the beneficiary needs. Coordinating appointments, helping the member assess their benefits, including supplemental benefits that they may be offered through their program, connecting them to help with social determinants of health. So that would be linking them with food, housing, and other community resources. Next slide please.

So, moving into some best practices for maximizing the IDT capacity are as follows. We have implemented the subject matter experts like I mentioned on the previous slide. We have nurse practitioners, physician assistants, pharmacists, behavioral health, and some of those other subject matter experts I have mentioned.

They help to assist with increasing interventions and improving outcomes for the complex beneficiaries that we do serve. There's clear roles in areas of accountability across this IDT. Intentionally small caseloads per IDT as well. For the FIDE-SNP, they average anywhere from 50 to 55 beneficiaries per caseload. This also allows for travel and there's pretty intensive home visits with that population as well.

The caseload sizes get a lot larger with our Dual Advantage program (D-SNP). The average - anywhere from 100 and it can be actually more than the 120 per caseload - is really based on the member's need level and what is all needed. But that care management is handled telephonically, so there's no home visits if they're enrolled only in our D-SNP program.

Another strategy for maximizing the IDT's capacity is creating a culture of learning, collaboration, staff retention. We have worked on proactive approaches to continuous quality improvement and assurance. We have staff focus groups. We have mock audits. We actually just went through a full CMS audit as well. So those mock audits came in exceptionally handy, and all of our staff were prepared for the actual audit. Opportunities for individual personal growth. Regular communication to our staff about training opportunities; lunch and learn opportunities are a big hit within our organization. Next slide please.

Here is a case example of quality improvement that we put into action earlier or actually not earlier this year, but very late in 2022 and it's evolved into this year 2023. In December of 2022, My Choice developed a new template approach that we used in the processes laid out below, excuse me, and lays out the structure and the activities for the IDT.

The template approach outlines when additional members are added to the care team meetings. It lists their position, their discipline, their credentials and helps support team communication. Members of the IDT leave the meeting with clear expectations regarding next steps.

So, if you look through those boxes here, you can see we had a baseline for IDT composition. The sole accountability rests with the CM and RN. We kind of transitioned here into the next blue box for the mock audit and focus groups where we identified a need for the additional staff support and clearer lines of communication and accountability across all of our care management teams and subject matter experts.

With all that feedback and learning experience, we created a new IDT template and expanded team composition. So, the IDT centralizes input across all clinical and lays out subject matter experts for each individual member record. It's very unique and specific to the member. And then this is still in progress. So, we're continuing the evaluation of this new IDT template.

Early findings do suggest improved understanding of team roles and opportunities for improved member engagement. Next slide, please.

Lessons learned from IDTs: team composition works best if it's flexible, so subject matter experts can participate in beneficiaries care coordination team as needed. So, it's best if we have that primary team, the RN and CM, but those other subject matter experts float in and out as needed, based on that members need. Having some really strong communication but flexibility makes that team composition work best.

Evaluating caseload sizes on an ongoing basis; acuity with new enrollments can impact care coordination and work volume. So, even if someone has a higher caseload of 50, but they don't have some very significant complex care management going on at the moment, they might be able to serve all those members and excel with all their needs and documentation. But if an IDT would have some member that has some really elevated care needs or some complex management going on, we might work with them to make sure their caseload size is adjusted appropriately to make sure they have the time to work with those members efficiently.

Fully integrated plans show promise for better beneficiary engagement. My Choice experiences more engagement and calls back from beneficiaries in our fully integrated plan. When members have both the long-term care and their acute and primary managed through our fully integrated model, we tend to have a lot of engagement and return phone calls from those members when we're trying to make contact with them.

Maximizing IDT capacity supports the maintenance of good communication and along with the beneficiaries. Good IDT communication is just going to make the communication with the beneficiaries excel as well. Next slide please.

Moving on to our second strategy which we are going to talk about leveraging HIE and CCPs to support coordination. Next slide please.

Best practices for leveraging HIE to receive timely health encounter data. So, this is definitely a really great strategy that we have implemented. So, My Choice contracts with WISHIN which is Wisconsin state designated Health Information Exchange.

We leverage it by… WISHIN sends our organization's information technology team a data file daily of beneficiaries' health encounters that is directly integrated into our care management system. My Choice also sends real time messages about beneficiary events at acute and post hospital facilities, admissions, discharges, visits, medical leave of absence, or death.

We get notification through our documentation system as well along with notification from our utilization team in regards to any of those events. My Choice Care management documentation system notifies relevant IDT members to assist with timely care coordination for that beneficiary. Early discharge planning, timely transfers to lower acuity settings, and it helps us schedule those follow up appointments as well. Next slide please.

Now I'm going to move into the kind of more the description of the community care plans. Community care plans provide a pathway of communication between beneficiaries and their healthcare providers.

So, not only do we have our ongoing care plan that is developed among the core team, but we also have one that is developed with really strong engagement and involvement from the nurse practitioners and physician assistants, if it's deemed appropriate for that member. This helps us to achieve desired health goals and it helps create collaboration with the beneficiary, their primary care physician, and all other IDT staff that are surrounding that beneficiary. For example, if a member goes to three different emergency rooms, that is shared and in their documentation system…will help those [in] primary care… those ED visits will help coordinate that member's care and make sure we're all on the same plan for continuity of care.

The community care plans include their condition, whatever unique circumstances that member might have, their goals, as well as the name and contact information and the roles of the IDT. So, everyone has access to that. We can make contact with each other right away.

Community care plans also have been helpful with preventing acute or increased readmissions for complex beneficiaries.

Our nurse practitioners or physician assistants work on developing those processes with those community care plans, and they go through the below process, so they walk through the IDT with the member, and work proactively with the NP and PA to identify, diagnose, and manage treatment plans for our high-risk beneficiaries. NPs and PAs lead the development of the community care plans and maintain the medical care plan of care in collaboration with the primary care provider. The PCP keeps the record of the community care plan and the awareness of the plan across all medical systems involved in that beneficiary's care.

Efforts are underway within My Choice to integrate the community care plans into the HIE. So, we really look forward to that and that'll be key to continuing the great progress with these. Next slide please.

So, this next slide just goes through an example of what we all include for these community care plans. So…there's background information listed on the community care plans. A beneficiary has increased hospitalization, advanced diastolic heart failure, longstanding type 2 diabetes, stage 4 chronic kidney disease and chronic obstructive pulmonary disease likely nearing end-stage heart failure. So, this is just an example of some of the background information we would provide on this specific beneficiary with My Choice and wanting to provide that. So, anyone reading that care plan knows their overall background of health complexities.

Some of the areas of intervention are noted through the beneficiary's care goals and then it lists, it clarifies an ongoing discussion to guide the treatment plan, hospitalization use, and overall care.

The community care plan also lists out by IDT activities. It has the name, the organization, contact information for anyone that is involved with that member's care plan. So, it could be the RN, CM, PCP, other specialists, nurse practitioner, supportive home care workers, anyone who's really vital in making that member safe [to] return to their community home or wherever they reside.

Others include… we include any other pertinent community supports or information, if they have a psychiatrist or mental health providers, anything like that. We would also list those out to under the IDT activity section.

Beneficiary goals and aligned strategies and interventions. These are key because not only does it tie into the background and IDT activities, but this is really the main goal of the care plan, right? So, this member is just an example, would want to remain in her own home to avoid hospitalizations. So, this is minimizing medical appointments that required her to reduce intake for the day because it also impacts her urinary incontinence and quality of life. This member's goal is also to consult with specialists and other providers regarding their goals. So, it just lays it out. This is a very slimmed down information. The care plans themselves are very robust in nature, but I thought it would be helpful just to share a brief example of overall what they include. Next slide please.

Moving on to Strategy 3, I'm going to talk about implementing initiatives to address health literacy and cultural competence. Next slide please.

An organization culture that values cultural competence. Cultural competence is a core component of education and training for all of our care management and care coordination staff.

Culturally and Linguistically Appropriate Services (CLAS) are defined as services that are respectful, in response to health beliefs, practices, and needs of diverse patients. CLAS is a way to improve the quality of services provided to all individuals, which will ultimately reduce health disparities and achieve health equity.

Partnerships with community organizations help infuse cultural competence into the design, implementation, and evaluation of our policies and practices, and ensure cultural and linguistic appropriateness.

We have also worked through establishing a collaborative partnership with an organization in one of our counties, which is called The Beacon. The Beacon is a resource center for people experiencing homelessness. The Beacon assists with housing and navigation services, which offer a mail center, identification system or assistance and access to phones, a computer lab, and other courses that may be relevant for that member. We do have a care coordinator that visits the Beacon weekly to engage and catch members organically when

they're kind of coming in and out of that resource center. This is something new our quality team has worked on.

We have engaged Nurse Disrupted. It's a telehealth mental health treatment option for members. My Choice Wisconsin sponsors hours for community members to receive services and this partnership helps address transportation issues, caregiver responsibilities, emergency department overcrowding, and health care staffing shortages. We're tracking member engagement and impact to well-being as telehealth promotes respect and privacy for our members. Next slide please.

In my last slide here before I transition it off, I'm going to talk about the health literacy workgroup that was just implemented in early 2023.

Our Population Health Manager had worked to develop a Health Literacy Workgroup to develop, implement, and evaluate a formalized plan to improve health literacy among beneficiaries and build awareness about the importance of this issue throughout our whole organization. A new health literacy screening tool is on track to be implemented into our care management system January 1st of 2024.

We also support members, member input, and education on the topic of health literacy to improve care coordination and outcomes. All written materials are developed at a 6th grade reading level to help with that. Demographic data, including member language needs or preferences, are tracked in our internal data system and documentation system, and they're analyzed for purposes of improving data accuracy and reliability and evaluating the impact of the CLAS standard on health equity and outcomes.

The health literacy work group is also responsible for proactively ensuring My Choice meets CMS requirements for a digital health literacy for Medicare Advantage enrollees. So, we're screening Medicare members for digital health literacy level in their screening and we're offering a digital health education program to beneficiaries and documenting types of education received.

Katie Palmisano (Facilitator)

Thank you so much, Kim. That was wonderful, thank you so much. Next, I'm going to toss to Karla Argandoña from Inland Empire Health Plan [IEHP]. Karla, the floor is yours.

Karla Argandoña

Thank you. Good morning, everyone. Once again, my name is Karla Argandoña and I'm a Senior Analyst here at Inland Empire Health Plan. And I'm going to go ahead and share with you guys Care Coordination and Communication: IEHP's Approach to Language Access. Next slide please.

So, just a little bit about IEHP and who we are. So, IEHP is a large Medicaid health plan and not-for-profit Medicare-Medicaid plan. We have 1.6 million members. We have over 7,000 providers and 3,000 team members that serve IEHP members. IEHP does serve the low-income individuals and families in San Bernardino and Riverside County in California, and we are predominately in Southern California.

So, we have over 30,000 members that are dually eligible and one-third of dually eligible members speak Spanish as their primary language. And 5 percent of dually eligible members who speak Spanish have an alternative format request. Next slide please.

So, we want to talk about real world scenarios and how would you respond. So, a member who is blind calls and wants access to a provider directory in Braille. A member with low vision is unable to memorize their member ID number. A member with low vision states they can no longer receive their materials in an audio CD because their CD player broke. A member's caregiver has Limited English Proficiency and needs an American Sign Language (ASL) interpreter at an impromptu visit to an urgent care center. A behavioral health provider refuses to see a non-English speaking member because they do not believe that therapy will work when an interpreter is needed. Next slide please.

So, these are some of the kinds of scenarios that did take place in our health plan, and these are some of the examples of creative solutions that may benefit members and plans. So, a provider directory in Braille may cost $25,000 and would be incredibly difficult to navigate. When our health plan started to provide alternative formats, one of our mistakes was to order a provider directory in Braille. We quickly realized that it was not efficient as a standard provider directory is 1,308 pages long. So, we received quite a few boxes that contained the material in Braille and quickly realized that a member would have difficulty navigating through the 30 plus boxes we received. So instead, what we do now is that we do offer an e-format directory instead. Or if a

member does not have appropriate hardware, we offer access to a device like a laptop or something similar. A laptop may cost anywhere from six [hundred] to five hundred dollars versus sending them something, a document in Braille that may not be efficient for them to utilize.

So, services like transportation vendors may require a member's ID number before setting up a service. Here at Inland Empire Health Plan, what we do is we have a small recording device that we provide to our members to record their ID information. We do offer it to be encrypted, passworded, or we do have security options as well for them.

We had a member once who had called us and stated that they no longer wanted to receive their audio CD files because their CD player broke. But he didn't want to be dependent on his son reading his letters to him so a broken CD player can be easily replaced. So, we also consider sending audio files if a member has a computer or MP3 capable devices like a smartphone. Next slide please.

The urgent cares are primary care sites, but unlike hospitals, most do not have video remote interpreting devices or in-person interpreters for beneficiaries or caregivers who use American Sign Language. So, consider purchasing devices for the network and offer access to VRI services via a vendor. And this is something that we have established here at IEHP all of our contracted urgent cares. We did provide them with VRI system and access to video interpreting services or when a member who does need those interpreting services at an urgent care facility has access to care.

The behavioral health [services] take time and it's a journey. So, we've informed behavioral health providers about the need to serve beneficiaries with LEP and we work with interpreter vendors to provide one or more interpreters for members seeing behavioral health providers' long term. Next slide please.

So, IEHP strategies to meet population needs. So, examples of IEHP's approach to meeting dually eligible members' communication and care coordination needs include building health plan infrastructure and staff capacity to track and meet member communication preferences and leveraging key partnerships to align communication and care coordination strategies. Next slide please.

Again, our Strategy 1 is building health plan infrastructure and staff capacity to track and meet member communication preferences. Next slide please.

So, we evaluate plan communication, accessibility, infrastructure. So, identify internal health plan stakeholders with the capacity to identify and track member communication, accommodation needs, information technology, health informatics, enrollment unit, Language Access Team. Here at IEHP we have our Independent Living and Diversity Services team, care coordinators, and member outreach team. So, we work closely together with different departments, and we do have meetings to just kind of track any type of accommodations that come into the health plan and how we can better serve our members.

So, ask yourselves: Do you have a dedicated team focus on communication, accessibility? Do they have the capacity to review quality? Do they train and promote services equitably? How do they collaborate with internal partners and care coordination teams?

At IEHP we realized we would need a team that focuses on accessibility needs. So, we hired full time employees who are cultural and linguistic specialists. Their roles support capacity, quality assurance, and support internal departments, and work with our external vendors as well.

So, identify the type of language access request. It is important to ask our members what type of accommodation they would need. Not every accommodation will be the same, so for instance alternative format requests. Our members do have the option to receive a standing request, meaning that every letter that gets sent out to them could either be sent to them in large print, Braille, or in audio CD in electronic format as well. Or sometimes the other option they have is a one-time request.

Sometimes they have a caregiver that may be assisting them, and that caregiver might need the form in large print. So spoken or sign language access. So, we do prefer our interpreters to be in person. We understand that sometimes that may not always be the option. So, we are we ensure that we have a telephonic option for our members and video remote for our ASL members. Next slide please.

So, build health plan communication accessibility infrastructure. So, strategies for promoting member access to communication accommodation. We educate all teams on accessibility.

We have care coordination teams and case management, grievance and appeals, sales and member services. Our member services is our very first - kind of - line of defense that we like to say. Here are the very first ones

that our members speak to sometimes. And so, we provide our team members with standard operating procedures and job aids to ensure that everyone has access to training documents as to how to provide our members with accommodations when it comes to communication. We also establish an in-person interpreter vendor relationship.

So, regardless of the visit type, we said our priority is to have an in-person interpreter by default and we only use video remote or telephonic interpretation as an as needed basis. We may provide additional benefits for plans. It could provide reducing waste, fraud, internal resources, and improve reporting for quality programs. We set alternative format thresholds.

So, we develop a process for large print communication via standard in-house or print vendor and we established approaches for producing large Braille documents, so we invest in e-formats. Next slide please.

So, our Strategy 2 is leveraging key partnerships to align communication and care coordination strategies. Next slide please.

It takes a village to identify and build key partnerships, so consider network provider collaborations to support member communication and care coordination. IEHP's independent living and diversity department works very closely with our pharmacy benefit manager, our IPAs (independent physician's associations) and urgent care settings.

So, they know that if our IPAs, pharmacy management, or urgent cares… any time that they come across maybe a barrier, they know how to communicate with our department and our cultural linguistic coordinators. Our specialists actually are able to train and assist them in their needs. Invest in vendors and strong service level agreements across all contract services to build robust language resources.

So, develop internal auditing and monitoring process, work with partners that members trust to identify, develop, and implement solutions to meeting member care needs. Community-based organizations always are very important.

IEHP recently held a meeting with our local CBO, with CODIE. So, that's the Center on Deafness - Inland Empire. And on our meeting, we realized that we need to provide the symbol for interpreter in all of our marketing materials as well as a TTY contact number.

This is why we find the importance in collaborating with our local CBOs to help identify our members' needs. But also, we like to collaborate with our resource center serving large volumes of individuals with LEP. Next slide please.

And oh, I want to say this is my last slide. So, thank you guys for your time.

Katie Palmisano (Facilitator)

Thank you so much, Karla. We will now move into our panel discussion with Kim and Karla. The first question I'd like to direct to Kim and then Karla may follow. How does staff retention and capacity building contribute to the success of care coordination and communication at your organization, Kim?

Kim Kunz

Thank you. One of the most effective strategies is to seek feedback from staff and act on feedback that can assist with improved communication. We have found that staff that are engaged and they feel valued, they're going to extend that level of service to our beneficiaries or our members.

Another thing we have noticed that staff retention enhances compliance on care coordination. It aids in patient care coordination and promotes prioritization and collaboration to assist with addressing members' changing needs.

Staff retention and capacity building contributes also to successful care coordination and overall communication. We have found that retaining valued staff really help ensure staff remain productive, they're engaged as well as providing continuity of care for all of our members.

Katie Palmisano (Facilitator):

Thank you, Kim. Karla, how about you?

Karla Argandoña

So, our organization emphasizes the importance of conducting team huddles, with each business unit. The huddles are structured where the team members can be transparent and share ideas with one another. We involve team members in the decision making and development of internal process, and we also encourage our team members to participate in professional development training.

Katie Palmisano (Facilitator)

That's great. Thank you so much Karla. The second question is how does your organization support dually eligible individuals and their caregivers in expressing their communication preferences? Karla, do you mind if we start with you?

Karla Argandoña

Yeah, so here at IEHP, we do provide information on communication preferences in several ways through the member handbook, evidence of coverage, and materials that are sent out to the member throughout the year. Our organization has a process in place to identify keywords or phrases when a member or caregiver expresses access needs.

For instance, if we hear a member state that they have vision problems and are unable to read the small font on letters, we educate them on alternative format request and provide them with local resources for those with low vision if needed.

Katie Palmisano (Facilitator)

Thank you, Karla. Kim, do you mind for describing My Choice Wisconsin's approach?

Kim Kunz

Absolutely. Our membership gets a health risk assessment completed after they enroll with us. The care coordinators go through the whole assessment with the members. The assessment has sections that we gather, Member preferences and preferred communication. We have sections that include but aren't limited to demographic information, education, culture, gender, identity section, memory, communication, health, literacy sections, along with support and strength.

So, the assessments and the member's information is reviewed throughout the year to make sure member preferences have not changed and the care team is aware of the member's preferences.

Katie Palmisano (Facilitator)

Thank you, Kim. All right, our third and final panel question, how has your organization established successful partnerships to support your communication or care coordination efforts? Kim, do you mind starting us off?

Kim Kunz

Absolutely. My Choice has vendors that we work closely with in regarding interpreter services. Two of them are Language Line and Pacific Interpreters. At My Choice Wisconsin, the customer service team has a robust process also on how to connect members immediately when they're in need of interpreter service.

Our training and education department has also developed tools for our care teams, our care coordinators and our IDT staff which is referenced in a document called Care Management Process Guide, interpretation service, and translation services.

So, this helps to work as a tool to support the team with how what they can offer the members in regards to interpreter services.

Katie Palmisano (Facilitator)

Thank you, Kim. Karla, do you mind providing your response to this question?

Karla Argandoña

Yes, yes. So, our organization has established different partnerships with local organizations like Inland Regional Center, Center on Deafness - Inland Empire, and Community Access Center to just name a few.

So, we do collaborate with them to ensure we are supporting the needs of our members and staying abreast on how we serve our diverse communities. And we also hold really close relationships with our interpreting vendor providers just to ensure that we are providing access needs to our members.

Katie Palmisano (Facilitator)

Thank you, Karla. All right. The presentations and panel discussion have been so incredibly insightful. We have one more poll for our audience asking, “Which of the strategies described by the presenters are you most likely to consider implementing at your own organization?”

Response options include staff capacity building (for example care coordination competencies, cross-departmental collaboration, or training relevant to communication accommodation) leveraging HIE or CCPs to support communication of beneficiary care needs, implementing initiatives to address health literacy and cultural competence, building health plan infrastructure to track and meet beneficiary communication preferences, and building key partnerships (for example with community based organizations to align communication and care coordination strategies).

So, please provide your response by selecting the button or entering your response via the chat and we will just give it one moment for folks to drop in their responses and I might move us right into our audience questions and answers given the time we have remaining.

So, thank you all to our audience for submitting your questions. We do have one question here at the top that we'd like to highlight for both Kim and Karla. What is the key lesson you have learned through your efforts and improving communication and care coordination? Kim, do you mind starting us off?

Kim Kunz

Absolutely. Can you repeat that just to make sure I'm on the right track?

Katie Palmisano (Facilitator)

Certainly, yes. What is a key lesson you have learned through your efforts in improving communication and care coordination?

Kim Kunz

One of the key things I feel like My Choice… for myself as a director over all the care management is engaging members in member satisfaction surveys along with our staff. And if you're gaining feedback and going and seeking information from the staff on process improvements to make sure there's some updates and process improvement is implemented.

So, it will improve care coordination and member care if the care team is satisfied, feels supported, and they have some ways to share ideas with their leaders on how they can make an impactful change to care coordination to help streamline things. It's just going to improve communication and service to the member.

Katie Palmisano (Facilitator)

That's great Kim. Thank you so much. And Karla, how about from IEHP? A key lesson that you've learned.

Karla Argandoña

It takes a team! At IEHP we work with internal departments and external vendors to improve our internal process. We have learned not to make assumptions and always ask questions as our members needs are different.

Katie Palmisano (Facilitator)

That's great. Thank you so much Karla. And just hopping back to the that last poll, it sounds like the strategies that our audience is most likely to consider include building those key partnerships to align communication and care coordination strategies as well as implementing initiatives to address health literacy and cultural competence.

So, thank you to our audience members for providing those responses to that final poll. Thank you as well to our presenters for offering those responses. In response to the audience Q&A, I'd like to move us forward here

and just wrap up our time together. The slides for today's presentation, a recording, and a transcript will be available on the Resources for Integrated Care website shortly.

Additional resources referenced during today's presentation are included at the end of this presentation and are available to you upon downloading the slides. If you have any additional questions or comments, please e-mail us at RIC@lewin.com and you can also follow us on Twitter, recently rebranded as X, at @Integrate_Careto learn more about our upcoming webinars or our new products.

I'd like to also alert you to an upcoming webinar scheduled here later this month. It's Intellectual and Developmental Disabilities and Behavioral Health: Leveraging Person-Centred Approaches. I invite you to click on the link on your screen or visit our website for additional information about what is sure to be an interesting event.

Please also complete a brief evaluation of our webinar so that we can continue to deliver high quality presentations. This evaluation will be included in a post event e-mail and will pop up on your screen at the conclusion of the webinar and should only take a moment to complete.

We also invite you to provide broader feedback on the resources or events that resources for integrated care hosts or releases throughout the year. This feedback is incredibly important to our team to ensure we provide you with helpful information, and that link is also included here.

I'd also like to highlight a few resources for you all today that will help support your use of person-centred communication and care coordination strategies, including a number from our Resources for Integrated Care Team. We also recently released the updated DCC-START Resource Guide. The Disability Competent Care Self-Paced Training Assessment Review Tool or DCC-START is intended to assist health plans, systems, and provider organizations to strengthen their efforts to provide integrated, coordinated care to their members with disability. The accompanying and recently updated resource guide provides a detailed list of resources that can be used to address the opportunity areas identified by the DCC-START.

And finally, this slide contains the references from our presentation, in case you would like to access additional information. I'd like to offer a message of gratitude to our speakers, Kim, and Karla for sharing your engaging presentations. Thank you as well to our audience members for your participation. Have a wonderful rest of your day. This concludes our event.