Integrated Care In Action Podcast: Strategies For Advancing Health Equity, Part 2

Nikki Racelis: Welcome to the second of our two-part Integrated Care in Action podcast on Strategies for Advancing Health Equity. In this podcast, we discuss how community partnerships, cultural competence, and member engagement can support health equity for individuals dually eligible for Medicare and Medicaid, whom we also refer to as "dually eligible individuals." The Integrated Care in Action podcast features discussions with experts to help providers and health plans deliver coordinated, high-quality care to dually eligible individuals.

I'm Nikki Racelis with Resources for Integrated Care, and today we're continuing our discussion with SCAN Health Plan's former Chief Medical Officer, Dr. Romilla Batra. A not-for-profit Medicare Advantage health plan, SCAN serves more than 285,000 members across California, Nevada, Arizona, Texas, and New Mexico. It also covers more than 48,400 dually eligible individuals, which include Dually Eligible Special Needs Plan members.

In 2023, I spoke with Dr. Batra to learn more about SCAN's health equity approach. Previously, Dr. Batra discussed SCAN's health equity initiative to reduce disparities in medication adherence among its members. We also learned how SCAN uses data to support its health equity efforts. If you have not already listened to Part 1, you can access it on SoundCloud and iTunes, and also on the Resources for Integrated Care website. In this episode, Dr. Batra will share her thoughts on the role that community partnerships, cultural competency, and member engagement also play in SCAN's health equity approach. Dr. Batra closes with recommendations for health plans and provider organizations working to advance health equity.

Engaging and collaborating with community partners, according to Dr. Batra, is an important way for health providers, including health plans, to advance health equity. SCAN runs its own organization, called "Independence at Home," which helps give SCAN insights into enrollee needs.

Dr. Romilla Batra: As a not-for-profit organization, we run our own organization called Independence at Home, which is trends in the community, understanding what the community needs are, engaging with community-based organizations, whether it be in the space of nutrition or transportation or emergency assistance, so have a lot of understanding of our older adults, our membership who live in these different communities. We also consider, obviously, our provider delivery system as core stakeholders in the community because they are the ones that make all these things happen and, and our main principle is how do we engage with these community organizations? How do we educate with them? How do we share data that is actionable? And how do we empower them to making things happen at scale? So, for example, in our Black populations, we looked at how can we bring education around why flu vaccine is important. What are the myths surrounding the flu vaccination? And I will say we partnered with our community-based physicians who helped us do kind of a webinar of sorts to answer questions that members may have and also clarify myths. Another good example that comes to my mind is we partnered with community-based organization that is present in areas which has higher prevalence of our Black membership. And outreaches to the Black membership builds trust, answers their questions, figures out what the barriers are, connects them to the right places to get those flu vaccinations. We're looking at those trusted resources in the communities that members may be seeking information from beyond their regular primary care physicians or their health plan. And so, we have developed a lot of meaningful relationship with faith-based organizations as well. So that's another example. And then the last example I would share is, what we noticed during the pandemic was…there were folks who were, perhaps did not have access to vaccinations because of their frailty, their chronic conditions, or they were homebound. We

partnered with an organization that dispatched EMTs in the home setting to not only vaccinate our members, but even their caregivers who were also at higher risk. So, those are some of the community-based partnerships and community-based organizations.

Nikki Racelis: Dr. Batra, thank you for those excellent examples. I'm very curious about the first example you brought up where you had community physicians speaking to some of your Black members about the importance of getting a flu shot. I know you have talked about some disparities with Hispanic members that you were trying to address previously, so I'm wondering, have you done anything similar for your Hispanic members?

Dr. Romilla Batra: That is absolutely correct, Nikki. When we thought about our Hispanic populations, we similarly thought, what could we do that is over and above and different and that addresses the need for that population. We worked very closely with one of our provider partners that specializes in this space and really serves Hispanic populations, and uses Promotoras, who are community health workers that speak the same language as the members or the patient. We not only conducted webinars, but also created other documentation or other content that would be used by that population. So those are some of the tools that we incorporated to address cultural competency, to address linguistic concordance, and also to address the issue of health literacy, which can be a, a challenge with some of our population, especially our dual Hispanic, Spanish-speaking population. I would use another example is, physicians prescribe medications, they prescribe in a certain language, and are very, very hard to understand sometimes manner, you know, a primary care physician will say some specific things which make sense to me as a physician, but maybe not make sense to a patient, especially if the patient speaks a different language. And so, an organization creates these contents that tell you when to take your medication, not only in your language, but also has like symbols, think of them as emojis, like, okay, this is morning, so there's a sun there, or this is evening. So those are the different tools that we have used thinking about health literacy, which impacts a lot of our population. So those are the few things that come to my mind.

Nikki Racelis: Since Dr. Batra noted that SCAN's health equity strategy considers cultural competency, linguistic competency, and health literacy, I was curious about the challenges and needs of the unique communities that SCAN serves. So, I asked about them and also about the role of cultural competency in addressing these challenges.

Dr. Romilla Batra: First and foremost, all of our member-facing staff are trained in a few things. One, we all are trained in cultural competency, that's foremost. We also did implicit bias training, we did the cultural humility training. We worked with our provider partners as well to do a similar kind of training. And through our own data and through looking at the literature, what we found is not only when you train people in delivering culturally competent care, but you find employees or you find individuals, whether they're pharmacists or they are care coordinators or community health workers, who come from the same communities as our members, who speak the same language, it makes a huge world of difference. What we tried to do through a lot of our efforts is a) still uptrain our own employees, but wherever possible, try to linguistically and culturally match them to the members that they were serving.

What this journey taught us very quickly is, in order for us to make, make things happen, and really reach the quality goals, we had to start from a place of listening. Start from a place of understanding. And then start from a place of building trust and relationship. What became very apparent to us very fast is, for us to really improve the care for these individuals, first we need to understand where they're coming from , not only with our members, but our employees. But then incorporating that in having those conversation, what we use with skillsets also what we use is something called motivational interviewing, which is what

matters to you and how do I make happen in terms of what matters to you, versus what matters to me as a clinician, which is, you should be taking your medicine. So really starting from a place of putting yourself in the shoes of the patients or the members that you are serving. And so, I think that was one of our big "Aha" moments.

It starts with a place of understanding what are the unique needs of the population that we are trying to serve. Our Duals population, for example, has a higher proportion of Hispanic and Spanish-speaking. They also, in addition to having chronic conditions, have conditions related to mental health and depression and, as you can imagine, it's sometimes really hard to find a psychiatrist or a psychologist, especially the ones that speak your language. And I'm super excited, this year we were able to offer as a supplemental benefit "mental health on demand," where for our Duals populations they can access mental health on demand through a telehealth platform with a licensed clinical social worker or a psychologist or psychiatrist. And so for us, it's super meaningful, and especially if transportation is a barrier for you.

I think the second example I would say as I think about understanding our population and understanding their specific need is one of the products that we introduced this year for our LGBTQ+ populations. It's called Affirm and as you can imagine, the LGBTQ+ population sometimes has a difficult time finding a provider who can truly understand their needs and so we were able to offer in this product a very curated journey through one of our partners that does the welcome and onboarding for our LGBTQ+ members and helps them connect to the right provider based on who they are and what their wants and needs are. So, I think those are the examples in how we are not thinking of our population as one size fits all, but trying to really see who they are, what languages do they speak, what makes them different, and what they may be thinking that we can offer either as a product or a benefit or a service.

We did a lot of member journeys to understand, what is a barrier when somebody gets prescribed a medication, doesn't speak the language, lives in an area which has high social vulnerability index, and may not have transportation, what is the barrier and how do we make it happen. So, putting ourselves in our members' shoes, getting our employees who speak the same language, listening, building trust over a period of time before getting to the action which is, okay, let's not talk about medication adherence was a big thing.

Nikki Racelis: Recent research supports SCAN's approach to person-centered care and cultural competence staff training and initiatives. For example, a 2020 study published in *Ethnicity & Disease* suggests that culturally and linguistically appropriate care delivery may reduce hospital length of stay for Medicare beneficiaries.[1] In addition, a 2021 study published in the *Journal of Nursing Management* found that cultural humility training may be linked to improved intercultural team effectiveness and inclusiveness.[2]

Another strategy that health plans and provider organizations can use to advance health equity is engaging with their communities. I asked Dr. Batra about the challenges SCAN has faced with community

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[1] Schiaffino, M. K., Ruiz, M., Yakuta, M., Contreras, A., Akhavan, S., Prince, B., & Weech-Maldonado, R. (2020). Culturally and Linguistically Appropriate Hospital Services Reduce Medicare Length of Stay. *Ethnicity & disease, 30*(4), 603–610. Retrieved from https://pubmed.ncbi.nlm.nih.gov/32989360/.

[2] Markey, K., Prosen, M., Martin, E., & Repo Jamal, H. (2021). Fostering an ethos of cultural humility development in nurturing inclusiveness and effective intercultural team working. *Journal of Nursing Management, 29*(8), 2724-2728. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/jonm.13429#pane-pcw-references.

engagement and outreach, as well as possible solutions. I was also curious about how SCAN identifies communities for its initiatives.

Dr. Romilla Batra: For us the challenge is sometimes what I'd say is member engagement using our usual resources. Our biggest means of outreach is cold-calling people, and as I tell my team Monday through Friday, eight to five, that's when we're trying to get a hold of our members and patients to see how we can work with them and engage with them. We started using community health workers, but I think we need to do a little bit more. We need to have different ways of engaging with our members and we are thinking outside the box for them, like should we be in our primary care physician offices? Should we be setting up pop-ups in local churches. Should we be engaging with our members through texting and emailing for those of them who are ready? Finding different ways of engaging with our members beyond the usual. Member engagement is always a challenge. And engaging members who speak a different language it makes it a little bit harder. Engaging with members who not only speak a different language, but perhaps may have lack of health literacy, makes it even harder. So that is always a challenge. And the last thing I would say is getting our providers along the journey, they're extremely busy physicians. When do we use them, how do we use them, how do we engage with them so that the journey is a together journey, is another big piece of the whole puzzle.

Nikki Racelis: Previously you talked about building trust and relationships with your members. Is that part of a challenge that SCAN experiences with community outreach?

Dr. Romilla Batra: Trust is always hard. Trust is especially harder for us when somebody's new to us. Our new membership has not interacted with us much. So that may take a time. And trust is sometimes harder in certain subsets of the population, as literature shows. Finding ways and connecting with people, understanding what mattered to them, solving for what mattered to them before we could even broach the topic of adherence was a big one. So yes, trust is always a big thing, trust always takes longer, in some communities more than the others, in some member more than the others.

Having people who speak your language, who can understand where you're coming from, who are willing to lean in, listen in, and walk in your shoes makes a whole world of difference. And I don't want to downplay the fact that it has to be in combination with other things. So, for example, if your copay of your medication is fifty dollars and you cannot afford it, no amount of trust is going to lead to that. So, it is hand in hand in conjunction with building access and affordability and mapping it to then culturally and linguistically concordant care.

Nikki Racelis: It sounds like SCAN has a deep understanding of how to build relationships and trust with your members, as you've just talked about, which helps you provide the health care that your members need. How do you identify communities or populations where initiatives may be implemented to help achieve or address health equity?

Dr. Romilla Batra: So, we, one more time, start with, the data, and we have different data points. One is our own internal data, as I said, we know where our membership lives. We know as well what their quality scores look like, who's doing well, who's not doing well. But then we overlaid things that represent lack of social needs being met, social drivers of health. So, overlay the population we know where they live, overlaid with the demographics of that particular area. So as you may be aware, social vulnerability index, so if we have a population that lives in high social vulnerability index areas, who have also indicated on their health risk assessment that they perhaps are having difficulty paying bills or getting food or getting transportation, and they also happen to have gaps in care as seen by our data, those

are the populations we really focus in on, and those are the places where we will partner with our, not only our providers, but community-based organizations, because we truly feel that it's in those areas, not only do you need to meet the medical needs of that population, you need to meet the needs around access, and affordability, and social needs in order to really move the needle.

I think we are fortunate because we are a Medicare managed care plan to be able to offer supplemental benefits that help address the social needs. So, for example, as we are thinking about A1C control, which is managing the diabetes better in our Hispanic populations, we know it's a function of not only medications, but it's a function of what food you eat, what education you have around the food that you eat. And so through our supplemental benefits, we can offer meals for chronic conditions for certain populations, which always helps, if their barrier is transportation, through our supplemental benefits, we can offer transportation so they can go to the physician, or go to the pharmacy and pick up their medications. So those are the things that we are incorporating as we are thinking about meeting needs.

Nikki Racelis: Since SCAN's strategy is so extensive and multifaceted, I asked Dr. Batra to summarize her top recommendations that other providers and health plans serving dually eligible individuals could consider implementing to advance health equity. As she explains, her top recommendations include making health equity a strategic priority; building trust; understanding your community's specific needs; and tying compensation of all staff to health equity goals, which Dr. Batra mentioned in Part 1 of this podcast.

Dr. Romilla Batra: First and foremost, as an organization, this should be, it has to be a strategic priority. It's not something that the quality department does it from the side of its desk and reports on it. People need to lean in and make it happen. So, make it core to your strategy, that's very important. Second thing I feel is that we all have to start from a place of learning, listening, understanding, building trust before we come with a swath of six different things that we want to do. So, it's really, really important to do that. I think the third thing also is that we need to understand that the needs of one community may differ from the needs of another community. And so, for us to be able to make a difference, we have to really lean into our provider systems, into our community-based organization system, into our own human resources and into the data resources. And together those things can make things happen.

Nikki Racelis: Excellent. I wanted to go back to something that you mentioned earlier related to tying compensation to health equity goals. So, I'm wondering if that is a key takeaway or a learning, something that you might recommend to other health plans or folks working on health equity initiatives.

Dr. Romilla Batra: I would highly recommend. We did it, and it was great because it didn't matter which department we were working with, it, we were all rowing in the same direction. Everybody was more open and willing to lean in, whether, as I said, legal for contracting, finance for making sure things were happening, HR for finding the right people, our member services for making those calls, our…so it became everybody's job to make it happen, so I would definitely say, it really helps when you have this as a strategic priority and it's a goal that is tied to some form of an incentive, it absolutely makes a difference.

Nikki Racelis: Regarding tying compensation to your health equity goals, was this applicable to all SCAN staff, the provider incentives that you mentioned earlier, or just to leadership's executive compensation?

Dr. Romilla Batra: The incentive goal applied to everyone within the SCAN as an organization, that was our goal. That being said, this year for the first time, we have introduced health equity metrics as a part of our provider incentive plan. We've had our provider incentive plan for many, many years, and, it has the usual incentives around making sure screenings are done appropriately, making sure people are getting access to care and medication adherence, but this time around, we introduced the same metrics that I've spoken about as a part of our provider incentive plan where the providers also are now aligned in making this the right thing happen in the right way, because there's incentives tied to it.

Nikki Racelis: I love that as part of the provider incentive plan and having that incentive also for all SCAN staff. I think that really helps instill a sense of ownership with their work.

It was a pleasure speaking with Dr. Batra to learn more about SCAN's health equity practices. If you're interested in reviewing additional health equity resources, please visit the Resources for Integrated Care website at www.resourcesforintegratedcare.com. Thank you for listening.

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