



INSTITUTE FOR  
MEDICAID INNOVATION



# MEDICAID MANAGED CARE'S PANDEMIC PIVOT:

Addressing Social  
Determinants of Health  
to Improve Health Equity



EPISCOPAL HEALTH  
FOUNDATION



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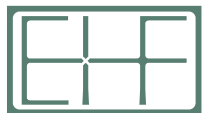


## INSTITUTE FOR MEDICAID INNOVATION

The [Institute for Medicaid Innovation \(IMI\)](#) is a national 501(c)3 nonprofit, nonpartisan research and policy organization focused on providing innovative solutions that address important clinical, research, and policy issues in Medicaid through multi-stakeholder engagement, research, data analysis, education, quality improvement initiatives, and dissemination and implementation activities. To remain relevant and responsive to the evolving needs of the Medicaid population, the Institute seeks to understand what works well in the Medicaid program, identify areas for improvement, and disseminate innovative initiatives and solutions that address critical issues. IMI is currently funded 100 percent through research grants and contracts. IMI does not lobby or advocate and is not a membership-based or trade association.

The *mission* of IMI is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity, and the engagement of individuals, families, and communities.

The *vision* of IMI is to provide independent, unbiased, nonpartisan information and analysis that informs Medicaid policy and improves the health of the nation.



EPISCOPAL HEALTH  
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Support for this project was provided in part by the Episcopal Health Foundation. By providing millions of dollars in grants, working with congregations and community partners, and providing important research, [Episcopal Health Foundation \(EHF\)](#) supports solutions that address the underlying causes of poor health in Texas. EHF was established in 2013 and is based in Houston.



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Steering Committee .....6

Executive Summary.....7

**CASE STUDIES: INNOVATIVE INITIATIVES**

**COVID-19 Response Plan**

Aetna Better Health of Texas.....15

**Flexible Housing Pool**

CountyCare Health Plan.....19

**Enhancing Maternal Health by Addressing Social Isolation**

Parkland Community Health Plan.....23

**Federally Qualified Health Centers (FQHC) Transformation Investment Program**

UnitedHealthcare Community & State.....27

**Freedom House 2.0**

UPMC Health Plan.....32

**Healthy U Behavioral Hub**

University of Utah Health Plans.....36

**Mana Mama**

AlohaCare.....40

**Safety Testing Overall Partnership (S.T.O.P.) COVID-19 Disparities**

UnitedHealthcare Community & State.....44

**EMERGING BEST PRACTICES**

**COVID-19 RESPONSE & VACCINATION**

**2021 COVID-19 Vaccine Response**

HAP Empowered Health Plan, Inc. ....49

**COVID High Risk Outreach Playbook**

CareOregon.....51

**COVID Kits**

Trillium Health Resources .....53

**COVID-19 Vaccine Outreach and Engagement Program**

Amerigroup New Jersey .....55

**COVID-19 Vaccine Strategy**

UPMC Health Plan .....57

**Educate, Access, and Support**

Humana Healthy Horizons in Florida .....59

**Got My Shot**

Aetna Better Health of Illinois .....61

**HEALTH CARE ACCESS & IMPROVEMENT**

**Adult Day Care Clinical Pharmacist Collaboration**

UnitedHealthcare Community & State .....63

**Community Health Workers Recruitment, Training, and Mobilization Initiative**

Amerigroup Iowa, Inc.....65

**COVID-19 Telehealth Capacity Support**

Health Net.....67

**Ho’oikaika Nā Kumu Waiwai Ola**

AlohaCare .....69

**Iowa Hispanic Diabetes Management Project**

Amerigroup Iowa, Inc.....71

**Martin Luther King Jr. Community Healthcare Street Medicine**

Health Net.....73

**Retinal Eye Camera Program**

Amerigroup Tennessee, Inc. ....75

**Tablet Loaner Program**

UnitedHealthcare Community & State .....77

## **FOOD & HOUSING ACCESS**

### **Changing Health: Amerigroup-Monroe Partnership (CHAMP)**

Amerigroup Iowa, Inc. ....79

### **COVID-19 Nutrition**

UnitedHealthcare Community & State .....81

### **Food Access**

Trillium Health Resources .....83

### **Los Angeles Food Bank Pilot**

Health Net. ....85

## **MATERNAL & CHILD HEALTH**

### **Community Care HUB—Maternal Home Visiting Program**

Gateway Health LLC d/b/a Highmark Wholecare .....87

### **Family Hui Pilot Program**

Health Net. ....89

### **Virtual Care Management for Maternity Members**

UPMC Health Plan .....91

## **COMMUNITY & WELLNESS RESOURCES**

### **Healthy Movement at Home**

Trillium Health Resources .....93

### **Marquette County Community Resource Fair—Express Style**

Upper Peninsula Health Plan. ....95

### **Virtual Wellness Workshops and Information**

Trillium Health Resources .....97



## NATIONAL STEERING COMMITTEE

Prior to publication of the final compendium, IMI sought input from independent clinical, scientific, and policy experts as peer reviewers who do not have any financial conflicts of interest. Please note that the conclusions and synthesis of information presented in this issue brief do not necessarily represent the views of individual peer reviewers or their organizational affiliation(s).

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## EXECUTIVE SUMMARY

When the COVID-19 pandemic began in early 2020, Medicaid managed care organizations (MCOs) opened their communication channels and quickly took steps to respond to the needs of their members and communities. Medicaid enrollees reached out to health plans asking for help, and health plans reached out to members to identify community needs. Medicaid MCOs pivoted to explore and implement ways to address the priorities indicated by enrollees, providers, and community partners.

With support from the [Episcopal Health Foundation](#) and [Robert Wood Johnson Foundation](#), the [Institute for Medicaid Innovation](#) (IMI) created this compendium profiling 33 exemplar initiatives. IMI conducted a national environmental scan in 2021 to:

- Capture the unique changes and programs created by Medicaid MCOs in response to the pandemic;
- Better understand innovation focused on meeting health and social needs of members, with an emphasis on programs addressing inequities exacerbated by the pandemic; and
- Identify initiatives across the country, with a targeted scan in Texas.

A group of Medicaid experts were invited to serve as peer reviewers as part of a blinded review process to review, score, and select the Medicaid MCO initiatives highlighted in this compendium. Furthermore, the reviewers selected eight Innovative Initiatives for in-depth interviews to further explore the drivers and implications of their approaches. The eight Innovative Initiatives, including four in Texas, are highlighted as case studies throughout the compendium.

The compendium is intended to inspire further innovation and capacity building to address inequities that limit access to services and opportunities to pursue health for individuals enrolled in Medicaid. Many of the needs addressed by these initiatives will continue beyond the public health emergency. As the pandemic has shown us, flexibility in Medicaid policy can support collective action to swiftly address inequities. The clinical, research, and policy opportunities in this compendium provide an agenda for future actions, spanning across stakeholders, including health plans, advocates, and state and federal policymakers.

## INITIATIVE TOPIC AREAS

Of the 33 featured initiatives, 25 initiatives are emerging best practices, with initial implementation and outcome data. Eight innovative initiatives offered varied opportunities for a more in-depth evaluation program implementation and impact. Initiatives range from direct provision of care, such as vaccination clinics, through deeper integration of health and social services such as housing, food, and transportation, and are organized into five categories of primary focus as listed below. Many of the initiatives intersected across multiple categories:

**1** COVID Response & Vaccination

**4** Maternal & Child Health

**2** Health Care Access & Improvement

**5** Community & Wellness Resources

**3** Food & Housing Access

## OVERALL THEMES

The pandemic was not experienced equally, but it did present many **common challenges**. Across national, state and local Medicaid health plans, there was vast common ground in general objectives, and variation flourished through community partnerships. The themes and lessons learned within Texas for example, as with many states or regions, tracked closely to those seen across the full compendium.

Medicaid MCOs rapidly shifted their operations to launch many “first ever” efforts and aimed to address **new priorities**, such as configuring telehealth reimbursement, reaching out to community partners to identify resources, or curating lists of community programs and associated contact numbers.

With the support of health plans, providers **shifted the location of health and social services** to increase access. Vaccinations were available in parking lots of national fast-food chains and at outdoor community events. Therapists were deployed to schools. Food and equipment was delivered to residences. Perinatal services were available from staff who traveled to the homes of pregnant people. Across the country, Medicaid-covered services were now available through



virtual platforms, which significantly improved access to care for enrollees, many of whom were quarantined for months at a time.

Flexibility in Medicaid policy and health plan investments allowed providers to **combine health and social services** such as hosting community events to simultaneously provide food boxes and COVID-19 vaccines. Health plans established new **partnerships** with community groups and non-profit organizations to ensure that efforts were culturally congruent, represented the needs of the community, and were accessible.

**Rapid Response.** By listening to immediate feedback from members and providers, MCOs identified community needs and responded in record time, which was supported by modifications to Medicaid policy, including more telehealth opportunities and the elimination of Medicaid eligibility redetermination. No matter the size of the health plan or scale of the investment, the Medicaid MCOs served as change agents to establish **partnership with communities and providers** in ways that would not have been possible across the Medicaid program in its entirety.

**Sustainability.** Post-pandemic, the health plans stated a **commitment to sustaining** initiatives and noted that continuation planning might depend on whether the pandemic-induced Medicaid policy flexibility and resources will remain after the public health emergency.

**Equity.** Health plans launched initiatives rapidly to **respond to immediate needs** of enrollees, but also strove to implement programs that **improved equity**, generally through one or more of the following approaches:

- Focusing resources where the impact of the pandemic was most severe;
- Developing strategies that ensured inclusiveness; or
- Addressing a pre-existing inequity in a new and intentional way.

Medicaid MCOs sharpened their understanding of inequities by analyzing disparities that were exacerbated during the pandemic. Although community data about health care access and economic stress were readily available, measurement and evaluation of these initiatives at the health plan level remained challenging. For many initiatives, quantitative and qualitative outcome data to **demonstrate the value and impact of their initiatives** will not be available for some time. In the meantime, the programs are using data on outreach and engagement, resources invested, and services delivered to evaluate the immediate impact of their efforts.

## LESSONS LEARNED

The Emerging Best Practices and Innovative Initiatives showcased in the eight case studies highlighted multiple important lessons learned.

**Managed Care Can Facilitate Innovation.** Medicaid MCOs accelerated their investment in social determinants of health through nimble and collaborative strategies.

**Value of Longstanding Investments.** The existence of established programs, partnerships, and infrastructure catalyzed the rapid and robust responses to address the needs of Medicaid enrollees. The Medicaid MCOs profiled in the Innovative Initiatives case studies had such existing foundations in place and could quickly build upon these resources to implement new innovative initiatives during the pandemic.

**Importance of Continuous Enrollment.** The pause in redetermination of Medicaid eligibility and enrollment, eliminating churn in the program, was a silver lining within the pandemic. Medicaid MCOs noted that it allowed members to stay covered long enough to get needed care and allowed health plans to shift resources to more direct work to support members' health and social needs.

**Telehealth Flexibilities Support Access.** The increased ability for clinicians to bill for telehealth services and for Medicaid MCOs to reimburse telehealth increased access to health care services, especially in health care deserts and for those where a traditional in-person appointment was not easily feasible (i.e., quarantine, transportation costs, childcare coverage).

**Flexibilities in Pay-for-Performance Programs.** Some states simplified their pay-for-performance programs to invest in initiatives that addressed social determinants of health and health equity. These policy modifications released resources, both time and funds, for Medicaid MCOs to focus on innovative initiatives.

## LOOKING AHEAD: IMPLICATIONS FOR THE FUTURE OF MEDICAID INITIATIVES

The declaration of the public health emergency, issuance of blanket waivers by the Centers for Medicare and Medicaid Services (CMS), and passage of the Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act supported an unprecedented opportunity for developing and initiating new initiatives. The initiatives highlighted in the compendium demonstrate that flexibility in Medicaid policy can support collective action to swiftly address inequities. Translating these successful efforts into long-term investments might be possible with ongoing support and infrastructure. The following clinical, research, and policy opportunities offer a potential roadmap.



### CLINICAL OPPORTUNITIES

- Explore ways to incorporate universal screening and referral systems for food and housing insecurity, loneliness, parenting stress, and access to technology.
- Consider prioritizing initiatives directly aimed at health equity and working directly with people experiencing health disparities to design initiatives.
- Explore how to bundle clinical and non-clinical services together in service delivery and payment.
- Partner with community-based organizations that can lead in identifying community needs and strengths. Honor their established community leadership role by sharing power with them to develop solutions together.



## RESEARCH OPPORTUNITIES

- Develop rigorous retrospective studies of innovative initiatives that take advantage of the natural experiments occurring over the pandemic, with an emphasis on evaluations that measure whether initiatives affected inequities, and identify the role of community strengths.
- Study the impact of Medicaid MCOs' innovations, not just on their members but also on communities where Medicaid enrollees live, work, and go to school.
- Evaluate factors that led to successful COVID-19 vaccination campaigns that had high rates of immunization for Medicaid members.
- Partner in research with Medicaid MCOs that collect data about their members' social determinants of health and/or the services provided to their members.
- Perform qualitative research to learn Medicaid enrollees' perceptions and lived experiences interacting with the initiatives.



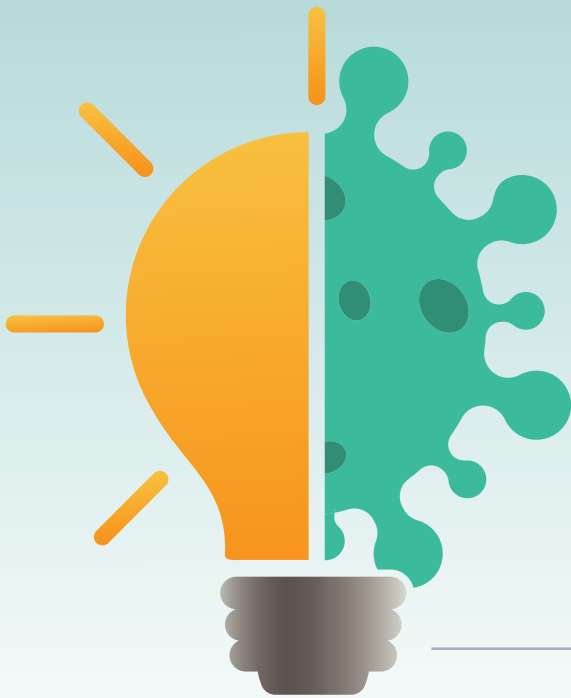
## POLICY OPPORTUNITIES

- Explore opportunities to incentivize both the achievement of health care quality goals and the implementation of initiatives needed to meet the goals.
- Bring together Medicaid stakeholders to identify additional flexibilities needed to increase timely access to information and services.
- Identify opportunities to minimize administrative burden of redetermination, including longer periods of eligibility and streamlined data collection.
- Support long-term sustainability of pandemic innovations and consider continued redeployment of resources toward initiatives that address the social determinants of health.

## CONCLUSION

As evident in the examples in this compendium, Medicaid MCOs demonstrated how they supported their members and communities in mitigating the devastating impact of COVID-19. They generously shared lessons learned to support collective action by everyone. However, a roadmap alone may not be sufficient—many questions remain unanswered, especially related to sustainability of the equity-focused momentum led by Medicaid MCOs, how to prioritize research and programs that address social determinants of health, and how to show value of equity-focused programs other than the traditional measures of return on investment.

The pandemic brought inequities to the forefront. The programmatic changes led by Medicaid MCOs are a testament to the power of collective action in response to glaring inequities. As we transition into a post-pandemic world, we must ensure that equity is central to programs and policies moving forward.



Case Studies:  
**INNOVATIVE  
INITIATIVES**

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*Please note that the inclusion of names of organizations, corporations, services, and/or products should be not be viewed as an endorsement or recommendation by the Institute for Medicaid Innovation.*



# COVID-19 RESPONSE PLAN

**Health Plan:** Aetna Better Health of Texas

**Parent Organization:** CVS Health

**Location:** Texas

**Aetna Better Health of Texas (Aetna)** serves Texas Medicaid enrollees in the Bexar, Dallas, and Tarrant service areas. Aetna provides services to enrollees in the STAR, STAR Kids, and CHIP programs.

CVS Health, the parent company of Aetna, has a longstanding history of investing in permanent supportive housing initiatives throughout the United States, most recently a \$185 million investment in 2021 with \$11.7 million directed to 171 housing units in Austin, Texas. As a corporation, the longstanding commitment to affordable housing and other health equity initiatives provided an important underpinning to Aetna's COVID-19 Response Plan.

Observing disparities in health, the economic impact of COVID-19, and recognizing the challenges in reaching communities through CVS stores or typical health plan outreach alone, the COVID-19 Response Plan was launched, which combines member-level support with community-level vaccination efforts and investments in social determinants of health (SDOH). This initiative reflects Aetna/CVS Health's three-pillared SDOH approach:

1. Identify members' health-related social needs,
2. Incorporate a strengths and resilience approach, and
3. Amplify the resources of the community.



”

Listen to the community, be flexible, and let the community tell you how to work with them.

## DESCRIPTION

Aetna's COVID-19 Response Plan included a set of **communication and engagement activities** for members. The objectives were to:

- Raise awareness and provide education on COVID-19 vaccines;
- Provide members with a single source for all COVID-19 information and vaccine-related incentives;
- Increase COVID-19 vaccination rates for Aetna members, specifically addressing barriers such as location of vaccination centers, transportation, and vaccine hesitancy; and
- Meet the medical and non-medical needs of both members and the community.

In addition to vaccine incentives (\$30 per person) and informational outreach, Aetna built in resources through the findhelp.org online social care network, integrated voice response (IVR), and text message campaigns. In addition, an interactive mobile app with supportive calls (Pyx Health) was launched to support members who are experiencing loneliness and social isolation.

## IMPLEMENTATION

### Changing “Business as Usual” for Member Engagement and Community-Level Strategies.

With the onset of the pandemic, Aetna redeployed field staff to call health plan members to understand where and how people were struggling with connections to needed resources and created “concierge” service to help members with needs—housing, food, utility bills, and access to care. Aetna also created a member community health worker training program, with the first cohort of three students enrolled in January 2022 and eight as part of a second cohort in April 2022.

Aetna community affairs worked with external agencies to host **listening sessions** in local communities to learn how testing and vaccine resources could be brought into “vaccine deserts.” **Community partners** were critical in disseminating Aetna information to the broader community in “digestible” ways. For example, one partner helped create educational talking points and advised that handouts were preferred over web-based information in some communities. Building on existing relationships with community-based organizations, food pantries, housing complexes, and findhelp.org, Aetna provided resources not only for members but also for communities at large.



**Expanding Support to Members with Mobile Technology.** Aetna assessed members' needs for assistance with Internet access during the COVID-19 pandemic. This was imperative to ensure that children could attend school and adults could work from home, and to enable access to telehealth. IVR and text message campaigns included questions about Internet access. As part of this work, members identified a need for automated information about findhelp.org regarding access to organizations that provided **free or reduced Internet service**.

**Supporting Provider Networks.** As an initial step, Aetna distributed personal protective equipment (PPE) to provider groups in the Dallas Fort Worth area to increase supplies for clinicians and their patients. In Texas, and across the country, CVS Health worked with provider groups in areas with large worker shortages to support recruitment, retention, and well-being through **value-based payment initiatives** specific to in-home care and nurses. Arrangements were tailored to clinicians' needs and included infrastructure payments to provide caregiver training to improve care coordination and support for caregiver as part of team building.

**Funding Food Distribution.** Recognizing the scale of food insecurity, and in response to overwhelming demand for food assistance across the country, in 2020 CVS Health launched a Round Up Campaign in support of Feeding America, a hunger relief organization with a nationwide network of foodbanks. Aetna continued educating members about ways to find and access food and other community resources.

## IMPACT

Through October 2021, the Aetna COVID-19 Response Plan **reached over 22,000 people** and **educated almost 12,000 members**. In addition:

- Aetna members and staff-supporting members conducted more than 12,636 searches in findhelp.org for social services and resources from April 2020 through March 2022; over 18 percent of searches were for food resources.
- Over 700 members accessed Pyx Health for virtual and telephonic resources support through May 2022; 43 percent of users who completed loneliness screens demonstrated improved scores over time.
- Texas food banks received over \$700,000 from this campaign in 2020-2021, which translates to approximately 7.1 million meals, 2.8 million of which reached communities of color and rural communities.

## OPPORTUNITIES

Aetna learned operational ways to better engage with members and identified content areas where they will sustain and replicate programming. This included:

- Replicating successful member outreach strategies when the redetermination process resumes.
- With the positive engagement seen with the Pyx Health resource, expanding resources to address members' loneliness and social isolation and promoting social connectedness.
- Continuing to hold member events at various CVS HealthHUB locations hosted by the member advocate team to provide health education, community resources, and information on plan benefits and the redetermination process.
- Continuing to bring member feedback to Aetna quality committees to identify challenges and opportunities.
- Developing longer-term support for providers in recruiting and retaining direct-care workers.

The initial funding directed to food needs has become a much larger national partnership with Feeding America to address food access inequities. Aetna is now partnering with Episcopal Health Foundation to apply data analytics and a strength-based community engagement approach to find successful strategies for promoting food security. Aetna will partner with other managed care and community organizations to spread this approach and improve the health of the community.

“

Go to community events, no matter the size, to meet community members and partners where they are.

Support the capacity of communities to serve one another, including members.

Utilize all the different strengths and resources the health plan can bring to bear.

”



## INNOVATIVE INITIATIVE

# FLEXIBLE HOUSING POOL INITIATIVE

**Health Plan:** CountyCare Health Plan

**Parent Organization:** Cook County Health

**Location:** Cook County, Illinois

Chicago and Cook County's **Flexible Housing Pool**—an established public-private partnership—provides permanent supportive housing, an evidence-based Housing First intervention for unhoused individuals. Supported by multiple community-based organizations and pooled funding from major investors—including the City of Chicago, Cook County Health, **CountyCare Health Plan**, and other local foundations and health systems—the Flexible Housing Pool was created to break the cycle of chronic homelessness, improve health outcomes, and reduce costs to the public healthcare system.

In 2019, **Cook County Health**, with the mission to elevate the health of Cook County, pledged \$1 million to the Flexible Housing Pool in recognition of housing as a fundamental social determinant of health (SDOH). In May 2020, in response to the pandemic, CountyCare Health Plan, the Medicaid managed care organization owned by Cook County Health, received a notice from the Illinois Department of Healthcare and Family Services to all Medicaid health plans, to **utilize pay-for-performance withhold funds to support community initiatives** addressing SDOH and behavioral health. CountyCare made a pledge of an **additional \$5 million** to the Flexible Housing Pool to house CountyCare members. Chronic homelessness had increased 46 percent in Chicago and Cook County between 2019 and 2020 (State of Homelessness: 2021 Edition, 2021). Because Black and Latino households experienced disproportionate levels of homelessness and financial distress exacerbated by the pandemic (Chicago Metropolitan Agency for Planning, 2021), CountyCare's housing investment was also intended to address racial and ethnic inequities.



”

Even though the population is small, it's a huge amount of detail that has to go into making sure it's successful for members.

## DESCRIPTION

CountyCare Health Plan's investment in the Flexible Housing Pool was earmarked to **provide money to cover rent, associated housing costs** (e.g., utilities and furniture), and **tenancy support** (e.g., housing case management) for 66 members for three years, prioritizing members who either had behavioral health conditions such as severe mental illness and/or substance use disorder or were families with children.

The model is innovative in several ways.

- **Multi-Sector Partnerships.** The Flexible Housing Pool initiative is a **collaborative effort** of governmental agencies, a Medicaid health plan, providers, and community-based organizations. The Corporation for Supportive Housing (CSH) provides project management and the Center for Housing and Health, with its subcontractors, provides support services for tenants.
- **Multidisciplinary Care Approach.** CountyCare's clinical services department leads the initiative. Care teams include an outreach specialist, a housing case manager, and a health plan care manager working with members and their providers.
- **Proactive Member Identification.** CountyCare identifies participants, using data from the regional **homelessness management information system (HMIS), jail medical records, medical billing claims, and real-time alerts** from the emergency department and inpatient visits from over 29 hospitals. Members' providers and care management staff also identify and refer individuals whom they assess would benefit from the program.

The goals of the initiative were to:

- Identify persons with high utilization of medical, correctional, and/or housing systems;
- Provide stable housing and tenancy support to 66 CountyCare members for three years;

“Housing First is an approach to homelessness that provides people with permanent housing as quickly as possible. Receiving services, sobriety, and other conditions of readiness are eliminated or reduced (SAMHSA, 2010).”

- Improve health outcomes and create savings by reducing hospital service use and increasing high-value, low-cost community-based care; and
- Develop a model of tenancy support as a covered service for consideration by Illinois Medicaid.

## IMPLEMENTATION

CountyCare made an initial commitment to housing as a social determinant of health in 2018 when the health plan was selected to participate in the Advancing Health Equity national learning collaborative, led by the University of Chicago, in partnership with the Institute for Medicaid Innovation and the Center for Health Care Strategies. The tipping point for implementing the Flexible Housing Pool Initiative as a **Medicaid payment model for equity-focused care transformation** was the flexibility to use state quality withhold funds during the COVID-19 pandemic.

Equity was embedded into the initiative by explicitly acknowledging the historic segregation that led to racial inequities in homelessness in Cook County; in 2019, 68 percent of people experiencing homelessness in the Chicago metropolitan area were Black, compared to 17 percent of the overall regional population (Chicago Metropolitan Agency for Planning, 2021). The Flexible Housing Pool also creates proactive member partnership structures and gives voice to those with lived experience through its **Lived Experience Advisory Council (LEAC)** and governance board, involved in all steps of program development.

A challenge in launching the program was developing workflows and confidentiality protections to engage members within the interdisciplinary care team of clinicians, housing providers, and health plan staff. This process slowed early implementation but ultimately strengthened the health component of the permanent supportive housing model.

## IMPACT

Measuring outcomes is critical for demonstrating **sustainability and impact**. CountyCare tracks the number of members referred, enrolled, housed in bridge and permanent housing, and remaining in housing throughout the program overall. The data are disaggregated by race, age, and gender. As of April 2022, 11 members were matched with an initial housing provider, one member was in bridge housing, and **48 members were in permanent housing**.

CountyCare developed a **quasi-experimental analysis** to compare pre-/post-housing total costs; prescriptions filled; care management utilization; and outpatient, inpatient, and emergency department visits for the housed group relative to those who were eligible for housing but ultimately were not housed. In addition, **participants rated their overall physical and mental health**, ability to complete activities, and connectedness to others at the time of housing and at one- and two-years post-housing.



## OPPORTUNITIES

The Flexible Housing Pool is based on a **collective investment model** with integrated funding and partnerships (e.g., the CountyCare COO is a member of the Flexible Housing Pool governance board). The initiative acknowledges that siloed efforts to interrupt the cycle of poor outcomes for unhoused individuals have been largely unsuccessful. The Flexible Housing Pool capitalized on synergies across both organizational leadership and member-centered care management.

CountyCare intends for its experience to **inform policy discussions** of Medicaid-covered tenancy support in Illinois as well as local, state, and federal opportunities to expand affordable housing infrastructure and funding models that would function similarly to supplemental nutrition programs and Medicaid.



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## INNOVATIVE INITIATIVE

# ENHANCING MATERNAL HEALTH BY ADDRESSING SOCIAL ISOLATION

**Health Plan:** Parkland Community Health Plan

**Parent Organization:** Parkland Health

**Location:** Dallas, Texas

Parkland Community Health Plan (PCHP) was established as a health plan by Parkland Health, Dallas' public health system. It offers Medicaid and CHIP services for children, teens, some adults, and pregnant individuals. PCHP was founded with the original goal of serving as a bridge to connect uninsured individuals with programs and services, and it has now expanded its goals to include connecting people to meaningful health and wellness resources.

Shortly before the pandemic, PCHP's new leadership team was seeking to build upon the health plan's existing community partnerships and make a bigger impact. PCHP learned about the Pyx Health platform which identifies individuals in need of support and offers them options for companionship and support through a mobile app and human staff and connects members at any time of the day or night to the health plan and community resources.

The COVID-19 pandemic resulted in increased financial strain for individuals as well as for social service organizations, many of which closed temporarily or permanently, creating increased stress and barriers for PCHP members. PCHP established a pilot partnership with Pyx Health to provide support and address the needs of its pregnant members through the pandemic.

## DESCRIPTION

PCHP offered access to Pyx Health, to pregnant members across urban Dallas County and surrounding rural counties. Through a chatbot, the app



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You need to do something different from what you've done in the past.

connected members with individuals (both human and automaton) who promptly listened without judgment, helped identify resources, provided guidance to appropriate care, and connected members with various PCHP benefits. The app used assessments of mental and physical well-being and social determinants of health to inform compassionate respectful interactions; and if indicated, prompted an outbound call from the staff to assist with urgent needs. It also compiled these results with user engagement data and provided reports to the health plan.

The pandemic distanced people from their friends and family and isolated members from medical appointments. Feelings of isolation and loneliness during pregnancy were exacerbated during the pandemic. PCHP learned that pregnant members ignored or hid these feelings because of common expectations that pregnancy should be a happy phase in life. To reduce loneliness and social isolation of pregnant members, the initiative aimed to:

- Increase clinical engagement with hard-to-reach members;
- Connect members to health plan and community resources; and
- Identify members at risk for postpartum depression and link them to behavioral health services.

## IMPLEMENTATION

A small group of PCHP leaders led the implementation by working with the vendor to establish data exchanges, create workflows, communicate across the organization about the new program, set up metric reports, and integrate the program with the health plan's health services team and behavioral health partners.

The Pyx Health pilot went live in the midst of the pandemic, when socializing was especially difficult and the pilot was able to provide members with one-on-one interactions and real-time connections to resources, such as food, diapers, and financial assistance. By providing members with access to the app, PCHP eliminated barriers to healthcare and addressed inequities in several ways.

- The app is available in both English and Spanish.

“We made sure to ask: 'if they click that button,' that we have thought through all the different possibilities.”



- As a cloud-based platform, the app used limited data and did not require a high-speed Internet connection.
- The app interacted with members in a non-intrusive, non-judgmental way, which encouraged members to share information about their emotional health.
- Assessments were used to identify social and health needs and workflows were in place that connected members to resources in real time.

## IMPACT

As of December 2021:

- More than 700 pregnant members downloaded and used the app;
- Of members who set up the app, more than half completed at least one behavioral health screening;
- Nearly 25 percent of all members who set-up the app engaged with an agent to find resources in their community; and
- Just over 10 percent of pregnant members utilized the tool daily.

Many success stories emerged from this pilot. For example, a 27-year-old Spanish-speaking member from Dallas County, who identified as lonely with mild to moderate depression, started actively using the app after the member enrolled in PCHP. Over a 40-day period, the member completed 44 activities in the app, using the chat function almost daily, and used the health plan's support center on three occasions. During this time their pre-/post- Patient Health Questionnaire (PHQ-9) depression screening also decreased, indicating improvement in depression symptoms.

A significant programmatic impact was the way the app's data informed the health plan about common needs among individual members. For example, interactions through Pyx Health revealed which members were struggling to get groceries, which led to feelings of stress and isolation. As a result, PCHP developed an additional value-added benefit expanding transportation resources to include rides to grocery stores.

## OPPORTUNITIES

PCHP strove to connect with members on their own terms and offer resources for members when they needed them most; they discovered that this pilot provided a consistent channel when, as a health plan, they might not have been available. Most surprising to PCHP was the finding that the peak hours for the use of Pyx Health were between 2 a.m. and 4 a.m. Another example was the use of the app by members who miscarried, an outcome that can be hard for a health plan to identify. Many members experiencing this loss continued to actively use the app. For PCHP, the ability to offer members a familiar resource preserved a crucial connection during a period of high stress.

PCHP has utilized the pilot as a way to inform the development and its value-added benefits, a unique way for Medicaid health plans to innovate to serve their membership. PCHP plans to continue offering Pyx Health to pregnant members for the foreseeable future and hopes to expand the program to a larger audience in 2022.



## INNOVATIVE INITIATIVE

# FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) TRANSFORMATION INVESTMENT PROGRAM

**Health Plan:** UnitedHealthcare Community & State

**Parent Organization:** UnitedHealth Group

**Location:** National, highlighting initiatives in Texas & Colorado

Federally Qualified Health Centers (FQHCs) serve 1-in-5 Medicaid enrollees (National Association of Community Health Centers, 2020). Early in the pandemic, **UnitedHealthcare Community & State** started hearing from FQHCs about challenges with staying open in the face of enormous decreases in patient visits, workforce shortages, and the need to adapt clinical practices to deliver necessary care while reducing exposure and spread of the virus. UnitedHealthcare moved quickly to identify funds and launched an initiative to support FQHCs during these critical early months of the pandemic. The **FQHC Transformation Investment Program** invested \$20 million in more than 300 health centers across 22 states serving 830,000 individuals.

**FQHCs are essential providers of health and social care** for individuals and communities, including 1-in-3 people living in poverty and 1-in-4 rural residents; two-thirds of community health center patients are members of racial and ethnic minorities (National Association of Community Health Centers, 2020). FQHCs employ multidisciplinary staff who **directly address social determinants of health** such as access to care, food security, housing, transportation, and employment (National Association of Community Health Centers, 2021).

The pandemic brought health equity to the forefront and accelerated UnitedHealthcare's health equity work. FQHCs are mission-driven organizations, governed by patient majority boards, where members of the community shape the direction and the focus of each health center. By design, FQHCs are located in communities where a significant goal of



## FIVE PATHWAYS FOR FQHCs:

- 1 Healthy children
- 2 Healthy pregnancy
- 3 People living with chronic conditions
- 4 Integrating behavioral and physical health
- 5 Addressing the pandemic

their services is to address health disparities. Recognizing the key populations served by FQHCs, UnitedHealthcare views this investment initiative as contributing to the advancement of health equity.

## DESCRIPTION

Funding from the FQHC Transformation Investment program helped FQHCs **broadly build capacity** to support their patients. FQHCs qualified for the program if they participated in the UnitedHealthcare Community Plan network and served 500 or more members. Investments benefited all patients served by the participating FQHCs, agnostic of their insurance carrier.

UnitedHealthcare defined **five pathways for FQHCs** to choose as the focus for their funding. Each pathway represented a population collectively served by UnitedHealthcare and FQHCs:

- Healthy children.
- Healthy pregnancy.
- People living with chronic conditions.
- Integrating behavioral and physical health.
- Addressing the pandemic.

The opt-in window for the program was March through June 30, 2020. For each pathway, FQHCs chose at least one of the following **capacity-building areas of focus**:

- Telemedicine and digital engagement.
- Novel care strategies.
- Transitions of care.
- Collaboration with community organizations.
- Addressing social needs.
- Other, specific to addressing the pandemic pathway.

FQHCs had flexibility for how they would use the investment within these parameters. UnitedHealthcare shared that they learned quite a bit about local communities when reviewing the individual plans.

## IMPLEMENTATION

**UnitedHealthcare's National FQHC Advisory Board**—a council that provides guidance to UnitedHealthcare on policy and practice issues—provided input to inform the design of the initiative. Advisory Board members include FQHC executives, such as the CEO of Spring Branch Community Health Center in Houston, Texas, and representatives from state and national community health and primary care organizations. Hearing from FQHCs, not only about their challenges as providers but also about the rippling crises through their communities, was a tipping point for UnitedHealthcare to take action.

UnitedHealthcare developed an approach to allocate funding based on 2019 utilization data. They worked with individual states on necessary regulatory approvals and set up processes to distribute the funds to the FQHCs.

Once the funds reached the FQHCs, they were used to meet immediate needs and to support FQHCs in adapting their distinctive clinical models and priorities to “meet patients where they were.” For example, the **Houston-based Spring Branch Community Health Center** with eight community locations and two mobile clinics, chose to focus their efforts on supporting healthy children by building their telehealth and digital engagement capacity and deploying novel care strategies to redesign their back-to-school vaccine activities.

 **IMPACT**

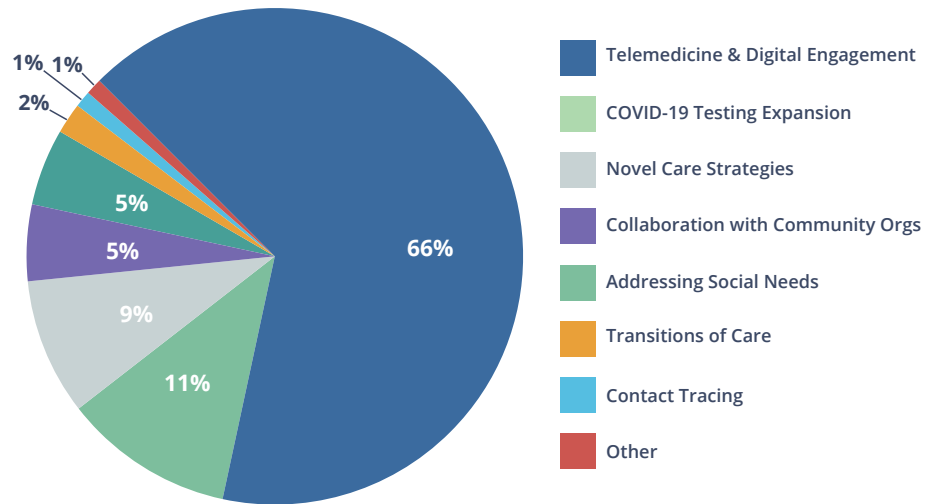
With the Transformation Investments, FQHCs used community-based solutions to expand access and improve outcomes. The majority of FQHCs (66 percent) focused on building their telehealth and digital engagement capacity to meet the identified needs of their patient population.

FQHCs committed to specific process measures aligned with their selected pathways to demonstrate how payments

were used for targeted transformation efforts. The Texas **Gateway Community Health Center, Inc.** is a long-established FQHC in Laredo, Texas. By expanding their telehealth capacity, the center was able to see 500 new patients each month and conduct nearly 1,900 telemedicine visits. The health center also extended their telemedicine capabilities into 100 nurse stations across four school districts to connect children and young adults with virtual care.

Of the participating FQHCs, 10 percent dedicated their capacity-building efforts to addressing social determinants of health or collaborating with a community-based organization, for example opening a food pantry and making food donations.

**Figure 1: UnitedHealthcare Community & State FQHC Capacity Building Areas Of Focus**



Source: UnitedHealthcare

 **OPPORTUNITIES**

UnitedHealthcare was successful with many but not all states in establishing agreements to use funds earmarked for healthcare claims differently in this investment initiative. **Flexibility while adhering to regulatory requirements** was an essential balance to strike.

UnitedHealthcare also noted several opportunities that could reduce barriers for initiatives addressing the social risk factors impacting health:

- Innovative payment programs
- Improved infrastructure for data sharing

UnitedHealthcare is taking the concepts and lessons learned and applying them in new initiatives. UnitedHealthcare offered the following advice to other MCOs: **“Listen to the ideas coming from provider and community partners such as FQHCs—they thought of things we would never think of.”** The pandemic presented an opportunity for health plans to co-develop solutions with local partners. UnitedHealthcare believes this will lead to greater impact in the long term.



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## INNOVATIVE INITIATIVE

### FREEDOM HOUSE 2.0

**Health Plan:** UPMC *for You*

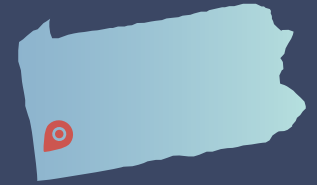
**Parent Organization:** UPMC Health Plan

**Location:** Pittsburgh, Pennsylvania

Access to jobs with fair pay is fundamental to equity. Employment as a social determinant of health (SDOH) took on new urgency when the pandemic caused widespread job loss. In July 2020, Pittsburgh-based University of Pittsburgh Medical Center (UPMC) launched the UPMC *for You* **Pathways to Work** initiative to provide training, education, and direct support to increase access to employment for UPMC Health Plan members. The program helped members find employment at UPMC, the largest healthcare provider and insurer in Pennsylvania, as well as connect members to jobs through the Medicaid Work Supportive initiative and public-private partnerships. Through the Pathways to Work program, **human resource professionals were available** to support health plan members seeking job opportunities and training programs.

As the pandemic played out, social unrest in the summer of 2020 following the murder of George Floyd increased attention on racial inequities and spurred further discussion at UPMC about the role of the health plan and health system in addressing health disparities. Pittsburgh was the location of the nation's first pre-hospital response program, Freedom House Ambulance Service, created in 1968 in partnership with Freedom House Enterprises, which worked on civil rights initiatives. UPMC decided to go beyond its Pathways to Work program to launch **Freedom House 2.0**, with goals to create an equitable model for employment opportunities and a new generation of emergency responders who could also address critical psychosocial needs.

Earlier training models of emergency medical services (EMS) were based primarily on managing trauma and cardiac care emergencies. The Freedom House 2.0 training **model moved beyond traditional EMS services** by also teaching first responders how to address poorly managed



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When we train students how to become an EMT in the field, they have a much broader holistic person view of the patients that they're dealing with and can do a better job of getting them to the correct system of care.



chronic medical and behavioral health conditions and other social determinants of health, such as food and housing insecurity.

## DESCRIPTION

Freedom House 2.0 provided **emergency first responder career training** and job placement support to individuals experiencing health and economic disparities while also building a diverse paramedic workforce of individuals within the community. Under the leadership of the program's medical director, Freedom House 2.0 educational staff provided mentorship and support to students throughout their **10-week training program** to support success. The program provided trainees with a monthly stipend as well as access to a food pantry, childcare when needed, and networking benefits such as coordinating job interviews.

Students selected for the program were required to be a resident of Allegheny County and have a high school diploma or GED. Freedom House 2.0 prioritized recruiting students who are UPMC *for You* health plan members as well as those who are under-employed or lost a job due to COVID-19. Of the 110 Freedom House 2.0 applicants, 48 percent had lost their job due to the pandemic; and 52 were ages 18 to 24. Students completing the program are eligible for careers as **emergency medical technicians (EMTs), community paramedics, or community health workers**. Graduates were guaranteed an interview with UPMC and job placement support.

“According to one graduate, 'It's like everything that could possibly stand in your way of trying to further your education was covered with this program.'”

## IMPLEMENTATION

The UPMC Center for Social Impact, part of the non-profit research arm of UPMC Health Plan, runs Freedom House 2.0, as well as a variety of housing, food security, and other social investment programs for UPMC members. The Center secured a \$235,000 grant from Allegheny County's public workforce investment board, Partner4Work, most of which goes to the students to eliminate economic barriers to participating in the program.

**Partnering with community organizations** is key to the success of the program. Recruitment for the program was in partnership with several community-based organizations. Each cohort was trained in a different neighborhood, with grant funds paying the local partner for use of space for the 10-week program. This model developed relationships, engaged partners in participant recruitment, and raised awareness in the community about other services available through UPMC Health Plan.

Ultimately, the program was **integrated with services** to UPMC *for You* members. For example, whenever the health plan identified somebody who had food insecurity, they delivered food to that person within 24 hours, connected them to food pantries, and got their SNAP application processed.

The Freedom House 2.0 model innovatively prepared students to connect people to the right resources at the most vulnerable point in their health care journey. Therefore, the **training is broad**, covering subject matter from psychomotor exams to mental health to trauma-informed care. As a result of **feedback from students** about how to improve the program, multiple adjustments were made to the curriculum to provide space and support when covering difficult topics, such as suicide, and addressing students' often traumatic life experiences.

## IMPACT

The program follows students after graduation to see where they were working and whether they retained or moved to different positions. As of June 2022, Freedom House 2.0's outcomes have been:

- 21 students graduated from the program;
- 85 percent employment rate for graduates;
- Graduates make an average of \$15.60/hour (minimum wage in Pennsylvania is \$7.25/hour);
- 15 BIPOC (Black, Indigenous, and People of Color) students have graduated from the program; and
- 10 graduates are employed by or were offered employment by UPMC.

## OPPORTUNITIES

UPMC received funding to begin its fifth Freedom House 2.0 cohort in 2022. The program will **expand recruitment** in Pittsburgh, **replicating the initiative** outside the region, and develop a future cohort to specifically **recruit non-English speaking participants**. The program has learned that in addition to the training components, a critical factor for success is to connect students with various benefit programs, including food and housing subsidies.

Freedom House 2.0 started a national conversation about the relevance of criminal background checks for EMT training, which are currently a barrier for individuals with a history of justice system involvement. **Broader policy change may be needed** to ensure a true equity framework for both employment opportunities and for developing a workforce with lived experiences to support effective work with communities.

Many EMS calls are the result of behavioral or social determinants of health not addressed in the National EMS Education Standards, which also omit healthy coping skills to mitigate the traumatic experiences EMTs encounter in the field. As a **model program**, Freedom House 2.0 aims to influence national training standards for the community paramedicine profession as well as to highlight what other cities can do across the country.

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Even though  
it's a job, I take  
it personally.”



# HEALTHY U BEHAVIORAL HUB

**Health Plan:** University of Utah Health Plans

**Parent Organization:** University of Utah

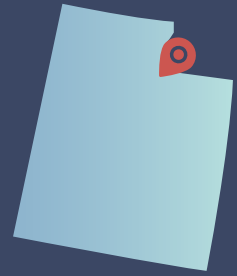
**Location:** Summit County, Utah

Summit County, Utah (population 40,000), has stark socioeconomic inequalities. With a median household income of \$106,973 per year, it is home to both the Sundance Film Festival and a migrant, primarily Mexican and Central American workforce that accounts for 40 percent of residents during the winter tourist season, up from 9.6 percent overall (United States Census Bureau, 2022).

In 2015, two teens died after using a synthetic opiate in Summit County. These tragic deaths galvanized the community to address the limited availability of mental health services and substance use disorder treatment. A community-based coalition was formed and wrote a five-year strategic plan, which was adopted by the county council; the coalition originated as a partnership among the county, Park City, providers, and non-profits and has grown to 300 active members.

As part of the strategic plan, the county issued a request for proposals to deliver Utah's Prepaid Mental Health Plan (PMHP) Medicaid benefits. In 2019, the contract was awarded to Healthy U Behavioral (HUB), a new managed care product of the University of Utah. Healthy U Behavioral, also administers substance use and mental health block grants and therefore streamlines behavioral health service delivery for Medicaid-eligible and uninsured individuals in Summit County. A Latino behavioral health committee was formed, comprised of Spanish-speaking residents and clinicians, to advise Healthy U Behavioral in serving the Latinx population.

The Healthy U Behavioral health plan went live in September 2019 and developed a network of contracted behavioral health providers, including the University's Huntsman Mental Health Institute, multiple community-based organizations, and onsite behavioral health providers in schools.



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When the pandemic shut down businesses and schools, it threw into stark relief the difference between the haves and the have nots in our community.

## DESCRIPTION

Early in the pandemic, Summit County's COVID-19 infection rate was in the nation's top-five per capita. As businesses shut down, service-sector workers lost jobs and were not eligible for unemployment benefits. Healthy U Behavioral and its role in the coalition accelerated access to its newly formed network for behavioral health care and social needs.

- **Team Up With Schools.** Providers teamed up with schools to ensure students' laptops were delivered to their homes to ensure access to both instruction and behavioral health care. School-based clinicians provided telehealth counseling to students and family members who were now available to seek care together. Healthy U Behavioral staff referred eligible members to an underused Internet service program that provides low-income families with free high-speed Internet, and they offered practical help for families to utilize their laptops for counseling and school.
- **Promote Behavioral Health Services.** Healthy U Behavioral partnered with Holy Cross Ministries and Peace House, an interpersonal violence and abuse victim services organization, to promote behavioral health services on social media and local media in English and Spanish. To support individuals in substance use recovery, the health plan partnered with the justice system to continue Drug Court via video conferencing and in-person access to urinalysis testing.
- **Bilingual/Bicultural Behavioral Health.** Healthy U Behavioral also partnered with the Huntsman Mental Health Institute in Salt Lake City to expand access to bilingual, bicultural behavioral health through a psychiatric clinic with services provided by a native Spanish-speaking psychiatrist and social worker.

## IMPLEMENTATION

Partners utilized intersecting forums and resources to creatively implement **innovative solutions.**

- **Q & A Video Conferencing Sessions.** Summit County Health Department launched public Q&A video conferencing sessions to address widespread COVID-19 safety concerns. Therapists from the Healthy U Behavioral network joined sessions, shared resources, and as needed, initiated private chats with participants to refer to care.
- **Social Work Licensing Exam.** To expand the bilingual, bicultural workforce and help qualified candidates overcome language bias in the social work licensing exam, Healthy U Behavioral used

American Rescue Plan Act (ARPA) funds to purchase study materials and private tutoring for 15 non-native English-speaking social work graduates preparing for the exam.

- **Social Determinants Of Health Coordinator.** Healthy U Behavioral added the county's new social determinants of health coordinator to its interdisciplinary care team.
- **Advocated For Improved Living Conditions.** As a member of the Latino Behavioral Health Committee, the health plan advocated for improved living conditions for residents who feared eviction for reporting their substandard housing by referring them to the county attorney and coordinating referral to community resources.

## IMPACT

In its first six months of operation, Healthy U Behavioral positioned itself such that when the pandemic occurred, they already had existing strong resources in place and were able to expand services.

**TABLE 1. CHANGE IN BEHAVIORAL HEALTH SERVICES**

Utilization/Access Metric	2019	2020
School-based BH services (counseling, child psychiatry, telehealth)	36 students	392 students
Medicaid-enrolled population using behavioral health services	300 individuals	2,400 individuals
Wait time for outpatient therapy appointments	90 days	4 days
Wait time (# of days) for BH medication management appointments	120 days	7 days
In-network clinicians	6	97

Healthy U Behavioral health plan only began in 2019 and attributes its success during the pandemic to **community resilience and assets** built after the tipping point of the 2015 tragedies. The health department, nonprofits, municipalities, school districts, law enforcement, parents, and health advocates, took **collective ownership** of community behavioral health, avoiding the “staying in your

lane” mentality. They are continuing **data-driven and community-driven strategic planning**. To inform the updated plan and goals, an evaluator was hired to collect scientifically valid demographic data and input from 2,400 residents who participated in surveys and focus groups.



## OPPORTUNITIES

Healthy U Behavioral recognizes that flexibilities in Medicaid policy for telehealth services and eligibility within the public health emergency were critical factors to their success but must also be combined with additional approaches.

- **Coordination Among Partners.** Diverse “boots on the ground” collaborators provide ongoing input to the Behavioral Health Executive Committee, a forum to communicate to county government.
- **Network Model.** Healthy U Behavioral recommends that a Prepaid Mental Health Plan utilize a network, which expands access to behavioral health and sites of care.
- **More Case Management And Peer Support.** Further innovation is needed to develop reimbursement for services that address barriers to health and health care, which make clinical behavioral health more effective and efficient.
- **Workforce Investment.** To address workforce shortages and ensure high-quality care, there is a continued need to support diverse individuals seeking careers in behavioral health.

Going forward, Healthy U Behavioral envisions a model that will generate and measure savings in areas such as law enforcement and health care, overall, by addressing behavioral health and social determinants of health through strong community partnerships.



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## INNOVATIVE INITIATIVE

### MANA MAMA

**Health Plan:** AlohaCare

**Location:** Hawai'i

**AlohaCare** is a community-founded health plan serving Medicaid enrollees in Hawai'i, actualizing the spirit of aloha by ensuring access to whole-person care. **Healthy Mothers Healthy Babies Coalition of Hawai'i (HMHB)** is a nonprofit dedicated to eliminating health disparities and increasing access to care for socially high-risk pregnant/birthing people and infants with a focus on Black, Native Hawai'ian, Indigenous, Compact of Free Association (COFA) migrants, and other people of color.

Prior to COVID-19, AlohaCare and HMHB were members of Hawai'i's perinatal collaborative working to improve health outcomes for our population. Perinatal care was consistently under scrutiny: Hawai'i received a D+ for preterm birth and has one of the worst health disparity ratios in the country, according to the 2020 March of Dimes Report.

The tourism-dependent economy was substantially affected by the pandemic, resulting in increases in unemployment and Hawai'i's imported food and provisions becoming scarcer and more expensive. In a September 2020 survey, HMHB and the Hawai'i State Commission on the Status of Women found inadequacies in prenatal care. HMHB saw the need and launched the **community-based midwifery model of care, Mana Mama**, utilizing a multidisciplinary approach to care for pregnant and birthing people. Key initial partners were AlohaCare and Direct Relief, providing funding to convert a former tourist van, and launched the Mana Mama Mobile Clinic (MMMC).

#### DESCRIPTION

HMHB creates **culturally-anchored programs** and materials and develops models in a responsive manner that increase access across the islands to holistic care for all pregnant and postpartum individuals and their families,



We call it innovative, but really it's radically simple.



with particular attention to subgroups that encounter health disparities in a state with a dramatically different demographic composition, including subgroups such as Native Hawai'ian Pacific Islander.

The Mana Mama program is a **community-based midwifery model** of holistic care with licensed midwives, lactation consultants, and a nurse practitioner that hires a diverse workforce to match its clientele. In addition to clinical services, participants receive comprehensive phone and telehealth support and referrals to mental health and social services.

## IMPLEMENTATION

Mana is loosely translated as a form of spiritual power and strength in Hawai'ian and Polynesian cultures. Mana Mama's purpose is to create a strong foundation for birthing people and their babies, while wrapping families in social services.

Mana Mama was developed in three phases. In the first phase, HMHB acquired the van and received funding from the Hawai'i Community Foundation to launch **Māna 'ai, a weekly food distribution program** during the beginning of the stay-at-home order. HMHB staff delivered food to bridge gaps as they also assisted families in connecting to Women Infant and Children (WIC) benefits and the Supplemental Nutrition Assistance Program (SNAP).

The second phase of Mana Mama was prompted when, in response to the pandemic, Hawai'i announced a change in its Medicaid managed care pay-for-performance program that reduced the number of quality measures from ten to five. Prenatal and postpartum care were now worth millions of dollars each, resulting in a combined clinical, equity, and business case for AlohaCare to partner with HMHB. HMHB felt that community organizations had historically pleaded for support to **address disparities among pregnant and birthing people**. The pandemic served as the tipping point for Medicaid and health plans to prioritize this population. AlohaCare sought not to be strictly a grant-maker, but also a partner and a source of sustainable revenue for HMHB.

“

Don't be afraid to do something that will make a difference.

Find one population, make an impact, and then move forward.

Know your community and learn lessons unique to your community.”

HMHB applied for AlohaCare's "access-to-care" funding to renovate the van to become the MMMC. The MMMC went live in March 2021, with resources for primary care/perinatal care, laboratory capabilities, a vaccine refrigerator, toilet, sink with running water, other medical equipment, and appealing décor. The third phase of Mana Mama's development occurred when Hawai'i urgently prioritized vaccinations, HMHB began mobile vaccine administration as well as laboratory testing for COVID-19.

“Everybody went head over heels for this van because it's really beautiful.”

AlohaCare shares member lists with HMHB; staff are trained to screen for and address behavioral/social needs and make referrals. Through its mobile and telehealth services, HMHB collects data about members' needs that it shares with AlohaCare.

Mana Mama's overall goals are to reduce disparities in outcomes such as preterm delivery and maternal/infant mortality and to lower costs related to birth and neonatal intensive care. Other objectives are to increase:

- Timely prenatal/postpartum visits;
- Perinatal depression screenings and follow-up;
- Vaccination in pregnant/postpartum members and their families; and
- Screening for social determinants of health and connecting families to social services.

## IMPACT

Since July 2021, Mana Mama outcomes include:

- 848 percent increase in calls and 606 percent increase in clients;
- 729 clinical visits conducted (health screenings, mental health services, prenatal/postpartum visits, lactation consultations, reproductive/family planning visits, COVID-19 testing);
- 1,348 COVID-19 vaccinations administered;
- 36 participants in Piko Pals new parent support groups;
- 85 Cribs for Kids clients received education and a free portable crib;

- 185 clients engaged on the 24-Hour telehealth platform;
- 100 community-based doula birth and/or postpartum services; and
- 548 households received rental assistance, partnered with Catholic Charities Hawai'i; host Intensive Outpatient Program (IOP) groups three days/week for women/mothers with substance use, partnered with Gino Clinic.

In 2022, an evaluation will utilize HEDIS™ prenatal, postpartum and perinatal depression screening measures and pregnancy intention screening. Outcome measures will include maternal mortality/morbidity and cost of care for pregnant members and infants.

## OPPORTUNITIES

Effectively improving health equity for Hawai'i's diverse population requires disaggregated race and ethnicity data, specifically including Native Hawai'ian, Asian, and Pacific Islander populations; such data can inform program development.

Pre-pandemic, Hawai'i approved licensure for certified professional midwives; however, these midwives could not receive reimbursement from Medicaid because the state has not created a new provider type. The Mana Mama pilot relied on an innovative method for AlohaCare to pay HMHB for services and data collection. The partners are proud of their hybrid payment model, which included integrated social services, but note that the program will be sustainable once the state Medicaid agency creates a provider type for licensed midwives as Medicaid providers and standard reimbursement codes that licensed midwives can bill.

Following the successful pilot, the goal is to have mobile clinics for every island—even those with few birthing people far between. HMHB aims to reach every one of them, which is Mana Mama's vision of health equity.

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## INNOVATIVE INITIATIVE

# SAFETY TESTING OVERALL PARTNERSHIP (S.T.O.P.) COVID-19 DISPARITIES

**Health Plan:** UnitedHealthcare Community & State

**Parent Organization:** UnitedHealth Group

**Location:** National, highlighting initiatives in Texas

Through **UnitedHealthcare Community & State**, UnitedHealth Group (UHG) provides health care benefit services to 7.7 million Americans in multiple states and communities through government programs including Medicaid. The organization quickly understood the pandemic was exacerbating pre-existing health disparities and access to care, and early data indicated substantial COVID-specific health disparities related to infection, testing, and morbidity and mortality rates. As a result, the **Safety Testing Overall Partnership COVID-19 Disparities (S.T.O.P. COVID) Initiative** was launched to address COVID-related disparities through strategic community engagement and partnerships, including improving access to healthcare services and resources, such as vaccinations and testing, as well as social needs such as access to healthy foods.

## DESCRIPTION

S.T.O.P. COVID operated at both the national and community levels to support communities through investment and partnerships with three objectives:

1. Improve **COVID-19 awareness** through education and outreach with culturally competent materials and on-site support.
2. Improve equitable access to **testing, referrals, and vaccinations**.
3. Improve **food security and referrals to social services**.

**National level.** An executive steering committee of organizational leaders oversaw and championed the S.T.O.P. COVID initiative, committing both financial and human resources.



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CBOs give us a line of sight into what our communities need and want, and we might not necessarily have that knowledge without our relationships with them. They have really helped us shape our priorities and what we need to deliver for the individuals we serve.

- The national data analytics team developed an internal COVID-19 medical intelligence tool, combining data from the Area Deprivation Index and COVID-19 case and morbidity data to identify “hotspot” communities to focus resources.
- More than 50 individuals across clinical, legal, financial, and logistics business areas comprised the national team.

**Community Level.** Teams of employees worked together at the local level to leverage existing partnerships and build new relationships including government, Federally Qualified Health Centers (FQHCs), other health facilities, and community organizations.

- S.T.O.P. COVID engaged sixteen communities across the District of Columbia and 11 states (California, Florida, Georgia, Kansas, Louisiana, Maryland, Minnesota, North Carolina, Ohio, Pennsylvania, Texas).
- More than 100 community-based and faith-based organizations were engaged in these partnerships.

The core model included the provision of COVID-19 testing, health and social service referrals, and food and safety support.

- COVID-19 testing sites were established in communities with the greatest need, thus reducing travel time for residents and improving access.
- Individuals who tested positive for COVID-19 or needed other medical services were referred to local FQHCs.
- Referrals to other services (for example, rent and utility assistance) were facilitated by community partners, often onsite during events.
- Food boxes, safety kits with masks, hand sanitizer, and other hygiene items and culturally appropriate educational materials were provided.
- Additional resources were provided to enable community partners to be effective, such as by covering extra staff time and equipment like refrigerators.

## IMPLEMENTATION

S.T.O.P. COVID initially focused on **improving access to health care services**, specifically COVID-19 testing. Greater understanding of COVID-related disparities quickly prompted expanded outreach, including the need to provide **food boxes, safety kits, and educational materials** to each person tested. Depending on community needs, S.T.O.P. COVID partnered with other stakeholders for referrals to medical and social services.

In 2021, the focus of S.T.O.P. COVID pivoted from COVID-19 testing to **COVID-19 vaccinations**, provided in partnership with local FQHCs. Although partnerships had existed previously, the teams began more intentionally working with local social service agencies, food pantries, faith leaders, public health departments, and FQHCs. Developing materials and messaging with partners was essential to establish trust and engagement with community members.

To meet the needs of each community, the organization had to be flexible and respectful to the permanent organizations and fixtures in the community. At times, this meant working with local partners with history in the community. UnitedHealth Group set up agreements to support local vaccine distribution and arrangements to channel resources directly to local agencies.

**Bexar County, Texas** was identified as an area with great need. In November 2021, Bexar County reported higher COVID-19 case and death rates than Texas and the United States. The vaccination rate in Bexar County was also lower than the United States vaccination rate. From November 11, 2021, through December 26, 2021, locally based teams worked with community health providers to administer **3,962 COVID-19 vaccines and 1,334 health and safety kits**.

## IMPACT

To measure impact in the targeted communities, all sites collected data on services provided, partnerships established, and jobs created, including:

- Approximately 50,000 COVID-19 tests collected;
- More than 14,000 COVID-19 vaccinations administered;
- Approximately 46,000 health kits distributed;
- More than 27,000 food boxes provided;

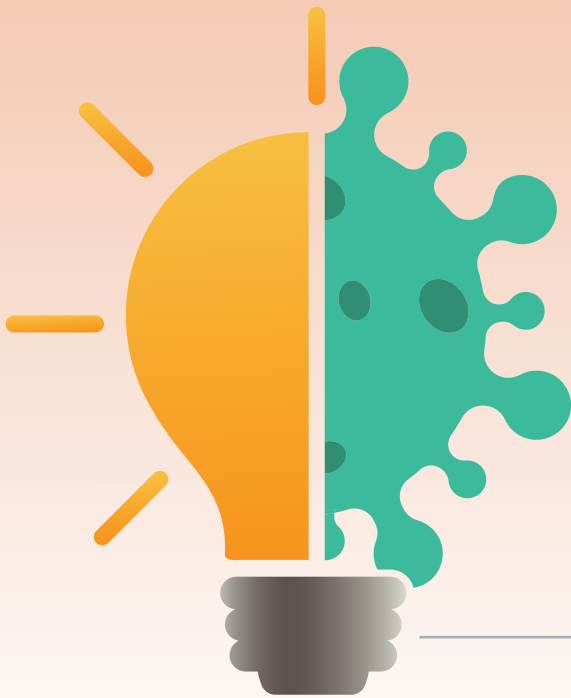
- More than 900 medical and nearly 2,000 social services referrals; and
- 58 jobs created.

Based on demographic data collected by some sites, services reached the intended populations more than 90 percent of the time, including persons of color. In a **post-initiative survey** of S.T.O.P. COVID sites, survey respondents indicated that the support of S.T.O.P. COVID was beneficial to community outreach and engagement efforts, strengthened stakeholder relationships, increased vaccination rates, and provided needed services and supplies to communities. Overall, the approximately 100 new strategic partnerships fostered by S.T.O.P. COVID will allow UnitedHealth Group to continue to address the social needs of communities through community-based partnerships.



## OPPORTUNITIES

Innovation is one of the five UnitedHealth Group core values. UnitedHealth Group recognizes that a **data-driven approach** as the foundation for identifying communities most in need. Relationships, another core value, were integral to the success of S.T.O.P. COVID. **Partner relationships** were mobilized to understand and aid the local community. Gaining the trust of community stakeholders was critical in engaging community members to utilize S.T.O.P. COVID services. UnitedHealth Group hopes to continue to develop innovative ideas and tools to further their mission of addressing health disparities and to address specific health care needs of persons who may encounter barriers to accessing healthcare.



# EMERGING BEST PRACTICES

*Please note that the inclusion of names of organizations, corporations, services, and/or products should be not be viewed as an endorsement or recommendation by the Institute for Medicaid Innovation.*





## EMERGING BEST PRACTICE

# 2021 COVID-19 VACCINE RESPONSE

**Health Plan:** HAP Empowered Health Plan, Inc.

**Parent Organization:** Health Alliance Plan (HAP) of Michigan, a subsidiary of Henry Ford Health

**Location:** Metro Detroit and Flint, Michigan

## DESCRIPTION

As the pandemic exacerbated socio-economic inequities, HAP Empowered Health Plan, Inc. quickly implemented its **2021 COVID-19 Vaccine Response initiative**. Partnering with social service, religious, educational, and community organizations, the program emphasized education and access to improve vaccination uptake, including drive-through vaccination events at local churches and commercial partners, such as McDonald's.

Southeastern Michigan was one of the first major metropolitan areas to suffer a COVID-19 surge, which created fear and confusion for residents who questioned the effectiveness of the public safety efforts, including vaccination. Historical failures related to widespread lead exposure in Flint, Michigan underpinned these feelings about the vaccine.

To address the community's concerns about vaccination, the health plan created **multi-faceted educational efforts**, including **tailored communications** for unvaccinated members with **segment-specific vaccine confidence messaging** for young mothers, working adults, and individuals with prior COVID-19 exposure.

HAP Empowered worked with Henry Ford Health to deliver **continuing medical education** training to physicians regarding vaccine hesitancy and patient coaching as well as incentives for offering vaccines to patients. In addition, Henry Ford Health **provided at-home vaccinations** for members and caregivers unable to leave their home. HAP Empowered expanded its



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To make vaccination events an enjoyable experience, drive-through vaccination participants were invited to dial-in to a designated radio station to share a collection of health-themed music.

transportation services to include trips to local grocery stores. Care managers connected members to local food pantries and food delivery services.

## OBJECTIVES

To prioritize outreach attempts, HAP Empowered developed a dashboard, using Social Vulnerability Indices, to identify members with high-risk factors such as social isolation and food insecurity.

Objectives of the program were to:

- **Establish Task Force and Planning Tools:** establish a COVID-19 Task Force in partnership with Henry Ford and develop the COVID-19 reporting dashboard to coordinate and track outreach and vaccination efforts.
- **Implementation of Vaccine Initiative:** educate members and providers about issues related to vaccine hesitancy, reach members at-risk of getting COVID-19, and connect at-risk people with community benefits.

## IMPACT

In 2021:

- HAP Empowered made more than 75,000 telephone calls;
- Over 80,000 vaccine doses were provided at HAP Empowered's Troy and Flint corporate offices;
- Over 18,000 vaccine doses were provided at religious organizations; 14,000 doses at educational institutions; and 36,000 doses at community centers and local venues; and
- Providers vaccinated an additional 1,000 high-risk members.

## REFLECTIONS

The initiative continues to inform the corporate mission to transform HAP Empowered to improve the health of the community. This initiative **sharpened HAP Empowered's dedication to continue encouraging general preventive services**, incentivizing members' engagement, pursuing local partnerships to educate members on health behaviors, and using data tools to support subpopulations and members at greater social risk.



## EMERGING BEST PRACTICE

# COVID HIGH RISK OUTREACH PLAYBOOK

**Health Plan:** CareOregon

**Location:** Oregon

### DESCRIPTION

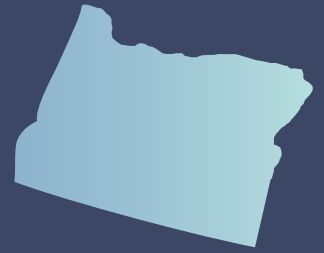
Equity was at the heart of CareOregon's COVID High Risk Outreach Playbook, which created a systematic, data-informed process to prioritize members most affected by existing health disparities and/or most at risk for poor outcomes related to COVID-19 while also addressing the social determinants of health.

When vaccinations became available, CareOregon used Race, Ethnicity and Language, Disability (REALD) data and risk scores to stratify members. Members who were over 65 years of age, had chronic conditions, identified as a person of color, or were unhoused were contacted first about vaccinations. In addition, CareOregon identified members who needed additional support to access the vaccines because of barriers related to geography, transportation, disability, language, culture and behavioral health conditions.

CareOregon engaged community-based organizations (CBOs) to provide support for culturally specific populations. Grant funds were leveraged to support CBO partners to bring vaccines to specific locations, working alongside trusted providers to increase vaccination rates.

CareOregon quickly learned that the major obstacles facing members were social health needs, many of which already existed within the community. The health plan was able to:

- Adapt current contracts for food delivery to include an expanded population;



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An equity toolkit for vaccines was developed and shared among all partners doing this critical work.

- Leverage Health-Related Service Funds (via an 1115 waiver) to pay for housing support, hotel stays, and other needs; and
- Use non-emergent transportation to include trips to grocery stores, pharmacies, and other critical social services.

## OBJECTIVES

CareOregon's goal was to achieve the following targets:

- 70 percent of members receive vaccinations;
- 70 percent of members who identify as BIPOC and/or English Language Learners receive vaccinations;
- 90 percent of secured scheduling slots are filled every week;
- Successfully report outreach efforts to the Oregon Health Authority; and
- Members and staff report a positive experience.

## IMPACT

As of November 2021, outreach staff reported that members expressed overall satisfaction with the program with 58.4 percent of the overall population and 70 percent of those older than age 65 were either fully or partially vaccinated.

## REFLECTIONS

This process allowed CareOregon to create an outreach and engagement plan that could be used for future large-scale public health needs. For instance, it has already adapted its playbook, replicating outreach efforts for the wildfires and heat wave of 2021. CareOregon also has approved additional staffing for a new Rapid Response Team to continue this work into the future.



## EMERGING BEST PRACTICE

### COVID KITS

**Health Plan:** Trillium Health Resources

**Location:** North Carolina

#### DESCRIPTION

The need for **personal protective equipment (PPE)**, initially in short supply at the start of the pandemic, was a cost burden and challenge for members and providers. **Trillium Health Resources** launched its **COVID Kit** initiative to provide PPE to members to safely attend medical appointments and day programs and to utilize food pantries.

Kits were also given to providers who offered outpatient and congregate services, including adult day, psychosocial rehabilitation, after-school, and treatment programs. Trillium wanted providers to have PPE to continue providing services safely, at a time when supplies were difficult to obtain.

Trillium worked with several vendors to purchase supplies. Staff packed and delivered kits to providers' offices, where they were distributed to members. **Provider kits** included disinfectant wipes and spray, hand sanitizer, no-contact thermometers, tissues, face shields and masks, gloves, and other items. All **member kits were packed in an insulated tote** and included PPE, a stress ball, a water bottle, and informational brochures in Spanish and English. The kits for children included all the same items plus coloring pages about germs and crayons. Through a link on the Trillium website, members could also submit a request for a kit to be delivered to them by mail.



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During times of mask mandates, kits were essential to ensure members could access community resources safely.

## OBJECTIVES

The goals of the initiative were to:

- Increase access to needed supplies and PPE;
- Increase health and safety of all members and providers; and
- Ensure that members had items needed to safely access resources in the community.

## IMPACT

Trillium Health created and distributed 600 provider kits and approximately 20,000 member kits. Members were observed wearing the Trillium masks in the community at banks, grocery stores, and provider agencies.

## REFLECTIONS

This initiative was responsive to a new need for PPE for all community members and Trillium was able to utilize the full amount of funding for kits that were distributed.



## EMERGING BEST PRACTICE

# COVID-19 VACCINE OUTREACH AND ENGAGEMENT PROGRAM

**Health Plan:** Amerigroup New Jersey

**Parent Organization:** Anthem, which officially becomes Elevance Health on June 28, 2022

**Location:** Essex, Passaic, Hudson, Union, and Atlantic Counties, New Jersey

## DESCRIPTION

In 2021, **Amerigroup New Jersey** worked with community partners within five counties to schedule COVID-19 vaccinations, educate members about vaccine hesitancy, and address social determinants of health, most importantly, food insecurity.

In addition to collaborations with community- and faith-based organizations, hospitals, federally qualified health centers, and providers, Amerigroup New Jersey's **COVID-19 Vaccine Outreach and Engagement Program** partnered with local businesses to raise awareness about COVID-19 vaccinations. Barber shops and beauty salons, supermarkets, and school districts sponsored community events and Q&A sessions in areas with low vaccination rates. Vaccination events were scheduled at **community locations** such as grocery stores, and to support members at these events, hair salons offered free haircuts, schools sponsored backpack give-ways, and food distribution was offered at health centers. Amerigroup New Jersey set up a **COVID-19 hotline**; members were informed about vaccination and educational events through social media.

Through outreach and social needs screening, **food insecurity was identified as a major issue**. As a result, Amerigroup New Jersey implemented **systematic food insecurity screening**, assisting members in SNAP enrollment, and providing a bridge of up to 14 days of free meal delivery until SNAP benefits began. The health plan also partnered with



## AMERIGROUP NEW JERSEY'S BRIDGE MEAL SERVICE

Amerigroup New Jersey assisted members in SNAP enrollment and provided a bridge of up to 14 days of free meal delivery until SNAP benefits began for more than 4,000 members.

food distribution organizations to enable grocery distribution to members at storefronts and larger community events.

## OBJECTIVES

The communities selected had disproportionately low vaccination rates, were primarily low income and minority populations, and were **identified by the state of New Jersey as priority communities**. The objectives were to:

- Educate and vaccinate as many eligible members deemed at highest risk; and
- Provide access to food programs and other needed resources.

## IMPACT

During its COVID outreach efforts, Amerigroup New Jersey outreached **145,555 members** and reported the following outcomes for their food initiatives, which became the focus:

- 8,786 members were identified as food insecure through the screening process and referred to food resources such as food pantries and SNAP;
- 4,043 members were referred for bridge meal boxes (1,063 received multiple boxes); and
- An additional 2,954 families received grocery boxes through Amerigroup's community-based distributions.

## REFLECTIONS

Amerigroup New Jersey is **now regularly screening for food insecurity**, and food resource referrals and distribution are now a standing process. Amerigroup New Jersey is also working differently in the community, such as engaging barbershops and beauty salons, in other initiatives related to health education and raising awareness of health topics, such as prostate and breast health screenings as well as the importance of immunizations.





## EMERGING BEST PRACTICE

# COVID-19 VACCINE STRATEGY

**Health Plan:** UPMC *for You*

**Parent Organization:** UPMC Health Plan

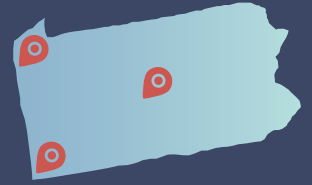
**Location:** Southwestern, Northwestern, and Central Pennsylvania

## DESCRIPTION

UPMC *for You's* COVID-19 Vaccine Strategy involved a wide range of actions to reach areas where vaccine access was limited and to engage people of color.

- Partnering with a **cross-cultural marketing and advertising** agency on a culturally focused vaccine outreach and engagement campaign to UPMC *for You's* ethnically diverse membership. Targeted messages delivered through **various engagement channels** aimed at creating awareness and trust.
- Informing dually eligible members (Medicare/Medicaid) through automated calls, text messages, and email about the Staying-In-Touch Education Series, a **virtual health education program** including COVID-19 vaccination information, and the availability of vaccinations in their area. The health plan also conducted targeted outreach on vaccination availability to members with high-risk conditions and how to connect to the UPMC Town Hall for resources.
- Strategizing how to use UPMC *for You's* **mobile vans to provide** vaccination clinics at congregate settings (including apartment complexes), in rural areas, and assisting at UPMC clinics.
- **Identifying homebound members** through the health plan's analytics team and arranging in-home vaccination days for members/caregivers.
- Supporting members through creating a **community resource guide**.

With a grant from the state, UPMC *for You* distributed **personal protective equipment** to members and direct care workers, including a 10-day supply of masks, gloves, gowns, and face shields. Furthermore, the health



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Before, during and after COVID, the innovation of virtual visits allowed us to have a much more personal experience with the members.

plan supported broader community vaccination efforts through **providing logistical support** and member services resources so that community partners could focus their efforts on outreach and engagement.

## OBJECTIVES

The objectives of the initiative were to:

- Launch a culturally focused marketing campaign and virtual education event;
- Build vaccination strategies that remove barriers for communities and people of color; and
- Provide logistical support for organizations in underserved areas.

## IMPACT

As of November 2021, UPMC **administered more than 1,498,540 vaccine doses to members.** They supported vaccination efforts via a range of partnerships in underserved rural and urban areas, including:

- Outreach/onsite support at various pharmacies in Pittsburgh, Erie, Washington, and Connellsville;
- Coordination with other MCOs to identify vaccination sites in the Pittsburgh area;
- Outreach support to veterans for vaccination initiatives in Allegheny, Butler, and Fayette Counties; and
- Partnership with the Neighborhood Resiliency Project (Hill District of Pittsburgh) for pop-up vaccination clinic pre-registration and scheduling.

## REFLECTIONS

UPMC *for You* initially provided logistical support through several partnerships depending on each organization's individual needs. The health plan expected to expand their logistical support by issuing a press release with a central email for organizations to contact if they have vaccine supplies and needed additional resources to increase the impact of their local vaccination efforts.



## EMERGING BEST PRACTICE

# EDUCATE, ACCESS, AND SUPPORT

**Health Plan:** Healthy Horizons in Florida

**Parent Organization:** Humana Inc.

**Location:** Florida

## DESCRIPTION

"Meeting members where they are" inspired Humana's **Educate, Access, and Support (EAS) initiative**. This multi-modal outreach model, launched in Duval County Florida, was developed in 2021 in response to disparities in COVID-19 vaccination rates for Black and African American Medicaid members. Humana innovated to improve COVID-19 vaccination rates through a hyperlocal approach using their proprietary hot spotting tool, Population Health One, which integrates clinical, social determinants of health (SDOH), and community resource datasets. The EAS outreach model is described as:

- **Educate.** For its initial statewide launch, Humana partnered with Edward Waters University to host "Let's Get Real about COVID," a public town hall featuring Humana leadership and African American community leaders from Jacksonville, Florida. To address hesitancy of Medicaid members, Humana member-, provider-, and community-facing touchpoints provided COVID-19 vaccination information.
- **Access.** Humana assisted members with scheduling appointments and transportation by partnering with organizations such as Broward Health Ambulatory Division, provider groups such as Federally Qualified Health Centers (FQHCs), and community organizations.
- **Support.** Unvaccinated members received support from Humana's 24-hour nurse line, care coaches, and social workers. Providers received data about unvaccinated members and resources to address vaccine hesitancy. In addition, community and faith-based organizations also received financial support.



## WHAT IS BOLD GOAL?

"Bold Goal" is Humana's population health strategy, which emphasizes SDOH parity by addressing unmet social needs as critical gaps in care.

## OBJECTIVES

Humana applied an equity lens to identify populations experiencing the highest level of need among Florida Medicaid members, acknowledging systemic barriers contributing to vaccine rate disparities. They engaged trusted community partners to co-develop the program with two main objectives:

1. **Directly work with members** to provide COVID-19 vaccination education and comfortable and safe options for care.
2. **Collaborate** with health systems, providers, and community/faith organizations to provide support and access to care.

## IMPACT

Between January and October 2021, the statewide EAS initiative resulted in:

- 65,758 emails and 180,664 text messages to members;
- 65 social media posts, reaching 252,977 consumers;
- 404,585 outreach calls;
- 28,737 completed vaccine assessments;
- 47,388 members assisted with appointments; and
- 30 community events.

Other outcomes of the initiative included the development of a vaccine assessment, expanded use of the 24-hour nurse line, and community partnerships.

## REFLECTIONS

Humana was able to expand the model statewide to reach a broader population of members. Although the EAS outreach initiative was developed in response to COVID-19, Humana plans to use this model beyond the pandemic (e.g., Humana launched the Louisville Community of Opportunity, a collaborative with partners to focus on health equity in Louisville, Kentucky's West End).



## EMERGING BEST PRACTICE

### GOT MY SHOT

**Health Plan:** Aetna Better Health of Illinois

**Parent Organization:** CVS Health

**Location:** Illinois



#### DESCRIPTION

Aetna Better Health® of Illinois (Aetna) created the ***Got My Shot*** outreach campaign using multiple methods to increase COVID-19 vaccinations across Illinois. The initiative included the following elements:

- **Mass Communication Outreach.** Through Q3 2021, Aetna conducted 360,000+ outreach calls, deployed 200+ social media posts, and sent 570,000 text messages, 480,000 mailers, and 67,000 emails. To resonate with members, the data and messaging campaign was enhanced every 30-45 days and following national updates or member feedback. Aetna addressed health literacy with accessible, actionable information across omni-channel messages.
- **Support for Providers.** Aetna identified resources that clinicians needed to offer vaccines: mobile storage units, personal protective equipment, and member engagement toolkits.
- **CVS Partnerships.** The HealthTag program reached members who were picking up prescriptions at CVS Pharmacy locations by offering onsite vaccines.
- **Vaccine Clinics and Access.** Aetna identified 11 clusters of members, totaling over 73,000 individuals, who were unable to travel to vaccination sites and partnered with local health departments to hold vaccine clinics at seasonal events. Aetna identified lack of transportation as a primary social determinant of health affecting vaccination rates. Transportation was arranged for members in need, especially older adults and people with disabilities.



Aetna produced a *Back to School 12+ COVID-19 Vaccine Message* with Chicago Bears Linebacker Roquan Smith, generating 97,000 impressions and engagements.

## OBJECTIVES

The goal of the campaign was to vaccinate all members by:

- Partnering with organizations to increase vaccination in remote areas and ZIP codes most affected by COVID-19 by utilizing the COVID-19 Community Vulnerability Index (CCVI), which combines data about sociodemographic (e.g., percent poverty) and occupational risk factors (e.g., percentage of essential worker population);
- Raising vaccine awareness and confidence;
- Promoting member incentives; and
- Supporting provider partners across Illinois.

## IMPACT

Within the first six months of the campaign:

- Members earned over \$1.8 million in COVID-19 vaccination incentives;
- Aetna purchased over \$60,000 of vaccine equipment for vaccine clinics;
- 125,000+ community members attended 170 events offered in targeted ZIP codes; and
- Members who received a HealthTag program message had a 4.38 percent higher vaccination rate than those who did not, leading to 1,107 additional vaccinated members.

## REFLECTIONS

AHIP described *Got My Shot* as “a total package” of outreach, coordination and partnerships and asked Aetna to present the campaign to the National Vaccinations Coordinator for the White House COVID-19 Response Team. Aetna plans to sustain and adapt the initiative throughout the pandemic.

## REFERENCES

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## EMERGING BEST PRACTICE

# ADULT DAY CARE CLINICAL PHARMACIST COLLABORATION

**Health Plan:** UnitedHealthcare Community & State

**Parent Organization:** UnitedHealth Group

**Location:** Texas

## DESCRIPTION

Medication adherence can significantly affect the health and well-being of individuals. The COVID-19 pandemic interfered with health care services such as access to prescriptions and support from pharmacists, and disrupted core daily routines that many rely on for taking their medications. To improve medication adherence and health outcomes for managed long-term services and supports members, UnitedHealthcare launched its **Adult Day Care Clinical Pharmacist Collaboration**.

The initiative engaged adult day care providers across Texas in virtual and in-person learning formats to provide information about medication management and UnitedHealthcare's pharmacy benefits. While the program focused on medication adherence, the initiative also prioritized **building relationships between adult day care providers, on-site nurses, and clinical pharmacists**. As adult day care providers and on-site nurses became more knowledgeable and aware of pharmacy resources, they were able to better share information with members.

In partnership with adult day care centers, the initiative provided the following support to members:

- **Virtual and in-person conferences** that support member engagement for medication management and disease condition education including glucose and blood pressure monitoring;
- **Pill boxes** to help organize medication regimens over the course of a week;



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In addition to medication adherence, the initiative also prioritized building relationships between adult day care providers, on-site nurses, and clinical pharmacists.

- **On-site nurse assistance** to help members schedule doctor's appointments; and
- **Educational materials and games** in multiple languages.

This initiative recognized that social determinants of health were exacerbated by isolation during the pandemic, particularly for members who could not access their interpersonal or interpreter supports. Providing a personal point of contact to a pharmacist and additional resources in multiple languages helped adult day care providers fill these gaps.

## OBJECTIVES

The overall goal of the initiative was to improve medication adherence for UnitedHealthcare members utilizing services at adult day centers through member and provider education, and distribution of member educational materials and resources. Ensuring that educational games and **resources were available in multiple languages**, increased equitable access to these resources.

## IMPACT

Timing, implementation, and reporting constraints prohibited initial data collection; however, the health plan intends to review outcomes as data become available.

## REFLECTIONS

UnitedHealthcare plans to continue the program of educating and providing resources to adult day care providers through remote and in-person education and distribution of materials. Their hope is that the training provided to the centers will encourage them to **continue accessing pharmacists**, utilize other pharmacy resources, and ultimately enhance the services and support they provide to members in adult day care.





## EMERGING BEST PRACTICE

# COMMUNITY HEALTH WORKERS RECRUITMENT, TRAINING, AND MOBILIZATION INITIATIVE

**Health Plan:** Amerigroup Iowa

**Parent Organization:** Anthem, which officially becomes Elevance Health on June 28, 2022

**Location:** More than 20 counties in Iowa



## DESCRIPTION

Prior to the COVID-19 pandemic, the Iowa Medicaid Enterprise, which unites state staff and contractors in performance-based Medicaid administration, had prioritized the need to build community health worker (CHW) capacity to serve the Medicaid population. The Iowa Chronic Care Consortium (ICCC) had established its online training program in 2019 with limited resources. In 2020, the pandemic increased existing health disparities and by June 2021, **Amerigroup Iowa** launched its Community Health Workers Recruitment, Training, and Mobilization Initiative with ICCC. This partnership represented the first time that a Medicaid managed care organization made a major investment in community health worker training in Iowa.

The **Community Health Workers Recruitment, Training, and Mobilization Initiative** sponsored community health worker training for 100 individuals. Amerigroup Iowa wanted to significantly increase the number of CHWs statewide, but it focused on specific counties where Health Employer Data Information Set (HEDIS™) measures showed statistically significant differences for Black and Latinx members. Community health workers would work in communities to advance population health initiatives focused primarily on managing chronic conditions.



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Community health workers unite nationally to support communities in achieving health, equity, and social justice.

—nachw.org

**CHWs partner with individuals** to help them navigate health care and engage with community organizations that address social determinants of health. For example, in Sioux City, Iowa, CHWs connect Siouxland Community Health Center patients with local resources such as the Community Action Agency of Siouxland.

## OBJECTIVES

The overall goal of the program was to **build community health worker capacity** and **implement population health initiatives** initially focused on maternal and child health, diabetes and asthma, and then in future years, expand to address other chronic conditions.

## IMPACT

In the first three training cohorts, **83 CHWs completed the training**. The fourth class began in January 2022 and by the end of March 2022, its goal to train 100 CHWs was achieved. To further identify impact and outcomes, ICCC will conduct **follow-up surveys** of individuals who were trained, to collect information about how the training is applied in day-to-day work as well as stories that demonstrate the outcomes of the initiative.

## REFLECTIONS

To ensure the sustainability of this work, the initiative obtained funding in the Amerigroup Iowa 2022 budget. ICCC and Amerigroup Iowa will offer **continuing education for CHWs** on chronic conditions, behavioral health, maternal and child health, disabilities, health disparities, and health equity. As Iowa does not require state level certification or continuing education for CHWs, this training series will fill that void while continuing to advance the skills and knowledge base of this important workforce.

## REFERENCES

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Iowa Chronic Care Consortium. (n.d.). Home page. <http://iowacc.com/>



## EMERGING BEST PRACTICE

# COVID-19 TELEHEALTH CAPACITY SUPPORT

**Health Plan:** Health Net

**Parent Organization:** Centene Corporation

**Location:** California

### DESCRIPTION

As medical appointments quickly shifted to virtual visits during the pandemic, Health Net launched its **COVID-19 Telehealth Capacity Support Program** to establish and expand telehealth services for enrollees in California’s Medicaid program, Medi-Cal. In 2020, Health Net awarded 138 Telehealth Capacity grants, totaling \$13.4 million. Health Net envisioned the program in coordination with the California Department of Managed Health Care (DMHC).

Funded organizations were located across California and included **independent practices, community clinics, and rural and Indian health centers**—many of which faced increased financial strain amid the ongoing pandemic. Nearly 20 percent of grantees (providers/practices) had no existing telehealth technology at the time of their application. Providers used the funding to purchase laptops, mobile devices, software, Internet access, and training/technical assistance.

The initiative demonstrated innovation in two significant ways:

- The total time frame for this new program was **under five weeks**, from program inception to solicitation and grant review to distribution of awarded funds.
- The grant model allowed providers to **innovate at the practice level**, implementing tailored telehealth processes that worked with their own patient populations.



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Our clinic staff has learned from the patients the barriers they face, not only to access quality health care but also in their daily lives.

## OBJECTIVES

- Provide tools for **safe access and continuity of care** for Medi-Cal enrollees through video visits, e-consultations, and tele-psychiatry.
- Expedite mass adoption of telehealth and “**digital health equity**,” the resourcing of high-quality digital healthcare to all socio-economic groups to reduce health disparities.

## IMPACT

Health Net engaged Harder+Company to summarize data reported by each grantee. Grantees identified the following benefits of providing telehealth services:

- 31 percent said funding allowed them to conduct routine checkups and wellness visits;
- 42 percent indicated that telehealth was an important tool for patient screenings;
- 17 percent provided health education, including nutrition, physical activity counseling, and smoking-cessation programs; and
- 16 percent reported success in providing mental health services.

One grantee described that the funding addressed the social determinants of health by enabling providers to “deliver unrestricted care to patients who are traditionally hampered by childcare issues, rigid work schedule conflicts, and other factors that constrain access to healthcare.” Through an additional grant program, Health Net provided \$429,000 to providers to distribute cell phones to their enrollees.

## REFLECTIONS

After this one-time grant, **Health Net is considering additional ways to support integration of telehealth** within provider practices, such as through a \$200,000 grant to the California Primary Care Association to improve workflows for virtual patient care. Helping providers develop resources to enhance efficiency and effectiveness of virtual care is expected to improve patient outcomes and staff satisfaction.



## EMERGING BEST PRACTICE

# HO'OIKAIKA NĀ KUMU WAIWAI OLA

**Health Plan:** AlohaCare

**Location:** Hawai'i



## DESCRIPTION

**Papa Ola Lōkahi (POL)** designates the Native Hawai'i Health Centers (NHHHC), which provide medical and enabling services to Native Hawai'ians. POL is also a leading agency in the Native Hawai'i & Pacific Islander Hawai'i COVID-19 Response, Recovery & Resilience Team. **AlohaCare** is a community-founded health plan serving Medicaid and dually-eligible enrollees across the state of Hawai'i.

In the wake of the disproportionate impact of COVID-19 on Native Hawai'ians, AlohaCare and POL agreed to **collaborate over the next six years** on culturally congruent strategic actions to improve the physical, mental, and spiritual health of Native Hawai'ians. **Ho'oikaika Nā Kumu Waiwai Ola** has three specific initiatives:

1. Develop a Social Determinants of Health (SDOH) Strategy.
2. Create and provide culturally responsive services.
3. Foster cultural congruency for health equity.



## OBJECTIVES

The initiative is grounded in the understanding that SDOH, including poverty, unemployment, and unstable housing, stems from **social inequities impacting Native Hawai'ians**, leading to high rates of disease exacerbated by the pandemic. This initiative prioritized the Indigenous Peoples of the Hawai'i Island through **culturally responsive and linguistically inclusive strategies** to:



## TRADITIONAL NATIVE HAWAIIAN VALUES GUIDE THE INITIATIVE:

As Partners, AlohaCare and POL commit to a set of traditional Native Hawai'i values to guide the initiative, including 'Onipa'a: We need to remain steadfast and resolute and persevere to overcome adversity.

- Partner with community service providers to educate healthcare stakeholders and providers to increase culturally responsive care delivery in Hawai'i.
- Connect members to community health services that target chronic conditions and SDOH through whole-person, whole-family, and whole-community wellness promotion.
- Build trust and accessibility of health care for Native Hawai'ians in targeted communities through expanding culturally responsive primary care.
- AlohaCare and POL agreed to collaborate on translated outreach materials for providers and community members, media stories, and community health promotion activities.

## IMPACT

AlohaCare and POL have established partnerships and a six-year commitment to collaborate on Ho'oikaika Nā Kumu Waiwai Ola, and have set goals, objectives, and targeted outcomes for the first year. In 2022, the initiative **aims to serve 46,000 Native Hawai'ians directly and indirectly** and collect data to further develop and track equity initiatives. Population health targets aim to increase use of screening and referral tools including:

- 10 percent increase in SDOH service referrals and 5 percent decrease in referral loop gaps;
- 20 percent increase in SDOH programs in communities with high proportions of Native Hawai'ians; and
- 150 additional members with completed health risk assessments, annual wellness visits, and referrals to traditional healing services.

## REFLECTIONS

AlohaCare and POL will sustain this initiative through August 2027 to narrow gaps in care, address barriers within health systems, and increase health equity for Native Hawai'ians in Hawai'i.



## EMERGING BEST PRACTICE

# IOWA HISPANIC DIABETES MANAGEMENT PROJECT

**Health Plan:** Amerigroup Iowa, Inc.

**Parent Organization:** Anthem, which officially becomes Elevance Health on June 28, 2022

**Location:** Woodbury County, Iowa



## DESCRIPTION

The **Iowa Hispanic Diabetes Management Project** aimed to improve diabetes management in rural Hispanic communities through **Amerigroup Iowa's** first culturally congruent engagement in partnership with the Siouxland Community Health Center (CHC), a Federally Qualified Health Center. Rural Hispanic communities experienced high rates of COVID-19 and faced other barriers to health, including living in a food desert as well as experiencing temporary work losses during the pandemic because of meat processing plant closures.

The Iowa Department of Public Health identified **diabetes as a preventive care priority** and Anthem's annual health disparities report demonstrated lower rates on Comprehensive Diabetes Care HEDIS™ Measure (Health Effectiveness Data Information Set) for Hispanic compared with Caucasian members in Iowa.

To improve diabetes management, Amerigroup Iowa's initiative assessed members' social determinants of health, provided Spanish and English **diabetes management education**, made **referrals to area resources**, and offered **interpreters for health care navigation** in person and via five newly funded **tablet devices for video interpreter services**. The initiative asked members to complete at least two hemoglobin A1c tests and attend **Living Well classes**, offered in Spanish at the Iowa State University Extension office.



Amerigroup Iowa also funded the Food Bank of Siouxland and the Community Action Agency of Siouxland to support members who experienced food and housing insecurity.

## OBJECTIVES

Amerigroup Iowa's target population was all 510 adult members with diabetes who received care at Siouxland CHC, with a priority focus on Spanish-speaking patients.

The goal for Measurement Year 2020 was to increase the HEDIS™ Comprehensive Diabetes Care rates by the following percentages for members who identify as Hispanic:

- 5 percent–HbA1c Control (<8)
- 5 percent–blood pressure control (<140/90)
- 3 percent–diabetic retinopathy eye exam

## IMPACT

The initiative **met its HbA1c control and blood pressure control goals** but did not meet the goal for completing eye exams. A tailored action plan was developed, including:

- Providing case management to secure referrals;
- Scheduling monthly calls with health plan representatives and Siouxland CHC to discuss member barriers and plans of care;
- Distributing a comprehensive list of in-network, local retinal eye exam providers; and

## REFLECTIONS

Despite the COVID-19 pandemic, this program became a successful part of a **three-year health equity and population health plan**. The program was extended to 23 additional counties in 2021 and is now expanding outreach to engage the Black community. Amerigroup Iowa is forging additional partnerships with other community health centers and diabetes centers.





## EMERGING BEST PRACTICE

# MARTIN LUTHER KING JR. COMMUNITY HEALTHCARE STREET MEDICINE

**Health Plan:** Health Net

**Parent Organization:** Centene Corporation

**Location:** Los Angeles, California

## DESCRIPTION

Health Net's **MLK Community Healthcare Street Medicine** initiative is a collaboration between Martin Luther King Jr. Community Healthcare (MLKCH) and Keck School of Medicine of the University of Southern California (USC), aimed at reducing disparities in health outcomes for people experiencing homelessness in South Los Angeles. By mid-2021, MLK Community Healthcare had treated more than 4,000 patients with COVID-19, which disproportionately affected persons who were experiencing homelessness.

In a new **"boots on the ground" Street Medicine Hospital Consult Service model**, integrating inpatient and outpatient care, Street Medicine medical providers start by establishing care with individuals during inpatient stays. Working with the inpatient hospitalist team, the Street Medicine medical team develops a treatment plan based on patients' unique living situation, supported by a **specialized team of social workers, liaisons, and community health workers**, who facilitate safe transfer to recuperative care, shelter, or street living upon discharge. In the Emergency Department (ED), community health workers establish trust with patients experiencing homelessness by utilizing community resources and coordination with social workers for referrals to services.

Within one week of discharge, patients received a **follow-up visit at their encampment or location of their choosing from the Street Medicine team** to assess access to food, water and bathroom facilities, perform medication reconciliation, provide masks and tents to encourage physical distancing, and manage post-discharge acute care and chronic disease.



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With the "boots on the ground" model, physicians develop a treatment plan based on patients' unique living arrangements.

The team utilized patient-specific goals and continues to provide continuity medical care until the patient is housed and establishes a medical home.

## OBJECTIVES

The overall goal of the program was to serve 500 patients experiencing homelessness in the first year and 1,000 patients in years two and three by achieving the following outcomes:

- Increased connection to primary and specialty medical care;
- Increased access to mental health and substance use disorder treatment;
- Improved sanitation and nutrition;
- Decreased avoidable hospital and ED visits; and
- Reduced disparities in hypertension and diabetes control.

## IMPACT

Program outcomes will be measured after one year and will utilize inpatient and outpatient medical records, including behavioral health and care management records. Results will be compared for patients enrolled in the Street Medicine program with those not enrolled.

## REFLECTIONS

The MLK Community Healthcare Street Medicine Program has a three-year implementation plan.

- **Year 1.** Focus includes laying the foundation, credentialing MLK Community Healthcare clinicians and community health workers, conducting a street-level needs assessment, forming community-based relationships, deploying the mobile team, and gathering outcome data.
- **Years 2 and 3.** The aims include optimizing the program, creating dedicated on-site space for the program including care management, and expanding staff for full inpatient, ED, and outpatient coverage.

USC's Street Medicine team will simultaneously provide MLK Community Healthcare with **training and professional consultation to establish an in-house, sustainable program.**



## EMERGING BEST PRACTICE

# RETINAL EYE CAMERA PROGRAM

**Health Plan:** Amerigroup Tennessee, Inc.

**Parent Organization:** Anthem, which officially becomes Elevance Health on June 28, 2022

**Location:** Tennessee



## DESCRIPTION

Amerigroup Tennessee's Retinal Eye Camera Program was developed in response to data from the first year of the pandemic: Only one of every three Amerigroup Tennessee members with diabetes had a diabetic retinal eye exam (DRE) performed in 2020, and Black members had even lower rates for receiving these exams. The percentage of visually impaired adults with diabetes in the United States is greater for Black individuals at 27.2 percent compared with White at 21.1 percent (Office of Minority Health).

Amerigroup Tennessee **engaged community stakeholders and providers to identify barriers to care.** They shared that a key obstacle to retinal exams was the required additional medical visit. The Retinal Eye Camera Program purchased **telehealth-enabled eye cameras** for ten primary care provider (PCP) practices in Tennessee to eliminate the need for an in-person appointment with an eye specialist; this was critical, as barriers related to transportation and social distancing were amplified because of COVID-19.

During a PCP visit, an image was taken of the eye and sent to an off-site ophthalmologist or optometrist who informed the PCP of the clinical findings. The innovative program improves the patient experience by allowing patients to complete **retinopathy screening during their PCP visit** without the need to make a second specialist appointment. To improve equity, Amerigroup Tennessee selected primary care practices across Tennessee that serve a high volume of Black patients.

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Early detection of diabetic retinopathy is vital to preventing vision loss for people with diabetes.

## OBJECTIVES

Through this initiative, PCPs use the camera to perform retinal eye exams with all patients as needed (**not limited to patients with specific insurance types**) to help improve outcomes for all people with diabetes. Specific objectives were to:

- Close 25 percent of the gap between rates of diabetic retinal eye exams among Black Amerigroup Tennessee members compared with Whites who were empaneled to participating PCPs; and
- Surpass the 33rd percentile in the Comprehensive Diabetes Care Retinal Eye Exam HEDIS™ (Healthcare Effectiveness Data and Information Set) measure for members with diabetes in the ten participating primary care practices.

## IMPACT

The initiative succeeded in closing 25 percent of the gap in rates of retinal eye exams between Black and White Amerigroup members and was on track to exceed the HEDIS™ 33rd percentile for this measure. The Retinal Eye Camera Program ensured that a broader population was able to benefit, and the program was a step forward in improving health equity for the Black population.

## REFLECTIONS

The current program runs through December 31, 2022. Given its initial success in meeting outlined objectives, Amerigroup Tennessee selected an additional two practices to include in the program in 2021 and is **planning statewide expansion in 2022**.

## REFERENCES

U.S. Department of Health and Human Services Office of Minority Health (n.d.), "Diabetes and African Americans," U.S. Department of Health & Human Services. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18#:~:text=In%202018%2C%20non-Hispanic%20blacks,with%20diabetes%20by%20a%20physician>



## EMERGING BEST PRACTICE

# TABLET LOANER PROGRAM

**Health Plan:** UnitedHealthcare Community & State

**Parent Organization:** UnitedHealth Group

**Location:** Massachusetts

## DESCRIPTION

At the onset of the pandemic, nursing homes were among the first facilities to go into a lock-down. Visitor restrictions left residents feeling isolated from family, loved ones, and medical representatives, which immediately affected residents' health and well-being. **UnitedHealthcare Community Plan of Massachusetts** began transitioning its services for nursing facility residents to telephonic/telehealth management per state guidance. The organization also polled its participating nursing facilities to determine their needs. As a direct result of the survey, UnitedHealthcare secured **28 tablets with video conferencing technology for distribution.**

The organization launched its **Tablet Loaner Program** for seven of its contracted nursing facilities that utilize their nurse practitioner model. The mobile devices were set up on the facilities' wireless Internet so that members could have telehealth visits with their nurse practitioner or physician assistant.

Virtual visits had not been facilitated in these nursing homes prior to COVID-19, and many of the nursing facilities did not have the required technology. The Tablet Loaner Program was an innovation that not only **enabled continued health care operations**, but also could be used by residents for personal **video conferencing with loved ones** when visits in nursing facilities were not permitted. This real-time visual connection helped overcome the isolation that emerged as an urgent social determinant of health during the pandemic.



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Not only does the tablet allow us to keep members in a safe care environment, it also helps to mitigate social isolation.

## OBJECTIVES

The nursing home setting was disproportionately affected by the pandemic during the initial outbreak of COVID-19. UnitedHealthcare responded by equipping nursing facilities that lacked virtual assistive technology to:

- Provide an innovative way to continue caring for members via virtual visits;
- Ensure that members had a way to communicate with loved ones and caregivers;
- Improve the quality of care; and
- Enhance after-hours care so clinicians could visualize changes in conditions and provide treatment plans for members.

## IMPACT

Tablets were provided to seven skilled nursing facilities which allowed continuity of care for members who could not see their providers face-to-face. Members were also able to engage in video conferencing with loved ones. Overall, this **improved the health and well-being** of members during the crisis and **alleviated some of the isolation** they felt from being separated from their providers and families.

## REFLECTIONS

UnitedHealthcare plans to continue the Tablet Loaner Program for as long as the COVID-19 Public Health Emergency status is in place. The organization views this initiative as going beyond clinical care to improve overall quality of life, by connecting the emotional, spiritual, and physical health of their members.



## EMERGING BEST PRACTICE

# CHANGING HEALTH: AMERIGROUP-MONROE PARTNERSHIP (CHAMP)

**Health Plan:** Amerigroup Iowa, Inc.

**Parent Organization:** Anthem, which officially becomes Elevance Health on June 28, 2022

**Location:** Iowa

## DESCRIPTION

Before the pandemic started, in 2019, **Amerigroup Iowa** launched the first phase of **Changing Health: Amerigroup-Monroe Partnership (CHAMP)**, a pilot project addressing housing instability and homelessness, food insecurity, and other social determinants of health. The pandemic exacerbated housing insecurity in Iowa, especially in the north Des Moines neighborhoods that have the highest Medicaid membership in the state. These burgeoning needs were validated by findhelp.org searches, media reports, and community information.

With grant funding, Amerigroup Iowa formed a **housing stability fund** to support members facing homelessness and housing insecurity. Grant funds allowed CHAMP to address specific unmet needs, including paying housing application fees and rent, utility bills, transportation to grocery stores, medical appointments or job interviews, automobile repairs, and more. CHAMP also provided transitional housing, including hotel accommodations for those transitioning from homeless shelters, incarceration, and a dozen members who were displaced by an apartment fire.

CHAMP joined with public schools and a wide range of community-based organizations, including shelter services, the YWCA Clinton, and an immigration services provider. In addition, **CHAMP was interwoven** with Amerigroup's overarching diabetes and hypertension management



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The housing stability initiative has provided a foundation for families literally starting over.

program to address health disparities for Black and Latinx members. Qualifying members were enrolled in case management.

## OBJECTIVES

Amerigroup Iowa's objectives for the expansion of the CHAMP program were to:

- Assist Amerigroup members to retain or secure stable affordable housing;
- Contract with community-based organizations to submit data about the number of members receiving housing support and services;
- Increase the number of members completing health risk assessments;
- Increase the number of members having annual primary care visits, screenings, and vaccinations;
- Reduce members' Emergency Department usage; and
- Increase members' case management engagement.

## IMPACT

Amerigroup Iowa **helped more than 600 members in 21 counties** retain or secure housing, avoid eviction, or transition from homelessness. All members completed initial health screenings and were enrolled in case management. Amerigroup Iowa case managers also collected and cataloged members' success stories.

## REFLECTIONS

Amerigroup Iowa intends to continue the CHAMP initiative through its 2022 budget, and clinical outcomes measurement will occur in the future evaluation phase, using claims runout in the second quarter of 2022. The initiative is **scalable and nimble** because Amerigroup Iowa CHAMP housing stability initiative forges first-ever collaborative partnerships with community-based organizations. Collaboration among Amerigroup Iowa and many agencies wraps services around the Medicaid population to address unmet needs.





## EMERGING BEST PRACTICE

### COVID-19 NUTRITION

**Health Plan:** UnitedHealthcare Community & State

**Parent Organization:** UnitedHealth Group

**Location:** National, 44 States and the District of Columbia

#### DESCRIPTION

The COVID-19 pandemic caused widespread disruption in food distribution and exacerbated financial hardships for individuals and families. As calls started pouring in from members, UnitedHealthcare identified food insecurity as an immediate challenge. Food insecurity is a fundamental social determinant of health that affects the Medicaid population's ability to achieve positive health outcomes. The **UnitedHealthcare COVID-19 Nutrition Initiative** established a unique process to distribute food quickly and seamlessly to members during the height of the pandemic.

UnitedHealthcare utilized intake information from care managers and call center representatives speaking with members who reported food insecurity. Requests were triaged and routed to representatives who, within hours, ordered **ready-to-eat meals or shelf-stable groceries to be shipped to members' homes** within one to seven days, depending on urgency of need.

UnitedHealthcare had not previously worked with many of the organizations providing food for this program, so the innovation in this initiative was in the **fast-tracked development of relationships and workflows** to ensure that together, UnitedHealthcare and their new partners could meet the urgent needs of members.



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As we received phone calls from members worried they did not have enough food to feed their family the next day, we knew we needed to step in.” In all, 398,076 meals were distributed as a result of this program to address food insecurity during the pandemic.

## OBJECTIVES

UnitedHealthcare had just one objective for this initiative: to assist members in addressing urgent food and nutrition needs during the pandemic. UnitedHealthcare states that “access to food is equity at its core: regardless of age, race, ethnicity, income, geography, employment, and transportation status, everyone deserves access to food.” To that end, the initiative did not require eligibility factors other than stating a need.

## IMPACT

The program served **13,000 members** across **44 states and the District of Columbia**. Nearly **19,000 referrals for nutrition support** were made, and a total of **398,076 meals** were distributed.

## REFLECTIONS

The program concluded in September 2020. UnitedHealthcare recognizes that food insecurity is an ongoing need, and that two weeks of groceries will not solve the problem. UnitedHealthcare is committed to connecting members to more sustainable food resources, such as Supplemental Nutritional Assistance Program (SNAP), other nutrition programs, and resources in their own communities. To develop a more sustainable long-term approach the organization convened a new internal work group to launch future projects to address food insecurity.



## EMERGING BEST PRACTICE

### FOOD ACCESS

**Health Plan:** Trillium Health Resources

**Location:** North Carolina

#### DESCRIPTION

Early in the COVID-19 pandemic, there were widespread food and supply shortages along with food pantries and food banks losing volunteers.

**Trillium Health Resources** responded by launching the following three Food Access Initiatives:

1. **Meal Delivery for Innovations Waiver**, in partnership with Clean EatZ Kitchen, Mom's Meals, and others, which provided members with two refrigerated or shelf stable meals per day.
2. The **Healthy Helpings** program, which partnered with a grocery store chain to add credit to members' grocery store loyalty card.
3. **Trillium's Neighborhood Connections** team, which offered linkages to community food resources through referrals and transportation to food pantries and grocery stores.

North Carolina's **Medicaid flexibilities** during the pandemic (referred to as Appendix K) allowed Trillium, for the first time, to offer healthy home-delivered meals to its Innovations Waiver members. Most members with intellectual and developmental disabilities (I/DD) had access to two home-delivered meals a day, which **reduced the burden on caregivers** to provide meals to members who normally would eat at day programs. Trillium provided rides by taxi or ride-hailing services for members who did not receive home-delivered meals or for those who chose to go to grocery stores or food pantries.

These initiatives utilized an online food request form that was easily accessible in plain language, in both English and Spanish. Information was also posted on Trillium's website and social media. Members could also



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We wanted to ensure that everyone who needed food could receive it.

request food access assistance through their care manager, the call center or their behavioral health or I/DD provider.

## OBJECTIVES

The overall goal of the initiative was to **ensure that members had access to nutritious foods**, through the following objectives:

- Partner with a grocery store to provide a produce purchasing credit;
- Implement home-delivered meals as a new Innovations Waiver service; and
- Encourage members and providers to utilize Trillium's Neighborhood Connections team to assist with referrals to food resources.

During this time, the health plan received requests from the general public who were not health plan members, and Trillium assisted them with food access.

## IMPACT

Over **500 members** were enrolled in the home-delivered meals program. The proportion of food resource **referrals increased from 9 percent to 22 percent**. Trillium connected **139 households** with community resources and SNAP benefits.

## REFLECTIONS

Throughout the pandemic, Trillium's Neighborhood Connections Department continued to receive referrals for social needs. Meal delivery will continue as a Medicaid-funded service for six months after the public health emergency ends. Healthy Helpings, a three-month program, was completed in December 2020. Trillium continues to look for opportunities to support food access through state Medicaid-approved **value-added services**.



## EMERGING BEST PRACTICE

# LOS ANGELES FOOD BANK PILOT

**Health Plan:** Health Net

**Parent Organization:** Centene Corporation

**Location:** Los Angeles, California

## DESCRIPTION

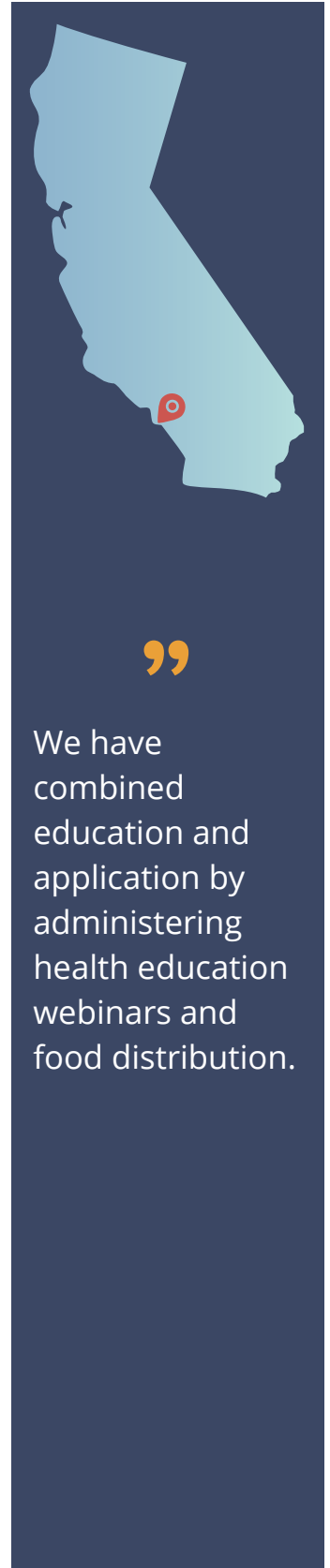
**Health Net** awarded the Los Angeles Regional Food Bank a grant to assist members in managing their health through increased food access and nutrition awareness. The **Los Angeles Food Bank Pilot** provided home-delivered groceries and went beyond food distribution to sponsor an **interactive, educational webinar series** on nutrition and its role in managing chronic illness. The COVID-19 pandemic was a good time to launch a series administered via virtual, since people spent more time at home and online.

The program was offered to members in South Los Angeles communities who have chronic high blood pressure and/or diabetes; **webinars were presented in English and Spanish**. The initiative provided **biweekly home-delivery of 50 pounds of produce and healthy shelf stable foods**, so participants could readily apply what they learned by having fresh ingredients to prepare. Participants self-reported blood pressure and blood sugar levels monthly.

## OBJECTIVES

The goal of the Los Angeles Food Bank Pilot was to address social determinants of health affecting both food access and chronic disease management through the following objectives:

- Encourage a relationship between the health plan and its members;
- Promote healthy lifestyle changes;



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We have combined education and application by administering health education webinars and food distribution.

- Provide education on healthy food options and practices; and
- Provide healthy foods to individuals experiencing financial or transportation barriers.

## IMPACT

The initiative engaged members in **learning about nutrition and chronic disease management**, however participation in the first phase of the pilot was not as high as anticipated. Because of the limited engagement in the first cohort, the Los Angeles Regional Food Bank proposed to offer in-person instruction at providers' offices for members without personal computers and internet access at home. The goal is to offer a **hybrid model**, adding in-person opportunities in a safe environment, open to participants who can access workshops on exercise and nutrition and social activities.

## REFLECTIONS

Health Net applied its **equity lens and lessons learned to scoping the next phase/cohort**, in which the Los Angeles Regional Food Bank plans to partner with a provider clinic to provide food distribution and nutritional instruction to two populations: individuals with chronic conditions and pregnant women.

Health Net's Giving Team granted funds to sustain the pilot for up to 12 months, based on participation. Health Net intends to **sustain the initiative** for Medically Tailored Meals through CalAIM, which stands for California Advancing and Innovating Medi-Cal, a multiyear plan to integrate California's Medi-Cal program with social services.



## EMERGING BEST PRACTICE

# COMMUNITY CARE HUB— MATERNAL HOME VISITING PROGRAM

**Health Plan:** Gateway Health LLC d/b/a Highmark Wholecare

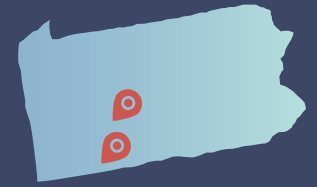
**Location:** Cambria and Somerset Counties, Pennsylvania

### DESCRIPTION

Gateway Health LLC d/b/a Highmark Wholecare partnered with the **1889 Jefferson Center for Population Health** to improve maternal health outcomes and reduce disparities by offering the **Community Care HUB—Maternal Home Visiting Program** for birthing persons living in Cambria and Somerset counties. The HUB is an organized, outcome focused network of Care Coordination Agencies (CCAs) that hired and trained community health workers (CHWs) who met individuals in their homes and assessed them from a whole-person care perspective. The HUB initiated one or more of 21 standardized pathways such as Adult Education, Developmental Referrals, Employment, Family Planning, Housing, Pregnancy, Medication Adherence, or Substance Use.

The program followed the **Pathways Community HUB model**, which addressed risk factors associated with poor health outcomes. The maternal home visiting program was available to first-time parents and caregivers of children with additional risk factors, from the prenatal period through the child's first 24 months of life. A unique feature of the HUB/ Gateway Health partnership was the **single point of contact at the managed care organization (MCO) for CHWs** to discuss members' issues and get connected to MCO resources.

In 2019, County Health Rankings showed that Cambria County ranked 65th out of 67 Pennsylvania counties for health outcomes; Somerset County ranked 31st. The **pandemic not only magnified inequities** and needs of at-risk members, but it also caused **increased hesitancy** to connect by phone or in-person with individuals outside of their communities. The HUB



Pathways serve as a tracking tool specific to each identified risk factor. The Pathway then tracks and documents each critical step, ending with ensuring the risk factor has been addressed. The Pathway is complete when a final outcome is achieved.

paired a participant with a community health worker from their community, which enabled them to make stronger connections and work collaboratively.

## OBJECTIVES

The overall goal was to improve maternal and infant health outcomes. Additional objectives were:

- Support parents/caregivers, children, and families;
- Individualize a strengths-based and family-focused program to engage families as active partners in their care;
- Provide identified areas of focus for assessment and activity; and
- Enhance capacity of home visiting programs.

## IMPACT

By November 2021, the HUB program had enrolled 21 members. Measurements included the **number of completed pathways or connections to community resources**, as well as pregnancy outcomes. A quality assessment and cost/benefit analysis is currently planned.

## REFLECTIONS

The initiative was launched with a grant from a community philanthropic organization. **Partnerships with Medicaid health plans are vital** to sustain community-based care coordination and expand the populations served. Gateway plans to expand to additional at-risk populations in 2022, including individuals with chronic conditions such as diabetes.

## REFERENCES

Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes. Rockville, Md.: Agency for Healthcare Research and Quality; January 2016. AHRQ Pub. no. 15(16)-0070-EF. Replaces AHRQ Pub. no. 09(10)-0088.





## EMERGING BEST PRACTICE

# LEAD4TOMORROW/FAMILY HUI PILOT PROGRAM

**Health Plan:** Health Net

**Parent Organization:** Centene Corporation

**Location:** Los Angeles, Sacramento, and Imperial Counties, California

## DESCRIPTION

In recognition of the challenges of parenting through the COVID-19 pandemic, Health Net funded the community-based organization, Lead4Tomorrow, to provide seven **Family Hui parental, peer-led support groups** throughout California. Family Hui, named for the Hawai'ian term "Hui," is a resilience-focused, peer-led positive parenting program that empowers parents and caregivers, while promoting healthy child development.

The need for **parenting skills and support** was even more essential during COVID-19 when lockdowns and virtual learning isolated families at home and limited in-person contact. Family Hui organizes parents and caregivers into groups of 6-10 families with children ages 0-5 years. **Group sessions were offered in a virtual platform** to prevent disruptions in group sessions, while keeping health and safety at the forefront.

Family Hui specifically addressed adverse childhood experiences, gave parents alternative ways to discipline and interact with their children, as well as provided a **support system of other parents** to explore numerous topics including trauma, resilience, and positive parenting techniques. Parents were afforded opportunities to develop leadership skills through specific programs, advocate for their children, and share their views. The **peer leadership** component of the group is unique and valuable, allowing group leaders to teach as well as learn from group participants. Depending on the wishes of the group, participants' children might also develop long-



Hui (hoo'ee) is a Hawai'ian term for a cooperative group working together for a shared purpose.

-Lead4Tomorrow.org

term relationships and community with each other.

## OBJECTIVES

The goal of the program was to support and empower parents/caregivers in the joys of raising their children and address the challenges in healthy ways through providing:

- A trauma-informed parenting curriculum;
- Leadership training for peer facilitators;
- Resilience-building activities; and
- Connections for parents to services to build a strong support community.

## IMPACT

In this new program, impact and outcomes will be measured through participants' completion of pre- and post-participation surveys. The goals of the survey will be to determine whether participants have gained a **deeper understanding of child development, empathy, resilience, and the importance of parental leadership**, as well as how well the program functioned. Feedback will allow program staff to learn how to support parents through the curriculum and other program practices.

## REFLECTIONS

As of June 2022, this initiative is developing groups for **foster parents/caregivers, parents of children with special needs and Tribes and families in the Hmong community**. Group sessions will be held on a virtual platform for as long as participants and staff feel more comfortable doing so and in alignment with local health ordinances; public health recommendations will continue to provide guidance on in-person meetings.



## EMERGING BEST PRACTICE

# VIRTUAL CARE MANAGEMENT FOR MATERNITY MEMBERS

**Health Plan:** UPMC *for You*

**Parent Organization:** UPMC Health Plan

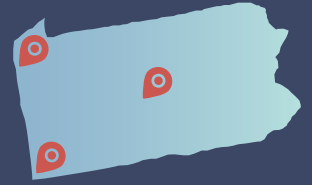
**Location:** Southwestern, Northwestern, and Central Pennsylvania

## DESCRIPTION

UPMC *for You* launched a virtual care management platform for its pregnant and birthing population in 2020 to better address social determinants of health during the pandemic. Through UPMC *for You*'s **Virtual Care Management for Maternity Members**, delivered via the UPMC AnywhereCare platform, virtual visits enabled care managers to individualize services and support.

Care managers built rapport with members through face-to-face communication, which allowed members to share concerns about **social determinants of health**. Any pregnant person was eligible to participate in the telehealth care management initiative with UPMC *for You* prioritizing direct outreach to members with first-time pregnancies, substance use history, and, by virtue of their race or ethnicity, have increased exposure to structural racism.

Through this initiative, UPMC *for You* also increased the number of **community-based organizations** it supported. It developed COVID-19 specific member resources related to the social determinants of health that were amplified during the pandemic such as employment and education.



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Before, during and after COVID, the innovation of virtual visits allowed us to have a much more personal experience with the members.

## OBJECTIVES

UPMC *for You's* goal was for the Virtual Care Management program to have a positive impact on birth outcomes and the overall well-being of members. Specific objectives were to:

- **Assess members' needs** related to social determinants of health and coordinate services;
- Work with members to **develop a transportation plan** to and from the hospital;
- **Provide face-to-face education** on baby basics, including safe sleep, calming techniques, and baby care;
- **Provide virtual breastfeeding classes, advice, and guidance;**
- **Assess for postpartum depression** and act on positive Patient Health Questionnaire (PHQ-9) screening scores; and
- Connect members directly to **pediatric care management** and **postpartum services**.

## IMPACT

Through November 2021, **1,705 members experienced virtual visits**, which was nearly **double the engagement rate** compared to telephone outreach alone. Outcomes for members served in 2020 showed that both mobile and virtual visits saw a statistically significant decrease in neonatal intensive care until (NICU) utilization after birth, compared with telephonic outreach.

## REFLECTIONS

Based on the initiative's success, UPMC *for You* **expanded the virtual care management program** to the pediatric care management team with plans to expand its use with non-pregnant adult members. The health plan team is eager to continue integrating social determinants of health resource navigation into virtual visits.



## EMERGING BEST PRACTICE

# HEALTHY MOVEMENT AT HOME

**Health Plan:** Trillium Health Resources

**Location:** North Carolina

### DESCRIPTION

When gyms, adult day centers, and psycho-social rehabilitation programs closed during the pandemic, **Trillium Health Resources** provided fitness equipment to members. **Trillium's Healthy Movement at Home** initiative was an extension of its existing program, which provided exercise bikes to programs for people with intellectual and developmental disabilities.

During the pandemic, Trillium **used reinvestment funds** associated with COVID-19 to purchase **exercise equipment for at-home member use**, including treadmills, bikes, ellipticals, weight trainers, and more. Many members used similar equipment at their day program sites, so they were familiar with the selections offered. By providing interactive equipment options, such as bikes with online training classes, members were engaged in fun new ways despite social isolation.

### OBJECTIVES

Trillium's goal was to provide this resource to all members, regardless of their ability. Members could request **equipment that best suited their needs**. The application process was made simple to avoid barriers to filling out the request form, and providers could offer support in submitting the request. Members without at-home Internet access, which was needed for online classes, were given non-interactive equipment. Wheelchair-accessible options were also offered. Additional objectives were to:

- Support members in achieving health and exercise goals during the pandemic;



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The social component of maintaining an exercise routine is enhanced by having the equipment in a location where families can use it.

- Provide an outlet for activity while accommodating safety and social distancing; and
- Offer a variety of equipment options including engaging interactive choices.

## **IMPACT**

All 101 members who applied for equipment received it. Many lived in rural communities where organized exercise activity sites were limited and/or inaccessible to people with disabilities.

## **REFLECTIONS**

Trillium will evaluate data to determine if outcomes support program continuation. Trillium plans to review health care data to determine the overall benefits of at-home exercise, including decreased utilization of the Emergency Department and other high-cost care.



## EMERGING BEST PRACTICE

# MARQUETTE COUNTY COMMUNITY RESOURCE FAIR—EXPRESS STYLE

**Health Plan:** Upper Peninsula Health Plan

**Location:** Marquette, Michigan

### DESCRIPTION

Through collaboration among community-based organizations, health care providers, faith-based organizations, and other agencies, the Upper Peninsula Health Plan (UPHP), a managed care and provider service organization, and Upper Peninsula Health Care Solutions Inc. (UPHCS), a nonprofit sister company to UPHP, converted its annual resource fair to the **Marquette County Community Resource Fair—Express Style** in response to the pandemic. This drive-through event allowed social service agencies to showcase resources in Marquette County and interact with community members in a safe way during the COVID-19 pandemic.

The fair provided information about services for housing, food insecurity, transportation, senior care, disabilities, women and children, and physical and mental health. In the wake of the pandemic, these resources were vastly underutilized. Social service and health care providers expressed having difficulty reaching those in greatest need.

- All attendees received a **Social Determinants of Health and Wellness Kit**, which included dental supplies, wipes, diaper vouchers, snack bars, nail care kits, medication minders, sun care supplies, and **updated information on how to access community services**.
- Brief **pre-recorded, resource presentations** were provided in the weeks leading up to the event. Organizations were **featured on social media platforms** and the UPHCS and UPHP websites.
- After driving the “Resource Lane,” attendees were offered **nutrition boxes from Feeding America West Michigan**, loaded directly into their vehicles.



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The impact that unmet basic needs have on overall health and well-being was magnified by the pandemic, across all populations.

- The final stop offered one of the first on-demand **COVID-19 vaccination** opportunities in the community; 14 attendees were vaccinated.

## OBJECTIVES

This event provided an unprecedented opportunity to mobilize existing resources and remove barriers so community members could access them. The organizers' first objective was to promote use of services in an interactive yet safe way. Their second objective was to improve coordination between health and social service providers, so they also hosted an "inward-facing" fair for providers to share resources among themselves.

## IMPACT

The "express style" Community Resource Fair had **786 total attendees** (up from 669 the previous year), representing **324 households**, including **202 seniors**, **187 children**, and **52 veterans**. Organizers agreed that the initiative was a successful way to increase utilization of services aimed at reducing disparities and improving health.

## REFLECTIONS

As long as the pandemic persists, Upper Peninsula Health Plan and Upper Peninsula Health Care Solutions, Inc plan to keep people safe by using both virtual and drive-through resources. Once the pandemic restrictions are lifted, they intend to return to an in-person format to best address individuals' needs. They are also planning a strategic expansion across the Upper Peninsula in 2022 to coincide with various Feeding America West Michigan mobile pantry distributions.





## EMERGING BEST PRACTICE

# VIRTUAL WELLNESS WORKSHOPS AND INFORMATION

**Health Plan:** Trillium Health Resources

**Location:** North Carolina

### DESCRIPTION

When the COVID-19 pandemic hit, **Trillium Health Resources'** Trillium's Neighborhood Connections Team pivoted to virtual workshops on COVID-19 and other health concerns. The **Virtual Wellness Workshop and Information** initiative provided a series of upbeat online videos that members could watch at home.

Virtual workshops **kept members engaged** and entertained at home when day programs, after-school programs, psychosocial rehabilitation, and employment programs closed because of COVID-19. Topics included general health, fitness, gratitude, self-care, personal safety, the importance of vaccination, and nutrition. **Instructional videos** also offered information on safe holidays at home, making craft items from scratch, growing a garden using vegetable scraps, grocery shopping online, making a budget, and more. Eat the Rainbow, a healthy eating workshop, shared food choices that were accessible to members at all income levels.

The Neighborhood Connections Department also prepared a **guide for families** to stay busy while at home, including virtual tours of landmarks and museums, easy activities to engage kids, and suggestions for making the most of outdoor locations.

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Providing a guide for creative family activities and fun, virtual learning opportunities was a new and different type of support offered by the health plan.

## OBJECTIVES

Workshops were offered by **staff of differing races and sexes** to appeal to Trillium's diverse membership and were presented at **varied levels and lengths** for people with all learning abilities. Workshops included **materials that were affordable to members**.

Objectives of the Wellness Workshops and Information initiative were to:

- Continue to connect with members to support wellness;
- Offer creative ways to stay active and avoid harmful behaviors during stay-at-home orders;
- Support members in maintaining social distancing and reducing anxiety;
- Support parents with children at home with engaging activities; and
- Reducing feelings of isolation.

## IMPACT

Trillium members viewed the workshops 85 times on the health plan's My Learning Campus platform. Posting the videos on social media increased members' access and viewership to **almost 1,700 views**.

## REFLECTIONS

Trillium now offers a hybrid model of virtual and in-person workshops for programs that have re-opened, based on visitation policies. Some providers requested continued access to the workshop material, and Trillium continues to develop remote workshops to evaluate their effectiveness based on data analysis of workshop views.



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